DRN-5516393

The complaint

Mrs B is unhappy that Legal and General Assurance Society Limited (L&G) stopped paying the monthly benefit following a successful claim made on a group income protection insurance policy.

What happened

Mrs B has the benefit of a group income protection insurance policy through her employer ('the policy'). Subject to the remaining terms, the policy can pay out a monthly benefit if Mrs B can't work due to illness after the deferred period.

A successful claim was made on the policy because L&G accepted that Mrs B was incapacitated as defined by the policy terms.

The claim was reviewed in 2023. L&G obtained information from Mrs B's oncologist, and she attended a chronic pain abilities determination (CPAD) in December 2023.

L&G notified Mrs B in early 2024 that it would be ending the claim, providing one month's notice. She appealed that decision and provided medical evidence in support. L&G maintained its decision to end the claim and Mrs B brought a complaint to the Financial Ombudsman Service.

Our investigator looked into what happened and recommended the complaint be upheld. He recommended L&G to reinstate the claim and pay backdated monthly benefits to the date the claim ended together with interest.

L&G disagreed. So, this complaint was passed to me to consider everything afresh to decide.

I issued a provisional decision explaining why I wasn't intending to uphold this complaint. I said:

……..

Firstly, I acknowledge and accept that Mrs B has been through a very difficult time and nothing in this decision should be taken to mean that I've overlooked the impact Mrs B's conditions have had on her health. I have every empathy for her situation, and I know that L&G's decision to end the income protection claim has financially impacted her.

The main focus of my decision is whether L&G has acted fairly and reasonably by taking the decision to end the claim when it did. I'm not a medical expert, so I've considered all the medical evidence when determining this issue.

The policy terms say:

> We will immediately end the payment of benefit if:

The insured member ceases to be a disabled member.

Disabled member is an insured member who at any time meets the definition of incapacity and not engaged in any other occupation.

Relevant to this complaint, the policy terms define incapacity as:

> Suited occupation
>
> Means the insured member is incapacitated by an illness or injury so that [she] is unable to undertake all occupations which we consider appropriate to [her] experience, training or education.
>
> For the purposes of this definition an occupation will not be considered to be inappropriate to an insured member's experience, training or education on the grounds that:
>
> i. the pay from such occupation may be lower than that paid to the insured member prior to the deferred period in relation to [her] own job or lower than
> the amount of member's benefit, or
>
> ii. such occupation lacks status or seniority associated with the insured member's own job.

When making a claim, it's for Mrs B to establish that she met this definition of incapacity. She was able to do that, and the monthly benefit was paid by L&G.

As L&G ended the claim, it's for it to show on the balance of probabilities that Mrs B no longer met the definition of incapacity, based on medical evidence. It's not for her to show that she continued to do so.

Has L&G fairly and reasonably ended the claim?

The insurance industry regulator, the Financial Conduct Authority ('FCA'), sets out rules and guidance for insurers in the 'Insurance: Conduct of Business Sourcebook' ('ICOBS'). ICOBS says insurers should act honestly, fairly and professionally in accordance with the best interests of its customers. It also says insurers should handle insurance claims promptly and fairly - and shouldn't unreasonably reject a claim.

I know Mrs B will be very disappointed but I'm intending to find that L&G did act fairly when ending the claim when it did. I'll explain why.

When a claim is accepted, it's common for income protection insurers to review claims from time to time. And in principle, I'm satisfied it was fair for L&G to review this claim.

A clinical report of consultation Mrs B attended with L&G's vocational clinical specialist dated July 2023 reflects:

- Mrs B was still experiencing fatigue and weakness to her left shoulder and left arm. She also felt like her 'mind was not there' and had general widespread joint pains.

- She'd discussed a possible return to work with her employer in August 2023. She felt her fatigue prevented her from returning on full time contractual hours but hoped to return on a phased basis (over three to six months).

- Mrs B reported improved concentration, could prepare snacks during the day, drive locally (for up to 30 minutes) and do short walks.

- Mrs B finished radiotherapy around four months ago.

- The assessor felt based on the information provided by Mrs B she was fit to begin a phased and supported to return to work in her own or suited (sedentary) role. And that Mrs B's function (as reported by her) had greatly improved, both physically and cognitively. The assessor felt a 12-week graded return to work would be appropriate, but Mrs B hoped that this could be extended with more flexibility.

A follow up consultation with L&G's vocational clinical specialist took place the following month and it's reflected that:

- Mrs B had agreed an early stage of a plan with her employer to return to work. Mrs B's function was improving, and she wished to return to work.

A clinical report of the consultation Mrs B attended with L&G's vocational clinical specialist dated September 2023 reflects that:

- Mrs B hadn't returned to work on a phased basis. She had underestimated her fatigue, joint and muscle pains.

