DRN-4982741

The complaint

Mr A complains that Legal and General Assurance Society Limited (L&G) has turned down 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 key events.

Mr A was insured under his employer's group income protection policy. The contract provided cover if Mr A became incapacitated from carrying out his own occupation due to illness or injury. The deferred period was 26 weeks.

In May 2023, Mr A was signed-off from work. His GP referred him for psychological treatment due to work-related anxiety. As Mr A remained unfit for work, he made an incapacity claim in December 2023.

L&G requested medical evidence to allow it to assess the claim. Mr A's 26 week deferred period ran from May 2023 onwards. So L&G determined that Mr A needed to show he'd been incapacitated due to illness for the whole of the deferred period and afterwards. It arranged for Mr A to speak with a vocational clinical specialist (VCS), as well as obtaining Mr A's medical records.

Ultimately, L&G concluded that Mr A's absence was down to work-related stress - which had been caused by workplace difficulties - rather than due to a pervasive mental health condition. So it didn't think Mr A's claim met the policy definition of incapacity and it turned down the claim.

Mr A was unhappy with L&G's decision and he asked us to look into his complaint.

Our investigator didn't think L&G had acted unfairly. She considered all of the available medical evidence. She didn't think it had been unfair for L&G to conclude that Mr A's absence was due to work-related stress and that therefore, he hadn't shown his claim met the policy definition of incapacity.

Mr A disagreed. In summary, while he accepted that his illness had been caused by workplace stress, he said he was suffering from anxiety and depression. He felt the evidence his GP had provided was enough to show that he had a valid claim. And he felt the VCS' assessment had been flawed.

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 A, 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 A that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mr A needing to make a claim and I don't doubt what a worrying and upsetting time this has been for him. In this decision though, I haven't commented on each point Mr A has raised and nor do our rules require me to. Instead, I've focused on what I think are 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, amongst other relevant considerations, such as regulatory principles, the policy terms and the available medical evidence, to decide whether I think L&G has treated Mr A fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mr A's employer's contract with L&G. Mr A 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 A's claim met the policy definition of incapacity. This says:

'Own occupation means the Insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.'

This means that in order for L&G to pay Mr A incapacity benefit, it must be satisfied that he had an illness or injury which prevented him from carrying out the essential duties of his own occupation for the entire deferred period and afterwards.

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 A's responsibility to provide L&G with enough medical evidence to demonstrate that an illness had led to him being unable to carry out the essential duties of his own occupation for the full 26 week deferred period between May and November 2023.

L&G assessed the available evidence and concluded that Mr A wasn't suffering from a pervasive mental illness which prevented him from carrying out his role. Instead, it felt that Mr A was suffering with a reaction to an upsetting workplace situation. So I've next looked carefully at the available evidence to decide whether I think this was a fair conclusion for L&G to draw.

I've first looked at the 'member statement' Mr A completed in December 2023. He stated that he was off work due to a '*mental health issue, anxiety, depression'.* He noted that he wasn't taking medication but was undergoing therapy. When he was asked about his daily activities post-incapacity, he said: '*trying to do same activities as recommended by Dr except work which was the main cause of my mental health issue'*.

Next, I've looked at a 'case report' setting out work-related concerns Mr A had had in May 2023. In brief, Mr A reported concerns about workplace harassment and bullying. And he stated that he'd raised a grievance. He referred to the impact the situation had had on him and his mental health. He explained that he wanted to be transferred to a different line manager and obtain an alternative role (amongst other things). And in January 2024, Mr A stated in an email that his absence from work was caused by the ongoing hostile environment.

I've gone on to consider the GP's records from the start of the deferred period onwards. In May 2023, Mr A was seen twice by a GP. The notes say that Mr A was suffering from a

depressed mood and work stress. A GP referred Mr A to psychology. The GP's referral letter of 15 May 2023 says: *'I would be grateful if you could assess and help Mr A for work-related anxiety'.*

Mr A was signed-off by his GP and fit notes extending his absence continued to be issued. There are no further detailed notes until January 2024, when Mr A's GP noted that Mr A was concerned that he had severe depression and anxiety and that he'd referred to bullying at work. At this point, Mr A was prescribed anti-depressant and anti-anxiety medication.

