DRN-5393643

The complaint

Miss P complains that Legal and General Assurance Society Limited (L&G) has turned down an incapacity claim she made on a group income protection insurance policy.

What happened

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

Miss P is insured under her employer's group income protection insurance policy. The policy provides cover if Miss P is incapacitated from carrying out her own occupation due to illness or injury. The policy deferred period is 26 weeks.

In April 2023, Miss P was signed off from work suffering from facial pain and fatigue, which was linked to treatment she'd previously received for another medical condition. Her employer subsequently made an incapacity claim on Miss P's behalf.

L&G asked for medical evidence to allow it to assess Miss P's claim. And it arranged for one of its Vocational Clinical Specialists (VCS) to speak with Miss P about her condition. The VCS concluded that Miss P would be fit to work in her own occupation with reasonable adjustments made to her role. L&G also asked its Chief Medical Officer (CMO) to review Miss P's claim. The CMO agreed that Miss P would be fit for work with reasonable adjustments. The CMO noted too that Miss P had been experiencing symptoms of facial pain and fatigue for a number of years and that there wasn't enough objective medical evidence to show Miss P's symptoms had significantly deteriorated.

On that basis, L&G concluded that Miss P hadn't met the policy definition of incapacity and so it turned down her claim.

Miss P was unhappy with L&G's decision and she asked us to look into her complaint.

Our investigator didn't think Miss P's complaint should be upheld. He felt it had been reasonable for L&G to rely on the available medical evidence to conclude that the policy definition of incapacity hadn't been met.

Miss P provided new medical evidence from her treating doctors, which the investigator went on to look at. But as the new evidence didn't change the investigator's view, Miss P asked for an ombudsman to consider her complaint. So the complaint was passed to me to decide.

I issued a provisional decision on 26 February 2025 which explained the reasons why I didn't think L&G had treated Miss P unfairly. I said:

'First, I'd like to reassure Miss P that while I've summarised the background to this complaint and her 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 Miss P needing to make a claim and I don't doubt what a worrying and upsetting time this has been for 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, the policy terms and the available medical evidence, to decide whether I think L&G handled Miss P's claim fairly.

I've looked closely at the terms and conditions of the policy, as these form the basis of Miss P's employer's contract with L&G. Miss P made a claim for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate for L&G to consider whether Miss P's claim met the policy definition of incapacity. This says that incapacity:

'Means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.

The insured member's capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him.'

This means that in order for L&G to pay Miss P incapacity benefit, it needs to be satisfied that she had an illness or injury which prevented her from carrying out her own occupation for the entire 26 week 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 Miss P's responsibility to provide L&G with enough medical evidence to demonstrate that an illness had led to her being incapacitated from carrying out her own occupation between April and October 2023 and beyond.

L&G assessed the evidence Miss P provided in support of her claim, including seeking the opinion of its clinical staff. And it wasn't persuaded that she'd shown she met the policy definition of incapacity. So I've next looked at the available medical evidence to assess whether I think this was a fair conclusion for L&G to draw.

Miss P's GP surgery sent L&G copies of her medical records. I can see that in April 2023, Miss P was signed-off from work with facial pain and fatigue. The GP stated that Miss P had chronic right sided facial pain following surgery in 2016. It seems that the GP continued to issue fit notes at Miss P's request on an ongoing basis, as she continued to experience these symptoms. The medical records also show Miss P had been signed-off with these symptoms prior to April 2023. In September 2023, the GP noted that they'd extended Miss P's fit note for a further three months, as she'd spoken to her manager and there was no other alternative role available to her. But the GP recorded that if another role did become available, they could amend the fit note.

In June 2023, Miss P was seen by an occupational health adviser (OHA). In brief, the OHA's report concluded that based on Miss P's reported symptoms, she was unfit for work in any capacity and that there were no adjustments or modifications that could be made which would allow Miss P to return to work.