- She'd spoken to her manager last week and advised that she didn't feel well enough to return to work until October 2023.

- She'd recently had a severe migraine, was less active than she'd previously reported due to joint pain, was feeling tired all the time, was doing things more slowly and was under the chromic fatigue team to manage her fatigue.

- The assessor still felt Mrs B was fit to undertake a suited sedentary role based on her reported level of recent activity and ability. But functional testing was advised to get a balanced and objective view of Mrs B's capabilities because Mrs B's subjective reporting had significantly changed the past two months.

Because of the conclusions of the vocational clinical assessments, I'm satisfied L&G fairly arranged for Mrs B to attend a two-day CPAD at her home in December 2023. The report concludes:

- Tests and observations were carried out to assess Mrs B's physical and cognitive abilities. "A review of the CPAD results indicates that the physical and cognitive abilities demonstrated by Mrs B cannot represent her true capabilities and I can only conclude that her actual abilities are far greater than she is willing to perform over both days of the assessment".

- "Her reported severe disability, pain and exertion levels, and demonstrated markedly restricted and limited workday physical tolerances, in addition of significant cognitive impairments during formal testing, therefore, cannot represent barriers preventing her from returning to her normal role on a full-time basis. This conclusion is based on the number of inconsistencies and discrepancies by Mrs B throughout the testing". The assessor set out detailed reasons to support their conclusions.

I appreciate that the CPAD gives a snapshot of Mrs B's capabilities over a two-day period.

However, I think it's fair and reasonable for L&G to place weight on this report and it's undertaken by an expert independent of the parties and based on objective tests (although is considered against Mrs B's subjective reporting of her symptoms). Particularly as there seems to be little in the medical evidence to explain why Mrs B's reporting of symptoms of what she was able to do changed between July and September 2023. And further the inconsistencies noted in the CPAD weren't only confined to inconsistencies in the reporting of what Mrs B said she could do in her daily life but also some inconsistencies with what she could do between tests during the CPAD.

The TSA report identified three suited roles for Mrs B. Having considered the contents of the report and the roles identified, I'm satisfied that L&G has reasonably relied on the TSA to conclude that there were suited roles as defined by the policy terms that Mrs B could do with reasonable adjustments and flexibility.

When provisionally deciding this complaint, I've also taken into account all points raised by Mrs B and the medical evidence she provided from medical professionals involved in her care for significant time, as part of her appeal.

Her GP said in February 2024 that:

- Mrs B's symptoms can fluctuate in nature, can cause significant post-exertional malaise and would be very difficult to assess over a period of days.

- She has poor concentration, reduced cognitive functioning, body pain and poor mobility.

However, this is largely based on Mrs B's reporting of symptoms whereas the CPAD was also based on objective testing. And I've explained above why I think L&G fairly relied on the results of the CPAD in conjunction with the vocational clinical assessments to conclude that Mrs B could return to work in a suited occupation.

Whilst the GP also said It would be detrimental to Mrs B's physical and mental health to return to work at that time, they don't explain why or why Mrs B couldn't carry out a suited occupation. So, I've placed less weight on the GP's letter.

I've also considered the letter of Mrs B's trainee health psychologist dated January 2024, who describes fluctuating symptoms. Whilst they conclude that a return to work at that stage would impede Mrs B's recovery, and that noise and light sensitivities in an office environment would be challenging, they don't explain why Mrs B was too unwell to work in a suited occupation with adjustments and flexibility.

I've also taken into account that Mrs B's oncologist wasn't able to provide much insight as to whether she was well enough to carry out a suited role.

So, overall, I don't think L&G has unfairly relied on its chief medical officer's opinion that based on the overall objective medical evidence, and as of early 2024, Mrs B wasn't prevented from doing a suited occupation (with reasonable adjustments) because of illness.
……..

I invited both parties to provide any further comments in response to my provisional decision.

L&G didn't raise anything. Mrs B disagreed with my provisional decision. In summary she said:

- she'd overestimated her ability to be able to return to work.

- the reduction in medication impacted her return to work.

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, I find no persuasive reason for me to change my provisional decision.

I was aware of the points raised by Mrs B in response to my provisional decision, when provisionally deciding this case.

I appreciate the points she makes, particularly around the reduction in medication. However, for reasons explained in my provisional decision – which is set out above and forms part of this final decision – I'm satisfied that L & G has acted fairly and reasonably by relying on the totality of the medical evidence to end the claim when it did. And that it fairly and reasonably concluded that Mrs B no longer met the policy definition of incapacity.

My final decision

I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs B to accept or reject my decision before 27 May 2025.

David Curtis-Johnson
Ombudsman