An tOmbudsman Seirbhísí Airgeadais agus Pinsean

Financial Services and Pensions Ombudsman

Ombudsman's Digest of Legally Binding Decisions

Volume 6 - Published July 2021

This document contains summaries of decisions issued in 2020 and 2021 concerning complaints from businesses.

Contents

The Financial Services and Pensions Ombudsman (FSPO)

The FSPO was established in January 2018 by the **Financial Services and Pensions Ombudsman Act 2017.** The role of the FSPO is to resolve complaints from consumers, including small businesses and other organisations, against financial service providers and pension providers.

We provide an independent, fair, impartial, confidential and free service to resolve complaints through either informal mediation, leading to a potential settlement agreed between the parties, or formal investigation and adjudication, leading to a legally binding decision.

When any consumer, whether an individual, a small business or an organisation, is unable to resolve a complaint or dispute with a financial service provider or a pension provider, they can refer their complaint to the FSPO.

We deal with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both parties. Much of this informal engagement takes place by telephone.

Where these early interventions do not resolve the dispute, the FSPO formally investigates the complaint and issues a decision that is legally binding on both parties, subject only to an appeal to the High Court.

The Ombudsman has wide-ranging powers to deal with complaints against financial service providers. He can direct a provider to rectify the conduct that is the subject of the complaint. There is no limit to the value of the rectification he can direct. He can also direct a provider to pay compensation to a complainant of up to €500,000. In addition, he can publish anonymised decisions and he can also publish the names of any financial service provider that has had at least three complaints against it upheld, substantially upheld, or partially upheld in a year.

In terms of dealing with complaints against pension providers the Ombudsman's powers are more limited. While he can direct rectification, the legislation governing the FSPO sets out that such rectification shall not exceed any actual loss of benefit under the pension scheme concerned.

Furthermore, he cannot direct a pension provider to pay compensation. He can only publish case studies in relation to pension decisions (not the full decision), nor can he publish the names of any pension provider irrespective of the number of complaints it may have had upheld, substantially upheld, or partially upheld against it in a year.

Formal investigation of a complaint by the FSPO is a detailed, fair and impartial process carried out in accordance with fair procedures. For this reason, documentary and audio evidence and other material, together with submissions from the parties, is gathered by the FSPO from those involved in the dispute, and exchanged between the parties.

Unless a decision is appealed to the High Court, the financial service provider or pension provider must implement any direction given by the Ombudsman in his legally binding decision. Decisions appealed to the High Court are not published while they are the subject of an appeal.

Publication of FSPO decisions

The FSPO has the power to publish legally binding decisions in relation to complaints concerning financial service providers under Section 62 of the **Financial Services and Pensions Ombudsman Act 2017.**

The legislation requires that decisions should be published in a manner that ensures that a complainant is not identified by name, address or otherwise and a provider is not identified by name or address. Publication must also comply with Data Protection legislation and regulations. Decisions appealed to the High Court are not published while they are the subject of legal proceedings.

When the Ombudsman issues a legally binding decision, that decision may be challenged by way of statutory appeal to the High Court within 35 calendar days from that date. For this reason the FSPO does not publish decisions before the elapse of the 35 day period available to the parties to issue a statutory appeal to the High Court. In addition, decisions which have been appealed to the High Court are not published, pending the outcome of any such Court proceedings.

Before any legally binding decision is published by the FSPO, it undertakes a rigorous and stringent review to ensure that the non-identification requirements of the Act are adhered to in order to protect the confidentiality of the parties.

The legislation also provides the FSPO with the power to publish case studies of decisions relating to pension providers, but not the full decision.

This Digest contains short summaries of a selection of 21 decisions. Some details within the summaries referenced in this Digest, such as names and locations, have been altered in order to protect the identity of the complainants. It is important to keep in mind that these are only short summaries.

This Digest of Ombudsman's decisions is the sixth volume in a series of digests.

Each of the digests and all published decisions are available at www.fspo.ie/decisions.

Information on how to access decisions and search for areas or decisions of specific interest in the decisions database is included on page 10 of this Digest.

In addition to the periodic Digests that feature summaries and case studies of decisions issued, the Ombudsman publishes his Overview of Complaints for the previous year, by the end of quarter one each year, which includes:

- a summary of all complaints made to the FSPO
- a review of trends and patterns in the making of complaints to the FSPO
- a breakdown of the method by which all complaints made to the FSPO were dealt with
- a summary of the outcome of all complaints concluded or terminated during that calendar year

Message from the Ombudsman

This is the sixth Digest of Decisions that I have published and the first Digest to focus entirely on legally binding decisions arising from complaints made by businesses. It features summaries of 21 decisions in relation to complaints from businesses, which were issued during 2020 and 2021.

Any business, whether a sole trader, a partnership, or a company can bring a complaint to my Office, once that business meets the eligibility requirement of having a turnover in the previous calendar year, of less than €3 million. I am aware that the vast majority of businesses operating in Ireland are therefore eligible to seek the services of my Office, as the reports published by the Central Statistics Office consistently make this clear. The CSO's most recent "Business in Ireland 2018" report confirms that 91.9% of such businesses meet the significantly lower microenterprise threshold, of a turnover of less than €2 million per annum.

It will be clear from the decisions featured in this Digest alone that the services of this office are used by a broad range of business involved in areas such farming, hairdressing, hospitality, construction, manufacturing, legal, medical and other services. My aim is to further highlight the availability of our services to businesses and organisations, that when a complaint has been made to a financial service provider about the conduct of that provider, and that complaint has not been resolved, my Office may investigate the conduct of the provider that gives rise to that complaint.

I also believe the decisions featured in this Digest will assist businesses, and indeed individuals, to make more informed decisions in relation to insurance and banking products and services.

Entering into an insurance contract or a banking relationship is an important decision that can have profound impacts. It is important for those entering into such arrangements to know their needs and to ensure that the contracts they enter into, meet those particular needs. It will be noted from some of the summaries and the full text of the decisions featured in this Digest that it is also important for a business or individual to know and understand what is required of them when they enter into a contract with a financial service provider.

I would encourage all businesses and individuals with insurance policies to ensure that they are aware of the obligations, processes and procedures set out in their insurance policy, in relation to, for example, the disclosure of information when incepting an insurance policy and the timeline, or other factors, relating to the notification of an insurance claim. The very serious consequences of not being aware of, or not meeting these obligations will be evident from some of the decisions summarised in this Digest.

Equally, there is a responsibility on a financial services provider to ask for the information it needs from a customer in a clear and understandable manner. It is also incumbent on financial service providers to supply the fullest and most clear information to consumers. It will be seen from some of the summaries and from the full text of the decisions featured in this Digest, that where a bank aggregated the accounts of customers without their knowledge, it had negative consequences for those customers.

COVID-19

A number of decisions featured in this Digest have a COVID-19 element.

In March 2020, we began to receive complaints arising from the circumstances surrounding the COVID-19 pandemic. The majority of these related to insurance. To date (July 2021), we have received 1,051 complaints where the complainant introduced COVID-19 as an element of their complaint. Already 760 of the 1,051 complaints received have been concluded.

The reason so many of these complaints have already been concluded is because of the measures we put in place to ensure the efficient management of COVID-19 related complaints. These measures included the prioritisation of complaints concerning business interruption insurance, in recognition of the importance to policyholders of achieving

a swift understanding as to whether they were entitled to benefits or payments from their insurer.

Of the COVID-19 related complaints we received, 180 concerned business interruption insurance.

Business interruption insurance complaints

Whether or not an insurance claim will be successful will depend on the cover available under the particular insurance policy wording.

It is clear from the summaries of the business interruption decisions in this Digest, and the text of the full decisions available within our Database of Decisions, that the circumstances surrounding COVID-19 related business interruption claims were exceptionally difficult for many of those businesses that brought their complaints to us. Businesses outlined the impact being experienced of their loss of the ability to trade, loss of stock and loss of rental income.

As with all insurance claims, whether or not a claim for indemnity for such losses will be successful, is dependent on the cover available under the policy. The decisions contained in this Digest in relation to business interruption insurance claims highlight the crucial importance of understanding the extent of the cover provided by an insurance policy and any conditions or limitations to that cover. For some complainants that brought their complaint to my Office, they believed that the closure of their business following Government restrictions, or other circumstances arising from the pandemic, would be automatically covered by their insurance policy. The decisions I issued highlight that in some complaints, I found that the specific wording of the policy did provide indemnity for such circumstances, while in other complaints there was clearly no indemnity available under the complainants' policies of insurance.

During the summer of 2020, while we were investigating complaints against a number of insurers, relating to business interruption claims, one insurer sought an order from the High Court, requiring me to cease my formal investigation of a complaint made against that insurer, in relation to a business interruption claim. In February 2021, the High Court struck out those legal proceedings, noting the agreement of the insurer to discharge certain legal costs to my Office and to the complainant. I welcomed the striking out of the case, which enabled me to continue with the adjudication of the complaint, which is now concluded.

Separately, while the FSPO continued to manage business interruption complaints through our various processes, a considerable amount of litigation on these matters was being dealt with, in parallel, by the Courts during 2020 and 2021. As with all High Court judgments, I have had regard to those judgments in arriving at my decisions. The outcome of those cases has provided clarity on certain policy wording.

