Significant Complaints Decisions

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Case 1- Ombudsman directs that more than €200,000 be paid to a former professional rugby player after his claim under the IRFU insurance policy was repudiated by the Insurance Company

The Irish Rugby Football Union (IRFU) has an insurance policy with an Insurance Company to cover players who may get injured. Professional rugby players are under contract to the IRFU and can qualify for a *Permanent Total Disablement* benefit if they cannot pursue their professional career, as a rugby player, after sustaining a serious injury.

This dispute involved a claim submitted by a former professional player. In August 2000, while under contract with the IRFU, the Complainant suffered a total dislocation of one knee while playing professional rugby in Ireland. The Complainant made various attempts at rehabilitation (which included participation at *amateur* rugby level) but these were unsuccessful. He had not played professional rugby since sustaining the initial injury and his contract with the IRFU was terminated in 2002. Four years after sustaining the injury, during which time he was under supervision by the IRFU medical team, it was concluded that he would not be able to return to professional rugby. The claim for *Permanent Total Disablement* was then submitted by the Complainant in 2004.

The Company repudiated the claim stating that it did not fall within the terms and conditions of the policy. The Company referred to the Complainant's ability to play amateur rugby since 2000 and that due to the late notification of the claim its position was therefore prejudiced as it had not been afforded the opportunity to medically assess his condition. The Complainant disputed the Company's decision and then referred the matter to the Ombudsman during 2006.

In considering the dispute the Ombudsman noted that the Policy clearly referred to playing rugby in a *professional capacity* and ability or inability to participate in *professional* rugby. Accordingly the Ombudsman decided that the cover had to be for the professional game only. If it was intended that both amateur and professional rugby would be covered by the same policy - and he had no knowledge of this - then the Policy as it existed was deficient. He noted with interest that the Company, the IRFU and its insurance advisors were, during March 2007, in discussions about what the policy covered. The Ombudsman was satisfied that it would be inequitable for the Complainant to suffer financial loss for this lapse on the part of the Company, the IRFU and its advisors to clearly define what they thought was covered.

The Ombudsman then had to consider the late notification of the injury to the Company and whether its position was prejudiced as a result. The Ombudsman noted that:

- Whilst the policy was silent as regards notification, nevertheless, the IRFU had some duty to at least notify the Company. On the other hand the Company was lax and must accept blame in not ensuring that there was a proper procedure laid down as to the methods by which notifications should have been made, at what time and by whom.
- The reality was that in this particular situation a player sustained a genuine injury; made efforts to rehabilitate himself; his contract was terminated and

despite the best medical assistance he had received, he was no longer able to pursue his chosen professional employment.

- There is an implied obligation of notification of an accident that may lead to an insurance claim. The Company not being on notice of a claim could, in normal circumstances, be prejudiced. However, in this case irrespective of when the Company was put on notice, and considering the medical evidence, it would not have altered the facts that the injury sustained in effect was, and is, a professional career ending injury.
- The Complainant genuinely tried as much as was humanly, medically and indeed sportingly possible to resume his professional career but it was not to be. It was then that he made the insurance claim - to which he felt he was entitled if the insurance contract was to be any way meaningful - to compensate him for his loss of employment.

In those circumstances, the Ombudsman had to bring equity into play in line with his statutory responsibilities. Accordingly the Ombudsman did not accept that the Company was prejudiced in being notified after a long period of time and as the policy was silent as regards notification anyway the Ombudsman decided that the policy should be construed in favour of the Complainant.

The Ombudsman directed the Insurance Company to pay the full benefit under the policy relating to the Complainant's claim - €190,461. Having due regard to the distress and expense this matter must have undoubtedly caused the Complainant, he also directed the Company to pay the Complainant another €10,000 in compensation.

Furthermore the Ombudsman directed the Company and the IRFU to enter into urgent negotiations so as to ensure that proper notification systems were in place within three months from the date of his April 2007 decision. Because the IRFU was the holder of this policy, he copied his Decision to the IRFU for information and any actions which it deemed appropriate to take.

Case 2 - Mortgage Brokers giving investment property advice needs clarity and less confusion – compensation totalling €61,000 awarded in three instances

In the January 2007 published decisions, the Ombudsman found that a mortgage broker had an undisclosed conflict of interest when he sold an investment apartment which he himself owned and the Ombudsman awarded €16,500 in compensation. One of the issues which arose in that dispute, apart from the conflict of interest, was that the broker in his defence stated that the principal who was acting for the broker was acting in a personal capacity. The Ombudsman did not accept that argument.

