DRN-4412369

The complaint

Mrs L 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 haven't set it out in detail here. Instead, I've set out a summary of what I think are the key events.

Mrs L is insured under her employer's group income protection policy. The policy provides cover in the event that Mrs L is unable to work in her own occupation, as a result of illness or injury. The deferred period is 26 weeks.

In February 2022, Mrs L was signed-off of work, suffering from a 'stress reaction'. She remained unfit for work and so, in April 2022, her employer made an incapacity claim on her behalf.

L&G considered Mrs L's claim submission and her 'member statement'. It appointed a vocational clinical specialist (VCS) to contact Mrs L to discuss her health. The VCS concluded that Mrs L was clinically fit to work. Having considered the VCS' findings and Mrs L's claim submissions, L&G didn't think there was enough medical evidence to show that Mrs L was clinically limited or functionally restricted from performing her own occupation. Instead, it considered that Mrs L's absence was down to situational stress caused by a close family member's illness and the need for her to provide care. So it didn't think Mrs L had met the policy definition of incapacity and it turned down her claim in June 2022.

Mrs L provided evidence from her GP in support of her claim, which didn't change L&G's position. In March 2023, Mrs L visited a consultant psychiatrist who diagnosed her with moderate depressive disorder and who concluded that she wasn't fit to work. So she asked L&G to reconsider the claim.

However, L&G maintained that there wasn't enough medical evidence to show that Mrs L had been incapacitated throughout the whole deferred period between February and August 2022. And therefore, Mrs L asked us to look into her complaint.

Our investigator thought it had been fair for L&G to conclude that Mrs L hadn't shown she met the policy definition of incapacity during the February to August 2022 deferred period.

However, he thought that the psychiatrist's letter of 20 March 2023 was persuasive evidence that Mrs L had now met the incapacity definition. And he noted that L&G's Chief Medical Officer (CMO) appeared to be of the same opinion. So he recommended that L&G should assess Mrs L's claim using a new deferred period start date of 20 March 2023. He thought that L&G should then assess whether Mrs L had shown she met the definition of incapacity between 20 March 2023 and the end of a new 26-week deferred period, ending on 18 September 2023. He concluded that if L&G was satisfied that Mrs L had demonstrated incapacity during the full March to September 2023 period, it should begin paying benefit from that date.

L&G accepted the investigator's recommendations and I understand it's written to Mrs L's GP to ask for more medical evidence to allow it to assess whether Mrs L was incapacitated for the full 26 week period after 20 March 2023 and beyond.

Mrs L disagreed with the investigator and I've summarised what she's said. She felt that L&G had failed to accept professional medical evidence which showed she'd been incapacitated from February 2022 onwards. She felt that L&G could and should have organised an independent medical examination to assess her health – and questioned whether it had chosen not to do so because it felt such a report would find in her favour. She didn't think the investigator had relied on her GP's evidence in a logical or balanced way. She felt it should be for L&G to demonstrate that her GP's evidence was incorrect or negligent. And she considered that if L&G had required specialist evidence of incapacity, it ought to have informed her of this at the outset. She was also concerned that L&G's actions had impacted the way her employer handled her absence.

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, whilst I'm very sorry to disappoint Mrs L, I think it's fair for L&G to assess her claim in line with a new deferred period start date of 20 March 2023 and I'll explain why.

First, I'd like to reassure Mrs L that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mrs L needing to make a claim and I don't doubt what a worrying and upsetting time this has been for her.

It seems clear that L&G has now accepted the investigator's recommendation that it should assess Mrs L's claim using a new deferred period start date of 20 March 2023 – the date of the consultant psychiatrist's letter. This letter stated that Mrs L had a diagnosis of depressive disorder of moderate intensity and concluded that Mrs L wasn't fit for work. I understand L&G has written to Mrs L's GP for new medical evidence to allow it to assess whether she met the policy definition of incapacity between 20 March 2023 and the entire following 26 week period up until 18 September 2023. This is the date at which benefit *may* become payable, if L&G is satisfied the evidence indicates that Mrs L met the incapacity definition throughout the whole, new deferred period.

Given L&G's acceptance of this recommendation, I don't think I need to make any further detailed findings on this particular point. For completeness though, I can confirm that I agree with the investigator's findings on this issue and for the same reasons. It seems to me then that the key issue I need to decide is whether it was fair for L&G to conclude that Mrs L hadn't shown she met the definition of incapacity prior to 20 March 2023.

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 policy and the available medical evidence, to decide whether I think L&G handled Mrs L's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mrs L's employer's contract with L&G. Mrs L'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 L's claim met the policy definition of incapacity. This says:

'Incapacity - 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.

The insured member's capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him.'

The policy says that L&G will begin to pay incapacity benefit after the end of the deferred period. This means that in order for benefit to be paid, Mrs L needed to have 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 L's responsibility to provide L&G with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the essential duties of her own occupation for the full 26-week deferred period between 22 February and 17 August 2022 and afterwards.