To date, 113 complaints concerning business interruption insurance have been concluded, through our various processes, including 38 complaints that were closed following the investigation of the complaint and a legally binding decision being issued. This Digest includes summaries of 12 of those legally binding decisions.

In my business interruption decisions, I have upheld complaints against three insurers. As with some legally binding decisions previously issued on other matters, some of these decisions have implications for other complainants and policyholders. Two of the three insurers against which complaints have been upheld, responded immediately indicating a willingness to apply those decisions to policyholders with similar circumstances. One insurer has since resolved 15 such complaints. This is something I very much welcome. It once again demonstrates the wider impact of the decisions issued by this Office.

One insurer has appealed a business interruption decision to the High Court, seeking to have that decision struck down. Complaints against that provider relating to similar policies will continue to be investigated by this Office, however, I will not issue preliminary decisions in relation to these complaints, or where preliminary decisions have already been issued, I will not conclude those adjudications, until the matter under appeal has

been determined by the High Court.

From March 2020, I recognised the importance of business interruption complaints and, in accordance with the ongoing co-operation between my Office and the Central Bank of Ireland (CBI), I ensured that the CBI was made aware of my approach to these complaints, and the outcomes of any legally binding decisions issued.

The themes that feature in some of the decisions summarised in this Digest include the following:

Outbreak of disease within a 25 mile radius

A number of decisions within this Digest concern a policy clause in insurance contracts that stated that the insurer would indemnify the insured for loss arising from interruption of, or interference with, the business following an occurrence of a notifiable disease within a radius of 25 miles of the business premises.

One complaint concerned Betty, who ran a printing shop and in March 2020, decided to temporarily close her shop, having realised that the shop would not be able to implement the Government's social distancing measures to keep employees and customers safe. In May 2020, Betty made a claim for business interruption losses as a result of the temporary closure, on the basis of a clause in her contract referencing an occurrence of a notifiable disease within a 25-mile radius.

The insurer argued that the clause in its contract only provides cover for losses when a specific outbreak of COVID-19, occurring within a 25-mile radius, had a direct effect on the business. It stated that it was not enough that there simply happened to be COVID-19 incidents within that radius, but these incidents must be the dominant cause of the business interruption. It argued that Betty closed her shop due to a Government response to a national health issue, not a localised event, and so it argued that this situation was not within the scope of the clause.

I decided that because social distancing measures had been required as a result of the COVID-19 pandemic and Betty had to close her shop as a direct result of being unable to implement social distancing in her shop, COVID-19 could be attributed as a cause of the losses under the contract. I concluded that Betty was entitled to have her claim paid by the insurer, as long as evidence of an occurrence of COVID-19 within a 25-mile radius was found around that time. The insurer had not asked for evidence of this when considering her claim.

I also concluded that even if no evidence of a COVID-19 case could be identified around the time Betty closed her shop, Government legislation enacted in April 2020 declared that 'every area' of the State was an area 'where there is known or thought to be sustained human transmission of COVID-19' and this was evidence enough at that time, that there was a case of COVID-19 within a 25-mile radius of Betty's business.

In my decision, I took the view that Betty's claim should have been paid from April 2020 and that the insurer's decision to decline Betty's claim was inappropriate, unfair, unreasonable and unjust. Although after my preliminary decision, the insurer in February 2021, then informed Betty that a recent High Court decision had provided 'welcome clarity' as to how the clause should operate under Irish Law and indicated that it would pay Betty's claim, I was of the firm opinion that the delay of eight months before the claim was admitted, led to considerable inconvenience for her. Therefore, I upheld Betty's complaint and directed the insurer to pay €12,000 in advance payment of the policy benefit owed to Betty for business losses, plus an additional €4,000 of compensation for the inconvenience it had caused.

Outbreak of a notifiable disease occurring at the premises

Several of the complaints investigated cited policy clauses that required that the loss of income be a direct result of interruption caused by an outbreak of any notifiable disease occurring at the business premises.

One such complaint was made by Gráinne, who closed her dental practice due to the outbreak of COVID-19. Gráinne's insurer informed her that her claim did not fall within the scope of her insurance cover. Gráinne complained to her insurer in May, stating that her practice had been closed down by official orders, to prevent the spread of a notifiable disease and that several cases had been recorded

in the area where her practice was located. She argued that if the outbreak was not occurring on her premises, then there would not have been orders to stop trading.

The insurer stated that Gráinne's policy covered outbreaks on her premises. As a result, the insurer stated that for cover to be triggered, it must be proven that an instance of COVID-19 illness in a person had occurred at the premises, and it was that outbreak/occurrence at the premises that caused the business interruption suffered. The insurer noted that Gráinne had not provided any evidence that a person who had been at the premises prior to its closure was ill with COVID-19.

In my decision, I accepted that the insurance policy did make clear that there must be an occurrence at the dental practice itself, for cover to be triggered. While the reasons Gráinne gave as to why the practice was closed would, undoubtedly, cause loss to her business, they were not covered by the policy. I accepted that the insurer was entitled to refuse cover and I did not uphold Gráinne's complaint.

Outbreak of disease not listed as an 'insured peril'

In some of the decisions issued in relation to business interruption insurance, an outbreak of disease was not listed as an 'insured peril'. This meant that those policies did not cover such an eventuality. In one such complaint, Ibrahim owned a property which was let as a charity shop. The tenant was unable to pay the monthly rent in full, due to its enforced temporary closure. The rent was Ibrahim's main income and means of providing for his family.

Ibrahim initially telephoned and then emailed the insurance company to enquire about a claim for loss of earnings. His insurance company advised him that he was not covered because the outbreak of a disease was not listed as an 'insured peril' in the insurance policy. The cover for loss of rent would only have arisen if there had been actual damage to the property arising from an insured peril.

I accepted that the insurance policy provided cover for loss of rent, only when that loss has occurred as a result of damage to the building rented and if the damage fell under one of the insured perils listed in the policy document. There was a broad range of insured perils covered in the policy, but outbreak of a disease was not one of these. Therefore, I did not uphold the complaint.

Notification of claims

It is important that insured businesses or individuals are aware of the obligations, processes and procedures set out in their insurance policy in relation to the timeline, or other factors, relating to the notification of an incident that could give rise to a potential insurance claim. Two of the decisions featured in this Digest demonstrate the serious consequences that can follow for the insured, from not reporting either a potential or actual claim in accordance with the requirements of the insurance policy.

In one complaint, a doctor had received notification of a personal injury claim concerning one of his staff. The injury had occurred on the surgery premises and he himself had administered sutures to the staff member. The doctor did not notify his insurer of this injury within the terms of his policy and despite having received a notification from the Personal Injuries Assessment Board, he did not notify his insurer until 10 months after the event.

I found that the policy was clear. It required the policyholder to act with immediacy and urgency in respect of anything that may give rise to a claim. Therefore, I accepted that the insurer was entitled to refuse the claim and I did not uphold the complaint.

A second decision of this nature concerns an insurer's refusal to indemnify a construction company arising from an accident experienced by an employee. The claims notification requirements contained within the policy specified 'immediate' written notice. The incident had been notified to the company's broker but not to the insurer. The insurer submitted that a 175-day gap between the incident occurring, and the notification could not reasonably be termed immediate. Because the notification requirements had not been met, I did not uphold the complaint.

These decisions highlight that cover may be refused when the obligations placed on a policyholder are not met and I would encourage all policyholders to ensure they familiarise themselves with such conditions within their

policy cover.

Aggregation of accounts

The 'aggregation' of accounts is a practice that is highlighted in two decisions contained in this Digest. This practice is complex and is one that I believe businesses, in particular, should be aware of. It is a practice that could affect personal banking customers also.

In one of the complaints featured in this Digest, the company had a business current account with a bank. It became aware that this account was transferred into the bank's 'non-performing' section, despite the company's contention that it did not have any debt. The company complained that it was not notified of this change by the bank and that the bank consistently failed to give an explanation for it.

The bank submitted that the management of the account was 'retagged' internally within its restructuring section. It explained that this is an internal process and can happen without a customer being aware. The bank said that the process is not dictated by arrears on an account, though typically accounts with arrears are reclassified. During the investigation of the complaint by my Office, the bank further clarified that the account was retagged under its 'aggregation policy' where it makes linkages between accounts, of different account holders, for various reasons, including shareholders, partners, signatories, family connections, and common risk factors.

I substantially upheld the complaint and directed the bank to pay a sum of €3,000 in compensation.

A second decision in this Digest concerns Fergus's business loan that had been moved to the problem debt division within his bank and thereafter, sold to a third party. In my decision, I did not accept that the transfer was due to 'a history of arrears on the loan account' as suggested by the bank. The investigation established that it was, in fact, due to 'aggregation' and an overall 'connection' which the bank had made with certain third party accounts. It was evident that Fergus was not aware of this for many years and the impact of any such 'connection' was never explained to him.

I substantially upheld the complaint and directed the bank to pay €15,000 in compensation.

In relation to these complaints, I accepted that the providers had a policy in place to aggregate certain accounts, in order to exercise appropriate credit management of customers who were connected. However, I had a difficulty with the conduct of the providers in 'connecting' or 'linking' accounts under an aggregation policy without the knowledge of the customer. I believe it is reasonable to expect providers to be open and transparent with their customers regarding these matters, to clearly inform customers that their accounts may be subject to this policy and to set out for its customers the most common reasons for aggregation and the potential impacts. For this reason, as part of my directions in these decisions, I directed the providers to review the approach of not informing customers of the existence of this policy.

