DRN-5089649

The complaint

Mr P complains that MetLife Europe d.a.c has turned down an incapacity claim he made on a group income protection policy.

What happened

The background to this complaint is well-known to both parties. So I haven't set it out in detail here. Instead, I've set out a summary of what I think are the key events.

Mr P is insured under his employer's group income protection policy. The policy provides cover in the event that Mr P is unable to work in his own occupation, as a result of illness or injury. The deferred period is 26 weeks.

In March 2023, Mr P was signed-off from work by his GP, suffering from stress and bereavement. As Mr P remained unable to return to work, he made an incapacity claim on the policy.

MetLife requested medical evidence to allow it to assess the claim. It calculated that Mr P's deferred period would end in September 2023 and so it determined that Mr P needed to show he'd been incapacitated due to illness for the whole of the deferred period and beyond. Having considered the medical evidence, it didn't think there was enough information to show that Mr P was clinically limited or functionally restricted from performing his own occupation. And it considered that Mr P's absence was down to a grief-reaction and challenging circumstances in his personal life, rather than a pervasive mental health condition. So it didn't think Mr P had met the policy definition of incapacity and it turned down his claim.

Mr P was unhappy with MetLife's decision and he asked us to look into his complaint.

Our investigator didn't think it had been unfair for MetLife to turn down Mr P's claim. He didn't think it had been unreasonable for MetLife to conclude that there wasn't enough evidence to show that Mr P had been incapacitated for the full deferred period and beyond.

Mr P disagreed. He went on to provide two letters from his GP practice which stated that he'd been signed off due to anxiety and depression caused by stress and bereavement.

MetLife considered the new medical evidence. But it didn't think it was persuasive medical evidence that Mr P had been incapacitated in line with the policy definition.

Our investigator still didn't think MetLife had treated Mr P unfairly. So Mr P asked for an ombudsman to review things. Therefore, 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 P, and I know how upsetting my findings will be to him, I don't think it was unfair for MetLife to turn down his claim and I'll explain why.

First, I was very sorry to hear about the circumstances that led to Mr P needing to make a claim and it's clear he's been through a very challenging and distressing time. I'd like to reassure Mr P that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent. In this decision though, I haven't commented on each point he'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, amongst other relevant considerations, such as regulatory principles and guidance, the policy terms and the available evidence, to decide whether I think MetLife treated Mr P fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mr P's employer's contract with MetLife. Mr P made a claim for incapacity benefit, given he wasn't fit for work. So I think it was reasonable and appropriate for MetLife to consider whether Mr P's claim met the 'own occupation' policy definition of incapacity. This says:

'An insured member, eligible employee or eligible partner, is incapacitated if:

- *they are unable to perform, due to illness or injury, the material and substantial duties required of them in their own occupation which they were performing immediately prior to being incapacitated; and*
- *are not following any other occupation.'*

This means that in order for MetLife to pay Mr P incapacity benefit, it needs to be satisfied that he had an illness or injury which prevented him from carrying out the material and substantial duties of his own occupation. And the policy says that MetLife will begin to pay incapacity benefit after the end of the deferred period. So this means that in order for benefit to be paid, Mr P needed to have been incapacitated in line with the policy terms 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 P's responsibility to provide MetLife with enough medical evidence to demonstrate that an illness had led to him being unable to carry out the duties of his own occupation for the full 26-week deferred period between March and September 2023 and beyond.

MetLife assessed the evidence Mr P provided in support of his claim, including seeking the opinion of its clinical staff. While it sympathised with Mr P's position, it concluded that he wasn't suffering from a functionally impairing, pervasive mental illness which prevented him from carrying out his role. Instead, it felt that Mr P was suffering with a natural reaction to a number of upsetting personal stressors and grief. So I've next looked at the available medical and other evidence to decide whether I think this was a fair conclusion for MetLife to draw.

I've first considered the claim form Mr P completed in July 2023. Mr P stated that he was suffering from stress. He said that he found it difficult to sleep and he was tired a lot of the time. He also said that because he felt worried and anxious, he found it difficult to concentrate. He explained how this affected his ability to carry out his role. He stated that he wasn't on medication, but that he saw a psychotherapist at least weekly and spoke to his doctor monthly. He added that he was able to do simple tasks. Mr P's employer's claim form also said that Mr P was off work with stress and anxiety.

Next, I've considered Mr P's GP records and the fit notes for the full deferred period. Each of the fit notes issued to Mr P in March, April, May, June, July and September state that he was unfit for work due to 'stress and bereavement'. And I've summarised below what I think are the key entries in Mr P's GP notes, which detail his discussions with his GPs practice.

In late March 2023, Mr P's GP records show that Mr P told the GP about bereavements which had affected him, as well as work-related pressures. The notes say that Mr P '*has a general feeling of sadness, although wouldn't describe this as depression'.* The records say that Mr P was: '*Already seeing a therapist weekly and is making good progress.'* And the GP noted both that Mr P didn't think medication would be useful and that the doctor agreed.

Next, in late April 2023, Mr P spoke with another GP. They noted: '*Off work with stress and bereavement….Seeing therapist weekly. Feels better mentally as not working.'*

Subsequently, the next month, the GP recorded: '*Talking to a private psychotherapist weekly… (Mr P) is finding helpful…Psychotherapist advised (Mr P) experiencing sadness as a natural reaction to events. No need for antidepressants at this time…Not ready to go back to work.'*

In late June 2023, the GP records say*: 'Feeling much better. Anxious about returning to work. Seeing private psychotherapist once a month who advised in view of anxiety about work (Mr P) to have a further month off.'* The GP stated that the next month, a phased return to work could be considered if Mr P felt ready.

