complaint

Mrs S brings this complaint on behalf of the estate of her husband, Mr S. She says that The Prudential Assurance Company Limited ('*Prudential*') has unfairly refused a claim for terminal illness benefit, which would have been payable before the policy expired in 2015.

background

I issued a provisional decision to the parties on 6 February 2019. It is attached to this decision and it should be read as part of my final determination.

On the information available to me, I didn't think Prudential had been unreasonable in refusing the claim. That was because the medical evidence did not support the later statements that Mr S would likely have had less than twelve months to live before the policy benefit expired in October 2014.

Prudential had nothing else to add.

Mrs S wrote a letter in which she confirmed she didn't accept the outcome of my provisional decision. She made various points, noting:

- it is wrong to say Mr S didn't try NIV in June 2014;
- there is further evidence (that Mrs S has supplied) in the discharge letter of June 2014 saying Mr S had tried NIV overnight but he wasn't able to tolerate it;
- up until the point he passed away, Mr S could not tolerate NIV – this is reflected in him having passed away very shortly after being removed from ventilation;
- in respect of Mr S improving after his chest infection, this was because each time he had a deterioration in his health, they would make adjustments to his daily routine;
- for example, this included no longer taking him out in the car because the seating position detrimentally affected his breathing and changing how he used the toilet;
- each time they faced an obstacle together, she and Mr S worked around it as best they could to prolong his life;
- it feels as though she is being penalised because Mr S lived longer than the retrospective twelve month assessment;
- she doesn't agree that he made an improvement - Mr S merely existed rather than lived for many years because of the severe nature of his degenerative condition.

my findings

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 remain of the same view; in the specific circumstances it wasn't unreasonable for Prudential's CMO to refuse to agree that the retrospective terminal illness definition was met before 22 October 2014. I am sorry to disappoint Mrs S because I realise she had hoped that a claim could be paid.

I'd like to thank Mrs S for taking the time to write further comments for me. I realise how hard she has found this process, and she's explained how distressing it has been to revisit the circumstances of her husband's illness.

I'd also like to thank Mrs S for supplying the June 2014 discharge letter, as this was not evidenced previously within our files from either party. But I'm sadly not able to determine that it changes my overall view of the complaint outcome.

I agree the letter clearly says that during his NIV trial Mr S had oximetry only in June 2014, since he wasn't able to tolerate NIV overnight. But while that supports some of the account of Dr D, I still have to be mindful of all the evidence when deciding what Prudential's CMO would likely have done at the time, had it been presented with a claim in 2014.

In my provisional decision, I set out a statement from Dr R which recounted the trial of June 2014. In that statement, Dr R explained how it was decided not to continue with NIV, in the first instance because Mr S did not get along with it but also because "*during the planned admission arterial blood gases and pulse oximetry were satisfactory".*

I fully understand the point Mrs S is making now, that Mr S would likely never have gone on to be able to tolerate NIV in the future, and that is borne out by what happened right up until when he passed away. But I can't use information we know now to determine what Prudential ought to have done in 2014. The correct way to assess a retrospective claim is to look back to determine (as closely as possible) what the insurer would have done if it was presented with a claim at the relevant time. It appeared that NIV remained a possible option for Mr S, but his temporary decline had also ceased such that it wasn't required anyway.

To explain for Mrs S, the purpose of the terminal illness benefit is to provide an advance payment of death benefit, where the evidence shows a person to have a life expectancy of less than twelve months, and where the CMO agrees this is the case. There is also a time limit on that claim because the benefit is only available up until twelve months before the policy ends. Protection policies of this nature have a fixed term and that does mean the insurer is only liable to provide cover for the period applied for at the outset.

It remains the case that Mr S did go on to improve in the short-term – by that I mean in the context of his debilitating condition there was a reversal in the recent deterioration caused by the chest infection of April 2014. The evidence from both consultants after this time reports that he became less symptomatic, and shortly before the expiration of the terminal illness benefit Mr S had gone on to have a radiologically inserted gastronomy tube fitted which led to a far more positive assessment by Dr D in September 2014.

As I said in my provisional view, I am not undermining the seriousness of the particular type of MND Mr S suffered from. I do recognise the severity of the condition. Mrs S's account is clear as to the total impact it had on both Mr S and his family. But I can't simply order Prudential to pay a claim on that basis because the policy Mr S had didn't include critical illness cover. It was life assurance and terminal illness cover. So I must look at whether or not Prudential was reasonable in how it applied those policy terms to Mr S.