Publication of decisions

The Oireachtas has given my Office significant statutory powers, including the power to publish my legally binding decisions. The Database of Decisions, available on our website, www.fspo.ie now contains the full text of more than 1,100 legally binding decisions, including decisions issued up to the end of February 2021 and those decisions contained within this Digest, some of which were issued after that date.

Given the increase in the number of decisions being issued and the increased interest in my decisions, I intend to publish my legally binding decisions on a monthly basis in the future.

In addition to publishing my legally binding decisions, I will continue to issue Digests of Decisions. By both publishing these decisions and the Digests of Decisions, I want to broaden the awareness of the role of this Office and promote a greater understanding of the types of complaints we receive and how we deal with complaints against financial service providers and pension providers.

Acknowledgements

Many of the decisions in this Digest highlight the difficult circumstances for complainants and providers, particularly since the start of the pandemic and I want to thank all our customers, both complainants and providers, for their cooperation with our various processes.

I wish to extend my thanks and acknowledge the support of the Chairperson, Maeve Dineen, and the members of the Financial Services and Pensions Ombudsman Council.

Finally, and in particular, I want to thank and pay tribute to the Deputy Ombudsman, MaryRose McGovern, the members of the Senior Management Team and all our staff for their ongoing commitment to delivering for our customers.

Ger Deering

Financial Services and Pensions Ombudsman

July 2021

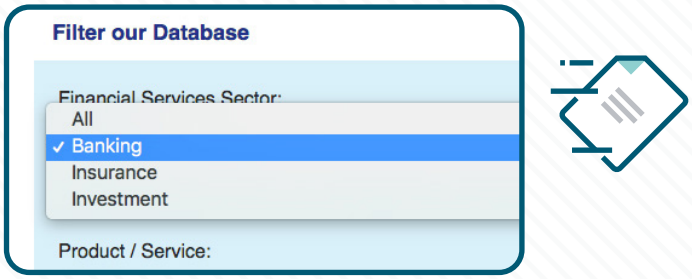
How to search our decisions on **www.fspo.ie**

Accessing our database of decisions

Our database of legally binding decisions is available online at www.fspo.ie/decisions. To refine your search, you can apply one or a number of filters.

1 Applying **filters** to narrow your search

To filter our database of decisions, you can firstly select the relevant sector:

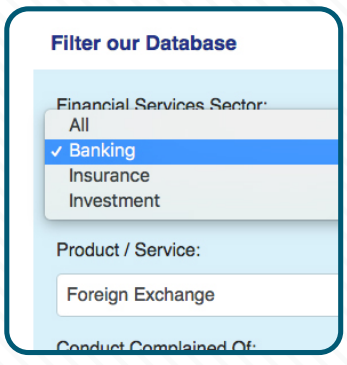


2

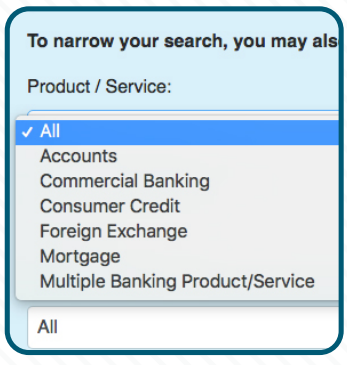
Having filtered by sector, the search tool will then help you to filter our **decisions** further by categories relevant to that sector such as:

- product / service
- conduct complained of

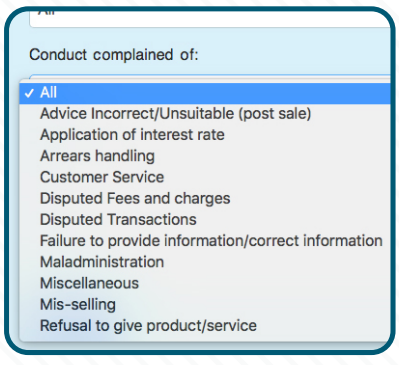
✓ Sector



✓ Product / Service



✓ Conduct complained of



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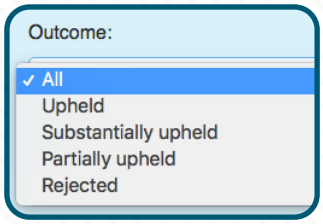
You can also filter our database of decisions by year, and by the outcome of the complaint, i.e. whether the Ombudsman Upheld, Substantially Upheld, Partially Upheld or Rejected the complaint.



Once you have found the decision you are looking for, click **View Document** to download the full text in PDF.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0052

Hair salon's business interruption claim rejected by insurer

Donna owned a hair salon and on 14 March 2020, Donna closed the hair salon, as she was unable to implement social distancing guidelines and she was aware of the presence of COVID-19 cases in the local area.

In May 2020, Donna made a claim to her insurer for business interruption losses as a result of the temporary closure of her business, on the basis of the wording of this contract clause:

> "The insurer will pay to the insured: ... Loss resulting from interruption of or interference with the business in consequence of any of the following events: ... any occurrence of a notifiable disease within a radius of 25 (twenty-five) miles of the premises".

The insurer informed Donna that her losses did not fall within the scope of the clause above and denied her claim. Donna complained, pointing out that there were three hospitals within a 25-mile radius that had cases of COVID-19 when she closed her premises. The insurer affirmed its decision. Donna referred her complaint to the FSPO and sought for the insurer to pay her claim for the maximum cover of €17,000.

In response to the Ombudsman, the insurer argued that Donna did not suffer any losses as a direct result of an occurrence of COVID-19 within 25 miles of her premises and that the Government's introduction of social distancing measures was a 'national response to a nationwide health issue' and were not 'in consequence of' any COVID-19 cases specifically within Donna's 25-mile radius. It also argued that Donna would have been forced to close regardless, as the social distancing rules, along with the eventual instruction for all non-essential retail to close, would have been enforced even if there were no COVID-19 cases in her 25-mile radius, due to the increasing incidents of COVID-19 nationwide.

The Ombudsman gave his preliminary decision to each party in January 2021. In his decision, the Ombudsman noted that Donna's contract stated that the insurer's maximum liability was 15% of the total sum insured, which amounted to €2,550.

The Ombudsman concluded that the reasonable interpretation of the clause in Donna's contract was that any occurrence of COVID-19 within the 25-mile radius was enough to trigger cover once it could be shown to have caused interruption to the business. The fact that there may have been COVID-19 cases outside the 25-mile radius was irrelevant.

The Ombudsman was satisfied that an occurrence of a disease, such as COVID-19, often brings with it public health interventions to prevent the risk of infection. The inclusion of the 25-mile radius in the contract would suggest, according to the Ombudsman, that the writers of the contract also believed this to be the case. Therefore, it could be said that COVID-19, which was a notifiable disease within Donna's 25-mile radius, caused an interruption and therefore loss to Donna's business. He found that by denying Donna's claim, the insurer had acted inappropriately, unfairly, unreasonably and unjustly.

The Ombudsman upheld the complaint and directed the insurer to make an advance payment of policy benefits of €2,000 to Donna, pending the calculation of the total benefit payable, as well as a further payment of €750 in compensation. Following a High Court decision in February, the insurer confirmed to the Ombudsman that it had recognised that the approach of the Ombudsman aligned with the Court's position. The insurer confirmed that it paid out €3,300 to Donna, which included the maximum entitlement of €2,550 as well as the €750 in compensation.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0183

Publican's claim for COVID-19 losses rejected by insurer

BKZ Holdings Limited (BKZ) owned a pub and in April 2020, it made a claim to its insurer for business interruption losses as a result of the temporary closure of its pub, due to the COVID-19 outbreak. BKZ's insurance contract stated that its business would be compensated for:

> "An imposed closure of the premises by order of the Local or Government Authority following ... outbreaks of contagious or infectious disease on the premises or within 25 miles of same."

Two weeks later, the insurer informed BKZ that it would decline its claim, on three grounds.

First, it did not believe that the clause applied to a global pandemic, but only applied in local cases within a 25-mile radius.

Second, it did not believe that the closure was caused by a local COVID-19 outbreak, but by a national shutdown resulting from the global pandemic.

Third, even if the closure was caused by a local outbreak, it did not believe that it could be said that the outbreak caused the business losses. Rather, in the opinion of the insurer, social distancing practices and public concern regarding the risk of infection would have caused the losses, regardless of whether the pub had been closed by order of Government Authority, as people would have been less likely to visit the pub.

BKZ appointed a claims manager who wrote to the insurer, providing evidence that cases of COVID-19 had been detected in a hospital, which was less than 5 kms away from the pub premises. The insurer informed the claims manager that it was upholding its original decision not to pay the claim. BKZ then referred its complaint to the FSPO.

In April 2021, the Ombudsman issued a preliminary decision indicating his intention to uphold the complaint, and to direct the insurer (i) to make an advance payment of a certain amount of policy benefit, pending the finalisation of the claim figures and (ii) to make a compensatory payment to BKZ, to recompense it for inconvenience caused by the insurer's disappointing approach to the claim, in early 2020.

The insurer advised in a submission to the Ombudsman, after the preliminary decision, that it had already made an interim payment of €19,000 to BKZ, representing 5% of the yearly maximum that could be paid out under its policy. It advised that further payments were pending the outcomes of further court litigation surrounding the issues. The Ombudsman noted that the insurer had in fact begun the process of paying the claim, and had reacted swiftly to start that process, after a particular judgment delivered by the High Court in February 2021.

