DRN-4663735

The complaint

Mrs H complains about Legal & General Assurance Society Limited's decision to decline her claim for total and permanent disability (TPD) benefit under her life and critical illness policy. She also complains about poor service and delays in dealing with the claim.

What happened

In brief summary, in November 2012, Mrs H took out decreasing term life and critical illness cover. The policy term is 20 years.

Mrs H claimed on the policy in October 2021, under the policy definition relating to total and permanent disability. But the claim was declined in April 2023.

Mrs H complained about poor service, delays and the decision to decline her claim. L&G issued a final response in November 2022, acknowledging poor service and offering £300 compensation for distress and inconvenience. In May 2023, L&G sent another final response letter, offering a further £200 for service issues and delays. But L&G maintained its decision to decline Mrs H's claim. It relied on the policy definition for TPD not having been met and that there were still treatment options available offering potential for improvement.

Mrs H brought her concerns to the Financial Ombudsman Service, but our investigator didn't uphold her complaint. So Mrs H asked for an ombudsman to issue a final decision. Mrs H maintains she meets the policy definition. She also say a surgical treatment option carries significant risk and pain and energy management is not a treatment but a symptom management strategy.

I'm aware Mrs H has provided evidence regarding her present circumstances and limitations. To clarify, as our investigator has previously explained, the scope of my decision is limited to the issues considered in L&G's final response letters of November 2022 and May 2023 – that is, delays and L&G's decision of April 2023 not to accept Mrs H's claim.

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 acknowledge the significant efforts Mrs H has made to evidence and support her complaint. My decision focuses on the points and evidence I consider material to the outcome. So, if I don't refer to a specific point or piece of evidence, it's not because I haven't read and thought about it. Rather, I don't consider it changes things.

Claim

I acknowledge Mrs H has a number of health issues which significantly impact her life. I'm aware she's referred to the Equality Act 2010, the fact she's in receipt of personal

independence payment (PIP) and that Waiver of Premium (WoP) benefit is being paid. I note that neither PIP nor WoP are permanent entitlements. And the Equality Act has a specific definition of disability. But it's not that definition Mrs H must meet for her claim to be paid. TPD will only be paid if Mrs H meets the definition set out in her policy, which is [my emphases]:

> *'Total and permanent disability -* ***unable to do three specified work tasks ever again.***
>
> *Loss of the physical ability through an illness or injury to do at least three of the six work tasks listed below ever again.*
>
> *The* ***relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement****, irrespective of when the cover ends or life assured expects to retire.*
>
> *The life assured must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.*
>
> *The specified work tasks are:*
>
> *Walking:*
> *The ability to walk more than 200 metres on a level surface.*
> *Climbing:*
> *The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.*
> *Lifting:*
> *The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.*
> *Bending:*
> *The ability to bend or kneel to touch the floor and straighten up again.*
> *Getting in and out of a car:*
> *The ability to get into a standard saloon car, and out again.*
> *Writing:*
> *The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.*
>
> *For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.'*

I've reviewed the medical records and the report prepared by the independent medical examiner (IME). I know Mrs H has raised a complaint about this report. But I'm aware L&G has also relied on the evidence of Mrs H's treating consultants.

The IME saw Mrs H in February 2022. His assessment was based on a combination of self-report from Mrs H and observation. Overall, the report suggests to me a balanced view of Mrs H's abilities. In the IME's opinion, Mrs H was able to perform five of the specified work tasks - those of walking, climbing, lifting, bending and writing. However, he also noted some day-to-day variation in symptoms and that reassessment may be required in the future. He suggested it was *'unlikely that her symptoms would improve, due to the degenerative nature of the conditions and that it was likely that her ability to complete all of the Activities of Daily Work activities may deteriorate with time, particularly when we consider walking and*

bending, as these were activities that she frequently found difficult at the time of the assessment.'

L&G also considered evidence from Mrs H's treating consultants. Firstly, two letters from her neurosurgeon. It's clear from both letters that her neurosurgeon was aware of Mrs H's other conditions.

