DRN-5042737

The complaint

Mr J complains that Legal and General Assurance Society Limited (L&G) stopped paying benefit for an incapacity claim he made on a personal income protection insurance policy. Mr J's also unhappy with L&G's delays in handling his claim.

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.

In January 2023, Mr J took out a personal income protection insurance policy to cover his own occupation. The policy included a deferred period of four weeks.

Unfortunately, in February 2023, Mr J had an accident abroad and hurt his wrist. He received some treatment abroad, but due to swelling, no fracture was diagnosed. Following Mr J's return to the UK, his wrist pain continued and he was unable to work in his insured occupation. So he made a claim on the policy.

L&G looked into Mr J's claim. It referred the claim on to one of its vocational clinical specialists (VCS) and referred Mr J for physiotherapy. Mr J underwent an initial physiotherapy assessment in May 2023. The physiotherapist thought Mr J likely had a scaphoid fracture and their report stated that Mr J needed an x-ray and a consultant's report. Mr J had an x-ray in mid-June 2023 which didn't find evidence of either an acute or historic scaphoid fracture.

Additionally, L&G asked Mr J's GP for his medical records. While the GP had continued to sign Mr J off from work, L&G noted that there was little evidence of clinical consultation about Mr J's wrist.

In October 2023, Mr J's employer arranged for him to speak with occupational health (OH). The OH concluded that Mr J was fit to return to work on a phased basis, with amended duties. They also concluded that Mr J's wrist would take around 12 months to fully recover.

L&G assessed the available medical evidence, including with clinical members of its staff. It felt there was little medical evidence to support why Mr J remained unfit for work. It concluded that it would usually expect a scaphoid fracture to heal within six to 12 weeks. So, it agreed to pay benefit between 23 March and 30 June 2023 to represent a 12 week recovery period.

Mr J was very unhappy both with L&G's decision and the way it had handled his claim. He felt the OH evidence indicated that he'd still been incapacitated after June 2023. He said he'd incurred a lot of debt and experienced financial hardship. And he was also very unhappy with the seven month delay in L&G making a claims decision.

L&G maintained its position to terminate benefit after 30 June 2023. But it agreed that there had been unreasonable delays in the handling of Mr J's claim and so it offered to pay him £500 compensation.

Remaining unhappy with L&G's decision, Mr J asked us to look into his complaint.

Our investigator concluded that L&G had treated Mr J fairly. But Mr J disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 5 September 2024 which explained the reasons why I didn't think L&G had treated Mr J unfairly. I said:

'First, it's clear that Mr J suffered a painful injury while he was abroad. I was sorry to hear about the accident and about the impact this had on him. I'd like to reassure Mr J that while I've summarised the background to his complaint and his submissions to us, I've carefully considered all he's said and sent. In this decision though, I haven't commented on each point Mr J's made 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, together with other relevant considerations, such as the policy terms, the available medical evidence and industry rules and guidance, to decide whether I think L&G treated Mr J fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mr J's contract with L&G. Mr J made a claim for incapacity benefit, given he wasn't fit for work. So it seems clear that by accepting the claim between 23 March and 30 June 2023, L&G accepted that Mr J met the policy definition of incapacity for this period. The policy defines incapacity as:

'Your inability, caused by illness or injury, to carry out your gainful employment or gainful self-employment…'

The policy terms also set out 'Conditions'. This state:

'For us to make the monthly benefit payments, you must be under regular and appropriate medical treatment as agreed with your treating doctor(s) for the condition that you are claiming for and must comply with the treatment recommendations. This may include:

- *medication,*
- *physiotherapy, and/or*
- *taking part in a rehabilitation programme, counselling or therapy.*

We may also request that you:

- *attend medical examinations,*
- *supply information relating to your incapacity,*
- *be available, if required, to meet with an appointed representative at your home for an interview in respect of the claim,*
- *undergo medical investigations (including blood tests), and/or*
- *produce medical and financial evidence in order to support the claim.*

The claim will be reviewed on both medical and financial grounds on a regular basis.

