DRN-5051220

The complaint

Mrs D complains that Liverpool Victoria Financial Services Limited (LV) has turned down incapacity claims she made on two personal income protection insurance policies.

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 key events.

In 2011, Mrs D took out two personal income protection insurance policies through a broker. Both policies were underwritten by LV and were intended to provide cover for Mrs D's own occupation if she was unable to work due to accident or sickness. One policy had a deferred period of six months, while the other policy had a deferred period of 12 months.

Unfortunately, in December 2017, Mrs D became unfit to work due to symptoms of achalasia. It seems she was last paid for work in February 2018. In December 2018, Mrs D made an incapacity claim on the policies. However, LV turned down the claim because it didn't think Mrs D had shown she met the policy definition of incapacity.

Mrs D was unhappy with LV's decision and she complained. LV issued a final response to Mrs D's complaint on 16 July 2019. Its letter gave Mrs D referral rights to bring her complaint to this service within six months of the date of that letter. Mrs D didn't get in touch with us at that point.

In late 2020, Mrs D got back in touch with LV to make another claim, as she said her condition had deteriorated. LV agreed to consider a new claim from 31 July 2019 onwards. However, it said that as Mrs D hadn't worked since 2017, her claim would no longer be assessed under the 'own occupation' definition of incapacity. Instead, it said it would consider whether Mrs D fulfilled the 'work tasks' definition of incapacity.

Having considered the medical evidence, LV didn't think Mrs D had shown she met the work tasks definition of incapacity. But in fairness to Mrs D, it also looked at whether Mrs D would've met the own occupation definition of incapacity during that time. It didn't think she had. So it turned down her claim.

Unhappy with LV's decision, Mrs D asked us to look into her complaint. She didn't think it was fair for LV to apply the 'work tasks' definition of incapacity when it assessed her claim. And she felt she'd provided enough evidence to show she met the 'own occupation' of incapacity from 2017 onwards.

LV let us know that it didn't consent to us looking at its decision to turn down Mrs D's 2018 claim, as it said it had been brought to us too late under our rules.

Our investigator said we couldn't look at Mrs D's original claim. And she didn't think it had been unfair for LV to conclude that Mrs D hadn't shown she met the policy definition of incapacity – either for work tasks or own occupation.

Mrs D disagreed and so the complaint was passed to me to decide.

I issued a provisional decision on 13 September 2024. In my provisional decision, I explained why I didn't think we could look into Mrs D's complaint about LV's decision to decline the 2018 claim and why I didn't think it had been unfair for LV to turn down the 2020 claim. I said:

'Why I can't look into the 2018 claim

Our service isn't free to consider every complaint that's brought to us. We're governed by rules set by the industry regulator, the Financial Conduct Authority (FCA). They're called the DISP rules and can be found in the FCA's handbook. The rules set out the complaints that we can (and can't) look into.

DISP rule 2.8.2 states that the Financial Ombudsman Service cannot consider a complaint if it's referred to us more than six months after the date of a financial business' final response letter unless that business consents to us looking into it. In this case, LV hasn't consented to us considering the complaint points covered by its final response letter of 16 July 2019 – namely, its decision to turn down the 2018 claim.

LV's final response letter told Mrs D that she had six months from the date of that letter to refer her complaint to this service. That meant that Mrs D had until 16 January 2020 to complain to us about LV's decision to turn down her 2018 claim.

But Mrs D didn't bring a complaint to us until December 2023, which was significantly more than six months after the date of LV's final response. On that basis, I find that Mrs D brought this particular complaint point out of time.

The rules say I can set the time limit aside if I'm satisfied a consumer's failure to comply with them was as a result of exceptional circumstances. There is no definitive list of what would be considered to be exceptional circumstances but the rules gives an example of where a consumer might have been incapacitated. Mrs D hasn't provided us with any reasons for the delay in bringing this part of her complaint and so I don't think I could fairly find that exceptional circumstances apply here.

On that basis, my provisional decision is that Mrs D complained about the decline of the 2018 claim too late and therefore, I don't have the power to consider this issue.

The decline of the 2020 claim

LV issued its final response to this complaint in September 2023 and therefore, I'm satisfied Mrs D did bring this part of her complaint in time. So I'll now go on to decide whether I think it was fair for LV to turn down Mrs D's 2020 claim.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So, I've considered, amongst other things, regulatory rules and guidance, the terms of the policies and the available medical evidence, to decide whether I think LV handled Mrs D's claim fairly.
I've first considered the terms and conditions of the policies, as these form the basis of Mrs D's contract with LV. Mrs D made an incapacity claim, given she wasn't fit for work. So I think it was reasonable and appropriate for LV to consider whether Mrs D claim met the policy definition of incapacity.

