FINANCIAL SERVICES OMBUDSMAN

COMPLAINTS DECISIONS in the October to December 2005 period

(a) Credit Institutions

Building Society repaid €29,000 to persons who switched their commercial mortgage and society directed to change its policy of fixed interest redemption charge

The Complainants, who had a commercial mortgage account with a building society, decided to change their mortgage to another financial service provider. When they applied to change, their original building society charged a redemption fee of €59,000 under the terms of the contract. They paid the redemption fee under protest, but complained to the Ombudsman that the fee was unfair and unreasonable.

Having investigated the case, the Ombudsman ruled that the provision in the mortgage agreement which the building society relied on to impose the fee was based on a fixed formula which could not, on any reasonable construction, be deemed to be a genuine pre-estimate of the loss arising from the early repayment of the mortgage loan . Therefore it was, in reality, a penalty and amounted to a clog or fetter on the equity of redemption and accordingly was invalid and unlawful. The Ombudsman gave his opinion that a fair measure of the loss to the Financial Service Provider would be €30,000. He therefore directed that the sum of €29,000 be repaid to the Complainants by way of compensation and this was accepted by the building society.

As the Ombudsman later received another complaint during 2005 along similar lines he has directed the society in question, to change its fixed fee policy and has also informed the Financial Regulator.

Nature of derivatives investment was not explained and €6,500 awarded

A couple decided to invest €80,000 out of their life savings of €100,000 in a short term Guaranteed Bond which it was claimed would earn a return in excess of deposit rates over the three year duration of the investment. The investment was based on derivatives. The customers were not informed of this. In the event, the investment produced a nil return. The Ombudsman found that the nature of the investment was never explained to these customers and was of the opinion that if it had been known, they might not have made the investment in question. The Ombudsman awarded €6,500 in compensation.

Excessive hire of cars on a credit card at the Olympic Games not upheld

The Complainant, a sporting body, allowed some of its members to use its Credit Card to hire cars at the Olympic Games in Athens. The Cardholder said it had sanctioned the hire

of cars amounting to €4,740. However, it received a bill for €9,400 when the Credit Card statements came in. The Cardholder said the Bank should be liable for the difference.

It emerged during the investigation that the additional car hire was undertaken by members of the sporting body, but the extra hiring had not been authorised. In the circumstances, the Ombudsman decided that there was a management or administrative failure on the part of the sporting body in relation to the conduct of its own affairs and that there was no negligence or breach of contract or failure of duty on the part of the Bank and the complaint was not upheld.

Credit Union –complaint of €23,000 allegedly missing from an account not upheld

Since 1 April 2005, complaints against Credit Unions are within the remit of the Financial Services Ombudsman and a number of complaints have been dealt with since October 2005.

In one case, a member complained that the sum of €23,000 was missing from his account which the Credit Union denied. The Ombudsman's investigation revealed that the Credit Union, in writing to the Complainant in 2004, had made a mistake in the figures presented. This, together with the fact that a change in the computer system used for producing statements, resulted in statements being presented in a different way. The Ombudsman noted that this naturally and understandably caused considerable confusion for the customer when he was trying to reconcile his account.

Nevertheless, the Ombudsman was satisfied after investigation that the evidence did not disclose that any sum of money was in fact missing from the account. The Ombudsman was satisfied that the Credit Union had made all reasonable efforts to provide the Complainant with a full statement of account showing all transactions from 1998 to date and indeed went to the trouble of providing account statements in both the old format as well as the new format in order to help the customer. The Ombudsman found that while a clerical mistake had been made, it had been corrected and there had in fact been no money missing from the account and the complaint was not upheld.

Credit Union did not inform a member of his rights and €250 compensation awarded

A Credit Union customer who applied for a top-up loan was refused the loan on the grounds that he was outside "*the Common Bond*", and that since the Credit Union had reached its limit for lending outside the Common Bond, he could not be given a loan. The complaint was that the Credit Union was negligent in that it failed to inform him that he should have had his account at a different Credit Union if he was to qualify for the Common Bond, and furthermore that the Credit Union never told him at any stage about the significance of his not being in the Common Bond. All Credit Unions are limited in the amounts of loans which they can offer to persons who are outside the Common Bond and the Credit Union has to ensure that such persons do not represent more than 10% of the Credit Union's total loan book.