Following a consultation in October 2022, the consultant wrote to Mrs H's GP giving an update of the situation. He compared imaging from June 2022 with that done in March 2014, shortly after symptoms first presented, and noted:

> *'There has been some progression of the right C6-C7 perineural cyst which is now extending into the spinal canal. There is a potential for a dynamic CSF process occurring that can irritate the right C7 nerve root. This would be in keeping with her symptoms. It is however unusual and I would advocate for repeat nerve conduction tests to look for any active denervation which will help guide further treatment. It is more than likely that further imaging will be required over an interval period.*
>
> *'[Mrs H] currently feels that her symptoms are not severe enough to require surgical intervention given that surgery will have potential risks and potential for complications. We have therefore agreed that we will get nerve conduction tests repeated and I will discuss her case in our Team Meeting and I will have a follow up conversation with her in due course once imaging has been completed and the Team discussion has occurred.'*

In March 2023, the consultant provided information to L&G. He summarised his observations following the consultation with Mrs H in October 2022. He further reported that:

> *'Nerve conduction studies [in February 2023] have shown evidence of mild chronic neurogenic changes in the right C7 distribution. There is no acute denervation seen.*
>
> *'[Mrs H] is currently awaiting further MDT discussion as to whether surgical intervention would be beneficial.*
>
> *'Further treatment planning is pending following MDT discussion.*
>
> *'Surgery is a potential that could be offered, however this has significant risk given the perineural cyst and hence the need to discuss at the Spinal MDT Meeting.*
>
> *'Mrs N is limited by pain in terms of activities relating to her right arm such as lifting bags, shopping etc.'*

The consultant was asked to comment on Mrs H's ability to undertake the specified work tasks. He recorded that she was able to walk more than 200m. He stated that her ability to access a standard saloon car had not been assessed and that her condition was unlikely to affect bending/straightening. But he noted that right arm pain and weakness would limit her ability to climb stairs, lift and write. I note that the consultant refers to limitations but does not say that Mrs H is unable to perform the specified work tasks ever again. I also note that further treatment planning was to take place following the MDT discussion.

In June 2022, Mrs H had a consultation with a consultant neuropsychiatrist, to whom she'd been referred by her GP in relation to chronic fatigue. In a follow-up letter to the GP, the consultant noted that common conditions associated with chronic fatigue had been screened for and results were normal. He concluded that a diagnosis of chronic fatigue syndrome

(CFS) could be established. Mrs H was referred for and subsequently took part in a fatigue management programme. No changes were made to her medication.

In terms of prognosis, the consultant commented:

> *'Many patients with CFS experience significant improvement with time, but unfortunately evidence suggest that some patients will plateau at a level below their pre-illness level of functioning.*
>
> *'Acute exacerbations are always a possibility. They can be caused by several factors, such as an infection or overexertion, or emerge unexpectedly. Relaxation and adequate rest will be essential for recovering from a setback, and any exercise should be stopped if symptoms worsen. Maintaining good sleep hygiene is important to preserve energy levels and prevent relapses.'*

Mrs H argues that energy management is simply a strategy to manage symptoms and not a treatment. I can understand her view. But regardless, the issue here is whether the policy definition has been met and that's not confirmed from the consultant's letter.

Overall, from what I've seen, L&G obtained Mrs H's medical records, as well as a specialist report from an IME Whilst I acknowledge that Mrs H has raised issues with the IME report, I'd expect to see an insurer obtain this sort of information in claims like Mrs H's. I think L&G investigated and assessed the claim reasonably, taking into account all of the medical evidence. It was entitled to rely on that evidence, which didn't confirm at the time that Mrs H met the policy terms necessary to qualify for total and permanent disability. So overall, I don't think L&G treated Mrs H unfairly in not accepting her claim.

I note that Mrs H's policy term has a number of years to run. So she'd be entitled to present any new information about her health circumstances to L&G for reconsideration.

Service

I've no doubt Mrs H has found the experience of making a claim frustrating, upsetting and inconvenient. I've thought about how L&G has dealt with Mrs H, and whether there were avoidable delays that exacerbated an already challenging and difficult time. L&G has acknowledged its claims progression and communication with Mrs H could've been better. But it's also highlighted that some delay was as a result of Mrs H awaiting further tests and difficulties obtaining a response from one of Mrs H's treating specialists.

I understand L&G has paid a total of £500 to Mrs H for poor service and avoidable delays. I'd expect to see this sort of figure where a business's mistakes had caused considerable distress and inconvenience over a period of time. So overall, I think this reasonably reflects the level of distress and inconvenience caused.

I'm therefore not going to ask L&G to do anything further in respect of this complaint. I'm sorry to send disappointing news to Mrs H.

My final decision

For the reasons given above I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 9 April 2024.

Jo Chilvers
Ombudsman