COLD CASE REVIEW

MARCH 2015

HAROLD A. WHELEHAN, S.C.

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Medical Expenses

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Backround

I was commissioned by the Financial Services Ombudsman's Bureau (FSOB) in December 2014 to undertake a project reviewing *"Cold Cases*" for the Bureau.

The purpose of the exercise is to comply with the recommendation made in 2013, subsequent to an audit of the Investigations Department of the FSOB whereby the auditor recommended that:

> "*the Bureau should consider developing a cold file review process. The process should ideally be done by a person independent of the investigation process, this will help in ensuring that it is an objective process. It should also have a formal reporting element so findings from the reviews can be considered by the Investigations Team. The number of files selected for this process should be dependent on available resources*".

Following a meeting with the Ombudsman (Mr. Prasifka) and the Deputy Ombudsman, Terms of Reference were proposed by them and accepted by me.

Terms of Reference

(1) An assessment of up to 30 cases to be undertaken from Findings issued in the calendar years 2013 and 2014.

(2) These cases are to be chosen from the following themes:

> Mortgages (to include Mortgage Arrears Resolution Process [MARP], trackers, maladministration), Investment, Account Administration, Medical Expenses, Critical/ Serious Illness Insurance, Life Insurance and Travel Insurance.

(3) Cases are to be selected randomly whilst ensuring that there is a range of providers, investigators (both internal and external) and persons signing the Findings.

(4) The Findings are to be assessed on the basis that they are balanced between legally sound, yet understandable, particularly having regard to the relatively informal process of the Financial Services Ombudsman (FSO). In this connection, refer to Section 57CI – adjudication of complaints.

This outlines how a complaint may be found to be substantiated or partly substantiated only on one or more grounds which are detailed. This should be commented on under the following headings:

> Clarity, quality, consistency in methodology and Findings, and judgement.

Is the level of detail appropriate – too much, too little? Individual views per Finding, together with overall views will form the basis of the report.

(5) Taking into account the above terms that recommendations be made as to any suggested actions, amendments in approach or practice which might be appropriate for the FSOB to consider going forward.

(6) Report to commence in January 2015 with expected completion in advance of next Council meeting on 9 March 2015.

The Selection of Cases for Review

I took delivery of 31 cases on 21 January 2015, under cover of a letter which explained how and why the cases to be reviewed were chosen in order to comply with Paragraphs (2) and (3) of the Terms of Reference, I attach the said letter as Appendix "A" hereof.

Approach to the Review

In making my assessment and comments, I have taken the perspective, not of a lawyer and not of a layman, but of one who practised law before the Courts for over 40 years and has for the past ten years been retired and living in "*the real world*". I have sought to review the cases and how they were processed, both as a lawyer and as a layman but applying a standard of judgement somewhere between the two as the statue [Section 57BK (4)] requires the Ombudsman:

> "***to act in an informal manner and according to equity, good conscience and substantial merits of the complaint without regard to technicality or legal form*".**

It follows that rulings (Findings) should be made in clear, informal, concise terms in order to be easily understood by the parties to the dispute and demonstrate that the complaint, has been fully investigated. It is also important that the written formal Findings contain a summary of the Case for the Complainant and the Case for the Respondent, a necessary commentary of the arguments of both parties and a resultant finding which is clearly expressed, reasoned and decisive. In cases where a complaint is substantiated or partly substantiated, redress for the Complainant must be expressed in language which is clear, reasoned and just, and the remedy/redress must be capable of practical enforcement.

General Comments

I have attached, by way of Appendix "B" to this report, a summary of each case reviewed and my particular comments thereon for reference and I also set out below my general comments by way of overview.

(i) *The methodology in investigating complaints and assembling the evidence and in evaluating the submissions of the Complainant and the Respondent is sound, consistent and effective. I have examined the complaints procedure followed by the FSOB and consider it to be adequate and appropriate and in the cases which I have reviewed, those procedures have been followed.*

(ii) *The question of whether an Oral Hearing is required or desirable was in all cases considered in the interest of enabling a properly informed decision to be reached.*

(iii) *The principles of natural justice appear to be to the forefront and applied in all cases reviewed.*

(iv) *The Findings were of a high standard* in all cases incorporating:*

(a) The background introduction.

(b) A summary of the substance of the complaint.

(c) A summary of the response to the complaint.

(d) An analysis of the complaint based on the relevant contractual/legal issues, with quotations from documents or testimony being referred where necessary.

(e) A comment on both the legal and factual issues arising between the parties.

(f) A decision based on the reasoning outlined in the Findings.

(g) In cases where a complaint was substantiated or partly substantiated the basis for the remedy was reasoned and directed in clear terms.

* See Recommendation (B)

(v) *Initially in going through the cases my impression was that the Findings were perhaps unduly detailed, even elaborate. However, as I progressed through the work and reflected, I formed the firm view that the comprehensive approach and the format being applied by the FSOB is correct and appropriate. This approach as reflected in the Findings demonstrates the respect with which each case is treated, and illustrated the basis for the ruling. It also enables the unsuccessful party to understand, and one hopes, to accept the Finding.*

(vi) *I believe that the FSOB in adjudicating on complaints has acted in full compliance with Section 57BK (4) which requires the Ombudsman:*

> *"**to act in an informal manner and according to equity, good conscience and the substantial merits of the complaint without regard to technicality or legal form**".*

(vii) *Whilst Section 57CI – (1) provides that the FSOB on completing an investigation can make a Finding in writing that the complaint is substantiated or is not substantiated or is partly substantiated in one or more specified respects but not in others, Sub-Section (2) of the Section enumerates seven different grounds (a) – (g) on which a complaint may be found to be substantiated or partly substantiated. Six of the grounds are straightforward and easily interpreted and applied. Ground (c) however is particularly difficult in terms of understanding and more particularly in terms of its intended application.*

It provides that a complaint may be found to be substantiated or partly substantiated if:

> *"**Although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice or standard is or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant**".*

When or how is such a provision to be applied?

It would seem that the legislators had in mind that in "certain circumstances", a subjective Finding should be made, favourable to the Complainant notwithstanding that the Provider had complied with the law, established practices and all regulatory controls. The Section entitles the Ombudsman to make a Finding and direct redress against a Provider in favour of a Complainant (even though the Provider has not broken his contract with the Complainant or been in breach of the law or any regulatory practice) if in the opinion of the Ombudsman the conduct complained of nevertheless is, or may be unreasonable, unjust, oppressive or improperly discriminatory in its application to the particular Complainant.

There is a legal presumption that a law is constitutional until it is found to be otherwise. However, it does seem to me that a Provider penalised on foot of this provision could argue strongly before a Court that having acted in accordance with its contract, the law, established practice and all regulatory standards, it should not be compelled to pay redress or make amends to a party aggrieved by its compliance with all its legal obligations.

In the absence of any statutory definition or guidelines, it is I believe necessary for the Ombudsman, in order to give dimension to the sub-section on a practical level, to develop criteria for his own guidance and those of his staff as to:

(a) when and in what circumstances this provision should be triggered

(b) how, in applying the provision, the question of redress should be approached so as to be fair and just both to the Complainant and to the Respondent which has been compliant with all its legal obligations.

Such criteria once established would bring a level of consistency to the application of the sub-section, and provide the basis for an explanation by way of response to any legal challenge to a decision based on the sub-section, or to a constitutional challenge to this section itself, should one arise. The existence of such guidelines or criteria would also enable the Ombudsman to more easily comply with Section 57CI (3) of the Act which requires the Ombudsman "to give reasons for the finding", in cases where Section 57CI (2) (c) is invoked in order to substantiate a complaint.

It would add to the transparency of the decision-making process if the general criteria could be exemplified by case studies (summarised) wherein Sub-Section 57CI (2) (c) was invoked in the past.

RECOMMENDATIONS

(A) In relation to Section 57CI (2) (c) establish criteria for:

(i) Triggering that sub-Section.

(ii) The application of the sub-Section.

(iii) The scope of any redress which may be offered to a Complainant by virtue of a complaint being substantiated solely by virtue of the existence of and the terms of that sub-Section.

(B) Notwithstanding my general comments at (iv) and (v) I feel that some refinement and greater clarity could be achieved generally in the presentation of Findings by a disciplined compartmentalising of the elements of each Finding under sub-headings within the Finding.

(C) I note that a significant number of the complaints resulted from a failure of the Complainant to understand the detailed provisions of the contract. In some cases, dispute arose as to what was said at the point of contract, and/or the extent to which documents were explained or not explained before signature. I recommend that the FSOB should bring this fact to the attention of Providers and use his best offices to influence them, in their own interest, to simplify their documentation, where possible reduce the volume of documentation, and ensure that the customer is fully aware of both the scope and limitations of any product which is sold.

HAW

March 2015

APPENDIX "A"

Harry A Whelehan SC

21 January 2015

Re: Cold File Review

Dear Harry

I refer to your discussions last month with Eversheds Solicitors and we are pleased to note your acceptance of instructions to undertake a project reviewing "*Cold Cases*" for the Financial Services Ombudsman's Bureau. The purpose of this exercise is to comply with a recommendation made in 2013, subsequent to an audit of the Investigations Department of this office, when the auditor recommended that

> *"The bureau should consider developing a cold file review process. The process should ideally be done by a person independent of the investigation process. This will help in ensuring that it is an objective process. It should also have a formal reporting element so findings from the reviews can be considered by the investigations team the number of files selected for this process should be dependent on available resources"*

I understand that you have been furnished with a copy of the Terms of Reference for the review, which includes a guideline that although the relevant cases are to be selected randomly, they should include Mortgages (MARP, Trackers, Maladministration), Investments, Account Administration, Medical Expenses, Critical Illness/Serious Illness, Life Assurance and Travel Insurance. In addition, those files should represent a variety of Findings for complaint investigations during the period selected, offering

- A broad range of Financial Service Providers,
- A variety of Investigators (both internal and external) who dealt with the adjudications and
- A mix of management members who signed those Findings.

