DRN-4980972

The complaint

Mr D, Mr G1 and Mr and Mrs G2 complain - as trustees of the late Ms S' Life Plan Trust – about Legal and General Assurance Society Limited's (L&G) decision to turn down a claim Mr G1 made on a life assurance policy.

The trust is represented by Mr G1.

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.

In August 2020, Ms S took out a life assurance policy through a broker which was underwritten by L&G and which was written in trust. During the application process, Ms S was asked how many alcoholic drinks she had in a typical week. Ms S answered five.

Following the application, L&G wrote to Ms S' GP, who provided a medical report which broadly supported Ms S' answers. L&G agreed to offer Ms S life assurance and the plan was set-up.

Sadly, Ms S passed away in August 2022. Her cause of death was recorded as hepatic failure and alcoholic liver cirrhosis. Mr G1 made a claim on the Life Plan.

L&G requested Ms S' medical records, including from the hospital which had treated Ms S. It noted that in March 2021, Ms S had been admitted with decompensated alcoholic liver disease (DALD). It also noted that she'd told the treating team that she drank around 100 units of alcohol per week and that she'd drunk large volumes of alcohol since she was 18. It referred Ms S' claim and the medical evidence to its Chief Medical Officer (CMO). Ultimately, L&G found that DALD was a condition which was caused by the long-term excessive use of alcohol. So it didn't consider that Ms S could have developed DALD only a few months after the policy began.

On that basis, L&G concluded that Ms S had misrepresented her alcohol intake when she took out the policy. And so it cancelled the plan from inception and refunded the premiums which had been paid for the cover.

Mr G1 was very unhappy with L&G's decision. He acknowledged that Ms S had had a past history of excess alcohol intake. But he said that at the time of application, her answers had been accurate. He referred to the medical report which L&G had obtained from Ms S' GP at that time. He asked us to look into this complaint on behalf of the trust.

Our investigator thought this complaint should be upheld. Briefly, while she thought it was likely Ms S had misrepresented her alcohol intake when she applied for the policy, she didn't think L&G had shown Ms S had made a qualifying misrepresentation at the time of application. So she didn't think L&G had been entitled, under the relevant legislation, to cancel the policy and refund the premiums. Instead, she recommended that the plan should be reinstated and that the life claim should be paid, together with interest.

L&G disagreed and it provided evidence and comments from its CMO. So the complaint was passed to me to decide.

I issued a provisional decision on 25 July 2024 which explained the reasons why I didn't think L&G had handled Ms S' claim unfairly. I said:

'First, I'd like to offer my sincere condolences to Mr G1 (and the other trustees) for the sad loss of Ms S. I don't doubt what a difficult and distressing time this has been for Ms S' family and friends.

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 relevant law, the available medical evidence and the policy documentation, to decide whether I think L&G handled this claim fairly.

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). CIDRA requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract. The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as - a qualifying misrepresentation. For it to be a qualifying misrepresentation, the insurer has to show it would have offered the policy on different terms - or not at all - if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

When Ms S took out the policy through a broker, she was asked a number of questions about her health and her circumstances. L&G used this information to decide whether or not to insure Ms S and if so, on what terms. L&G says that Ms S didn't correctly answer the questions she was asked during the application process. This means the principles set out in CIDRA are relevant. So I think it's fair and reasonable to apply these principles to the circumstances of Ms S' claim.

L&G thinks Ms S failed to take reasonable care not to make a misrepresentation when she applied for the policy. So I've considered the available evidence to decide whether I think this was a fair conclusion for L&G to reach.

First, when considering whether a consumer has taken reasonable care, I need to consider how clear and specific the questions asked by the insurer were. During the sales process, Ms S was asked:

'How often do you drink alcohol?'

Ms S answered 'Weekly'. She was next asked:

'During a typical week, how many alcoholic drinks do you have?' For example, a drink is a glass of wine or a glass or bottle of beer.'

Ms S answered: '5.'

Next, Ms S was asked:

'Have you ever been told by a health professional that you should reduce the amount of alcohol because you were drinking too much?'

Ms S answered: 'No.'

In my view, L&G's questions were clear and specific enough to have prompted Ms S to provide it with the information it wanted to know. In particular, I think Ms S was asked a clear question about whether she'd ever been given medical advice to reduce the amount of alcohol she drank.

Next, I need to consider whether I think L&G has shown that Ms S didn't take reasonable care to answer its questions. So I've turned to consider Ms S' medical records to assess whether or not I think it's provided sufficient evidence to demonstrate, on balance, that Ms S did misrepresent her alcohol intake at application.

