DRN-4299375

The complaint

Miss D complains about the way that Vitality Health Limited handled a claim she made on a personal private medical insurance policy.

Miss D's represented by Mr M.

What happened

The circumstances of this complaint are well-known to both parties, so I haven't set them out in detail here. Instead, I've focused on what I think are the key issues.

In February 2022, Miss D applied for a personal private medical insurance policy with Vitality. Cover began on 5 March 2022 and the policy was underwritten on a Continuing Personal Medical Exclusions (CPME) basis. This included a moratorium clause which was effective from 5 March 2017.

Unfortunately, on the same day the cover began, Miss D was admitted to hospital as an emergency and needed to undergo surgery for the removal of part of her colon. Following the surgery, she had a stoma.

In September 2022, Miss D contacted Vitality to make a claim for surgery to reverse her earlier operation. Initially Miss D didn't provide Vitality with a GP referral letter, which Vitality said it needed to progress the claim. Following the receipt of that information, Vitality decided it required further medical evidence from Miss D's GP about Miss D's medical history, which it received a few days later.

Vitality concluded that the new evidence provided by the GP needed to be assessed by its underwriters. However, it didn't refer Miss D's claim to the relevant team for almost three weeks. Once the new evidence had been reviewed, Vitality identified more questions about Miss D's medical history and so it wrote to her GP again for further information. But when the new report was received, Vitality noted that it didn't include some of the evidence it had asked for. So it required more information before it could decide whether or not to approve Miss D's claim.

The relevant information was received at the end of January 2023 and Vitality approved Miss D's claim on 1 February 2023.

Miss D was very unhappy with the way Vitality had handled her claim and so Mr M complained on her behalf. Miss D was unhappy with the delays and the lack of communication from Vitality throughout the life of the claim. So Mr M asked us to look into Miss D's complaint.

Vitality maintained that it had needed to obtain medical information to verify the claim and therefore, it didn't agree that it was responsible for all of the delays Miss D had experienced. But it did agree that there had been some delays it was responsible for and that there had been communication failings. So it paid Miss D £150 compensation to reflect the impact of its service errors.

Mr M subsequently let us know that although Miss D's reversal surgery had been planned as one operation, the surgeon had now recommended that the surgery take place over two stages. He and Miss D felt that the delays in approving the claim had led to the surgery now needing to be carried out across two procedures.

Our investigator felt it had been reasonable for Vitality to require additional medical evidence to allow it to assess whether the claim was covered. That's because he felt the GP's initial and subsequent evidence had indicated that Miss D's surgery could be linked to a condition which could have been caught by the moratorium. So he didn't agree that Vitality was responsible for all of the delays in assessing the claim. He did think though that there were periods when it could have progressed the claim sooner.

He considered the available medical evidence. He noted that in June 2022, three months after the original surgery, Miss D's surgeon had referred to a small hernia having developed at the site of her stoma. The surgeon had also said that they'd consider a reversal of the original surgery around three months later. However, by March 2023, the surgeon stated that Miss D had developed a large hernia, which was very symptomatic for her. And they'd recommended a staged approach to the reversal surgery at this point.

The investigator considered that the evidence indicated Miss D's hernia had grown significantly larger between the time the claim was made and the time it was approved. He felt it was the growth of the hernia which had made staged surgery necessary. So he felt that the delays in Vitality approving the claim had caused Miss D significant distress and inconvenience and he didn't think £150 compensation was sufficient to reflect this. Instead, he recommended that Vitality should pay Miss D total compensation of £500.

Mr M said he didn't think that £5000 would be enough compensation to reflect the anguish and upset Miss D had been caused by Vitality's handling of her claim.

Vitality didn't agree with the investigator. It felt the surgeon's letter indicated that the reason a staged surgery had been recommended was to reduce the risk of mesh infection. It wrote to Miss D's specialist to ask specifically why two-stage surgery had been recommended.

The surgeon responded to say that the primary reason for recommending staged surgery was to reduce the risk of mesh infection.

I issued a provisional decision on 28 July 2023, which explained the reasons why I thought Vitality should pay Miss D a total of £300 compensation. I said:

'First, I understand that Miss D has now undergone the reversal surgery and unfortunately, suffered complications as a result. I hope she is now beginning to recover well.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they must provide policyholders with reasonable guidance to help them make a claim. So I've considered, amongst other things, the terms of Miss D's insurance contract and the available medical evidence, to decide whether I think Vitality treated her fairly.

It's common ground that Miss D's policy cover began on 5 March 2022 on CPME terms. This meant that she would have the same cover for any existing medical conditions that she'd held with her previous medical insurer. This included a moratorium with a start date of 5 March 2017. As such, before it accepted any claim on the policy, I think Vitality was entitled to be satisfied that the claim wouldn't be caught by the terms of the existing moratorium clause.