The GP provided Mr A with a letter in support of his claim in January 2024 and I've set out below what I think are their key points:

'I met this man who…reports being the victim of …bullying... (Mr A) informs me that he has been consulting with a clinical psychologist who has growing concerns about his mental health and feels he has severe depression. After consulting with (Mr A) and exploring his mental health I would say these fears are founded regarding both anxiety and depression.

I have commenced (Mr A) on antidepressants…and issued (medication) for physical symptoms relating to anxiety.'

L&G arranged for Mr A to speak with a VCS and I've carefully considered the VCS' resulting report dated December 2022.

Initially, the report set out an 'introduction and medical history' section. The VCS noted: '*The member cited work related stress due to conflicts with others and this began impacting his mental health causing panic attacks and insomnia…*

The VCS asked whether, in Mr A's opinion, if perceived work-related issues were resolved, or if the role was within another place or organisation, could he perform his job? Mr A answered *'yes, perhaps not immediately however.'*

Mr A was asked if there were any other factors or perceived barriers that were preventing the member from returning to work? The VCS responded:

The member cited work related issues although was cautious about going into detail as he was concerned this may be shared with his employers. He feels his main barrier currently is poor concentration and his poor mental health.

The VCS was asked for their opinion on Mr A's ability to carry out his insured role. The VCS stated:

'*Based on the members reporting today, and in the absence of medical evidence to the contrary, in my clinical opinion the primary reason for absence appears to be work related stress and the priority now should be for the member and employer to find solutions to address the concerns and a way to support the member back to work. Reassuringly at this stage, there is no indication of escalation of care, requirement for medication or mental health team input and it would appear the absence is primarily due to a non-clinical cause. While this has now caused some clinical symptoms, the priority remains with the employer to now manage the situation as there is unlikely to be a further clinical solution until this takes place.'*

I've thought very carefully about all of 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 evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn't my role to interpret medical evidence to reach a clinical finding

– or to substitute expert medical opinion with my own - and it would be inappropriate for me to do so.

It's clear that Mr A was suffering from symptoms which can be indicative of a significant mental health condition. I'm mindful too that Mr A's GP stated in January 2024 that they felt Mr A's concerns that he had severe anxiety and depression were well-founded and that at this point, anti-depressant and anti-anxiety medication was prescribed.

But, I have to bear in mind the totality of the medical and other evidence which was available to L&G when it assessed the claim. The GP's evidence from the deferred period makes specific reference to Mr A suffering from work-related anxiety. It doesn't seem that Mr A was prescribed medication for his condition until *after* the deferred period had ended. And the GP's letter of January 2024 post-dated the deferred period. The VCS' clinical opinion was that Mr A's barriers to work were work-related and that the main reason for his absence was work-related stress. And it's clear that Mr A had reported concerns about workplace bullying and a difficult workplace situation and referred to his hostile working environment as being the cause of his symptoms.

Nor do the fit notes or GP records I've seen explain how or why Mr A's symptoms would have prevented him from carrying out the essential duties of his role.

As such, taking into account the totality of the medical and other evidence available to L&G when it assessed this claim, I think it was reasonable for it to conclude that the evidence showed that during the deferred period, Mr A was suffering from an understandable reaction to the very difficult workplace situation in which he found himself. And that the main reason for Mr A's absence during the deferred period was likely a reaction to the work-related stress he was experiencing as opposed to a mental or physical health condition.

I note Mr A is unhappy because L&G didn't ask for further information or write to his therapist. As I've explained above, it's a policyholder's responsibility to show they have a valid claim on their policy. And I don't think it was unreasonable for L&G to conclude that it had enough evidence to make a claims decision without asking for another assessment or writing to ask for evidence from Mr A's therapist.

On this basis then, I don't think it was unfair for L&G to conclude that Mr A's absence wasn't due to an incapacity in line with the policy definition. Instead, I think it fairly concluded that Mr A's absence was more likely due to work-place stress. I'd add that I think it was reasonable for L&G to rely on the medical evidence from the deferred period, including the VCS' report.

I'd like to reassure Mr A that I'm not suggesting that he was fit for work. I appreciate he was medically signed-off. And I understand he's been through a very difficult time. But I need to decide whether I think he's shown he met the policy definition of incapacity for the whole of the 26 week deferred period. As I've explained, I don't think he has.

Overall, despite my natural sympathy with Mr A's position, I don't find it was unfair or unreasonable for L&G to turn down his claim.

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 A to accept or reject my decision before 10 February 2025.

Lisa Barham
Ombudsman