THE HIGH COURT

[2011 No. 88 MCA]

IN THE MATTER OF AN APPEAL PURSUANT TO SECTIONS 57C L OF THE CENTRAL BANK ACT 1942 (AS INSERTED BY SECTION 16 OF THE CENTRAL BANK AND FINANCIAL SERVICES AUTHORITY OF IRELAND ACT 2004)

BETWEEN

JACINTA DE PAOR

APPELLANT

AND

THE FINANCIAL SERVICES OMBUDSMAN

RESPONDENT

AND

QUINN HEALTHCARE

NOTICE PARTY

JUDGMENT of Mr. Justice Brian J. McGovern delivered on the 20th day of December, 2011

1. This matter comes before the court by way of a notice of motion seeking an order pursuant to s. 57 CM(1) and (2) of the Financial Services Authority of Ireland Act 2004, affirming the finding of the Financial Services Ombudsman made in relation to the appellant on 24th February, 2011, but modifying that portion of the finding relating to quantum of compensation payable by the financial services provider to the complainant.

2. The facts are not in dispute. In October 2007, the appellant joined Quinn Healthcare's (the Provider) medical expenses insurance scheme, taking out a Personal Care Plan for herself and her son. In August 2008, she was diagnosed with breast cancer and underwent surgery for this condition in September and October 2008. She contacted the Provider by telephone in October 2008 following surgery, to enquire about cover for her further treatment, and in particular, a course of radiation treatment

at the Mater Private Hospital. She was advised by the Provider that this treatment would not be covered under her Personal Care Plan, but that if she transferred to a Family Care Plan for a slightly higher premium, she would be covered for the specific form of radiation required. On the basis of this advice, the appellant agreed to change her policy to a Family Care Plan and proceeded with her medical treatment plan on the understanding that she would be covered for the radiation treatment. It subsequently transpired that she would require chemotherapy before the radiation treatment and she rang the Provider in January 2009 to notify them of the change. She was informed by the Provider that she was not covered for either radiation or chemotherapy as her cancer was considered to be a pre-existing illness and her Family Care Plan had a two-year waiting period before she would be entitled to make a claim on it. The Provider ultimately agreed to cover her for eight sessions of chemotherapy but refused to cover her for radiation treatment.

3. The appellant complained that by failing to honour the assurances given to her and refusing to cover her for radiation treatment, and classifying her condition as pre-existing, the Provider caused her inordinate stress and worry in relation to payments for various elements of her ongoing cancer treatment and forced her to suspend further treatments required (such as bone density scans, MRI and CT scans and ECGs) pending a resolution of the dispute which she referred to the Financial Services Ombudsman in April 2010.

4. The Provider acknowledged that the appellant was incorrectly advised during a telephone call with one of its staff on 13th October, 2008, in relation to benefit in the Mater Private Hospital and that she should have been told that there was a waiting period of two years which would apply to the increased benefit available under the Family Care Plan following the change of scheme. The Provider also accepts that one

of its staff told the appellant in January 2009 that she would be covered for chemotherapy and radiotherapy in the Mater Private Hospital, but that a shortfall and an in-patient excess would apply. The Provider acknowledged that this information was incorrect, as a two-year upgrade waiting period should have applied to the policy.

5. When the Provider received claims from the Mater Private Hospital, they were rejected. The Provider contacted the appellant on 3rd February, 2009, to explain that she had been given mistaken information, but on that occasion, agreed to cover the claim made by the Mater Private Hospital on an *ex gratia* basis and to cover the eight chemotherapy sessions which were to follow at the Mater Private Hospital. At the same time, the appellant was advised that radiotherapy in the Mater Private Hospital would not be covered under the Family Care Plan, but that radiotherapy would be covered in any of the hospitals under the Personal Care Plan. The Provider advised the appellant in writing that any further treatment relating to her condition would be subject to the two-year upgrade rule.

6. After the matter was referred by the appellant to the respondent, the Provider acknowledged and apologised for its errors and the distress this caused to the appellant during her treatment. The Provider agreed to pay all outstanding claims for radiotherapy and chemotherapy and informed the appellant that the two-year upgrade waiting period would be waived in her case, and that accordingly, she would have cover for all eligible treatment of any symptoms occurring after the date when the appellant initially joined the Provider's scheme in October 2007, up to the Family Care Plan level of benefit. The Provider also stated that five outstanding claims for Mater Private Hospital treatment which had been rejected due to the application of the two-year waiting period would be paid in a sum totalling €8,740.05, and that as gesture of goodwill for the stress and inconvenience caused to her, the Provider would

pay directly to the appellant the cost of the shortfall and also the in-patient excess applicable under the Family Care Plan to the five claims, which amounts to an additional sum of €989. The Provider further advised the Financial Ombudsman that it had contacted the accounts department in the Mater Private Hospital to let them know that these outstanding claims would be paid in full and that future treatment for the appellant's current illness would be covered up to the Family Care Plan level of cover.

7. The Ombudsman raised further queries with the Provider who acknowledged that the complainant had received further communications from the Mater Private Hospital on 26th April, 2010, seeking payment of unpaid invoices, and that this unfortunate situation had arisen because the Provider's next payment run was not until 14th May, 2010, and that the outstanding invoices were not paid until that date. The Provider also arranged for the appellant's son to be changed to the Family Care Plan with effect from October 2008, which is the same date as the appellant joined the plan. The Provider agreed to cover the cost of this change of membership for the two-year period 1st October, 2008, to 30th September, 2009, and from 1st October, 2009, to 30th September, 2010.

8. The respondent considered the complaint of the appellant against the Provider and issued his report on 24th February, 2011. In his report, the respondent made a number of findings. Only one of those is contested by the appellant. It is not necessary, therefore, to set out *in extenso* those findings.

9. The matter of which the appellant complains is the award of compensation made to her for distress and inconvenience. The sum awarded was €850. In his report, the respondent said:

> "*Since referring the complaint to the Ombudsman, the Provider has attempted to resolve this complaint to the Complainant's satisfaction. While I am pleased to note these positive actions taken by the Provider, which helped to restore the financial position of the Complainant and offer reassurance for the future, my finding is that this particular case merits an award of compensation to the Complainant for distress and inconvenience suffered in the sum of €850.00*"

10. The appellant argues that this is simply not sufficient, having regard to the several negligent misstatements made by the notice party which caused additional and unnecessary distress to the appellant at a time when she was vulnerable and worried on account of her ill health. In written submissions, the appellant states that such a sum would be considered a very low award on the District Court scale and that the Ombudsman did not act in accordance with s. 57BK(4), "*according to equity, good conscience and the substantial merits of the complaint*".

11. Written submissions were also delivered on behalf of the Financial Services Ombudsman. There is a large measure of agreement between the parties as to the legal principles which apply in appeals of this nature. In *Ulster Bank v. Financial Services Ombudsman and Others* [2006] IEHC 323, Finnegan P. laid down the following test for an appeal pursuant to s. 57 C.L. of the Central Bank Act 1942, (as inserted by s. 16 of the Central Bank and Financial Services Authority of Ireland Act 2004):-

> "*To succeed on this appeal, the plaintiff must establish as a matter of probability that, taking the adjudicative process as a whole, the decision reached was vitiated by a serious and significant error or a series of such errors. In applying the test, the court will have regard to the degree of*

expertise and specialist knowledge of the defendant. The deferential standard is that applied by Keane C.J. in Orange v. The Director of Telecommunications Regulation and Another and not that in The State (Keegan) v. Stardust Compensation Tribunal."

12. The respondent submits that the decision of Finnegan P. in the *Ulster Bank* case may be broken down into the following distinct elements:

(i) The burden of proof is on the appellant;

(ii) the onus of proof is the civil standard;

(iii) the court should not consider complaints about process or merits in isolation, but rather should consider the adjudicative process as whole;

(iv) in light of the above principles, the onus is on the appellant to show that the decision reached was vitiated by a serious and significant error or series of such errors;

(v) in applying this test, the court will adopt what is known as a deferential stance and must have regard to the degree of expertise and specialist knowledge of the Ombudsman.

This approach was followed by MacMenamin J. in *Molloy v. Financial Services Ombudsman* in a judgment on 15th April, 2011 (Unreported), and in *Ryan v. Financial Services Ombudsman*, 23rd September, 2011 (Unreported).

13. The respondent also relies on the judgment of Hamilton C.J. in *Henry Denny & Sons v. Minister for Social Welfare* [1998] 1 I.R. 34 at 37-38, where he said:

"*I believe it would be desirable to take this opportunity of expressing the view that the courts should be slow to interfere with the decisions of expert administrative tribunals. Where conclusions are based upon an*

> *identifiable error of law or an unsustainable finding of fact by a tribunal, such conclusions must be corrected. Otherwise, it should be recognised the tribunals which have been given statutory tasks to perform and exercise their functions, as is now usually the case, with a high degree of expertise and provide coherent and balanced judgments on the evidence and arguments heard by them, it should not be necessary for the courts to review their decisions by way of appeal or judicial review.*"

14. In *Hayes v. Financial Services Ombudsman*, High Court, 3rd November, 2008 (Unreported), MacMenamin J. stated at p. 18 of the judgment:

> "*What has been established, therefore, is an informal, expeditious and independent mechanism for the resolution of complaints. The respondent seeks to resolve issues affecting consumers. He is not engaged in resolving a contract law dispute in the manner in which a court would engage with the issue.*"

15. In *Square Capital v. Financial Services Ombudsman* [2010] 2 I.R. 514, McMahon J. agreed with the analysis of MacMenamin J. in *Hayes* and observed that:

> "*From reading the statutory provisions and from a consideration of the functions, powers and flexible procedures mandated by the Act, it is obvious that the office of Ombudsman is different from an ordinary court discharging its lawful functions.*" (P. 519)

16. The parties agree that it is not the function of the court to place itself in the shoes of the Financial Services Ombudsman. The test is whether the decision was vitiated by a serious error or series of such errors.

17. The scheme provided for under the legislation is "*to enable . . . complaints to be dealt with in an informal and expeditious manner*", see s. 57BB. Section 57BK(4) of the Act provides that the Ombudsman is:

> "*. . . entitled to perform the functions imposed, and exercise the powers conferred by this Act free from interference by any other person and when dealing with a particular complaint, is required 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.*"

The respondent argues that the decision made by the Ombudsman in this case was validly made and within jurisdiction and is not vitiated by any serious and significant error or series of such errors.

18. If the Court was to treat matters such as this as an appeal on quantum in the usual sense, it is likely that such appeals would frequently come before the courts arising out of decisions of the Ombudsman. If that were permitted, it would have the effect of frustrating the purpose of the scheme which is aimed at informal resolution of consumer issues. The whole purpose of the legislative scheme is to keep the process - so far as possible - out of the courts.

19. In this case, the appellant was clearly given misinformation. But if she had been given the correct information, she would not have been entitled to have all her treatment covered. Yet, this has now been done and she has been given other benefits to which she would not have been entitled but for the mistake made by the Provider. All of these matters were taken into account by the respondent in his findings. These findings comprehensively cover all the issues that arise on the dispute between the appellant and the Provider and he has taken into account the errors made by the Provider and the steps taken to ameliorate the financial consequences for the appellant

when she acted on the misinformation. The issue in this appeal is not whether I would have awarded a greater sum for stress and inconvenience, having regard to all the surrounding facts, but rather, whether, "*taking the adjudicative process as a whole*, the decision reached was vitiated by a serious and significant error or a series of such errors".

20. I find nothing in the decision that would meet that test, and accordingly, with regret, I must dismiss the appeal.