DRN-5127905

The complaint

Miss B complains that Legal and General Assurance Society Limited (L&G) hasn't settled a critical illness claim she made on a life insurance policy.

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 April 2024, Miss B made a critical illness claim for benign spinal cord tumour on her life insurance policy. Unfortunately, Miss B had been suffering from severe back pain and leg numbness. An earlier MRI scan had shown that she had lumbar disc problems and that she had Tarlov cysts.

L&G asked for medical evidence to allow it to assess Miss B's claim. Miss B was seen by an orthopaedic and spinal surgeon (who I'll call Mr A) and by a consultant neurologist (who I'll call Mr H). Miss B told L&G that both doctors felt that given the complexity of the surgery she needed, she should be seen by a neurosurgeon. But she said an NHS appointment with a neurosurgeon couldn't be arranged until early 2025.

Based on the reports L&G received from Mr A and Mr H, it didn't think the evidence showed Miss B's illness met the policy definition of a benign spinal cord tumour. L&G said it needed more information from Mr A and Mr H, but despite its requests for evidence, the doctors hadn't responded. It acknowledged there'd been some avoidable delays in the handling of Miss B's claim though, so it offered to pay her £300 compensation.

Miss B was very unhappy with L&G's decision and she asked us to look into her complaint. She said that neither Mr A nor Mr H would be in a position to provide further evidence because she needed to be seen by a neurosurgeon. And she felt it was unfair for L&G to conclude that her claim didn't meet the policy definition of benign spinal cord tumour. She also told us that she'd since developed serious cardiac issues which she put down to stress.

Our investigator didn't think L&G had handled Miss B's claim unfairly. She didn't think L&G had acted unreasonably when it decided that the claim didn't meet the definition of a benign spinal cord tumour. She thought it had taken reasonable steps to try and obtain more evidence from Mr A and Mr H. And she thought L&G had already offered Miss B fair compensation for its delays in handling the claim.

Miss B disagreed. In brief, she said that Mr A and Mr H couldn't provide the information L&G said it needed because they weren't neurosurgeons. And she felt that if L&G had arranged for her to see a neurosurgeon in April 2024, the claim could have been resolved, and she could already have undergone the treatment she needed.

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 Miss B, I think L&G has already made a fair offer to settle her complaint and I'll explain why.

First, I'd like to reassure Miss B that while I've summarised the background to her complaint and her submissions to us, I've very carefully considered all that's been said and sent. It's clear that Miss B has been through a very difficult time. I was sorry to hear about the impact of her spinal condition on Miss B's life and the pain it causes her.

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 medical evidence, to decide whether I think L&G has treated Miss B fairly.

I've first considered the policy terms and conditions, as these form the basis of the contract between Miss B and L&G. I must make it clear that this is a life insurance policy with critical illness cover. It isn't a private medical insurance policy and it isn't intended to cover private medical treatment. Instead, it's designed to pay a lump sum in specific situations.

Miss B made a claim under the critical illness section of her policy for a benign spinal cord tumour. The policy says that L&G will pay the full amount of life cover in certain, specific circumstances, which includes if a policyholder' *is diagnosed with an illness or undergoes a medical procedure as defined in the section headed 'Critical Illness Definitions'.* The contract states:

'If the life insured has a critical illness it must be verified by a medical specialist who holds an appointment as a consultant at a hospital in the UK and whose specialism we reasonably consider is appropriate to the critical illness.'

L&G has listed the critical illnesses it covers under the terms of the policy and has defined each of those conditions. The definitions set out the criteria which need to be met in order for a critical illness claim to be covered. So I've next set out below how L&G defines a benign spinal cord tumour:

'Benign spinal cord tumour – resulting in either specified treatment or permanent symptoms

A non-malignant tumour or cyst originating from the spinal cord, spinal nerves or meninges within the spinal canal, resulting in either:

· surgical removal;
· radiotherapy;
· chemotherapy; or
· permanent neurological deficit with persisting clinical symptoms.'

And L&G has defined what it means by permanent neurological deficit with persisting clinical symptoms as follows:

'Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the life insured's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.'

I think the policy terms make it clear that L&G will only pay critical illness claims for benign spinal cord tumour if the medical evidence shows that a policyholder has a non-malignant tumour or cyst which has been surgically removed; or that has resulted in radiotherapy or chemotherapy or which has caused permanent neurological deficit with persisting clinical symptoms. So I think it's clear that in order for a claim to be payable, the evidence must show a benign spinal cord tumour was the cause of any neurological deficit with persisting clinical symptoms.

