DRN-4524953

The complaint

Mrs M is unhappy that The Original Holloway Friendly Society Limited ('OHFS') stopped paying the monthly benefit following a successful claim on her income protection insurance policy.

What happened

Mrs M has the benefit of an income protection insurance policy ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Mrs M is unable to work due to illness after the deferred period.

A successful claim was made on the policy in respect of Mrs M's inability to work because of illness in 2022, and OHFS paid the monthly benefit until it stopped doing so in mid-2023. That's because OHFS concluded that the medical evidence no longer supported that she met the policy definition of incapacity. This was, in part, based on the results of an independent chronic pain abilities determination ('CPAD') carried out in March 2023.

Mrs M appealed that decision. OHFS issued its final response letter maintaining its decision to stop paying the monthly benefit. Unhappy, Mrs M complained to the Financial Ombudsman Service. Our investigator looked into what happened and upheld her complaint. He recommended that OHFS:

- reinstate Mrs M's monthly benefit, backdating any payments that would have been paid if it had remained in place and adding 8% simple interest to each amount (from the date each benefit should've been paid until the date of settlement).
- pay £500 compensation to Mrs M for the impact of unfairly terminating her claim.
- reimburse Mrs M for the monthly premiums she's paid for the policy since the claim was unfairly terminated together with 8% simple interest from the date on which each premium was paid since the claim was terminated to the date on which they're refunded.

OHFS didn't agree. So, this complaint has been passed to me to consider everything afresh 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.

The insurance industry regulator, the Financial Conduct Authority ('FCA'), sets out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says insurers should act honestly, fairly and professionally in accordance with the best interests of its customers. It also says insurers should handle insurance claims promptly and fairly - and shouldn't unreasonably reject a claim.

The policy says:

> Definition of incapacity; In respect of a member who is regularly engaged in a remunerative occupation or occupations immediately prior to the commencement of the injury, illness or disease giving rise to the claim, incapacity shall mean the total inability of the member to perform all of the essential duties of his own occupation and is not following any other occupation.

When making a claim, it's for Mrs M to establish that she met this definition of incapacity. She was able to do that, and the monthly benefit was paid by OHFS. As OHFS terminated the claim - it's for it to show (on the balance of probabilities) that Mrs M no longer met the definition of incapacity, based on medical evidence. It's not for her to show that she continued to do so.

Requesting the CPAD

In principle, I don't think it was unreasonable for OHFS to ask Mrs M to take part in the CPAD carried out by an independent registered occupational health therapist. I'm satisfied that OHFS is entitled to keep the claim under review.

When discussing whether the CPAD should take place, Mrs M's consultant respiratory physician provided a letter which reflects:

> Her main symptoms are of severe fatigue, exercise intolerance, cognitive impairment, and orthostatic intolerance (difficulty coping with an upright position). She suffers with post-exertional symptom exacerbation (PESE) which can be triggered by both physical and cognitive exertion. Through drug treatment, resting and pacing Mrs M has reached a period of stability where she is able to manage her symptoms day-to-day, through severely restricting activities.
>
> Any form of prolonged activity can carry a risk of permanent harm/disability. For this reason, the World Physio organisation, World Health Organisation, NICE and Society of Occupational Medicine advise against undue exercise/exertion when PESE is present.
>
> To undertake a 3…hour cognitive and physical test in someone with Mrs M's condition, would…be unethical and potentially very harmful.
> Additionally, Mrs M cannot travel easily, the stress of this alone may be enough to set her back into a relapse of her condition.

I've also seen a letter from Mrs M's GP dated December 2022 reflecting that Mrs M was living with "significant post exertional symptom exacerbations" and asking for the CPAD to be undertaken closer to her home. They also say that Mrs M "would benefit from being able to space out the testing over a number of days, with sufficient time to recover and prevent her crashing. It can take weeks to months for her to recover if she does not pace adequately her activities".

To mitigate the impact on Mrs M – and to take into account the comments made by the GP - the CPAD was arranged over two days with a day off in between. And OHFS' Chief Medical Officer (CMO) reviewed the NICE guidelines provided in support of Ms M's position and concluded that Mrs M hadn't been diagnosed with those conditions. I think that was a reasonable conclusion to make.

Did OHFS act fairly and reasonably when terminating Mrs M's claim?

I'm not a medical expert. So, I've relied on all the evidence available to me when considering whether OHFS reasonably terminated Mrs M's claim, when it did. Where there is conflicting medical evidence, I've considered what's more persuasive in the circumstances of this case.

This is a finely balanced case, so I've kept in mind that it's for OHFS to establish that Mrs M no longer meets the definition of incapacity. And overall, I don't think OHFS fairly and reasonably terminated Mrs M's claim. I'll explain why.

