DRN-5455667

The complaint

Mr S complains that Legal and General Assurance Society Limited ('*L&G*') has unreasonably refused a claim he made under a group income protection policy.

What happened

Mr S was a member of his employer's group income protection policy, underwritten by L&G – though his employment has since ended in August 2024. At the time he was employed, Mr S's policy was designed to pay monthly benefit of 50% of his salary should he be incapacitated due to an illness or injury preventing him from completing the essential duties of his occupation throughout a deferred period of 26 weeks and beyond. This applied for a 24-month period, following which the policy definition changed to a wider definition based on any suited occupation.

Mr S first went off work sick in December 2022. Though he did briefly attempt a return to work, this was sadly unsuccessful and in February 2023 he was signed off sick again. In May 2023, Mr S's employer assisted him in pursuing a claim to L&G. Mr S confirmed on his claim form that he was unable to work due to depression and anxiety.

In June 2023, Mr S underwent a remote assessment with a vocational clinical specialist ('*VCS*'). A further assessment took place in July 2023. However, it was noted by the VCS that he did not want to engage with other therapy. L&G therefore informed Mr S's employer that it would be closing his claim.

In September 2023, Mr S reinstated the claim process, noting he now realised he should engage with treatment if this assisted his claim. After attending a further VCS assessment the following month, he agreed to begin cognitive behavioural therapy ('*CBT*') through L&G's chosen provider.

In October 2023, Mr S also underwent an independent medical examination via a remote meeting with a consultant psychiatrist. In this assessment, his employment was discussed, and the claim was referred to L&G's chief medical officer ('*CMO*') for consideration. The CMO concluded that Mr S appeared to have suffered a total breakdown in his working relationship with his employer, and this appeared to be the main barrier in preventing his return to work. The CMO also believed Mr S could undergo CBT alongside a phased return to work.

In December 2023, Mr S was offered further CBT sessions, but he didn't want to take up L&G's offer.

In January 2024, L&G refused Mr S's claim. Mr S appealed the claim decision in February 2024, noting though he had since gone back to work, his employer had called an ambulance for him due to concerns about his depression. He said his medication had been increased, which also showed the impact of his illness. Mr S also undertook a subject access request with L&G, which was completed in May 2024. He then reconfirmed his appeal following a review of the information supplied to him in the subject access request.

L&G treated Mr S's appeal as a complaint. It issued a final response letter to the complaint in June 2024, where it said though Mr S told it that the extent of his depression included concerns regarding suicidal thoughts, his GP had not escalated his treatment pathway beyond the CBT offered through L&G. And similarly, when his employer had called an ambulance for him in January 2024, this was refused by Mr S and no further action was taken by the attending medical professionals.

Overall, L&G remained of the view that Mr S's inability to return to work had been primarily driven by issues in his employment, and though Mr S was reluctant to engage with medical treatment, it did not see any objective medical evidence that would have (previously) prevented him from attempting a return to work.

Mr S thereafter lodged his complaint with this service. One of our investigators reviewed the complaint, but she didn't think it should be upheld. She felt the medical evidence suggested Mr S had been unable to work because of workplace issues, which did not resolve when he briefly attempted to return to work in early 2023. She did not doubt the impact of Mr S's mental health impairment which required (increased) medication; however, she didn't think he had shown that his illness was the reason he was unable to work, rather than the workplace stressors which had caused him to go off sick on both occasions.

Mr S disagreed, sending further comments via emails to our investigator. He said, in summary:

- The investigator did not refer to the appointment that he had with the psychiatrist – at L&G's request – where it was set out that he was not fit to work.
- Despite Mr S finding the psychiatrist abrasive, the psychiatrist concluded that he could not currently work, due to his mental health.
- His GP also reaffirmed this by providing statements of fitness for work ('fit notes') throughout this period.
- The dose of his medication was high – and not indicative of moderate depression, as had been suggested by L&G.
- It was incredibly challenging for him to seek help; this in turn impacted his mental health to the extent that the medical evidence included reference to suicidal thoughts.
- He did engage with the CBT that was enforced by L&G, despite it suggesting otherwise.
- However, it was only through his own research that he began to understand his condition in better detail.
- Given he had done his own research, he refused further CBT, but he did this only because L&G said it was optional.
- It is only with hindsight that he realises he shouldn't have attempted the brief return to work, but this was caused by the impact of his severe depression and advice from a friend at the time.
- He feels that the weight of evidence – his testimony, the medical evidence and the amount of time spent off work – should reasonably have shown he has met the policy definition.
- He wants his complaint to be reconsidered by an ombudsman.

Though she considered the further submissions from Mr S, our investigator did not change her view on the complaint. She felt that L&G had fairly concluded that Mr S's barrier to work was the workplace environment, and therefore the requirements of the policy wording hadn't been met.