***If you don't provide the evidence we ask for we may stop your monthly benefit payments**.*

If your claim is accepted after we have assessed it both medically and financially the monthly benefit will be paid one month in arrears following the end of the deferred period and at monthly intervals until the earliest of:

- *the end of your incapacity.' (My emphasis added.)*

In summary, I think the policy terms make it sufficiently clear that L&G will regularly review a claim it's paying to check whether a policyholder remains incapacitated in line with the policy terms. And that if L&G thinks the evidence shows a policyholder is no longer incapacitated, it will stop paying the claim. In my experience, neither of these terms are unusual in income protection insurance policies. And generally, I think an insurer is entitled to periodically review a claim to ensure a policyholder still meets the policy definition of incapacity.

I've looked carefully at the available evidence. It's clear Mr J suffered a painful wrist injury while abroad. The translated medical certificate from the time of the accident states that Mr J 'sustained an injury to the right thumb right hand' and a plaster splint was applied.

Following Mr J's return to the UK, he was signed-off from work by his GP in early March 2023 with a 'sprain of wrist and/or hand', following a telephone appointment. Later that month and in April, May and early June 2023, Mr J was issued with fit notes providing the same diagnosis.

During April 2023, Mr J spoke with L&G's VCS, who referred him for assessment with a physiotherapist. The VCS concluded that Mr J was likely restricted from carrying out his insured role.

Mr J had an initial assessment in mid-May 2023 with the physiotherapist. Their report shows that the physiotherapist believed Mr J likely had a scaphoid fracture, but that Mr J needed an x-ray and a medical report before further action could be taken.

The GP's records show that Mr J underwent an x-ray of his right wrist in mid-June 2023. The x-ray report stated:

'Satisfactory joint alignments are maintained.

No definite evidence of acute fracture. No evidence of remodelling to suggest a previous scaphoid fracture.'

It doesn't appear either that Mr J was seen by a consultant or specialist who formally diagnosed a scaphoid fracture.

Unfortunately, later in June 2023, Mr J suffered other injuries and his mental health was affected. Mr J was prescribed anti-depressant medication, although his fit notes still stated that he was unfit to work due to a wrist injury.

The VCS reviewed Mr J's claim in early July 2023. While Mr J continued to self-report symptoms of his fine motor skills being affected, the VCS noted that: 'the customer's injury occurred in February 2023, I would have expected the hand to have healed and a return to work to have taken place by now…' The VCS also referred to the lack of objective medical evidence to support the claim.

Mr J's GP surgery continued to issue him with fit notes which said he wasn't fit to work due

to a wrist injury. The GP's notes don't indicate that he had any face to face appointments specifically to discuss his wrist injury between July and September 2023, the point at which his full medical records were sent to L&G.

In October 2023, Mr J spoke with OH over the phone. Based on Mr J's reported symptoms, the OH concluded that his symptoms would resolve within 12 months and that Mr J was fit to work on a phased return basis, on amended duties, returning to full time hours within four weeks. However, Mr J didn't return to work.

L&G assessed the evidence, including with members of its clinical staff. Overall, it wasn't persuaded there was sufficient medical evidence to show that Mr J remained incapacitated from his role. It noted that the average recovery time for a scaphoid fracture was six to 12 weeks and so it agreed to accept and pay Mr J's claim in line with a 12 week period of incapacity to allow recovery.

I've thought very carefully about the evidence that was available to L&G at the time it settled and then stopped Mr J's claim. 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.

And having considered all of the evidence, I don't think it was unfair or unreasonable for L&G to have concluded that there wasn't enough objective medical evidence to show Mr J had been incapacitated after 30 June 2023. While the GP continued to sign Mr J off work, there's no reference in his medical notes to how the injury affected him, no referral for specialist orthopaedic input and his x-ray seemed to be broadly clear. I think it was reasonable for L&G to accept and pay Mr J's claim in line with the maximum recovery time its clinical staff considered it would have taken for a scaphoid fracture to have healed – even though there's no definitive evidence that Mr J had sustained such an injury.

