DRN-4820764

## The complaint

Mr K complains that Legal and General Assurance Society Limited (L&G) has turned down an incapacity claim he made on a personal income protection insurance policy.

## What happened

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

Mr K holds a personal income protection insurance policy, which covers his own occupation. The policy includes a deferred period of 13 weeks.

In October 2022, Mr K was signed-off from work with stress. As he remained unfit for work, he made an incapacity claim on the policy in December 2022.

L&G requested medical evidence from Mr K's GP to allow it to assess the claim. And it asked one of its Vocational Clinical Specialists (VCS) to speak with Mr K. Based on the available medical evidence, L&G concluded that Mr K was suffering from work-related stress. So, it wasn't satisfied that Mr K had met the policy definition of incapacity and it turned down his claim.

Mr K appealed. He provided evidence from his GP which stated that he'd been diagnosed with depression in February 2023 and that he was also on anti-depressant medication.

Therefore, L&G agreed to review the claim and reassess it using a new deferred period beginning on the date of Mr K's diagnosis of depression. It asked for further medical evidence from Mr K's GP and it arranged for him to speak with another VCS. L&G also referred the medical evidence to its Chief Medical Officer (CMO) for a clinical opinion. But it still concluded the evidence showed that the primary reason for Mr K's absence was work-related stress. So it maintained its decision to decline Mr K's claim.

Unhappy with L&G's decision, Mr K complained. While L&G didn't change its claims decision, it did pay Mr K a total of £600 compensation for the trouble and upset caused by assessing his claim and his appeal.

Remaining unhappy with L&G's position, Mr K asked us to look into his complaint. He provided us with a copy of a letter from an occupational health (OH) doctor dated 20 July 2023. The OH doctor had stated that Mr K wasn't fit to work in any occupation due to anxiety and depression, which also manifested in physical symptoms. While it seems this report was sent to L&G when Mr K initially complained, L&G told us it hadn't seen it. Upon review of the report, L&G still didn't change its stance.

Our investigator didn't think Mr K's complaint should be upheld. She assessed the available medical evidence and she didn't think it had been unreasonable for L&G to consider that Mr K's absence was caused by work-related stress rather than an illness. She was satisfied L&G had referred the evidence to appropriate clinical specialists. So she didn't think it had been unfair for L&G to conclude that Mr K hadn't shown that he met the policy definition of

incapacity. And therefore, she concluded it'd been fair for L&G to turn down Mr K's claim. She was also satisfied that L&G had already paid Mr K fair compensation for the delays in its handling of his claim.

Mr K disagreed. He maintained that the medical evidence showed his mental health had prevented him from working for any employer, regardless of the ongoing issues in the background. He felt the investigator had ignored evidence which supported his claim.

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 Mr K, I don't think it was unfair for L&G to turn down his claim and I'll explain why.

First I'd like to reassure Mr K that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. I'm very sorry to hear about the circumstances that led to Mr K needing to make a claim and I don't doubt how upsetting and worrying the situation has been for him and his family. Within this decision though, I haven't commented on each and every point he's made and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly and that they mustn't turn down claims unreasonably. I've taken those rules into account, together with other relevant considerations – such as regulatory principles, industry rules and guidance, the policy terms and the available medical evidence - to decide whether I think L&G handled Mr K's claim fairly.

L&G has assessed Mr K's claim twice – making its first claim decision in February 2023 and its second decision in August 2023. So I've considered whether I think it acted fairly on both occasions and I'll deal with each in turn.

I've first considered the terms and conditions of the policy, as these form the basis of Mr K's contract with L&G. Mr K made a claim for incapacity benefit, given he wasn't fit for work. So I think it was reasonable and appropriate for L&G to consider whether Mr K's claim met the policy definition of incapacity when it assessed this claim. I've turned then to look at L&G's definition of 'incapacity'. The policy says:

*'If you are in gainful employment or gainful self-employment at the time of incapacity we will consider you to be incapacitated once we have assessed your claim as set out in the section headed "Assessing your claim" and are satisfied that you have no capacity for working in your own occupation, on any basis, as a direct result of your injury or illness.'*

This means that in order for L&G to pay incapacity benefit, it must be satisfied that Mr K had an illness which prevented him from carrying out his own occupation, on any basis, for the entirety of the deferred period(s) and afterwards. The policy doesn't cover Mr K being unable to work at a specific workplace or for a specific employer. L&G needs to be satisfied that Mr K was unable to carry out his own occupation at any workplace or for any employer during the deferred period(s) and beyond.

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 Mr K's responsibility to provide L&G with enough

evidence to demonstrate that an illness had led to him being unable to carry out the duties of his own occupation first for the full 13-week deferred period between October 2022 and January 2023 and then for the second deferred period between February and May 2023.

L&G assessed the evidence Mr K provided in support of his claim (including with clinical members of its staff) and didn't conclude that he met the policy definition of incapacity. Instead, it considered that Mr K was suffering from a stress reaction to a worrying workplace situation. 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.

*L&G's first claim assessment*

When Mr K first made a claim in December 2022, he explained the symptoms he was experiencing to L&G, including panic, breathlessness and chest pain. He told L&G he'd been diagnosed with stress.

L&G asked Mr K's GP to provide Mr K's medical records. In my view, this was a reasonable and appropriate step for L&G to take. So I've looked carefully at Mr K's medical records for the period between October 2022 and January 2023.

On 28 October 2022, Mr K's GP signed him off with stress. The GP's notes say:

'*Clearly work is a major stressor. Challenging period…pressure from management. Finding it all a bit much.'*

On 7 December 2022, the GP recorded that Mr K: '*Has been being bullied at work…getting marked stress symptoms, palpitations and anxiety going into work. Work putting pressure on.'* The GP issued a fit note stating that Mr K was unfit for work due to work related stress.

This was followed by three further fit notes issued during December 2022, which all stated that Mr K was unfit for work due to work related stress and anxiety.

The GP wrote a letter to L&G dated 12 January 2023, which said that Mr K's diagnoses were anxiety and depression, with work related stress. The GP stated that the treatments were: '*Firstly and most importantly, time away from work that has triggered this mental illness….'*

And the GP said: '*This was unfortunately all triggered by (Mr K) having a…move placed on him by his work…'*

L&G asked a VCS to assess Mr K. I've looked closely at the VCS' report of January 2023 and I've set out below what I consider to be their key findings:

'*The customer states the reason for his absence is work related. There has been bullying at work from directors. He has raised a grievance and attended a meeting last week. This increased his anxiety. He reported that it has been a 'nightmare' but felt writing everything down helpful. States there has also been exclusion and unnecessary performance management. This includes constant changes to targets he was hitting. The stress caused chest pains which worried him and spoke to his GP. They ruled out heart issues and was told he has work related stress and anxiety.*

*They suggested that he have an OH review for longer term support and management…*
*His anxiety has increased from (a) hearing last week. There was a lot of different emails he had to manage which was causing stress. They are also going through a…capability process which is adding stress.*

The VCS stated what they believed to be factors or perceived barriers preventing Mr K from returning to work as follows:

*'The customer states his main barrier is working with (a manager)….He doesn't want to work with them.'*

They made the following comments about Mr K's ability to undertake his insured role:

*Based on the customers reporting today, in my clinical opinion the customer is medically fit to return to work. He reports going absent from work due to perceived work-related issues. From his reporting, his daily function is not restricted.. . In my opinion this case is not primarily medical. The customer is suffering from stress type symptoms which are directly related to work related issues. This has caused him to experience stress. It may be worth noting that "stress" in itself is not a clinical illness but instead is used in general parlance to describe an adverse reaction (which can manifest as physical and/or psychological symptoms e.g., disturbed sleep, anxiety, anger etc.) to particular situations due to incompatibly between the person and the situation for non-medical reasons*.

The VCS concluded: '*It is in my opinion, that if the work-related factors were removed/resolved, there should be no reason why he could not return to work in some capacity.'*

I've thought very carefully about the evidence that's been provided. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the information provided by both medical professionals and other experts to decide what evidence I find most persuasive. It's clear that between October 2022 and January 2023, Mr K was suffering from symptoms which can also be indicative of a significant mental health condition. His GP made reference to Mr K suffering from anxiety and depression. I'm mindful too that he was prescribed anti-depressant medication to treat his symptoms.

But, taking into account the totality of the medical and other evidence considered by L&G when it initially assessed the claim, I don't think it was unreasonable for it to conclude that the evidence showed that the main reason for Mr K's absence was a stress reaction to the work situation in which he found himself. And that the main reason for Mr K's absence during the first deferred period was likely the workplace stress he was experiencing as opposed to a clinically impairing mental health condition. It also appears, from the GP's records and the VCS report that Mr K's main triggers were concerns about work. As such, I don't think it was unfair for L&G to rely on the medical evidence to turn down this claim.

*L&G's second claim assessment*

Another GP provided L&G with a further letter in March 2023. This letter set out Mr K's physical symptoms. It explained that Mr K's previous medication hadn't seemed to work and that new medication had been prescribed. The GP also said:

*'I can confirm a new diagnosis of depression on 16/2/23.'*
They added: '*I can confirm that his anxiety and depression was increased in the run up to the grievance hearing…The patient isn't fit to work in any occupation until the new medication will assist better.'*

Given the GP's letter, L&G decided to reinstate Mr K's claim and assess it using a new deferred period beginning 16 February 2023 and ending in mid-May 2023. I think this was a very fair response from L&G. I'd reiterate that in order for the claim to be payable, Mr K needed to provide enough evidence to show that he was incapacitated in line with the policy terms between *February and May 2023* and afterwards.

Again, I've considered the medical evidence from that period when considering whether I think L&G reassessed this claim fairly.

In mid-February 2023, the GP recorded that Mr K had: *'started a full grievance procedure with the company and has aggravated his anxiety…(He'd) had a grievance meeting with work and had to discuss bullying again. Reactivated the symptoms of anxiety and worsening mental health.'* The accompanying fit note cited work related stress, anxiety and depression as the reason for Mr K's absence.

In mid-April 2023, the GP noted that Mr K had started legal proceedings and filed an appeal with his company. They recorded Mr K was suffering from: '*Sleepless nights again and more anxious and tired with all this additional stress.'*

And in early May 2023, the GP notes state '*appeal hearing yesterday – aggravated a lot of anxiety and stress…not keen on talking therapies. But maybe if still feeling low after (legal action) is over'.*

Each of the fit notes issued during the relevant period stated that Mr K had work related stress, anxiety and depression.

L&G arranged for Mr K to be assessed by another VCS in May 2023. Again, I've set out what I feel to be their key findings below:

'*The customer advised (a change in family circumstances) and his GP extended his fit note to cover this.*

*The customer said (a family member had been unwell) and he is at the hospital several times a week and the customer is attending with (them) most of the time.*

*The customer advised he feels his situation has gone from bad to worse. He started a grievance procedure with his employer, and he said this spiralled him into a lower mood. The customer is waiting on an appeal he lodged. The appeal hearing was carried out over 10 days ago. The customer stated this has added to the anxiety and low mood.'*

The VCS provided their opinion on Mr K's ability to carry out his own role. They said:

*'Considering the evidence and information available to date, in the absence of any objective medical evidence to the contrary, and based on the customer's reporting today, in my clinical opinion this case is not primarily medical. The customer is experiencing stress type symptoms which are related to perceived work-related issues and (family situation).This has caused them to experience stress.*

*As such the customer would be fit to return to work in their insured role with their present or alternative employer if the stated issues were not present.'*

And the VCS provided a summary, which stated*:*

*The customer reported a history of perceived work related issues as well as being worried about (family situation).*

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*The customer has been prescribed two different antidepressant medications neither of which are reported to be helping the customer and this may be due to the customer being absent from work due to a stress reaction as a result of the perceived work related issues and his (family situation).*

*Considering the evidence and information available to date, in the absence of any objective medical evidence to the contrary, and based on the customer's reporting today, in my clinical opinion the customer is absent due to perceived work related stress and the stress of his (family situation) and as such would be fit to return to work with their present or alternative employer if the stated issues were not present.*

*Whilst the customer is fit to return to work, he is unlikely to do so until the perceived work related issues are addressed…'*

