DRN-4997990

The complaint

Ms M complains about Liverpool Victoria Financial Services Limited's decision to decline her claim for permanent total disability benefit under her life and critical illness policy.

What happened

The history to this complaint is well known to the parties, so I won't repeat all the details here. In brief summary, in August 2011, Ms M took out decreasing term life and critical illness cover. The policy term is 18 years.

Ms M initially contacted LV about making a claim in August 2020, saying that she was in the process of being retired on medical grounds. The claim for permanent total disability was in connection with osteoporosis, fibromyalgia, anxiety and depression. Having sought the opinion of its medical officer, LV said there was insufficient evidence to support the claim at that time. The claim was put on hold, pending the finalisation of the medical retirement.

In March 2023, Ms M contacted LV again, having had her application for medical retirement approved. In August 2023, LV declined Ms M's claim, saying that the policy definition for permanent total disability had not been met. Relying on medical evidence, LV said that Ms M had not received all reasonable treatment options.

Ms M appealed, questioning LV's assertion. LV sought further advice from its chief medical officer. He said he couldn't support Ms M's condition being permanent on the level of evidence and lack of treatment. LV maintained its decision to decline the claim.

Ms M brought her concerns to the Financial Ombudsman Service, but our investigator didn't uphold her complaint. So Ms M asked for an ombudsman to issue a final decision, maintaining she meets the policy definition and has sought support and treatment from medical professionals.

To clarify, as our investigator has previously explained, the scope of my decision is limited to the issue considered in LV's final response letter of September 2023 – that is, its decision of August 2023 not to accept Ms M'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 Ms M 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.

I recognise Ms M has a number of health issues which significantly impact her life. I appreciate she's been medically retired from her former employment and that she's in receipt of personal independence payment (PIP) – reviewable again in October 2025. But meeting the tests for these entitlements does not automatically mean Ms M's claim with LV will succeed. For that to happen, Ms M must meet the definition for permanent total disability set out in her policy, which is:

> *You are totally and permanently unable to carry out all the main duties of your occupation, because of sickness or accident before the age of 70.*
>
> *Your occupation is the occupation you were in when you became ill or had the accident which prevented you from working. By main duties, we mean the duties that can't reasonably be left out without affecting your ability to do your job. If you were not in paid or unpaid work at the time of claim, the work tasks definition will apply.*
>
> *'Occupation' means a type of job with certain characteristics; it does not mean a specific job with a particular employer.*
>
> *It is important to understand that for us to pay a claim under either Own Occupation cover or Work Tasks cover, we need to be satisfied that your disability is expected to last for the remainder of your life, irrespective of when your policy ends, or when you retire.*
>
> *This means we won't pay a claim if we determine you are only partially or temporarily disabled, or the medical evidence we have received in connection with your claim indicates that your disability is not expected to last for the remainder of your life.*
>
> *We will pay a claim if the medical evidence we have received in connection with your claim shows that you have received all reasonable treatment options, these have been given a reasonable time to work, and have still failed to show any improvement in your symptoms.*

I've reviewed the claim record, medical records and other information Ms M's provided. In September 2020, when Ms M's claim was initially being considered, LV sought the opinion of its medical officer. Dr M responded as follows:

> *I do not think we can approve [permanent total disability] with the information available.*
>
> *I would expect her to see the pain clinic to help her manage her pain with less sedating on medication and to improve energy levels. She is on two types of codeine which will be making her feel tired.*
>
> *She needs a formal diagnosis of fibromyalgia and to check that more serious illnesses have been ruled out.*
>
> *Osteoporosis is not a risk for a desk job so would not prevent her working.*

In November 2020, Ms M's GP, Dr E, wrote a 'to whom it may concern' letter, seemingly in connection with her application for medical retirement. She said:

> *[Ms M] has a diagnosis of chronic fatigue syndrome and fibromyalgia. She also has anxiety and depression.*

These conditions cause her significant symptoms and I believe it would be impossible for her to get back to work.

I would fully support the idea of ill health retiral.

In May 2021, LV wrote to Ms M to explain that it would be putting the claim on hold until Ms M had concluded the ill health retirement process, seen specialists for her conditions and commenced treatment for those conditions. It asked Ms M to provide details of the specialists seen and treatments commenced.

When her claim was reopened in March 2023, a further letter from her GP, Dr H, in connection with her application for medical retirement, was provided. The letter said:

[Ms M] has a history of anxiety and depression, fibromyalgia symptoms and chronic fatigue. She also has osteoporosis and has had several fractures in the past six years. Her main debilitating symptoms are chronic pain, fatigue, poor mobility, low mood and anxiety.

These are all long term medical conditions, which are difficult to manage and I would advise that there will be a permanent impact on her ability to work.