As I've set out above, L&G arranged for Miss P to consult with a VCS (a nurse) in July 2023. I've looked at the VCS' report and I've set out below what I believe to be their key conclusions:

'Based on the members reporting today, in my clinical opinion, there does appear some scope for the member to return to her own occupation with adjustments in the generic role. The member reported barriers of pain and fatigue affecting her work ability however she appears to have an adequate typical day function. She is not under specialists and there appears no restriction on her driving despite her reported dizziness. The member was able

to provide a full and detailed history today and although she appeared to be struggling at times, reasonable adjustments are likely to support her return to work.

It does appear based on the history she may be able to return to work with flexibility from her employer…Reasonable adjustments could support the member back into the workplace. I have not arranged a follow up with the member as she appears fit to return to her own occupation and have uploaded a return-to-work plan.'

L&G's CMO reviewed all of the evidence in January 2024 and again, I've set out below what I think is their key finding:

'My opinion is there insufficient objective evidence of an illness or injury of sufficient severity to result in ongoing and total incapacity for the member relative to the demands of her generic own occupation, based on my review of the evidence.'

In March 2024, following L&G's decision to decline Miss P's claim, her GP wrote a letter in support of it. They reiterated that Miss P had a history of right-sided facial pain, which was triggered by her work equipment. The letter said that Miss P had been seen by neurology in January 2024 and was waiting for an MRI. The GP stated that Miss P 'has struggled at work because of her symptoms which are poorly controlled. She does not feel able to return to work.'

And Miss P also let L&G know that the DWP had carried out an assessment with her and found her to have limited capacity for work.

L&G asked the CMO to re-review the claim, taking into account the GP's letter and Miss P's appeal. In my view, this was a reasonable and appropriate step for it to take. The CMO stated:

'There is no further medical evidence to support any significant change in her condition, noting my comments are from c 6 months ago now. Medication…is not a pre-requisite for work with reasonable adjustments, noting her overall function and the wider evidence to date, in my view.

The member…has been proactively looking to remain with the employer in an amended role.'

Miss P provided a further OHA report, dated August 2024, which found that Miss P was unfit to carry out the duties of her role.

I've thought very carefully about all of the evidence that's been provided and which was available to L&G when it made its final decision on Miss P'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.

It's clear from the evidence that Miss P has been suffering from ongoing and painful symptoms. And I accept that her GP referred her for further investigation and concluded that Miss P isn't fit to work. I also appreciate that in June 2023, the OHA considered that Miss P wasn't fit for work in any capacity. This was restated by another OHA over a year later. It does seem that both OH reports were based on Miss P's self-reporting of her symptoms.

However, I don't think the GP clearly explained how or why Miss P's symptoms would prevent her from carrying out the generic duties of her own occupation. And a DWP *assessment doesn't generally consider the same criteria an insurer takes into account when assessing whether or not a member meets the terms of an income protection policy.*

In the circumstances, I don't think it was unreasonable for L&G to place more weight on the expert clinical opinion of its CMO to conclude that Miss P's condition didn't meet the policy definition of incapacity during the deferred period. That's because the CMO is a specialist in occupational medicine. Nor do I think it was unreasonable for the CMO to conclude that the medical evidence indicated Miss P had been suffering from similar symptoms for a number of years, which hadn't prevented her from working, and that there was little evidence of a significant deterioration in her condition between April and October 2023. I think there was little objective medical evidence to outweigh the findings of L&G's CMO and that therefore, it wasn't unreasonable for L&G to find that Miss P's claim wasn't covered by the policy terms.

In February 2025, Miss P sent us new medical evidence from her GP and neurologist. Generally, L&G would need to be given a chance to assess any new medical evidence to consider whether or not it alters its understanding of a member's claim. In this case, the investigator took the evidence into account, as well as sending it to L&G – although I note L&G hasn't provided any comments on the new evidence. In these very particular circumstances, given L&G has had an opportunity to look at the new evidence, I think I can fairly comment on it within this decision.

