DRN-4955452

The complaint

Mr L's complained that Aviva Life & Pensions UK Limited unfairly declined his critical illness claim after he suffered a stroke.

Mr L appointed a representative part way through the complaint process. References to submissions and comments by Mr L include those made on his behalf by the representative.

What happened

In early 2023, Mr L took up the group critical illness cover offered by Aviva through his employer. Six months later, he had a stroke. So he submitted a claim. Aviva declined the claim because they said it fell within the policy's "*Associated Conditions*" exclusion.

Aviva explained that, because Mr L had joined the scheme less than two years before his claim, they had to consider whether he'd had a pre-existing or an associated condition. They said Mr L had had an associated condition (which is defined in the policy), because his medical records showed he'd had hypertension – which was associated with a stroke.

Mr L challenged Aviva's conclusions. He said that he was misdiagnosed with hypertension and that his elevated blood pressure had been caused by other medical conditions, as well as "white coat syndrome".

Aviva reviewed their position but didn't change their claim decision. So Mr L brought his complaint to our service. Our investigator reviewed all the available information and concluded Aviva didn't need to do anything differently to resolve the complaint. He was satisfied Mr L's medical records recorded multiple high blood pressure readings and it was reasonable for Aviva to have relied on these, as there was no indication in the records that they were high due to "white coat syndrome".

Mr L didn't agree with the investigator's view. So I've been asked to make 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.

Having done that, I'm not upholding Mr L's complaint. I acknowledge this will be unwelcome news and I'm sorry about that. I hope it will help if I explain the reasons for my decision.

As the investigator explained, it's not the role of the Financial Ombudsman Service to provide medical opinions or to decide whether the claim should be paid. Rather, it's to decide if Aviva have acted fairly and reasonably in reaching the decision they did.

The starting point is the policy terms and conditions. There's no dispute the policy provides cover in case of a stroke. What's in issue is whether or not the claim should be declined on the basis of the exclusion.

Associated conditions are dealt with in the section of the policy called *"What is not covered?"* Under the sub-heading *"Associated critical illnesses and operations"*, the policy says:

*"We will not pay claims if the **member** or **child** has had an **associated condition** prior to the date they joined your scheme".*

The policy defines which conditions are associated with the covered conditions. Hypertension is associated with stroke. I'm satisfied that's clear. So I've considered Mr L's submissions that the exclusion didn't apply, because he didn't have hypertension.

As part of their assessment of the claim, Aviva obtained Mr L's medical records. These recorded a diagnosis of hypertension in 2010, which was followed by regular check ups over the following seven or eight months. The records show that the diagnosis was recorded as an error in September 2013.

But, even if the readings in that period are discounted, there are further entries recorded in November 2013, 2018 and 2022, all of which start *"Problem: Hypertension"*. So it seems to me that Aviva's conclusion Mr L had hypertension before joining his company scheme is reasonable.

Mr L has said the raised blood pressures recorded coincided with episodes of his other medical conditions and aren't evidence he had hypertension. I've thought about this, but I'm not persuaded that's a conclusion I can reasonably draw. None of the entries above mention any condition other than hypertension. There is an entry 2½ weeks after the 2022 reading which records Mr L told his GP one of his other medical conditions had flared up "*recently*". But I don't think that's enough for me to say that condition, rather than hypertension, was the cause of his high blood pressure readings 2½ weeks previously.

Nor am I persuaded that Mr L's readings were solely due to "white coat syndrome". There are no readings on his records prior to 2022 which clearly show his blood pressure was only raised when he was with medical professionals. This was confirmed by his own GP who wrote a letter saying:

"…[Mr L] didn't ever have the diagnosis confirmed with home blood pressure readings. Therefore there is a possibility that this was all white coat hypertension."

The GP did confirm that Mr L was asked to provide home monitoring in 2022 and that showed he wasn't hypertensive at that time.

While I accept the contents of the GP's letter, it doesn't confirm that Mr L's earlier records were wrong. I understand Mr L contacted his GP about this and was told they couldn't say that was the case.

I can see that Aviva referred the evidence to their Chief Medical Officer (CMO) and asked the CMO whether Mr L suffered from "white coat syndrome". The CMO's opinion is clear that Mr L has hypertension, based on a pattern of elevated readings - including home readings – the lifestyle advice given and the ongoing review of whether to prescribe him medication.

Mr L challenged this evidence by submitting that the high blood pressure readings don't constitute a diagnosis of hypertension, because the high readings weren't followed up following NICE guidelines.

I've considered this, but it doesn't change my view. It's not my role to say whether Mr L should, or shouldn't, have been diagnosed with hypertension – it's to decide whether or not Aviva's decision was reasonable, based on the available evidence. While I acknowledge

Mr L is adamant he didn't suffer from hypertension, his medical records don't support that. Aviva had the position reviewed by their CMO who reviewed his records and concluded he did have the condition.

So I think the conclusion Aviva drew was reasonable and they don't need to do any more to resolve Mr L's complaint.

My final decision

For the reasons I've explained, I'm not upholding Mr L's complaint about Aviva Life & Pensions UK Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr L to accept or reject my decision before 30 October 2024.

Helen Stacey
Ombudsman