

annual
report
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Financial Services
Ombudsman



Our Mission Statement

To adjudicate on unresolved disputes between Complainants and Financial Service Providers in an independent and impartial manner thereby enhancing the financial services environment for all sectors.



ANNUAL REPORT 2008

Presented to the Oireachtas under Section 57BR of the Central Bank and
Financial Services Authority of Ireland Act, 2004.

PRN: A9/0462

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FINANCIAL SERVICES OMBUDSMAN

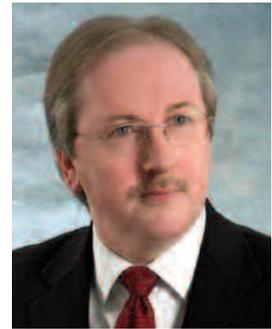
ROLE AT A GLANCE

As Financial Services Ombudsman I can investigate, in an impartial and independent manner, complaints from individual customers and small businesses who have unresolved disputes with Financial Service Providers who are either regulated by the Financial Regulator or are subject to the terms of the Consumer Credit Act 1995.

I can award compensation of up to €250,000 where a complaint is upheld. My findings as Ombudsman are binding on both parties subject only to an appeal by either the Complainant or the Financial Service Provider to the High Court.

My role is therefore a quasi-judicial one and whether a complaint can be upheld or not is determined on the basis of evidence furnished, examined and reviewed.

CHAIRPERSON'S REPORT



In what was a very busy and challenging year, additional change was introduced when the new Financial Services Ombudsman Council, comprising five members of the outgoing Council and two new members, came into being on 29 October 2008.

As one of its statutory functions, as prescribed by the Central Bank and Financial Services Authority of Ireland Act 2004, Council appointed the Ombudsman and the two Deputy Ombudsmen in 2005. Thereafter and throughout 2008 the business of the Council related mainly to discharging its other statutory functions which are:

- ❖ *to prescribe guidelines under which the Ombudsman is to operate;*
- ❖ *to determine the levies and charges payable for the performance of services provided by the Ombudsman;*
- ❖ *to keep under review the efficiency and effectiveness of the Office and to advise the Minister for Finance, either at the Minister's request or at its own initiative, on any matter relevant to the Ombudsman's operation, and*
- ❖ *to advise the Ombudsman on any matter on which he seeks advice.*

While the Ombudsman is responsible for the operation aspects of the Financial Services Ombudsman's Bureau (the Office) finances, the Council, acting on the advice of the Minister for Finance, has overall responsibility for accounting standards. To that end the Council, with the assistance of the Audit Committee, ensured that Government policy on the pay and conditions of service of the Ombudsman, the Deputy Ombudsmen and all staff members has been complied with, as well as Government guidelines on the payment of Council Members' fees and expenses. The Council noted that the Guidelines for the Appraisal and Management of Capital Expenditure Proposals are being complied with and that appropriate Corporate Governance principles

are also reviewed and monitored for effectiveness in application. The Council adheres to the Standards and Ethics in Public Office legislation and has ensured, and will continue to ensure, that the appropriate Statements of Interests are made by both by the Council members and by the relevant staff of the office of the Ombudsman.

The Council has no role regarding complaints resolution, as this is statutorily the independent function of the Financial Services Ombudsman. However, the Council cannot ignore the constant and not insignificant increase in the Bureau caseload and the complexity of the matters the Ombudsman has had to consider. Despite these difficulties the overall throughput and the public profile of the office is both impressive and crucial to providing much needed consumer confidence. Council is also monitoring the effect of High Court judgments on the Ombudsman's role and will keep under review the new procedures the Ombudsman put in place resulting from the judicial review judgment of July 2008.

Council is anxious to ensure that the expeditious, accessible and informal approach which the Ombudsman is statutorily required to adopt is not replaced by a more formal tribunal styled format. When considering the 2009 budget, Council determined that the legal fees as set out were such as would be necessarily incurred in the normal course of business expenditure of the Bureau. Council is confident of the careful and prudent consideration and measures adopted by the Ombudsman in ensuring expenditure at a level that was appropriate.

I am greatly honoured to be appointed by the Minister for Finance as Council's Chairperson and I wish to state my high regard and gratitude to all of my fellow Council Members who each give of their significant expertise with true professionalism and consideration. A special



note of sincere thanks and appreciation extends to the former Chairperson, Con Power, and the three outgoing Council members for their understated role and input to successfully ensuring the establishment and operational capacity of what is an exemplary Office in the financial services regulatory arena. This Council will use its best endeavours to ensure that remains the position and, where possible, enhance it.

On behalf of myself and my colleagues on the Council I would mention how we are appreciative of the significant input of the former Secretary to the Council, Michael Brennan and that of the current Secretary Jim Bardon.

I also wish to pay tribute to the Minister for Finance and the staff of his Department, for the time and the support to my, the Council's and Ombudsman's role.

Finally, I wish to thank in particular Joe Meade, Deputy Ombudsmen Caroline Gill and Gerry Murphy, the heads of administration and investigations and all of the staff for their individual and combined efforts. It has been through those combined efforts and leadership that we have ensured that an effective, progressive and cost-efficient Bureau not just exists, but rather is in increasing demand due to the high regard and position in which it is held by the citizens for whom it exists.

The Council and I look forward to working with the Ombudsman in our combined commitment to continuous improvement and serving the needs of all who have reason to contact his office.

Dermott Jewell

Chairperson

Financial Services Ombudsman Council

17 February 2009



FOREWORD FROM FINANCIAL SERVICES OMBUDSMAN



I am pleased to present, to the Financial Services Ombudsman Council, my fourth Annual Report as Financial Services Ombudsman, dealing with my Office's activities for 2008. On 1 April 2005 my Office came into existence as a statutory body.

2008 IN SUMMARY

The Office was extremely busy in 2008 as:

- ❖ 5,947 complaints were received a significant increase of 36% over 2007
- ❖ 4,887 complaints were resolved and closed
- ❖ 62% were resolved to the complainants satisfaction with 38% rejected
- ❖ 17,450 complaints have been received since 1 April 2005 with 87% or 15,100 complaints resolved
- ❖ Of the 2,340 complaints on hand at year end 1,485 are at the initial stages of exchange of documents etc while 855 are under investigation. Indeed over 1,600 complaints were received in the last quarter of 2008
- ❖ 19,000 phone calls were received, an increase of 83% while 180,000 visits were made to our website compared to 70,000 in 2007
- ❖ 99.9% of statutory levies of €4.3m were collected
- ❖ IT systems overall were revised and the complaints handling management systems were updated considerably
- ❖ Revised complaints handling procedures were put in place in a very short period to take account of a High Court judgment

- ❖ Office administration continued to be highly effective and efficient though revised complaints procedures have slowed our work considerably
- ❖ Quality control review of findings made was carried out by a retired Supreme Court judge.

I consider that conservatively over €45m has been refunded to consumers as a result of my findings since April 2005

In my 2007 Annual Report I indicated that I was more than satisfied that significant progress had been achieved in a relatively short period and 2008 was no exception. The high profile of the Office, particularly because of the Findings made, the increasing number of complaints and information requests being received, the media attention paid to our work and the significant Court Judgements all added to a year of great achievement, but also great complexity. My role attracted favourable profile especially when television programmes portrayed continuing unacceptable practices of alleged misselling of investment products to the elderly, an area where I had expressed serious concerns in the previous two years.

HIGH COURT JUDGMENTS AND APPEALS IN GENERAL

My findings on a complaint are binding subject only to an appeal to the High Court by either party and as a statutory officer I am also subject to judicial review. An appeal to the High Court is a statutory protection for both parties if they feel I have not made the correct finding. Indeed as an office which can, and does award substantial amounts of compensation, it is inevitable that some such challenges will arise.



Three matters in particular merit attention

(a) High Court judgment

The judicial review, appeal and constitutional challenge by Davy Stockbrokers against a Finding of mine in the Enfield Credit Union complaint were of great significance. In the July 2008 judicial review judgment the Court quashed my decision and remitted the matter to me for the purposes of the complaint again being investigated and adjudicated upon using revised procedures- this did not arise as Enfield Credit Union withdrew its complaint during August 2008. I appealed the judgment to the Supreme Court on 26 August 2008 and I await the outcome.-see part III.

The issue concerns my procedures including *inter alia* exchange and discovery of documents, preliminary findings and oral hearings. As a result of this judgment my procedures for dealing with complaints had to be revised while complaints on hand at 30 July had to be put on hold until the revised procedures were drawn up. These were put in place at the earliest possible opportunity, 27 August, after careful consideration of the judgment and further legal advice. The revised procedures are outlined in detail in Part III. These procedures have resulted in the Office being much slower in resolving complaints as the average resolution time for complaints which was 3 months, is now taking at least 5 months.

It is a matter for speculation whether the accepted offer of €35m by Davy during 2008 to resolve the matter of alleged mis-selling of perpetual investment bonds to Enfield and around 130 other credit unions would ever have been made if I had not made my January 2008 finding in the Enfield Credit Union complaint.

(b) Appeals in general

It would be unrealistic to expect that no appeals will be made. I never consider the possibility of an appeal arising before I make any Finding as I must and do reach my Findings having considered the facts and evidence submitted by both parties. Naturally I vigorously defend

my actions in Court and I do not regard the appeal judgment as the Ombudsman winning or the appellant winning – it is just part of the statutory process. Incidentally by 31 December 2008, only 0.2% of my findings - 8 by Financial Service providers and 16 by complainants - have been appealed and out of 14 appeals closed at that date, only 2 judgments were against me.

(c) Legal costs

€1.3m was incurred in 2008 in respect of legal expenses which were necessary to defend High Court actions taken against my findings. I cannot stop anyone appealing a Finding of mine but I must be able to defend my actions. Indeed, a Financial Service Provider who was not satisfied with a High Court judgment in my favour did not hesitate to appeal to the Supreme Court. I would only decide to appeal a High Court judgement to the Supreme Court, after I obtained and considered legal Counsels' opinion, and where I ultimately felt it necessary and appropriate that a major matter needed a judgment of the highest court in the land. I feel it would only arise in rare instances.

I always look for my costs when an appeal is not successful or withdrawn though collection of same from lay litigants is not easy. I must have the necessary funding to ensure that I can defend my actions and I cannot be left short-funded when appeals arise as otherwise I would simply be a useless 'quango'. To date, with the support of the Council who set the levy and the Minister for Finance who sanctions it, I am pleased to record that I have not been left short-funded.

COMPLAINTS

I readily acknowledge and appreciate the efforts being made by the financial services sector overall to ensure that customers are treated in a fair and proper manner. Despite this, complaints to my Office will inevitable arise in certain instances. The activities and findings of my Office, the public perception of my office's role since its

inception in 2005, the downturn in the economy, the turmoil in financial markets, the fall in investment values and a loss of trust amongst consumers in financial institutions, has led to a considerable growth in my office's work. I am pleased that as a result of my Office's work over 62% of complaints were resolved to complainants' satisfaction while the remainder were not upheld.