In this case, LV concluded that the relevant definition of incapacity to apply was 'work tasks'. Mrs D considers that as she took out 'own occupation' cover, her claim should be assessed under that definition. I've looked carefully at the policy terms.

Pages six and seven set out 'own occupation cover'. This says:

'In this section, the words 'unable to work' and 'Inability to work' mean that we will pay a claim if, following your waiting period, because of sickness or accident, you are totally unable to carry out all the main duties of your occupation and aren't doing any other paid or unpaid work. The words 'able to work' and 'ability to work' mean that you can work.

By main duties, we mean the duties that can't reasonably be left out without affecting your ability to do your occupation. When assessing your ability to carry out those duties, we will consider whether there are any changes that you or your employer can reasonably make that would allow you to continue in your occupation.

Your cover is restricted if you are not doing your occupation before the accident or sickness prevented you from doing it. If this is the case you are still covered but we will use the more restrictive measures explained under Work Tasks cover in section A2 to work out whether to pay a claim.' *(My emphasis added).*

Page nine explains the 'work tasks cover' as follows:

'In this section, the words 'unable to work' and 'inability to work' mean that due to sickness or accident you are unable to do any paid or unpaid work and you cannot carry out at least three of the following activities, using appropriate equipment to help you but without the help of another person:

- *Walking - to be able to walk a distance of 200 metres on flat ground (with the use of a walking stick or other aid if necessary) without stopping.*
- *Climbing - to be able to walk up or down a flight of 12 stairs (with the use of a handrail) without stopping.*
- *Bending - to be able to bend or kneel to pick up something from the floor and stand up again.*
- *Communicating - to be able to answer the telephone and take a simple message.*
- *Eyesight - to be able to read a standard daily newspaper or to pass the standard eyesight test for driving, (after correction by spectacles or contact lenses if necessary)*
- *Dexterity - to be able to use a pen, pencil or keyboard.*
- *Healthcare - to be able to make arrangements to see a doctor and take regular medication as prescribed.*
- *Financial Independence - to be able to understand the value of money, and handle routine financial transactions.*

If you are not in paid or unpaid work before the accident or sickness prevented you from working, you are still covered, and we will still use the above measure to work out whether to pay a claim.'

LV considers that as Mrs D had told it she hadn't worked after December 2017, the work tasks definition applied. Mrs D believes that as her illness started in December 2017, own occupation cover was the correct definition to use.

In my view, as LV treated Mrs D's 2020 claim as a new claim, backdated to be considered from 31 July 2019, it was fair and reasonable for it to apply the work tasks definition. That's because at the time of the claim, Mrs D hadn't been working for around eighteen months.

Despite this though, in fairness to Mrs D, LV also considered whether the own occupation definition applied. I think this was a very fair response from LV in the circumstances.

In either case, in order for LV to pay Mrs D incapacity benefit, it must be satisfied either that she had an illness or injury which totally prevented her from carrying duties of her own occupation or that she was unable to carry out at least three of the work tasks listed above.

The policy says that LV will begin to pay incapacity benefit after the end of the deferred period. This means that in order for benefit to be paid, Mrs D needed to have been incapacitated in line with the policy terms for the entire waiting periods of six months and beyond for one of the policies and 12 months and beyond for the other.

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 Mrs D's responsibility to provide LV with enough medical evidence to demonstrate that an illness had led to her being incapacitated for the full policy waiting periods and beyond.

LV assessed the available medical evidence and it says it sought the opinion of its clinical staff. While it sympathised with Mrs D's position, it didn't think the evidence showed she met either definition of incapacity. So I've considered the medical evidence to decide whether I think this was a fair conclusion for it to reach.

Both LV and Mrs D have provided us with medical evidence, both from Mrs D's treating specialists and from her GP. It's clear that Mrs D was suffering from symptoms of achalasia during the relevant waiting periods and that those symptoms had been long-standing. Specialist letters show that Mrs D underwent a number of tests during that time, including a barium swallow and a gastroscopy. She was undergoing other therapies during this period and she was seen by a dietician.

In December 2019, a consultant gastroenterologist, who I'll call Dr F, wrote to LV. Dr F said: 'I cannot comment on exactly what is happening at work but clearly this condition can cause regular vomiting.' Dr F explained how these symptoms might impact on Mrs D's role. Another consultant gastroenterologist (who I'll call Dr S) wrote to Dr F on 6 November 2020.

Dr S' letter stated that Mrs D suffered from symptoms of dysphagia and chest pain with every meal and that she regurgitated intermittently. Dr S noted that Mrs D hadn't lost weight, as she'd adapted her eating and this had made her symptoms less severe. Dr S indicated that they wanted Mrs D to carry out a swallowing test and that they'd gone on to discuss treatment options with Mrs D. Dr S stated too, in January 2021, that Mrs D's symptoms had impacted on her quality of life and her ability to work, given her symptoms were so varied and severe.