I've borne in mind the OH's conclusions that Mr J would have been fit to start a phased return to work in October 2023 – around three months after the last date of benefit payment. However, I've also taken into account that the OH didn't see Mr J in person, nor did they have the chance to carry out a physical assessment of his symptoms. Their conclusions were based on Mr J's self-reporting. As such, I don't think L&G acted unreasonably by placing more weight on the limited objective medical evidence it had rather than the OH's report.

Overall, despite my natural sympathy with Mr J's position and I'm sorry to hear he's been in financial difficulties, I don't think L&G acted unreasonably when it relied on its clinical staff's opinion and the objective medical evidence to conclude that Mr J no longer met the policy definition of incapacity after 30 June 2023.

That means that I don't find L&G acted unfairly when it terminated Mr J's claim on 30 June 2023, based on the evidence it had at that time. It's open to Mr J to provide L&G with further evidence to support his position should he wish to do so. If he's unhappy with the outcome of any assessment of new medical evidence he may send to L&G, he may be able to bring a new complaint to us about that issue alone.

With that said, L&G accepts it didn't handle this claim as well as it should have done. There were long delays in it assessing evidence and it didn't proactively update Mr J. I don't doubt this caused him additional, material trouble and upset at an already worrying time, over a period of some months. So I think it was appropriate for L&G to offer to pay Mr J compensation of £500 to reflect this. In my view, £500 is a fair, reasonable and proportionate award which fairly compensates Mr J for the unnecessary distress L&G's claim delays likely caused him. It seems that L&G has already paid Mr J this award and I'm not proposing to

direct it to pay anything more. However, if it hasn't done so, L&G should now pay Mr J £500 compensation.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

L&G didn't respond by the deadline I gave.

Mr J didn't accept my provisional decision and I've summarised his further submission below:

- He wanted to clarify issues and information which he didn't think had been treated seriously enough;

- He'd never been in a situation like this before and didn't really know what to do – or what the right procedures were in terms of recovery. So he'd relied on the opinions of his GP and his insurer;

- The GP had simply told him that his injury would heal in time and there was nothing more the GP could do:

- L&G had referred Mr J for rehabilitation, so the GP hadn't needed to. But when Mr J had arrived for rehabilitation, he'd been found to need an x-ray. And even though Mr J said he'd sent the results on to the specialist, they hadn't responded to Mr J's messages. He felt he'd relied on L&G too much and it had led him to believe it would provide all medical help;

- Mr J had suffered further injury in a serious, separate incident a few months after his initial accident. He felt L&G had trivialised this and hadn't provided sufficient support;

- It hadn't been his choice not to return to work on amended duties – his employer had told him it couldn't provide an alternative role for him. And his role had required him to have full mobility in both hands. When he had returned to work around 12 months on from the accident, his other wrist had been affected due to overuse;

- He referred to the policy terms I'd set out in my provisional decision and explained why he didn't think L&G had adhered to them. He questioned why L&G hadn't sent him to a specialist to confirm his fitness to work if it hadn't had enough evidence to show his claim was valid;

- He asked me to explain exactly what medical evidence L&G would require in order to support a conclusion of a valid claim;

- He felt the compensation he'd been offered was outrageous and he questioned how he'd been meant to cover his living costs over seven months using that money;

- Mr J said that if he'd been told in June 2023 that his benefit would be stopping, he'd have resigned from his actual role and taken up another job elsewhere. Instead, he's been pushed further into debt, his injuries have worsened and his mental health has been affected;

- He arranged his own specialist. In response to my provisional decision, he provided a medical report from that specialist.

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 sorry to disappoint Mr J, I still don't think L&G has treated him unfairly for the same reasons I gave in my provisional decision. I've also carefully considered Mr J's further submissions and comments – although in this final decision, I've focused on what I consider to be the key points.

I appreciate that Mr J found himself in a worrying and unfamiliar situation when he needed to make a claim. I'd reasonably expect L&G, as the insurer, to explain the claims process in broad terms to Mr J and to explain broadly the kinds of medical evidence it needed to assess the claim. It isn't my role to tell L&G what evidence it can and should require when it considers claims – although in my experience, this will often include medical records, specialist reports and input from OH.