During 2008

- ❖ I made Findings regarding the sale of inappropriate products, policy reviews not being carried out on time, specified illness cover and income protection benefit exclusion issues. Conflicts of interest not being disclosed and 'wrap-around' insurance products were also of concern to me as well as the way some complaints should never have reached my office if the institutions had dealt with the matter in a proper manner.
- ❖ I was extremely concerned that a few Financial Service Providers were not alone guilty and culpable in selling inappropriate products, but their actions in trying to defend those practices to me were, to say the least, not representative of the financial services sector, and merited the highest condemnation from me. I stated publicly that some of the practices were akin to *wild-west* situations and should not be contemplated in any society. I trust I will not have to refer to such issues again.
- ❖ Some of the complaints I upheld (*albeit a small but significant number*) indicated that inappropriate products were sold, especially to the elderly, and conflicts of interest were not disclosed in other instances. The era when financial institutions could take advantage of anyone, but especially the elderly and the disadvantaged, is over as far as I am concerned. I will not hesitate to award compensation and publish such nefarious action. However, I know and welcome the fact that the financial services industry is making strenuous efforts to prevent

such abuses happening in future, but for even one to arise is one too many.

- ❖ The Financial Regulator's information notes on serious illness cover and on travel insurance as well as its reminders to financial service providers of their responsibilities for dealing properly with elderly customers and to ensure that whole of life insurance policy reviews were carried out on time took into account serious concerns I had already conveyed to it.
- ❖ In May 2008 the Irish Nationwide Building Society informed me that €1.56m had been refunded when the 'look back' exercise requested by me in 2006, following the settlement in my favour of the judicial review proceedings taken by the Society against me, was completed under the general supervision of the Financial Regulator. While I was pleased to note that my actions led to benefits for consumers the final figure was substantially less than what had been originally estimated by the Society—€3m to €6m. I was very surprised at how low the final figure turned out to be and I communicated my concerns to the Financial Regulator.
- ❖ As regards particular Investment Bonds sold with an insurance company 'wrap-around'
 - My main concern was whether or not the 'wrap-around' product was clearly understood by the sellers, promoters and purchasers as being in reality a product backed by an Irish company, which was a financial institution—ISTC—established in June 2005 but not regulated by the Financial Regulator. When this institution went into examinership investors lost everything. However I am strongly of the view that future products of this nature merit careful consideration by the industry as to their overall suitability, but in particular, their common understanding by ordinary people. The overall sale of these Bonds was also the subject of review by the Financial Regulator and during 2008 I liaised closely with the Regulator on this matter.



- I upheld some complaints and rejected others about these bonds but I inferred from some comments that I was expected to uphold all of these complaints. However my role as Ombudsman is to be an independent and impartial arbiter of unresolved disputes and complaints are only upheld when after a full investigation, I find that there had been negligence or failure of duty of care on the part of the Financial Service Provider which sold the investment.
- I communicated with the Financial Regulator my serious concerns about the investment committee and manager of a credit union being culpable in investing €1m in this bond. I was concerned that procedures as operated when making investments- to sign 'blindly' the application form and not read the detailed prospectus- if adopted by other credit unions after getting investment advice from brokers would seriously put at risk the members' funds given in trust to credit unions. I was also highly critical of the part played by the investment advisory firm and I directed it to pay €500,000 to the credit union. Both parties have since appealed my finding to the High Court.

QUALITY CONTROL

As part of a quality control initiative in 2008 I had a sample of Findings reviewed by a retired Supreme Court judge. He informed me that my Findings were very well grounded and arrived at in a highly satisfactory manner. I intend to have a similar review carried out during late 2009 so as to assess how the revised procedures put in place in August 2008 are performing.

CONTEXT OF OMBUDSMAN'S ROLE

From the foregoing it is appropriate to put my role in context which is to investigate and rule on complaints in an impartial and independent manner. While I am not a consumer champion or consumer advocate nevertheless, my role and the actions taken by me since inception on 1 April 2005 cannot but have enhanced the overall financial services environment and especially for consumers.

In that regard, my role has to be seen as part of a *four-leaf clover*, the other leaves being the Financial Regulator, a combined industry and consumer leaf as well as the Department of Finance. The root is firmly the Oireachtas as it ultimately gives me the statutory powers I exercise. While performing specific roles, nevertheless all parties work closely together to ensure the best environment for consumers. Therefore exchange of information and ideas between the Financial Regulator and my office will continue to be crucial. We each have different roles, but both are directed at achieving the best environment for consumers to be fairly treated. The efforts being made by the industry overall to be more transparent and informative are positive developments while a more educated and enlightened consumer population will not be slow to complain.

The fact that the number of complaints received against Financial Service Providers and resolved by my office is growing steadily each year demonstrates that both consumers and providers are satisfied that my office provides an impartial, independent and cost-free dispute resolution system in financial matters.

FUNDING

My office is funded by a statutory levy and the Office's running costs in 2008 were €5.1m. Collection of the statutory levies was highly satisfactory while running costs overall were kept under tight control.

APPRECIATION

Naturally the progress of my office and its well established position in the Irish financial services environment could not have been achieved without the dedication and commitment of my relatively small permanent and contract staff for which I am extremely grateful. We are all conscious that complaints are getting more complex with each passing day and we are open to the possibility of High Court challenge.

The number of telephone calls, emails and personal callers to my office during the year has shown a substantial increase. This is an indication that people regard my office as a valuable source of information. It is my aim to keep our switchboard personalised as I do not agree with an automated call centre being in my office. While the office is very busy it is office policy to return every phone call within 30 minutes, and hopefully we only fall down on rare occasions. Indeed the aggressive manner of a minority of people who contact my office staff is to be deprecated. Complainants have to realise that I cannot uphold all complaints while providers have to accept that I can find against them. While I have sympathy with their plight it is regrettable that I had to call on the assistance of the Gardai on a few occasions to remove troublesome people from my office. My staff, in line with my directions, had on a few occasions to terminate phone calls when abusive people came on the line including alas the odd financial service provider and the odd legal personage.

A new Council with a new Chairperson came into being on 29 October 2008 and I look forward to working with them in the harmonious way I worked with the outgoing Council. I pay tribute to the outgoing Chairperson, the outgoing Council members as well as the new appointed members for ensuring that our respective roles operate smoothly.

I am gratified for the support of the Government, the Oireachtas, Department of Finance officials, the Financial Regulator, the Pensions Ombudsman and the National Consumer Agency. I am also grateful to the wider financial services sector, the media, Eversheds O'Donnell Sweeney Solicitors and the other members of my legal support team, Crowley's DFK as internal auditors, the Comptroller and Auditor General as well as consumers

and anybody else who have made our objective that much easier to attain.

OUTLOOK

We all live and operate in challenging and demanding times. A public statutory office like mine has to be capable of rising to those expectations while respecting due process and not compromising quality of work. My Office is well established and is the subject of the highest expectations from Complainants and Financial Service Providers alike which we do our best to live up to. In the current troubled economic times an increase in complaints is inevitable. All the regulation in the world is of little use to an individual consumer if it cannot have easy access to an effective cost-free and speedy system of redress outside of the Courts so as to ventilate the alleged wrong done and have it remedied in a reasonably short timeframe. My office will continue to provide such a system in a cost-effective, impartial and efficient manner.

However the increased workload combined with adhering to public policy requirements regarding budget and resources will inevitably put strains on the Office in providing such an efficient and effective service. We will endeavour and must address that challenge in as practical and efficient way as possible. In that regard the hosting by me in June 2009 of the annual conference of the International Network of Financial Ombudsmen Schemes will assist us all in achieving our mandates as financial problems are worldwide phenomena.



Joe Meade
Financial Services Ombudsman

17 February 2009



part:one

Our Role & Operations

PART I

OUR ROLE & OPERATIONS

THE ROLE OF THE FINANCIAL SERVICES OMBUDSMAN

The Financial Services Ombudsman is a statutory officer who deals independently with complaints from consumers about their individual dealings with all Financial Service Providers that have not been resolved by the providers after they have been through the internal complaints resolution systems of the providers. The Ombudsman is therefore the arbiter of unresolved disputes and is impartial. Broader issues of consumer protection are the responsibility of the Irish Financial Regulator. All personal customers, limited companies with a turnover of €3m or less, unincorporated bodies, charities, clubs, partnerships, trusts etc. can complain to the Ombudsman.

It is a free service to the Complainant, compensation up to €250,000 can be awarded and decisions are binding subject to appeal to the High Court

CO-OPERATION WITH THE PENSIONS OMBUDSMAN AND THE FINANCIAL REGULATOR

Meetings were held at various stages throughout the year with both staff and management of this Office and staff and management of the Pensions Ombudsman and the Financial Regulator. The provisions of the Memorandums of Understanding to which the three offices are signatories are adhered to.

During the year this Office and the Financial Regulator issued a joint press statement regarding research on Irish consumers' willingness to actively complain about personal finance issues. In response to the increasing awareness of both the Financial Regulator's Office and the Financial Services Ombudsman, the Financial Services Ombudsman stated:

"The numbers of complaints about financial services firms received and resolved by my office is growing consistently each year. Both consumers and Financial

Service Providers are satisfied that my office provides an impartial, independent and cost-free dispute resolution service. The co-operation of both offices will continue to be crucial going forward in achieving the best possible outcome for consumers. While we each have different roles, both are directed at achieving the best environment for consumers to be fairly treated."

FIN-NET AND CROSS BORDER CO-OPERATION

The Financial Services Ombudsman is a member of FIN-NET. FIN-NET is a financial dispute resolution network of national out-of-court complaint schemes in the European

Economic Area countries (the European Union Member States plus Iceland, Liechtenstein and Norway) that are responsible for handling disputes between consumers and Financial Service Providers, i.e. banks, insurance companies, investment firms and others. This network was launched by the European Commission in 2001.

Within FIN-NET, the schemes cooperate to provide consumers with easy access to out-of-court complaint procedures in cross-border cases. If a consumer in one country has a dispute with a Financial Service Provider from another country, FIN-NET members will put the consumer in touch with the relevant out-of-court complaint scheme and provide the necessary information about it.

During 2008, 38 complaints were referred to this Office through the FIN-NET scheme, with Complainants being referred here by the Financial Ombudsman Service in the UK, le Médiateur de la Fédération in France and Dienst Ombudsman De Post in Belgium. This Office also referred 76 Complainants to other members of the FIN-NET scheme.



PUBLIC INFORMATION ROLE

This year was another successful year in terms of raising the profile of the Office. Our success depends on the high level of public awareness of our role. In 2008 I took part in a number of radio, television, newspaper and industry magazine interviews.

Staff attended and presented at a number of industry roadshows, exhibitions, public libraries and universities. The staff of the Office engaged in a wide range of public presentations to ensure that the public are well-informed on the nature of the service provided by the Office. These events are a useful platform to gather feedback from the public.

