DRN-4534493

The complaint

Mr W complains that Legal and General Assurance Society Limited (L&G) has terminated benefit for an incapacity claim he made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr W is insured under his employer's group income protection insurance policy. The policy provided cover if Mr W became incapacitated from carrying out a 'suited occupation'.

In October 2019, Mr W was signed-off work suffering from depression. His employer made an incapacity claim on the policy, which L&G accepted and monthly benefit was paid. L&G kept the claim under regular review and in February 2021, it appointed an Independent Medical Examiner (IME) to assess Mr W. The IME is a consultant psychiatrist, who I'll call Mr F. Mr F concluded that Mr W could be suffering from Attention Deficit Hyperactivity Disorder (ADHD), rather than depressive disorder. The claim remained in payment and remained under periodic review by L&G.

Subsequently, in April and June 2022, Mr W spoke with one of L&G's vocational clinical specialists (VCS) about his ongoing symptoms and activities. Based on those discussions, L&G concluded that Mr W no longer met the policy definition of incapacity and that he was fit to return to work on a phased basis. So in July 2022, L&G let Mr W know that it would be terminating payment of his claim in August 2022.

Mr W was very unhappy with L&G's decision and he appealed. He didn't agree with the VCS' conclusion. In September 2022, he was assessed by a further consultant psychiatrist, who I'll call Mr D, who diagnosed Mr W with ADHD. He'd also undergone talking therapies, which his GP said hadn't been successful. He asked us to look into his complaint.

While Mr W's complaint was with our service, L&G considered his appeal. It wrote to Mr W's GP for further information. Having considered that information, L&G appointed Mr F to further assess Mr W's fitness for work. Mr F examined Mr W in March 2023 and ultimately concluded that Mr W was now fit for a phased return to work. On that basis, L&G maintained it had been reasonable for it to terminate payment of Mr W's claim in August 2022.

Our investigator didn't think L&G had treated Mr W fairly. He didn't think L&G had shown Mr W no longer met the policy definition of incapacity when it decided to terminate the claim in July 2022. And he also felt Mr F's report of March 2023 had been biased in favour of L&G. So he didn't think it had been fair for L&G to rely on it. He recommended that L&G should reinstate and pay Mr W's claim, effective from the original termination date, together with interest. He also recommended that L&G should pay Mr W £500 compensation for the distress and inconvenience its handling of the claim had caused him.

L&G disagreed with the investigator's findings. Mr W felt he should be paid around £5000 compensation; he felt that the claim should be paid for the remainder of the policy term. He

had concerns about the way L&G had handled his complaint and he was concerned about the potential tax implications of the award the investigator had recommended.

I issued a provisional decision on 24 November 2023, which explained the reasons why I didn't think it had been unreasonable for L&G to terminate benefit from the point it received Mr F's March 2023 report. I said:

'First, I'd like to reassure both parties that while I've summarised the background to this complaint and the parties' detailed submissions, I've carefully considered all that's been said and sent to us. It's clear Mr W has been through a very difficult and distressing situation and I was very sorry to read about the impact he's said L&G's handling of the claim has had on him. Within this decision though, I haven't commented on each point that's been made and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

It's also important that I make the parameters of this decision clear. I will only be considering the evidence which was available to L&G up until the point it issued its final response to Mr W's complaint on 4 April 2023, endorsing its decision to terminate benefit in August 2022. I appreciate Mr W has said his condition has significantly deteriorated since that time. If Mr W has new, objective medical evidence which shows that his condition has deteriorated since 4 April 2023, he'll need to send this evidence to L&G for its review. That's because it wouldn't be appropriate for me to make any finding on evidence or comments which L&G hasn't had an opportunity to consider or assess. If Mr W is unhappy with any new, further assessment of his claim, he may be able to bring a new complaint to us about that issue alone.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. So I've carefully considered, amongst other things, the policy terms and conditions and the available evidence, to decide whether I think L&G has handled Mr W's claim fairly.

It's a general principle of insurance that it's for a policyholder to provide enough evidence to show that they have a valid claim on their policy. This means that at the outset, it was Mr W's responsibility to provide L&G with enough medical and other evidence to demonstrate that he met the policy definition of incapacity. It's common ground that L&G was satisfied that Mr W was incapacitated in line with the policy terms and it accepted his claim in 2020. Once an insurer accepts an income protection insurance claim, the burden of proof switches. I generally take the view that in order for it to show it terminated Mr W's claim fairly and reasonably, L&G needs to provide enough evidence to show that he no longer meets the definition of incapacity. With that said, I don't think it's unreasonable for an insured person to also provide evidence in support of their claim if he or she so wishes.

I've first considered the policy terms and conditions, as these form the basis of Mr W's employer's contract with L&G. L&G concluded that Mr W no longer met the policy definition of incapacity and so I've looked closely at the relevant definition of incapacity – suited occupation. The policy says that 'suited occupation':

'Means the insured member is incapacitated by an illness or injury so that he is unable to undertake all occupations which we consider appropriate to his experience, training or education.'

As I've explained above, it's clear that in 2020, L&G accepted that Mr W met the policy definition of incapacity. However, that doesn't mean it's required to pay the claim indefinitely, or that it's unable to ask for more evidence to support the ongoing payment of benefit. The policy terms explicitly allow L&G to ask for supporting evidence to show that an insured member remains entitled to benefit. And generally, I don't think it's unfair or unreasonable for an insurer to periodically review an income protection insurance claim to determine whether an insured member remains incapacitated in line with the policy terms.

I've gone on to consider then whether I think L&G has provided enough evidence to show that Mr W no longer met the policy definition of incapacity – both when it initially terminated the claim and when it considered Mr W's appeal.

Was it fair for L&G to terminate Mr W's claim in August 2022?

It seems to me that L&G's decision to terminate benefit in August 2022 was largely based on Mr W's discussions with its VCS about his fitness to potentially return to work. While I appreciate that the VCS is a rehabilitation specialist, I don't think the nature of Mr W's discussions with them was sufficiently indicative to show that he was fit to return to work on a phased basis.

I say that because at that point, Mr W was still waiting for the ADHD assessment Mr F had recommended he undergo over a year earlier. It seems L&G had previously continued to pay Mr W benefit on the basis of Mr F's suggestion that Mr W could have ADHD and the potential impact of such an undiagnosed condition on his ability to work. In July 2022, Mr W hadn't been formally diagnosed with ADHD. And I don't think the nature of his discussions with the VCS were definitive enough evidence to indicate that he no longer met the policy definition of incapacity. It seems too that he was still waiting for talking therapies to help manage his symptoms. These therapies began in August 2022.

As part of Mr W's appeal, his long-standing GP, Dr A, wrote letters to L&G. One of those letters was dated 17 October 2022 and included the following:

'(Mr W) has been diagnosed with severe depression and anxiety, and more recently, ADHD…he has tried multiple medications and various talking therapies. He is currently taking (a medication) but unfortunately, it has yet to be effective.'

Dr A set out a list of Mr W's reported symptoms and referred to limited functional ability in terms of self-care, carrying out daily tasks and time-keeping, amongst other things. They explained that the talking therapies hadn't resulted in an improvement in Mr W's condition. And Dr A didn't feel Mr W was fit for work until a successful treatment regime had been devised.

Based on what I've seen so far, I don't currently think L&G had enough medical evidence to show, on balance, that Mr W no longer met the policy definition of incapacity at the point it terminated benefit in August 2022. And so I don't currently find it was fair for it to have stopped paying Mr W benefit at this point.

Was it fair for L&G to rely on Mr F's report of March 2023?

As I've set out above, L&G isn't obliged to pay a claim indefinitely. So even though I don't think it was fair for L&G to have terminated benefit in August 2022, I don't think it was unreasonable for L&G to have appointed the IME – Mr F – to review the available medical evidence and to assess Mr W. I don't agree with our investigator that as part of its review, L&G wasn't entitled to have engaged an IME to assess whether Mr W still met the definition of incapacity.

I've carefully considered the contents of Mr F's report dated 31 March 2023. Given the sensitivity of his findings, Mr F suggested that instead of the report being shared directly with Mr W by L&G, it should be shared with his GP for onward discussion. I understand L&G did send Dr A a copy of the report, although it isn't clear whether or not Mr W has now had sight of it. But given Mr W's specific observations about Mr F and his findings, it seems most likely to me that he now has had an opportunity to consider it. If this isn't the case, Mr W should let me know in response to this provisional decision. In the circumstances though, rather than

quoting directly from the report, I think it's more appropriate for me to briefly summarise Mr F's main conclusions and the conclusions I found most compelling:

- *He felt Mr W's treatment plan indicated mild-moderate mental health conditions which wouldn't usually be associated with a prolonged absence from work;*

- *Mr W's diagnosis of depressive disorder had been made by a mental health practitioner, rather than a doctor, and that a subsequent report had been completed by an inexperienced practitioner. This report had formed the basis of Dr A's evidence to L&G;*

- *He didn't think Mr W's self-reported symptoms were consistent with his treatment and nor did he think the treatment Mr W was undergoing precluded a supported return to work;*

- *Mr W's diagnosis with ADHD wouldn't generally be a barrier to being in work. Mr F suggested adjustments Mr W's employer could make to support him;*

- *Mr W didn't have symptoms of a mental illness causing specific functional impairment or limitation and there was no medical reason preventing a graded return to work.*

In my view, it wasn't unreasonable for L&G to rely on Mr F's expert opinion and to find his opinions more persuasive than the evidence provided by Mr W's GP and the mental health practitioners. It isn't my role to make a clinical decision about Mr W's fitness to work, nor to substitute expert clinical opinion with my own. Instead, I need to weigh-up the available evidence and relevant medical expertise, to decide what evidence I find most persuasive.

Our investigator felt Mr F's report was biased and dismissive. I'm afraid I don't agree. Mr F is a specialist in his field and a consultant psychiatrist. It seems he carried out a detailed assessment with Mr W and he clearly explained his conclusions. I've seen nothing to suggest he was biased in any way.

I appreciate it seems many of Mr W's answers to Mr F in March 2023 were broadly similar to the responses he gave during the assessment of February 2021. However, in 2021, Mr F broadly speculated whether the cause of Mr W's symptoms was undiagnosed ADHD, and whether it was ADHD which was affecting his ability to work. By March 2023, an ADHD diagnosis had been made. In my view, this doesn't indicate Mr F reported in a biased or dismissive way – simply that he focused instead on whether he felt Mr W remained incapacitated, given his diagnosis and potential treatments.

Mr W feels strongly that L&G should have sought the opinion of his treating psychiatrists. I'm mindful that in October 2022, Dr A was liaising with another psychiatrist about Mr W's condition and that Mr W had also been seen by Mr D who'd diagnosed him with ADHD.

However, I haven't seen any persuasive evidence from either of the other specialists which would negate Mr F's findings on Mr W's fitness to return to work. I understand why Mr W would have preferred L&G to write to Mr D, who he says is his treating psychiatrist. But based on the available evidence, I don't think it was unreasonable for L&G to appoint Mr F to objectively assess whether Mr W remained incapacitated in line with the policy terms and conditions.

I sympathise with Mr W's position and I appreciate how disappointing this decision is likely to be to him. But based on all I've seen so far; I don't think L&G unfairly relied on Mr F's report to turn down his appeal. And I currently think that L&G has provided enough expert evidence to show that at the point it received Mr F's report, Mr W no longer met the policy definition of

incapacity. That means I think L&G would've been reasonably entitled to cease benefit at that point, given Mr W didn't engage with a phased return to work.

Should L&G pay Mr W compensation?

It's clear how distressing Mr W has found this situation. He's told us about the impact the claims decision has had on him and I understand he feels that the stress has led to the development of other worrying medical conditions.

I explained above why I didn't think it had been fair for L&G to terminate the claim in August 2022. So I think that L&G ought to pay Mr W compensation to reflect the distress and inconvenience he was caused during the period between August 2022 – and March 2023. That's because I think, during this time, the claim ought to have remained in payment. I don't doubt how unnecessarily upsetting it was for Mr W when his claim was initially wrongly terminated and the natural worry it caused him. In my view, £300 is a fair and reasonable award to reflect the upset and frustration Mr W was caused during this period. That's because I haven't seen any medical evidence which indicates that L&G's handling of the claim is the cause of Mr W's new medical conditions.

Mr W feels that a far higher award of compensation is warranted. But I currently think £300 is a fair, reasonable and proportionate compensation award. I understand he has concerns about the way L&G responded to his complaint – but as the investigator explained, we have no power to tell a financial business how to operate or how to deploy its staff. I've seen nothing to suggest that L&G unfairly or unreasonably failed to engage with Mr W during the complaint, or with this service while this complaint has been with us.

Summary

In summary, I don't think it was fair for L&G to have terminated benefit in August 2022. So I'm intending to direct L&G to reinstate and pay Mr W's claim, from the date it was terminated until the date it received Mr F's March 2023 report. It must add interest to each benefit payment at an annual rate of 8% simple, from the date each benefit payment was due until the date of settlement.

I'm currently intending to find that after L&G received Mr F's March 2023 report, it would have been reasonably entitled to conclude that Mr W no longer met the policy definition of incapacity. So I don't plan to tell it to pay any further benefit after that date.

And I'm intending to direct L&G to pay Mr W £300 compensation to reflect the distress and inconvenience its handling of the claim between the termination of the claim and the receipt of the report in March 2023 caused him.

I appreciate Mr W has concerns that backdated payment of benefit might produce an additional tax liability. This isn't a point L&G has had a chance to consider and it isn't clear that at this time, any tax liability has crystallised or indeed, will crystallise. I'm also mindful that the redress I propose to award differs from our investigator's recommendation. If Mr W later incurs an additional tax liability as a result of the delayed payment of benefit, he may be able to make a new complaint to L&G about that specific issue.'

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

L&G agreed with my provisional findings. It said that payment would be made to Mr W's employer directly, so it couldn't control tax implications. But it said it could ask Mr W's employer to provide Mr W with the necessary forms to get a tax rebate if tax was overpaid.

Mr W didn't agree with my provisional decision and he told us that he hadn't seen Mr F's March 2023 report, which we provided to him in line with the rules of natural justice. He's sent in detailed further evidence and submissions in response to my provisional findings. I can confirm that I've carefully read and considered all that he's provided to me, but in line with the informal nature of our service; I've summarised what I think are his main points:

- L&G should not have engaged an IME and it had done so too quickly;
- It wasn't fair or reasonable for L&G to terminate benefit based on a medical report which it either knew to be inaccurate at the time, or ought reasonably to have known to be inaccurate based on the evidence;
- Mr F had made demonstrable factual errors in his report, which L&G was aware of. For example, Mr F had referred to Mr W being diagnosed with depression by a mental health practitioner, but Mr W's medical notes showed he'd been diagnosed with depression by a doctor in 2019;
- Mr F had suggested that if Mr W's reported functional issues were as the result of a mental health condition, the involvement of secondary care would be necessary. But L&G were aware that Mr W was already under the care of Dr D;
- He felt L&G had provided Mr F with incomplete evidence from Dr D and questioned whether this was a coincidence;
- Dr D had found there was evidence of Mr W's objective low mood, despite Mr F's finding to the contrary. Dr D had instructed Mr W's GP to continue to treat him for depression. And Mr W had had a reasonable belief that L&G would write to Dr D for more information, given it had asked for Dr D's details;
- Mr W felt it was problematic for Mr F to take into account the VCS' findings. I had noted in my provisional decision that it had been unfair for L&G to terminate the claim based on the VCS' conclusions, so it was inconsistent for me to say that it was acceptable for Mr F to have considered them;
- L&G had tried to unreasonably influence Mr F and had denied both Mr W and his GP from challenging Mr F's findings;
- The IME's report should be correct and it isn't, given the evidence which was already available to L&G at the time of Mr F's appeal. Therefore, Mr W felt there was an open question as to what decision L&G would have made had Mr F's report been accurate;
- It can't follow that L&G is entitled to rely on Mr F's report, given the factual inaccuracies contained in it. If I allow it to do so, I am making a clinical judgement, which I'm not authorised to make. Therefore, the status quo should have prevailed and the claim should have remained in payment;
- L&G has employed and acted on false information. These are serious mistakes and therefore Mr W felt that I must conclude that it was never justified to terminate benefit. Otherwise, he considered that I would be allowing a financial business to knowingly rely on false evidence to financially profit at the expense of its customers. Profiting in such a way isn't legal;
- The evidence indicated that Mr W's self-reporting about his treatment and symptoms was more reliable than Mr F's, who'd reported in general terms about the effectiveness of Mr W's treatment and his ability to work;

- The compensation I'd awarded was insulting and he didn't think it was consistent with our service's published guidelines. He considered he'd been substantially impacted by L&G's original termination of benefit;

- L&G had approached Mr W following the provisional decision as if it had been a final decision. He felt this was a scare tactic;

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 Mr W, my final decision is the same as my provisional decision and I'll explain why.

As I explained in my provisional decision, whilst I've carefully considered all Mr W has said and sent us, I've focused on addressing what I consider to be the key issues. This is in line with our role as a quick and informal service, which is an alternative to the courts. And while relevant law is one consideration I take into account, I make decisions based on what I consider to be fair and reasonable in all of the circumstances.

I'd also reiterate that as I am not a medical professional, it would be entirely inappropriate for me to make clinical findings or to make a finding on how L&G's position might change if Mr F's report was ultimately found to contain errors. As I've stated above, I've considered the evidence which was available to L&G at the time it issued its final response to Mr W's complaint.

It's clear Mr W feels strongly that Mr F's report contained factual inaccuracies which undermine his conclusions. It's also clear that he has concerns that L&G failed to share relevant medical evidence with Mr F ahead of his assessment with Mr W. I asked L&G for its comments on Mr W's concerns. L&G referred to the fact that Mr W made a request for Mr F's report in April 2023, which was shared with Mr W's GP. However, neither Mr W nor the GP appeared to have found there to have been such significant factual errors in the report so as to challenge them until after I issued my provisional decision. It also said that the evidence it provided to Mr F had been supplied by Mr W's own GP practice. This meant that if any information was missing, it was because it had not been included in the information the practice sent to it.

Having considered the medical evidence which is available on file, I can see that the information provided to Mr F tallies up with what Mr W and his GP appear to have sent L&G. I've seen no persuasive evidence that L&G deliberately withheld medical evidence from Mr F in order to influence Mr F's clinical conclusions. Nor am I persuaded, on the evidence before me, that L&G provided Mr F with information it either knew to be false, or ought reasonably to have known to be false.

However, given Mr W's concerns and in particular, his reference to missing medical evidence, L&G has suggested that it can write to Mr W's GP to request any missing medical information. It said it can then send this information on to Mr F for his comments. In my view, this is a fair, reasonable and appropriate response from L&G, which fairly deals with Mr W's concerns about the accuracy of the available medical evidence. It's open to Mr W to give his consent to L&G for it to take such a course of action. If Mr W is unhappy with the outcome of L&G's review of any further medical evidence he or his GP are able to provide, he may be able to make a new complaint about that issue alone.

Mr W has referred to L&G's failure to contact Dr D to obtain more information about his

condition and fitness to work. I acknowledge that Dr D did say that Mr W's mood was objectively low. And I appreciate he has a diagnosis of depression. However, as I explained above, I think it was reasonable for L&G to appoint Mr F to assess Mr W's condition. I don't think this is evidence that it acted unfairly or sought to ensure it could terminate benefit. And I've still seen no medical evidence from Dr D or another treating consultant psychiatrist to suggest that Mr W remained incapacitated by his symptoms in line with the terms and conditions of the policy.

I explained in my provisional decision why I thought it had been fair and reasonable for L&G to rely on Mr F's report and I set out the key conclusions I found to be compelling. Given the evidence available to L&G when it issued its final response to Mr W's complaint, I still don't think it acted unfairly when it concluded that the report showed Mr W no longer met the policy definition of incapacity. It remains the case that I haven't seen any medical evidence from a relevant specialist with expertise in psychiatry which shows, on balance, that Mr W remained incapacitated in line with the contract terms, or which contradict Mr F's opinion.

On that basis, while I know how upsetting my decision will be for Mr W and I sympathise with his position, I still don't find it was unfair for L&G to have relied on Mr F's report to turn down Mr W's claims appeal. This means I still think it was entitled to terminate benefit with effect from the date it received Mr F's report.

It's clear Mr W also feels that the compensation I proposed in my provisional decision was insulting. I've borne in mind our published information about compensatory awards when deciding what I think is fair and reasonable to reflect the impact on Mr W of L&G's termination of benefit between August 2022 and March 2023. But I'm still satisfied that an award of £300 is fair and reasonable based on these circumstances. Our awards aren't designed to punish or fine the businesses we cover and we take into account the individual circumstances of each case when considering what we think fair compensation should be. I've also awarded interest on the settlement for the period between August 2022 and March 2023 which compensates Mr W for the period he was deprived of access to this money. I don't think, based on all I've seen, that it would be appropriate for me to award additional compensation here.

Mr W has referred too to L&G's approach to him following my provisional decision. I can understand why Mr W feels this was inappropriate, given I hadn't made a final decision at that point. But it seems to me that this was more likely to have been a mistake on L&G's part, rather than an attempt to scare Mr W into accepting my findings.

Overall, in summary, I still don't think it was fair for L&G to have terminated benefit in August 2022. So I direct L&G to reinstate and pay Mr W's claim, from the date it was terminated until the date it received Mr F's March 2023 report. It must add interest to each benefit payment at an annual rate of 8% simple, from the date each benefit payment was due until the date of settlement.

I find that after L&G received Mr F's March 2023 report, it would have been reasonably entitled to conclude that Mr W no longer met the policy definition of incapacity. So I'm not telling it to pay any further benefit after that date.

And I direct L&G to pay Mr W £300 compensation to reflect the material distress and inconvenience I think its handling of the claim between the termination of the claim and the receipt of the report in March 2023 caused him.

My final decision

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

uphold this complaint in part.

I direct Legal and General Assurance Society to:

- Reinstate and pay Mr W's claim from the date it was terminated in August 2022 until the date it received Mr F's report in March 2023;

- Add interest to each benefit payment at an annual rate of 8% simple, from the date each payment was due until the date of settlement*; and

- Pay Mr W £300 compensation.

*If considers L&G that it's required by HM Revenue & Customs to deduct income tax from that interest, it should tell Mr W how much it's taken off. It should also give Mr W a tax deduction certificate 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 W to accept or reject my decision before 12 March 2024.

Lisa Barham
Ombudsman