L&G assessed the evidence Mrs L provided in support of her claim, including seeking the opinion of its clinical staff. While it sympathised with Mrs L's position, it concluded that she wasn't suffering from a functionally impairing illness which prevented her from carrying out her role. Instead, it felt that Mrs L was suffering with a stress reaction to a family member's illness, which didn't amount to a defined medical problem. So I've next looked at the available medical and other evidence to assess whether I think this was a fair conclusion for L&G to draw.

I've first looked at the member statement completed by Mrs L at the time of her claim. She stated that she was absent from work because:

'(Family member) became seriously unwell in December 2021 and a result, I have been under a lot of stress and struggling to cope, my doctor signed me of (sic) unfit to work due to Stress Reaction.'

Mrs L set out how her incapacity had affected her daily life. She stated:

'Looking after (relative) full time, trying to calm (them) at (frequent) times of distress, trying to get (them) into some routine, up and out of bed, washed and dressed and trying to get (them) to eat. Taking (relative) to (their) hospital and medical appointments. Unable to leave (them).'

I note she referred to difficulties she experienced in dealing with daily chores.

Next, I've considered the available medical evidence and what was noted on Mrs L's fit notes during the full deferred period and afterwards. Based on Mrs L's entries on the member statement, I think it was reasonable for L&G to look further into the claim. And I don't think it was unreasonable for L&G to ask the VCS to discuss Mrs L's health and circumstances with her. I've set out below what I think were the VCS' key conclusions:
'The member reports that she is under a lot of stress at home and having to attend to her unwell (relative). Her sleeping hours are erratic and she not sleeping well. She is caring for her (relative) all the time and feels run down from it. She feels unable to leave (them) due to how dependent (they have) become.

The member reports that the medication has helped her chest tightness, but she explained that she does not feel she will be able to return to work until her (relative) is well again.

The member reports that her entire day is spend caring for her (relative)…She explained that she has to supervise (them) constantly due to the severity of (their) condition.

She reports doing the shopping and domestic chores. The member is doing this with her husbands (sic) support as one of them must always be with her (relative).

Future intentions: The member explained that she intends to return to work when her (relative) is well, and she is not required to care for (them) on such a heavy basis.

Fitness to work: Based on the overall evidence available at the time of the assessment, it is my opinion that the member is fit to undertake her role. From a clinical perspective, it is unclear what would preclude her from undertaking her role. The member reports taking absence from work in February 2022 due to a stress reaction, secondary to her family member becoming very unwell. However, the history (provided by the member) shows that she has largely taken up a caring role for her relative. She is providing daily care and support for her relative in response to their current health issues and dependency. The information shows that the member is functioning at a reasonable level to support her relative. The level of due diligence required in caring for someone who is acutely unwell to this degree is suggestive of good cognitive ability. Whilst the member finds comfort and reassurance in being close to and caring for her relative, the information and her current level of daily function suggests that she would be able to meet the cognitive demands of her job role.

Barriers to work The member explained that she needs to be at home to care for her relative who is dependent on her and that she could not manage her job as well as this due to the demands placed on her at home.'

In my view, the VCS clearly concluded that, based on Mrs L's account, her absence was largely due to a stress reaction caused by her caring responsibilities. And they found Mrs L was fit to work in her insured role. I don't think it was unfair or unreasonable for L&G to have relied on the VCS' opinion and Mrs L's testimony to conclude that she hadn't shown she met the policy definition of incapacity.

Following L&G's initial decision to turn down the claim, Mrs L provided a letter from her GP, dated 27 October 2022 – over two months after the deferred period had ended. Again, I've set out the GP's key conclusions:

'I can confirm that (Mrs L) has been suffering from extreme anxiety and low mood secondary to her (relative's) current health issues.

She is significantly incapacitated as a result of this and is in a constant state of anxiety which affects her concentration causing memory lapses, she has disturbed sleep and is constantly fatigued as a result. She is emotional and weepy with low mood and has been having panic attacks. These panic attacks cause her to hyperventilate, have palpitations and chest tightness…She has been certified as unfit for work since 16th February 2022 and she currently remains unfit for work.'

L&G wrote to Mrs L's GP on 28 November 2022 to ask for more information about her health and it chased up this information again in December 2022. But the GP didn't respond. So I think it was reasonable for L&G to rely on the medical evidence it did have. It referred Mrs L's case to its CMO and I've set out what I believe to be their main findings:

‘Stress can mimic symptoms of clinical mental illness. The GP’s clinical management to date and statement linking the member’s symptoms to her relative’s condition indicates their view (as confirmed by the member) that the main issue here is stress, based on my interpretation of their letter.

Her condition is unlikely to resolve with pharmacological agents or psychological therapy, noting this is a stress reaction secondary to her relative’s condition. There is no pending transformative therapeutic intervention or treatment escalation, as this is not clinically indicated.