The presentations and events attended by the Financial Services Ombudsman and staff both, nationally and internationally, as well as attendances at this Office are as follows:

1. PRESENTATIONS

(a) Ireland

Insurance Institutes - Cork, Dublin, Galway, Limerick and Sligo
 Over 50s trade shows in Galway, Dublin and Cork
 Compliance conferences in Dublin and Cork
 Waterford Institute of Technology
 Limerick/ Clare Credit Union Chapter
 Kildare Credit Union Chapter
 NUI Galway law faculty
 FBD Insurance
 RSA (Royal & Sun Alliance)
 Ulster Bank Group
 Irish Banking Federation and Institute of Bankers
 Public Affairs Ireland
 Experian Ireland Ltd
 Dublin Public Library
 Insurance Institute's first annual CPD conference
 Insurance Claims Assessors
 Association of Compliance Officers
 Irish Institute of Credit Management
 Joint III/ACOI/IBA/ LIA conferring ceremony in UCD

(b) International

International Network of Financial Ombudsmen - New York
 British and Irish Ombudsman Association - Edinburgh
 EU Commissioner for Consumer Protection - Brussels

2. VISITORS TO OFFICE BY OFFICIALS FROM

EU Commission
 European Parliament
 Czech Republic Central Bank

3. MEETINGS

Professional Insurance Brokers Association
 Irish Brokers Association
 Irish Insurance Federation
 Irish Banking Federation
 Irish League of Credit Unions
 VHI
 Department of Health and Children
 Prudential Insurance
 European Consumer Centre
 Irish Insurance Institute
 IFSC based Financial Service Providers
 Individual Financial Service Providers
 Individuals

4. MISCELLANEOUS

Articles in Consumer and Financial Service Providers magazines
 Media interviews
 Website competition for transition year students
 Second level educational syllabuses for business
 Attendance at various financial services functions

ORGANISATIONAL MATTERS

PERFORMANCE MANAGEMENT & DEVELOPMENT SYSTEMS (PMDS)

The Office introduced PMDS in 2007 and this was continued in 2008. Staff members' performances for 2008 were reviewed by their relevant manager and a suitable training and development plan was agreed.

STAFF TRAINING

The Financial Services Ombudsman's Office recognises its staff as a key resource and provides training opportunities for staff members to enable them to develop their knowledge and skills. Training and development of staff may be carried out by formal 'in house' courses or by courses provided by professional external training companies. The Office encourages and assists staff to take advantage of relevant further education at all stages of their career.

PARTNERSHIP

The Office is committed to Partnership, and the Partnership approach is one in which staff are consulted and involved in the management and development of the Office.

COMPLAINTS HANDLING PROCEDURES

Our complaints procedures were reviewed on an on-going basis throughout 2008. In particular, in light of the High Court Judgement in July 2008 our amended procedures were put in place in August 2008.

IT SYSTEMS

Further development of our Case Management System took place in 2008. Older laptops were replaced with models capable of being encrypted. All laptop hard disks are now fully encrypted. We upgraded our Server in December 2008 (new hardware and software installed). Accounts and Payroll packages were also upgraded.

COLLECTION OF LEVIES

The Central Bank and Financial Services Authority of Ireland Act 2004 - Sections 16, 57 BE and BF - provides that levies are payable by Financial Service Providers to enable the Financial Services Ombudsman's Bureau carry out its statutory functions. The levy amounts are prescribed by the Financial Services Ombudsman Council with the consent of the Minister for Finance. Levies were successfully collected from the majority of Financial Service Providers. In 2009 we plan to introduce a direct debit facility for the payment of levies for Intermediaries.

ROAD SHOWS

We made numerous presentations in the Dublin area and had a stand at the Over 50's shows in Dublin, Cork and Galway. We were due to take part in the Tullamore Show in August. Unfortunately, this was called off at the last minute due to bad weather. However, we hope to return to Tullamore in 2009.

STRATEGY STATEMENT

The Strategy Statement and Business Plan 2007-2009 was published in September 2006. Its targets and objectives are under constant review and are being implemented in accordance with the timeframes outlined in the Statement.



COMPLIANCE WITH LEGISLATION

The Office complies with all statutory requirements in the areas of Health and Safety, Equality, Parental Leave and in other areas as follows:

Freedom of Information Acts 1997 and 2003

The Freedom of Information Acts will apply to the administration aspects of the Office. Investigation files cannot be made available via Freedom of Information requests due to their statutory quasi-judicial nature.

Ethics in Public Office Acts 1995 and 2001

The Office adheres to the provisions of the Acts and to Standards in Public Office Commission's Guidelines for Office Holders.

Official Languages Act 2003

The Office is fully compliant with the Official Languages Act 2003. Standard letters and documents are translated into Irish and the website has an Irish section also. The Office also has an appointed Irish Officer to deal with queries in the Irish Language.

Data Protection Acts 1988 and 2003

The Office adheres to the provisions of the Data Protection Acts 1988 and 2003 and will constantly review this adherence. Due to the sensitive nature of the information the Office receives it is necessary that access to data is available only to those who are involved in the investigation of complaints.

THE FINANCIAL SERVICES OMBUDSMAN COUNCIL

MEMBERS OF COUNCIL

The Financial Services Ombudsman Council is appointed by the Minister for Finance. Until October 2008 the Council members were as follows:

Dr Con Power (Chairperson)
Mr Dermot Jewell
Mr Paul Joyce
Mr Paddy Leydon
Mr Paul Lynch
Mr Paddy Lyons
Mr Jim McMahon
Mr Frank Wynn
Ms Caitriona Ní Charra

In October 2008 the Minister appointed the following as members of the Financial Services Ombudsman Council for a five year period.

Mr Dermott Jewell (Chairperson)
Mr Michael Connolly
Mr Paddy Leydon
Mr Tony Kerr
Mr Paddy Lyons
Ms Caitriona Ní Charra
Mr Frank Wynn

Mr Michael Brennan was Secretary to the Financial Services Ombudsman Council from 31 January 2008 until 31 December 2008.

COUNCIL SUB-COMMITTEES

Audit Committee:

Members: Mr Paddy Lyons (Chairperson), Mr Noel O'Connell, Mr Dermot Jewell (until October 2008 replaced by Mr Michael Connolly since October 2008).

Finance Committee:

Members until October 2008: Mr Paddy Lyons (Chairperson), Dr Con Power, Mr Dermot Jewell, Mr Paul Lynch, Ms Caitriona Ní Charra.

Members since October 2008: Mr Paddy Lyons (Chairperson), Mr Frank Wynn, Mr Dermot Jewell, Ms Caitriona Ní Charra.

Attendance from October 2008 until December 2008 was as follows:

| | Meetings |
|--------------------------------|----------|
| Mr Dermot Jewell (Chairperson) | 2 |
| Mr Michael Connolly | 2 |
| Mr Paddy Leydon | 2 |
| Mr Tony Kerr | 1 |
| Mr Paddy Lyons | 1 |
| Ms Caitriona Ní Charra | 1 |
| Mr Frank Wynn | 2 |

Remuneration and Governance Committee

Members until October 2008: Dr Con Power (Chairperson), Mr Paddy Leydon, Mr Frank Wynn.

Members since October 2008: Mr Dermot Jewell (Chairperson), Mr Paddy Leydon, Mr Frank Wynn, Mr Tony Kerr.

COUNCIL SUB-COMMITTEES

Audit Committee

Met on 3 occasions

Finance Committee

Met on 3 occasions

MEETINGS

COUNCIL

During 2008, the outgoing Financial Services Ombudsman Council held 6 formal meetings until October 2008 while the new Council had 2 formal meetings.

Attendance until October 2008 was as follows:

| | Meetings |
|----------------------------|----------|
| Dr Con Power (Chairperson) | 6 |
| Mr Dermot Jewell | 5 |
| Mr Paul Joyce | 6 |
| Mr Paddy Leydon | 6 |
| Mr Paul Lynch | 4 |
| Mr Paddy Lyons | 6 |
| Mr Jim McMahon | 5 |
| Mr Frank Wynn | 6 |
| Ms Caitriona Ní Charra | 4 |

Remuneration and Governance Committee

Met on 13 occasions

COUNCIL REMUNERATION / EXPENSES

The Minister for Finance decides the level of fees to be paid to the Council members; €14,000 is paid to each member with €24,000 to the Chairperson. Claims for reimbursement of travel and subsistence expenses at current public service rates are submitted quarterly.



part:two

Complaints

PART II

COMPLAINTS

OVERVIEW

The core business is complaints resolution. During 2008:

- ❖ 5,947 complaints were received, an increase of 36% over 2007; 3,332 complaints were made against the Insurance sector and 2,615 complaints about Credit Institutions;
- ❖ 17,455 complaints have been received since the office's inception on 1 April 2005; at 31 December 2008, 2,340 complaints were not resolved or 13% of all complaints received;
- ❖ Despite the increase in activity overall 87% of all complaints received have been resolved and it must be noted that 1,616 complaints alone were received during the final quarter of the year while a July 2008 High Court judgment has slowed down our resolution progress compared to former years;
- ❖ 4,887 cases were concluded during 2008; this included 1,853 (38%) where after I initially referred complaints to the Financial Service Provider they were resolved without any further action having to be taken by me;
- ❖ 3,034 complaints were concluded after direct involvement by me and the following %s arise

- ❖ 3,012 complaints overall were resolved in Complainants' favour when account is taken of those 1,853 complaints – 62% overall with 65% for Credit Institutions and 59% for Insurance sector complaints;
- ❖ There was a huge surge in complaints from 382 in 2007 to 1,034 about alleged misselling and the reduced value of investments;
- ❖ Account transactions, mortgages, lending problems, investments and credit card disputes were the main complaints received about Credit Institutions ;
- ❖ Motor, travel, life assurance and investment policies were the main Insurance sector complaints.