The insurer also made several arguments against the Ombudsman's preliminary decision. It argued that 'almost all' insurers in the UK and Irish markets, had come to the same conclusion as it had, regarding the clause within the policy. It also argued that to determine that all insurers were 'automatically considered' to have acted inappropriately, just because they had 'subsequently turned out to have been incorrect', was itself inappropriate.

When the Ombudsman concluded the adjudication of the complaint, he made clear that his legally binding decision was based solely on the insurer's conduct, and not on the conduct of any other financial service provider.

Continued on page 13

Insurance

Continued from page 12

He confirmed that his decision was based on the facts and circumstances of this particular complaint, and was in no way an 'automatic' decision.

The Ombudsman found that BKZ had suffered great inconvenience as a result of the insurer refusing the claim for almost a year, and he took the view that BKZ ought to be compensated accordingly. The Ombudsman directed the insurer to make an additional advance payment of policy benefits of €28,500 to BKZ, to bring the benefit level paid to 12.5% of the maximum available under the claim, and he also directed the insurer to pay €20,000 in compensation.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0140

Insurer rejects business interruption claim from printing shop

Betty ran a printing shop and on 21 March 2020, at the beginning of the COVID-19 outbreak, she decided to temporarily close the shop, having realised that the shop would not be able to implement the Government's social distancing measures to keep employees and customers safe. The Government then ordered all non-essential retail to close three days later. In May 2020, Betty made a claim for business interruption losses as a result of the temporary closure, on the basis of the following wording in her insurance contract:

> "The insurer will pay to the insured: ... Loss resulting from interruption of or interference with the business in consequence of any of the following events: ... any occurrence of a notifiable disease within a radius of 25 (twenty-five) miles of the premises".

In June 2020, the insurer informed Betty that it was declining her claim, as her company's losses were not covered by the contract clause. Betty complained to her insurer about the decision in July 2020, but the insurer advised her that it was upholding its decision not to pay her claim. Betty then referred her complaint to the FSPO.

In response to the Ombudsman, the insurer argued that the clause in its contract only provides cover for losses when a specific outbreak of COVID-19, occurring within a 25-mile radius, has had a direct effect on the business. It stated that it was not enough that there simply happened to be COVID-19 incidents within the radius; these incidents must be the dominant cause of the business interruption. It argued that Betty closed her shop due to a Government response to a national health issue, not a localised event, and so this situation was not within the scope of the clause. When Betty complained about the decision, the insurer informed her that it had 'sought legal opinion,' which 'confirmed we had correctly interpreted' the clause.

It continued to argue this position until February 2021, when it informed Betty that a recent High Court decision had provided 'welcome clarity' as to how the clause should operate under Irish law. It then indicated that it would pay her claim.

In his decision, the Ombudsman was satisfied that, as social distancing measures had been required as a result of the COVID-19 pandemic and Betty had to close her shop as a direct result of being unable to implement social distancing in her shop, COVID-19 could be attributed as a cause of the losses under the contract. The Ombudsman concluded that Betty's company was entitled to a policy benefit payment as long as evidence of an occurrence of COVID-19 within a 25-mile radius was found around that time. The Ombudsman found that the insurer had not asked for evidence of this when considering her claim.

The Ombudsman also noted, that even if no evidence of a COVID-19 case could be identified around the time Betty closed her shop, Government legislation enacted on 7 April 2020 declared that 'every area' of the State was an area 'where there is known or thought to be sustained human transmission of COVID-19.' This declaration was sufficient evidence that there was a case of COVID-19 within Betty's 25-mile radius. This meant that Betty's claim should have been valid from at least 7 April 2020.

The Ombudsman took the view that the insurer's decision to decline Betty's claim was inappropriate, unfair, unreasonable and unjust. While the insurer later indicated that it would pay Betty's claim, the delay of eight months led to considerable inconvenience for her. The Ombudsman upheld the complaint and directed the insurer to pay €12,000 in advance payment of the policy benefit owed to her company for business losses, plus an additional €4,000 of compensation for the inconvenience caused by the delay in admitting the claim.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0072

Dental practice claim for business interruption

Gráinne is a dentist, who had an insurance policy on her dental practice. On 16 March 2020, Gráinne temporarily closed her dental practice, due to the general outbreak of COVID-19 in Ireland. The Government later issued a direction on 28 March for dental practices to cease providing routine dental services and to only carry out emergency dental treatments. The Dental Council also issued a statement which stated that most general dental procedures should not be carried out unless there was an appropriate level of PPE worn, which Gráinne did not have. As a result, the dental practice could not open.

On 30 March, Gráinne made a claim on her insurance policy for business interruption losses, as a result of the temporary closure of her dental practice due to the outbreak of COVID-19. In making the claim, Gráinne relied on the following clause:

> "We will also pay for: ... Loss of income and/or increased cost of working as insured by this section incurred by you as a result of interruption or interference with the business caused by: an outbreak of any notifiable disease occurring at the premises."

In April, Gráinne's insurer informed her that her claim did not fall within the scope of her insurance cover. Gráinne complained to her insurer in May, stating that her practice had been closed down by official orders to prevent the spread of a notifiable disease and that several cases had been recorded in the area where her practice was located. She argued that if the outbreak was not occurring on her premises, then there would not have been orders to stop trading. In June, the insurer informed Gráinne that its position was unchanged.

Gráinne then referred her complaint to the FSPO.

In response to the Ombudsman, the insurer stated that Gráinne's policy covered outbreaks on her premises. As a result, the insurer stated that, for cover to be triggered, it must be proven that an instance of COVID-19 illness in a person occurred at the premises, and it was that "outbreak"/occurrence at the premises, that caused the business interruption suffered. In this instance, the premises referred to the dental practice. The insurer noted that Gráinne had not provided any evidence that a person who had been at the premises prior to its closure on 16 March 2020 was ill with COVID-19.

In his decision, the Ombudsman was satisfied that the insurance policy made clear that there must be an occurrence for COVID-19 at the dental practice itself for cover to be triggered. While the Ombudsman accepted that the reasons Gráinne gave as to why the practice had been closed would cause loss to a business, those losses were not covered by the policy. Gráinne did not supply any evidence of on outbreak of COVID-19 at the dental practice itself. Therefore, the Ombudsman accepted that the insurer had not acted wrongfully in its decision and he did not uphold Gráinne's complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0187

Bakery's claim for business interruption and loss of stock

Emmet owned a bakery and cake shop and in April 2020, Emmet made an insurance claim for business interruption losses as a result of the temporary closure of his shop due to the COVID-19 outbreak. Emmet's insurer declined his claim, stating that Emmet was only covered for damage resulting from a disease found on the premises. The diseases covered by the policy, the insurer argued, did not include COVID-19.

In June 2020, Emmet complained to the insurer about its decision and also raised the matter of cover for loss of stock. The insurer wrote to Emmet to confirm it was upholding its original decision not to pay his claim. Emmet then referred his complaint to the FSPO.

In its response to the Ombudsman, the insurer gave four reasons as to why it rejected Emmet's claim. It claimed that the cover only applied for loss following damage to the property, that COVID-19 was not on the list of diseases that were covered by the policy, that there was no instance of any disease in the premises regardless and that it was not clear that Emmet's loss was caused by COVID-19 itself, but rather from the Government directive to close non-essential retail.

In respect of Emmet's claim for loss of stock, the insurer said that in order to make a claim for stock, the damage to stock had to be as a result of an insured peril. As Emmet's stock was not damaged as a result of an insured peril, namely one of the diseases listed on the insurance contract, there was no cover.

In his decision, the Ombudsman accepted that the contract was clear that it would only provide cover for damage in relation to the diseases listed in the contract, which did not include COVID-19.

The Ombudsman also accepted that Emmet's stock had not been damaged by COVID-19 itself, so it was therefore not covered in this respect. However, the Ombudsman found that there were two other clauses in Emmet's contract that referred to loss of stock which the insurer had not considered when it responded to Emmet's claim. The Ombudsman concluded that the insurer should have considered whether Emmet's claim was covered under the part of the contract that provided cover against 'business interruption resulting from deterioration or contamination of stock held for business purposes and stored in refrigeration plant.'

The Consumer Protection Code 2012, states that the insurer "must offer to assist in the process of making a claim, including, where relevant, alerting the claimant to policy terms and conditions that may be of benefit to the claimant." In light of this, the Ombudsman was not satisfied that the insurer identified all of the potential cover available under Emmet's policy that was applicable, or likely to have been applicable, to his claim for loss of stock. As a result of this, the Ombudsman was not satisfied that the insurer had properly assessed Emmet's claim for loss of stock, and he partially upheld the complaint. He directed the insurer to reassess Emmet's claim for loss of stock on the basis of the entire insurance contract and to make a compensatory payment of €750 in recognition of its failure to properly assess the claim.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0188

Claim for loss of rent by property owners

Orla and Pat held a business insurance policy on a property which they let out to a hairdresser. The couple submitted a claim to their insurance company in March 2020 for loss of rent, after their tenant was forced to close their salon due to the COVID-19 outbreak. They relied on the following clause to make their claim:

> "This extension provides cover against business interruption resulting from the following: A case or cases of any of the notifiable diseases (as listed below) at the premises, or caused by food or drink supplied from the premises."