L&G decided to refer Mr K's claim to its CMO, an expert in occupational medicine, for a further clinical opinion. I've considered the CMO's comments carefully. They referred to Mr K's preparation of legal action, which was time consuming. They felt *'there was no evidence of a serious mental illness (e.g. psychosis), no mention of treatment escalation or referral to CMHT or a psychiatrist, which is appropriate and reassuring in my view. The member is being managed in primary care and his main treatment appears to be…medication which he reports is ineffective, in line with his diagnosis being work-related stress, where…medication is unlikely to be beneficial.'*

The CMO also said: '*The medical diagnosis and treatment the member is receiving is not indicative of mental illness of sufficient severity to totally preclude work in his own occupation, with reasonable adjustments, as appropriate in my opinion…*

*In summary, my opinion is that there is insufficient objective evidence to support total incapacity of the member in his own occupation for the relevant period, noting that he is very unlikely to resume work with his current employer…given the circumstances.'*

Again, I've very carefully considered all of the available medical evidence. It's clear Mr K did have a diagnosis of mental health conditions and that he was prescribed medication. But I don't think it was unfair for L&G to rely on the evidence to reach the conclusion that the main reason for Mr K's absence (which caused his conditions to become aggravated) was his work-place situation. I think both the GP's notes and L&G's clinicians' evidence reasonably support this conclusion. And I think the evidence points towards the cause of Mr K's upsetting symptoms between February and May 2023 being the workplace issues he'd experienced. I think it indicates too that he was suffering from an understandable reaction to his personal circumstances and a workplace situation with his employer, rather than suffering from severe mental illness which prevented him from carrying out his role for that or any other employer.

Mr K sent us a copy of an OH report dated July 2023 which he says formed part of his appeal to L&G. It seems an OH report was sent to L&G in August 2023, but L&G says this wasn't received, although it's now told us that the report hasn't changed its position. It's important to note that the report is dated two months after the second deferred period ended. I can see the OH doctor did set out Mr K's self-reported physical symptoms, referred to the medications he was prescribed and that he was, by that point, on a waiting list for talking therapy. And I note that OH doctor said that Mr K wasn't fit for any work. But I don't think L&G acted unfairly when it concluded that this report *didn't* show that Mr K was incapacitated during the deferred period. Nor is it clear that the OH doctor had access to Mr K's medical records or notes when they assessed him. So I'm not persuaded that this report is sufficient evidence to show that L&G unreasonably declined Mr K's claim.

Overall, this means I don't find that L&G acted unfairly when it decided that there wasn't enough evidence to show Mr K was incapacitated in line with the policy definition. Instead, I think it fairly concluded that Mr K's absence during the second deferred period was more likely due to workplace stress and a reaction to his circumstances.

I'd reassure Mr K that I appreciate he wasn't medically fit for work – his GP signed him off and I appreciate he's suffered upsetting and debilitating symptoms. But that isn't enough to show that he fulfilled the policy definition of incapacity. And, as I've explained above, I don't think L&G acted unfairly when it relied on the available medical evidence to turn down Mr K's claim.

Mr K has provided us with further medical information in support of his claim. However, as the investigator explained, it wouldn't be appropriate for me to comment on any additional medical evidence L&G hasn't had a chance to see – including any further medical records or details of any further referrals. If Mr K would like L&G to assess any new evidence, he'll need to send it directly to L&G for its consideration.

*Compensation*

While I don't find L&G acted unreasonably when it turned down Mr K's claim, it's clear it acknowledges that it didn't handle the claim as well as it should have done. There were significant delays in its assessment of the evidence – particularly in relation to Mr K's appeal and delays in it referral of evidence to its CMO. It also delayed sending a response to Mr K's complaint. I don't doubt that waiting for a period of months for a claims decision during an already worrying time caused Mr K additional, unnecessary trouble, upset and worry. So I think it was reasonable and appropriate for L&G to pay Mr K compensation to reflect this.

In my view, the £600 compensation L&G has already paid Mr K is fair, reasonable and proportionate to reflect the material distress and inconvenience I think its claims handling errors caused him. So I'm not telling it to pay anything more.

**My final decision**

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr K to accept or reject my decision before 25 July 2024.

Lisa Barham
**Ombudsman**