- The CPAD report – carried out by a registered occupational health therapist – reflects that Mrs M reported the barrier preventing her returning to work as her inability to undertake the physical demands of her role due to pain, tiredness, limited mobility, and reduced concentration.
- The CPAD report states that "due to most of the tests not being undertaken due to safety concerning her fatigue and concentration levels, the majority of physical tests and all of the cognitive tests were not performed on day 1, and the physical tests were stopped early on day 2".
- However, the tests undertaken on day 2 did, in the occupational health therapist's view, illustrate "significant symptom exaggeration". It's reflected that "these scores are lower than patients suffering from severe traumatic brain injuries, stroke, and dementia. Individuals within this score range would typically require significant support to perform everyday self-care and routine functions and cognitive function challenges are often clearly evident within general communication and interaction with such individuals. This is not, however, the case with Mrs M".
- Further, after the CPAD report was issued, OHFS contacted the registered occupational health therapist and raised further queries. I've taken these into account including their observation that Mrs M was able to walk around at the same pace as her husband and was on her phone.
- However, I think it's important to note that the CPAD report also reflects the registered occupational health therapist was unable to provide a full validity classification of the CPAD tests or comment on Mrs M's ability to return to her normal role. And "whilst it is noted that there were numerous inconsistencies during testing, it should also be stated that Mrs M appeared visibly fatigued (pale) at the end of testing on both days of CPAD". This was after sessions lasting 2 and 2.5 hours respectively. It was recommended that Mrs M be referred for a fatigue management program to determine whether such a programme would be of benefit to her.
- From looking at OHFS's assessment of the claim at the time, I don't think reasonable weight was placed on this particular observation made by the registered occupational health therapist and how her fatigue impacted her ability to carry out all the essential duties of the role she was doing before her incapacity.
- The objective tests carried out by Mrs M, which the CPAD report reflects demonstrated significant symptom exaggeration, included pinch testing and cognitive ability. Whilst important and relevant objective evidence, the role Mrs M was doing immediately before incapacity involved more than these capabilities. The tests in respect of other relevant capabilities including balance, reaching, lifting and stooping weren't undertaken.
- So, whilst I can understand why OHFS has – in part – relied on the results of the objective tests to conclude that Mrs M no longer met the definition of incapacity and terminating the claim, I don't think the results are wholly determinative in considering whether Mrs M remain incapacitated in the circumstances of this particular case.
- I also think Mrs M's consultant respiratory physician's letter dated 17 July 2023 ('the

consultant's letter') is relevant. The consultant's letter reflects that Mrs M "has debilitating fatigue and cognitive impairment affecting her concentration, processing and reasoning. She has a diagnosis of Postural Orthostatic Tachycardia Syndrome (POTS) which means she is intolerant of exercise and unable to remain upright for any length of time. She also has post-exertional symptom exacerbation (PESE), a well-described phenomenon in Long COVID where any or all of these symptoms become worse after exertion, causing deterioration (which can be permanent) with over-exertion. This is due to an issue with oxygen uptake and transfer from blood vessels into muscles and also impaired ability of cells to produced energy".

- It's also reflected that Mrs M "is currently graded as between 40-50% recovered on the CFS Functional Ability Scale (Note this is 40-50% of functioning at a basic level, not of pre-morbid fitness)". This is classed as 'moderate to severely affected'. The consultant then sets out how this would affect her functionality.
- The consultant's letter goes on to say: "I clinically assessed (Mrs M) last week. She is awaiting a NHS respiratory consultation following the finding of moderate airflow obstruction on spirometry tests. She still has evidence of significant POTS despite drug therapy. I have increased her medication…Her blood tests over the last 3 years have shown evidence of an underlying clotting disorder and microvascular/endothelial (blood vessel) disease". And concludes that Mrs M "is incapable of returning to work, even for 16 hours a week, given her level of disability".
- Mrs M had been under her medical care for around nine months by this time. And whilst there is a professional connection between them, I'm satisfied that the consultant is an expert in her field. I've no reason to doubt her professional integrity or that she would inaccurately report Mrs M's medical examinations.
- So, looking at all the medical evidence – some of which is conflicting – against the essential duties of the insured occupation, I'm not persuaded, on the balance of probabilities, that OHFS has fairly and reasonably established that Mrs M no longer met the policy definition of incapacity.

Monthly premiums paid for the policy

The policy says:

> premiums must be paid regularly whilst the member is on the funds or Sickness Benefit shall cease Provided that should the member be in receipt of 52 weeks continuous benefit payment then from the 53rd week of continuous benefit payment the payment of premiums by the member to [OHFS] shall be waived and will recommence upon the member's recovery and the payment of sickness benefit ceasing.

Although Mrs M hadn't been in receipt of the monthly benefit for 52 weeks continuously, she says that OHFS had agreed to waive the monthly premiums whilst she was receiving the monthly benefit.

Our investigator put this to OHFS in an email dated 7 December 2023 and, when responding, OHFS didn't dispute Mrs M's submission on this point. So, I'm prepared to accept what Mrs M says about the premiums.
I think it would be fair and reasonable for OHFS to reimburse the monthly premiums Mrs M has been paying for the policy again since the claim was terminated together with simple interest at 8% per year.

Distress and inconvenience

I'm persuaded that ending the monthly benefit has had more than just a financial impact on Mrs M. I'm satisfied that she's been put to the inconvenience of contesting the decision to terminate the claim, at an already difficult time for her.

I'm also satisfied that being unfairly deprived of the monthly benefit under the policy because it was unfairly terminated by OHFS would've caused her unnecessary and significant worry and upset.

I'm satisfied that OHFS should pay her £500 compensation for distress and inconvenience to reflect this.

Putting things right

I direct OHFS to:

- reinstate Mrs M's monthly benefit, backdating any payments that would have been paid if the claim hadn't been terminated in mid-2023.
- add simple interest at a rate of 8% per year to each monthly benefit that ought to have been paid since mid-2023, from the date each benefit should've been paid until the date they're actually paid.
- pay £500 compensation to Mrs M for the distress and inconvenience she experienced because OHFS unfairly terminated her claim.
- reimburse Mrs M for the monthly premiums she's paid for the policy since the claim was unfairly terminated together with simple interest of 8% per year from the date on which each premium was paid by her since the claim was terminated to the date on which they're refunded.

My final decision

I uphold Mrs M's complaint and direct The Original Holloway Friendly Society Limited to put things right as set out above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs M to accept or reject my decision before 15 February 2024.

David Curtis-Johnson
Ombudsman