DRN-5973246

The complaint

Miss T complains that Aviva Life & Pensions UK Limited (‘*Aviva*’) refused a claim she made under a group income protection policy.

What happened

Miss T is a member of her employer’s group income protection policy. Benefit of 50% of Miss T’s salary is provided under the policy in the event that she is incapacitated due to illness or injury, for the duration of a 52-week deferred period and beyond.

In January 2020, Miss T’s employer lodged a claim for income protection benefit on Miss T’s behalf to Aviva.

Miss T had been off sick since September 2018 – a time at which she had sadly been the victim of an assault leading to both physical and mental injuries. A few weeks after this incident, Miss T’s family member had a medical emergency. Then a further few weeks later, Miss T was involved in a serious a car crash whilst overseas. Consequentially, Miss T was left suffering with notable anxiety and mental health concerns as well as needing rehabilitation for an arm injury (and later, whiplash). She was signed off sick by her GP with both posttraumatic stress disorder (‘*PTSD*’), as well as ‘stress at work’ from February to April 2019. Miss T thereafter received a formal diagnosis of PTSD in May 2019 from a consultant psychiatrist, Dr B.

In March 2020, Aviva rejected the claim. It noted that by June 2019, Dr B was reporting that Miss T had made progress which included completing administrative tasks by September 2019. And it also noted that by October 2019, the barrier to Miss T returning to work was resolving issues in the workplace – including considering moving to a different team.

Overall, Aviva said it hadn’t seen sufficient evidence that Miss T’s illness prevented her from performing her own occupation for the full deferred period. It took the view that by 28 September 2019 – the date at which the deferred period ended – Miss T could have returned to her occupation on a graded basis, with appropriate support and adjustments from her employer.

Due to the impact of her mental health and other wider personal circumstances, Miss T was unable to revisit the claim decision until August 2024 when she provided a written complaint to Aviva, a number of years after she had returned to work. It initially refused the complaint, given the time that had passed, and it told Miss T she was out of time to pursue the matter. However, it thereafter agreed to revisit the claim after Miss T explained that she had been advised by Aviva in June 2020 that there was no time limit to appeal its decision.

In September 2024, Aviva rejected Miss T’s claim appeal. It did, however, agree to pay Miss T £750 as a payment to reflect the upset she had been caused by Aviva saying a complaint would be out of time when Miss T had set out why it was made within the time limits applying to the Financial Ombudsman Service. In respect of the appeal to the 2020 claim decision, Aviva was not prepared to change its view. It said it had measured Miss T’s claim in respect of her PTSD – not just stress at work – but felt the medical evidence didn’t sufficiently

demonstrate that she was incapacitated from performing her own occupation.

Miss T brought her complaint to this service. She explained in greater detail the impact that Aviva's claim refusal had on her which included an associated medical situation that was exacerbated by Aviva rejecting her claim – though she did not consent to us sharing any detail with Aviva, so I cannot relay that any further here. I thank Miss T for explaining that impact, and I do not underestimate how difficult things have been for her.

Miss T also said that Aviva had unfairly suggested she could return to work with adjustments to her hours. However, her role necessitated long hours and was stressful – this was something she had discussed with Dr B. it did not alter the fact that her GP continued to sign her off as unfit to work.

One of our investigators reviewed the complaint but she didn't think it ought to succeed beyond Aviva paying the compensation it had already offered to Miss T. She concluded that Aviva had been reasonable in refusing the claim.

Miss T disagreed. She asked for her complaint to be referred to an ombudsman and provided further written submissions. I have considered these in full. In summary, Miss T said:

- She struggles to understand why Aviva could believe that she could work in any capacity at her job, given the severity of the symptoms of her PTSD.
- Her role is highly stressful and takes place within an extremely demanding, client-focused environment.
- To have returned to work during the deferred period would have been detrimental to her mental health.
- Though her GP fitness certificates did mention stress at work for some months from February 2019, these were then changed back to PTSD.
- However, this didn't mean that she wasn't suffering with PTSD throughout.
- Her job required weekend working, long hours and high levels of stress – if she had returned any sooner, she'd have suffered from burnout.
- She feels Aviva has made no genuine efforts to assess her medical evidence and has failed to act in good faith towards her.