The wider evidence from the time did not discount NIV in the future, even where Mr S hadn't tolerated it well during his trial. But even if it could be said that NIV as a treatment option was not open to Mr S, he remained hypercapnic with acceptable ABG levels with a broader life expectancy from Dr D of one to five years. Further, he was not going to be reviewed by the respiratory clinic again until April 2015 by which time the policy benefit had ended. Because of this I remain of the view that Prudential was reasonable in refusing the claim since the available evidence from the time doesn't support that Mr S would've had a valid terminal illness claim before the benefit expired on 22 October 2014.

my final decision

Despite my sympathy for Mrs S, I do not believe Prudential has behaved unfairly or unreasonably. I therefore do not uphold the complaint made on behalf of the estate of the Mr S.

Under the rules of the Financial Ombudsman Service, I'm required to ask to accept or reject my decision before 22 April 2019,

Jo Storey
ombudsman

copy of provisional decision

complaint

Mrs S brings this complaint on behalf of the estate of her husband, Mr S. She says that The Prudential Assurance Company Limited ('*Prudential*') has unfairly refused a claim for terminal illness benefit, which would have been payable before the policy expired in 2015.

background

Mr S took out a life assurance policy with Prudential for a twenty-year term. It had a level sum assured of £55,000 payable in the event of a valid claim. The policy included terminal illness benefit up until the final twelve months of the policy.

In 1997, Mr S was sadly diagnosed (and later confirmed to have) a rare type of Motor Neuron Disease ('*MND*').

Mr S's policy expired on 22 October 2015, without any claim having been made. He originally pursued a separate complaint about the ending of the policy, as Mr S said he didn't know the policy was for a fixed term. Following that complaint, Mr S made a backdated claim on his policy for terminal illness benefit.

Prudential refused the claim. It said the information it received from Mr S's GP and neurologist didn't show the policy definition to have been met. That was notwithstanding that Mr S had never made a claim during the policy term, and he had survived beyond the end date of the cover.

Mr S then made a further complaint via an appointed legal representative. It supplied two letters from Mr S's treating consultant neurologists, Dr H, and Dr D from September 2016.

Dr H said that she had been treating Mr S since the 1990's and he was one of an estimated 5% of MND patients experiencing prolonged survival from the date of diagnosis. Despite that, she confirmed from 1997 Mr S had a less than 70% chance of surviving twelve months or more, and a 95% chance of it being under five years. She said by all expected standards of analysis, Mr S had a life expectancy of less than twelve months in September 2014.

Dr D said Mr S was unwell in April 2014, at which time his respiratory function fell dramatically. She confirmed, at that time, Mr S had a life expectancy of less than twelve months.

Prudential's Chief Medical Officer ('*CMO*') issued a detailed reply to the complaint. In summary, he said:

- when dealing with retrospective terminal illness claims, a single snapshot may not represent the full clinical picture;
- though Mr S was suffering from a low period of respiratory deficiency in April 2014, he had improved by May 2014;
- he did not require non-invasive ventilation ('*NIV*') at that time, and still did not to date (late 2016);
- though Mr S's forced vital capacity ('*FCV*') levels dropped down significantly from 48% in August 2012 to 18% in April 2014, by September 2014 it had increased to 23% and he was recorded as feeling significantly better in respect of shortness of breath;
- the period of time at which Mr S suffered from breathing difficulties and a chest infection was temporary and not sustained. It could not reasonably be said this was a progression of his MND, and therefore the basis upon which the retrospective life expectancy was given was not correct;
- if a claim had been made in April 2014, the treating consultants would have been asked as to whether maximal therapy had been tried and if so, whether Mr S's deterioration was continual;

- in July 2016, Dr D said Mr S could pass away within the next twelve months, but she also gave him a life expectancy of 1-5 years;
- that lack of certainty (even though Mr S's claim would have needed to be submitted by October 2014) shows Mr S's life expectancy was not known up to the point the terminal illness benefit ended;
- in his view, Dr D would not have been able to give the same retrospective life expectancy assessment had she been asked in May 2016;
- Dr H had not been Mr S's treating consultant for a number of years, nor had she given a reason for giving an estimate of life expectancy as at September 2014.