I've thought very carefully about all of the evidence that's been provided and which was available to LV when it made its final decision on Mrs D's complaint in September 2023. 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 and it would be inappropriate for me to do so.
It's clear that Mrs D was suffering from symptoms which were long-term in nature, which required extensive investigation and which impacted on her day to day life. However, taking all of the available evidence into account, I don't think it was unreasonable for LV to conclude that Mrs D hadn't shown she was totally prevented from carrying out the duties of her own occupation for the full waiting periods. I say that because it seems that she had developed some self-management technique, it seems her symptoms had improved and she'd maintained her weight. She'd also undergone different therapies to help treat her

condition. And I don't think the treating doctors have clearly explained how or why Mrs D would be totally prevented from carrying out her insured role during the relevant waiting periods.

Nor do I think it was unreasonable for LV to conclude that Mrs D hadn't shown she met the work tasks definition of incapacity either. I say that because there's no medical evidence to demonstrate that Mrs D was unable to carry out any of the six listed tasks above at any point.

On that basis then, while I sympathise with Mrs D's position because I appreciate she's been suffering from achalasia for a number of years, I don't think LV acted unfairly or reasonably when it concluded that Mrs D hadn't shown she was incapacitated in line with the policy terms. This means that I currently don't think it was unfair for LV to turn down the 2020 claim.

I understand Mrs D has made a new claim from 2023 onwards. I'm sorry to hear that her condition appears to have worsened. It will be for LV to assess the claim and decide whether it thinks any available evidence Mrs D may provide shows that she is incapacitated in line with the policy terms.'

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

LV confirmed it had nothing more to add.

Mrs D said she was sad to see that I'd provisionally decided not to uphold her complaint and I've summarised her comments. She felt the available medical evidence did demonstrate her total inability to work. In particular, she referred to Dr S' letter and Dr S' conclusions; a letter from her GP dated October 2021, which referred to the impact of her condition on her day-to-day function; and Dr F's conclusions.

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 Mrs D, my decision is the same as my provisional decision and for the same reasons and I'll explain why.

Why I can't look into the 2018 claim

Mrs D hasn't commented on my provisional finding that she brought the complaint about the decline of the 2018 claim to us too late under our rules. So I see no reason to change my conclusions on this point.

My decision on jurisdiction

My decision is that we can't consider Mrs D's complaint about LV's decision to decline the 2018 claim.

The decline of the 2020 claim

I'd like to reassure Mrs D that I have carefully considered the available medical evidence. I do appreciate that Dr S, the GP and Dr F have provided evidence which refers to the impact of Mrs D's symptoms on her and how these might affect her ability to work. I understand that

her symptoms were severe and that Dr S commented on how these symptoms affected Mrs D's quality of life and ability to work. The GP clearly referred to Mrs D's poor sleep and the lengthening of otherwise simple tasks. And I'm mindful that Dr F noted that Mrs D reported struggling with vomiting on a daily basis, which could impact on her ability to do her job. Dr F also said it was highly likely that these symptoms had been present since 2018 – which was likely to have stopped her working in 2017.

However, as I've set out above, the medical evidence also seems to show that Mrs D had developed some self-management techniques; her symptoms had improved and she'd maintained her weight. And it remains the case that she'd undergone therapies to treat the condition. I accept that Mrs D was suffering from symptoms which were long-term in nature, which required extensive investigation and which impacted on her day to day life. However, weighing up all of the evidence as a whole, I still don't think it was unreasonable for LV to conclude that Mrs D hadn't shown she was totally prevented from carrying out the duties of her own occupation for the full waiting periods. And I still don't think Dr S', Dr F's or the GP's evidence is clear or specific enough to explain how Mrs D would be totally prevented from carrying out her insured role during the relevant waiting periods.

It remains the case too that I still don't find it was unreasonable for LV to conclude that Mrs D hadn't shown she met the work tasks definition of incapacity either. I still don't think there's enough medical evidence to show that Mrs D was unable to carry out any of the six listed tasks above at any point during the 2020 claim.

On that basis then, while I sympathise with Mrs D's position and I'm sorry to cause her further upset, I don't find that LV acted unfairly or reasonably when it concluded that Mrs D hadn't shown she was incapacitated in line with the policy terms. So overall, I don't think it was unfair for LV to turn down the 2020 claim.

My final decision

For the reasons I've given above, my final decision is that LV didn't act unfairly when it turned down the 2020 claim.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs D to accept or reject my decision before 29 October 2024.

Lisa Barham
Ombudsman