Our investigator was not prepared to change her view on the outcome of the complaint. She explained that the complaint would be referred to an ombudsman to which both parties had further time to provide any additional comments for consideration.

Miss T thereafter made a subject access request to establish the extent of medical evidence supplied by Aviva. She also asked for an additional extension to provide comments, should she have any to make upon reviewing the medical evidence.

Miss T thereafter lodged a separate customer service complaint relating to our investigator, on the basis that she wished for a further extension to provide written submissions to this service by the end of October 2025, given she had made a subject access request, and this hadn't been agreed to.

I realise Miss T's strength of feeling about her customer service complaint and I can see that our investigator provided a full written reply to that service issue, as well as providing Miss T with information as to how she could escalate her concerns further if required. I shan't therefore be commenting on our customer service in the context of my decision, though I note that Miss T's required extension date of October 2025 has passed in any event.

Aviva has not made any other comments. 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'd like to thank the parties for their patience whilst this matter has awaited an ombudsman's decision. I also wish to send Miss T my best wishes. I understand how revisiting the circumstances surrounding her claim has been distressing for her and I appreciate Miss T's effort in providing submissions for us to consider, given these concern sensitive issues.

However, I am not able to uphold a complaint or direct a business to pay out on a claim merely because of my empathy for a complainant. And though I recognise Miss T would like this service to examine the documentary evidence in relation to the refusal of her claim. However, I don't agree that is what is required here.

My role isn't to substitute my view for that of a business but instead, to determine if a business has acted fairly in all the circumstances of a complaint. And I will take into account laws, regulations, best practice and industry guidance when considering what I find to be fair and reasonable. When reaching my conclusions, I've focused solely on what I consider are the key issues in the complaint. Our rules allow me to take this approach; it simply reflects the nature of our service as a free alternative to the courts, and no discourtesy is intended by it. If there's something I haven't mentioned, it isn't because I've ignored it. It's since I don't need to comment on each individual argument to be able to reach what I consider is the right outcome in the circumstances.

So, I haven't undertaken my own assessment on the medical evidence to decide the outcome of the claim, but rather, I have examined if Aviva behaved fairly when determining its requirements as set out under the contract of insurance with Miss T's employer.

Having done so, I agree with our investigator that Aviva doesn't need to do anything further to resolve this complaint. That means I won't be asking Aviva to pay the claim retrospectively, though I do agree it ought to honour the payment it has already offered for the mishandling of Miss T's appeal to her claim. I know this will be a disappointment for Miss T, but I'll explain my reasons for reaching this view below.

Regulatory rules require Aviva 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 Miss T's employer's group policy to determine whether I believe Aviva treated her fairly and reasonably by refusing her income protection claim.

The policy terms set out when the income protection benefit is payable after the deferred period, and the policy schedule defines incapacity as:

> "*Incapacity or incapacitated shall mean that a member is incapacitated, by reason of illness or injury, when the insurer is satisfied that the employee is incapable of performing the material and substantial duties of his or her own occupation and is not following any other occupation.*
>
> *Material and substantial means duties that are normally required for and/or form a significant and integral part of the performance of the member's own occupation and which cannot be reasonably omitted or modified by the member or the employer.*"

Having reviewed all of the medical evidence it was permitted to access by Miss T, Aviva determined that it hadn't seen sufficient medical evidence to determine that the impact of Miss T's PTSD caused her to be unable to complete the material duties of her insured occupation over the deferred period from 29 September 2018 to 28 September 2019, and thereafter. And based on everything I've seen, I don't find Aviva to be unreasonable in reaching that view.

To satisfy the policy definition, Miss T had to demonstrate, on balance, that her illness was the primary reason for her incapacity and the impact of that illness prevented her from undertaking the essential duties of her employment. Miss T's diagnosis, the impact of the symptoms caused by that diagnosis and the need for her ongoing treatment weren't in dispute. However, the policy wording required Miss T to evidence that she was totally incapacitated from working in her insured role.