However, in late July 2023, the GP noted: '*Doesn't feel ready to go back to work. I note recent bereavements... Overall, starting to feel calmer.'*

And in September 2023, the GP notes say: *'(Mr P) and psychotherapist do not feel (Mr P) needs antidepressants. He is experiencing a normal grief reaction. Concentration and appetite much better than 6/12 ago.'*

In October 2023, following the initial decline of Mr P's claim, it seems he was suffering from anxiety attacks, poor sleep and dark thoughts. So he was prescribed medication. He was given a further fit note which said he was unfit for work due to stress and bereavement.

After MetLife initially declined Mr P's claim, his psychotherapist wrote to MetLife. They explained in detail Mr P's history and the very challenging circumstances he'd faced. Again, I've summarised what I think are the key points:

'Psychotherapy is not a medical or psychiatric treatment but a private, professional psychologically supportive relationship…

Mr P is an atypical psychotherapy client in that he has been subjected to an inordinate amount of continuous stress, loss and grief, and with many overlapping crises. I am amazed that he has been able to carry on as long as he has done without having a major breakdown requiring intense psychiatric in-patient treatment. It is his nature to put on a brave face and minimise what he is shouldering to the outside world, even to his GP….
In my professional opinion, Mr P is recovering slowly but surly [sic] but it will require further time away from the stress of the workplace.'

In April and July 2024, two GPs at Mr P's practice provided further evidence. The first of those letters said;

‘This is to confirm that Mr P was signed off from work from 22 March 2023 until (January 2024) for anxiety and depression due to bereavement and stress. He was unable to work during this period.’

The second GP confirmed the duration of Mr P’s absence ‘when he had symptoms of depression’. They noted that an anti-depressant had been prescribed to improve Mr P’s sleep and mood. And they said: ‘*This man had dark thoughts, panic attacks, difficulty falling asleep, early morning wakening, suicidal thoughts and anxiety…He had a cough caused by silent reflux aggravated by stress and anxiety.’*

I’ve thought very carefully about all of the evidence that’s been provided. I must make it clear that I’m not a medical expert. In reaching a decision, I must consider the available medical and other evidence provided both medical professionals and other experts to decide what evidence, on balance, 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 P was suffering from upsetting symptoms which sometimes can indicate that a person has a functionally-impairing, pervasive mental illness. I’m sorry to hear about the impact those symptoms had on Mr P. I also appreciate that two of Mr P’s GPs later said that Mr P had had depression and anxiety and/or symptoms of depression. I’ve borne this in mind very carefully.

But, I have to bear in mind the contemporaneous medical evidence which was available to MetLife when it assessed the claim and when it issued its final response to Mr P’s complaint.

During the full deferred period, based on telephone discussions with Mr P and based on Mr P’s self-reported symptoms, the GP signed him off with stress and bereavement. They didn’t conclude in either the fit notes or their records that Mr P had a formal diagnosis of depression or anxiety during that period. The GP instead listed the personal bereavements and stressors Mr P was experiencing as the cause of his symptoms. The notes also indicate that Mr P told the GP that both he and his psychotherapist believed he was experiencing a normal grief reaction, rather than suffering from a diagnosis and functionally impairing mental illness. The records show too that during the deferred period, neither Mr P nor his GP thought he needed anti-depressants to treat his symptoms. And it seems from Mr P’s own account that he could carry out simple daily tasks. I’m also mindful that the medical evidence doesn’t indicate how or why Mr P would’ve been incapacitated from carrying out the material and substantial duties of his own occupation for the full deferred period and beyond.

As such, having considered all of the medical and other evidence available to MetLife when it assessed this claim, I think it was reasonable for it to conclude the evidence showed that during the deferred period, Mr P was suffering from an understandable reaction to the very difficult situation in which he found himself and a number of personal bereavements and stressors. And that the main reason for Mr P’s absence during the deferred period was likely a reaction to the stress and grief he was experiencing as opposed to a diagnosed mental health condition.

I note that Mr P is unhappy that MetLife didn’t organise its own medical review of his condition. This is an option that MetLife might sometimes take. But it isn’t obliged to. And in this case, I think it was reasonable for MetLife to rely on the medical evidence it already had to make its claims decision.

On this basis then, I don’t think it was unfair for MetLife to conclude that Mr P’s absence wasn’t due to an incapacity in line with the policy definition. Instead, I think it fairly concluded

that Mr P's absence was more likely due to a reaction to his circumstances and the very upsetting personal stressors he'd experienced.

I'd like to reassure Mr P that I'm not suggesting that he was fit for work. I appreciate he was medically signed-off as not fit for work. 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.

It's open to Mr P to obtain new medical evidence in support of his claim, should he wish to do so. But Mr P would need to send any new medical evidence to MetLife for it to consider and to decide whether or not it alters its understanding of Mr P's claim. If Mr P is unhappy with the consideration of any new evidence, he may be able to make a new complaint to us about that issue alone.

Overall, despite my natural sympathy with Mr P's position, I don't find it was unfair or unreasonable for MetLife 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 P to accept or reject my decision before 27 November 2024.

Lisa Barham
Ombudsman