Miss P's GP again set out details of Miss P's history of facial pain and spasms following her past treatment. They stated that Miss P had tried adaptations at work which hadn't helped. The GP stated:

'Miss P has a long-term condition with ongoing symptoms. She is currently taking (medication) to manage her symptoms.'

The neurologist enclosed a copy of a clinic letter from January 2024. They said:

'During this consultation, we did not talk much about your work. I can imagine that having such a condition makes work very difficult…Clearly, how you do your work will be very important as to how it provokes these symptoms.

…

I think probably an occupational health doctor would be able to offer a much better opinion as to how this affects your work in order to help with your appeal.

All I can say is that your symptoms are disabling and I am sure they are precipitated by the work that you do.'

It doesn't seem to me that either the GP or neurologist have explained in a detailed way why Miss P's symptoms would mean she was fully incapacitated from carrying out the duties of her own occupation. Indeed, the neurologist seems to have indicated that they're not sufficiently qualified to make an occupational health decision. I'm mindful that L&G's CMO, who is an occupational health doctor, has already had an opportunity to consider Miss P's medical records and offer an opinion on her ability to work. As I've said, their conclusion is that Miss P isn't incapacitated in line with the policy definition.

As such, I don't think the new medical evidence Miss P has provided is enough to persuade me that L&G acted unfairly when it concluded that Miss P hadn't shown she met the policy definition of incapacity throughout the deferred period.

I'd like to reassure Miss P 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 afterwards. As I've explained above, I don't currently think she has.*

On that basis then, I don't think L&G acted unreasonably when it turned down Miss P's claim.

It's open to Miss P to obtain new medical evidence in support of her claim, should she wish to do so. I must make it clear that she would need to a send this to L&G for its consideration. It would then be for L&G to decide whether the new evidence alters its understanding of her claim. If Miss P is unhappy with any further assessment of her claim, she'd need to make a new complaint to L&G about that issue alone.

Overall, while I sympathise with Miss P's position, I don't think L&G has treated her unfairly. And I don't currently think it was unfair or reasonable for L&G to turn down her claim.'

I asked both parties to send me any additional evidence or comments they want me to consider.

L&G accepted my provisional findings.

Miss P disagreed with my provisional decision and I've summarised her responses:

- Her facial spasms started in 2023, not in 2016 – so they couldn't be considered to be pre-existing;
- She found talking about her symptoms and situation difficult and she felt there'd been a lack of sensitivity or understanding;
- Medical professionals had suggested adjustments her employer could make to support her, but her employer hadn't agreed to implement them.

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 sorry to disappoint Miss P, I still don't think it was unfair for L&G to turn down her claim for the reasons I gave in my provisional decision. I'll now explore Miss P's further points.

When L&G and its clinical team assessed Miss P's claim, her symptoms were considered in the round. This means L&G took into account all of Miss P's symptoms during the deferred period to decide whether or not it believed her claim met the policy definition of incapacity. While one of Miss P's specific symptoms may not have begun until 2023, L&G needed to decide whether *all* of her symptoms meant she was incapacitated from carrying out the essential duties of her role throughout the deferred period and beyond. I explained in my provisional decision why I thought it had been fair for it to conclude that Miss P hadn't shown she met the policy definition of incapacity throughout the deferred period. And based on all I've seen; I still don't think L&G treated Miss P unfairly. I think it took fair and reasonable steps to obtain relevant medical information and to seek appropriate clinical opinion when it assessed her claim.

Miss P has raised concerns about her employer's failure to implement potential adjustments which may have allowed her to carry on working. However, L&G isn't responsible for Miss P's employer's actions or for arranging adjustments for Miss P with her employer. If Miss P is unhappy with her employer's actions, she'll need to complain about those issues directly to her employer.

Overall, I do sympathise with Miss P's situation and I know she's been through a difficult time. I'm sorry to cause her further upset. But based on all of the available evidence, I don't think L&G acted unfairly when it turned down her claim.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss P to accept or reject my decision before 15 April 2025.

Lisa Barham
Ombudsman