In this case, before Vitality could accept the claim, it needed to ensure that Miss D's

condition wasn't linked to any condition which might fall within the scope of the moratorium. The GP's first referral letter referred to Miss D suffering from a diverticular abscess in 2013, which Vitality considered could be linked to the condition she was claiming for. So I think it was reasonable for Vitality to ask for more information about Miss D's medical history. And when the GP responded to Vitality's information request, they indicated that Miss D had previously 'sort of' suffered from episodes of the condition she was now claiming for. Again, they referred to the diverticular abscess of 2013. Accordingly, I can understand why Vitality felt it needed more information to assess whether or not the claim should be covered.

And when the GP sent further information to Vitality, they didn't include information Vitality had asked for. This meant that Vitality wasn't able to make a claims decision. It didn't receive all of the information it had asked for from the GP until 19 January 2023. This was the point at which I think it had enough medical evidence to show that Miss D's claim was covered by the policy terms.

It follows then that I don't think I could fairly find that Vitality was for responsible for the majority of the delays in Miss D's claim being approved. There were some months where Vitality was waiting for medical evidence I think it was reasonably entitled to see before it could confirm whether or not the claim should be authorised.

Nonetheless, I agree with our investigator that there are two specific periods where Vitality was directly responsible for delays in the progression of the claim. The first was between 3 and 22 November 2022, when Vitality failed to pass on medical evidence to its underwriting team. And the second delay was between 19 January and 1 February 2023, while the claim was referred again to the underwriting team, before being approved. These periods amount to total avoidable delays of around 22 working days.

It's clear too that there were communication failings while Vitality assessed the claim. Mr M asked for updates and call-backs which simply weren't forthcoming. I've seen emails between Mr M and Vitality in which he set out the impact the situation was having on Miss D. I think it's reasonable and appropriate then for Vitality to compensate Miss D for the impact the avoidable periods of delay and Vitality's service failings had on her.

So I've gone on to consider what I think fair compensation should be. In doing so, I've looked carefully at the medical evidence provided by Miss D's surgeon. I appreciate that both Mr M and the investigator concluded that it was Vitality's delays which had resulted in Miss D requiring a two-stage operation rather than one. I've thought about this carefully.

I can see from the surgeon's letter of June 2022 that at this point, Miss D had developed a small hernia on the stoma site and that three months later, the surgeon would consider laparoscopic surgery to reverse the original operation. There's no reference here to the surgery being carried out in two stages.

It's clear too that by March 2023, the surgeon noted that Miss D had developed a large hernia. And that they recommended a two-stage operation to reverse the original surgery. I agree then that there was clear, recorded hernia growth between June 2022 and March 2023. I note though that I don't have a copy of any clinic letter dated around September 2022, which was the point Miss D made the claim. It seems to me that given the surgeon had agreed to carry out the reversion surgery, it's likely that another clinic appointment had taken place in and around September 2022. So I can't say what size the hernia was at the time the claim was made.

But I also note that within their letter of March 2023, the surgeon said: 'Although we could do this as a combined procedure, the risk of mesh infection would be too great in my opinion. I have therefore advised a staged approach.'

The surgeon provided further information to Vitality which is dated 30 May 2023. Vitality asked:

'Please can you confirm the primary reason for proposing two stage procedure (sic) for this member please? And is it owing to the risk of mesh infection?'

The surgeon responded: 'Biological mesh lacks the tensile strength for repair. It may be necessary to use prolene mesh. Yes – to reduce the risk of mesh infection.'

I think it's appropriate to place weight on the surgeon's evidence. That's because they are the expert in their field, responsible for Miss D's care. And the evidence they've provided doesn't support a conclusion that Miss D needed two-stage surgery because the size of the hernia had grown, or that it was because of any delay in Vitality authorising the claim.

Instead, the evidence indicates that the two-stage surgery was proposed to mitigate the risk of mesh infection. As such, I don't think I could fairly or reasonably conclude that the delays in the approval of the claim were the reason Miss D required two-stage surgery rather than the one operation which had originally been considered. Therefore, I don't think it would be reasonable for me to award compensation for this particular point.

However, as I've set out above, Mr M had made clear to Vitality the impact the delays in its assessment of the claim had on Miss D's mental health and he told Vitality that Miss D was in pain. As I've said, I think 22 working days of delay can be attributed to Vitality. So if the claim had been referred to underwriting sooner than it was, the claim could likely have been approved around 22 working days earlier. This was additional, unnecessary time where Miss D was upset and in pain. And Vitality accepts that there were clear communication failings.

As such, I don't currently think £150 is fair compensation to reflect the trouble and upset Miss D was caused at a time when she was already distressed and in pain. In my view, a total award of £300 (inclusive of the compensation Vitality has already paid) is a fair and reasonable award to reflect the impact I think its service issues had on Miss D.

Overall then, I currently plan to direct Vitality to pay Miss D a total award of £300 compensation, less the £150 it's already paid.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

Vitality said it accepted my provisional findings. Mr M said he disagreed with many of my comments, but that he and Miss D had nothing to add.

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, as neither party has provided me with any substantive new evidence or comments, I see no reason to change my provisional findings.

So my final decision is the same as my provisional decision and for the same reasons.

My final decision

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

I direct Vitality Health Limited to pay Miss D a total of £300 compensation, less the amount it's already paid her.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss D to accept or reject my decision before 11 September 2023.

Lisa Barham
Ombudsman