It's a general principle of insurance that it's for a policyholder to provide enough evidence to show they have a valid claim on their policy. This means it was Miss B's responsibility to provide L&G with enough medical evidence to show that her claim met the policy definition of a benign spinal cord tumour. L&G considered the available medical evidence and concluded it wasn't enough to show Miss B's claim met the relevant policy definition. So I've considered whether I think this was a fair conclusion for L&G to draw.

When Miss B first made a claim, she included a copy of a letter dated April 2024 from Mr A, a consultant orthopaedic and spinal surgeon. In summary, Mr A concluded that an MRI scan showed that Miss B had evidence of degenerative disc changes in her lumbar spine with some small disc protrusion. He stated: '*She does not have any clinically significant neural elemental compromise. She has facet degenerative changes which could explain her back pain…She has Tarlov cyst…'* Mr A suggested that Miss B might benefit from branch blocks and injections to manage her back pain. And he asked that Miss B be referred to neurosurgery.

The MRI report Miss B included with her claim form (dated December 2023) set out the degenerative changes in Miss B's spine and small disc protrusions which had been found. The report found that '*cystic areas were seen in the mid to lower sacral canal…these are likely to be Tarlov cysts, usually incidental.'*

While Dr A recommended that Miss B be referred to neurosurgery, it seems she was told that an NHS appointment couldn't be arranged for around nine months. On that basis, it seems a neurology appointment was arranged with Dr H for June 2024. His report said:

'From a neurological perspective, the pain is not radiculopathic nor is it neuralgic, it's dull pain and as she tells me, the right leg is totally numb. I have examined her, and I can confirm that her examination showed normal strength, normal reflexes and the tone is normal. There are presence as [sic] Tarlov cyst as well in the MRI which in my opinion is usually incidental….

There are degenerative changes in the spinal and lumbar spine MRI but no compression. There are facet joint degenerative changes which can explain the back pain as per Mr A...

In my opinion, I have explained that the sensory numbness that she is presenting is likely functional….The second is with regards to the pain. I totally agree with Mr A that she should have the pain injections as detected in Mr A's letter.'

Based on the available medical evidence, I don't think it was unfair for L&G to conclude that Miss B hadn't shown her claim met the policy definition of benign spinal cord tumour. I say that because neither Mr A nor Mr H attributed Miss B's symptoms (including her leg numbness) to the Tarlov cysts. Instead, Mr H specifically stated that Tarlov cysts are usually incidental. And, both doctors seemed to agree that Miss B's pain was caused by spinal

degenerative changes. There's also no evidence to suggest Miss B underwent surgery to remove the cysts, nor chemotherapy or radiotherapy to treat them.

I do appreciate that Miss B feels that it wasn't fair for L&G to rely on Mr A and Mr H's evidence because they're not neurosurgeons. But L&G isn't responsible for any delay in the NHS being able to offer Miss B a neurosurgery appointment. And in the circumstances then, I find it was reasonable for L&G to rely on the evidence of a consultant spinal surgeon and consultant neurologist when it assessed whether Miss B's claim was covered.

L&G hasn't turned down Miss B's claim. Instead, it's said it needs more evidence to determine whether or not her claim meets the relevant policy definition. In my view, this is a fair response from L&G. So I think it was reasonable and appropriate for L&G to ask for more information from Mr H and Mr A, in the absence of a neurosurgeon's opinion. And I don't think I can fairly hold L&G responsible for any delay in Mr H or Mr A providing further evidence. Without further medical evidence to show Miss B's condition meets the policy definition of a benign spinal cord tumour though, whilst I sympathise with Miss B's position, I don't think I could fairly tell L&G to pay her claim.

With that said, L&G accepts that there were some avoidable delays in its handling of the claim which caused Miss B some unnecessary frustration and upset. These were its delays in calling Miss B back and a broadly three-week delay in writing to Mr H and Mr A to ask for more information (although, as I've said above, neither doctor responded). So it offered to pay Miss B £300 compensation. In my view, £300 is a fair, reasonable and proportionate award to reflect the additional impact of these relatively short periods of delay on Miss B while she was already going through a difficult time. L&G must now pay Miss B £300 compensation if it hasn't already done so.

My final decision

For the reasons I've given above, my final decision is that L&G has already made a fair offer to settle this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss B to accept or reject my decision before 2 January 2025.

Lisa Barham
Ombudsman