The next month, the insurance company informed the couple that it had declined their claim. The couple complained to their insurer, arguing that there is 'no disputing that "business interruption" is included in the insurance agreement' and demanded the insurer 'make good on the clause.' The couple made a complaint to the Ombudsman on the basis that they had been assured over the phone that rent losses would be protected no matter what led to the closure to the property, and the insurer had never made them aware of any exemptions to this rule when the contract was signed.

In response to the Ombudsman, the insurer explained that it had informed the couple that it declined the claim for three reasons. Firstly, the list of diseases referred to in the above clause did not include COVID-19. Secondly, the clause stated that any losses suffered must result from a case of the disease in the premises itself, which in this instance meant the salon. No such case was reported. Third, the insurer had decided that the business interruption had not been caused by COVID-19, but because of 'social distancing practices and widespread public concern regarding the risk of infection.'

However, the insurer later stated to the Ombudsman that it had made an error in its advice to the couple, as the clause above only applied to customers insured against losses of gross profit or gross revenue. Since Orla and Pat were only covered for loss of rent, the above clause did not apply to them.

Under the couple's contract, their property was only insured against damage to the property, caused by a number of perils. Damage caused due to a disease was not one of the listed perils.

In his decision, the Ombudsman accepted that Orla and Pat's policy contract did not cover them for the claim that they wished to make. This was true regardless of whether or not the above clause applied to them, which, in the current situation, it did not. The Ombudsman also found no evidence that the insurer had informed them that rent losses would be protected 'no matter what.'

However, the fact that the insurer assessed the couple's claim using the ineligible clause showed that it had not properly reviewed the couple's policy before refusing their claim. In recognition of this error by the insurer, and given the confusion and ensuing inconvenience that it must have caused to the couple, the Ombudsman partially upheld the complaint and directed the insurer to make a compensatory payment to the couple of €750.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2020-0415

Physiotherapist's claim for business interruption losses

Dermot was a physiotherapist and in March 2020, he temporarily closed his practice due to the COVID-19 outbreak. He notified the insurance company of a claim for business interruption losses as a result of the temporary closure due to the outbreak of COVID-19. He relied upon the following clause in his contract:

> "Cover interruption or interference with the Business in consequence of an occurrence of a Notifiable Disease, the discovery of vermin or pests at the Premises, an accident causing defect in the drains or other sanitary arrangements at the Premises, all of which cause restrictions on the use of the Premises on the order or advice of the competent authority."

The insurer declined his claim, on the grounds that there was no outbreak of COVID-19 on Dermot's premises which had caused Dermot to close his business.

Dermot was dissatisfied with this response, stating that he believed that the policy wording was ambiguous on this matter. He stated that, by leaving out the words 'at the premises,' the clause could be read that the disease in question only had to exist in the community for a claim to be accepted. Following this, Dermot made a complaint to the FSPO.

In response to the Ombudsman, the insurer asserted that, as Dermot did not provide any evidence of a case of COVID-19 on the premises, it could not pay out the claim. Regarding the wording referenced by Dermot, it stated that this was sourced from a summary document, not the full contract.

The full contract read:

> "The insurance by this Policy will extend to include loss resulting from interruption or interference with the Business... in consequence of any occurrence of a Notifiable Disease at the Premises... which causes restrictions on the use of the Premises on the order or advice of the competent authority."

The Ombudsman was satisfied that the clause from the contract quoted by the insurer meant that a case of COVID-19 had to have been traceable to Dermot's premises. As there had not been one, he found that the insurer was entitled to decline Dermot's claim.

While Dermot was correct that the clause he quoted did not state that the disease had to occur at the insured premises, the Ombudsman found that the document the clause came from, namely, the Policy Summary of Cover, had clear wording which stated that it did not list all of the terms and conditions of the policy and was only a summary document. Accordingly, the Ombudsman did not uphold Dermot's claim.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0186

Solicitors' claim for temporary closure

A firm of solicitors held an insurance policy for its practice. In April 2020, the solicitors made a claim for business interruption losses against their insurance policy, as a result of the temporary closure of their practice due to the outbreak of COVID-19. Their insurance company declined the claim, stating that the solicitors' contract clause read as follows:

> 'We will pay for loss of income occurring during the indemnity period, resulting from damage by an insured cause... the definition of damage is extended to... an outbreak of any notifiable disease occurring at the premises.'

The temporary closure of the solicitors' premises was, according to the insurer, not as a result of an outbreak of a disease occurring at the premises. It also argued that any loss that occurred was as a result of the consequences of the pandemic and in particular the requirements of social distancing, not COVID-19, or any other disease.

The solicitors complained to the insurer regarding the decision, but the insurer advised them that its decision remain unchanged. The solicitors then brought their complaint to the FSPO, arguing that the insurer's reasons for declining the claim were 'not sound in law' as the clause above was ambiguous, given that the clause does not exclude a situation of a 'pandemic at the premises.'

In response to the Ombudsman, the insurer stated that since the solicitors had no cases of COVID-19 on the premises when it closed, there was no outbreak of a notifiable disease as required by the policy wording.

In his decision, the Ombudsman accepted that the language used in the policy contract was premises-specific, and the premises were clearly defined as 'the buildings and the land within the boundaries belonging to them.'

As a result, the Ombudsman was satisfied that the solicitors' policy, as it was written, required a case of COVID-19 to be found at the premises themselves. As there was no evidence of an outbreak of COVID-19 at the premises, the cover was not triggered. Accordingly, the Ombudsman did not uphold the complaint.

READ THE FULL DECISION HERE

Decision Reference: 2021-0002

Owner of dual businesses suffers losses

Alison operated two businesses at the same property, trading as both a Bed and Breakfast and another business, and held two separate insurance policies with the same insurer. Alison notified her insurer in March 2020 of a claim for loss of income, as a result of the temporary closure of her Bed and Breakfast and the other business, due to the outbreak of COVID-19. The insurer declined her claim.

As a result, Alison made a complaint to the FSPO and sought for the insurer to admit her claims for loss of income to the total amount of €550 per week, from 15 March 2020.

The policy wording offered cover for:

> "4. LOSS OF INCOME
>
> It is agreed that the Company will indemnify the Insured in respect of Loss of Trading Profit in the event of Loss of Income following damage to the insured Property caused by an insured Peril under Section 1.
>
> The maximum amount payable under this Extension shall not exceed €6,500 unless otherwise stated in the Schedule".

In response to the Ombudsman, the insurer stated that Alison was only covered for loss of income, on both policies, when the insured property suffered damage caused by any insured peril listed in the policy. The imposed closure of the premises by order of a local government authority, following the outbreak of a contagious or infectious disease, was not on the list of insured perils. As a result, the insurer had declined Alison's claim.

In his decision, the Ombudsman accepted that the insurer was entitled to decline Alison's claim for loss of income as a result of the temporary closure of her businesses due to the outbreak of COVID-19, as the terms and conditions of her insurance policies did not cover such circumstances.

The Ombudsman accepted that the contractual provisions agreed between the parties did not cover the circumstances in which Alison found herself, and accordingly, he did not uphold the complaint

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2021-0042

Dentist's claim for business interruption

Declan is a dentist, who held an insurance policy for his dental practice. In March 2020, Declan made a claim for business interruption losses as a result of the temporary closure of his dental practice from 18 March 2020 for a period, due to the outbreak of COVID-19.

The insurer declined Declan's claim in April 2020, and then, in a subsequent review in June 2020, stood by its original decision.

Following this, Declan made a complaint to the FSPO.

In response to the Ombudsman, the insurer explained that it had informed Declan that his insurance provided cover if the business at the premises was interrupted or interfered with as a result of loss or damage to contents or buildings. According to the insurer, no 'loss or damages' had been caused to the contents of the buildings or to the premises, nor was COVID-19 an insured peril that was covered in the policy. In addition, the insurer noted that there were no circumstances under which Declan's insurance policy provided cover where his business was closed due to the occurrence of a notifiable infectious disease at the premises.

Accordingly, the insurer argued that it had declined Declan's claim in accordance with the policy's terms and conditions.

In his decision, the Ombudsman accepted that Declan's policy clearly stated that, in order for his cover to be triggered, business interruption must have arisen from some loss or damage to either the contents of his dental practice or to the premises of the dental practice itself. There was no evidence that this was the case.

As the financial losses suffered by Declan were not caused by any damage, which was covered by the policy, the insurer was entitled to decline his claim and he did not uphold his complaint.

READ THE FULL DECISION HERE

Decision Reference: 2021-0144

Complaint regarding sale of insurance policy

Ivana was a partner in a business partnership. In 2009, she took out a 'key person' insurance policy with the insurance company through a financial adviser. The policy protected the business she ran with the partner, in the event of her death.

In 2010, the partnership dissolved and Ivana set up a new company where she was the sole director. In 2012, Ivana asked the insurer to transfer the insurance policy to her new company. The insurer did so and continued to take monthly premiums in payment for the policy.

Ivana wound down that company in 2019 and sought to transfer the policy to cover her in a personal capacity. The insurer refused, and Ivana was advised by a broker to cancel the policy, as it could not be transferred to her in a personal capacity.

The broker also advised that the policy should never have been transferred to her new company after the partnership dissolved. As a single director company, the policy was no longer appropriate for her circumstances.

Ivana stated that the insurer should have advised her in 2012 that this was the case. In her complaint to the FSPO, Ivana stated that the insurer facilitated the transfer of ownership of a key person policy, that was not suitable for her needs or for her company's needs. Ivana was also unhappy that the insurer refused to transfer the ownership of the policy, into her personal name in 2019.

In response to the Ombudsman, the insurer stated that Ivana's financial adviser was copied on every email during the process of moving the policy from the dissolved partnership to the new company in 2012.

The insurer said that it did not act as adviser to Ivana or her company at the time of the change of ownership and it had no obligation to provide advice.

Regarding the request to transfer the policy to a personal capacity, the insurer stated that it couldn't fulfill the request, as it would alter the purpose for which the policy was taken out. The purpose of a key person policy is to ensure that a suitable benefit payment will be made to a business in the event of the death of a key employee. By definition, it cannot be used to make a payment to a person, therefore it is not suitable as a personal policy.

In his decision, the Ombudsman found that when Ivana asked the insurer to transfer the policy over to her company, she signed an 'Ownership Declaration' which stated that the insurer 'does not accept responsibility for the suitability of this form in any particular case or for its legal... consequences.' The Ombudsman also accepted that Ivana did have independent financial advice throughout the process.

The Ombudsman did not accept that the insurer was obliged to assess or advise Ivana as to the appropriateness of the desire to change the ownership of the policy from the partnership to the company. The Ombudsman also found that the insurer did not indicate or approve the suitability of the ownership change, simply by carrying out Ivana's instructions in 2012. The Ombudsman also accepted that the policy was a business policy and it would not be appropriate for the insurer to transfer the cover to a personal capacity, owing to the very significant difference in the purpose of cover.He did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2020–0037

Farm policies cancelled after fire

Joe held a number of farm insurance policies with an insurer. On a night in July 2016, his farm and machinery were set on fire. Joe notified his insurer of the fire and the following day one of their representatives attended his farm. The insurer paid Joe approximately €265,000 in respect of these claims but during its investigation it became aware of an ongoing dispute and that the fire was caused by a malicious act. The insurer cancelled four of Joe's policies in September 2016 on the basis of this information.

Joe stated that he was only given four days' notice of the cancellation of his policies and that he was not informed what the matters of concern were that led to the cancellations. He submitted that when he requested the arbitration clause in the various policies be invoked, the insurer replied advising him to make contact with the FSPO.

Joe contended that the events caused him extreme stress and frustration after having to deal with the destruction of his farm and business and that he felt his good name and character was ruined by the insurer. Joe further stated that he had lost his income and that he could not get insurance from any other insurer due to the cancellation.

The insurer stated that although the claim proceeded to settlement, the information the claims department discovered in relation to his dispute, together with the cause of the fire being malicious in nature, were matters of grave concern with regard to the continued operation of the policies. It said that it acted within the terms of the contracts in making the cancellations and that the reasons behind the cancellations were discussed with Joe's loss assessor. The insurer pointed out that after discussions, it did offer liability-only insurance to Joe but that he did not take up this offer.

The Ombudsman found that the insurer had advised Joe in a very vague and general manner that his policies were cancelled. He pointed out that a decision to cancel a policy of insurance has significant implications and consequences for the insured and he found it unreasonable not to provide Joe with the reasons for its decision.

While the Ombudsman accepted that the period of notice was as required from the date of each notification letter, he believed it was unreasonable for the insurer to cancel the policies in the manner in which it did. The Ombudsman stated that it would have been more reasonable for the insurer to decide not to renew Joe's policies when they expired approximately three months later or, at the very least, to better communicate the intention to cancel the policies. The Ombudsman welcomed that the insurer later offered a more limited form of insurance, but noted it was unfortunate that this compromise was not offered in the first place.

The Ombudsman partially upheld the complaint and directed the insurer to once again offer the liability only insurance for Joe to consider. He also directed the insurer to pay a sum of €3,000 compensation.

READ THE FULL DECISION HERE

Decision Reference: 2020-0344

Professional indemnity claim denied

Dr. S took out a commercial insurance policy for his surgery with an insurer through his broker. In March 2018, one of his employees sustained an injury while working, sustaining a significant cut from a scalpel. Dr. S administered a number of sutures to the wound and another employee drove the injured employee home. The employee later attended hospital and received vaccines for hepatitis B. The employee also completed an internal accident report for the incident.

In January 2019, Dr. S's broker notified his insurer that legal proceedings were being taken by the employee against the surgery and he made a professional indemnity claim on the policy. Dr. S stated that the delay in notifying his insurer was because he was not initially aware of any potential claim until notified by the Personal Injuries Assessment Board (PIAB) that it had authorised the employee to pursue legal proceedings in September 2018. Even at this point, he considered it was still not clear there was a claim until he heard further from the employee or her solicitor. Ultimately his HR advised him to notify his solicitors of a claim and the insurer was contacted. The insurer denied Dr. S indemnity due to the lack of early and immediate notification of the incident.

The insurer submitted that such a serious incident is precisely the type of event that requires early and immediate notification, so it is afforded the opportunity to carry out an early investigation and, if appropriate, seek to resolve the matter in a timely manner. The insurer also observed that it was very evident from the PIAB letter that the employee was making a personal injuries claim and had appointed solicitors.

It further noted that in November 2018, the employee's solicitors wrote to Dr. S with a Circuit Court Personal Injuries Summons and following a lack of response, to this and a subsequent letter, ultimately a Motion for Judgment in Default of Appearance was served, all before they were notified.

The Ombudsman accepted that the incident which occurred in March 2018 was not an insignificant or minor injury. He noted that Dr. S was aware of the incident on the day it occurred, as he was the one who administered the sutures and because it was his business and his employee, he ought reasonably to have been aware of their attendance at hospital.

When considering correspondence received from PIAB, the Ombudsman found it was clear that a claim for compensation was being made by the employee. Moreover, despite the advanced stage of matters, by December 2018, he had still not notified the insurer. The insurer was first notified of the claim more than 10 months after the incident occurred and no reasonable explanation for the delay, was provided.

The Ombudsman found that the obligations placed on Dr. S by his policy were clear and required him to act with immediacy and urgency in respect of essentially anything that may give rise to a claim. The Ombudsman accepted that the insurer was entitled to refuse indemnity to him and he did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2020-0371

Property owner's claim for reduction in rent rejected by insurer

Patrick owns a commercial property with a tenant who trades as a restaurant. The tenant was unable to pay the monthly rent in full, due to its temporary closure arising from restrictions brought in during the outbreak of COVID-19.

Patrick contacted his insurance company in April 2020, to query making a claim about loss of rent. He was advised that the criteria for cover were a verified financial loss as a result of an outbreak of disease at the premises itself and the subsequent closure of the premises on the advice of the relevant authority as a result.

The policy wording provided that:

> "Notifiable Disease
>
> The insurance by this Policy will extend to include loss resulting from interruption or interference with the Business carried on by the Insured at the Premises in consequence of:
>
> 1. (i) any occurrence of a Notifiable Disease (as defined below) at the Premises or attributable to food or drink supplied from the Premises
>
> (ii) any discovery of an organism at the Premises likely to result in the occurrence of a Notifiable Disease ...
>
> which causes restrictions on the use of the Premises on the order or advice of the competent authority ...
>
> Special Conditions
>
> (a) Notifiable Disease means illness sustained by any person resulting from:
>
> (i) food or drink poisoning or
>
> (ii) any human infectious or human contagious disease (excluding Acquired Immune Deficiency Syndrome (AIDS) an outbreak of which the competent authority has stipulated will be notified to them".

In his complaint to the FSPO, Patrick stated that for the months of April and May, his rental income was reduced by approximately €2,000 but that his insurance company had declined to accept any responsibility. He had expected that his insurance policy would cover him in the event of any loss of earnings.

The insurance company argued that the relevant cover only applies when a business is impacted by the occurrence of a disease at the insured premises. Patrick had not advised of an occurrence of COVID-19 at the restaurant itself, only of the Government order in March 2020 for all restaurants to close, implemented to assist in stopping the spread of COVID-19. The Insurance company stated that whilst this did impose a restriction on the use of the insured premises, it was not specifically related to an outbreak at his restaurant. As a result, they did not believe that the policy criteria were satisfied.

The Ombudsman stated that like all insurance policies, Patrick's property owner's insurance policy did not provide cover for all eventualities and was subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

He accepted that the insurance company correctly advised Patrick that the terms and conditions of his insurance policy did not cover the situation he found himself in. As this was not a situation that was covered by the terms of the policy in place, the Ombudsman did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2020-0372

Retail property owner's claim for loss of rental income rejected by insurer

Ibrahim owned a property which was let as a charity shop. As a result of nationwide Government COVID-19 restrictions, the tenant was unable to pay the monthly rent in full, due to its enforced temporary closure.

The tenant had only been able to pay 50% of rental costs from 15 April 2020, resulting in a net monthly loss of nearly €1,400. The rent was Ibrahim's main income and means of providing for his family. Ibrahim initially telephoned and then emailed the insurance company to inquire about a claim for loss of earnings. His insurance company advised him that he was not covered as the outbreak of a disease is not listed as an 'insured peril' in the property owner's insurance policy. The cover for loss of rent only arises in circumstances where there is actual damage to the property arising from an insured peril.