Complaints trends data were published on our website in July 2007 and January 2008.

| | Insurance | Credit Institutions |
|----------------------------------|-----------|---------------------|
| Upheld | 10 | 18 |
| Mediation and settlements | 24 | 25 |
| Resolved in complainants' favour | 34 | 43 |
| Not upheld | 39 | 33 |
| Outside remit | 20 | 16 |
| Advisory referrals | 7 | 8 |

| Overall activity | | |
|--|------|------|
| | 2008 | 2007 |
| Active complaints at 1 st January | 1280 | 1440 |
| New complaints received | 5947 | 4374 |
| | 7227 | 5814 |
| Complaints closed following | | |
| Ombudsman involvement | 3034 | 2863 |
| Amicably * | 1853 | 1671 |
| | 4887 | 4534 |
| Active complaints at 31 st December | | |
| Initial contact with office | 248 | 143 |
| Pre investigation | 1237 | 857 |
| Under Investigation | 855 | 280 |
| | 2340 | 1280 |
| * Amicable Resolution means resolved after initial referral by Ombudsman to financial service provider | | |



| Complaints Received | | | | | |
|--------------------------------|------|-------------|------|-------------|------------|
| | 2008 | | 2007 | | % increase |
| (a) Insurance Sector | | | | | |
| Insurance Companies - life | 1453 | | 857 | | |
| Insurance Companies - non life | 1320 | | 1189 | | |
| Health Insurers | 183 | | 182 | | |
| Intermediaries | 259 | | 147 | | |
| Others | 117 | 3332 | 70 | 2445 | 36 % |
| (b) Credit Institutions | | | | | |
| Banks | 2065 | | 1588 | | |
| Building Societies | 144 | | 99 | | |
| Credit Unions | 49 | | 56 | | |
| Stockbrokers | 63 | | 28 | | |
| Intermediaries | 158 | | 72 | | |
| Others | 136 | 2615 | 86 | 1929 | 36% |
| Total | | 5947 | | 4374 | 36% |

| Complaints Resolved by Financial Service Provider category | | | | | | |
|--|------------|---------------------|------------------------|-------------|---------------|--------------------|
| | Upheld | Amicable Resolution | Mediated / Settlements | Not upheld | Outside Remit | Advisory Referrals |
| (a) Insurance Sector | | | | | | |
| Life Companies | 86 | 311 | 143 | 285 | 156 | 27 |
| Non Life Companies | 60 | 545 | 184 | 276 | 117 | 55 |
| Health Insurance | 7 | 79 | 36 | 49 | 2 | 1 |
| Intermediaries | 7 | 79 | 36 | 34 | 24 | 11 |
| Others | 1 | 23 | 3 | 5 | 28 | 28 |
| Total | 161 | 1037 | 402 | 649 | 327 | 122 |
| (b) Credit Institutions | | | | | | |
| Banks | 214 | 687 | 267 | 377 | 144 | 45 |
| Building Societies | 18 | 41 | 18 | 26 | 16 | - |
| Credit Unions | 2 | 16 | 5 | 14 | 6 | 1 |
| Stockbrokers | 1 | 10 | 16 | 15 | 6 | - |
| Intermediaries | 20 | 35 | 25 | 26 | 9 | 2 |
| Others | 1 | 27 | 9 | 4 | 43 | 43 |
| Total | 256 | 816 | 340 | 462 | 224 | 91 |
| Grand Totals | 417 | 1853 | 742 | 1111 | 551 | 213 |

| SUMMARY OF COMPLAINTS CONCLUDED | | | |
|---|-------------------------|----------------------------|--------------|
| | <i>Insurance Sector</i> | <i>Credit Institutions</i> | <i>Total</i> |
| (a) Amicably | | | |
| <i>Resolved after initial referral to Financial Service Providers</i> | 1037 | 816 | 1853 |
| (b) Concluded following Ombudsman involvement | | | |
| Upheld | 161 | 256 | |
| Settlements and mediation | 402 | 340 | |
| Not Upheld | 649 | 462 | |
| Outside Remit | 327 | 224 | |
| Advisory Referrals | 122 | 91 | |
| | 1661 | 1373 | 3034 |
| Total | 2698 | 2189 | 4887 |
| (c) Resolved to Complainants' satisfaction | | | |
| (Amicably, upheld and settlements) | 1600 | 1412 | 3012 |
| | 59% | 65% | 62% |

| COMPLAINT TRENDS BY AREA OF BUSINESS | | |
|---|-------------|------|
| (a) Credit Institutions | | |
| | 2008 | 2007 |
| Accounts Transactions | 617 | 588 |
| Mortgages | 517 | 348 |
| Investment Disputes | 413 | 190 |
| Lending Problems | 358 | 272 |
| Credit Card Disputes | 331 | 279 |
| ATM Disputes | 161 | 91 |
| Service | 123 | 49 |
| Other | 78 | 88 |
| Foreign Exchange | 17 | 24 |
| Total | 2615 | 1929 |



| COMPLAINT TRENDS BY AREA OF BUSINESS | | |
|--|-------------|------|
| <i>(b) Insurance</i> | | |
| <i>Non Life</i> | | |
| Travel | 360 | 387 |
| Motor | 569 | 482 |
| Household Buildings | 155 | 126 |
| Household Contents | 85 | 72 |
| Payment / Loan Protection | 100 | 93 |
| (Savings Policy / SSIs) | 17 | 37 |
| Mobile Phones | 37 | 32 |
| Commercial | 42 | 31 |
| Personal Accident | 21 | 29 |
| Hospital Cash Plan | 18 | 35 |
| Miscellaneous (including, inter alia, pet, farm, computer, marine, dental and insurance) | 117 | 70 |
| Total | 1521 | 1394 |

| COMPLAINT TRENDS BY AREA OF BUSINESS | | |
|---|-------------|------|
| <i>(c) Life</i> | | |
| Medical Expenses | 175 | 182 |
| Life Assurance including PHI | 514 | 299 |
| Investment Policy | 621 | 192 |
| Endowment Policy | 80 | 53 |
| Mortgage Protection | 79 | 90 |
| Pension | 199 | 129 |
| Salary Protection or Income Continuance | 66 | 62 |
| Critical / Serious Illness | 77 | 44 |
| Total | 1811 | 1051 |

| TOTAL INSURANCE | | |
|-----------------|-------|-------|
| | 2008 | 2007 |
| | 3,332 | 2,445 |



| COMPLAINT TRENDS BY NATURE OF COMPLAINT | | |
|--|-------------|-------------|
| Credit Institutions | 2008 | 2007 |
| General Account Issues | 294 | |
| Misleading Information/Mis-selling | 219 | |
| Fees & Charges | 189 | 190 |
| Mortgage Issues | 168 | |
| ATM Withdrawals | 161 | |
| Interest Rates | 153 | 94 |
| Service Issues | 152 | 70 |
| Repayment Terms | 138 | |
| Insurance Issues | 135 | |
| Disputed Transactions | 127 | |
| Credit Card Issues | 110 | |
| Lending Issues | 109 | |
| Investment Issues | 90 | |
| Other | 78 | |
| Investment Loss | 74 | |
| Opening/Closing Accounts | 74 | |
| Transfer of funds/account | 72 | |
| Cheques | 66 | |
| Credit Rating | 64 | 68 |
| Redemption/Change of Mortgage | 58 | |
| Refusals | 54 | |
| SSIA Issues | 19 | 36 |
| Dormant Accounts | 11 | 11 |
| *Maladministration/Negligence | | 1460 |
| Total | 2615 | 1929 |

| Insurance Sector | 2008 | 2007 |
|--------------------------------------|-------------|-------------|
| Repudiation of Claim | 736 | 758 |
| Claims handling Issues | 195 | 210 |
| Customer Care | 121 | 141 |
| Maladministration | 504 | 169 |
| Mis-selling | 462 | 98 |
| Misrepresentation | 83 | 87 |
| Settlement Amount | 169 | 123 |
| Lapse/ Cancellation of policy | 158 | 134 |
| General Advice | 51 | 51 |
| Pre-Existing Condition | 83 | 48 |
| Policy Reviews | 175 | 86 |
| Premium Rates | 47 | 76 |
| Non Disclosure | 34 | 44 |
| Surrender Values | 105 | 62 |
| Paid up Policy values | 51 | 67 |
| Direct Debit | 9 | 4 |
| No Claims Bonus | 24 | 26 |
| Third Party Insurers | 42 | 25 |
| Commission Charges | 48 | 21 |
| Subrogation | 11 | 35 |
| Bonus Rates | 4 | 9 |
| Policy Renewal | 29 | 21 |
| Declined Quotation | 13 | 13 |
| Pre-Accident Value | 18 | 5 |
| Unfair Treatment | 7 | 11 |
| Share Allocation | 62 | 2 |
| Premium Collection | 11 | 10 |
| Fraud | 1 | 4 |
| Unclassified/ Outside Bureau's Remit | 79 | 45 |
| Total | 3332 | 2445 |

** The systems in 2007 did not breakdown this category into the 2008 detail*



| COMPLAINTS RECEIVED SINCE 2005 | | | |
|--------------------------------|-------------------------|----------------------------|--------------|
| | <i>Insurance Sector</i> | <i>Credit Institutions</i> | <i>Total</i> |
| (a) Yearly | | | |
| 2008 | 3332 | 2615 | 5947 |
| 2007 | 2445 | 1929 | 4374 |
| 2006 | 2229 | 1566 | 3795 |
| 2005 | 2190 | 1147 | 3337 |
| % Increase over 2007 | | | |
| % Increase over 2006 | 36% | 36% | 36% |
| % Increase over 2006 | 10 % | 23% | 15% |
| % Increase over 2005 | 2 % | 37% | 14% |

PUBLISHED FINDINGS

Significant findings made during 2008 were published on the website in July and November 2008 and January 2009. These are also published in part V of this report and can be summarised as follows

UPHELD

- ❖ Insurance agent drove a vulnerable farmer living alone to an ATM cash point to secure sale of unsuitable health policies while another agent stayed behind in the house - action condemned, premiums of €1,520 returned and €1,500 compensation
- ❖ Naive bank official facilitated an 'interfering neighbour' to improperly deal with and change the account status of elderly siblings' joint deposit account of €106,000 - the 85 year old was in hospital and the 79 year old was deaf; €1,200 compensation and apology
- ❖ Husband, aged 69, met with the Bank, invested €100,000 in a fund which then fell sharply in value to €68,000 and signed what purported to be his wife's signature - €52,000 refunded by bank to wife
- ❖ €50,000 award following delayed review of Unit Linked Whole of Life Policy for couple in their late 60s who had by then paid over €60,000 in premiums – increase from €780 to €2,000 in monthly premium sought; systemic problem also identified in 1,800 other cases
- ❖ Bank's threatening letter *debacle* costs it €4,000 ; the bank's systems were at fault
- ❖ Bogus non resident account allegedly held by a member of the Gardai merited €2,000 compensation – building society did not really appreciate the gravity of its mistake

- ❖ Accountant's unnecessary delay in submitting financial accounts to Insurance Company had serious consequences for Claimant's Income Protection claim- able to get claim reopened
- ❖ Loan protection insurance not extended to consolidated loan-bank directed to write off €17,000 of a €23,000 loan as original loan was protected
- ❖ €7,500 awarded for 'partly unsuitable' investment advice
- ❖ Switch of Medical Plans recommended by the Health Insurer resulted in no cover for cardiac treatment expenses; restoration to original Medical Plan, without a two year waiting period, and €5,000 compensation
- ❖ Lack of clarity as to what was covered under an insurance travel policy-€600 awarded for stolen lap top and a review of former claims follows
- ❖ €15,000 award as Broker did not draw to the Complainant's attention the possibility of increasing her disability cover
- ❖ Lost property title deeds merits €3,500 compensation against bank
- ❖ €8,000 awarded against credit union over loan insurance for a disabled person; bad customer service and unhelpful approach overall
- ❖ Incomplete address on motor insurance company records had serious consequences for teenage driver after an accident- company had to meet accident damages
- ❖ €325,000 specified illness cover directed to be paid and application of Insurance Company's 'loss of independence' test criticised
- ❖ €250,000 unsuitable investment in a geared property fund to be refunded
- ❖ Fall of €13,500 in €100,000 investment after one year merits an award of €3,000
- ❖ Reduction from 50% to 20% in no claims bonus for minor car damage caused by a 70 year old was too harsh; reduced to 5% for one year only
- ❖ Allegation of €35,000 Investment Bond fraud against a foreign broker merited payment of €25,000 by an Irish insurance company
- ❖ PRSA charging structure and complaint handling by Insurance Company was highly unsatisfactory- €14,000 compensation and premiums refunded
- ❖ Sale of €20,000 assurance policy did not meet sale guidelines- €5,000 award
- ❖ Permanent Health Insurance benefit confusion resolved and €91,000 arrears paid
- ❖ Personal Accident Benefit definition was not clear - 50% benefit paid
- ❖ Travel Insurance
 - Definition of 'relative'/'step-parent'; 75% refund of €1,100 claim
 - Cancellation of holiday due to pre-existing illness merits 50% award of Stg€1,500
- ❖ €7,500 lost from old age pensioner's bank account by fraudulent ATM withdrawals
- ❖ Overdraft facility not requested by person receiving 'Social Welfare' benefit –portion of balance to be refunded
- ❖ €70,000 compensation for bad investment advice loss of €110,000
- ❖ Credit Union's worthless investment of €1m merited €500,000 award but Union and Investment broker severely criticised



