DRN-5329266

The complaint

Ms S is unhappy that Aviva Insurance Limited (Aviva) has declined her Personal Accident claim.

What happened

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

Ms S had a personal accident policy arranged through her employer. The policy was underwritten by Aviva.

Ms S had an accident and injured her ankle in 2019. She had surgery and submitted a claim for Permanent Partial Disablement (PPD) to Aviva. It assessed the claim and offered to pay Ms S 15% of the total benefit payable of £31,250 for her ankle injury. Ms S didn't accept this, and so Aviva referred this to its Chief Medical Officer (CMO). A desktop review was carried out and Ms S's loss of function in the toes was 30% and for the ankle was 40%. So, Aviva offered a revised increased amount. Ms S didn't accept this offer. The claim was then referred to an Independent Medical Examiner (IME). Aviva informed Ms S that the offer could change depending on what the report says. The IME assessed the loss of function in the ankle at 10% and therefore lowered the offer to £3,125.

Ms S wasn't happy and brought her complaint to this service. A final decision was issued which said Aviva hadn't done anything wrong in settling the claim for £3,125. The ombudsman said though that Ms S could obtain a specialist's opinion on what her loss of use was within 24 months of the accident as stated within the policy terms and conditions. She could then provide this to Aviva to re-assess.

In 2022, Ms S submitted a claim for Permanent Total Disablement (PTD). Ms S sent evidence to Aviva which showed she was no longer working and was unfit to return to work. The claim was declined. She brought the complaint to this service. Our investigator didn't think the claim had been declined unfairly.

In September 2024, Ms S made a complaint to Aviva as she'd submitted a claim for PPD which it had declined. Aviva issued a final response on 8 January 2025. It said the new medical evidence was provided over five years since the accident and it cannot consider a worsening of the symptoms past the 24-month period.

Unhappy, Ms S has asked this service to consider the claim decline by Aviva. Our investigator didn't uphold the complaint. He didn't think Aviva had declined the claim unfairly or outside the terms of the policy. The new medical evidence that Ms S provided was from an assessment carried out more than two years after the accident and a worsening of the symptoms couldn't be considered.

Ms S disagreed and asked for the complaint to be referred to an ombudsman. So, it's been passed to me.

In summary, Ms S said Aviva has acted unreasonably and has failed to follow the policy terms and the guidance provided by this service from a final decision that was issued on a previous complaint. Ms S said she would like Aviva to acknowledge the findings of the report from the IME and reconsider her claim based on the new percentages of loss of work-related function and loss of mobility. The whole situation has left Ms S in significant financial and emotional distress.

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.

Industry rules set out by the regulator (the Financial Conduct Authority) say that insurers must handle claims promptly and fairly and shouldn't unreasonably reject a claim. I've taken these rules into account when making my final decision about Ms S's complaint.

Having done so, I'm sorry to disappoint Ms S, but I won't be upholding her complaint. I'll explain why.

At the outset, I wanted to make clear the parameters of this decision. I understand that Ms S has referred to a previous final decision issued by an ombudsman at this service. The decision, in February 2022, said that if Ms S wished to obtain her specialist's opinion on what her total loss of use was within 24 months of the accident (as this is the timeframe set out by the policy terms), she should provide this to Aviva for consideration. I want to be clear that I understand why Ms S has referred to this final decision as this was why she sent new medical evidence to Aviva for re-assessment of her claim. But I can't comment on the final decision any more than this. And I can't comment on the other complaint this service looked at or any medical evidence prior to bringing this complaint. I can only look at the claim and Ms S's complaint referred to in the final response of 8 January 2025.

It's also important to point out that we're an informal dispute resolution service, set up as a free alternative to the courts for consumers. In deciding this complaint I've focused on what I consider to be the heart of the matter rather than commenting on every issue or point made in turn. This isn't intended as a discourtesy to Ms S. Rather it reflects the informal nature of our service, its remit and my role in it.

I need to determine whether Aviva has declined Ms S's claim fairly.

Accidental Bodily Injury is defined in the policy as:

> '*Bodily injury caused by an Accident and which solely and independently of any other cause (except illness directly resulting from medical or surgical treatment rendered necessary as a result of such injury) occasions the death of or loss or disablement to the Insured Person within 24 months from the date of the Accident by which such injury is caused.'*

I can see Ms S sent Aviva further medical evidence for her claim to be re-assessed for Permanent Partial Disablement. I've considered the medical evidence.

The medical report carried out by a Consultant Occupational Physician was on 21 April 2024. The conclusion of the report was that Ms S was significantly disabled in everyday activities in the region of 40% and in respect of her work in the region of 50-60%. This percentage disability related to her injury in April 2019. A further update was provided by the physician which stated that he remained of the same opinion as stated in the report of 21 April 2024 regarding her disability.

Ms S's GP also provided a report stating her opinion was that she was permanently totally disabled due to the sustained injuries in April 2019.

Both reports are detailed and provide Ms S's medical history as well as an assessment of her current medical state following the injury in April 2019. It's clear that Ms S's condition has worsened since the accident in April 2019 and that she is suffering. I understand based on the reports why Ms S thinks she should now receive an increased benefit in line with the physician's report. However, I have to consider that Ms S has provided medical evidence which is almost five years after the injury actually happened. The reports are an assessment of Ms S's situation as at April 2024. So, given that the latest assessment was carried out in April 2024, I don't think the claim has been re-assessed unfairly or that it's been declined unfairly. The issue isn't that the assessment was carried out in April 2024 but that it doesn't provide a medical opinion of Ms S's condition with 24 months of the injury.

I've considered Ms S's comments that there's nothing is the policy terms that states medical evidence can't be provided and re-assessed and there's no time limit given. But the issue is that the new medical evidence Ms S has provided shows her state of condition at around April 2024 – and not her condition within the 24-month period. The physician has provided his opinion based on Ms S's percentage loss almost five years after the injury.

I've also considered Ms S's dissatisfaction as to the delays caused by Aviva in making a decision about the claim. I note that Aviva was communicating with Ms S's solicitor who was representing her on her previous complaints. It continued to communicate with the solicitor until Ms S informed Aviva that they were no longer representing her and to direct communication to her instead. Once this service had made Aviva aware, it re-assessed the claim and provided Ms S with a final response. I can also see Aviva apologised for the confusion in its communication. As such, I don't think avoidable delays were caused by it and I don't think they were unreasonable.

I realise the understandable strength of feeling Ms S has on this matter. But, overall, taking everything into account, I don't think Aviva declined her claim outside the policy terms and conditions or did so unfairly. I also don't think it caused avoidable or unreasonable delays in dealing with the claim. I'm sorry to disappoint Ms S, but it follows that I don't require Aviva to do anything further.

My final decision

For the reasons 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 Ms S to accept or reject my decision before 10 April 2025.

Nimisha Radia
Ombudsman