The insurance company noted that the policy wording provided that:

> "Item on Rent
>
> The Company will pay in respect of buildings which have suffered Damage
>
> A the loss of rent being
>
> the actual amount of the reduction in the rent receivable by the Insured during the Indemnity Period solely in consequence of the Damage
>
> B the additional expenditure being
>
> the expenditure necessarily and reasonably incurred in consequence of the Damage solely to avoid or minimise the loss of rent during the Indemnity Period but not exceeding the amount of the reduction avoided by such expenditure
>
> except that in the event of underinsurance the amount payable shall be adjusted in accordance with special provision 4 ['Underinsurance']".

The insurer said in the initial response to Ibrahim, that he was advised that in order to be covered for loss of earnings there would need to have been an outbreak of the disease at the premises, resulting in its closure by the relevant authority. The insurance company subsequently noted that this was not correct information for the insurance policy in question and that the loss of rent cover only applied in circumstances where there is actual damage to the property.

The insurance company also acknowledged that Ibrahim's initial query should have been passed to the Claims Team for consideration and it offered €250 compensation as a result of the delay in registering the claim and assessing it, which he accepted.

Notwithstanding this, after fully assessing the claim, the insurance company declined Ibrahim's claim as there was no actual damage to the property and therefore it did not fall within the remit of the cover.

The Ombudsman was satisfied the insurance policy only provided cover for loss of rent, where that loss has occurred as a result of damage to the building rented and where the damage falls under one of the insured perils listed in the policy document. There was a broad range of insured perils covered in the policy but outbreak of a disease was not one of these.

The Ombudsman accepted that the insurance company was entitled to decline his claim and he did not uphold the complaint.

Insurance

READ THE FULL DECISION HERE

Decision Reference: 2020-0484

Business owner's public liability claim rejected by insurer

Terry took out an insurance policy for his business premises with an insurer in July 2014 and renewed cover on 20 August 2015. The policy included public liability insurance. Terry made a claim in early 2016 when a member of the public claimed to have suffered an injury after a fall in a corridor.

Terry stated that the insurer firstly 'reserved their rights in respect of the claim' and temporarily suspended his policy after commissioning a survey and asserting that repairs were required on the premises. After the repairs were carried out, the insurer then declined his claim. Initially it relied on two clauses relating to the work required at the premises and one clause relating to CCTV requirements.

Terry queried the validity of all three clauses and made a complaint in relation to the instruction to undertake repairs, the suspension of the policy, the reliance on the CCTV clause and subsequent denial of the claim.

The insurer initially maintained that it was entitled to reject the claim on all three clauses noting that the terms and conditions of the policy entitled it to request Terry to complete repair works and that there was an obligation to 'make' and to 'retain' CCTV footage (as opposed to simply having a CCTV camera). Following extended interaction between Terry and his insurer, it abandoned its reliance on the two clauses relating to repairs. This stemmed both from the fact that the clauses had been misquoted and that a survey commissioned by the insurer did not actually support any breach of terms.

The Ombudsman noted that the policy endorsements quoted in relation to repairs were indeed misquoted, as the wording cited in letters to Terry imposed a greater onus on him, than the actual wording contained in his policy.

In considering the clause relating to CCTV, the Ombudsman noted it was clear that the policy did not expressly require the maintenance of a CCTV system to record or to 'retain' footage. The Ombudsman therefore accepted that none of the grounds the insurer relied on for rejecting the claim were justified.

In relation to the temporary suspension of cover, the Ombudsman accepted that the insurer was entitled to carry out a risk survey and to detail certain risk minimisation work that must be completed in order for cover to be retained, but he took the view that no legal basis had been shown for the suspension of the policy.

The Ombudsman had serious concerns about the manner in which the insurer sought to deny the claim. However, he welcomed that the insurer, on receipt of the preliminary decision, acknowledged its errors, provided an explanation for its conduct, outlined the measures taken to avoid a recurrence and indicated its willingness to admit the claim and pay compensation.

Given that the insurer had not acknowledged its errors until after it had received the preliminary decision, the Ombudsman substantially upheld the complaint and directed the insurer to admit the claim for assessment of benefit, to make a payment of compensation of €20,000, and to pay all reasonable legal expenses already incurred by the complainant.

READ THE FULL DECISION HERE

Decision Reference: 2020-0165

Company not indemnified after failing to immediately notify claim

In July 2016, LMNO Construction (LMNO) notified its broker by telephone of an accident experienced by one of its employees, but 'due to an oversight' on the part of the broker, it did not notify the details to the insurer.

In January 2017, a letter from a solicitor acting for the injured party was forwarded to the broker, who in turn forwarded the letter to the insurer's claims representative shortly after. LMNO paid the policy excess after a loss adjuster was appointed in March 2017 and it believed that the insurer was dealing with the claim. However, it was informed later that the insurer was not in a position to offer indemnity under the policy based on the late notification.

The broker who supported LMNO in making a complaint to the FSPO, fully accepted that it had made an innocent error, but did not accept that this prejudiced the insurer in any way in its investigation of the claim, submitting that all data/witnesses were still available for interview and that time was clearly not of the essence given the loss adjustor did not investigate the matter for three months.

The insurer stated that the reason it refused indemnity was because LMNO did not fulfil the claims notification requirements contained within the policy which specified 'immediate' written notice. The insurer submitted that a 175-day gap between the incident occurring, and the notification could not reasonably be termed immediate. The insurer further stated that the request for payment of the excess was standard and did not amount to a confirmation it had accepted the claim.

The Ombudsman noted that the facts of the matter were not in dispute between the parties. Furthermore, there was no dispute that there was a clause which placed an obligation on the policy holder to 'immediately' give notice of any event which may give rise to a claim.

In light of this, the Ombudsman accepted that a delay of 175 days did not meet the requirements of the claims procedure, albeit that the delay was caused by the broker.

The Ombudsman also accepted that while the insurer did not need to demonstrate prejudice to decline the claim, it was likely that it would in fact have been prejudiced in its ability to defend it, because it could not conduct a prompt and proper investigation.

The Ombudsman did not accept that the request for the payment of the excess amounted to a confirmation of cover. He did, however, believe it unreasonable of the insurer not to return the excess and noted that this eventually occurred, but only after a significant delay. The insurer offered €250 in compensation for this delay, which the Ombudsman found to be adequate.

The Ombudsman accepted that the insurer was entitled to refuse to indemnify LMNO and he did not uphold the complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2021-0016

Company account is 'reclassified' by bank without customer's knowledge

XZ Ventures Ltd. (XZ) held a business current account with a bank. It became aware in July 2012 that this account was transferred into the bank's 'non-performing' section, despite XZ's contention that it did not have any debt. XZ only became aware of the change through a separate complaint it had made to the FSPO. XZ complained that it was not notified of this change by the bank and further contended that the bank consistently failed to give an explanation for it. The account remained in this classification between May 2012 and December 2013.

The bank submitted that the management of the account was 're-tagged' internally within its restructuring section in July 2012. It explained that this is an internal process and can happen without a customer being aware. The bank said that it is not dictated by arrears on an account, though typically accounts with arrears are reclassified. It further clarified that the account was re-tagged under its 'aggregation policy' where it makes linkages between accounts for various reasons, including shareholders, partners, signatories, family connections, and common risk factors. It argued that it was not obliged to share its internal policies in this regard.

While the bank accepted that it was standard practice to issue a handover letter confirming a transfer to its restructuring section, to all borrowers in a particular connection, in these circumstances, where XZ was not a borrower, it argued that there was no such requirement. The bank made the point that the credit grading on the account never changed. It apologised for the concern that the matter had caused and offered a goodwill offer of €500.

The Ombudsman accepted that the bank was correct in pointing out that 'aggregation' is a requirement under prudential regulations imposed by the Central Bank and accepted its entitlement and indeed, duty, to aggregate accounts. However, he had difficulty with the bank's conduct in 'connecting' or 'linking' the company account, without the knowledge of XZ. This left XZ at a complete loss to understand why its account was being managed in the manner it was.

The Ombudsman believed it reasonable to expect the bank to be open and transparent with its customers regarding the fact that it has an aggregation policy, to clearly inform customers that their accounts may be subject to this policy, and to set out for its customers the most common reasons for aggregation and its potential impacts. He therefore directed the bank to review its approach of not informing customers of the existence of this policy.

The Ombudsman noted the offer of €500 in compensation but, given the seriousness of the information withheld and the inconvenience caused in seeking clarification, he believed this to be inadequate. He substantially upheld the complaint and directed the bank to pay a sum of €3,000 in compensation to XZ.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2020-0455

Bank transfers business loan to third-party and freezes current account

Fergus took out a business loan for €589,000, repayable over a 20-year term, to his bank. This loan was restructured in 2009 when he had difficulty repaying the loan for a short period of time. Although the account fell into arrears for a period of four months in 2011, Fergus challenged the bank's later assertion that there was a history of arrears. He believed the late payments the bank referred to, were a result of automation issues.

The bank wrote to him in October 2015, advising him that he had to repay the loan in full, or seek alternative arrangements within 60 days. Although he queried this, he received no response until he was advised in April 2016, that his loan was now with the 'Problem Debt' division. Despite numerous and ongoing attempts to discuss the matter with the bank, Fergus was notified in October 2016 that his loan was being transferred to a third party. Fergus also submitted that the bank froze his current account in late 2016, resulting in failed direct debits for his loan and life assurance and that he again made several attempts to get an explanation, without success.