- ❖ Incorrect bogus non resident account notification which led to a subsequent tax settlement of €200,000 merited only €12,500 award
- ❖ €1,850 to be repaid for credit and debit card transactions in a foreign nightclub
- ❖ Misplaced property title deeds over 20 years merited €47,000 compensation as well as €20,000 refund of legal costs
- ❖ Review of transcript of phone call regarding unauthorised credit card transactions of €6,700 while on honeymoon resulted in full refund
- ❖ €74,000 directed refunded to solicitor who was defrauded when year old cheque for €111,000 was cashed and paid out on by a bank
- ❖ Medical Expenses Insurance and Pre-Existing Condition Waiting Period
- ❖ Daughter's €90,000 investment allegedly for 90 year old mother
- ❖ SSIA roll over
- ❖ Proper notification to transfer funds was not given
- ❖ Charges applied to investment bond were correct
- ❖ Encashment value of policy could not be based on phone value
- ❖ Other private car insurance cover did not extend to commercial vehicles

❖ Travel insurance

- Loss of money and valuables while mugged on holidays
- Lost baggage complaint and delayed baggage issue

NOT UPHELD

- ❖ €1m investment in bond was worthless
- ❖ €60, 000 losses on CFD stock broking account
- ❖ Stolen property claim while on holidays was not credible
- ❖ Cancelled cheque – detail furnished after encashment had already happened
- ❖ Motor insurance dispute concerning notification of policy cancellation
- ❖ Death certificate determined that personal accident travel insurance was not payable
- ❖ Insurance Company not responsible for failure of car engine
- ❖ Provider was entitled to alter in-patient only medical insurance cover

MAJOR ISSUES ARISING DURING 2008

CREDIT UNIONS INVESTMENTS AND HIGH EXPOSURE TO RISK

From considering complaints by credit unions about being mis-sold investment products I have serious concerns as to how credit unions invest members' monies. I communicated with the Financial Regulator my serious concerns about the way the Investment Committee of a credit union were culpable in investing €1m in an insurance bond as well as the actions of the Intermediary. I was also concerned in light of a €35 m settlement that, if this is how Credit Unions in general are operating it exposes the funds of members of Credit Unions to a degree of unacceptable risk which cannot be countenanced in any financial service organisation entrusted with members' money. The matters which gave rise to my concerns comprise the following

€35M STOCKBROKER SETTLEMENT

During 2008 a settlement was reached between a stockbroking firm (Davy) and various credit unions in the sum of €35m where bonds sold by this firm were not performing well. This followed a finding of mine in a particular complaint by a credit union where I held that the bonds were inappropriate but this finding was remitted back to me by the High Court to be readjudicated following a judicial review judgment –see appeals section of this report.

€1M LOSS

In another case a credit union, following advice from an Investment Intermediary (intermediary) invested €1m in a different insurance 'wrap around' bond which proved worthless.

In this case a meeting was arranged between the Intermediary and the Investment Committee of the Credit Union - two board members and the manager-in which the Bond was discussed.-a wrap around insurance company bond. It was clear, that there was a mutually beneficial professional relationship over, at least, the last

four years between the parties. It was also clear that the Investment Committee did not have expertise in financial management of a level that should be expected when one is investing large amounts of money. The Investment Committee relied, to a significant degree, on the advice proffered to it by the Intermediary which had proved beneficial over the previous four years. According to the evidence the advisory meeting lasted between 15 – 30 minutes at the outside. It was also obvious that both the Investment Committee and the Intermediary were all aware of the fact that security of capital was an essential element to any investment decision which would be made.

It was also significant from the evidence that the Chairman of the Investment Committee specifically raised a question about capital guarantee and all parties agreed that whilst it was not specifically stated that it was fully capital guaranteed, it was indicated that it would take four to five major banks to fail for the capital to be in danger. Indeed, I noted from the evidence at the Oral Hearing that the Chairman of the Investment Committee stated that *'if I had known that the capital was not guaranteed I would have run a mile from it'*. I also noted that the Intermediary indicated that at no stage did he suggest that the capital was guaranteed by the Insurance Company. However, it was obvious to the Investment Committee present that they felt they were buying an Insurance company backed Bond and that they were very happy to buy such a Bond.

It transpired from the evidence that the application form and brochure were left with the Investment Committee by the intermediary at the conclusion of the short meeting and presentation. After this short meeting the Investment Committee decided to invest in the Bond. However, they all agreed that they, in effect, blindly signed the application form and did not read the brochure, or indeed the conditions under which they were investing. They all stated that they decided to invest and signed the application form without reading either the form or the brochure or without taking any cognisance of the special conditions which were outlined in the application form. In this regard, they did not pay any attention, in my view, to the very important caveat, *'I acknowledge and understand that there is a risk that the price of the fund falls to zero and hence I may receive nothing back'*.



As regards the Intermediary a crucial question in this case was whether it took reasonable care to ensure that the Bond being marketed and 'talked up' by these Companies was a suitable investment product for its client, the Credit Union. Mere reliance on the assurances of the unregulated entity and the Insurance Company's was not sufficient.

Indeed, it was also significant that at the meeting, the very important condition in the policy document and the application form that total loss could arise was not specifically drawn to the attention of the Credit Union. What happened at the meeting was that after a short presentation the application form was left with the Investment Committee and the Intermediary did not go through it in detail. As there was a clear indication that a total loss could arise, and bearing in mind what the Chairman indicated about that possibility happening, that point alone should have been made crystal clear so that everybody understood that in a worst case scenario the possibility of total loss of capital would arise. The fact that this was not specifically pointed out and that everybody understood this remote possibility as it was, is a serious derogation of the Intermediary's duty in advising its clients.

In normal circumstances, where negligent investment advice was given, it is not unusual for me to direct that the investment should be bought back at the full price paid. However, in this instance I considered that the Credit Union was itself responsible for the disaster which occurred. I am on public record on numerous occasions about the importance of everybody reading over a document before signing it, but above all for sales personnel to be clear and precise on all issues when they are advising any person who is going to invest. In the circumstances I considered that the Credit Union must bear a proportion of the loss. I assessed that at 50% and accordingly I directed that €500,000 must be refunded to the Credit Union as well as any commissions and charges paid.

Both parties appealed my finding to the High Court.

OMBUDSMAN'S SURPRISE AT HOW LOW THE LOOK BACK FIGURE OF €1.56M PAID BY IRISH NATIONWIDE BUILDING SOCIETY WAS

I referred in previous Reports to the first ever High Court Judicial review proceedings against me, as Financial Services Ombudsman, taken by the Irish Nationwide Building Society in January 2006. In the course of deciding a complaint I had directed the Society in January 2006 to change its rules and its practice of charging automatic six months interest when commercial mortgages were redeemed early. I considered that this was not a genuine pre-estimate of loss and was in effect a penalty, and therefore unlawful. I had also brought the matter to the Financial Regulator's attention for any *look back* action it deemed necessary. The High Court proceedings were settled in my favour in May 2006 with full costs awarded.

In September 2006 agreement was eventually reached between the Society and my Office as to how the early redemption charge should be calculated for future and past cases, based on a formula which calculates the actual loss to the Society, if any, caused by the early redemption. Following discussions with me the Financial Regulator and the Society agreed in October 2006 to do a '*look back*' exercise under the general superintendence of the Financial Regulator, going back six years from my decision, and undertook to reimburse previous borrowers in accordance with the newly agreed formula.

Originally it was reckoned by the Society itself that the amount involved in the *look back* could be €3m and it later rose to *circa* €6m, particularly following the action that was necessary to be taken when I discovered, after I received a complaint in March 2007, that the process was not being carried out in line with what had been agreed between the Regulator, the Society and me. In May 2008 the Society informed me that €1.56m had been refunded when the '*look back*' exercise was completed.

While I am very happy with the overall outcome in that consumers benefited from the actions that I took I noted

that the final figure was substantially less than what had been originally estimated by the Society. I can readily appreciate that first estimates can be an unreliable guide but my own informed calculation was that somewhere between €3m and €3.5m would be a more realistic figure. I was very surprised at how low the final figure turned out to be and I communicated my concerns to the Financial Regulator.

However the Regulator, acting on legal advice, was prohibited from discussing the detail of its interaction with the Society on this issue but stated that the Society liaised very closely with it throughout the reimbursement programme and that the Regulator was satisfied with the overall manner in which the Society dealt with the issue. Also neither the Regulator nor the Society would supply me with the number of consumers who benefited from this *look back*.

‘WRAPPED AROUND’ INSURANCE INTERNATIONAL SECURITIES TRADING CORPORATION (ISTC) BONDS SALES

During the year I investigated complaints against some credit institutions, insurance companies, brokers, intermediaries and stockbrokers in respect of particular Investment Bonds sold or advised by those Providers. The return on these bonds was linked to the performance of an Irish unregulated financial services company, ISTC Ltd, which subsequently went into examinership in late 2007/early 2008. The investments were then worthless. It appears from media reports that around €40m were sold.

Significant and substantial monetary loss naturally arose for all investors and it was not surprising that I, as Ombudsman, received complaints where investors had not got satisfaction when they initially sought recompense from the Providers who sold them the Bonds. Complaints received indicated that the Bonds were mainly sold in May/ June 2007 and the minimum investment was €50,000. I was pleased to note that in many instances I did not have to carry out an

investigation as the matters were resolved to the Complainant's satisfaction having been initially referred by my office to the Provider concerned as part of the resolution process. Naturally I am not aware of the settlement terms, but I am pleased that complaints have been resolved. Indeed I understand that other investors had their complaints resolved without having to have recourse to my office. I compliment those institutions for their appropriate remedies.

However, noting the age profile of some of the Complainants, I was seriously concerned as to why this product was sold to them at all as I have serious reservations as to whether it could ever be an appropriate investment product for people of advanced years. As Ombudsman I had another general worry that some of the Bonds were sold with an insurance company 'wrap-around'. My main concern was whether or not the 'wrap-around' product was clearly understood by the sellers, promoters and purchasers as being a product of the Irish company, which was a financial institution established in June 2005 but not regulated by the Financial Regulator. I am strongly of the view that future products of this nature merit careful consideration by the industry as to their overall suitability, but in particular, their common understanding by ordinary people. The overall sale of these Bonds is also the subject of review by the Financial Regulator and during 2008 I liaised with the Regulator on this matter.