The member has the functional ability to resume work in her own occupation, in my view, with reasonable adjustments, as appropriate, but the role of being a full time carer to her (relative) is precluding her from resuming work, in my view, alongside situational anxiety relating to her (relative’s) condition. My opinion is this absence does not meet the policy criteria decision.’

Mrs L appealed L&G’s decision again following the visit to the psychiatrist. And at this point, after a further request to the GP and to Mrs L’s employer, copies of Mrs L’s medical records up to June 2023 were provided, along with an occupational health report dated April 2022. I’ve considered this evidence carefully, as much of it spans the original deferred period.

The GP records listing the fit notes issued between February and October 2022 all state that Mrs L was signed-off due to ‘acute reaction to stress’. An GP entry of 16 February 2022 states:

‘*Under a lot of stress with son’s health…Mrs L feeling increasingly anxious and stressed and not sleeping well.’*

And in April 2022, occupational health had found and reported:

‘As you are aware Mrs L is absent from work because of difficult personal circumstances, which are ongoing and which there is no timescale for resolve at the time of writing. She is having support from her family, and they are also providing pastoral support to her as well.

Mrs L is keen to resume work, however this does appear impossible with her current situation.. remains unfit for work due to exacerbation of stress, which is perceived to be due to personal circumstances.’

In November 2022, the GP began to issue fit notes giving a diagnosis of stress at home. Fit notes providing this diagnosis continued to be issued each month afterwards. No formal diagnosis of depressive disorder was made until 20 March 2023.

I’ve thought very carefully about all of the evidence that’s been provided. It’s important I make it clear that I’m not a medical expert. I cannot substitute clinical judgement for my own. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide which I find most persuasive and whether I think L&G considered this claim fairly, based on that evidence.

It’s clear that Mrs L was suffering from symptoms which can also be indicative of both a significant mental health condition and a physical illness. I’ve borne in mind the GP’s letter of October 2022. But, I have to bear in mind the contemporaneous records of Mrs L’s diagnoses by her treating doctors – some of which also post-dated the GP’s letter. In my view, those records do indicate that the treating doctors found she was experiencing a stress reaction to her personal circumstances. This means for the original full deferred period and

for several months afterwards, Mrs L's GP noted that she was suffering from a stress-reaction. The GP notes list the personal stressors Mrs L was experiencing. And I think both the CMO's conclusions and occupational health evidence point to the cause of Mrs L's symptoms being an acute reaction to stress.

As such, taking into account the totality of the medical and other evidence available to L&G, I think it was reasonable for L&G to conclude that the evidence showed that during the deferred period (and up to the date of Mrs L's diagnosis with depressive disorder), Mrs L was suffering from an understandable reaction to the very difficult situation in which she found herself and her home situation. And that the main reason for Mrs L's absence during the deferred period was likely a reaction to the stress she was experiencing as opposed to a mental or physical health condition.

I note that Mrs L is unhappy that L&G didn't organise an independent examination, or expressly tell her what evidence she needed to provide. But, as I've explained, it was for Mrs L to demonstrate that she met the policy definition of incapacity. I don't think L&G was responsible for arranging such an examination in these circumstances. I think L&G clearly explained, in June 2022, why the claim hadn't been accepted. So it was open to Mrs L to have obtained a specialist opinion earlier if she'd wished to do so. Nor do I think I could fairly hold L&G responsible for any decisions Mrs L's employer may have made or which it may go on to make.

On this basis then, I don't think it was unfair for L&G to conclude that Mrs L's absence wasn't due to an incapacity in line with the policy definition. Instead, I think it fairly concluded that Mrs L's absence was more likely due to a reaction to her circumstances.

I appreciate Mrs L was medically signed-off. And I understand she's been through a very difficult time. But I need to decide whether I think she's shown he met the policy definition of incapacity for the whole of the 26-week deferred period dating from February 2022 until August 2022. As I've explained, I don't think she has.

Overall then, despite my natural sympathy with Mrs L's position, I don't find it was unfair or unreasonable for L&G to turn down this claim for the period prior to 20 March 2023.

As I've set out above, L&G has written to Mrs L's GP to ask for more information about her health between June and September 2023. It's now for L&G to consider that evidence, in line with the remaining terms and conditions of the policy. If L&G is satisfied that Mrs L met the incapacity definition between 20 March and 18 September 2023, (and afterwards), then benefit will become payable. I must make it clear that I'm not directing L&G to *pay* Mrs L's claim from 18 September 2023. If Mrs L is unhappy with the outcome of L&G's new assessment of her claim, she'll need to make a new complaint to L&G about that issue alone before we can potentially help with it.

My final decision

For the reasons I've given above, my final decision is that it was fair for L&G to consider that Mrs L didn't meet the definition of incapacity during the original deferred period.

However, I direct Legal and General Assurance Society Limited to assess Mrs L's claim using a new deferred period start date of 20 March 2023. It must consider whether she met the definition of incapacity for the full 26-week period after 20 March 2023 and afterwards, in line with the terms and conditions of the policy.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs L to accept or reject my decision before 4 December 2023.

Lisa Barham
Ombudsman