DRN-5226802

The complaint

Mrs S complains that Vitality Life Limited turned down an incapacity claim she made on a personal income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out what I think are the key events.

Mrs S holds personal income protection cover. The policy provides cover if Mrs S is incapacitated from working in her own occupation due to accident or sickness. The policy deferred period is three months.

In November 2023, Mrs S was signed-off from work suffering from pelvic girdle and back pain. While she'd been suffering symptoms for around seven months, she'd been on leave prior to November 2023. Mrs S was also suffering from carpal tunnel syndrome and plantar fasciitis. The GP had referred Mrs S for physiotherapy and advised her to take pain relief medication.

As Mrs S remained signed-off work, she made an incapacity claim on the policy in January 2024.

Vitality looked into Mrs S' claim and it obtained medical evidence from Mrs S' GP and a copy of an Occupational Health (OH) report. In June 2024, it arranged for Mrs S to undergo a Functional Capacity Evaluation (FCE) and it considered Mrs S' job description. It concluded that Mrs S hadn't shown she met the policy definition of incapacity. In brief, that's because the FCE found that Mrs S' test results couldn't represent her true capabilities and that therefore, her actual abilities were far greater than she was willing to perform during the assessment. And Vitality considered there was insufficient evidence to show that Mrs S would be unable to perform the majority of her role. Instead, it considered that she could work in her own occupation with reasonable adjustments.

However, Vitality acknowledged that there'd been an unreasonable delay in its handling of Mrs S' claim and it paid her £850 compensation to reflect this.

Mrs S was unhappy with Vitality's decision and she asked us to look into her complaint. She also referred to a similar complaint she'd previously brought to us which we'd upheld.

Our investigator didn't think Mrs S' complaint should be upheld. He was satisfied that it was fair and reasonable for Vitality to rely on the findings of the FCE to turn down Mrs S' claim.

Mrs S disagreed. In summary, she said she'd provided medical evidence from her doctor and from OH which supported her claim. And she didn't think it was fair to rely on the FCE report, which she said didn't reflect the events of the assessment.

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 Mrs S, and I know how upsetting my findings will be to her, I don't think it was unfair for Vitality to turn down her claim. I'll explain why.

First, I'd like to reassure Mrs S that while I've summarised the background to her complaint and her detailed submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mrs S needing to make a claim and I don't doubt what a worrying and upsetting time this has been for her. In my decision though, I haven't commented on each point that Mrs S has 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 industry principles, the policy terms and the available evidence, to decide whether I think Vitality handled Mrs S' claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mrs S' contract with Vitality. Mrs S made a claim for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate for Vitality to consider whether Mrs S' claim met the policy definition of incapacity. This says:

'A standard definition means that illness or injury makes you unable to perform the material and substantial duties of your own occupation. These are the duties that are normally needed to do your own occupation and that cannot reasonably be omitted or modified by you or your employer. To meet this definition, you must also not be working in any other occupation for payment or profit.'

This means that in order for Vitality to pay Mrs S incapacity benefit, it must be satisfied that she had an illness or injury which prevented her from carrying out the material and substantial duties of her own occupation for the full three month 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 Mrs S' responsibility to provide Vitality with enough medical evidence to demonstrate that an illness or injury had led to her being unable to carry out the material and substantial duties of her own occupation for the full deferred period and beyond.

Vitality assessed the evidence Mrs S provided in support of her claim, including arranging the FCE. Overall, it didn't think she'd shown she met the policy definition of incapacity. So I've next looked at the available medical evidence and other expert evidence to decide whether I think this was a fair conclusion for Vitality to draw.

First, I've considered Mrs S' medical records. The GP said that her first consultation for pelvic girdle and back pain was in May 2023. In June 2023, Mrs S was still experiencing pelvic girdle pain and advised to continue with physiotherapy. In July 2023, the GP stated that Mrs S was experiencing ongoing lower back, pelvic, hand and foot pain. She was sent for blood tests and referred to Women's Health physiotherapy. In late December 2023, Mrs S was still experiencing symptoms of back, pelvic, hand and foot pain. She was diagnosed

with pelvic girdle pain, plantar fasciitis and carpal tunnel syndrome. She was also referred to orthopaedic ICATS at this point. She was prescribed over the counter pain relief medication.

The GP reported that Mrs S' symptoms had the following impact on her ability to work:

'Difficulty with walking, bending and lifting due to current symptoms. May also experience problems with manual dexterity due to hand/wrist symptoms. I am not familiar with the exact nature of (Mrs S') job so cannot comment more specifically.'

Mrs S was issued with fit notes which stated that she wasn't fit to work due to her symptoms of back ache and pelvic pain.

Next, I've considered the OH report of 11 March 2024, which was completed by a Consultant Occupational Health Physician following a telephone consultation. The OH report stated:

'I have not physically examined your employee or undertaken a direct mental state examination today since it is a telephone consultation. I base my medical advice strictly upon a clinical history obtained from your employee….

In my opinion, (Mrs S) remains medically unfit to return to work now due to ongoing impairing symptoms and I have not identified any work adjustments that could support a return to work sooner.

If management is able to accommodate further sickness absence, I estimate further sickness absence of at least another 3 to months or more is expected to allow sufficient time for her ongoing GP/NHS medical reviews and treatments.'

As I've explained, Vitality arranged an FCE for Mrs S, which was carried out independently. I've set out below what I consider to be the key findings of the FCE report, dated 27 June 2024:

'The purpose of the FCE was to explore (Mrs S') physical abilities in addition to her pain and exertion levels, restrictions, and limitations, and compare this to the functional requirements of her own occupation…on a full-time basis.