Mr S's legal representative disagreed. It said the CMO had widened the requirement of the terminal illness definition to require that the treating specialist must be able to state that there is continuous deterioration and despite all available therapies having been tried, life expectancy is very likely to be less than 12 months. However, the policy wording had different criteria, that primarily being a statement from a specialist, and confirmation of agreement from Prudential's CMO. It believed that the relevant evidence had therefore been supplied.

Prudential said that the CMO was not widening the policy terms. Rather, in saying what was needed to reach a conclusion of a life expectancy for such a claim, he was merely setting out the wider considerations needed to give his acceptance of the medical opinions from Mr S's consultants. In this case, the CMO did not agree with the views of Dr D or Dr H from September 2016. It noted Mr S had the right to refer a complaint to the Financial Ombudsman Service.

Mr S referred the matter here, supported by Mrs S. Mrs S said the medical evidence was clear that Mr S had been told he had less than twelve months to live during the relevant period he was able to claim on the policy.

One of our adjudicators reviewed the complaint. He noted how in April 2014 Mr S had been given less than twelve months to live by his neurologist when he developed respiratory problems. So he had written to Dr D and Dr H to ask for further clarification as to why Mr S's life expectancy was not recorded in the contemporaneous records and how each of them had reached their conclusions in 2016. He also asked Dr D to clarify whether her assessment was given with reflection to any treatment options open to Mr S in April 2014.

Dr H gave a revised view that 70% of MND patients had less than 70% chance of surviving more than three years from diagnosis. And of the remaining 30%, the vast majority survive no longer than eight years. Mr S had clearly exceeded those timescales, meaning in her view he would definitely have been told he had less than twelve months to live, had he asked for that prognosis in September 2014.

Dr D said that because of the progressive and fatal nature of MND, there was rarely a requirement to continue to revisit a patient's life expectancy in detail. Patients are informed at the outset as to the likely prognosis of the condition. She explained how life expectancy across differing types of MND could vary; however, when people develop neuromuscular respiratory failure this is associated with a shortening of life expectancy. Patients are rarely made aware of this, given the significant anxiety caused when being given such news.

In Mr S's case, the respiratory team found him to be hypercapnic (an abnormal level of carbon dioxide in the bloodstream) upon testing. Dr D said this indicated that he had type 2 respiratory failure. She said that this was generally a very poor prognostic sign and the very vast majority of MND patients with hypercapnia would have a life expectancy that could be measured in months. Dr D said the estimate of twelve months or less was made irrespective of any treatment that was or was not proposed by the respiratory team.

Mrs S's legal representative added that the diagnosis of MND was not the relevant point for the purposes of the policy wording, what the wording required was a diagnosis of a life expectancy under twelve months. It reiterated that both consultants had given this diagnosis.

Mr S sadly passed away in 2017. His complaint was thereafter pursued by Mrs S, on behalf of Mr S's estate.

The adjudicator recommended that the complaint be upheld. He felt that Dr D had given confirmation of a clear life expectancy as at April 2014 so Prudential ought to pay a claim as if it had been accepted in 2016.

Prudential disagreed. It passed the matter back to its CMO. He reiterated many of the same points previously issued in reply to the legal representative. He also said:

- in the case of terminal illness (and chronic or progressive disease in general) it is important to look at the trend of the disease over months or years, rather than one single instance within that ongoing history;
- it is not possible to view Mr S's deterioration in April 2014 as anything other than temporary since he recovered within one month;
- this was without the need for the treatment proposed by Dr D;
- by contrast, Dr D's assessment of Mr S's life expectancy in July 2016 was given when he was stable, and this proved to be accurate;
- in his view, Mr S's lung function remained stable because he did not require any form of NIV until early 2016;
- the reason for Mr S's deterioration was a chest infection, not MND;
- he also believes Dr D has cherry picked a point in time at which she could reasonably have said Mr S may not live for a further twelve months, but this is a biased picture of a wider set of circumstances.

Mrs S said Mr S had never properly recovered from his downturn in April 2014.

The complaint was passed to me for a decision. Upon review of the medical evidence in late 2018, I asked (via our adjudicator) for more evidence from Dr D. This included asking for her comments on the recent assessment made by Prudential's CMO.

Dr D said:

- a regional study was undertaken on 73 MND patients diagnosed in an eighteen-month period between 2014 and 2015. Of the 20 of these patients suffering from hypercapnia, thirteen passed away within less than twelve months. The average survival rate from when hypercapnia was diagnosed was 9.2 months;
- there was a wider overseas study relating to the impact of hypercapnia on patients with the ALS type of MND. In that study, patients who did not comply with or accept NIV passed away within 0.12 years (as opposed to 1.27 years with NIV);
- when she referred Mr S urgently for the NIV trial in April 2014 he didn't appear to have evidence of a chest infection, and it wasn't mentioned by the clinic in May 2014. However, by June 2014 he did remain hypercapnic. NIV was tried at this time but not tolerated by Mr S.
- Mr S did stabilise in the following months in that he became less symptomatic, but his FCV levels did not improve in any meaningful way, increasing only to 23% in September 2018. In her view, Dr D said Mr S suffered from persistent type 2 respiratory failure and her estimate of his life expectancy as at April 2014 was accurate.

Prudential's CMO also made some final comments. He said:

- hypercapnia varies in severity levels and Dr D hasn't specified how Mr S would have been categorised;
- similarly neither study presented by Dr D gave comparable levels of hypercapnia such that Mr D's circumstances could be properly measured;
- the evidence from the time in 2014 does suggest Mr D had a chest infection, and it's not reasonable to disregard it;

- though it's been said NIV was attempted and not tolerated by Mr D in June 2014, there isn't evidence to support that;
- in his view, a criteria for making a terminal illness claim assessment would be to see that all available treatments have been tried and this didn't happen;
- given NIV significantly increased the life expectancy of patients in the second study, had Prudential been considering a claim at that time, it would have awaited the results of NIV, by which time Mr S would have improved.

my provisional findings

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Before I go any further, I'd like to thank the parties for their patience whilst this complaint reached a final decision, given further evidence has been sought. I realise how difficult the circumstances are for Mrs S and her family, given the nature of this decision.

This complaint is finely balanced, and I've had to ensure I weigh up all of the evidence, particularly the conflicting medical opinions. Having done so, I believe Prudential has been reasonable in the circumstances to refuse the claim. And unless I see any other evidence to alter my findings, I'm likely to issue a decision rejecting the complaint.

what does the policy require?

Mr and Mr S's solicitor made several points about the policy wording, specifically regarding what is needed for Mr S to satisfy a terminal illness claim. I agree that the policy wording is central to the complaint, as I need to determine if Prudential reasonably declined a claim under those terms. I also agree that it is not appropriate for Prudential to look at any wider terms than those stated. The policy definition says:

> "*5.1 If during the Term of the Policy the Assured is diagnosed as having a life expectancy of less than twelve months the Sum Assured shall be payable subject to:*
>
> *(i) receipt of such evidence provided at the expense of the Owner as the Company may require from a medical specialist as to the reduced life expectancy*
> *(ii) the acceptance of the opinion in (i) above by the medical officer of the Company*
> *(iii) the right of the Company to require the Assured to undergo a medical examination by an examiner specified by the Company in the United Kingdom at the expense of the Owner*
> *(iv) the unexpired Term of the Policy being at least twelve months.*"

Throughout the complaint, Prudential and its CMO have suggested that there must be evidence that Mr S had undergone all available treatment options open to him in April 2014. It says that if a claim had been made at that time, it would have been postponed until evidence of the failure of such treatment (ostensibly NIV) had been supplied.

The policy wording does not require evidence of that nature. It specifically says within the first point that a medical specialist ought to evidence a policyholder's reduced life expectancy. In this case, two consultant neurologists felt able to give those retrospective statements.

However, the mere provision of such a confirmation is not enough to meet the policy terms. There are three additional terms to satisfy, and Prudential can reasonably apply them. Since point three is not applicable and point four applied up to 22 October 2014, it is the second point that remains in dispute – that being if the CMO has acted fairly in refusing to agree with Dr H and Dr D's estimates.

has Prudential's CMO acted fairly in refusing to accept the evidence of reduced life expectancy?