Another case concerned a woman who had money to invest as a result of a divorce settlement and had sought advice from a multi agency investment broker. Acting on the advice she was prevailed upon to invest €100,000 in a Bond and €51,000 as a deposit on the purchase of two apartments to be built in Liverpool. In regard to the purchase of the Bond she had no complaint. Her complaint was in respect of the advice to invest €51,000 in the two apartments. In respect of this investment, a deposit on two apartments, she was advised that she would not have to complete the

purchase because the properties in question would be "*flipped over*" prior to closing and she would then have a handsome profit of approximately €20,000. She handed over the money for the deposit. Fourteen months later she was told by the broker that unfortunately due to a downward turn in the market for apartments in Liverpool, there would not now in fact be any "*flip over*" and that consequently she would now have to get a mortgage of €500,000 to complete the sale. In the event she was unable to do this and she forfeited her deposit of €51,000 and had to pay €3,000 in costs. In this case also, it was argued that the person doing the property deal was also carrying it out in a personal capacity and was not employed by the intermediary. The Ombudsman did not accept that defence either and awarded the Complainant compensation totalling €40,000 for a property investment where she had lost €54,000.

The Ombudsman then received a further complaint involving another mortgage intermediary. In this case, again a property was involved where investment advice was sought and a property purchased. However a mortgage could not later be obtained and the matter did not work out to the satisfaction of the Complainant. In this instance the Ombudsman awarded €5,000 compensation towards costs incurred.

Two matters are of significant concern to the Ombudsman:

- In two instances the mortgage advisors tried to indicate that the person was acting in a personal capacity, when manifestly they were not. This may be arising in other cases which have not come to his attention.

- The type of investment advice being sought may be solely financial advice or, as in these three cases, combined with property purchases and mortgage facilities. Consumers have been given investment advice on the basis that the property can be acquired overseas; that a mortgage will be secured if needs be, but that it is more than likely the property will be '*flipped over'*, i.e. sold on, and therefore there will be no need to conclude the sale. When this does not happen the consumer may not be able to raise a mortgage and may be at a loss financially.

In the Ombudsman's opinion there is alas confusion as to the objectivity of the financial advice being given and indeed there is an unhealthy relationship when advice on property and general financial advice is given by the same broker. The Ombudsman appreciates that it must be difficult for consumers to determine whether such a person is operating as an estate agent or as a mortgage advisor. However, in the three cases so far decided by the Ombudsman significant issues regarding independent financial advice and conflict of interest have arisen which he has brought to the attention of the Financial Regulator so that these issues may be considered in the overall review of the mortgage intermediary area.

Case 3-Unsuitable €10,000 Investment sold to an unemployed single mother - sales practices of Insurance Company questioned

This dispute related to a personal investment. The investment selected was a Unit Linked Fixed Interest Fund. Despite the selected Fund being the most conservative available from the Insurance Company it was not guaranteed to maintain the value of the investment.

The Complainant had €10,000 to invest which she had in a credit union account. She insisted that the Sales Representative told her he would look after her cash and she withdrew the €10,000 from the credit union and invested it in the Fund. She was dismayed on discovering after three months a fall of over €500 in value of her investment. A further fall some weeks later led to a higher loss and when she surrendered the policy eight months later she lost €1,100.

The Complainant felt she was misled as to the nature of the investment. The Company on the other hand stated that a Fact-Find was completed and pointed to documentation issued at the outset. The Company argued that the investment was affordable and was suitable for the Complainant's attitude to risk. The Ombudsman noted that a signed Fact-Find, completed by the Sales Representative, included the following

> *The client has money lodged with the Credit Union which she wants to move to get a better investment return. The "investment risk attitude" was classified as "slight". The Complainant was described as "single" and "unemployed". She had 2 young children dependents and was living with her parents.*

While the Ombudsman recognised that a Fact-Find was completed and that explanatory documentation issued to the Complainant he considered, in the circumstances of the case that the Complainant relied on the representations of the Company's Sales Representative. The Ombudsman also felt that the Complainant did not understand that there could be a negative value, particularly in the early years. In his view, her circumstance as a top priority required the preservation of capital at all times. The Ombudsman understood her panic when the value fell repeatedly and considered that this investment plan was not a suitable investment vehicle for the Complainant and therefore should not have been offered to her.

The Ombudsman directed that it was appropriate that the investment of €10,000 should be returned in its entirety to the Complainant.

The Ombudsman would not expect many such Funds to be purchased by individuals generally. He would expect them to be usually part of a portfolio, to be switched into when the outlook for equities is seen as poor. Up front charges mean the Fund value cannot be positive in the first year. In an environment of rising interest rates, Unit Linked Fixed Interest Bond Prices will fall even though they are earning a guaranteed interest rate. Accordingly the Ombudsman referred the matter to the Financial Regulator to review the sales practices of the Company and the appropriateness of selling Unit Linked Fixed Interest Bonds to low income clients who have limited capital.