Whilst I cannot comment on individual findings made by me, I did not uphold some of the complaints as I was satisfied that the investors who invested in these Bonds were perfectly aware of the risks which were associated with them - for example in three instances complaints from individuals involving €1,000,000, €350,000 and €50,000 of investments were not upheld while in two other cases €105,000 was awarded where a person lost €200,000 while €70,000 was awarded for another investment of €110,000. In regard to a Credit Union investment of €1,000,000 I only directed that €500,000 be refunded for inappropriate advice given by an investment intermediary as the Union itself was culpable in not carrying out its responsibility to protect its members' funds.

Some of the financial service providers who sold the bonds indicated to me that neither ISTC nor the



Insurance Company fully apprised them of the risks involved.

However I had to decide whether the providers who sold the bonds exercised a proper duty of care in ensuring that no misleading information was given at the point of sale. The allegations made against the insurance company or ISTC by the providers who sold the bonds were not matters for me to decide on.

I was also somewhat surprised at comments expressed to me that I should have upheld all of these complaints. However my role as Ombudsman is to be an independent and impartial arbiter of unresolved disputes and complaints are only upheld when after a full investigation, I find that there had been negligence or failure of duty of care on the part of the Financial Service Provider which sold or gave advice about the investment to the consumer.

DEFICIENCIES IN SALES PROCESS OF INSURANCE BOND

I received several complaints about a particular investment insurance bond which investors considered was unsuitable as it had fallen considerably in value in a short period. I dealt with these complaints in the normal manner, I upheld some complaints and I have already published one such finding. The Complainants generally stated that they proceeded to make the investment as they were told by the Company that the product was secure, offering a return better than a deposit account. The Company however stated that the Complainants were willing to invest in equities as well as other asset classes, in order to achieve the required growth in their investment.

Following my consideration of the documentary evidence, including the Financial Review, I was critical of the Company's sales process, in a number of respects. I found that the *'focused Financial Review'* showed no evidence of any particular focus on issues such as the level of acceptable investment risk, or preferred investment term. I noted that the company's own understanding of the precise risk tolerance of the

Complainants was confused and had led to incorrect information issuing initially to the Complainants, after they had complained to the Company.

I also expressed significant dissatisfaction with the Company's practice of providing essential information as regards the features/elements attaching to various different risk categories, by way of pages on the screen of a lap-top or a desk-top computer, in paragraphs printed in a size which made it more difficult, in my opinion, for a potential investor to absorb the information in question.

I was also severely critical of the terminology used by the Company to classify risk, categories which included *'100% Growth'* and *'100% Active Growth'*, which I found carried connotations only of the positive, without any real sense of an alert to the risk involved that negative growth could result in significant loss in value. I also found that the *'Reasons Why Document'*, was inadequate in respect of its contents.

I indicated to the Company that these aspects of the Company's sales process and sales documentation required its urgent attention. I also informed the Financial Regulator of my concerns about this matter as it may also apply to other investors and indeed other products. The Regulator indicated that the matter would be followed up as part of its themed inspection programme.

CONCERNS ABOUT INVESTMENT PRODUCTS PERFORMANCE

The virtual collapse of global equity markets has seen an increase in investment led complaints to my office. Equity components of investments whether small or large have in many cases suffered terribly. Fears of recession have added further jitters to already anxious equity markets and have led to further falls in investments.

Investments seemed attractive in the fast growing Irish 'tiger' economy but with the financial turmoil recently experienced, many Complainants now believe they

should have received far more cautionary advice before signing up for any short or long term investments. Complainants relied on the knowledge and expertise of financial advisers but frequently complain that there should have been more explicit and stronger warnings as to the potential risk of losses with investment products.

Complaints in this area have predominately related to the:

- ❖ point of sale of the investment products and
- ❖ fund performance of the chosen investment.

This office, inter-alia, examines the contract terms, the suitability of the product for the person investing, whether the product/s offered any guarantees and whether the relevant codes of conduct and the requirements of the Consumer Protection code since 2007 for selling such investment products to the public. Our investigation of the sale of investment products reviews the documentation issued by Financial Services Providers and the literature relied on during the sale of such investment products. In particular, we investigate whether the level of risk was clearly explained in such documentation. Furthermore, of particular relevance to certain types of investment products, when investments are falling in value and investors wish to withdraw their funds, is that we investigate the extent to which the possibility of the application of Market Value Reductions was explained. We also look at the issue of quotation dates and actual surrender dates. This is very relevant where a policy holder receives a quote from a Company and believes this to be the surrender value; however, a quote is not the final surrender value which generally relies on signed surrender forms being submitted to the Company and may also rely on specific company valuation dates.

Many Complainants allege that they were not properly advised of the risks associated with the investment or that the level of risk was misrepresented during the sale of the product. We review whether the sales person discussed the negative aspects of the investment as well as the potential gains. Naturally many investors are cautious over the risks involving investments so the risk preferences, financial needs, returns of the current market and the economic cycle are considered by the

Office and whether these elements were clearly explained at point of sale by the salesperson.

In general, investment complaints can be dealt with through written submissions from both parties. However, where there is an issue of fact in dispute between the parties to the complaint which cannot be fairly resolved without hearing the parties I will conduct a formal oral hearing in private.

The main problem generally is disappointment with the subsequent performance of the fund.



Appeals and Judicial Review

part:three



PART III

APPEALS AND JUDICIAL REVIEW

GENERAL

An appeal to the High Court is a statutory protection for both parties if they feel I have not made the correct finding. It would also be unrealistic to expect that no appeals will be made but I never consider the possibility of an appeal arising before I make any Finding. I must and do reach my Findings having considered the facts and evidence submitted by both parties.

By 31 December 2008 appeals were made by Financial Service providers in 8 instances while 16 complainants also appealed- this represents 0.2% of findings made. Of the 14 appeals concluded, 2 judgments found against me. After one High Court judgment an appeal has been made to the Supreme Court by a provider while I have also made one as outlined hereafter.

IMPORTANT JUDICIAL REVIEW AND APPEAL

Davy stockbrokers on 8 February 2008 lodged an appeal and also sought a judicial review of a Finding I made on 21 January 2008. Davy also challenged the constitutionality of the Ombudsman's powers. The media carried extensive detail of the court action on Saturday 9 February 2008. As I considered the matter was then in the public domain, I published on Monday 11 February 2008 the full Finding I had made on my office's website, and I also issued a short media release. Media interviews with me followed later that day.

In my Finding I held that Enfield Credit Union had not been informed as to the real nature of the investment; Davy had failed to exercise its proper duty of care in advising the Credit Union to purchase Bonds which were on a level of risk that did not ensure security of capital; the Bonds had no definite maturity date; had no Step-Up Clauses and were subordinated. For those reasons I held that the Bonds were unsuitable investments for this Credit Union and I directed Davy to pay Enfield Credit Union the sum of €500,000 in exchange for the three Bonds and to refund all fees and commissions paid in relation to the purchase of the Bonds.

The judicial review application amounted to a root and breach challenge to almost every aspect of my procedures, up to and including a Constitutional and European Convention of Human Rights challenge to the legislation that governs my Office. Davy also issued a statutory appeal against the merits of my decision. By order of the High Court, both the judicial review proceedings and the appeal proceedings were accepted into the Commercial List of the High Court and it was directed that the judicial review would be heard in advance of the statutory appeal.

The judicial review proceedings were heard by the High Court on 8, 9 and 10 July 2008. By reserved judgment delivered on 30 July 2008, the Judge found in favour of Davy on the following issues where he held that

My Office did not have jurisdiction to operate an internal appeal whereby a finding is made by my Deputy, which can then be reviewed by me;

My Office should have made discovery, to both parties, of all materials that I relied on in reaching my decision;

I should have permitted Davy to have an oral hearing;

My decision was flawed because of a failure to indicate which part of the legislation it was made under.

In his judgment, the Judge found against Davy on the following two issues:

Whether there is a statutory obligation on my Office to attempt and embark upon mediation in respect of every complaint;

Whether in the absence of specific Regulations being made, my Office has any jurisdiction at all to hear complaints.

The Court quashed my decision and remitted the matter to me for the purposes of the complaint of Enfield Credit Union again being investigated and adjudicated upon- this did not arise as the complaint was subsequently withdrawn during August 2008.



The judgment of the High Court clearly has fundamental implications for the manner in which my Office deals with complaints from consumers. In particular, at the end of his judgment the Judge set out a twelve-step procedure which he indicated that my Office should now follow. I took account of what was stated in the Judgement and revised procedures were put in place with effect from 27 August 2008.

I appealed the judgment to the Supreme Court on 26 August 2008 while Davy has cross-appealed in respect of the two issues in my favour. I await the Supreme Court's judgment.

Enfield Credit Union informed me in mid August 2008 that it had then withdrawn its complaint following settlement terms with Davy by it and other credit unions that were also sold these bonds- media reports indicate that over €35m was the total overall settlement figure involved. Incidentally before the judgment was delivered Davy's legal team informed the High Court and my legal team that a settlement had been reached with Enfield.

REVISED COMPLAINTS PROCEDURES

Lodging a complaint

When a complainant contacts the Financial Services Ombudsman's office (this office) it will be sent a Complaint Form. This should be completed, signed and returned to this office within 14 days and accompanied by any letters, or documents which have been sent to and/or received from the Financial Service Provider (Provider) and any other documents that it feels should be put before this office in handling the complaint. A complainant's written authorisation is required if it wishes to be represented by a third party.

When the Complaint Form is received by this office it is assessed to determine whether the complaint falls within the remit of the Ombudsman or whether it should be investigated. It may be necessary to request further information from the complainant at this point. If the matter is deemed to be outside the remit of the Ombudsman or a decision is made not to investigate it

the complainant will be informed as to why it cannot be investigated.

If the complaint is deemed to be within the remit of the Ombudsman, the complainant will be advised to write to a nominated member of senior management in the Provider concerned stating the complaint as concisely as possible, asking the designated member of senior management to give the matter his/her attention and to issue a Final Response letter. A copy of the complaint form and attachments will on that date be also sent to the Provider.

A Final Response letter must be issued when the complaint has been reviewed by the nominated member in the Provider. This letter outlines the Provider's position in relation to the matter in dispute and must be issued within **25** working days. If the complainant is not satisfied with the explanation or response made by the Provider, it must submit the Final Response letter to this office within **15** working days of the Provider issuing same.

MEDIATION

When this office has received the Complaint Form and the Final Response letter issued by the Provider, it will assess the complaint and the option of mediation will be offered to both parties by the Ombudsman as a means of resolving the matter. If mediation is not availed of or is unsuccessful then a formal investigation of the complaint by the Ombudsman will begin.

INVESTIGATION

In the course of investigation the Provider will be required to answer a series of questions posed by the Ombudsman and to submit any material and make any submissions which the Provider sees as being desirable to put before the Ombudsman or which the Ombudsman requires to see, to enable the Ombudsman to investigate and adjudicate upon the complaint. This must be done within **20** working days.