I am now attaching for your attention 31 of our original files for complaint investigations during the relevant period. I have spent some time reviewing our statistics for the period and I am satisfied that the cases selected for review, whilst random, offer a representation of the work of the Bureau in the period selected, on complaint files which concluded during that time, by way of a formal Finding issued by the FSOB to the parties.

Those files have been varied not only in terms of product type, as outlined in the Terms of Reference, but have also been broadly constituted to represent the work of the 4 signatories within the FSOB (Financial Services Ombudsman, Deputy Financial Services Ombudsman, Head of Investigation and Head of Legal Service) and they include a mix of investigations assigned to both internal investigative staff and external drafting contractors.

The file selection encompasses 31 investigations spread across complaints against 25 different Financial Service Providers in respect of the product types identified, and I have also attempted to offer you some visibility on the considerable variety in terms of the size and complexity of our investigations, and procedural features, eg interlinked complaints running in parallel where they are maintained against 2 separate and distinct financial service providers, and some instances of investigations which ultimately proceeded by way of Oral Hearing, prior to the adjudications being finalised.

If any query arises in respect of any aspect of the enclosed files, please do not hesitate to contact me.

Yours Faithfully,

MaryRose McGovern
Head of Investigation

APPENDIX "B"

Index of Case Reviews

Household Buildings

Mortgages

Medical Expenses

Income Protection/Critical Illness

Complaint (1)

Background

The Complainant set up an investment bond via an independent intermediary. The purpose of the bond was to improve net return from cash deposits.

The Complainant was sent an illustration by the Respondent confirming the Complainant's intention to invest 100% of cash into the bond on a deposit account, the illustration showed indicative growth over a period with interest being reinvested on a gross basis and rolling up.

Pursuant to this proposal, the bond was established and the money was invested for a three year period at 4% interest.

The illustration had also indicated that the Respondent's fee would be 0.13%.

Complaint

A dispute arose when it transpired that the Respondent:

(a) Had not been rolling up the interest gross but rather crediting it to a non-interest bearing transaction account.

(b) The Respondent was charging an annual fee of 0.18% rather than the 0.13% which appeared in the illustration.

(c) That the fee had been increased by 0.5% due to the application form submitted by the Complainant having ticked a box which gave rise to a standard death benefit being included in the package.

Finding

The Finding recites the facts and the dispute by reference to the documents and found in favour of the Complainant in relation to the way in which the interest ought to have been applied gross and rolled up to the capital sum and directed the Respondent to pay the difference between what was received by the annual payment, as against what he would have received, if the investment had been made on the basis which had been proposed to him in the illustration with which he was provided.

Concerning the enhanced fee charged by the Complainant of 0.18% the Ombudsman accepted the submission of the Respondent that the intermediary (for whom the actual Respondent had no responsibility) had ticked the box in the application form on behalf of his client, and the Company reasonably proceed to charge the appropriate fee.

Comment

This ruling required a significant insight into the investment area and I can only comment that having read the presentation of the case I understood both the nature of the transaction and the reasons for the Finding, something which I would not have understood on a plain reading of the documents on the file.

I was pleased to note that the Finding was accepted by the Respondent.

Complaint (2)

Background

The Complainant is one of 12 persons forming a partnership for the purpose of investing in a commercial property in Dublin. The investment was to be arranged by a Financial Advisor. In April 2006 the partnership re-financed the project through a loan from the Respondent, secured on the property with a final maturity of 31 December 2015.

The Complainant's investment amounted to €500,000 which represented a holding in the property of 4.18% - there were capital allowances attaching to the property which expired in 2011.

The loan was to be repaid with annual interest and capital payments on a non-recourse basis.

Complainant's Case

The Complainant complained on his own behalf only. He complained that it was always made clear to him at the time of his original investment that in the worst case scenario he would lose his original investment but he could not be exposed to further loss. In the events that happened before the expiry of the buildings tax life in February 2011 the Bank threatened to sell the asset in circumstances which would have left the Complainant with a significant tax liability. The Complainant contended that the threat by the Bank was used to extract funds from the Complainant over and above his original investment. He contended that the conduct of the Bank was oppressive and exerted pressure on him in circumstances where there was no benefit to the Bank as the claw-back of capital allowances would not have been of benefit to the Bank.

The Complainant sought the return of €104,212 paid to the Bank and also the release of funds from the Bank to pay the continuing tax liability arising from the rental profit.

Respondent's Case

The Respondent disputed the Complainant's complaints and said that the Complainant and the partnership were independently advised to provide a capital contribution rather than have the Bank appoint a Receiver for the purpose of selling the property. The Bank claimed it was merely exercising its legal entitlement on foot of the loan agreement and another agreement called the First Re-Statement agreement dated 16 December 2010 freely entered into by the

Complainant after independent legal advice from solicitors, an investment company and a firm of accountants.

File

The file is clear in relation to the complaint and the response to the complaint.

Finding

The Finding contains a detailed analysis of the original loan agreement governing the transaction and the loan to value covenant therein, including a summary of the history of the transaction and the documentation surrounding the Bank moving against the partnership in May 2009 from which it is clear that the partnership agreed on a solution to the problem to remedy the breach of "LTV" covenant and signed a document to that effect on 16 December 2010 after being fully independently advised. The said document had been approved and accepted by each member of the partnership, including the Complainant.

The Finding found that the Complainant and his partners committed themselves in writing to a solution for the immediate difficulty presented to them by the breach of the LTV covenant, that the Bank had been entitled, while there was a breach of the LTV covenant in being, to seek to complete the sale of the property and that accordingly the Bank in threatening to effect such a sale could not give rise "*to a well founded complaint against the Bank*".

The complaint was found to be "*not substantiated*".

Comment

This complaint amounted to a grievance by a Bank customer who believed that his loan, having been secured against the property purchased with the funds advanced for the loan, could not give rise to any further liability over and above the amount of his original borrowings.

While it was unfortunate that the property market changed and the LTV covenant was breached, the partnership decided to enter into an agreement with the Bank to deal with the issue, avoid selling the property by making a capital payment which agreement superseded the earlier non-recourse provision.

Complaint (3)

Background

The Complainants sought advice from the Respondent for the investment of €2.4m which they had as a result of the sale of a family business.

The Respondent was retained by the Complainants as a financial/investment advisor in relation to the investment of the said monies.

In summary, the Complainants regarded themselves and presented themselves as conservative investors and wanted to secure €1m of their investment in a capital guaranteed investment and the balance in an income generating investment to supplement their income from property investments, in view of the fact that they were not entering into employment subsequent to the sale of the family business.

Complaint

The complaint is that the Respondent was in breach of duty to the Complainants, recommended unsuitable investment products, gave negligent advice and provided a poor level of service.

Certain of the complaints related to transactions in excess of six years prior to the making of the first complaint and these are not dealt with pursuant to Section 57BX (3)(b) of the Central Bank & Financial Services Authority of Ireland Act 2004.

The Complainants claimed significant financial losses as a result of the investments which they made allegedly on the advice of the Respondent and also had complaints about the commissions received by the Respondent in relation to effecting investment switches during the period when it was acting for them.

Respondent's Case

The Respondent claimed to have fully and properly informed himself of the Complainants' requirements when he acted for them.

He provided documentation in support of this contention and in the documentation and in the subsequent Oral Hearing explained in detail the relationship which existed with his clients in his role as their financial advisor.

Oral Hearing

Because of the various and significant conflicts of fact which arose in the course of written submissions, seven points of conflict were identified and provided the basis for and subject matter of the Oral Hearing. The Complainants were represented by a Chartered Accountant and the Respondent was represented by a Barrister at Law, instructed by solicitors. The Oral Hearing took place on 19 March 2014.

Finding

The Finding, while limited to the conduct of the Respondent in the six years prior to the making of the complaint, did review the parties' relationship and how it developed and progressed from early 2006. The Finding went on to review the Fact Find of 2006 and many documents which were generated over the period of the relationship between the Complainants and the Respondent and the evidence, both documentary and oral (generated by the Oral Hearing) and the submissions made by and on behalf of the parties through the correspondence with the FSOB.

At the end of a lengthy resume of the evidence and the arguments, it was concluded that there was no misconduct or wrongdoing by the Respondent.

It was also found that the complaints relating to the fees and commission were not substantiated, having regard to the evidence contained in the documentation by the various product providers and the information contained in those documents.

The Complainants acknowledged in the Oral Hearing that they did not read the information provided, even though detailed information was forwarded to the Complainants setting out the nature of the products and relevant information, including that relating to fees and commission being incurred.

The complaint was not substantiated.

Comment

The reduction of this enormous file (including transcripts of oral evidence) to a summary of the case and the succinct Finding was a major exercise leading to a well reasoned Finding. In this case it was clear that the Oral Hearing was of considerable assistance to the Ombudsman as was the fact that the correspondence leading up to the Oral Hearing and the Hearing itself were conducted by a lawyer on the one side and an accountant (investment specialist) on the other side which facilitated the focus on the issues to be decided.

Whilst I suspect the same conclusion would have been reached without an Oral Hearing, it was important that the seven headings, which had been identified for examination at the Oral Hearing, were vented at the Hearing and each side had the opportunity of presenting its case and challenging the case of the other party.

Complaint (4)

Background

This case involved a complaint by a husband and wife against both the Respondents concerning:

(a) A complaint against a subsidiary of the Respondent for having allegedly mis-sold three investments to them between 2005 and 2006.

(b) A complaint against the Respondent for having mis-sold two loans to facilitate two investments arranged by the first named Respondent in the years 2005 and 2006.

Preliminary Decision

The Ombudsman decided to take both complaints together as the Respondent has overall responsibility for the subsidiary.

It was also decided that having regard to significant conflicts of evidence that oral evidence would be taken in an attempt to resolve the conflicts of evidence.

The Investments

The investments involved €80,000, €50,000 and €100,000 in 3 products respectively.

Summary of Complaints

(i) Invitation to invest was unsolicited by the Complainants.

(ii) There was no proper discussion or explanation of the investments – their advantages or disadvantages.

(iii) No other or different investment options were proposed or discussed by the Respondents with the Complainants.

(iv) The Complainants had no experience in investment or evaluation of risk.

(v) The investments lacked diversity and balance and were improvident.

(vi) The nature of the investments lacked access to liquid funds over a range of investments.

(vii) No consideration was given to the clarity of the investments in the light of the illness with cancer of the first named Complainant or to the fact that by virtue of his cancer diagnosis and the treatment which he was receiving therefor that he would not be able to procure life assurance.

(viii) Account was not taken of the fact that the Complainants had three dependent children.

Summary of Respondent's Case

Product A

This was proposed in correspondence, followed by meetings and discussions with explanations at the Respondent's branch in Cork.

Every aspect of the investment was fully explained and discussed with an official of the Respondent and a declaration was signed by each of the Complainants stating that they had read the prospectus and the application form and were fully aware of the timeframe, risk factors (set out on Page 29 and 30 of the prospectus) and the costs entailed.

The Respondents were not made aware of the first named Complainant's illness.

Product B

The Complainants were advised by a Financial Planning Expert and an Investment Advisor with the Respondent.

They opted for high risk investment, signed a Fact Find Declaration having had the benefit of an information memorandum of 52 pages and signed a Declaration accepting that they had read the document which outlined the risks involved.

Product C

The Complainants were advised by the Financial Planning Expert and another official at their business premises, the risks were fully explained to them, the nature of the investment was described, the charges which would be levied in respect of placing of the investment and the procedures for withdrawal of the funds from the investment were fully outlined.

The Complainants wanted time to consider it.

On 3 August 2006 there was another meeting with the first named Complainant only and the application form for the bond was completed by the first named Complainant and later signed by the second named Complainant.

Evidence A large file of documents was assembled in the course of the investigation and the transcript of an Oral Hearing was generated and considered. At the Oral Hearing both the Complainants and the Respondents were represented by counsel.

The decision in this case involved consideration of:

(a) Documentary evidence produced by the parties.

(b) Written submissions by and on behalf of the parties.

(c) Oral evidence (as recorded in the transcript).

(d) Submissions at the Oral Hearing.

Findings The Findings which are summarised at Page 38 of the Finding comprise 28 pages of analysis and discussion, the issues of fact as disclosed by the documents, as against the conflicts of fact sought to be explored at the Oral Hearing in addition to the terms of the various documents signed by the Complainants. While it was found that none of the investments were mis-sold to the Complainants, it was found that the sales process followed by the first named Respondent were in breach of duty in relation to two of the investments, i.e. Product A and Product C.

An award was made respectively of €20,000 and €10,000 in respect of the breach of duty in each of those cases.

It was found that there was no valid complaint against the Respondent in respect of its part in making the loans available to the Complainant.

Comment This case like so many others demonstrates the serious need to make the public aware of the implications of signing declarations without having read, considered and fully understood the documents. The dispute was largely resolved in favour of the Respondent because the Complainants signed declarations committing them to the terms of the documents above their signatures – despite their strong contention that they relied on the Respondent's representatives whom they trusted to the extent that they did not read the documents!

Complaint (5)

Background

In September 2010 the Complainant was contacted by the Respondent and after an exchange of information and informing the Respondent's representative of his requirements, he entered into a personal retirement bond (PRB) having specifically informed the Respondent that he required an investment which would enable him to take part of the proceeds of the bond in a tax-free lump sum and part as a taxed lump sum.

In the course of preparing the documentation the Respondent wrongfully described the Complainant as a 50% proprietary director of a certain accountancy firm (the firm).

After approximately 2 years the Complainant sought to realise the proceeds of the bond. Considerable delays ensued, and notwithstanding discussions with the Respondents, the filling out of documentation, and meetings with representatives of the Respondent over a long period (2 years approx.) it became apparent that a non-specified difficulty arose in relation to the bond.

Complainant's Case

The Complainant alleged that he had been badly informed and wrongly advised in relation to the terms of the bond in which he had entered, was not supplied with copies of the documentation when they were completed by the Respondent, he having earlier completed his side of the contractual documentation, he left the balance to be completed by the Respondent. Despite requests for the completed documentation, it was not supplied to him. The nature of the difficulties which arose was not explained to him and he was misled. He alleged that the Respondent, by wrongly describing him as a proprietary director of the firm took his investment outside the scope of legislation, and thereby prevented him from recovering the proceeds of his investment, partially tax-free and partially subject to tax.

The Complainant sought an apology from the Respondent, payment of the benefit in accordance with the terms of the PRB he purchased, a refund of the fees charged to date, interest and compensation for the considerable time and effort which he spent in seeking to resolve the problem in correspondence and by negotiation and discussion with the Respondent.

Respondent's Case

The Respondent claims it sold the PRB to the Complainant in good faith and that it sought to ensure compliance with legislation and Revenue requirements. It claimed that the Complainant chose a PRB over a PRSA both of which options had been explained to him. It was acknowledged during the Oral Hearing that an error had been made by the Respondent's representative in recording the employment status of the Complainant.

The Respondent also claimed that it had furnished copies of all documents to the Complainant, and he could have cancelled the policy if its terms were not acceptable to him within the cooling-off period.

The Respondent claimed it had done everything possible to obtain the benefits sought by the Complainant, and offered an *ex gratia* payment of €4,605.70 which it contended would put the Complainant in the position in which he would have been, if the difficulty with the Revenue rules had not been encountered.

Oral Hearing

In this case an Oral Hearing understandably was found to be necessary and was carried out on 13 October 2014. The Complainant was the only witness on his own behalf and represented himself at the Hearing. The Respondent called evidence from five witnesses and was represented at the Hearing by two in-house solicitors.

Finding

The Finding contains a review of the evidence and a consideration of the documentation and it was noted in particular that the error made by the Respondent's representative in describing the Complainant as a proprietary director of the firm was for the first time admitted by the Respondents at the Oral Hearing.

The Finding concluded that the PRB was mis-sold due to the mistake on the part of the Respondent in classifying the Complainant as a 50% proprietary director of the firm which led to the Complainant being unable to receive the benefits which he had contracted for and which he would otherwise have received. It was also found that the Respondent in standing over its earlier submissions, and not admitting the error in the classification of the Complainant for over 20 months was stressful to the Complainant and unjustified.

The Finding incorporates 12 bullet points (Page 17 of Finding) with specific criticisms of the Respondent's handling of the case concluding that the investigation revealed a *"wholly unacceptable standard of customer service*".

[An overall award of €10,000 was made over and above the funds standing in the PRB (it having been established that the legislation which had posed a problem for the Complainant in redeeming his funds had since been amended and was no longer to the Complainant's disadvantage)].

Reprimand

Apart from the reprimand by the Ombudsman in the Finding, a copy of the Finding was sent to the Central Bank for consideration as to whether any action needed to be taken by the Central Bank in relation to the conduct of this case by the Respondent.

Comment

This case raised very complex issues and generated voluminous documentation, and a transcript of the evidence from the Complainant and five witnesses for the Respondent. During the Oral Hearing, the Respondent's representative accepted in evidence the error she made and it was obvious that the Complainant was exposed to great delays and stress for over a 2 year period.

The Oral Hearing, while fully justified, clearly delayed a resolution of the matter. The Respondent by calling five witnesses to testify and being represented by two in-house solicitors against the Complainant put the Complainant in a very difficult position without "*equality of arms*" perhaps he was fortunate to be an accountant with insight and tenacity. The rights of the Complainant were nonetheless well protected by the manner in which the complaint was investigated and the Respondent's case challenged.

The investigation and the Oral Hearing exposed the lack of merit in the Respondent's stance and in its dalliance in meeting its responsibility or showing any concern for the Complainant.

The monetary payment directed, the reprimand of the Respondent by the Ombudsman and the reference of the matter to the Central Bank seem a proportionate response on the part of the Ombudsman.

Complaint (6)

Background

Two directors of the Complainant company invested a sum of €250,000 in a Fund Policy in May 2007.

Prior to making the investment, the Complainants had a lengthy meeting with the Insurance and Investments Manager of the Respondent where discussions took place as to nature of the investment which would be most suitable to the Complainants having regard to their attitude to risk, the return which they would expect and the duration of the investment.

The Respondent's Investment Manager took written details from the Complainants relating to their circumstances and the information provided by the Complainants was recorded on a document known as "Fact Find". The information gathered at the meeting is recorded in the Fact Find document was very comprehensive and ranged over a broad number of headings.

This document was signed by the Complainants on 3 May 2007 and the document signed contained a number of declarations to the effect that the Complainants had read the Company's Terms of Business that they had understood the information provided, that they had been advised on various levels of risk which would be involved in different types of investment and that they understood that the recommendations made by the Respondent's advisor were based on information provided by them etc. etc.

In 2008 the Complainants encashed the policy, suffering a loss in excess of €76,000.

Complainants' Case

The Complainants allege that the Respondent failed to act with due care, skill and diligence in the sale of the policy and recklessly or negligently misled the Complainants with regard to the real or perceived advantages and risks of making the investment.

They also alleged that the Respondent failed to provide them with the appropriate documentation to enable them to properly consider the investment, failed to notify them of the cooling-off period and failed to provide them with the Terms & Conditions of the investment.

Respondent's Case

The Respondent's case was that the Complainants were fully, properly and adequately advised in relation to their investment after careful examination of their circumstances and an evaluation of their attitude to the proposed investment. While the Complainants were not seen as experienced investors, they presented as successful business people with the capability of understanding simple and straightforward language and having deliberated with the Insurance & Investments Manager of the Respondent, and furnished her with all of the information she required to compile the Fact Find document, heard her presentation and discussed the matter with her, signed the Fact Find, signed the document which had been compiled during the meeting, which document incorporated confirmation that they had received and read a copy of the Company's Terms of Business etc. etc.

Issues Which Arose

Significant issues of fact arose between the complaints made by the Complainants and the response of the Respondent and in particular the contents of the documents presented by the Respondent.

Oral Evidence

The Ombudsman ruled that because of the extent and nature of the conflict on issues of fact that an Oral Hearing should be conducted and this was carried out on 20 March 2014. Unfortunately, notwithstanding that both the Complainant and the Respondent were legally represented and evidence was given by one of the Complainants and by the Insurance & Investments Manager and a colleague of hers, the issues of fact in dispute were not made any easier to resolve, despite the examination and cross-examination of the witnesses.

Finding

The Finding is detailed and well reasoned and understandably relies heavily on the documents signed by the Complainants and the written record of information provided by the Complainants and recorded in the Fact Find document.

The Finding also contains a succinct and clear statement of the obligations of the Complainants to have been satisfied before signing the documents that they clearly understood the import of what they were signing. It also contained a clear statement of the obligations of the Respondent to exercise professional skill, care and diligence, and to act honestly and fairly and professionally in the best interest of the customers.

It was concluded that the evidence did not support the complaint that the investment was mis-sold or that undue pressure was exerted upon the Complainants. It was also found that the losses sustained on the investment could not be shown to have arisen as a direct result of any misrepresentation, inducement or negligent investment advice of the Provider.

The complaint was not substantiated.

Comment

While this in many ways was a straightforward conflict between the Complainants and the Respondent, as to what transpired at the pre-investment meetings in terms of advice, attitude and understanding, the existence and presentation of the documents signed by the Complainants, given the straightforward language in those documents and the nature of the acknowledgements and declarations incorporated therein, even in the context of the oral evidence taken, could not be overturned.

The manner in which the Finding analysed the documents and the responsibility of the parties, and the issue to be decided and the onus of proof very clearly expressed how the decision was arrived at and why.

While the exercise of taking oral evidence may not have assisted greatly in arriving at the decision, it was a proper and appropriate measure and fairly offered each side the opportunity of presenting their account of the substance and atmosphere which existed at the time of the contract. In the end, the fact that an Oral Hearing was held must make it easier for the party who was disappointed with the result to accept that the matter had been fully and completely investigated and ruled upon.

Complaint (7)

Background

The Complainant took out a policy of travel insurance in June 2011 anticipating a holiday in August 2012.

As a result of a myocardial infarction and cardiac bypass surgery in June/July 2012 the holiday was cancelled on 12 July 2012.

The Respondent repudiated the policy on the basis of non-disclosure of a pre-existing medical condition.

The Complainant contended that the obligation to disclose a pre-existing medical condition was not given due prominence at the point of sale of the policy, and was only apparent on reading the small print of the policy. He also contended that the wording was ambiguous as it was not clear whether hypertension, which he had, but was well controlled with medication, fell within the category of conditions requiring disclosure.

Furthermore the Complainant contended that the policy was suitable for persons under the age of 80 years of age whereas he disclosed his age as 84 at the time of contract.

Respondent's Case

The Respondent relied on

(a) Clause 3 of the medical health requirement section of the policy which requires a disclosure of (*inter alia*) any cardiovascular problem or other heart condition, hypertension (raised blood pressure), blood clots ... and

(b) Evidence from the Complainant's Medical Practitioner which confirmed that the Complainant had a history of essential hypertension for a number of years and was on medication therefor.

Finding

The policy was invalid, having been sold to a person who was over 80 years of age, it being a policy appropriate only to a person under 80 years of age.

There was full disclosure of information and documents concerning the investigation of this claim and it was found that the complaint could not be substantiated.

However, taking into account the terms of the Consumer Protection Code, it was found that the Respondent did not act with due care, skill and diligence, or in the best interests of the consumer in selling a policy which was invalid. It also failed to meet the requirements of the Complainant in his application for cover. The Complainant ought to have been made aware of the age related restriction under the policy. The insurance policy was therefore mis-sold to the Complainant.

The purported refund of the policy premiums to the Complainant was not regarded as adequate, having regard to the Respondent's poor administration in the processing of the application in particular, its failure to note or have regard to the actual age of the Complainant at the time of contract; an award of €1,000 was made to the Complainant.

Comment

This case was a very detailed one, in which a strict construction of the insurance contract was appropriate. The invoking of the Code of Conduct in order to both compensate the Complainant and penalise the Respondent was justified. It was a good and measured approach to the case.

Complaint (8)

Background

This complaint relates to a claim for compensation by the Complainant against the Respondent. The Complainant had taken out travel insurance through the Respondent acting as an intermediary. While abroad, the Complainant sought a copy of the policy from the Respondent; she was informed that the policy had not been renewed and she was also informed that cover could not then be effected as she was already abroad.

The Complainant suffered a fall with very significant immediate and long term consequences.

The belief that she did not have travel insurance greatly complicated matters, led to lengthy hospitalisation abroad, expense and great inconvenience for her family in getting her home. Sometime after her return to Ireland a valid policy current for the period of her holiday was discovered which had been placed by the Respondent with the Underwriters.

The insurance company repudiated liability under the policy, and while the Complainant complained to the Financial Services Ombudsman Bureau about the repudiation, that complaint was not substantiated. [Complaint (9)].

Complainant's Case

This complaint involved a claim for redress on behalf of the Complainant arising out of the hardship, distress and anxiety suffered by her and her family and caused by the Respondent's wrongly informing the Complainant that she did not have travel insurance, when in fact she did, leading to great distress and inconvenience being caused to her and her family in the months following the accident by having to manage her treatment abroad, and repatriate her from her own family resources.

Respondent's Case

The Respondent accepted that a mistake had been made but denied that they mis-informed the Complainant. They contended that the Complainant when requiring a copy of the policy gave a reference number for a policy which had in fact expired and was not current and that the Respondent's employee had correctly answered the specific query.

However, the Respondent accepted that if a cross-check had been carried out by their employee against the Complainant's name, a valid policy would have been discovered; they also accepted that such a check should have been carried out. The Respondent offered €500 by way of compensation for the inconvenience caused by their mistake.

Finding

The Finding deals with the Consumer Protection Code 2006 and finds that there was a lack of documentary evidence regarding the existence of a written suitability statement for the policy issued to the Complainant; it also found that there was an absence of evidence that the Respondent adequately addressed the issue of the Complainant's existing medical condition.

Furthermore, it found that the record-keeping of the Respondent was deficient in that there was no record of the Complainant's policy having been renewed which led to the denial of the existence of a policy.

It was also noted that the Respondent was unable to furnish evidence of the renewal letter, or a written suitability statement on which it could rely as evidence that the Complainant failed to make a declaration of pre-existing conditions.

Finally it was found that the Respondent's customer service generally provided a poor level of customer service when the Respondent was asked to furnish documentation.

Remedy

It was found that the offer of €500 by way of compensation was inadequate and an award of €4,500 was made.

Comment

It was appropriate that this complaint and the related complaint were dealt with by the same person in the FSOB.

Each case received and deserved very close attention and analysis.

In this case the Finding is fully justified in measuring the facts against the Consumer Protection Code which is appropriately quoted and set out and the analysis and the conclusions are easily understood and, I hope, appreciated by both the Complainant and the Respondent.

Complaint (9)

Background

The Complainant took out a travel policy on 21 November 2011 intending to travel to the Middle East to visit her daughter. While in the Middle East she fell on 1 April 2012, became disorientated, was hospitalised in the Middle East for a long period before being repatriated to Ireland on 30 June 2012.

As a result of the accident she is now blind, partially incontinent and incapable of living alone (as she had been doing prior to her departure from Ireland).

While the Complainant was in hospital her daughter e-mailed the intermediary concerning her travel insurance and was informed that the policy was not in force as it had not been renewed at the expiration of the previous policy. In October 2012 a valid policy covering the period of the Complainant's illness was discovered in her home which provided insurance cover for the period that she was abroad.

The daughter continued to manage her mother's illness in hospital in the Middle East (the expense being borne by the employer of the daughter) but there was great distress and anguish caused to the family and the Complainant due to the logistical and financial problem of repatriating her home. This was ultimately overcome by another daughter flying to the Middle East and assisting getting her mother home and admitted to a Dublin Hospital.

Complainant's Case

The claim on the policy was advanced by the Complainant's daughter on her mother's behalf in relation to the expenses incurred in relation to medical treatment and travel and also in relation to the fact that her mother was now registered blind consequent upon the fall which she suffered in the Middle East.

Respondent's Case

The Respondent repudiated liability on the basis initially that the period of the Complainant's travel was in excess of 45 days but later recanted on this.

The claim was next rejected on the basis that the Complainant failed to make a disclosure of a pre-existing condition which was the cause of, or alternatively rendered her vulnerable to the consequences of becoming blind as a result of the fall.

The Respondent made an *ex gratia* offer to settle the case, broadly speaking on the basis of paying the flight expenses incurred by the Complainant as a consequence of the accident and the repatriation of the Complainant to Ireland. (The medical expenses had been discharged by the Complainant's daughter's employer earlier).

Finding

The Finding involved a very detailed and lengthy analysis of:

(a) The policy provisions.

(b) The medical history of the Complainant pre and post accident.

(c) Extensive correspondence on behalf of the Complainant by her daughters and similar correspondence and extensive documentation emanating from the Respondent.

It was, I believe, correctly concluded that the Complainant was unable to establish that the pre-existing condition with which she had been diagnosed in 2006 was not a relevant factor in the serious consequences which flowed from her fall in the Middle East while covered by the travel insurance.

It was also clear from the medical evidence provided in support of the Complainant's claim that her medical advisors would have regarded the pre-existing condition from which she suffered as a material fact which ought to have been disclosed in her declaration for the policy. The complaint was not substantiated.

Comment

It does seem harsh in this case given the fine balance of the medical evidence between what the Complainant was advised in 2006 when she received the diagnosis of the earlier condition and the medical opinion expressed since the accident, one wonders if this was a case in which the provisions of Section 57CI (2) (c) ought to have been invoked, given that the non-disclosure by the Complainant was based on the Beaumont Hospital report dated 16 August 2006 *"she does not have any significant visual impairment*" ..... "*the only indication for considering surgical intervention would be a deterioration in her vision*" ..... "*there would be no particular need for her to attend our joint pituitary clinic and it may be appropriate to organise visual field testing on an annual basis for approximately two years and if this does demonstrate a*

deterioration in her visual fields, it might be appropriate to reassess at that point in time and if she does remain stable for the next two years then she could be left to refer herself back in the event of there being any deterioration in her vision at some stage in the future".

The evidence suggested that her sight had not deteriorated in the five or six years nor had she been referred back for further treatment. Could it be unreasonable or unjust in those circumstances to penalise the Complainant for not disclosing something over five years after it had shown itself (as predicted by the doctors) to be benign!!

Complaint (10)

Background

The Complainants took out a policy of travel insurance on 25 February 2013 in anticipation of a five month trip to a number of countries to take place over a four month period in 2013.

In March 2013 the first Complainant's mother was diagnosed with terminal cancer. The Complainants cancelled their trip on 11 March in the light of the "*terminal*" diagnosis.

Complaint

The Complainants sought to recoup the cost of their holiday on foot of the insurance policy but this was declined by the insurance company as it transpired in the course of investigating the claim that the first Complainant's mother had suffered from cancer and had been treated for cancer over a period prior to the "*terminal*" diagnosis.

The Complainants disputed the right of the insurance company to void the claim and complained that the Company, in the course of dealing with the complaint, was in breach of the Consumer Protection Code 2012.

Investigation & Findings

The investigation involved a consideration in detail of the terms of the particular policy of travel insurance effected by the Complainants, the medical records of the first Complainant's mother, together with a report from her General Practitioner. The medical evidence and records were gone into in detail in the findings (which unfortunately reveal that the first Complainant's mother died in mid 2013).

Having reviewed the evidence the Ombudsman was satisfied that the Complainants were aware that the first Complainant's mother had suffered from cancer for a number of years, that she had been hospitalised and though she had been discharged from hospital, she was subject to ongoing surveillance and treatment at the inception of the policy.

Accordingly the complaint was not upheld.

On the secondary issue as to whether the Respondent failed to comply with the Consumer Protection Code 2012, the relevant provisions of the Code are recited in detail in the Finding and the sequence of events is recited in the context of the complaint.

While it was found that the Company made its decision on the Complainants' claim expeditiously, it was acknowledged that a delay had occurred in the communication of the decision to the Complainants, though evidence was not available to say that such delay was the fault of the Respondent and so this aspect of the Finding was not upheld.

Conclusion Neither complaint was substantiated.

Complaint (11)

Background & Complaint

The Complainant and her late husband had a joint policy of assurance on their respective lives. The premium payments fell into arrears. Subsequent to writing four letters informing the Complainant that the premiums were in arrears and the policy would lapse, the Respondent lapsed the policy on 12 September 2011.

The Complainant's husband died on 2 February 2012.

It appears that neither of the last two letters which gave rise to the lapse of the policy had been addressed to the Complainant. Indeed the last of those letters to the deceased did not even refer to the Complainant as a joint holder of the policy.

Finding

Notwithstanding the foregoing, it was found that the wording of the policy was clear and succinct and understandable, and it was the responsibility of the insured to pay the premiums. It was the responsibility of the insured to be aware of whether the premiums were paid or not.

While the last two letters from the Respondent were only addressed to, and apparently for the deceased, the earlier two letters of warning had been addressed to, and received by the Complainant.

In the circumstances a "*customer care award*" of €25,000 was directed by the Ombudsman as the complaint was partly upheld pursuant to Section 57CI (2) (g).

Comment

An interesting issue arose in that the Respondent claims to have notified its agents of the default on the part of the Complainant and her husband in paying their premiums on time.

This is clearly found not to have relieved the Complainant or her husband of the obligation to maintain the payments due under the policy, but left open the possibility of a complaint being made against the agent by the Complainant through the FSOB.

Complaint (12)

Background

The Complainant is a widow whose husband died in February 2009. Her husband who was an accountant and had a building business had managed the family's affairs. He had effected a number of insurance policies with the Respondent during his life. Sometime in 2004 he lost the ability to manage his own affairs and the Respondent was informed of this by telephone in 2005 and by letter from the Complainant in 2006.

One of the policies was for the benefit of the deceased's building company, another was for his own benefit and a balance of five policies were taken out in the name of the deceased and the Complainant.

Unfortunately premiums ceased to be paid on the policies and some had lapsed prior to the death of the deceased.

Notwithstanding the lapse of the policies due to non-payment of premium, the Respondent paid out on four of the policies which had been in the joint names of the deceased and the Complainant on the basis that they had not advised the Complainant, whose is a joint beneficiary under these policies, that she could take over responsibility of paying the annual premiums.

Complaint

The Complainant contended that having paid out on some of the policies it was inconsistent for the Respondent not to pay out on the others and it was also contended that the policies having lapsed, the Complainant had a right to reinstate the policies. The Company contended that the policy taken out for the benefit of the deceased's company would not be reinstated at the insistence of the Complainant as she had no standing in relation to that policy. Insofar as the lapsed policies on which payment had not been made were concerned, the Company contended that an application to reinstate these policies would not have been successful as the deceased's illness had occurred and for reinstatement purposes it is improbable that he would have been able to procure the declaration of health which would be needed in order to effect a reinstatement.

File

In this case a very torturous investigation was carried out in relation to the various policies in order to trace their origin,

their beneficiaries and their status at the date of the deceased's death.

The Respondent, in the course of the investigation, made all the information available which enabled the Ombudsman to analyse and rule on the legitimacy of the Complainant's claim.

The confused picture was greatly clarified by the analysis and the methodology applied in bringing the issues together and while the Finding is quite difficult to follow, it is hard to see how such a diverse case could have been more succinctly expressed in terms of the issues, presentation of the arguments and the actual findings.

Conclusion The complaint was not substantiated.

Complaint (13)

Background

The Complainant and her late husband applied for a mortgage protection policy from the Respondent in November 2011 (having previously had mortgage protection policies on which they defaulted and which lapsed).

The Complainant's husband died on 7 December 2011.

In the lead up to the mortgage protection policy being finalised there had been discussions and correspondence between the parties which led to the policy being effected. Before the policy came into force, the Complainant and her husband had completed forms and questionnaires, most particularly relating to ill health. Unfortunately, they failed to disclose in response to specific questions, that the deceased had suffered from and had treatment for and received advice for mental illness.

The Complainant and her late husband had been advised verbally and in writing of the need to make full disclosure of all material facts and that the consequences of a failure to make such disclosure would lead to a voidance of the policy.

Complainant's Case

The Complainant claimed that on the death of her husband she was entitled to be paid out on foot of the policy.

Respondent's Case

The Respondent claimed they were entitled to void the policy on the basis of non-disclosure of material facts, in particular in response to specific questions and in the light of the written information contained in the "*record of conversation"* application, and other documents.

Other issues arose in relation to the earlier history between the Complainant and her husband and the Company and lapse of earlier policies and the contracting for the policy the subject matter of the complaint.

Comment

The file, while quite extensive relating to the net issue involved, is comprehensive and well ordered.

Finding

The Finding determined two issues:

(i) Whether the non-disclosure by the Complainant's late husband entitled the Company to repudiate the claim in accordance with the policy terms **and**

(ii) Whether the Company sold the Complainant and her late husband a mortgage protection policy unsuitable to their needs.

The Finding is detailed in setting out the arguments for the Complainant and the Respondent and reciting the relevant passages of the documents on which the Respondent relied to repudiate the claim.

In conclusion it was found that the complaint was not substantiated and that the policy was correctly and justifiably voided by the Respondent, with a further finding that the Complainant and her late husband were not sold a policy unsuitable to their needs.

Comment

While the issue in this case was quite net and the facts clear and undisputable, it was, I believe, appropriate that the findings were as detailed and explanatory of the decision so as to render the decision understandable, if not acceptable, to the Complainant.

Complaint (14)

Background

The Complainant took out a life care policy with the Respondent in November 2008 as a part of a mortgage loan application with the Bank. The policy was later cancelled in August 2013.

Complainant's Case

The Complainant relied on the Respondent to advise on whether his cover with another provider was as good as the Respondent's, having been advised that the Respondent's policy was more favourable, he switched his cover to the Respondent.

The Complainant believed his policy with the Respondent would provide him with income benefit of €500 per week. His actual earnings at the time of the policy were €846. However the policy to which he switched provided that benefit could not exceed 50% of his earnings at the time of injury.

The Complainant suffered an injury in June 2013 and was out of work until September 2013 and claimed benefit under the policy of €500 per week, but was only paid benefit of 50% of his income as of the date of injury.

Respondent's Case

The policy provided a maximum benefit of 50% of earnings at the date of injury, the Complainant's salary had dropped at the date of the policy and the Respondent accepted that the Complainant was entitled to 50% of his salary at the date of injury.

Issue

The issue was whether the policy was mis-sold by the Respondent to the Complainant and whether he was badly advised or misled in and about the transaction.

Finding

From a review of the documents and the policy it was found that the Respondent had complied with the terms of the policy, but that the terms of the policy were misleading in a number of respects, *inter alia,* calculating a premium on the basis of a benefit of €500 when at the time of the policy, the Complainant, (having regard to his earnings at that time), could only expect to receive a maximum benefit of €420.

Secondly terms of the policy itself were somewhat obscure as to the basis upon which the benefit under the policy would be calculated having regard to the Complainant's actual earnings prior to, or at the time of the events giving rise to the claim.

The complaint was substantiated and a compensatory sum of €2,500 was awarded which in addition to the €2,507.12 already paid by the Respondent, thereby restoring the Complainant effectively to the position which he believed he would have been in at the time he entered into the policy.

Comment This was a straightforward and well reasoned decision.

Complaint (15)

Background

The Complainant signed a good health declaration in 2004 on a form presented to him, the policy being to cover his own life and that of his wife.

The wife died nine years later of lung cancer.

Respondent's Case

The claim was repudiated on the basis that the declaration of good health had not been signed by the Complainant's wife so she was therefore not covered. Also medical records disclosed subsequent to the death of the wife showed that she had had repeated colonoscopies for the removal of polyps in the years prior to taking out the policy.

Finding

The Ombudsman ruled by virtue of Section 57BX of the Act he could not look at the marketing data relating to the policy and was confined to starting with the application form and information disclosed therein, together with the insured's medical history.

The Finding upheld and substantiated the complaint based on Section 57CI (2) (c) of the Act due to the facts:

(a) Lack of definition in the policy of *"good health".*

(b) The Complainant's evidence that the deceased's medical condition was not affecting her day to day life.

(c) The absence of knowledge at the time of the contract of the extremes at which the Complainant's medical condition could manifest itself

Comment

This difficult case was well reasoned and the application of Section 57CI (2) (c) seems both appropriate and well reasoned – the harshness and the injustice of the strict application by the Respondent of "*in good health*" provision in the absence of a policy definition of the term allowed the Ombudsman to construe the term more leniently in favour of the Complainant in the interest of fairness.

Complaint (16)

Background

The Complainant suffered water damage in his home. He did not inform the insurance company of the damage or a potential claim until eight days had elapsed, during which time he had carried out extensive stripping of the interior of the building affecting all rooms. The Respondent was ultimately informed of the damage on a Friday and arranged an inspection by a loss adjuster on the following Monday (some eleven days after the damage was caused and stripping had been effected).

Respondent's Case

The Company repudiated the claim, the house having been gutted by the time the Company could arrange an inspection, contending that the investigation of the claim was irreparably prejudiced as the Company couldn't decide conclusively whether the insured peril was the cause of the damage. It was also contended by the Respondent that the Complainant was in breach of the conditions of the policy in not reporting it immediately and also in stripping out the house (in excess of what was required by way of emergency repairs).

Finding

The Ombudsman decided that by virtue of a conflict of evidence an Oral Hearing should be held and this was held on 7 November 2014 and enabled the Ombudsman quite easily to resolve the crucial facts that were in issue in that:

(a) The Complainant accepted in reply to the solicitor for the Respondent that by the delay in reporting the event, he had put the Respondent in an impossible position.

(b) The Complainant had been advised by his own builder on the day of the flood to advise his insurance company of the flooding (and it also appears on at least one other occasion before the report was made).

(c) The Complainant's independent assessor agreed with the Respondent's assessor that the extent of stripping carried out by the Complainant went beyond "*emergency repairs*". (The policy, having a provision requiring the Complainant not to go ahead with repairs, other than emergency repairs, without the approval of the Respondent).

In resolving the question as to whether the Respondent was reasonable in repudiating the claim in the circumstances, the oral evidence from both the Complainant and the Respondent expressly agreed that the work went beyond "*emergency repairs*". They also agreed that the delay in reporting and the extensive stripping of the house compromised the investigation by denying the Respondent the opportunity to assess the cause and the extent of the damage.

Accordingly the complaint was found not to be substantiated.

Comment

The file in this case is complete and well ordered.

The decision on the repudiation was dictated by the policy terms, combined with the undisputed elements in the evidence of the Oral Hearing.

Complaint (17)

Background

The Complainants had a home insurance policy with the Respondent and the claim arises out of a claim for "*subsidence*" in their house, the subject matter of the policy.

Complainants' Case

The Complainants live in a house some 80 years old and in 2009-2010 during and after a spell of very cold weather, noticed cracks and bulges in the external walls of the house. They presented a claim supported by engineering and other professional evidence contending that the damage was the result of subsidence.

Respondent's Case

The Respondent, by its experts, contended that the damage was not caused by subsidence but was more likely caused by wear, tear, gradual deterioration and failure to maintain.

Issues

Did the damage result from an insured peril? Subsidence would be covered under the policy whereas wear and tear or lack of maintenance would not.

Finding

The Finding necessarily involved a detailed and close reading and evaluation of the conflicting sides of the arguments, each one supported by professional reports. The presentation of the case for the Complainant and for the Respondent is clear and concise, as is the analysis of the technical evidence.

The complaint was not upheld. Neither were the subsidiary complaints, to the effect that the Respondent was hasty in closing the file and was tardy in paying out invoices to the Complainants for tests which the Company required them to carry out in support of their claim.

Comment

A well presented case on each side with a balanced analysis and well reasoned judgement on all issues.

Complaint (18)

Background & Complaint

The Complainants applied for a mortgage loan for a new home in August 2008. On 2 September 2008 they received an offer of a tracker loan at 1.25% above the ECB, said rate to apply for the term of the loan. On 28 October 2008, a letter offering a 2 year fixed rate of interest was offered and accepted.

The Complainants contend that they never received advice or explanation as to the difference between a tracker variable rate and a bank home loan variable rate of interest. They contended they were of the belief that at the end of the 2 year fixed period they would be permitted to avail of the tracker rate which had been originally offered.

The Complainants contended that the letter offering the 2 year fixed rate of interest was not clear as to what situation would arise for them at the end of the 2 year period.

Respondent's Case

The Respondent contended that the Complainants made a choice in accepting the terms of the letter of 28 October 2008 and that the letter of offer was clear as to what the contractual situation would be post the 2 year period [General Condition 7 (b)]. It was also contended that the Complainants had the option and election as to how they would proceed at the end of the 2 year period and in default of election by them, the default provisions were clear.

Finding

It was found that the letter of 28 October 2008 was the basis of the loan and this letter superseded the earlier letters. The said letter clearly provided for the application of a variable rate at the end of the 24 month period and the details of repayments to be made after the 24 month period were set out. The letter went on to detail the repayments to be made, i.e. 276 instalment payments variable at 5.450%.

It was further noted that the Complainants had the benefit of a solicitor "*who looked after the legalities*" when they were buying their house.

Comment A clear, well reasoned ruling and findings in the context of quotations from the written contractual documents identified as governing the relationship between the parties.

Question Given that the Complainants accepted the offer contained in the letter of 28 October 2008 in the belief that they would be permitted to avail or revert to the tracker terms at the expiration of the 2 year period it may have justified or required an Oral Hearing to test if there was any basis that the belief was caused by something said, written or done by the Respondent !

Complaint (19)

Background

The Complainants took out a mortgage loan with the Respondent which was drawn down on 2 February 2006 at a tracker rate 0.95% above ECB rate. In February 2007 they decided to switch the loan to a fixed rate 5.05% until 5 March 2010.

The Complainants "*understood"* that after 5 March 2010 their loan repayments would revert to the original tracker rate as that rate was to apply for the term of the loan. They also allege that they were assured by the Respondent that the loan would revert to the tracker rate agreed originally. They claim they never agreed to the standard variable rate nor was there an agreement that the original tracker rate would be relinquished by them except for the period ending on 5 March 2010.

Respondent's Case

The Respondent rejected the claim that an employee had advised the Complainants that they could or would return to the original tracker rate – though the identified employee could not remember the precise conversation he had, he was adamant that he would have advised that at the end of the fixed rate period, they would return to the variable or fixed rates as would be available after 5 March 2010.

Finding

The Ombudsman was faced with a conflict of evidence, a conflict between the Complainants on the one part who were contending that they had been given a verbal assurance in relation to the rate of interest that would apply at the end of the fixed rate and the evidence of the employee that he would never have given the advice which the Complainants claimed they had received. This dispute was resolved in favour of the Bank on the basis of the employee's statement that he would never have given the type of advice that the Complainants claimed they had received and the fact that the written contract and terms of the agreement were notified to the Complainants and also that the Complainants were on notice that the Bank's standard variable rate would apply in March 2010 if they failed to select one of the interest rate options offered by the Bank and certain other correspondence between the parties.

The complaint was found to be not substantiated.

Comment

This decision, like any case with a conflict of evidence, is very difficult to resolve and I assume that if the Complainants' assertion that the employee gave them verbal advice on which they acted and in which they believed that the dispute would have been resolved in favour of the Complainants, rather than in favour of the Respondent, then perhaps this is a case in which oral evidence, in fairness (and with the benefit of hindsight) might have been used to explore the veracity or likely accuracy of what was spoken on the telephone.

Complaint (20)

Background

The Complainant had a mortgage account with the Respondent and had the benefit of Tax Relief at Source. In 2010 the Complainant made an overpayment of €30,000 to facilitate mortgage payments over a four year period. During the four year period, the Bank, in compliance with Revenue requirements, changed the way it applies Tax Relief at Source to mortgage accounts.

Complaint

The Complainant contended that the Bank had misinterpreted how the Tax Relief at Source should be applied to his account, resulting in a loss of Tax Relief at Source benefits to him of €550.80.

File

The file is short and succinct and clear.

Finding

It was contended by the Bank that it wrote to the Complainant on a date in November 2013, notifying him of Revenue directions relating to the Tax Relief at Source, informing him of the changes and furnishing him with a document of frequently asked questions and the answers to those questions to enable him to decide how he might rearrange his affairs.

The Complainant claims he did not receive the letter.

The Ombudsman accepts that the Bank wrote to the Complainant (though no precise date could be established save that it was in November 2013).

The Ombudsman also believed that the Complainant did not get the letter.

The Bank offered to the Complainant €100 in November 2014.

The Complainant raised the issue as to whether the change in operation of the Tax Relief at Source was Revenue driven or a mis-application of Revenue direction by the Respondent and quoted an official to whom he had spoken in the Collector General's office dealing with Tax Relief at Source, whom the Complainant alleged in his letter (14 May 2014) would refute the Respondent's interpretation of the new provision. In this letter he also suggested that the Revenue website would not confirm the Respondent's application of the ruling was correct.

In the event, the claim of the Complainant was not upheld.

Comment

In this case, while the Finding went against the Complainant, there was no follow-up enquiry with the Complainant or with the Revenue as to whether his contention could be correct as to the alleged misinterpretation or mis-application of the Revenue provisions by the Respondent. It appears that he could have been invited to procure evidence from the identified official to whom he spoke which could have been obtained either through the Complainant or through the Bank and also the question of the information disclosed on the Bank's website could, and perhaps should have been investigated, in order to specifically deal with the Complainant's allegations.

Complaint (21)

Background

The Complainants took out a mortgage with the Respondent for an investment property in April 2007. They also took out a mortgage indemnity insurance at the same time.

Complaint

A complaint was lodged with the Financial Services Ombudsman's Bureau in July 2013 (more than six years after the contract was initiated with the parties).

The Complainants alleged that the mortgage indemnity policy was mis-sold to them and also they sought an explanation on the debiting of their account with an amount in respect of the product and claimed that this feature operated by the Respondent had not been explained to them satisfactorily.

The lodging of a complaint with the FSOB was preceded by a number of earlier letters of complaint from the Complainants to the Respondent to which no response had been made by the Respondent.

There had been a 'phone discussion" on 20 May 2013 between the second named Complainant which was regarded by the second named Complainant as unhelpful and rude.

In addition, there had been a meeting between the second named Complainant and the Respondent whereat a final response to the initial queries had been promised – such a response was not received.

Finding

After an exhaustive presentation of the facts and the arguments and perusal of the documents, it was found that the Bank acted within its rights and dealt with the complaints in a satisfactory manner.

However, it was found that the Respondent was in breach of the Consumer Protection Code 2012 in failing to respond to the complaints which had been notified to them in the letters referred to above and also in the delay in sending a letter with their final explanation.

It was acknowledged that the Respondent had apologised for their breaches of the Code and they were directed to pay to the Complainants €200.

Comment

The detailed analysis of the complaint and the communications between the Complainants and the Provider is impressive and resulted in a strong ruling:

(a) On the Provider's right to deal with the complaints in the manner in which it did.

(b) On the breach by the Provider of the Consumer Protection Code marked with a fine to the Provider and compensation to the Complainants.

I note that Section 57BX of the Central Bank & Financial Services Authority of Ireland Act 2004 provides:

> "*(3) A consumer is not entitled to make a complaint if conduct complained of (b) occurred more than 6 years before the complaint made*".

While this is referred to in the beginning of the Finding, and by implication was ruled not to apply, it would have been better to recite that the matter complained of arose post 28 February 2013 and related to the Respondent's lack of response to that letter, and accordingly the Complainants were entitled to make a complaint and have it adjudicated upon.

Complaint (22)

Background & Complaint

The Complainants had a mortgage account with the Respondent. The mortgage was subject to a Mortgage Arrears Resolution Process. The Complainants had sought various repayment proposals in respect of the mortgage account which they claim had not been considered by the Respondent. The Complainants also contend that the Respondent failed to properly engage with them and to consider their repayment proposals.

The complaint was that the Respondent had unreasonably refused to engage with the Complainants and to implement the Complainants' mortgage repayment proposal.

Respondent's Case

The Respondent's case is that the Mortgage Appeals Board has rejected the Complainants' repayment proposals and has suggested that the mortgage is unsustainable.

File

The file is comprehensive and well ordered.

Note

It arose after the investigation, but before the Finding was issued, that while the Respondent complied with the requirements of Section 39 of the Code of Conduct on Mortgage Arrears, and thereby adequately considered the Complainants' request for an alteration in the payment arrangements the Complainants **had earlier been wrongly advised by the Respondent** that they did not qualify for the Mortgage Arrears Resolution Scheme.

Finding

On this issue, the Ombudsman ordered:

(i) The Respondent to immediately engage with the Complainants and assist them with their application to the mortgage to rent scheme.

(ii) The Respondent to pay €400 immediately to compensate the Complainants in recognition of the breach of Chapter 2.2 (2) of the Consumer Protection Code.

The complaint was partly substantiated.

Comment The findings contain a clear summary and analysis of a complex case and a methodical and balanced application of the Consumer Protection Code.

Complaint (23)

Background & Complaint

The Complainant held a mortgage with the Respondent Bank from March 2006 to May 2009. The loan was drawn down on 31 March 2006 at a discounted tracker interest rate of 0.85% above the ECB rate, due to the Complainant's status as a holder of a specific current account. In July 2006 in view of interest rates rising the Complainant applied to fix the interest rate applying to her mortgage until 31 July 2008. She claims that she was assured by her broker and an official of the Respondent that she would be entitled to return to the original tracker rate upon expiry of the fixed rate period. She also claimed that her original mortgage agreement stipulated that the tracker rate of interest would apply "*for the life of the home loan term*".

However when the fixed rate term concluded, her account was placed on the Bank's standard variable rate and not on the tracker rate which had applied earlier. The Complainant also alleged that she was not given the option of switching to an alternative tracker rate and claimed that her account was simply switched to the standard variable rate without her being given option or explanation in the latter.

The Complainant denies that she was issued with a letter dated 1 July 2008 wherein the Respondent claimed she was informed of the interest rate options available to her on the expiry of the fixed rate term. The Complainant claimed that in a telephone conversation on 14 July 2008 she was given no choice but informed that she would be switched to the Bank's standard variable rate after 31 July 2008 – she also noted that no reference had been made to the letter allegedly sent by the Respondent to her on 1 July 2008 outlining the interest rate options which would be available to her at the expiry of the fixed rate term.

Note

The Complainant moved to another Provider in May 2009 being dissatisfied by the manner in which she had been dealt with by the Respondent.

Remedy Claimed

The Complainant sought the difference in interest paid by her from the end of the fixed rate term compared with what would have been paid under the tracker arrangement which governed the initial period of the mortgage and the reinstatement of the tracker or alternatively payment of the difference in cost to her for the duration of the mortgage.

Finding

A very thorough evaluation of the facts and after significant questions had been addressed to and answered by the Complainant and Respondent, the Respondent was not able to produce a copy of the letter allegedly sent, or provide any proof of it having been sent to the Complainant. Similarly, there was no recording of the telephone call above referred to.

It was found that there was an ambiguity/discrepancy in the documents which could have misled the Complainant and that the Respondent should have alerted the Complainant to the ECB rate 0.85% on 1 August 2008.

The complaint was substantiated.

Remedy

The Complainant had since moved to a new Provider over whom the Ombudsman had no jurisdiction.

The compensation computation was complex, though balanced and fair and as well reasoned, resulting in an award of €25,000 to the Complainant.

Comment

This was an immensely complex and difficult case, well researched and investigated, resulting in a Finding and a just award well reasoned.

Complaint (24)

Background

The Complainants agreed an offset mortgage facility with the Respondent in 2007.

Early in 2014 the Respondent advised the Complainants that it was ceasing its personal banking operations in Ireland and it would terminate all current and deposit accounts by May 2014. The Respondent offered a standard 1% discount on the interest rate payable on the mortgage in recognition of the withdrawal of the linked account facility.

The Complainants contend that they were advised by the Respondent that they should look into getting a new mortgage. The Respondent contended that it was contractually entitled to withdraw its products and services on two months' notice.

Complaint

The Complainants stated that the mortgage facility which they held, had been changed in character from what had been previously sold to them and were upset and confused by their situation into the future, given the Respondent's decision.

Remedy Sought

The Complainants sought a continuation of the offset mortgage with their associated accounts or in the alternative a replacement product with the same features and if that could not be achieved, they sought compensation for inconvenience and angst caused to them.

Respondent's Case

The Respondent stated that there had been no change in the Terms & Conditions applying to the Complainants' mortgage account. They claimed they were entitled to terminate their current and savings accounts pursuant to the General Terms & Conditions. It also contended that their Terms & Conditions had been updated on a number of occasions and that it would not be reasonable to suggest that they could never be changed.

Finding

The Finding is a detailed and elaborate examination of the Terms & Conditions between the parties, the particular conditions applying to the agreement between the Complainants and the Respondent and an examination of the likely practical effect of the proposed changes for the

Complainants. At the end of the Finding the complaint was upheld and a remedy directed under four different headings.

The complaint was substantiated.

Comment

The Finding in this case involved a detailed examination of the original mortgage offset agreements, an investigation of how the offset facility worked, together with an evaluation of how any new arrangement proposed by the Respondent would work out for the Complainants when compared with the original mortgage and offset arrangements which had been contracted for in 2007.

The investigation clearly established the existence of a "*side letter*" which required the Complainants to maintain at least one mortgage account and one offset current or one offset savings account with them. It was found after detailed analysis of the Terms & Conditions that the side letter formed part of the agreement between the Complainants and the Respondent and clearly provided that the Respondent, if removing an account from an offset portfolio, must ensure that it was not the last mortgage account or linked account causing an unwanted termination of the offset portfolio. The side letter also provided that the offset portfolio "*must contain at least one mortgage account and one linked account either offset current or offset savings*". It was fairly and properly concluded that the Respondent, despite their Terms & Conditions, had acted in a way that sought to contravene the contractual arrangements between them and the Complainants and this resulted in the withdrawal of an inherent feature of the loan, something which was not authorised by the agreement between the parties or by the General Conditions.

The reasoning is clear and close in arriving at a decision which, in my view, is akin to a finding of estoppel against the Respondent based on their conduct and based on the terms of the original agreement entered into in 2007.

Redress

On this aspect of the case, great care was taken to identify and analyse the elements of the complaint which merited compensation in order to restore the Complainants to the position they would have enjoyed if the Respondent had not been in breach agreement which they had with the Complainants.

The Finding, in addition to restoring the Complainants (as near as possible) to the position they would have achieved but for the Respondent's breach of contract, also measured a sum to compensate the Complainants for the stress and inconvenience caused to them during the process of formulating and pursuing their complaint to date and further directed measures to cover the period while the new arrangements directed were being put in place.

Complaint (25)

Background

The Complainants entered into an agreement for an offset mortgage with the Respondent in 2011. In early 2014 the Respondent advised the Complainants that it was terminating its personal banking operations in Ireland and that the Complainants' linked accounts would close on 25 April 2014. The Complainants were offered a reduction of 1% on the interest rate payable on their mortgage for the outstanding term of the loan, together with an additional discount of 0.45% because they had a specific high net worth product with the Respondent. The Respondent claimed to be entitled to withdraw the current account facilities in the light of Clause 4.1 of its "*General Terms & Conditions for all Products and Services*".

Complaint

The Complainants claimed they were being unfairly treated since before the closure of their accounts by the Respondent they were not paying interest on the mortgage as they had sufficient funds in the linked accounts to offset the balance outstanding on the loan. They reckoned they would pay an additional €7,000 in interest over the term of the loan.

Respondent's Case

The Respondent claimed that there had been no change to the Terms & Conditions applying to the Complainants' mortgage account. It claimed that it was entitled to terminate their current and savings accounts pursuant to the General Terms & Conditions – which Terms & Conditions had been updated on a number of occasions and that it was reasonable to change the Terms & Conditions during the term of the loan.

Finding

The Finding is detailed and summarises the history of the contractual relationship between the parties from the correspondence underlying it. It also involved a detailed analysis of the General Terms & Conditions for all products and services of the Respondent dated November 2013. The Terms & Conditions on which the Respondent relied however were not the Terms & Conditions in existence when the mortgage was agreed in December 2011.

The Respondent was unable to produce the Terms & Conditions which existed at the date of the original contract between the parties in 2011 and in this regard a Finding was

made that the Respondent was in breach of its obligations pursuant to the Central Bank's Consumer Protection Code 2006 and 2012.

It was also found that the Respondent failed to demonstrate that it was entitled to introduce the versions of the Terms & Conditions subsequent to 2011 on which it sought to rely to justify the termination of the Complainants' linked accounts.

It was also found that the mortgage account and linked accounts together formed the offset mortgage package which was offered to the Complainants by the Respondent and was accepted by the Complainants.

Interestingly, notwithstanding the findings summarised above, the Ombudsman went on to invoke Section 57CI (2)(c) of the Central Bank & Financial Services Authority of Ireland Act 2004 to indicate that in the circumstances of this case a Finding under that Section would have been justified on the facts of the case.

"***See discussion in the body of the report relating to the above referred to proviso*".**

Remedy

While the Ombudsman deciding this issue had evidence concerning attempts to settle the dispute between the parties it became necessary to establish a basis upon which the Complainants could be restored (insofar as possible) to the position which they would have been in if the Respondent had not sought to alter the basis of the original agreement of 2011. Four headings were established under which remedies needed to be formulated and this was done by a combination of directing the Respondent to re-issue the Complainants with a proposal which had been made to them in August 2014 which gave the Complainants a choice of remedy.

The Respondent was also directed to pay compensation based on certain calculations suggested by the Ombudsman in addition to payment of a sum to compensate them for the inconvenience and stress which they endured in pursuing the remedy and while the new arrangements for their mortgage were being put in place on foot of the direction of the Ombudsman.

Comment This is a very comprehensive and detailed judgement, legally sound and balanced in terms of fairness with a solution arrived at which is practical, fair and just and in my opinion, fully merited invoking Section 57CI (ii)(c) of the Act.

Complaint (26)

Background & Complaint

The Complainant in October 2012 had breast surgery and follow-up treatment which was covered by her policy of health insurance.

In 2013, she required a further procedure (free lipid [fat] transfer). The need for this procedure resulted from the fact that some aspect of the earlier procedure required attention.

Complainant's Case

The Respondent refused to meet the cost of the additional procedure as it was not a procedure listed in the schedule of benefits to her policy. The Complainant contends that the procedure required was a follow-up on the procedure which she had in 2012 and since that procedure was covered under the policy so should the follow-up treatment.

The Complainant's surgeon wrote in support of the claim stating that the Complainant was suffering from asymmetry of her breast and needed the procedure above referred to in order to improve asymmetry and shape.

Perusal of the schedule of benefits discloses that the procedure referred to is not in the schedule.

The complaint was found not to be substantiated as:

(a) The procedure is not in the schedule of benefits, and

(b) The procedure did not come within the ambit of the procedure which the Complainant underwent in 2012.

Comment

In this case it seems to me that the decision could justifiably have gone either way. There must be some attraction in the Complainant's case that the corrective measure related back to the original procedure. Is this not a case in which the provisions of Section 57CI (1) (2) (c) ought to have been at least considered, if not applied?

Complaint (27)

Background

The Complainant changed from a particular health scheme (A) with the Respondent to another health scheme (B). This change was effected at renewal of the policy in September 2013.

In November 2013 the Complainant, in the course of having a health check which involved an angiogram, was found to be in need of some stents which were duly administered necessitating an overnight stay in a Dublin Hospital.

Complaint

The Complainant claimed for the cost of the angiogram and the subsequent admission for stents.

Respondent's Case

The Respondent repudiated the claim as it was assessed by it under the earlier form of cover contending that the Complainant's symptoms had occurred under that plan.

Investigation

The investigation of the Complainant's pre-existing medical history established that the Complainant had had some earlier tests carried out which recommended cardiac investigation even though the Complainant did not have any symptoms.

The investigation revealed a great deal of medical information concerning the Complainant's medical history and that of two of his siblings.

At the end of the day despite a great deal of evidence, correspondence and examination of documents the claim came down to an issue concerning the definition of pre-existing injury which under the policy clearly means the existence of an injury or illness whether it has been diagnosed or there are symptoms or not.

Furthermore, even if the Complainant's injury had been assessed under the second health scheme (B) package, the Complainant would have had to wait two years in order to avail of the increased cover.

Finding On both grounds the Complainant's complaint was found to be not substantiated. The Finding recited at Pages 5 & 6 thereof a sequence of events which greatly simplified understanding of the conclusion arrived at in this case.

Comment This is a case where the close call as to whether Section 57CI (2) (c) should be "*considered*" is evident, and I believe this case illustrates the need for having guidelines/criteria as to when that sub-section should be considered – and applied!

Complaint (28)

Complaint	The Provider wrongfully ceased payment of the Complainant's disability benefit under an Income Protection Scheme.
Background	The Complainant received disability benefit under the Income Protection Scheme between March 2011 and July 2013. Benefit discontinued as the Respondent considered the Complainant to be no longer totally unable to work due to sickness or accident.
Respondent's Case	The Respondent relies on definition of disability in the Policy and relies on medical evidence.
Finding	Claim not substantiated under Section 57 CI (2).
Comment	Clear, well summarised balanced presentation of the evidence on the file, which was built up over the investigation, followed by a strong and appropriate application of the policy conditions in the light of the medical evidence. A straightforward issue arose and was easily resolved, the detailed summary and resume behind the Finding is fully justified for the purpose of enabling the unsuccessful Complainant to understand and accept the ruling.

Complaint (29)

Complaint The first named Complainant complained that the policy relating to serious illness cover was mis-sold as the illness from which he suffered was not covered by the policy.

History The first Complainant made three separate claims in respect of a cancerous diagnosis in the following years:

2009
2011
2013

File The file in this case developed significantly and many issues arose. Considerable acumen and judgement was required in order to deal with the policy, legal and medical issues which arose and these are succinctly and clearly set out in a coherent and understandable way.

Finding The Finding established that the Provider's decision to refuse benefit was supported by the medical evidence and accordingly the complaint was not upheld.

Comment The author of the Finding expressed sympathy at the conclusion of her findings for the very, very difficult situation in which the Complainant found herself.

The findings are exemplary but I wonder if this might be the type of case in which one might have considered invoking Section 57 CI (2) (ii) (c) of the Central Bank & Financial Services Authority of Ireland Act 2004.

Complaint (30)

Complaint	(i) Company wrongly turned down claim for benefit (ii) Company failed to give correct information on the policy.
History	The Complainant joined the Plan in 2001 and the Complainant's wife joined as a spouse/partner.
Complainant's Case	The Complainant and his wife legally separated and divorced 8 years later. The Complainant lived with his partner in a "*spousal*" type situation from the date of separation.
Eligibility	Members of the permanent staff of the Respondent aged between 18 and 60 years were eligible to participate; spouse/partners under the age of 60 years also eligible within the Scheme. Partners defined as person living in a spousal type relationship for 12 months or more. After his divorce the Complainant continued to pay premiums on his wife's policy but never applied to substitute his partner for his wife on the policy. If the Complainant wished to substitute his partner for his wife an application would, under the policy, be required to be made after the "*spousal*" situation arose. No application to remove the spouse on the benefit of the policy was made after the "*spousal*" situation with her ceased following the separation. The premium continued to be paid by the Complainant. The Company offered to refund the premium paid by the Complainant for his wife's cover (€420.85).
Issues	Apart from the issue as to whether the Complainant was entitled to claim benefit under the policy on the history outlined above two further tangential issues arose:

(a) Complainant's partner was an employee of another financial service provider and was entitled to join the Scheme in her own right, which she did in 2004.

(b) The policy does not permit payment out of two claims for the same illness.

Finding

The complaint was not substantiated and the Respondent was found to have administered the policy correctly.

The Finding of this extremely challenging case, with many issues arising, is very clear in its presentation and analysis and the Finding is fully justified having regard to the terms of the policy and the history of the Complainant's relationship with his wife and his partner.

Comment

The file in this case was methodically built up and clearly assembled and was well structured by the Provider and marshalled by the Ombudsman's office.

The methodology employed throughout the investigation and the approach to the analysis of the issues from the documents led to a clear balanced and coherent judgement.

Complaint (31)

Complaint	Refusal to pay benefit arising from diagnosis of rheumatoid arthritis. The definition in the policy of rheumatoid arthritis is too restrictive especially since the Company introduced a new definition of rheumatoid osteoarthritis in 2008 and therefore acted unfairly in not using a revised definition in the Complainant's case.
File	The file was in good order and while the case was straightforward, the decision was simplified by a medical report provided by the Complainant's treating doctor, wherein he stated his medical opinion, having considered the terms of the policy, that the Complainant's condition of rheumatoid osteoarthritis did not meet the definition in the policy.
Finding	The complaint was not substantiated as the Complainant's condition did not meet the definition of rheumatoid osteoarthritis in the policy for which the Complainant contracted. The revised definition did not apply to the Complainant's Policy.
Comment	While this was a straightforward case of a disappointed Complainant not coming within the clear terms of her policy and not having her claim supported by her medical treating specialist, the analysis of the case in detail and the manner in which the Finding was spelled out, is succinct and clear both on the issues of fact, the law in relation to the merit of the claim and the appropriate definition of rheumatoid osteoarthritis applicable under the Policy.