Mrs S declined several tests due to fears of aggravating her symptoms, however, a review of the FCE test results that were possible to be undertaken indicate that the functional abilities demonstrated by Mrs S cannot represent her true capabilities and I can only therefore conclude that her actual abilities are far greater than she was willing to perform during the assessment. Therefore, Mrs S' self-reported severe disability, pain, and exertion levels, and her demonstrated markedly restricted and limited workday tolerances during formal testing cannot represent barriers preventing her from returning to her normal role. This conclusion is based on the number of inconsistencies and discrepancies demonstrated by her throughout testing….

Furthermore, Mrs S reported and demonstrated severe level of disability during formal testing does not correlate with her reported abilities to undertake some activities of daily living. This again indicates that her actual level of function is far greater than she demonstrated during direct FCE testing…

Mrs S reported severe levels of disability, exertion, and pain during the FCE. However, it is noted that she was able to converse normally at all times and there were no organic signs (breathlessness, constant agitation, or sweating) normally associated with these levels, indicating that there is evidence of significant symptom exaggeration during testing…

Whilst Mrs S demonstrated on direct testing significant left and right key, tip, and palmar pinch strength deficits, these abilities were observed to increase markedly on distraction observations and testing. This indicates that she performed with submaximal effort and attempted to simulate weakness in these direct tests. Therefore, the results of these tests should be viewed as invalid and further indicative of her ability to function to a greater extent than she was prepared to demonstrate during formal testing.

Mrs S demonstrated no meaningful ability to reach out during formal testing, however, during distraction testing, her ability to reach out was observed to be far greater. This is further indicative of her ability to function to a greater extent than she was prepared to demonstrate on direct testing…

Based on the above inconsistencies and discrepancies, it is concluded that Mrs S attempted to simulate disability during FCE testing, and therefore her reported levels of disability, pain, and exertion, and demonstrated markedly restricted and limited physical workday tolerances during formal testing cannot be viewed as barriers preventing her from returning to her normal role.'

In August 2024, after the claim was declined, Mrs S' GP wrote a letter in support of her claim. Again, I've set out below what I think are the key points:

'I believe that (Mrs S') symptoms…will improve with time and further treatment. However, they have caused her significant debility and impacted negatively on her activities of daily living. At present, they continue to limit her, causing difficulties with bending, lifting, manual dexterity and prolonged weight bearing…

Understandably, the impact of these physical symptoms and the fact they have rendered her unfit for work have also affected (Mrs S') mental health. She describes symptoms of anxiety and stress related symptoms…

During multiple GP and physiotherapy assessments from March 2023 to date, she has been assessed as totally unfit for any work, due to the severity of her symptoms and the associated loss of function.

The nature of her job, the travel time involved in getting to work and the loss of function she has experienced due to her back, pelvic, hand and foot pain were all considered and, as her GP, I felt she was unable to work in any capacity during that time.'

I've thought very carefully about all of the evidence that's been provided and which was available to Vitality when it made its final decision on Mrs S' complaint. 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 – or to substitute expert medical opinion with my own - and it would be inappropriate for me to do so.

It's clear that Mrs S was suffering from painful and persistent symptoms. I'm mindful that Mrs S' GP is supportive of her claim and has explained why they believed Mrs S was unfit for work. And I accept that a consultant OH physician concluded that Mrs S was unfit for work and would remain so for some months.

On the other hand, I need to bear in mind that the GP's evidence seems to be based on Mrs S' self-reported symptoms. And the OH report specifically refers to the fact that their opinion is based on Mrs S' reporting of her clinical history. As such, I think it's fair to conclude that much of this evidence is subjective in nature.

The FCE was paid for by Vitality but was carried out by an independent company. I've seen no evidence that Vitality was seeking to impose barriers to Mrs S making a successful claim by arranging the FCE – insurers often arrange independent assessments when considering income protection claims. The FCE was carried out by a medical professional and was based on a number of functional ability tests. So in my view, this is persuasive objective medical evidence of Mrs S' capacity at the time of the assessment.

I appreciate Mrs S has been undergoing physiotherapy and that she was referred to ICATS. But I haven't seen enough compelling medical evidence from Mrs S' physiotherapist or orthopaedic specialist which shows how or why her symptoms would prevent her from carrying out the material and substantial duties of her role.

Having considered all of the available evidence, I don't think it was unfair for Vitality to place more weight on the objective findings of the FCE when it considered Mrs S' claim. I can see that it also clearly assessed the medical evidence alongside an assessment of Mrs S' job profile, as I'd reasonably expect it to do. And based on the independent, objective conclusions of the FCE, I don't think it was unreasonable for Vitality to conclude that Mrs S hadn't shown she met the policy definition of incapacity.

I'd like to reassure Mrs S that I'm not suggesting that she was fit for work. I appreciate she was medically signed-off. And I understand she's been through a very difficult time. But I need to decide whether I think she's shown she met the policy definition of incapacity for the whole of the deferred period and beyond. As I've explained, I don't think she has.

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

Vitality accepts it didn't handle Mrs S' claim as promptly as it should have done. It didn't give an outcome to her claim until October 2024 – around 10 months after the claim was made. This was clearly unreasonable and I don't doubt it caused Mrs S additional, unnecessary trouble and upset at an already worrying time. I can also see that she was put to some inconvenience in chasing things up with Vitality and that it failed to respond to her when it said it would. Vitality has paid Mrs S total compensation of £850 to reflect the impact of its claims handling on her. In my view, this is a fair, reasonable and proportionate award to reflect Mrs S' distress and inconvenience while her claim was being considered.

Overall, whilst I sympathise with Mrs S' position, I don't think Vitality acted unfairly or unreasonably when it turned down her 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 Mrs S to accept or reject my decision before 14 February 2025.

Lisa Barham
Ombudsman