Case 4- Bank directed to furnish to the beneficiary of an army compensation award a copy of the payable order - made payable to him but lodged to his solicitor's account –and awarded €1,000 for its failure to do so earlier

A former Irish soldier, who now lives in London, was granted an Army Deafness Compensation award and he was represented in Ireland by a firm of solicitors. The payable order made payable to him was sent to his solicitors by the Department of Defence.

The Complainant was awarded IR£20,000 compensation and he alleged that without his permission or authority the solicitors in question lodged the payable order, made payable to the Complainant, to his (solicitors) firm's account and having done so, deducted IR£2,500 in respect of fees (even though fees had already been paid by the Department) and forwarded the balance to the Complainant. The legal advice centre in London contacted the Ombudsman, on behalf of the Complainant, when the bank would not give him a copy of the cashed order as he was led to understand that his *'signature'* was endorsed on the back of the order. The Ombudsman noted that the Complainant had himself maintained two Irish bank accounts in the same branch where the solicitors also had their account.

The complaint stated that the solicitors in question deducted a sum in respect of fees, without the express authorisation from the client and the Ombudsman also noted that the £2,500 deduction was before the Law Society. It was not the role of the Ombudsman to consider the correctness or otherwise of the action of the solicitors.

The question for the Ombudsman to consider was whether the Collecting Bank had acted wrongfully in facilitating the transaction. The payable order was purported to have been endorsed by the Complainant but the Complainant stated, and the Ombudsman accepted, that the Complainant had never seen the payable order, let alone endorsed it. The Ombudsman, after getting the Bank to furnish him with a copy of the lodged payable order, was satisfied that the signature of endorsement could not be that of the Complainant. Having considered the matter the Ombudsman decided that the evidence did not disclose that the Bank had acted negligently or in bad faith so as to lose the protection of section 4 of the Cheques Act 1959 which is given to Collecting Banks. This section provides *inter alia* that where a bank in good faith and without negligence lodges a cheque to an account it is not negligent in its failure to concern itself with the absence of, or irregularity in, the endorsement of a cheque even where that account has no title to the cheque in question.

However, the Ombudsman did find against the Bank in that when the Complainant initially tried to pursue the matter, the Bank refused to provide any information to him on the grounds of its duty of confidentiality to its customer, the solicitors who had lodged the payable order. The Ombudsman found that the refusal of the Bank to provide any assistance whatsoever to the Complainant (e.g. in refusing to furnish him with a copy of the paid payable order, even though he was the true owner of it) was unreasonable in the circumstances and unfair to the Complainant.

The Ombudsman awarded €1,000 in compensation and directed that a copy of the paid payable order (front and back) be furnished to the Complainant. The Ombudsman also made it clear that this finding was made without prejudice to any

other remedy, if any, that the Complainant may have elsewhere against the firm of solicitors concerned in respect of the IR£2,500 loss which he claimed against them.

Case 5- Repatriation claim submitted by the parents of a deceased tourist was handled in an insensitive manner by Travel Insurance Company, hearsay evidence by the Company was not accepted by the Ombudsman and he directed the Company to pay £4,000 sterling

This dispute concerned the refusal by an Irish based Travel Insurance Company to pay a claim for repatriation costs of the deceased Insured under a Travel Insurance policy on the grounds that an exclusion under the policy applied to the circumstances of this case, namely that ''*the underwriter is not responsible for any claims arising from… being under the influence of alcohol…"*. The deceased Insured- a UK citizen- died while on holidays in Spain and a claim for the cost of repatriating his body was submitted to the Company. The benefit payable under the policy, the repatriation costs, were payable to the next of kin of the Insured, in this case, the Insured's parents. The maximum amount of benefit payable under the policy in relation to repatriation expenses was £3,000 sterling.

The primary cause of death recorded on the Insured's Death Certificate was Cardio Respiratory Failure and no secondary cause of death was recorded. The Company, in asserting that the Insured died as a result of being under the influence of alcohol, sought to rely on witness statements from companions of the Insured, the hotel director and resort manager of the hotel where the Insured died. The Company did not submit any autopsy report, coroner's report or a toxicology report and did not rely on any such documents in its initial repudiation of the claim or indeed in its submissions made to the Ombudsman.

Based on the evidence submitted and the events surrounding this dispute the initial Finding by the Ombudsman's Investigating Officer was that the evidence submitted by the Company was insufficient to prove, on the balance of probabilities, that the claim and, therefore, the death, arose as a result of the Insured "*being under the influence of alcohol"*. The Company was therefore requested to pay the repatriation expenses incurred in respect of the Insured, the Complainants had already been invoiced for this by the funeral assistance company, and an additional £500 sterling in compensation.

The Company was dissatisfied with this Finding and made further submissions on the matter to the Ombudsman. In his final decision the Ombudsman stated that

- When seeking to rely on an exclusion clause under a contract of insurance to deny the claim the burden of proof rests on the Insurance Company to prove that the circumstances of the loss fell within the exclusion.
- Where the standard of proof was *the balance of probabilities* the degree of probability required is proportionate to the nature and gravity of the issue in dispute.
- The nature and gravity of the allegation being made i.e. that the Insured's death arose as a result of the Insured "*being under the influence of*

alcohol" must be taken into account and regard must be had to the effects such a determination would have on the Insured's family.

- In relation to the evidence submitted by the Company in support of its case the statement of the hotel director and resort manager in relation to what was said by third parties was purely hearsay in nature.
- The only probative value of the statements given by the companions of the Insured was as to alcohol consumed on the day prior to death not as to actual cause of death. Such statements must be considered having regard to the circumstances in which they were taken.
- He did not accept that the Company, the party who bears the burden of proof, should be allowed to rely on a lack of evidence in support of its contentions. The evidence available to the Company at the time of the claim and at the time of its refusal to pay the claim was not sufficient to entitle the Company to rely on the exclusion under the policy. The Company should have sought further evidence before repudiating the claim – at a minimum an autopsy report on the Insured.
- The Company did not cite any medical authority in support of its original case or indeed in its detailed submission to him.

The Ombudsman accordingly found the Company's handling, assessment and repudiation of the claim to be totally incorrect and *highly* insensitive to say the least. In upholding his Investigating Officer's Finding he directed the Company to pay the **total** repatriation expenses incurred in respect of the Insured -£3,396 sterling due to the funeral assistance company and any interest which may have accrued on the debt. He also directed that the Company pay the Complainants £500 sterling for distress caused.

Case 6- Medical submissions by Insurance Company not accepted by Ombudsman and Specified Illness Cover payment of €165,000 is made

This dispute concerned the refusal by an Insurance Company to pay a claim under a Specified Illness Cover Policy on the grounds that the Complainant's medical condition did not satisfy the policy definition for Myocardial Infarction (Heart Attack).

The Company requested and obtained a report from the Complainant's own General Practitioner and a Consultant Cardiologist. The Company proceeded to evaluate the Complainant's illness against the definition of Heart Attack under the policy. The Company asserted that based on the medical facts it concluded that the Complainant did not have a Heart Attack as defined under the plan.

On the basis of the conflicting medical opinions in relation to this case, the Ombudsman felt that it was appropriate to seek from a leading Consultant Cardiologist an independent medical opinion on the matter solely to give him some guidance from a medical perspective. It was not sought to be the ultimate determination of this dispute. The independent medical opinion stated that the Complainant did suffer from typical chest pain, that there were electrocardiography changes consistent with a diagnosis of myocardial infarction and that a rise in cardiac enzymes was noted.

The Ombudsman, in consideration of the medical evidence and the advice he received, was struck by two factors:-

- *the physical examination of the Complainant post admission to hospital*
- *the various opinions/advices in relation to the occurrence of Myocardial Infarction had to be considered in light of the contemporaneous reports of the Complainant's presenting condition(s).*

Whilst the Ombudsman acknowledged the individual advices proffered, he stated that it was his duty alone to make a decision on all of the facts presented and considered by him. The Ombudsman found on the balance of probabilities that the Complainant suffered a Myocardial Infarction within the policy definition. Accordingly the complaint was upheld and €165,000 was paid to the Complainant.

Case 7- *Widow considers a Credit Union nominated account 'disinherited' her out of €12,700*

The Ombudsman received two complaints arising from the system of Nomination Forms for Credit Union deposit accounts.

Under the Credit Union Act 1997, an account holder may nominate a person to receive up to €23,000 from an account on the death of that account holder.

In one of the complaints considered by the Ombudsman the account holder- an elderly man- nominated his daughter-in-law, a fact quite unknown to the account holder's wife. He apparently opened the account by withdrawing money from a bank account. On his death, 15 months later, the Credit Union paid out €12,700 to the daughter-in-law. The account holder's surviving spouse, a woman in her late 70s, brought a complaint to the Ombudsman that her legal entitlements were ''set at nought'' by this method of dealing with the deposit account of her late husband.

In this case and in the other case dealt with, the complaints were not upheld because the Ombudsman's investigation disclosed no fault or failure on the part of the Credit Unions concerned.

However, in the light of these two complaints the Ombudsman took the view that the circumstances of these cases raised wider questions of public policy in that the Nomination system may be unfair to people, such as surviving spouses. In effect the system could be used to deprive a surviving spouse of his/her statutory rights under the provisions of the Succession Act 1965.