I note how Aviva has explained it felt Miss T could have returned to work with adjustments during the deferred period. It said this noting how Miss T had relied on therapy and psychiatry appointments without medication – and these appointments showed improvements by June 2019, where Dr B had said she was "*doing more now… taking some exercise and… not on medication at present*". By the following month, Dr B said:

> "*Overall, she is feeling better, She has more hope. She found therapy to be very beneficial. Miss [T] is able to do most of the activities of daily living… I am pleased overall that this lady is improving with therapy.*"

Dr B also raised areas where Miss T still had concerns, which included concentration and sleep though he noted he only intended to see her once or twice more before returning Miss T to her GP's care.

Overall, Aviva believed that with some adjustments in place, Miss T would have been able to undertake *some* work during the deferred period – or put another way, that she wasn't entirely incapacitated from working the material and substantial duties of her role altogether. That may have included reduced hours, a phased return to work or a temporary adjustment in terms of duties.

I haven't seen any objective reason to determine that Aviva has drawn unfair or unreasonable conclusions from the information it has been presented with by Miss T and her employer. There wasn't specific evidence to determine Miss T's functionality, such as a vocational assessment, but Aviva contends that this did not mean Miss T was unable to undertake all of her duties. Contrastingly, by September 2019, Dr B had set out that:

> "*When I saw this lady, her mood was brighter. She had more energy. Her concentration is a bit better. She is sleeping better. She is occasionally tearful. She is not suicidal. This lady needs to focus on the things that are important which are [unrelated personal matter] and gynaecological issues. I think in the reasonably near future she could rehabilitate back into work… hopefully matters can be progressed with HR.*"

And in respect of Miss T's physical injuries, it was noted by her treating consultant in February 2019 that he recommended a phased return to full work. I am therefore satisfied that Aviva fairly concluded that it did not believe the impact of Miss T's mental health issues prevented her undertaking the essential duties of her insured role for the full deferred period and beyond, based on the medical evidence it had seen. It follows that I do not believe that this complaint should succeed in respect of Aviva's decision to decline Miss T's income protection claim.

Turning to the administrative issues, I agree with both parties that Aviva unreasonably refused to consider Miss T's complaint because of the passage of time, when it should not have done so. I agree that this failure caused additional concern to Miss T at what was already a difficult time for her, and some compensation ought to be awarded for that.

What this service does is consider if a business has treated a complainant unfairly because of its actions or inactions. And if it has done so, we then go on to consider what ought to be done to put the mistake(s) right. As well as putting right any financial losses in a complaint (though there are none in this circumstance since I agree the claim was fairly declined), we also consider the emotional or practical impact of any errors on a complainant.

Overall, I believe the proposed payment of £750 was reasonable in the circumstances where Aviva caused upset and frustration for Miss T. The mistake had a medium-term impact on Miss T as she had to liaise with Aviva and her employer to establish her right to complain, during a time when she was dealing with additional issues and reliving the impact of the distressing circumstances which led to her original claim.

When we consider awards of this nature, we do not fine or punish businesses; the Financial Conduct Authority undertakes the role of regulator. Instead, we consider the impact upon a complainant. It may be helpful for Miss T to review the guidance available on our website which explains the amounts and types of awards made in instances of upset, trouble, inconvenience and distress caused by businesses in the complaints we see at this service.

Putting things right

I believe that Aviva has taken reasonable steps to resolve the complaint. This was by apologising to Miss T for its initial refusal of her complaint, by promptly considering it thereafter and by offering to pay her £750 for the upset she had been caused by the impact of its mistake. I think this offer is fair in all the circumstances. I note Miss T did not accept this offer. So, my decision is that Aviva should pay £750 to Miss T, as it hasn't been able to make that payment to her to date.

My final decision

For the reasons explained, I uphold this complaint in part. I do not uphold the complaint regarding the declined income protection claim.

However, I agree that the refusal to review Miss T's complaint was unfair, given she had already previously confirmed with Aviva that a time limit did not apply to her appeal. This caused her additional upset at an already difficult time. I find that Aviva's offer to pay Miss T £750 compensation for the impact of its error is reasonable in the circumstances.

I therefore direct Aviva Life & Pensions UK Limited to pay Miss T £750. I make no other award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss T to accept or reject my decision before 22 December 2025.

Jo Storey
Ombudsman