These responses and documents will be copied to the complainant who will be given **10** working days to submit any observations. Any observations from the complainant will be copied to the Provider who will be given **5** working days to submit any further observations.

It should be noted that any medical data will only be copied to the complainant's nominated medical professional.

All the circumstances surrounding the complaint will then be examined. Further information or supporting documentation may be requested from both parties. Every case is judged on its individual merits. The time taken to investigate a dispute depends on the complexity of the individual case as well as outside factors, such as the availability of relevant material. In general, we aim to complete the investigation within **20** working days. However, for certain cases supplementary information will be necessary which may cause the **20** working days to be extended.

After reviewing the evidence the Ombudsman will consider whether an oral hearing is necessary. If an oral hearing is held then the oral evidence given under oath at that hearing will be reviewed together with the documentary evidence and a Finding will be issued to both parties.

Where an oral hearing is not deemed to be necessary a Finding will issue to both parties after all the evidence has been reviewed in full.

FINDING

The Finding of the Financial Services Ombudsman is legally binding on both parties, subject only to appeal by either party to the High Court. A party has **21** calendar days from the date of the Financial Services Ombudsman's Finding in which to appeal to the High Court.



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Financial Statements

REPORT OF THE COMPTROLLER AND AUDITOR GENERAL FOR PRESENTATION TO THE HOUSES OF THE OIREACHTAS

I have audited the financial statements of the Financial Services Ombudsman's Bureau for the year ended 31 December 2008 under the Central Bank Act 1942 as amended by the Central Bank and Financial Services Authority of Ireland Act 2004. The financial statements, which have been prepared under the accounting policies set out therein, comprise the Statement of Accounting Policies, the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement and the related notes.

RESPECTIVE RESPONSIBILITIES OF THE OMBUDSMAN AND THE COMPTROLLER AND AUDITOR GENERAL

The Ombudsman is responsible for preparing the financial statements in accordance with the Central Bank Act 1942 as amended by the Central Bank and Financial Services Authority of Ireland Act 2004, and for ensuring the regularity of transactions. The Ombudsman prepares the financial statements in accordance with Generally Accepted Accounting Practice in Ireland. The accounting responsibilities of the Ombudsman are set out in the Statement of Responsibilities of the Financial Services Ombudsman. My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland). I report my opinion as to whether the financial statements give a true and fair view, in accordance with Generally Accepted Accounting Practice in Ireland. I also report whether in my opinion proper books of account have been kept. In addition, I state whether the financial statements are in agreement with the books of account. I report any material instance where moneys have not been applied for the purposes intended or where the transactions do not conform to the authorities governing them.

I also report if I have not obtained all the information and explanations necessary for the purposes of my audit. I review whether the Statement on Internal Financial Control reflects the Bureau's compliance with the Code of Practice for the Governance of State Bodies and report any material instance where it does not do so, or if the statement is misleading or inconsistent with other information of which I am aware from my audit of the financial statements. I am not required to consider whether the Statement on Internal Financial Control covers all financial risks and controls, or to form an opinion on the effectiveness of the risk and control procedures.

I read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements.

BASIS OF AUDIT OPINION

In the exercise of my function as Comptroller and Auditor General, I conducted my audit of the financial statements in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board and by reference to the special considerations which attach to State bodies in relation to their management and operation. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures and regularity of the financial transactions included in the financial statements. It also includes an assessment of the significant estimates and judgments made in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Bureau's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations that I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements. Without qualifying my opinion I draw attention to note 8 of the financial statements which outlines the uncertainty regarding the ultimate financing and recognition of the pension liability.

OPINION

In my opinion, the financial statements give a true and fair view, in accordance with Generally Accepted Accounting Practice in Ireland, of the state of the Bureau's affairs at 31 December 2008 and of its income and expenditure for the year then ended.

In my opinion, proper books of account have been kept by the Bureau. The financial statements are in agreement with the books of account.



Gerard Smyth

For and on behalf of the Comptroller and Auditor General

6 April 2009



STATEMENT OF RESPONSIBILITIES OF THE FINANCIAL SERVICES OMBUDSMAN

“Sections 57 BP and BQ of the Central Bank Act, 1942 as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act, 2004 require the Financial Services Ombudsman to prepare financial statements in such form as may be approved by the Financial Services Ombudsman Council after consultation with the Minister for Finance. In preparing those financial statements, the Ombudsman is required to:”

- ❖ Select suitable accounting policies and then apply them consistently;
- ❖ Make judgements and estimates that are reasonable and prudent;
- ❖ State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- ❖ Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Bureau will continue in operation

“The Ombudsman is responsible for keeping proper books of account, which disclose in a true and fair manner at any time the financial position of the Bureau and which enable it to ensure that the financial statements comply with Section 57 BQ of the Act. The Ombudsman is also responsible for safeguarding the assets of the Bureau and for taking reasonable steps for the prevention and detection of fraud and other irregularities.”

A handwritten signature in black ink, appearing to read 'J. Meade'.

Joe Meade

Financial Services Ombudsman

2 April 2009

STATEMENT ON THE SYSTEM OF INTERNAL FINANCIAL CONTROL

The Financial Services Ombudsman (Ombudsman) acknowledges as Ombudsman that he is responsible for the Financial Services Ombudsman's Bureau (Bureau) system of internal financial control.

The Ombudsman also acknowledges that such a system of internal financial control can provide only reasonable and not absolute assurance against material error.

The Ombudsman sets out the following key procedures designed to provide effective internal financial control within the Bureau:

- ❖ As provided for in Section 54B of the Central Bank Act, 1942 as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act, 2004 the Ombudsman is responsible for carrying on, managing and controlling generally the administration and business of the Bureau. The Ombudsman reports to the Financial Services Ombudsman Council (Council) at their meetings which are generally held on a bi-monthly basis.
- ❖ The Council and the Bureau have adopted and implemented a Code of Practice for the Governance of the Financial Services Ombudsman Bureau based on the Department of Finance Code of Practice for Governance of State Bodies.
- ❖ The Ombudsman has also put in place a set of Financial Procedures setting out the financial instructions, notes of procedures and delegation practices. The Audit Committee reports to the Ombudsman and Council. The Committee met on three occasions in 2008. The Ombudsman monitors and reviews the efficiency of the system of its internal procedure.
- ❖ The Internal Audit Firm carried out a risk assessment analysis of the Bureau and its business during 2008; implications of any such potential risk were evaluated and reviewed by the Ombudsman in 2008. Action was taken to ensure that the identified potential risks were being managed in an appropriate manner. A detailed internal audit programme of work was agreed and completed in 2008.

REVIEW OF INTERNAL CONTROLS

I have reviewed the effectiveness of the system of controls. I have examined the internal audit reports and the minutes of the audit committee meetings. Where control deficiencies are highlighted I ensure that remedial action is taken.

I also note that the internal audit programme of work is ongoing and I will ensure that any recommendations highlighted during the currency of the internal audit programme will be implemented.



Joe Meade
Financial Services Ombudsman

2 April 2009



STATEMENT OF ACCOUNTING POLICIES

The significant accounting policies adopted in these financial statements are as follows:

BASIS OF ACCOUNTING

The Financial Statements are prepared under the accrual method of accounting, except as indicated below, and in accordance with generally accepted accounting principles under the historical cost convention.

LEVY INCOME

Council regulations made under the Central Bank and Financial Services Authority of Ireland Act, 2004 prescribe the amount to be levied for each category of Financial Service Provider. Levy income represents the amounts receivable for each service provider calculated in accordance with the regulations and based upon providers identified by the Bureau and information supplied to it. Bad debts are written off where deemed irrecoverable.

TANGIBLE FIXED ASSETS

Tangible fixed assets are stated at cost less accumulated depreciation. Depreciation, charged to the Income and Expenditure Account, is calculated in order to write off the cost of fixed assets over their estimated useful lives, under the straight-line method, at the annual rate of 5% per annum for building refurbishment, 33 1/3% for computer equipment and 25% for all other assets. A full year's depreciation is charged in the period of the acquisition.

CAPITAL ACCOUNT

The capital Account represents the unamortised value of income used for capital purposes.

FOREIGN CURRENCIES

Transactions denominated in foreign currencies are converted into euro during the year at the exchange rate on the day of the transaction and are included in the Income and Expenditure Account for the period. Monetary assets and liabilities denominated in foreign currencies are converted into euro at exchange rates ruling at the balance sheet date and resulting gains and losses are included in the Income and Expenditure Account for the period.

SUPERANNUATION

For certain staff members the Bureau is in discussion with the Department of Finance regarding the future financing and management of a defined benefit superannuation scheme. Pending a decision on the matter a provision calculated as a percentage of relevant salaries has been made. (See note 8)

For other staff members the Bureau makes contributions to a defined contribution scheme. (See note 8)

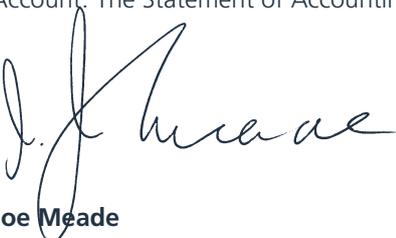
These amounts are charged to the Income and Expenditure Account as they fall due.

INCOME AND EXPENDITURE ACCOUNT

FOR THE YEAR ENDED 31 DECEMBER, 2008

| | Notes | 2008 € | 2007 € |
|---------------------------------------|-------|------------------|------------------|
| Income Receivable | 2 | 4,565,662 | 4,408,993 |
| Transfer to/from Capital Account | 3 | 37,252 | (478,859) |
| | | 4,602,914 | 3,930,134 |
| Administration Costs | 4 | (5,143,167) | (3,700,464) |
| Surplus/(Deficit) for the year | | (540,253) | 229,670 |
| Balance at 1st January | | 1,275,079 | (1,045,409) |
| Balance at 31st December | | 734,826 | 1,275,079 |

The Bureau has no gains or losses in the Financial Year other than those dealt with in the Income & Expenditure Account. The Statement of Accounting Policies and notes 1 to 12 form part of these Financial Statements.