In April 2023, responding to a request from LV for updated information from May 2021 onwards, Ms M's GP, Dr W, said:

The above patient has an informal diagnosis of fibromyalgia and chronic fatigue syndrome with symptoms in keeping with this first mentioned in October 2020.

She first presented in 2018 with anxiety and depression. Her past prescribed medication for antidepressants was 2021 and has had no active medications for anxiety and depression in twelve months [sic].

She has a diagnosis of Osteoporosis from a DEXA in 2017.

She has had no hospital appointments in four years and nil are outstanding.

The updated medical evidence also included details of Ms M's last six surgery, home or telephone consultations, which dated from October 2020 to April 2023. Primarily, these related to the issuing of fitness of work certificates and/or requests for repeat prescriptions. Additionally, some records relating to blood tests carried out abroad in September 2022 were provided.

In August 2023, LV sought the opinion of its chief medical officer (CMO). He said it was very difficult to support the claim without input beyond Ms M's GP. He commented that Ms M had tried antidepressants (with some improvement in 2020) though some reports suggested she had not taken them since 2021. The CMO did not consider Ms M's osteoporosis to be relevant, commenting that she'd not had a fracture for four years, almost certainly because she was on medication.

The CMO noted that the latest GP report said Ms M's chronic fatigue syndrome/fibromyalgia was a 'informal diagnosis' and remarked that Ms M had not seen a specialist for four years, nor been seen in a pain clinic.

He concluded by saying:

> *We are far from the position where all treatment options have been exhausted. I accept that her description suggests current unfitness, but I simply cannot support this being permanent on the level of evidence and the lack of treatment.*

When Ms M asked LV to reopen her claim in 2023, she said that due to pressures on the NHS, during and since the pandemic, access to any treatments had not been available. Ms M said that continued to be the case, but notwithstanding the situation, she had engaged in all treatment options that had been available to her. It was her understanding that there were no cures for any of her conditions and treatment options were focussed on managing symptoms.

In August 2023, Ms M also provided additional information to support her appeal against LV's decline decision, citing 2022 clinical guidelines from the Royal College of Physicians (RCP) and NHS website information regarding fibromyalgia. In particular, Ms M said that current clinical advice indicated specialist diagnosis was not required and that other clinicians could be well placed to diagnose fibromyalgia. Additionally, Ms M said her local pain clinic advised that chronic pain is largely managed in the community by the individual with support from their GP.

In her recent submissions to this service, in September 2024, Ms M said she'd spoken to her GP regarding the requirement for referral to a specialist. She was advised that, in line with current established practice, there is no need for a referral to rheumatology as there are no suitable treatments available to her beyond continuing to manage her symptoms through medication, diet, exercise, lifestyle etc. From what I can see, this information post-dates LV's claim decline and final response letter.

I can understand Ms M's frustration regarding the issues relating to diagnoses from her GP and the treatment she's had for her conditions. But this doesn't mean I think LV's decision, relying both on the medical evidence provided to support the claim and the comments of its chief medical officer, is unreasonable. From what I've seen, much of the information Ms M provided relates more specifically to her application for medical retirement – not her ability to meet the policy terms for permanent total disability, although I acknowledge there is inevitably crossover. And her more recent information is reports of her conversations with clinicians, rather than first-hand evidence from those clinicians. Additionally, the RCP clinical guidelines are generic, rather than clinical opinion specific to Ms M.

In May 2021, LV gave Ms M clear information about its reasons for placing her claim on hold. In 2023, Ms M provided the outcome of her medical retirement application and information and arguments about why LV's other outstanding requirements were either not necessary or difficult to achieve in practical terms.

I don't think it was unreasonable for LV to raise concerns about the lack of specialist referrals for Ms M's conditions and the absence of evidence to confirm that all reasonable treatment options had been tried and failed to show improvement in her symptoms. I'll also say that the further evidence LV has highlighted as absent in Ms M's claim is the sort of evidence I'd expect to see in a claim of this nature.

From everything I've seen, I think LV investigated and assessed the claim fairly, placing weight on the gaps in the medical evidence and relying on the opinion of its CMO to conclude that Ms M had not met the policy terms necessary to qualify for permanent total disability. So overall, I don't think LV acted unreasonably in declining Ms M's claim. I'm therefore not going to ask LV to do anything further in respect of this complaint. I'm sorry to send what I'm sure will be unwelcome and disappointing news to Ms M.

Finally, I note that Ms M's policy term has a number of years to run. So she'd be entitled to

present any new information and opinion about her health circumstances to LV for reconsideration, should her situation change.

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 Ms M to accept or reject my decision before 14 January 2025.

Jo Chilvers
Ombudsman