DRN-4652764

The complaint

Mr B and Mrs B complain that The Prudential Assurance Company Limited deferred a claim under their serious illness cover. They also complain about the level of payout subsequently made and about poor customer service.

What happened

The background to this complaint is well known to the parties, so I won't repeat it in detail here. In summary, Mr and Mrs B applied for life and serious illness cover in January 2015. Most unfortunately, in December 2022, Mr B was diagnosed with Parkinson's Disease. In January 2023, he claimed on the policy.

Initially, Prudential deferred the claim for six months, saying the policy definition hadn't been met. Mr and Mrs B brought a complaint to the Financial Ombudsman Service. However, following the deferral period, Prudential sought further medical evidence, resulting in it accepting the claim and making a payment of £6468 at severity level D under the policy. It also offered Mr and Mrs B a total of £800 compensation for distress and inconvenience, having accepted there'd been avoidable delay during the claim and poor communication.

Our investigator confirmed with Prudential that the scope of the complaint would now include the entirety of the claim. However, she thought Prudential had acted fairly in terms of the claim deferral and ultimate payment level. She also thought £800 fairly reflected the level of distress and inconvenience caused to Mr and Mrs B. As Mr and Mrs B disagreed their complaint has come to me to issue a final decision.

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.

I'm aware I've summarised the background to this complaint. No discourtesy is intended by this. Instead, I've focused on what I find are the key points. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts. I recognise Mr and Mrs B will be disappointed by my decision and I'm sorry about that. But for the following reasons I'm not going to ask Prudential to do anything more in respect of this complaint.

Claim deferral

Under the serious illness terms of Mr and Mrs B's policy, for a claim to be successful, Mr B's condition must meet the following policy definition:

> *'Parkinson's Disease – resulting in permanent symptoms'*

> *'A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability.'*

I've seen a Treating Specialist Report from Mr B's Consultant Neurologist, Dr A, dated January 2023. Dr A confirms that Mr B was diagnosed with Parkinson's disease in December 2022. Under a section asking for details of any permanent neurological deficit with persisting clinical symptoms, Dr A records, *'mild difficulty with right foot (dragging). No other abnormalities.'* Mr B had recently started on drug therapy and his response was recorded as, *'stable.'* In terms of his lifestyle, Dr A notes that Mr B is *'fit. Does cycling.*' She is asked to provide the Modified Ranking Scale measurement for Mr B, which she states is 1. This scale is an internationally accepted measure of disability for neurological conditions, with a scoring range from 0-5, with 5 being the most severe. The assessment must be made by a consultant neurologist. Additional evidence from a procedure report by a consultant radiologist, related to a diagnostic scan in October 2022, also makes reference to Mr B having noticed a '*faint tremor in his right hand and some decreased swinging when walking.'*

In March 2023, Prudential wrote to Mr B to explain its decision to defer his claim for six months. It told him it was too early to establish his response to treatment and as such permanency of impairment couldn't yet be determined.

I can appreciate Mr and Mrs B's frustration, as Mr B had recently been diagnosed with an incurable, degenerative neurological condition. But diagnosis alone is not sufficient for a claim to be paid. I'm satisfied that at this stage, the full policy definition hadn't been met. So I think Prudential's decision to defer the claim was fair.

I've also seen a letter Dr A wrote later in March 2023, giving an update on Mr B's condition. She records his initial symptoms and makes reference to medication potentially helping with symptoms, but not curing them. She also refers to having agreed to arrange some physiotherapy to look at some dexterity exercises. She concludes by saying:

> *'This gentleman has a definite diagnosis of Parkinson's disease which will cause permanent clinical impairment progressively.'*

I don't see anything in this letter that would cause me to question the fairness of Prudential's deferral decision, because Dr A does not confirm there is permanent clinical impairment – only that there will be at some time in the future.

Claim decision

To reassess the claim at the end of the deferral period, Prudential requested up to date information from Dr A. I've reviewed her report dated November 2023. Dr A notes that there has been a mild improvement of symptoms. But she now assesses Mr B's condition as 3 on the Modified Rankin Scale. In explaining the change she states that *'there has been progression of the condition over the last year.'* And in response to being asked to provide details of any permanent neurological deficit with persisting clinical symptoms, she states, *'decreased mobility and tremor.'*

In light of this report, Prudential accepted the policy definition had been met and that a payment was due. Mr B's policy provides primary serious illness cover. This means his claim will be paid according to the severity level of the impairment. On the basis of the updated report from Dr A, Prudential paid out to Mr B at level D, the lowest of the four levels available under his policy. On the medical evidence provided, I think this was a fair assessment. For a higher payment to be paid at levels C to A, Mr B's level of impairment would need to be assessed according to his ability to perform functional activity tests (FATs). I've listened to a

call between our investigator and Mr and Mrs B's representative in December 2023, during which FATs were discussed. Given the progressive nature of Mr B's condition, our investigator explained that the policy allows for additional claims to be made, upon further deterioration.

Customer service issues

Prudential has acknowledged poor claims handling and customer service, including avoidable delay and poor communication. I've no doubt that Prudential's mistakes have caused substantial distress, upset and worry over the life of the claim. And for impact on that scale, I'd expect to see an award of at least £750. Prudential has apologised for its errors and paid £800 compensation to Mr and Mrs B. I appreciate Mr and Mrs B feel this award is insufficient. But in all the circumstances I think this reasonably reflects the level of distress and upset caused.

So to conclude, I'm satisfied Prudential acted fairly with regard to the claim decisions made and has paid compensation which reasonably acknowledges the impact of its poor customer service.

My final decision

The Prudential Assurance Company Limited has already paid Mr B and Mrs B £800 to settle this complaint. I think that's fair in all the circumstances, so I don't require it to do anything more to put things right.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr B and Mrs B to accept or reject my decision before 1 May 2024.

Jo Chilvers
Ombudsman