The issue of the Common Bond is central to the powers of the Credit Union when granting loan facilities to certain members and is indeed central to the limits of such powers following the enactment of the Credit Union Act 1997. It seems that previous management at the particular Credit Union had failed to ensure that it operated within those limits and this is why the Complainant was, on previous occasions, able to avail of facilities which should not, strictly speaking, have been made available to him.

The Ombudsman was satisfied that while the Complainant was not entitled to the loan as of right, nevertheless the Credit Union did have a duty to advise the Complainant of his position in regard to the Common Bond when he initially joined the Credit Union, or at any time subsequently. This was a failure on the part of the Credit Union in its duty to its customer and the Ombudsman awarded €250 compensation.

Credit card anti fraud measures are appropriate even when they cause inconvenience

A Credit Card customer of a Bank went on holidays to the Far East. While in Hong Kong he tried to use his Credit Card to make purchases. His Card was rejected. It turned out the Bank had placed a stop on his Card because the proposed amounts had triggered the Bank's fraud prevention system.

The Complainant was very annoyed about this and complained to the Ombudsman that the Bank had exceeded its powers and been in breach of contract. The Bank said in its defence that during the course of standard monitoring procedures at the Fraud Prevention Department, it became necessary for the Bank to make contact with the Complainant in order to verify that the transactions in question were genuinely his and were valid. The Bank telephoned the Complainant's mobile 'phone but he did not have it with him in the Far East. As a result of the Bank's inability to contact the Complainant, it was decided to place a fraud prevention marker on the account until such time as contact with the Complainant could be established in order to verify the transactions. Accordingly, when the Complainant next sought to use his Card, the transaction was declined and was referred for voice authorisation. However, the retailer did not follow the required process and did not seek voice authorisation, as a result of which the automatic transactions were refused. The Complainant argued that as he visited the Far East every year for a number of years past, the Bank should not have triggered the fraud prevention mechanism.

The Ombudsman found that the use by Financial Service Providers of fraud prevention measures is in the interests of Credit Cardholders. While a bank has a duty to act reasonably, there was no evidence in this case that, having regard to the size of the transactions and the location, the Bank had acted unreasonably. The fact that a fraud prevention marker is placed on an account, even if the purchases were authorised and the transactions were valid, does not suggest that the systems in place are flawed.

A Credit Card company is required to balance the interests and convenience of its customers with the requirement to prevent fraud and in this case, the Ombudsman found that the Bank had acted reasonably. While there was a delay in establishing contact with the Complainant, once contact was established, the fraud prevention marker was removed

and the Complainant proceeded to use his Credit Card in the normal way. The Ombudsman found that the Bank had acted correctly in the circumstances of this case and the complaint was not upheld.

Bank was wrong to withhold title deeds and €5,000 compensation was awarded

A Bank had withheld the Title Deeds of a property where the mortgage had been vacated because the customer seeking the return of the Deeds (which were unencumbered) had an outstanding overdraft with the Bank which had not been paid and the Deeds had been held originally on a "all sums due" type of mortgage. As a result of the refusal to release the Deeds, the Complainants lost a profit opportunity.

On investigating the case, the Ombudsman found that there had been a mortgage but it had subsequently been vacated and while the Complainants may have been a party to an "all sums due" mortgage, once that mortgage was vacated the overdraft was no longer subject to the Terms and Conditions which had been in place prior to the vacation. The Ombudsman said he was satisfied that whatever entitlements the Bank may have had prior to vacating the Mortgage Deed, once the Deed of Mortgage had been vacated the Bank no longer had any legal right to retain the Deeds of the Complainants' property. While observing that no doubt the Bank was somewhat frustrated by the Complainants' failure to repay the overdraft in accordance with assurances which they had given, nonetheless the failure of the Bank to release the Title documents was wrongful and was unfair to the Complainants.

The Ombudsman awarded compensation of €5,000 which he directed was to be paid by way of a credit to the Complainants' current account rather than by bank draft. This was because the overdraft had been called in and the Complainant had a duty to repay it. Therefore it would not be equitable as between the Bank and the Complainants that the €5,000 compensation should be paid over without being offset against the monies due and owing on the overdraft.

(b) Insurance sector

A complex total permanent disability and critical illness claim for €100,000 was initially rejected by the insurance company but a mediated settlement of €33,000 was reached by the Ombudsman

A claim was submitted to an insurance company in 2000. There were two elements involved i.e. a claim for Total Permanent Disability and a claim for Critical Illness. The company had rejected both by October 2004 which came in total to €100,000. The Complainant then referred the matter to the Ombudsman and also argued that the Company delayed in coming to its decision and did not keep him properly informed of progress of claim.

After initial review the Ombudsman, while satisfied that the Complainant did not meet the Total Permanent Disability criteria for benefit, felt it necessary to seek independent medical and legal advice in relation to the Critical Illness Claim as very complex and serious issues of medical definitions, cause and effect as well as legal precedents arose. While the Ombudsman noted that the Company sought information from the Complainant regarding his family's health history, the Company medically assessed the claims and repudiated same on the ground that the Complainant did not meet the policy criteria on basis of its own medical information. The Ombudsman's examination and observations only related to whether the Complainant met the policy criteria having regard to his own medical history and information.

The independent medical consultant who the Ombudsman engaged differed in a significant way with the Company's views but his advice was not conclusive either. Indeed the legal advice received and reference to case law indicated that this was a difficult case to be definite on. The Ombudsman also noted that in the course of its investigation of the claims the Company sought information from the Complainant regarding his family's health history and it was the Company's case that the Complainant declined to provide complete information requested in that connection.

Taking account of all these matters and being conscious of the time it had taken to get the matter to a stage where a decision by the Ombudsman was possible the Ombudsman felt it appropriate in October 2005 to suggest a possible resolution to the Company without putting any monetary value on its effect at that stage. The Company responded that in view of all the circumstances the Company was prepared to offer, on an *ex gratia* basis only, an amount of €32,300 in full and final settlement of this matter and that the payment, in accordance with the policy terms and conditions, would then bring the entire policy to an end.

Having regard to all the aspects of this highly complex and difficult case the Ombudsman found that the Company's offer was both fair and reasonable in the circumstances. The complainant accepted the decision also.

A complaint of this complexity indicates that resolutions of certain complaints are not easy, are time consuming but at least the Ombudsman can eventually succeed by mediation in agreeing a fair and balanced outcome without the matter having to go to

Court. In this regard he is very appreciative of the cooperation he receives from complainants and financial service providers in his efforts to make what has ultimately to be a balanced decision overall.

Payment Protection Plan, including Disability Benefit – Benefit reinstated as complaint upheld

The Complainant brought his case to the Ombudsman seeking reinstatement of his disability benefit under a payment protection plan he had taken out in late 2000. Three years later the Complainant suffered a disability relating to his back and his claim was admitted by the Company. Later, in mid 2004, the Company re-assessed the claim indicating that continuing disability was due to a "*Pre-Existing Condition*" and therefore not covered.

The Payment Protection Plan included the following:

> "Specific Disability Exclusions
>
> In addition to the General Exclusions, no Disability Benefit will be paid:
>
> * *For pre-existing illnesses, i.e. if caused by or contributed to by any medical or physical condition (including chronic or recurring conditions) in respect of which* ***you have suffered or sought treatment or advice in the 6 months period immediately prior to the effective date of protection."***

Initially in late 2003 the Company paid the claim (on a monthly basis). In mid 2004 the Company decided to re-assess the claim and discovered the Complainant had made progress in some areas but remained disabled. The Company made further investigations into the Complainants medical history and found that the Complainant had suffered a back problem some 20 years earlier and had some problems with back pain from time to time.

However, at the time of original notification of claim in early 2003, the Company had asked the following question of the Complainant's doctor:

> *"Please advise if he suffered or sought treatment or advice for the same complaint in the six months prior to a specified date in 2000''*
>
> and the doctor replied
>
> *"In the six months prior to the specified date in 2000 I did not see him at all for any reason."*

The Ombudsman's view on this matter was that on a reasonable interpretation of the exclusion it did not apply on the basis of the medical evidence submitted in this case. The

medical evidence supported the Complainants assertions that he had "not suffered or sought treatment or advice in the six months period immediately prior to the effective date of protection". As the doctor had categorically stated that he had not seen the Complainant in the six months prior to specified date in 2000 and confirmed that he did not see the Complainant "at all for any reason" it was the Ombudsman's finding therefore that the Company was to reinstate benefit to the Complainant. This was acceptable to the Company.

Medical Expenses Insurance - Following a review by the Ombudsman of the administration and handling of a claim for the cost of surgery undertaken outside of Ireland the claim was met, without admission of liability, at an amount that would have been paid if it was carried out in Ireland.

In July 2002 the Complainant had surgery for a reconstruction of a ligament. This surgery was performed in the United Kingdom. In October 2002, following a review of medical evidence surrounding this case, the Company repudiated a claim for the refund of medical expenses relating to the Complainant's surgery stating that it did not meet the criteria for benefit in relation to *treatment abroad*.

The Complainant argued that a genuine misunderstanding took place between himself and an Irish Consultant regarding the nature of the surgery carried out. The Complainant stated that he informed the Company of the circumstances of his operation and updated them throughout the period leading up to the procedure in the UK. He only became aware of any potential problem regarding cover after the operation took place. The Complainant argued that this aspect of the claim reflected a problem with respect to the Company's approval procedures and the claim's administration.

The Company stated that while Complainant had reconstruction of a ligament performed in the UK in July 2002 he was originally referred for a specific joint replacement. In accordance with its policy conditions the Company did not provide cover if the member got treatment abroad. However, in exceptional circumstances and subject to *prior approval* and satisfaction in full of specified criteria, the Company do meet the claim. The Company also stated that as the treatment performed was readily available in Ireland they were not in a position to allow any benefit towards the costs incurred. It considered that the time taken to issue a decision regarding approval for the procedure related to the complex nature of the procedure in question.

Evidence submitted by both parties to this dispute indicated that the Complainant's treatment abroad was available in Ireland. As the treatment was available in Ireland, the Ombudsman indicated to the Company that while there were good grounds for not upholding the complaint, there were certain other factors to be considered and he invited the Company's further comments before he reached his final decision *viz* though the treatment was available in Ireland the matter had been discussed with the Company before he went to the UK, the administration of the request for prior approval by the

Company could have been better and a genuine misunderstanding could have arisen in discussions with respect to prior approval but this could not be proven.

The company then indicated to the Ombudsman that the complaint had been correctly assessed and rejected in accordance with the terms and conditions of his contract but in view of specific circumstances involved in this case and the matters the Ombudsman had drawn attention to it was prepared to offer in this specific case an *ex-gratia* payment of €3061 which would be the cost it would meet if the operation was carried out in Ireland. It represented approximately 50% of the claim (without admission of liability).

The Ombudsman considered that the response of the Company was an appropriate one and he commended them for their approach. Accordingly, he directed that €3061 should be paid by the Company as a contribution towards the Complainants costs without admitting liability and this was accepted by the complainant.

Medical Insurance – a claim for the cost of a hip replacement was not upheld but the particular policy exclusion needs clarity

The Complainant joined the Voluntary Health Insurance scheme in late 2000. The Complainant was admitted to hospital in November 2003 for a hip replacement and subsequently submitted a claim to the Company for benefit for this treatment

The Company repudiated the claim on the grounds that the condition for which the Complainant was treated was present since early 2000, prior to the Complainant's application for membership and thus was not covered in accordance with rule 3d of the Company Healthcare Rules, Terms and Conditions of Membership. However, the Complainant stated that according to the medical advice he had received his hip was not in need of replacement prior to joining the Company and the symptoms of the hip replacement had developed subsequent to the joining of the Company Insurance plan.

The Company stated that based on the medical information it received, the condition for which the Complainant was treated was present prior to her application for membership and therefore in accordance with rule 3d of the Company Healthcare Rules, Terms and Conditions of Membership, that no benefit was payable in respect of the costs incurred as it states.

Policy Provisions

Rule 3) Joining [Company] Healthcare;
(d) *"no benefits are payable for medical conditions the date of onset of which is determined on the basis of medical advice, to have been prior to the date the member was included on the contract, unless the member has been insured continuously for a minimum period of time"*

The minimum period is as follows:

MEMBER'S AGE WHEN HE/SHE IS INCLUDED	*MINIMUM PERIOD*
Under 55	*5 years*
55-59	*7 years*
60 or over	*10 years*

If the medical condition giving rise to the claim is determined on the basis of medical evidence to have arisen prior to the date of joining, the Company will not provide benefit. From the medical evidence submitted the symptoms of the Complainant's condition were present prior to taking out the insurance. Having taken into consideration all the circumstances, the Ombudsman was satisfied, in this specific case that from the medical evidence submitted the date of onset of the Complainant's condition arose prior to the date the Complainant joined the Company.

While he did not uphold this specific complaint the Ombudsman is in discussion with the Voluntary Health Insurance Company about this Policy condition and whether people are fully apprised of and indeed fully appreciate its implication before taking on insurance cover.

Stolen motor vehicle – Ombudsman increased valuation offer by €1,000 to €3,700

The Complainant's car was insured for €5,000.The car was stolen in 2004 and a claim was submitted to the Company. The Complainant was unhappy with the settlement amount offered by the Company and believed the car was worth considerably more. Furthermore the Complainant was unhappy with the manner in which his claim was dealt with.

The Company stated that in the valuing of the vehicle the Company engineer conducted extensive market research in compiling the valuation. This evidence was submitted. The fact the vehicle was previously in an accident and had a very high mileage were both contributing factors used by the Company in reaching their valuation. The Company increased their initial offer of €2,000 to €2,700 in the hope of reaching an amicable solution.

On reviewing the policy the Ombudsman was satisfied that the Complainant was entitled to be indemnified for the "market value" of the insured car. Accordingly, the Complainant submitted a number of valuations from car guides, dealers and websites for his car taking into consideration, *inter-alia*, the vehicle's history, its mileage, age and condition.

It appeared from a review of this material that the vehicle in question, despite its age and mileage, held its value. Having had regard to the pre-accident valuations put forward by both parties, and having regard to a number of independent valuations obtained by, and

research carried by out by my staff, the Ombudsman recommended that the Company increase its pre-accident value by a further €1,000. This was acceptable to the Company.

Household Buildings Policy – Alleged Storm Damage of €80,000 not upheld.

Household insurance policies cover loss or damage caused by insured events set out in the policy document. In order to succeed in an insurance claim it is necessary for the Insured to prove that the loss or damage has been caused by an insured event.

This dispute concerned a claim in respect of damage to the roof of a dwelling house. The claim was submitted to the Insurance Company in June 2004 relating to damage allegedly caused by a storm in March 2002. The claim was for €80,000. The Complainant stated that she only became aware of the extent of the damage when her building contractor viewed the roof before he commenced routine repair work some two years later. The Company repudiated the claim on the grounds that it had been prejudiced by the late notification of the damage caused and also pointed to fact that no evidence existed to suggest the damage was the result of a storm but rather due to other factors. The policy provision made it clear that with regard to the notification of a claim the Company was to be informed *as soon as possible.*

The case involved the submission of much evidence with respect to the cause of damage and whether it was the result of storm damage or the actual construction of the house. While the Complainant referred to a storm occurring in early 2002, no specific date was given for the event and indeed it was suggested that it might have occurred later that year. No meteorological reports were submitted by the Complainant.

In the absence of specific dates of when the damage occurred and on the evidence submitted by both parties, the Ombudsman could not hold that the damage caused was the result of a storm without further evidence being obtained. He therefore sought and got independent technical evidence which indicated that other factors were the cause of the damage, and that the damage could not be attributed to a storm in any event. Furthermore he noted from the meteorological office records that in the period in question no adverse storm conditions prevailed in that part of the country which could have caused roof damage.

While he considered that the delay in notification of the claim may indeed have prejudiced the Company's ability to assess liability nevertheless on considering all the other evidence the Ombudsman could not uphold the complaint.

Life Assurance – A with profits Endowment Policy should not have been issued and accordingly the premiums paid had to be refunded

The Complainant case was that he asked a Company representative for a term assurance policy only, but that, unknown to him, two policies were set up *i.e.* a term assurance and

a with profits endowment policy. When the Complainant discovered he had two policies he made contact with the Company representative. It was the Complainant's case that the representative promised to sort matters out but that he never did. Eventually, both policies lapsed, but the term assurance was replaced. The Complainant was not happy with fact that he paid premiums on a policy, (the with profits endowment policy), that he stated he never required and sought a return of premiums.

A Fact-Find, which was said to have been completed at time of sale by the Company representative, was not available for inspection. In the absence of a Fact-Find and on the submissions made by the parties to the dispute the Ombudsman decided that the Company was to treat the 'with profits' endowment as cancelled from inception and to return the premiums paid by the Complainant.

Whole of life policy allegation of misleading information - compromise settlement agreed

The Complainants' protection plan was a whole of life policy and commenced in October 1988. The policy was taken out in connection with a house mortgage; the Mortgage was repaid in 1999. The Complainants alleged that they were misled by the Company when deciding to continue with the Policy in 1999. It was alleged that they were advised in 1999 to continue with the policy, that the premium would not change and that it would have a surrender value in excess of £1,000. The premium did increase and when the Complainants sought to cash in the policy in 2004, they were informed that there was no surrender value. The Complainants wanted the Company to continue the policy and waive the premiums owed.

The Company pointed to a surrender value of just less than €200 on the tenth anniversary of policy in 1998. The Company argued that it was unable to find any basis to support the assertion that the policy would have a surrender value of the amount alleged by the Complainants. The Company also argued that the advice given in 1999 to continue with the policy was given because if in the event that it was cancelled and the Complainants later decided to seek alternative life cover the cost would be likely to exceed the cost of the premium under the existing policy. The Company stated that the policy was a protection plan and did not have any savings component. The premiums were paid simply to sustain the benefits under the policy. The Company also pointed to a review carried out in 2003 when a premium increase was recommended and was accepted by the Complainants. The April 2004 premium was not received due to the direct debit being returned by Complainants' Bank as unpaid. Despite further demands the premiums remained unpaid and the policy lapsed. Before the dispute was referred to the Ombudsman the Company did offer to reinstate the policy on payment of outstanding premiums but this was unacceptable.

The Ombudsman noted that as this policy was a Unit Linked Whole of Life Policy, in accordance with the policy terms Policy Reviews were carried out. The policy provided for review and that there was a duty on the Company to carry out reviews to ensure that

the premium being paid was sufficient to maintain the policy benefits. The premiums were applied in accordance with the Policy Conditions, initially to buy units in the fund, but in the main to pay for the cost of the Life Cover. Premium payments ceased in respect of this policy in April 2004, the fund was exhausted and no surrender value was payable. The Company's explanation regarding the advice given in 1999 to continue with the plan held some merit *i.e.* alternative life cover would have been likely to exceed the cost of premium under the existing policy. The Ombudsman also noted that there was no documentary evidence supplied by the Complainants to support the allegation that a surrender value of in excess of £1,000 was given in 1999. However, he further noted that the Company failed to supply to the complainants certain documentary evidence regarding the value of policy between the period 1998 and 2001.

While he could not uphold the Complainants' claim for the Company to continue the policy and waive the premiums owed the Ombudsman felt that the Company should again offer to reinstate the Complainants' policy but waive 50% of outstanding premiums also. Future premiums would be subject to the normal review in accordance with the policy terms and conditions. This was acceptable to both parties.

Joe Meade
Financial Services Ombudsman
February 2006.