Fergus complained that the bank never explained to him that his loan could be sold to another entity, that his requests for an explanation went unanswered, that the bank failed to explain when, why or how the loan became a problem debt and that the loan was not 'non-performing'. Fergus also raised an issue with the bank's policy to 'aggregate' certain loans with 'familial connections' when this became known to him, while his complaint was being investigated by the Ombudsman.

The bank responded that Fergus agreed to the terms and conditions of the loan. Furthermore, it stated that a loan did not need to be considered as non-performing in order to sell the debt to a third-party.

It asserted that a history of arrears raised concerns over the long-term viability of his loan and that once the final deadline for the loan account closure had elapsed, it was not under any obligation to accept any further transactions on his current account.

In relation to the sale of the loan, the Ombudsman noted that the bank could not supply a copy of the applicable terms and conditions due to the 'significant passage of time'. It was also clear that the bank communicated very little with Fergus from October 2015 to December 2016 with regard to both his loan and current account, despite Fergus's efforts. No reference was made to his current account until a letter dated October 2016, which was issued to an incomplete address and highly unlikely to have been received by Fergus.

Although the bank issued a notice of closure in relation to his account, in October 2015, this did not actually happen until December 2016, over a year later. Given the absence of contact from the bank regarding either of his accounts in the interim, the Ombudsman was of the view that it was reasonable for Fergus to assume that the notice was an error or had been withdrawn. A subsequent lack of clarity regarding the classification of his loan as 'non-performing' was also extremely unhelpful. Fergus made repeated efforts, to no avail, in an effort to try to understand why his accounts were being managed in the manner in which they were. The reason only became clear during the investigation by the FSPO.

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Banking

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The Ombudsman did not accept the bank's argument that it had moved the account to the problem debt division due to 'a history of arrears on the loan account'. He was of the view that it was due to 'aggregation' and the overall 'connection' with third-party accounts. It was evident that Fergus was not aware of this for many years and the impact of any such "connection" was never explained to him. While the Ombudsman accepted that the bank had a policy in place to aggregate certain loans so that it may exercise appropriate credit management of customers who are connected, he believed it was reasonable to expect the bank to be open and transparent with its customers.

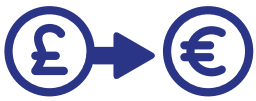
The Ombudsman directed the bank to review its approach of not informing customers of the existence of this policy. In addition, having regard to all the failings he had identified, the Ombudsman substantially upheld the complaint and directed the bank to make a compensatory payment of €15,000 to Fergus.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2020-0278

Refinancing a GBP loan to Euro



Saoirse and Mia had a property investment business. They purchased an investment property in the UK with the assistance of a loan in GBP from a lender. They asserted that when their relationship manager moved jobs to a new lender, he approached them to refinance their loan with a Euro loan using a forward foreign exchange contract (FFEC) to mitigate the risk of currency fluctuations. Saoirse and Mia explained that when the UK interest rate was high, compared to Euro rates, the lender suggested they consider converting their loan to Euro, as it would be to their benefit.

As their investment property was rented, the rent was used to service and repay the underlying borrowings. Rent was received in GBP and as a result of subsequent strengthening of GBP against the Euro, and the drop in the value of property, they found themselves in a position that they were unable to repay their loan, in a large part due to the conversion of the loan to Euro.

They believed that these facilities had been mis-sold to them, that they should have had the risks involved explained to them and they should have been advised to obtain independent financial advice. They also complained that they were advanced €250,000 more than was required to refinance the loan.

The lender stated that it was approached by representatives of Saoirse and Mia first in relation to refinancing and that the pair, of their own free will, sought to convert their loan to Euro. It stated that the option to avail of legal advice was always open to them and that they were evidently very experienced in dealing with commercial transactions. It contended that the offer letter from the business unit of the lender was very clear and that it was their choice to accept the terms.

The lender did not see what detriment they could have suffered by entering into the FFEC. It did not dispute the sum advanced and provided a detailed breakdown of how it was dispersed.

The Ombudsman noted that while Saoirse and Mia did not appear to have been professional investors, they were nonetheless very wealthy individuals with a number of investment properties and a familiarity with exchange rates and awareness and involvement in their financial affairs.

The evidence suggested that they or someone on their behalf approached the lender with a view to refinancing the loan. The Ombudsman was not satisfied there was anything about the Euro loan that rendered it unsuitable or that the lender misrepresented it. Neither was he provided with any evidence to suggest the lender recommended or advised an FFEC. It appeared that Saoirse and Mia had some form of advice around the time they entered into the loan agreement. The Ombudsman was satisfied there was no obligation on the lender to advise them to seek advice or that the loan was mis-sold.

While Saoirse and Mia asserted that more funds were advanced than were necessary, the Ombudsman noted that they signed and accepted the loan offer letter, which clearly stated the amount being advanced, and it was open to them to draw down no more than was necessary. He did not uphold the complaint.

Banking

READ THE FULL DECISION HERE

Decision Reference: 2020-0019

Company says bank should not have made loan facilities available

PY Products (PY) first took out a business loan of €35,000 with its lender in August 2008. This was followed by a temporary overdraft in December 2009 and a top-up loan of approximately €13,000 and restructure of payments in January 2010, as the business was struggling to keep up with its outgoings. The repayments were set to semi-annually in May 2010.

The directors of PY stated that the top-up loan was wrongfully granted as it should have been obvious at the time that PY could not maintain repayments at the current level. They also maintained that the loan agreement of May 2010 was 'reckless', setting PY on a difficult road with interest penalties and extra interest mounting as a result of no regular payments being made.

The directors also made a complaint that in June 2011, a request for a small overdraft had been refused on the grounds of PY's inability to repay. Overall, they submitted that the lender did not act in the best interests of PY and the directors were unhappy with the application of interest, interest surcharges and penalties on the business loan and business current account.

The lender submitted that each application for credit was assessed on its own merits and that PY willingly entered into the agreements on a fully informed basis. In relation to the overdraft request, the lender noted that it could not be sanctioned as the account was being managed by its collections department. The lender stated that PY knowingly applied for refinance of its original business loan and amended the repayment frequency. It pointed out that the terms and conditions advised of the interest and fees applicable and these were validly and correctly applied.

A further arrangement in May 2014 provided that interest would be suspended, however the lender acknowledged that owing to an administrative error, this did not occur and it offered the return of €1,543 in that respect.

The Ombudsman noted that PY, by its own admission, had applied for the loans, drawn down those loans, and utilised the funds. He took the view that as the original loan was not in arrears, there was no reason for the lender not to facilitate the top-up or subsequent restructures applied for. He noted that the courts have made it clear over the last number of years that there is no legal basis to an allegation of 'reckless lending'. He would not interfere with the lender's commercial discretion in refusing an overdraft facility.

The Ombudsman noted that PY expressed dissatisfaction at being granted the loan and equally was not happy with not being granted an overdraft facility and it was difficult to comprehend the apparent conflict in those positions. Whilst he noted PY's difficulty in meeting its repayments, it remained the case that it was contractually obliged to make them.

The Ombudsman however, partially upheld the complaint, pointing out that it was disappointing that the lender had not yet returned the €1,543 in interest owed to PY. He directed the lender to repay this amount together with a repayment of surcharge interest of €580, which the lender no longer sought to charge. He also directed the lender to make a compensatory payment of €850 to PY.

3 STEPS to making a complaint to the FSPO

1 Contact your provider

You should make your complaint with whoever provided the service or product to you, this could be your bank, insurance company, credit union, money lender etc.

You should speak or write to either the person you usually deal with, or ask for the complaints manager to make a complaint.

What information should you give them?

- ☑ **Make it very clear that you are making a complaint.**
- ☑ **Explain your complaint.**
- ☑ **Suggest how they should put it right.**

Provide detailed information, including:

- **Relevant dates, places and times**
- **Details of any phone conversations and meetings** (e.g. who was involved, when they took place and what was said)
- **Copies of relevant documents,** such as contracts, statements, emails, letters, invoices and receipts.

BEFORE MAKING A COMPLAINT TO THE FSPO, YOU MUST GIVE YOUR PROVIDER A CHANCE TO SORT OUT THE PROBLEM.

2 Be patient and persistent

The provider should deal with your complaint through its complaint handling process. The provider may take up to 40 working days to deal with your complaint.

When you complain to the provider be persistent. If nothing happens, call the provider to check on the progress of your complaint.

The provider should fully investigate your complaint, in accordance with its internal dispute resolution process. This is known as IDR.

At the end of IDR, the provider will let you know its position regarding your complaint, so that either:

- The provider issues a final response letter and you are satisfied with the resolution of your complaint.
- The provider issues a final response letter and you are not satisfied with the resolution of your complaint.

A final response should set out what the provider has done to investigate your complaint through its internal dispute resolution process. It should advise you to contact the FSPO as your next step, if you are not satisfied.

3 Contact the FSPO

If you are not satisfied after receiving your final response letter, you may contact the FSPO. To progress your complaint, we will need:

A A fully completed complaint form

&

B A copy of your final response letter.

If you are having difficulty getting the final response and 40 working days has passed or if your provider is not engaging with you, please let us know and we will follow up on the complaint for you.

An tOmbudsman Seirbhísí
Airgeadais agus Pinsean

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