DRN-4982962

The complaint

Mr R has complained that Legal and General Assurance Society Limited (L&G) terminated a claim made under his employer's group income protection policy.

What happened

The background to this complaint is well known to the parties. In summary Mr R has been in receipt of monthly benefit under his policy since December 2015. It was ceased in June 2022 but re-accepted in May 2023 following an appeal and referral here.

In September 2023 when reviewing the claim L&G referred Mr R to a Vocational Clinical Specialist, and when Mr R challenged those findings to a Clinical Psychiatrist. Based on the evidence L&G said that Mr R could return to work in his own occupation and that benefit would end in March 2024. Mr R disagreed and provided further information. L&G asked the psychiatrist to review the information, but their conclusion remained the same.

When L&G maintained its conclusion Mr R referred his complaint here. Our investigator didn't recommend that it be upheld. They didn't find that L&G had acted unreasonably when terminating Mr R's benefit.

Mr R appealed. He said that the investigator had included a section on the key medical evidence but omitted the evidence (three doctors) who supported his claim. He reiterated that he wasn't able to return to his high-pressured occupation and felt that he had been treated very unfairly.

As no agreement has been reached the matter has been passed to me to determine.

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've summarised the background to this complaint – no discourtesy is intended by my approach which reflects the informal nature of this service. If I don't comment on something, it's not because I haven't considered it. It's because I've focused on what I find are the key issues in this complaint. My approach is in line with the rules we operate under. I recognise that Mr R will be disappointed by my decision, but I agree with the conclusion reached by the investigator. I'll explain why.

- The regulator's rules say that insurers mustn't turn down claims unreasonably. So I've considered, amongst other things, the policy terms and the available evidence, to decide whether I think L&G treated Mr R fairly in terminating his claim when it did.

- There is no dispute as to the background of this complaint or the policy terms. The dispute is as to L&G's assessment of the medical evidence. As all the medical evidence has been seen by the parties it serves no purpose for me to repeat it in detail here.

- L&G terminated Mr R's claim which had been in payment for several years. It is therefore for L&G to show that he no longer meets the policy definition of 'disabled member'. This is, as far a relevant here, that in the opinion of L&G Mr R meets the incapacity definition. Here this is that Mr R 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.

- In his appeal Mr R has pointed out, correctly, that there were three medical reports which said that he couldn't carry out his old, high-pressure role, but could probably work again in a less pressured environment. That is not in dispute and I've seen the reports he refers to – a detailed report from 2019 and two further reports from 2021 and 2022. But L&G will review claims and, in this decision, I am considering the review that led to L&G's December 2023 final response that benefit would cease in 2024.

- Following a report from a Vocational Clinical Specialist in November 2023 a conclusion was reached that Mr R's continued absence from work was due to work stress. The Clinical Specialist noted that the only treatment Mr R had had in the past years was antidepressant medication. He had not had regular GP appointments since 2018 and no further treatment plan was advised. The Clinical Specialist's opinion was that given Mr R's good level of daily function, he would benefit from having the focus and routine that work provides. Following this L&G referred Mr R for an independent medical examination with a Consultant Psychiatrist. I think that was fair.

- The Consultant Psychiatrist reported in December 2023. He concluded, and I paraphrase, that Mr R wasn't suffering from any functional restrictions or symptoms consistent with the presence of a depressive episode or adjustment disorder. He said a phased return to work would be possible, with organisational adjustments.

- Mr R didn't agree with the conclusion in the report. Medical evidence (the three reports referred to above) together with Mr R's written appeal was sent to the Consultant Psychiatrist for his further consideration. The Consultant Psychiatrist reviewed the evidence and wrote and addendum report. That report has also been seen by the parties but concluded that the information didn't alter the opinion reached in December 2023 after he assessed Mr R. In all the circumstances and having reviewed the medical reports and Mr R's comments I'm satisfied that L&G fairly reviewed his claim and concluded that Mr R no longer met the policy definition of incapacity.

- Mr R makes the point that having been out of his insured role for nine years, he didn't believe many experts in the field of occupational health would agree that after that length of time away from the coal face his ability to pick up the role again would be successful. I do have sympathy here and agree that it would likely take time and adjustment. But this is not the criteria against which L&G needs to review the claim. It is whether or not *illness* prevents Mr R from carrying out his former role. Based on the recent medical evidence it obtained, I don't find that L&G treated Mr R unfairly in reaching the conclusion that he no longer met the policy definition of incapacity.

- It follows that I don't require L&G to reinstate Mr R's claim. I'm very sorry that my decision doesn't bring Mr R welcome news.

My final decision

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 R to accept or reject my decision before 2 January 2025.

Lindsey Woloski
Ombudsman