DRN-4634828

The complaint

Mrs G complains that Aviva Life & Pensions UK Limited terminated a claim she made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the key events.

Mrs G is insured under her employer's group income protection insurance policy. She was employed on a part-time basis, for 18 hours per week. The policy provides cover if an employee becomes incapacitated due to illness or injury.

Unfortunately, in 2013, Mrs G was diagnosed with cancer and underwent treatment. And in 2014, she was diagnosed with metastases and underwent radiotherapy. As Mrs G wasn't fit for work, her employer made an incapacity claim on the policy, which Aviva accepted.

Mrs G was able to begin a phased return to work in 2015. But unfortunately, she was diagnosed with a new cancer in 2016 and therefore, she was signed-off work again. Mrs G's claim remained in payment and she continued to be medically signed-off. Her symptoms included ongoing physical and cognitive fatigue.

As part of its claim review, Aviva appointed an Independent Medical Examiner (IME) to assess Mrs G. The IME, who I'll call Dr C, a consultant occupational physician, provided Aviva with their report in January 2019. Dr C concluded that while Mrs G remained incapacitated at that point, she was likely to be medically fit to consider options to return to work by October 2019. Aviva continued to pay Mrs G's claim.

In October 2021, Aviva appointed a further IME, Dr M, a consultant in occupational medicine, to assess Mrs G. Dr M concluded that, on balance, Mrs G was fit to return to work. He recommended that she begin a phased return to work. He also considered Mrs G should be encouraged to go back to an exercise programme and yoga.

Based on Dr M's report, Aviva concluded that Mrs G no longer met the policy definition of incapacity. So it terminated her claim in December 2021 and notified her employer. It paid a further six months of reduced benefit to represent a phased return to work plan.

It doesn't appear that Mrs G's employer let Mrs G know that her claim had been terminated for around a nine-month period. At that point, Mrs G appealed. Her employer referred Mrs G to a separate occupational health (OH) company and she was assessed by an occupational health physician I'll call Dr S. Dr S felt Mrs G wasn't fit to work and they considered that Mrs G should be assessed by a psychiatrist. Mrs G's GP also wrote a letter in support of her claim.

As such, Mrs G's employer appointed Dr B, a consultant psychiatrist, to assess Mrs G's condition. They concluded that Mrs G wasn't fit to work and that before attempting to return to work, she should undergo neuropsychometric testing to assess her cognitive abilities.

Aviva considered the new medical evidence from Dr S and from Dr B. It appointed a third IME, Dr H, a consultant in occupational medicine. Dr H provided their report in March 2023. In brief, Dr H agreed with Dr M's 2021 findings and concluded that Mrs G was fit to return to work, although they considered that Mrs G should undertake a slower phased return. And Dr H also felt that Mrs G's employer should make reasonable adjustments for her return.

Following its review of Dr H's report, Aviva maintained its earlier decision. It paid Mrs G two further months of benefit to facilitate discussions between Mrs G and her employer, so it could accommodate her phased return to work.

Mrs G was unhappy with Aviva's decision and she asked us to look into her complaint. She felt Aviva had ignored the evidence from Dr S, Dr B and her GP and that it had failed to carry out a cognitive assessment in line with Dr B's recommendations.

Our investigator didn't think Aviva had treated Mrs G unfairly. In summary, he didn't think it had been unfair for Aviva to place more weight on Dr M and Dr H's reports than it had on Dr S and Dr B's reports. That's because he felt Dr M and Dr H were more qualified in the field of occupational medicine. Therefore, he considered it had been reasonable for Aviva to rely on their conclusions to initially terminate benefit and then to maintain its decision.

Mrs G disagreed and I've summarised her responses to the investigator. She considered that given Dr B was a consultant psychiatrist, it was surprising that Aviva hadn't accepted their opinion or taken up their recommendation for a neuropsychometric assessment. Nor was there evidence that Aviva had asked Dr H to comment on Dr B's recommendation. She felt that as Dr S, Dr B and her GP all recognised her cognitive difficulties and unreadiness to begin a phased return to work, it would have been reasonable for Aviva to accept this evidence or carry out further investigations itself. She considered it was unreasonable for Aviva to do nothing to assess her cognitive function. She referred to Dr H's comments regarding the lack of reporting of her condition to the DVLA and she felt these were erroneous.

And Mrs G also felt Aviva had failed to provide relevant documentation to Dr H – in the form of her rebuttal letter to Dr M's findings. She stated that Dr H hadn't carried out a meaningful assessment of her cognitive abilities and had relied on a superficial check of her memory. However, she later realised she'd misremembered details. The investigator had referred to Dr S', Dr B's and the GP's findings being less reliable because they were based on Mrs G's self-reported symptoms. However, as all three IMEs had also relied on Mrs G's self-reporting, she felt the information should be equally weighted. Mrs G was concerned too that the IMEs hadn't had a detailed understanding of the cognitive abilities required for her role.

The complaint's been passed to me to decide.

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, whilst I'm very sorry to disappoint Mrs G, I don't think it was unfair for Aviva to terminate her claim and I'll explain why.

First, it's clear that Mrs G has suffered many years of very worrying and distressing diagnoses and symptoms. I was sorry to hear about the circumstances that led to her claim and her continued poor health. I don't doubt what a worrying time this must have been for her.

This claim has been in payment for some years. This means that there is extensive medical and other evidence and both parties have provided detailed submissions. I'd like to reassure both parties that I've read and carefully thought about all they've said and sent us. In reaching my decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

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 insurance policy and the available medical evidence, to decide whether I think Aviva treated Mrs G fairly.

I've first considered the policy terms and conditions, as these form the basis of the insurance contract between Mrs G's employer and Aviva. I appreciate Mrs G has raised concerns that she hasn't been provided with a copy of the policy documents. However, this contract is between her employer and Aviva. Therefore, Mrs G isn't entitled to a copy of the policy terms. It's open to her to request a copy of the policy documentation from her employer should she wish to.

There's no dispute that Mrs G's claim was initially assessed and accepted in line with the 'own occupation' definition of incapacity. This says incapacity means:

'The member's inability to perform on a full or part-time basis the duties of his or her normal occupation, as a result of their illness or injury.'

The policy goes on to say that Aviva will pay benefit until the end of a member's incapacity (amongst other things).

In my view, Aviva's terms indicate that subject to other conditions, it will continue to pay benefit, for as long as it's satisfied that a policy beneficiary remains incapacitated. It's clear that whilst Aviva accepted that Mrs G was entitled to policy benefit for some years, it now considers that she's no longer incapacitated and is able to return to work in her own occupation. So I've thought about whether I consider this was a fair conclusion for Aviva to reach.

It's for a policyholder to provide enough evidence to show that they have a valid claim under their policy. However, once a claim is in payment, it becomes the insurer's responsibility to show that the policyholder no longer meets the policy terms. Generally, I think it's fair and reasonable for an insurer to periodically review income protection claims and request medical evidence to determine whether a claim remains payable. So I think Aviva was reasonably entitled to commission IME reports during the life of the claim.

I've looked carefully at the available medical evidence. It's clear that initially, Mrs G was undergoing cancer treatment for her diagnoses, including radiotherapy and chemotherapy. She was also prescribed medication to treat her conditions. But it appears that following her treatment, Mrs G's main symptoms were caused by physical and cognitive fatigue. Based on the medical evidence Aviva was provided, I don't think it acted inappropriately or unreasonably by appointing Dr C to assess Mrs G in December 2018.

So I've looked closely at Dr C's report and I've set out what I believe to be their key conclusions:

'I do not feel that (Mrs G) is currently fit to return to her role but with her current rate of progress, I think it likely that she will be fit to look at returning to her role, on a phased rehabilitation programme, initially on restricted duties in 10 months of this examination. She can then have time to build on her improving levels of health and daily activities, seek further

support and address her family issues…

(Mrs G) is likely to be medically fit to consider options for a return to work with additional support by October 2019. There is no indication that she is permanently unfit for her role on the current evidence but because she has been out of work for a prolonged period of time, she would certainly benefit from discussions with her employers to look at an appropriate induction, training and an appropriate programme for rehabilitation and work hardening…

I do feel that further engagement through cancer support services would help (Mrs G) continue with her rehabilitation and return to normal day to day activities and help her address a number of family concerns.'

Dr C was also asked whether Mrs G had engaged in any voluntary work. They responded:

'As far as I am aware, Mrs G has not been participating in any voluntary work but this could be an option for her to begin the return to work process.'

Based on the date of Dr C's report, it seems that they believed Mrs G would be fit to return to work, on a phased basis, in October 2019. Dr C also recommended that Mrs G should engage with cancer support services and that she could consider voluntary work.

The evidence indicates that Aviva didn't appoint a further IME in October 2021. Instead, it appears that the claim remained in payment until Aviva appointed Dr M to assess Mrs G's condition in October 2021. Given the time lapse between Dr C's report and the appointment of Dr M, I think Aviva's actions were more than reasonable.

Dr M sent Aviva their report in November 2021. It appears, from the report, that Dr M had the opportunity to review Mrs G's medical records as part of their overall assessment. Again, I've set out below what I think are the report's key conclusions:

'On the balance of probability, I am of the opinion that she could return to work at this time. Her return to work should be done with support from Management and colleagues for her to return to work 10 hours per week, worked over 3 days. Hopefully she could increase to her contracted annual average 18 hours per week after 3 months back in the workplace. Initially working from home, giving her extra flexibility, could be of assistance…

She should be encouraged to try to go back on an exercise programme, and yoga, which I am of the opinion, did prove therapeutic for her. This would help her manage her fatigue…

I do not feel that she is especially motivated at this time to return to the workplace, and is very apprehensive that she would be unable to cope with the stress and pressure in work when she returned…

She was helping to manage her fatigue by a specially devised exercise programme and yoga, which stopped (due to a family situation). At present, I do not feel that she is doing anything specific to help manage her fatigue, but was having counselling, which finished earlier this year.'

In my view, it wasn't unreasonable for Aviva to rely on the opinion of Dr M, a consultant in occupational medicine, to conclude that Mrs G was fit to return to work and that she was no longer incapacitated by the policy terms. While I appreciate Mrs G disagreed with some of Dr M's reports, I don't think it was unfair for Aviva to place weight on the findings of an expert in occupational medicine. And it seems to me that Dr M's conclusions broadly tallied with Dr C's earlier findings.

Therefore, I don't think Aviva acted unfairly when it decided to terminate benefit in December 2021. I think it acted reasonably by paying six months of benefit to represent a graduated return to work for Mrs G. And I also think Mr M gave Mrs G clear recommendations for actions she could take to help aid her recovery. The policy terms require members to take reasonable steps to help with their recovery.

As such, I think Aviva provided enough evidence to show that in December 2021, Mrs G no longer met the policy terms. So in my view, it became Mrs G's responsibility to provide enough medical evidence to rebut Aviva's conclusions. I don't agree that Aviva was obliged to accept Mrs G's evidence or carry out further investigations once it had shown the claim was no longer payable.

It's unfortunate that Mrs G's employer didn't let her know about Aviva's decision until so many months after the claim had been terminated. However, once it did so, Mrs G provided Aviva with new medical evidence in support of her position. So I've also looked at this evidence carefully.

Mrs G's GP wrote a letter in support of her claim in September 2022. They said:

'(Mrs G) still suffers from attacks of fatigue from her treatment for breast cancer following treatment to her brain. This leaves her struggling to undertake complex tasks such as anything that requires concentration and focusing and she finds that if she does this she informs me she feels very fatigued and becomes overwhelmed and anxious very quickly leading to a relapse in her symptoms.'

I can see that her employer arranged for her to see Dr S. I've looked carefully at Dr S' reports which pre-date Aviva issuing its final response to Mrs G's complaint in April 2023.

In November 2021, Dr S said:

'In my opinion (Mrs G) is not fit for work based on the information she has relayed to me taking into account her current symptoms and reported activity levels…

(Mrs G) and I agree that she was currently not fit for work based on our consultation today. I have advised her to continue discussions with her GP regarding additional resources and specialists that may assist with many of her symptoms including fatigue coach.

Due to her appealing the decision from her group income protection provider regarding her ongoing private health insurance I will make arrangements as per your request for an Independent medical examination (IME), if that is practical and commercially appropriate and will revert with those arrangements.'

It was subsequently arranged for Mrs G to see Mr B, a consultant psychiatrist. Again, I've set *out what I think are their key conclusions:*

'(Mrs G) is highly motivated and is keen to return to work, but I think this would need to be very carefully handled.

I think there are some questions that need to be considered. Whether there has been any cognitive decline due (earlier treatment). Therefore, I would recommend that before this lady thinks about going back to work she should have a detailed neuropsychometric assessment by ideally someone (local to Mrs G) to assess if there has been any permanent damage to her cognition from this treatment…

Therefore, I would encourage her to think about doing some voluntary work to start off

getting herself back into a work place situation. If she did go back to work it would have to be on a very graded basis and something very simple would have to be found starting off only 1-2 hours per week at a lower level than she would normally do.

With all respect to Dr M's report, I think (their) prognosis for this lady is optimistic. I accept that she is able to undertake the activities of daily living, but they have to be very carefully planned with lots of rest time. (Dr M) notes…that on the balance of probability they are of the opinion that she could return to work with support over a three month period. I am afraid I would disagree. I think there needs to be further investigation and this lady would most certainly not cope with the type of work that she was doing before.

On the balance of probability at this present time, I do not think she is well enough to work. There needs to be some steps beforehand.'

Dr S reviewed Mr B's report and in January 2023, provided a further assessment. They said:

'(Mrs G) is not fit for work based on our consultation today. The independent medical examiner Dr B also found her unfit for work stating the need for further steps before consideration of fitness for work. (They have) recommended a neuropsychometric assessment and further tests with the specialist followed by graded steps via voluntary work before consideration for a return to work.

I would concur with this opinion, I am happy to refer (Mrs G) on if that is appropriate, for further assessment with a neuropsychologist and fatigue specialist.'

I've considered this evidence very carefully. It's clear that medical specialists, including an occupational health physician, considered that Mrs G remained incapacitated and that she should undergo neuropsychometric testing. However, I don't think this evidence was enough to mean that Aviva ought reasonably to have reinstated Mrs G's claim. That's because it doesn't appear that Dr B had reviewed Mrs G's medical records as part of their assessment of her condition and I do think these were relevant to the assessment of her overall condition and the provision of a detailed analysis as to why she was prevented from working. And I think that as a consultant in occupational medicine, Dr M's evidence is more persuasive than that of a consultant psychiatrist or an occupational health physician.

Nonetheless, Aviva appointed Dr H to assess Mrs G. I think this was a fair response from Aviva in the circumstances. I don't think it was required to arrange a neuropsychometric assessment – especially given it seems Dr S offered to arrange this for Mrs G's employer – which it doesn't appear to have taken up. Nor have I seen evidence that Dr H (or indeed Dr M) didn't take into account relevant information or have enough knowledge of Mrs G's job role to be able to reach an informed opinion about her capacity to return to work.

Dr H provided their report in March 2023. As above, I've set out what I think are their key conclusions:

'Taking into consideration the current clinical state, in my opinion, on the balance of probabilities (Mrs G) is medically fit to perform the material and substantial duties of her usual occupation on a part time basis equivalent to her pre-cancer contractual obligation…

I do not feel (Mrs G) is totally incapacitated from performing her usual occupation…I believe (Mrs G) is presently medically fit to return to work in accordance with the Definition of Incapacity…In my assessment she is reasonably motivated in general however I am not sure she is particularly motivated to return to work…

I do not agree with Dr B's conclusion about her inability to resume work at that time. I only

have access to the report and I am not aware whether Dr B undertook a detailed analysis of (Mrs G's) functional capability the same as I have done. It is clear that (Mrs G) has retained a good level of functional capability including running a household, providing support to her (family), travelling abroad which consisted of some physically demanding activities. Furthermore, there was no indication of cognitive impairment in my observation and she was able to provide detailed answers - with some minimal pauses when talking about her holidays over the past 7 years…

I am of the view that there is no cognitive reason - or any other medical reason - to prevent her from resumption of work.'

Dr H also said they believed that had Mrs G acted on Dr M's 2021 recommendations with regard to an exercise and yoga programme, she'd have been in a better position to return to work during 2022.

I've thought very carefully about the evidence that was available to Aviva at the time it terminated Mrs G's claim and later, in April 2023, when it issued its final response to the complaint. It's important I make it clear that I'm not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive.

And having considered all of the evidence, I don't think it was unfair or unreasonable for Aviva to place more weight on the conclusions of Dr M and Dr H when it considered whether Mrs G still met the policy definition of incapacity. That's because, as I've said, I think that as a consultant in occupational medicine, Dr M was well-placed to make a finding as to whether Mrs G remained incapacitated in 2021. Given Dr M's findings, I'm satisfied that Aviva provided enough evidence to demonstrate that Mrs G no longer met the policy terms at that point.

I think it's clear that Dr H did take into account medical evidence which was supportive to Mrs G's claim (in the form of Dr B's report) when they assessed her. However, as I've said, Dr B isn't a specialist in occupational medicine. And I don't think they provided a detailed analysis of how or why Mrs G's particular symptoms would prevent her from carrying out her role. I appreciate Dr S is an expert in occupational medicine – but both Dr H and Dr M are consultants in occupational medicine, with well-respected medical credentials. And I think both Dr H and Dr M have provided clear and detailed reports as to why they believe Mrs G no longer met the policy definition of incapacity. These reports are mainly corroborative and accord with Dr C's earlier findings. So in the circumstances, I find Dr M and Dr H's evidence more persuasive than the evidence provided by Dr B, Dr S or Mrs G's GP, which I think is more general in nature.

Overall, despite my natural sympathy with Mrs G's position, I don't think Aviva acted unreasonably when it relied on the medical evidence of Dr M or Dr H to conclude that Mrs G no longer met the policy definition of incapacity. That means that I don't find Aviva acted unfairly when it terminated Mrs G's claim in December 2021, based on the evidence it had at that time. And nor do I think Mrs G has since provided sufficient evidence to support her position.

It's open to Mrs G to provide Aviva with further evidence to support her position which post-dates its final response of April 2023 should she wish to do so, including the arrangement of a private neuropsychometric assessment. If she's unhappy with the outcome of any assessment of new medical evidence she may send to Aviva, she may be able to bring a new complaint to us about that issue alone.

I'd add too that it seems Mrs G's employer may have been paying Mrs G a portion of her

salary following Aviva's claim termination. Under the terms of the policy, Aviva is entitled to deduct any income a member receives from the benefit payment it pays. Therefore, it's *possible* that Mrs G may already have been paid more by her employer during the relevant period than she'd have been entitled to under the policy terms, although this isn't clear.

My final decision

For the reasons I've given above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs G to accept or reject my decision before 8 July 2024.

Lisa Barham
Ombudsman