This service isn't a court; it's set up to provide informal dispute resolution – and my duty is to determine a complaint by reference to what is, in my opinion, fair and reasonable in all the circumstances. And where there is conflicting evidence, I'll decide what I believe is the most persuasive, on balance. Both the CMO and Dr D have given very detailed responses to this service on a number of occasions and it isn't my role to decide if either of those is incorrect. I'm required to decide if it was a fair response by the CMO to reject the medical opinion of the consultants, principally Dr D.

The CMO does not accept the retrospective assessments given by either doctor, but particularly Dr D given that she was Mr S's treating consultant at the relevant period.

I believe the CMO was reasonable in having refused the retrospective statements. The reason I say that is that though I have no doubt as to their credibility, the evidence from the time in 2014 is contradictory to what's being said now.

It is clear that in April 2014, Mr S's health took a significant and detrimental turn. His lung function had reduced considerably from his last review with Dr D, some eighteen months earlier. It was for that reason that in her clinic letter of 14 April 2014 she confirmed her suspected diagnosis of "*neuromuscular respiratory failure, symptomatic*". Accordingly, Dr D referred Mr S to Dr R, a consultant in respiratory medicine.

Dr D noted Mr S had been referred with a view to undergoing NIV. In her letter, she said:

> "*We discussed the implications of non-invasive ventilation (NIV) as a treatment with himself and his wife today…He is keen on keeping family life as normal as possible and has concerns about using an NIV machine in front of his kids. Mr S is keen to live as long as possible and there is a survival benefit in MND patients who tolerate non-invasive ventilation and so he needs to consider this.*"

Dr D did not consider Mr S had a chest infection when assessing Mr S in April 2014. She confirms in her clinic letter that Mr D was at risk of getting such an infection, so she endeavoured to put together a letter he could pass to any treating doctor if he had to attend hospital for that reason.

The parties disagree about Mr S's true clinical picture after this date.

I have carefully reviewed the account of Dr R, because the CMO and Dr D have markedly different views on what went on thereafter. In her latest letter of 5 October 2018 Dr D says that Mr S had no recorded chest infection but he remained hypercapnic. She also notes he couldn't tolerate NIV in June 2014; Dr D says this was an understandable challenge given his marked limb weakness impaired his inability to remove his mask during NIV.

The CMO says Mr S did have a chest infection, and NIV wasn't pursued. Having reviewed the medical records from the time, it seems this conclusion was accurate. Dr D's clinic letter of 17 June 2014 (following an appointment on 12 June) says, "*he had a chest infection just after his last clinic appointment in April*". Her next clinic letter of 16 September 2014 also says "*he has had no further chest infections since the one he had at Easter 2014*".

In her correspondence with our adjudicator, Dr D has told us how the reduction of symptoms did not mean Mr S was no longer hypercapnic, and that an increase of 5% still represented a finding of type 2 respiratory failure. I accept that. It's supported by a comment Dr D on 16 September 2014 where she confirms Mr S "*has no new symptoms from a respiratory point of view*".

However, I do think the CMO has been fair in saying a wider picture of Mr S's overall health ought to be taken than just a snapshot in April 2014. Had a claim been lodged at that time, Prudential would have asked the treating consultants (at that time Dr D and Dr R) for their view on Mr S's life expectancy. The evidence from the time does suggest that after having had a chest infection, Mr S began to improve.

Dr R saw Mr S again in September 2014. In his letter following the appointment, he recorded:

> "*Today in clinic [Mr S] reports that he has felt significantly better in the past few months. Where he previously struggled to complete sentences due to shortness of breath and weakness, he now can comfortably hold a conversation. He denies any symptoms of shortness of breath at night and sleeps right through.*
>
> *…Based on [Mr S's] clinical improvement, slight improvement in his pulmonary function tests and stable arterial blood gas sample, we do not feel it is necessary to proceed with NIV at present. I have reassured [Mr S] today and have advised him that we will review him again in approximately 6 months' time in the Ventilation Clinic.*"

I realise that a fluctuation in being symptomatic may not alter the assessment of a person's life expectancy. But in Mr S's case, in June 2014 he remained a possible candidate for NIV. Though Dr D says Mr S didn't tolerate NIV, the evidence differs slightly on that point. Dr D is right that Mr D did not tolerate the treatment particularly well. However, that wasn't the sole reason it was discontinued. When recounting Mr S's May 2014 admission to the clinic, Dr R said:

> "*At this time based on his pulmonary function tests and maximal muscle pressures [Mr S] was admitted for an elective trial of NIV. This trial was not very well tolerated however during the planned admission arterial blood gases and pulse oximetry were satisfactory. Therefore the decision was made not to proceed with NIV at that time.*"

The June letter from Dr D also says, "*I understand he had been in the respiratory unit in the [local] Hospital for a trial of non-invasive ventilation but it was felt that he wasn't very symptomatic and didn't need it at the present time and is to be reviewed in 6 months."*

I appreciate that it was possible that Mr S might go on to find NIV intolerable, if he had required it in the future. And for that reason, Dr D feels because Mr S continued to have an FVC reading indicative of hypercapnia, he would have had a survival rate that was far lower than a patient who could comply with NIV. But that doesn't have regard for the wider picture at the time and it contradicts her letter of 14 April 2014 which encouraged Mr S to consider NIV given its survival benefit.

It is the case that Mr S had a chest infection later in April 2014, as the evidence from both consultants supports that. And following recovery from that infection he became less symptomatic. Further, the first study Dr D evidenced looked at patients whose arterial blood gas ('*ABG*') results demonstrated hypercapnia. By May 2014, Mr S's results were satisfactory, and that was one of the reasons as to why NIV was not pursued. The letter from Dr R does not read as if NIV was discounted as a further treatment option in the future, but rather that it wasn't necessary at that time. That was because Mr S's health had improved.

In September 2014, Dr D recorded how Mr S had undergone a type of radiologically inserted gastrostomy tube, and it had been successful for him. He was noted as 'feeling brilliant'. Dr D commented on that, and noted how his respiratory function was unchanged. She recorded that she was "*delighted that he is doing well. He does have neuromuscular respiratory impairment and appears to be coping amazingly well.*"

I realise that saying Mr S was coping well does not, of itself, alter any statement from Dr D as to his likely life expectancy. But I do agree with Prudential that in the circumstances Mr S's health remained unchanged from a respiratory perspective (that being hypercapnic but with acceptable ABG levels).

Dr D has given her retrospective view about Mr S's life expectancy had she been asked in April 2014. Before this, she also estimated Mr S's life expectancy when asked by Prudential in June 2016 as '*1-5 years*'. Mr S remained (by Dr D's assessment) hypercapnic at that time too.

But, even if Dr D had stated it was less than twelve months, Prudential's CMO was entitled to consider the other medical evidence available from Dr R and to look at Dr D's clinic letters.

The policy terms require acceptance from the CMO. He says he would have concluded Mr S's deterioration was temporary, and he would have wanted to determine whether Mr S could undergo NIV, if it was further required. Though I disagree with the CMO in inferring that all available treatment options *must* be undertaken before Prudential could admit a claim, I do think it is fair for an insurer to ask a policyholder's treating doctors as to whether there is any treatment which could have a direct effect on his or her life expectancy.

Dr D has confirmed in her second study that patients who can tolerate NIV have a life expectancy on average of 1.27 years. Given Mr S showed signs of clinical improvement, I don't believe it would have been an unreasonable proposal in these circumstances to await the review from the respiratory clinic of September 2014. And as quoted above, Dr R didn't feel NIV was needed at present and this would be reviewed in April 2015.

In summary, the CMO's retrospective refusal is something I give more weight to; this is not based on a measure of any professional's knowledge or experience but merely on the wider evidence from the relevant time, particularly the evidence of the findings from Dr R at the respiratory clinic.

My findings in no way intend to disregard the seriousness of the type of MND that Mr S sadly suffered from. I realise that Mr S's survival exceeded the estimates or the majority of patients as first given by Dr H. But I have to look at all the evidence before me in reaching an outcome that is fair to both parties. I must do that by deciding if the policy terms were correctly applied.

I currently believe Prudential has acted legitimately in refusing the claim, since the evidence does not appear to support that Mr S would have had a viable terminal illness claim at any time before the benefit expired on 22 October 2014.

my provisional decision

I propose to reject this decision for the reasons set out above.

I now invite the parties to provide our adjudicator with any further submissions they may wish to make by 6 March 2019. If either party should require an extension to that deadline, for example, to seek further evidence then a request ought to be passed to our adjudicator for me to consider. Following this, I will issue my final decision.

Jo Storey
ombudsman