Joe Meade
 Financial Services Ombudsman

2 April 2009



BALANCE SHEET

AT 31 DECEMBER 2008

| | Notes | 2008 € | 2007 € |
|--|-------|------------------|------------------|
| Fixed assets | | | |
| Tangible assets | 5 | 539,523 | 576,775 |
| | | 539,523 | 576,775 |
| Current assets | | | |
| Bank and Cash | | 107,924 | 75,815 |
| Bank Deposit Accounts | | 3,482,324 | 2,948,676 |
| Debtors and Prepayments | 6 | 103,772 | 24,765 |
| | | 3,694,020 | 3,049,256 |
| Creditors (amounts falling due within one year) | | | |
| Creditors and accruals | 7 | 2,959,194 | 1,774,177 |
| | | 2,959,194 | 1,774,177 |
| Net current assets | | 734,826 | 1,275,079 |
| Creditors (amounts falling due after one year) | | - | - |
| Net assets | | 1,274,349 | 1,851,854 |
| Represented by | | | |
| Capital Account | 3 | 539,523 | 576,775 |
| Accumulated surplus at 31 December | | 734,826 | 1,275,079 |
| | | 1,274,349 | 1,851,854 |

The Statement of Accounting Policies and notes 1 to 12 form an integral part of these Financial Statements

Joe Meade
Financial Services Ombudsman

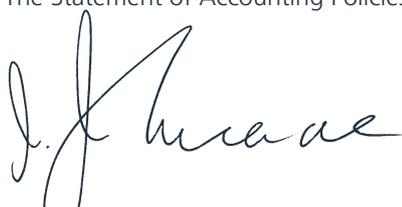
2 April 2009

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 DECEMBER 2008

| | 2008 € | 2007 € |
|---|------------------|------------------|
| Reconciliation of deficit to net cash inflow from operating activities | | |
| Surplus/(Deficit) for the year | (540,253) | 229,670 |
| Transfer to/(from) capital account | (37,252) | 478,859 |
| Depreciation charge | 131,111 | 111,533 |
| Interest (received) | (98,000) | (58,055) |
| (Increase)/decrease in debtors | (79,007) | (1,399) |
| Increase/(decrease) in creditors | 1,185,017 | 753,800 |
| Net Cash Inflow from Operating Activities | 561,616 | 1,514,408 |
| Cash Flow Statement | | |
| Net Cash flow from Operating Activities | 561,616 | 1,514,408 |
| Return on Investments and Servicing of Finance | | |
| Interest received | 98,000 | 82,369 |
| Interest paid | | (24,314) |
| Capital expenditure | (93,859) | (98,883) |
| Financing | | (491,508) |
| Increase in cash | 565,757 | 982,072 |
| Reconciliation of Net Cash Flows to Movement in Net Funds | | |
| Increase in cash in the year | 565,757 | 982,072 |
| Changes in net funds resulting from cash flow | | |
| Net funds at beginning of the year | 3,024,491 | 2,042,419 |
| Net funds at the end of the year | 3,590,248 | 3,024,491 |

The Statement of Accounting Policies and notes 1 to 12 form an integral part of these Financial Statements.



Joe Meade
 Financial Services Ombudsman

NOTES

(FORMING PART OF THE FINANCIAL STATEMENTS)

1 ESTABLISHMENT OF THE COUNCIL AND BUREAU

The Financial Services Ombudsman's Bureau, established under the Central Bank and Financial Services Authority of Ireland Act 2004, is a corporate entity and consists of the Financial Services Ombudsman, each Deputy Financial Services Ombudsman and the staff. It is a statutory body funded by levies from the financial service providers. The Bureau deals independently with complaints from consumers about their individual dealings with financial service providers that have not been resolved by the providers. It began operations on 1 April 2005 in line with the provisions of Statutory Instrument 455 of 2004.

The Financial Services Ombudsman Council is appointed by the Minister for Finance. Its functions as laid down in the Act are to:

- ❖ appoint the Ombudsman and the Deputy Ombudsman
- ❖ prescribe guidelines under which the Ombudsman is to operate
- ❖ determine the levies and charges payable for the performance of services provided by the Ombudsman
- ❖ approve the annual estimate of income and expenditure as prepared by the Ombudsman
- ❖ keep under review the efficiency and effectiveness of the Bureau and to advise the Minister for Finance on any matter relevant to the operation of the Bureau
- ❖ Advise the Ombudsman on any matter on which the Ombudsman seeks advice.

The Council has no role whatsoever regarding complaints resolution.

Council and Bureau Expenses

The expenses of the Council are met from Bureau Funds.

NOTES CONTINUED

(FORMING PART OF THE FINANCIAL STATEMENTS)

2 INCOME LEVY

Section 57 BD of the Central Bank Act, 1942 as inserted by the Central Bank and Financial Services Authority of Ireland Act 2004 provides for the payment of an income levy by financial service providers to the Bureau on terms determined by the Financial Services Ombudsman Council. The Central Bank Act 1942 (Financial Services Ombudsman Council) Regulations, 2007 set the actual rate for the year ending 31 December 2008.

Other income is from an Ex Gratia settlement in full and final settlement of an insurance claim.

Income for the period is as follows:

| | 2008 € | 2007 € |
|---------------|------------------|------------------|
| Levy | 4,357,662 | 4,326,624 |
| Other Income | 110,000 | - |
| Bank Interest | 98,000 | 82,369 |
| Total | 4,565,662 | 4,408,993 |

3 CAPITAL ACCOUNT

| | 2008 € | 2007 € |
|---|----------------|----------------|
| Opening balance | 576,775 | 97,916 |
| Funds allocated to acquire fixed assets | 93,859 | 98,883 |
| Repayment of capital element of finance lease | | 61,250 |
| Repayment of capital element of loan | | 430,259 |
| Amortisation in line with depreciation | (131,111) | (111,533) |
| Transfer from/to Income and Expenditure Account | (37,252) | 478,859 |
| Balance at 31 December | 539,523 | 576,775 |



NOTES CONTINUED

(FORMING PART OF THE FINANCIAL STATEMENTS)

4 ADMINISTRATION COSTS

| | 2008 | 2007 |
|----------------------------|------------------|------------------|
| | € | € |
| Salaries and Staff Costs | 1,959,465 | 1,681,022 |
| Staff Pension Costs | 464,863 | 396,059 |
| Staff Training | 42,779 | 22,394 |
| Bad Debt Write Off | 3,693 | 8,353 |
| Bad Debt Provision | 15,311 | 7,600 |
| Council Remuneration | 131,333 | 136,000 |
| Council Expenses | 23,802 | 40,714 |
| Council Legal Fees | 50,000 | - |
| Rent and Rates | 212,229 | 243,158 |
| Building Loan / Lease | - | 24,314 |
| Maintenance | 34,251 | 37,626 |
| Conference and Travel | 46,333 | 42,295 |
| Consultancy Fees | 307,200 | 191,400 |
| Information Activities | 64,682 | 69,047 |
| Cleaning | 21,258 | 23,459 |
| Legal Fees | 1,254,945 | 374,110 |
| Insurance | 23,951 | 9,197 |
| Stationery Costs | 72,041 | 39,658 |
| Other Administration Costs | 257,817 | 216,982 |
| External Audit | 13,750 | 13,750 |
| Internal Audit | 12,353 | 11,793 |
| Depreciation | 131,111 | 111,533 |
| Total | 5,143,167 | 3,700,464 |

Staff Numbers

The number of persons employed (permanent) in the financial year 2008 was 29 (28 in 2007).

NOTES CONTINUED

(FORMING PART OF THE FINANCIAL STATEMENTS)

5 TANGIBLE FIXED ASSETS

| | Computer Equipment € | Office Fittings, Furniture & Equipment € | Building Refurbishment € | Total € |
|---------------------------------|----------------------------|---|--------------------------------|----------------|
| Cost | | | | |
| At 1 January 2008 | 151,977 | 146,495 | 485,000 | 783,472 |
| Additions during period | 65,870 | 27,989 | | 93,859 |
| At 31 December 2008 | 217,847 | 174,484 | 485,000 | 877,331 |
| Accumulated Depreciation | | | | |
| At 1 January 2008 | 90,226 | 67,971 | 48,500 | 206,697 |
| Charge for period | 63,406 | 43,455 | 24,250 | 131,111 |
| At 31 December 2008 | 153,632 | 111,426 | 72,750 | 337,808 |
| Net Book Value | | | | |
| At 31 December 2008 | 64,215 | 63,058 | 412,250 | 539,523 |
| At 31 December 2007 | 61,751 | 78,524 | 436,500 | 576,775 |

6 DEBTORS AND PREPAYMENTS

| | 2008 € | 2007 € |
|----------------|----------------|---------------|
| Debtors | 3,700 | 4,439 |
| Accrued income | | 8,059 |
| Prepayments | 100,072 | 12,267 |
| | 103,772 | 24,765 |



NOTES CONTINUED

(FORMING PART OF THE FINANCIAL STATEMENTS)

7 CREDITORS (AMOUNTS FALLING DUE WITHIN ONE YEAR)

| | 2008 € | 2007 € |
|------------------------------|------------------|------------------|
| Trade creditors and accruals | 942,453 | 343,300 |
| Pension Contributions | 2,016,741 | 1,430,876 |
| | 2,959,194 | 1,774,177 |

8 SUPERANNUATION

In accordance with Section 57BN of the Central Bank Act 1942, as inserted by Section 16 of the Central Bank and Financial Services Authority of Ireland Act 2004, the Council has drafted a superannuation scheme which has been submitted to the Minister for Finance for approval. The scheme is a contributory defined benefit superannuation scheme based on the Department of Finance Model Public Sector Scheme. Pending legislative confirmation of the pension finance arrangements, we present this information required by FRS 17 by way of a note only. The scheme is being operated on an administrative basis with the consent of the Minister.

The Ombudsman proposed to the Department of Finance that the liability for benefits paid under the Scheme should be assumed by the State in return for payment annually of a percentage of the salaries of scheme members. The Department of Finance then sought advice from the Office of the Attorney General on this issue and is satisfied that a legislative amendment will be required before it progresses the matter. In view of this requirement the Department proposes to introduce a legislative amendment at the next appropriate opportunity. The contributions to be paid over to the Exchequer will be at a level where the Exchequer is not exposed to liabilities in excess of the revenues accruing over the years to the Exchequer. The Minister reserves the right to adjust the rate of contribution in the future in line with future actuarial adjustments on costs. The Department of Finance also indicated that this overall approach to funding the superannuation scheme is consistent with the principle accepted that the overheads associated with establishing a funded scheme is not justified where the number of staff is relatively small.

In addition, staff who transferred from the former Insurance and Credit Institutions Ombudsman offices on the date of establishment could opt to continue with their existing defined contribution scheme. These schemes, which include life cover benefit, are administered by private pension providers. Once employee and employer contributions are paid over the Bureau has no further liability. Alternatively, transferred staff could opt to become members of the Bureau scheme from the date of transfer. In these cases the Bureau received amounts on surrender of the employee's entitlements under the defined contribution schemes. The amount will be used for the purchase of added years under the Bureau scheme in accordance with the provisions of Department of Finance Model Public Sector Scheme.

Employee contributions and amounts received in respect of entitlements surrendered by transferred employees are retained by the Bureau pending a decision by the Minister for Finance as to how the scheme should be managed. These amounts are included in creditors.

The Pension liability at 31 December 2008 is €4,100,000. (2007: €3,300,000) This is based on an actuarial valuation carried out by a qualified independent actuary using the financial assumptions below for the purpose of FRS 17 in respect of Bureau staff as at 31 December 2008. Under the proposed pension funding arrangements this liability would be reimbursed in full, as and when these liabilities fall due for payment.

NOTES CONTINUED

(FORMING PART OF THE FINANCIAL STATEMENTS)

The main financial assumptions used were:

| | 31-Dec-08 | 31-Dec-07 |
|------------------------------|------------------|------------------|
| Discount rate | 5.5% | 5.5% |
| Rate of increase in salaries | 4.0% | 4.0% |
| