DRN-5126734

The complaint

Mr M has complained that Legal and General Assurance Society Limited declined a claim he made for critical illness.

What happened

Mr M made a claim under his decreasing term assurance with critical illness policy in 2023 as he had unfortunately suffered a stroke in 2022. That claim didn't succeed as L&G didn't find that Mr M met the policy definition of stroke. But L&G said that Mr M could contact L&G again if his circumstances changed.

Mr M returned to work some months after the stroke, but found he was suffering from fatigue at the end of the day. His occupational health team felt that the fatigue he was suffering from was post-stroke fatigue so Mr M asked L&G to re-consider his claim. It did so, but still didn't find that he met the policy definition of stroke.

Our investigator didn't recommend that the complaint be upheld. They didn't think that L&G had reached an unfair conclusion. Mr M appealed.

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.

Although I've summarised the background to this complaint - no discourtesy is intended by this. Instead, I've focused on what I find are the key issues here. Our rules allow me to take this approach. It simply reflects the informal nature of our service as a free alternative to the courts.

The 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, the relevant law, the policy terms and the available evidence, to decide whether I think L&G treated Mr M fairly.

Mr M's policy definition of stroke is:

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms

Mr M's initial claim didn't succeed as L&G said that the medical evidence didn't show that Mr M met the policy definition. This complaint doesn't concern that claim decline, but the subsequent decline when Mr M sent in evidence of fatigue.

Mr M was able to return to work following his stroke, but his testimony is that although he was able to perform his duties as normal, the concentration required by his occupation and all the related tasks he needed to perform took a toll on his energy level. When he returned home from work he would suffer real fatigue, resulting in needing to take time off to restore

his energy.

L&G considered the further information that Mr M submitted and obtained information from Mr M's GP. Having done so it still didn't find that he met the policy definition for a claim to be paid.

I can appreciate Mr M's frustration – he believed that his policy would offer cover him when he needed it. Instead he has been left feeling let down and had to make some difficult financial decisions.

However I don't find that L&G treated Mr M unfairly when it concluded that the further evidence regarding the fatigue that Mr M was suffering meant that the met the policy definition of stroke.

It reviewed Mr M's claim promptly. The existing medical evidence did show that Mr M met the definition in part – his consultant confirmed in 2023 that there is evidence of death of brain tissue. However they also confirmed that Mr M hadn't been left with any neurological deficit.

Although it is not in dispute that Mr M now suffers from fatigue there is no conclusive medical evidence to show that this is a persisting clinical symptom of permanent neurological deficit resulting from Mr M's stroke. Of course if Mr M does have any further medical or neurological evidence he can submit this to L&G for its consideration.

I'm sorry that my decision doesn't bring Mr M welcome news at this time.

My final decision

For the reasons given, 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 M to accept or reject my decision before 13 February 2025.

Lindsey Woloski
Ombudsman