In some circumstances, if an insurer feels it's necessary, it may choose to appoint an independent medical examiner to assess a policyholder's condition as part of a claim. But there's no obligation for it to do so if it considers it can make a decision based on the existing medical and other evidence. This means I don't think L&G was required to appoint an independent medical examiner to examine Mr J when it considered his claim. And from what I've seen, L&G applied the policy terms in a consistent and fair way.

It's important I make it clear that while L&G's VCS arranged a physiotherapy appointment for Mr J as part of the claim assessment to determine whether his claim was valid, an insurer wouldn't generally take over a policyholder's medical care during the life of a claim. That's the role of the treating doctors. Instead, insurers will generally rely on the specialist evidence provided by a policyholder's medical team when assessing claims. As such, I wouldn't reasonably have expected L&G to arrange specialist orthopaedic appointments for Mr J or to devise a treatment plan for him.

In this case, as I've explained, the physiotherapist thought Mr J needed an x-ray. It seems this took place and there wasn't found to be clear evidence of a scaphoid fracture. It appears that Mr J sent a copy of the x-ray to the physiotherapy team in August 2023 and it looks like the physiotherapist replied to Mr J – although it isn't clear what was said. L&G's notes indicate that Mr J went abroad and also that the physiotherapist was waiting for a consultant's report before they could begin treatment. I haven't seen sufficient evidence to suggest that Mr J saw a consultant at that point. This means I haven't seen enough evidence to show me that L&G made any errors in its referral to the physiotherapist or afterwards.

I appreciate Mr J was involved in an upsetting incident in June 2023 and that he suffered further injuries. I don't doubt how distressing this situation must have been for him. But having considered the evidence from the time, I've seen no persuasive evidence that L&G failed to take into account the impact of the incident on him when it assessed this claim.

And I have to bear in mind, as I explained in my provisional decision, that there was little available medical evidence from the time to show that Mr J was incapacitated from carrying out his own role. There's little evidence of face-to-face appointments with Mr J's GP, the x-ray was normal and there's nothing to suggest Mr J was referred for orthopaedic treatment. So while I've borne in mind what he's told us about the effect of his injury on his ability to carry out his insured role and I've taken into account OH's comments, I still don't think it was unfair for L&G to rely on the available evidence and the clinical opinion of its staff to conclude Mr J would likely to have been fit to return to work after a 12-week period. I'd add that the OH report didn't find Mr J was totally prevented from carrying out his own

occupation. Instead, it said he could return to work on a phased basis, on amended duties. OH also concluded that Mr J could have returned to work full time after a four week period. I appreciate Mr J says that his employer couldn't accommodate these adjustments. But I can't reasonably hold L&G responsible for any actions on the part of Mr J's employer.

Overall, I do sympathise with Mr J's position and I'm very sorry to hear about the emotional and financial impact this matter has had on him. But I simply don't think it was unfair for L&G to conclude that Mr J was no longer incapacitated in line with the policy terms after 30 June 2023. So I'm not telling it to pay further benefit.

Mr J has provided me with new specialist evidence to support his claim. But as L&G hasn't seen this evidence, it wouldn't be appropriate for me to comment on it here. That's because I'm not a claims handler. It's open to Mr J to send the evidence to L&G for it to consider. And if he's unhappy with any assessment of that new evidence by L&G, he may be able to make a new complaint to us about that issue alone.

I understand Mr J is unhappy with the compensation L&G offered him. It isn't designed though to cover Mr J's costs or to replace his income. It's a payment to reflect the trouble and upset its delays in the handling of Mr J's claim likely caused him. Having thought about everything, I remain satisfied that £500 is a fair award of compensation and I direct L&G to pay Mr J this amount if it hasn't already done so.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that L&G has already settled this complaint fairly.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr J to accept or reject my decision before 4 November 2024.

Lisa Barham
Ombudsman