In these circumstances the Ombudsman decided to refer the issue to the Registrar of Credit Unions (the Financial Regulator) so that full consideration could be given to the public policy issues raised arising from the circumstances disclosed by these complaints.

Case 8- ATM card cash withdrawals of large sums across Bank counters needs review to prevent fraud

A customer had his ATM Card stolen from his place of work at lunchtime. Before he noticed the Card was stolen, a withdrawal was made at 2:26 p.m. and another one at 2:29 p.m. from ATM machines amounting to €550. Following this, at 3:37 p.m., the thief presented himself at the branch where the Complainant's account was held and asked for, and was given, €4,000 across the counter on production of the stolen ATM Card and the PIN.

The Ombudsman found that the customer must have been negligent in regard to his PIN and therefore the Bank could not be held liable when the Card and PIN were used at the ATM and the customer must bear the loss for these two transactions.

However, the Ombudsman felt the matter was altogether different in the case of the withdrawal which took place across the counter at the branch. He found that the Bank had not adhered to its own security provisions and in his opinion the Bank failed in its duty of care to the Complainant because of that. A withdrawal of €4,000 constitutes a substantial sum for any customer to withdraw in cash and a customer is entitled to expect that such sums will not be withdrawn from their accounts across a counter at a branch unless by themselves or somebody authorised by them on production of proper identity. Clearly nothing of the kind happened in this case where a thief and a fraudster simply had to present the stolen Card with the correct PIN in order to obtain €4,000 of the Complainant's money from his own Bank.

The Ombudsman was satisfied that the branch was negligent in facilitating the €4,000 withdrawal without asking for proof of identification beyond that of a Card and PIN. In those circumstances the Ombudsman awarded €4,000 to the Complainant in respect of this aspect of the complaint, but made no award as to the two transactions from the ATM machines.

Some weeks earlier a similar fraud was perpetrated against the same Bank at a branch in a different part of the city. In this case also the *modus operandi* was the same with the fraudster presenting himself at the account holder's branch and withdrawing €2,500 from the account on presentation of the Card and stating his PIN Number. In this case the Ombudsman ordered the payment of €2,500 compensation.

The Ombudsman also drew the attention of this particular Bank to what may possibly be a systemic failure in its systems or procedures and indicated that these procedures should be reviewed so as to prevent, or make less likely, this kind of fraud taking place again while acknowledging that ease of customer service was a Bank priority.

Case 9 - Phone records help Ombudsman's work; payments of €310,000 and €35,000 arose while a complaint against a stockbroker was rejected

Many dealings with financial service providers are conducted over the phone and are later confirmed by correspondence but not in every instance. For that reason financial service providers record phone conversations and are allowed to retain them for a

specified period of time, or where a dispute has arisen or where a potential dispute may arise. When investigating complaints the Ombudsman may call for transcripts or indeed the tapes of such phone conversations and on occasions providers themselves furnish them in response to matters raised by the Ombudsman's staff in the course of complaints investigations. The Ombudsman considered them to be of significant value to his work in the following three cases.

- An Insurance Company repudiated a claim made under a mortgage protection policy, stating that relevant medical information had not been disclosed when the policy was being set up. The Complainant and his wife had applied for a mortgage protection policy in January 2003. The policy was due to come into effect in March of that year. In February 2003 (one month before the policy was due to come into effect) the Complainant's wife was suddenly and unexpectedly diagnosed with a serious illness. Two years later she passed away and a claim was made under the policy. The Company repudiated the claim, stating that the Complainant's wife had not disclosed her serious illness before the policy came into effect. The Complainant denied this and stated that his wife had telephoned the Company upon diagnosis of her illness as she was worried that her illness may have affected the level of cover offered. As there were conflicting statements as to what information was given to the Company, the Company phone records for the period in question were requested by the Ombudsman. Following this request, the Company, on listening to the phone recordings, discovered that the Complainant's wife *had indeed* advised the Company of her illness in advance of the policy coming into effect but this information had not been properly recorded by the Company. As a result, the Company immediately paid the benefit under the policy which amounted to €305,000. While the Ombudsman complimented the Company for this prompt action he directed it to pay a further €5,000 in compensation for the distress undoubtedly caused at a very difficult time.

- In another case involving foreign exchange dealings a dispute arose as to an instruction given to an Irish based financial service provider by a customer and where it was alleged he had lost €50,000. The customer, who resided in the UK, had insisted that the provider was negligent in not carrying out his directions; he had been a long standing customer and had engaged regularly in foreign exchange dealings and speculation by phone and email contact. Having read the transcripts of the conversation - the Ombudsman requested them after it was indicated in the provider's earlier submission that the transcripts supported its position - the Ombudsman was satisfied that the complaint was justified and awarded €35,000 in compensation.

- A Stockbroker and a client had entered into a contract under which the Stockbroker was to supply certain services in connection with the client's business. The complaint was that the Stockbroker's actions in terminating the agreement between the parties, without prior notice to the Complainant, constituted conduct that was unreasonable and unjust. The Ombudsman was satisfied, after listening to recordings of over eighty minutes of phone conversations between the parties, that the complaint was not justified.

Case 10-Switching of Bank Account and abysmal lack of communication between Banks

A customer wished to transfer his account from one Bank (A) to another Bank (B) and instructed his Bank accordingly. Bank B sent the transfer form to Bank A, in accordance with the voluntary Banking Code of Practice for transfer of accounts. The Manager of Bank A 'phoned the Complainant to say that although he had received a form from Bank B, he could not act on it and was returning it to Bank B. In spite of the fact that the Complainant notified his Bank that he wanted to close his account, and sent a cheque to effect this, Bank A did nothing about it and continued to execute direct debits on the account. Bank A insisted that the account was never closed.

The Ombudsman found it surprising that the Manager of Bank A had never written to the Complainant to say that the account was still open. Eventually when the matter had been referred to the Head Offices of the Banks the wishes of the Complainant began to be implemented.

The Ombudsman found there was an abysmal lack of communication between Bank A and its customer and between the two Banks. It was obvious to him that the Code of Practice covering this situation had failed in this instance. He awarded €1,000 in compensation against Bank A and instructed that the Complainant should be repaid interest charged on his account during the ten months it took to sort out this matter.

Case 11- Advice by Insurance sales agents was highly unsatisfactory

The Ombudsman, after investigating two complaints about two different Insurance Companies, considered that the advice given by their sales representatives was highly unsatisfactory.

<u>Case A</u>

The Complainant sought a return of her capital IR£ 17,500 plus interest on an Investment Bond arranged in 2000. While the Insurance Company acknowledged that on encashment in June 2004, after allowing for earlier partial encashments, a loss was sustained, it pointed out that the Bond did not have a capital guarantee. This Bond was arranged in 2000 following the Complainant transferring a lump sum to a Bank to secure a loan for her son. The Complainant stated that she was happy to have the funds on deposit in the Bank but was advised to speak to a Representative of the Insurance Company- a tied agent of the bank- who persuaded her to place the funds in the Bond. In 2002, the Complainant discovered to her horror that the value had fallen by a considerable amount.

The Complainant explained in her submission to the Ombudsman that these funds were her retirement lump sum - her only financial security after 33 years in employment- and it was hard to see how their use in a non-guaranteed Bond could be justified. The Complainant also stated that she never received a Policy although the Ombudsman noted that it was assigned to the Bank as the loan guarantee. The Company pointed to the Application Form, signed by the

Complainant, including the following:" *The value of the Bond can go down as well as up and is not guaranteed"* The Company also drew attention to the Bond Brochure and to a clear "*Word o*f Caution" that values are not guaranteed. The Ombudsman noted however that a necessary Fact Find had not been completed by the Company.

While the Ombudsman considered that the Complainant had to take some responsibility for entering into the Bond he considered that more appropriate advice from the Bank and the Company would not have placed her in an equity linked investment on top of her commitment of the funds as security for a family loan. As the loss on the Bond was €4,700 he directed the Company to pay 75%, €3,500, in full and final settlement of the complaint.

<u>Case B</u>

The Complainants stated that they were canvassed on a number of occasions by an Insurance Company sales representative who, at the time the dispute was submitted to the Ombudsman, had left the Company and was not available for comment. The Complainants invested IR£3,000 on the representative's many alleged assurances that they were guaranteed a minimum return of their IR£3,000. This was a single premium plan invested in a European Equity Fund, it had no guarantees, and Fund value could go up and down. A minimum death benefit was payable. In the event the investment value fell. The Complainants asked the Ombudsman that the Company honour the guarantee they stated they were given by the Company Agent. They also sought compensation for the stress caused.

The Ombudsman expected a *Fact find* to have been completed at time of sale. This was not done on the explanation that one was completed 12 months earlier in relation to another Policy. In correspondence the Company also referred to the Complainants as "experienced investors" but this investment was only IR£3000. The Ombudsman did not accept these statements as credible explanations.

The Company also pointed to the documentation issued, which explained the workings of the Policy and that the investment could fall in value. While the Ombudsman strongly believes that Policyholders must read the documentation issued to them, however, in the circumstances of this case he accepted that the Complainants relied totally on the sales representative's advice. The Ombudsman considered that the Complainants invested in this product believing they were guaranteed at least their money back and he therefore directed the Company to refund the IR£3,000.

Case 12-SSIA account opened at the wrong rate

A woman who opened an SSIA account at what she thought was a fixed rate of interest found, when the account matured five years later, that it had been all the time at a variable rate contrary to what she had agreed to. The Bank in question only offered a variable rate account.

The Ombudsman was struck by the fact that this person, when she opened her SSIA account, was an employee of a company-not a financial service provider. Her employer was also actively promoting this particular SSIA product along with the Bank who was located in her employer's premises. As her contributions were also deducted from her weekly wages it was considered by her as an easy way to save and therefore a very attractive product.

The Ombudsman also noted that she did not get a copy of the terms and conditions until she requested them when the account was about to mature. In those circumstances he considered that she may not have been acquainted with, or apprised of, all of the account's finer points by the Bank.

Having examined the evidence submitted by both parties, the Ombudsman came to the conclusion that, on the balance of probabilities, the Complainant did seek an SSIA paying a fixed rate of interest and that she was led to believe she was getting this. So as to place the customer back in the position she would have been in if the SSIA had been at the fixed rate, the Ombudsman awarded her €1,000 in compensation.

Case13- Relationships break -up can significantly affect life assurance policies

The Complainant in this instance stated that he was unable to claim a critical illness benefit following a serious operation in February 2004, on the grounds that a previous policy held by him and his ex-partner had lapsed in April 2003. He alleged he had applied for a new single life policy providing cover for him but this had not been put in place by the Insurance Company. It appears that the relationship break-up occurred in late 2002.

The Complainant furnished to the Ombudsman a lengthy and detailed submission of conversations and meetings which took place between him and the Company's Financial Advisor. The Complainant maintained that the Financial Advisor advised him to firstly let the joint life policy lapse, and then to take out a new single life policy in his own name. The Complainant stated that he had completed a proposal for a new policy in mid April 2003. On the other hand the Company submitted that the Complainant had advised the Financial Advisor that he was not in a position to maintain the monthly payments on the plan, and had agreed to contact him once he was in a better situation financially to either revive the current plan, or propose for a new plan on a single life basis. The Company stated that no proposal for a new policy had been received from the Complainant in 2003. However the Complainant's ex partner had incepted a separate policy in March 2003 following a meeting with the same Advisor in early 2003.

As the two parties provided very different accounts of meetings and conversations which had taken place in and around 2003/2004, it was necessary for the Ombudsman's Investigating Officer to have regard to the documentary evidence. This revealed that the Complainant had submitted, as part of his evidence, a Personal Finance Review dated February 2003, completed by the Company's Financial Advisor which indicated that, while the Company's recommendations were for the Complainant to address his life cover and critical illness shortfalls, the agreed action

was for the Complainant to top up his AVC pension, and that the other shortfalls would be addressed at the next review, scheduled for February 2004.

The Investigating Officer found that there was no evidence that a proposal for a new plan or for the revival of the lapsed policy was ever completed by or on behalf of the Complainant. It was also found that no premium was paid by the Complainant to the Company in respect of a new policy, and as a result was satisfied that there had been no consideration from the Complainant for a new single life policy. Both parties were given 25 days in line with Ombudsman's procedures to accept the Finding or to make further submissions before the Ombudsman came to a final decision.

The Complainant was unhappy with the Finding and requested to meet the Ombudsman. The Complainant had made requests during the course of the investigation to meet with the Investigating Officer, or the Ombudsman. As a general rule, Complainants are not met in person during the course of an investigation as most investigations are carried out by reviewing documentary evidence. However, there are occasions, particularly at final review stage, where the Ombudsman may decide to meet with either of the parties to elaborate on certain conditions or where the Ombudsman feels that persons may not be capable of expressing their genuine thoughts in writing. The Ombudsman felt that this was an occasion where it was appropriate to meet the Complainant. The Ombudsman is also empowered to take evidence under oath from employees of financial service providers.

At the meeting between the Ombudsman, the Investigating Officer, and the Complainant, who was accompanied by a relative, the Complainant stated that he had been advised by the Company's Financial Advisor to let the life policy lapse and to contact him when he received the lapse notice from the Company. The Complainant stated that he and his relative met the Financial Advisor around April 2003, and that he completed a proposal for a new policy at this meeting, the relative confirming that he had witnessed the Complainant's completion of same and was willing to swear this under oath.

At a subsequent meeting between the Ombudsman, the Investigating Officer, and the Company's Financial Advisor, who was accompanied by the Company's Head of Sales Operations, the Advisor denied having advised the Complainant to let the policy lapse and to contact him once he received the lapse notice from the Company. In addition he stated that he had no recollection of a meeting in April 2003, and that the Complainant had not requested a new policy in April 2003. He also stated that the meetings which took place in the period 2003 to early 2004 were to do with encashing an SSIA policy, and topping up an AVC policy - the Ombudsman noted that the SSIA was enchased in January 2004 apparently against the Advisor's advice. With regard to notes of the meetings, he did not have any as, at the time, he kept his notes in a diary which he cleared every couple of months. He was also willing to give sworn evidence.

During the meetings the Ombudsman noted that the Financial Advisor personally knew the Complainant and his ex-partner very well and had advised them over many years on investments. Following those meetings, the Ombudsman considered that it was unnecessary to take evidence under oath, or indeed to seek sworn affidavits from all of the parties.

In arriving at his Final Decision, the Ombudsman stated that he fully accepted and recognised that both parties to the complaint had a genuine belief that they were correct in their recall of events. While he was mindful that the break-up of a relationship can cause emotional problems, he had to consider the matter in a fair, impartial and dispassionate manner and take account of all factors, including documentary evidence. He agreed with his Investigating Officer's finding and though not upholding the complaint the Ombudsman awarded €8,000 on the grounds that some aspects of the customer care by the Company were not to the standard that he would have expected including the record keeping by the Advisor.

In a general comment the Ombudsman noted that Financial Advisors of the Company generally meet with customers every year to review their financial situation and indeed to sell them some more products if needs be. The Ombudsman finds nothing inappropriate with that. However, where the Financial Advisor knows both parties and is aware of a relationship break-up, the Ombudsman requested that appropriate additional steps be taken by the Company to ensure that the serious consequences of a policy lapsing would be clearly drawn to their attention.

Case 14-House being underinsured resulted in a reduced settlement amount

The Complainant submitted a claim under his household insurance policy for the subsidence of his private house. The Insurance Company stated that the building sum insured at the time of notification of the loss in 2002 was €237,000 having index linked the building sum insured up to that date, but it also stated that the building should have been insured for €270,000. The Company claimed that the Complainant's house was underinsured, applied the average clause and offered the Complainant €132,000 in settlement of his claim. The total reinstatement expenditure, according to the Complainant, amounted to €145,000.

The Complainant disputed that his private house was underinsured. He argued that the policy terms were ambiguous. However, the Ombudsman examined the terms of the policy and found them not to be ambiguous. The Complainant had various complaints in relation to his household insurance policy and its wording, but ultimately the Ombudsman advised him that there is an onus also on the Insured to determine whether or not the terms and conditions of cover are suitable to his needs, when effecting and /or renewing his annual household buildings and contents policies.

The Complainant also submitted that he relied on index linking over the years. The rates of index linking applied to the Complainant's building sum insured by the Company for the years previous to the submission of the claim were therefore examined. The Ombudsman noted that at the renewal date immediately prior to the date of loss, the Company applied a rate of index linking of 25% to the Complainant's building sum insured. The Complainant was made aware of the need for this particular rate by the Company in correspondence prior to its application as it had previously reviewed the general adequacy of the buildings and contents sums insured of the policies it provided and considered that many sums insured were inadequate. If the Complainant had not accepted this 25% rate of index linking, his house would have been significantly underinsured.

However the Ombudsman pointed out that whilst index linking partly assists in preventing underinsurance, it cannot be relied upon alone. He pointed out to the Complainant that index linking can only work properly if the sum insured initially is correct. He commented that there is an onus on the Insured at all times to advise the insurance company of the correct valuation of his or her property for policy purposes and to review this valuation regularly. The Ombudsman noted that the Complainant's annual renewal notices also highlighted to the Complainant the importance of reviewing his sums insured annually and that if in doubt, it was the Insured's responsibility to seek appropriate advice in respect of the insured values.

In relation to the substantive part of this complaint, whether or not the Complainant's house was underinsured, the Ombudsman examined the submissions of both parties to the dispute. He also consulted the guidelines set out in the Society of Chartered Surveyors "Guide to House Rebuilding Insurance" (SCS Guide) for the relevant period and area in Ireland. These guides are available free of charge to the public and are intended to assist people in valuing houses for insurance purposes. The cost rates included in this guide are only a guideline to the minimum value for which an Insured should insure a house.

The measurements of the Complainant's building were requested from both parties and compared by the Ombudsman. The total floor area of the house was then calculated and multiplied by the relevant cost rate according to the SCS Guide to determine what the required sum insured should have been. The Ombudsman considered the cost rates used by the Company to calculate what the building sum insured should have been in 2002, and found that the cost rate it used also allowed for some benefit of the doubt in the Complainant's favour.

Having reviewed further information from the Company regarding its calculation of €132,000 the Ombudsman accepted that the average clause was correctly applied in this case. The Company's original offer of €132,000 to the Complainant was found to be correct, fair and reasonable and the complaint was not upheld by the Ombudsman.

Joe Meade
Financial Services Ombudsman
3 July 2007