Following Ms S' application for the policy, L&G sent her GP a medical report for completion. The form asked for Ms S' alcohol consumption during the last three recordings. The GP recorded that in 1994, Ms S' alcohol amount/frequency was '7 week', in 2017, it was '14 week' and in May 2018, it was '2 week.'

I've looked carefully at Ms S' medical records from shortly prior to and at the time of application. In December 2017, the GP noted that Ms S was a 'moderate drinker', drinking 3-6 units per day, although a clinic letter dated from the same month and year states that Ms S drank about 14 units per week. And the medical records show that in May 2018, Ms S was given advice about alcohol consumption.

By Mr G1's account, Ms S had had a history of excessive alcohol intake which dated back to her early adult years. But he said that at the time of application, she was drinking around five drinks per week.

Having carefully considered the medical records from shortly before and around Ms S' policy application, it isn't clear that there's sufficient contemporaneous evidence to show Ms S was noted to be drinking excessively. Indeed, the contemporaneous medical evidence corroborates the answers Ms S gave L&G and the testimony provided by Mr G1.

Nonetheless, it's clear that by March 2021, Ms S was suffering from symptoms of DALD which required hospital admission; care under the liver team and that her symptoms recurred and deteriorated over time. In March 2021, the hospital notes state that Ms S was drinking 1.5 bottles of wine per day (previously three bottles of wine per day). And in April 2021, Ms S' Hepatology Nurse Specialist noted that Ms S 'tells me she drinks over 100 units a week' and Ms S 'has consumed large amounts of alcohol since she was 18 years old.' In June 2021, Ms S underwent a FibroScan which gave an extremely high score and demonstrated 'a level of liver cirrhosis.'

L&G's CMO has provided their opinion and information from relevant sources, such as the NHS, which in brief, state that cirrhosis is end-stage liver disease, which occurs and develops over many years. And I note that the sources also say that the most common cause of cirrhosis is drinking too much alcohol over many years. One source states that 'alcohol-related cirrhosis usually develops after 10 or more years of heavy drinking.'

Based on Ms S' medical evidence, the CMO said:

'It is medically implausible for an individual to progress to both end-stage alcohol-related liver disease (cirrhosis) and that too of a severity (decompensated cirrhosis) within 7 months

at the stated level (or a reasonable multiple) of alcohol consumption, irrespective of how many years a pattern of five drinks per year was occurring for, based on my review of the evidence and condition…

It would be reasonably accepted by a typical group of UK GMC registered medical practitioners (and is confirmed by medical research) that reaching a FibroScan value of 70.0 kPA would necessitate sustained alcohol consumption far in excess of 5 drinks per week and closer to the reported 100 units per week for at least 12 months to (much more likely) several years, noting the physical exam findings, overall evidence and severity of cirrhosis the FibroScan confirms. This predates the policy start date…by a considerable margin, as evidenced above and in my opinion.'

I've thought about the CMO's evidence very carefully. I accept it does indicate that Ms S had likely been consuming more than five drinks a week for some time. I also accept the post-sale evidence suggests, on balance, that such a pattern of drinking had been ongoing for at least a year, if not many years, and that this level of drinking pre-dated the policy. So while the contemporaneous medical records don't indicate that Ms S was drinking more than she'd said at the time of policy application, I think it's more likely than not that she was, based on the totality of the post-sale medical evidence.

And, as I've said, Ms S' medical records show that on 23 May 2018, her GP recorded the following:

'Health ed. – alcohol
(Patient history) Advice given on alcohol consumption…Y'

I acknowledge the GP report provided at application states that Ms S hadn't been advised to reduce her alcohol intake because it was 'hazardous'. But Ms S was asked whether she'd ever been told by a health professional that she should reduce the amount of alcohol because she was drinking too much. On balance, it seems more likely than not that that Mis S had been told to reduce her alcohol consumption by a health professional, around two and a half years before she took out the policy. So I think she ought to have answered 'yes' to this question. As such, I currently think that Ms S did make a qualifying misrepresentation under the policy terms.

Next, in order for L&G to rely on the legal remedy available to it under CIDRA, it needs to show, on balance, that Ms S made a 'qualifying' misrepresentation. In other words, that it would have offered cover on different terms - or not at all - if it had been aware of all the facts.