Mr S said he appreciate the consideration our investigator had given. However, he still

wanted the complaint to be reviewed afresh by an ombudsman. Over some further emails, he also noted:

- L&G set out that he didn't otherwise engage with treatment, such as counselling. He had tried this through the GP some 20 years previously and it hadn't worked for him.
- As set out before, he did listen to the GP – by increasing the dosage for his medication and undergoing CBT.
- He feels L&G has undertaken a tick box exercise, but it had already decided to avoid paying his claim at any cost.
- It is only with hindsight that he realises it was so difficult to navigate depression, because his mind was working against him.
- Ultimately, he feels L&G's actions are an egregious denial of a legitimate claim.

L&G didn't have anything further to add. The complaint has now been passed to me.

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.

I thank both parties for their patience whilst this matter has awaited an ombudsman's decision.

I've fully reviewed all the information before me, including the representations Mr S made following our investigator's view. However, in reaching my findings, I've focused on what I consider to be the central issues. I don't need to comment on every argument in order to reach what I believe is the right outcome in the circumstances. Our rules allow me to take this approach; it reflects the informal nature of our service, as a free alternative to the courts.

On that basis, I haven't set out the complete details of Mr S's medical or employment circumstances, though I've carefully considered everything I've seen when reaching my decision. I also send Mr S my best wishes as I realise that his circumstances have been incredibly hard. I was pleased to hear that he says he is doing much better in recent months.

Regulatory rules require L&G to handle claims promptly and fairly and to not unreasonably reject a claim. I've therefore considered the evidence provided by the parties alongside the terms and conditions for Mr S's employer's group policy to determine whether I believe L&G treated him fairly and reasonably by refusing his claim and subsequent appeal.

Having done so, I agree with our investigator that this complaint should not be upheld. That means I won't be asking L&G to pay the claim retrospectively. I know this will be a disappointment for Mr S, but I'll explain my reasons for reaching this view below.

The policy terms set out when the income protection benefit is payable (for the first 24 months on an own occupation basis) after the deferred period, as follows:

> "*Own occupation*
>
> *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."*

Mr S's absence covering the deferred period began from 8 February 2023, after he had attempted a return to work the previous month. He discussed this during his medical assessment with the psychiatrist as well as during the VCS appointments. He also explained to our investigator how he wasn't properly supported following his first absence for depression and anxiety, so he had no choice but to take further time off.

Mr S's employer also gave an account of Mr S's attempt to return to work. L&G concluded from all of the evidence that the stress and upset caused by ongoing issues in the workplace contributed to Mr S being unable to work, as well as impacting his mental health.

I must be fair to both parties in a complaint. I haven't seen objective evidence to demonstrate how the effects of depression and anxiety caused Mr S to be unable to complete the material and substantial duties of his role from 8 February 2023 to 7 July 2023 (the deferred period) and beyond.

Rather, L&G has, in my view, reasonably concluded that the circumstances of Mr S's attempt to return to work resulted in him taking additional time off sick, following a period of many months where Mr S reported a deterioration in the working relationship with his line manager, as well as other wider concern with his working environment. These events impacted Mr S's mental health, and this was set out in notable detail during his VCS appointments and the assessment with the consultant psychiatrist in October 2023.

It is clear from the evidence that Mr S has been through a very difficult period and that only with perspective he has come to realise just how challenging his mental health has been. I do understand why in February 2025 and thereafter he may not have felt able to carry out his occupation for the reasons he has given. Unfortunately, this doesn't mean the above policy definition was met, as that definition requires him to be prevented from working due to being incapacitated by illness.

I do appreciate that Mr S has undergone specialist care in the form of CBT. I can see this has assisted him in alleviating some of the impact of his condition(s) along with his own efforts and his GP's adjustment to his medication. And I'm mindful that such treatment may be addressing underlying mental health issues that aren't solely tied to the impact of stress through employment. However, to satisfy the policy definition Mr S needed to demonstrate, on balance, that his illness was the primary reason for his incapacity. And the weight of evidence shows that Mr S became absent from work due to issues in the workplace, including a lack of support, undue pressure and a negative line management relationship.

From the medical evidence supplied to L&G along with accounts from Mr S and his employer, its CMO had concluded that if Mr S were able to address his workplace stressors or have the opportunity to work with another organisation in a similar role from home, he could resume work with reasonable adjustments alongside receipt of medical treatment and psychological support. I am persuaded by this, and believe L&G has reached a reasonable conclusion on the face of all the evidence in the circumstances.

It follows that I do not believe that this complaint should succeed in respect of L&G's decision to decline Mr S's income protection claim. I cannot therefore agree that it has treated Mr S unfairly or unreasonably in concluding that he hadn't met the policy definition of incapacity during the deferred period and beyond.

My final decision

I am unable to uphold this complaint or make any award.

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

reject my decision before 7 July 2025.

Jo Storey
Ombudsman