DRN-5400499

The complaint

Mrs J is unhappy that Legal and General Assurance Society Limited (L&G) has declined her income protection claim.

What happened

Mrs J is insured under her employer's group income protection policy. The policy pays a benefit in certain circumstances if Mrs J is unable to carry out her employment, after a deferred period of 26 weeks. L&G is the underwriter of the policy.

Mrs J was first off from work in October 2023. She did not return to work as she was feeling very unwell. Some of the reported symptoms were fatigue, feeling anxious, low mood, poor concentration and difficulty sleeping. She was prescribed medication for depression and was on a waiting list for therapy.

She submitted a claim to L&G. It reviewed the medical information and declined her claim. It said the objective medical evidence was not supportive of Mrs J's incapacity and the claim was declined as it didn't meet the definition of incapacity as per the terms and conditions of the policy.

Mrs J appealed L&G's decision to decline the claim. It reviewed further information but maintained its position.

Mrs J made a complaint to L&G about her claim being declined and that she was unhappy L&G's Chief Medical Officer (CMO) wrote to her GP. L&G said its decision to decline the claim hadn't changed and it hadn't treated Mrs J unfairly by requesting information from her GP.

Unhappy, Mrs J brought her complaint to this service. Our investigator didn't uphold the complaint. He didn't think there was sufficient medical evidence to meet the definition of incapacity as per the terms and conditions of the policy or that she's been treated unfairly.

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

In summary, Mrs J feels strongly that her doctor's diagnosis and the occupational health doctor's report have been disregarded. There is a leaning towards her illness being stress instead of depression. Mrs J also said the action L&G took to write to her doctor was unacceptable and unprofessional.

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.

At the outset, I wanted to acknowledge that the whole situation has been very difficult for Mrs J. Whilst I understand that she is unwell, my role is to reach an independent and impartial outcome that's fair and reasonable, based on the information available to me. I

don’t doubt that Mrs J has been impacted by her depression, but this doesn’t automatically mean that L&G must pay her claim.

The relevant 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 terms of this income protection policy and the circumstances of Mrs J’s claim, to decide whether I think L&G treated her fairly.

It’s 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 Mrs J. Rather it reflects the informal nature of our service, its remit and my role in it.

I’ve first considered the terms and conditions of this policy, as it forms the basis of the contract between L&G’s employer and L&G.

The wording in the policy document is as follows:

> *‘Own occupation*
>
> *Means the insured member is incapacitated by an illness or injury that prevents him from performing the essential duties of his own occupation immediately before the start of the deferred period.’*

Generally, in insurance, it’s for the consumer to show their claim is valid. In this case, Mrs J is required to provide medical evidence to show she is unable to work and cannot perform the essential duties of her employment due to injury or illness.

For the avoidance of doubt, I’m not medically qualified so it’s not for me to reach any determinations about Mrs J’s medical diagnosis or to substitute expert medical opinion with my own. Instead, I’ve weighed up the available medical evidence to decide whether I think L&G acted fairly and reasonably in declining Mrs J’s claim.

I’ve been provided with medical evidence relating to Mrs J’s illness. The issue for me to determine is whether I think the medical evidence supports L&G’s decision that Mrs J doesn’t meet the policy definition of incapacity. This is the test that I have to consider.

The occupational health assessments supported Mrs J’s inability to work based on the symptoms she reported. The follow-up occupational health assessment in April 2024 said Mrs J was struggling with her depression which was the primary reason for her absence from work. She was due to have her medication increased and was on a waiting list for therapy. The assessment was that Mrs J was unfit to work due to depression and needed time for the treatment of medication and therapy.

The GP medical records note that in November 2023, Mrs J was struggling with work-based issues. The GP referral for counselling states Mrs J was experiencing depression from a work-related difficulty and from caring for a relative. The notes confirmed that Mrs J was on medication and on a waiting list for therapy. In February 2024, her GP noted that Mrs J’s symptoms pointed towards a diagnosis for depression.

I’ve considered the clinical report dated 12 March 2024. This said Mrs J was off from work from October 2023, and she didn’t return to work. The reason noted for the absence was depression due to a family trauma and caring responsibilities. She wasn’t prescribed medication and was referred for counselling and had one session. Mrs J then started

medication in January 2024 but stopped as she didn't feel it was helping. Later there are notes that the dosage increase was being considered. Mrs J reported that she wouldn't be able to return to work in any capacity. The report said without medical evidence to the contrary, this was not a medical issue. Mrs J could return to her role with reasonable adjustments as she was suffering from stress like symptoms directly related to personal stress.

The CMO's opinion was based on an independent review of all of Mrs J's medical records. In his opinion, the GP didn't suggest a diagnosis, therapy or treatment escalation that totally excluded Mrs J from working through the deferred period and beyond. He stated that there was insufficient objective evidence of an illness or injury of sufficient severity to result in total and ongoing exclusion from her own occupation.

I've thought carefully about the medical evidence and all of the other information provided. But I have to look at this in its totality. The occupational assessments and the GP records are based on self-reported symptoms. Whilst Mrs J was prescribed medication and has been referred for therapy, I note there has been no further intervention or escalation for treatment. There are notes in the GP records as well as the occupational health assessments that there are work-based issues alongside the caring of a family member. However, the care responsibilities have been reduced to once a week from the information available. L&G's CMO reviewed all of the medical information. So, on balance, I think this carries more persuasive weight.

I don't agree that the doctor's diagnosis or the occupational health assessment have been disregarded. These have been taken into account when L&G reviewed the claim. I appreciate the outcome of the claim wasn't what Mrs J had wanted. But that doesn't mean evidence had been disregarded.

And whether there has been a leaning towards stress rather than depression, in the circumstances, I don't think makes a difference. It's the medical evidence that's been reviewed in its entirety to reach an outcome and as I've said above, the test is whether the illness or injury meets the definition of incapacity, and which precludes Mrs J from working. I don't doubt that Mrs J is feeling unwell.

I also understand L&G's CMO contacting her GP directly caused her concern. However, I don't think this action was unreasonable. Mrs J had given her consent for L&G to obtain medical records and share her medical information with her doctor for the purposes of reviewing her claim.

Ultimately, the test is whether Mrs J meets the definition of incapacity as per the policy terms and conditions. And having reviewed everything, I don't think it's likely she does. I'm not persuaded there's sufficient medical evidence to say Mrs J is incapable to carry out the essential duties of her own occupation.

Based on all the available evidence, I'm sorry to disappoint Mrs J. But I don't think L&G has declined her claim unfairly. I don't find that there are any reasonable grounds upon which I could direct L&G to pay Mrs J's claim. It follows therefore that I don't require L&G to do anything further.

My final decision

For the reasons given above, I don't uphold Mrs J's complaint about Legal and General Assurance Society Limited.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs J to accept or

reject my decision before 13 May 2025.

Nimisha Radia
Ombudsman