L&G has provided us with commercially sensitive, confidential underwriting information. This shows what level of alcohol intake would be above its risk tolerance level and would lead to an application for life cover being declined. This guidance shows that if a policyholder had been advised to reduce their alcohol intake, even if their alcohol intake matched what Ms S had declared at the time of sale, an application for Life cover would have been declined. And it also shows that if Ms S had been drinking at the level indicated by the CMO and nurse at the time of sale, L&G would also have declined to offer a policy.

This means then that I think L&G has shown that Ms S did make a qualifying misrepresentation under CIDRA and that it's therefore entitled to rely on the remedy available to it under the Act. That's because I'm currently satisfied that if Ms S had told L&G about the alcohol advice she'd been given, it wouldn't have offered her a policy at all. L&G classified Ms S' misrepresentation as deliberate or reckless. CIDRA says that in cases of deliberate or reckless misrepresentation, an insurer is entitled to decline a claim, cancel the policy from inception and retain the premiums. In this case though, L&G refunded the policy

premiums after it cancelled the policy. So it seems to have applied the legal remedy for careless misrepresentation. In my view, this was a fair response from L&G.

Overall, despite my natural sympathy with Mr G1's position, I don't currently think L&G acted unfairly when it turned down this claim, cancelled Ms S' policy and refunded the premiums.'

I asked both parties to send me any further evidence or comments they wanted me to consider.

L&G had nothing to add.

Mr G1 didn't accept my provisional findings and I've summarised his response. He said that following the application, L&G had written to Ms S' GP to obtain a report to support the application. It had then gone on to offer her cover with no adjustment to the premium or to conditions. So he questioned how, following Ms S' passing and a further review of the medical records, L&G could now fail to honour the policy that was taken out in good faith and supported by Ms S' GP. He felt that if Ms S had been given advice to reduce her alcohol consumption, and she'd forgotten this, it should have been picked-up by L&G's review of her medical records at the time of application. He said he was present at the time of application, and he'd believed, to the best of his knowledge and belief, that Ms S' answers were accurate. He also referred to a part of the CMO's evidence which he believed to be incorrect - so he questioned what else the CMO may have got wrong. And he stated that the situation was having a real financial and mental impact on both him and his family.

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 cause Mr G1, his family and the other trustees further upset and disappointment, while I've carefully considered Mr G1's further comments, I still don't think L&G handled this claim unfairly for the same reasons I gave in my provisional decision and which I've set out above. I'll now go on to address Mr G1's further comments.

Both parties agree that L&G asked Ms S' GP for a report before it agreed to accept her life assurance application and offer her cover. However, I must make it clear that this was a targeted report, which asked Ms S' GP to answer a series of specific questions. L&G *didn't* obtain a copy of Ms S' full medical records at this point and so it didn't review her full medical history before it accepted her life cover application.

As I set out in my provisional decision, the GP's report stated that Ms S hadn't been advised to reduce her alcohol consumption because it was hazardous. In my view, L&G was reasonably entitled to rely on the answers the GP gave in the targeted report when it considered whether to offer Ms S life cover and if so, on what terms. And because it didn't review her full medical records ahead of the claim being made, I don't think L&G could or ought reasonably to have known that Ms S had most likely been given advice to reduce her alcohol consumption around two and a half years before the policy was taken out. Therefore, I don't find that L&G had enough medical information at the outset to turn down Ms S' application. And, as I've set out above, L&G has provided evidence which shows that if Ms S had told it about the advice to reduce her alcohol intake, her application would have been declined - even if her intake matched what she declared when she applied for the policy.

I appreciate Mr G1 has concerns about the accuracy of the CMO's conclusions. I'm not a medical expert and it isn't my role to substitute clinical opinion with my own. But I'd add that I

don’t think it was unreasonable for L&G to take into account all of the medical evidence it was provided with when it assessed Ms S’ claim.

It’s clear that Ms S’ sad passing and the decline of this claim have had a real impact on Mr G1 and his family. I also entirely accept that Mr G1 believed the answers Ms S gave at application to be correct. I am sorry to hear about all they’ve been through and I know how disappointing my decision will be to them. But overall, I still think L&G acted reasonably when it concluded that Ms S had made a qualifying misrepresentation under CIDRA. And that it didn’t act unfairly when it turned down the claim, cancelled the policy and refunded the premium.

My final decision

For the reasons I’ve given above and in my provisional decision, my final decision is that I don’t uphold this complaint.

Under the rules of the Financial Ombudsman Service, I’m required to ask Mr D, Mr G, Ms G and Mr G as trustees of the late Ms S’ Life Plan Trust to accept or reject my decision before 2 October 2024.

Lisa Barham
Ombudsman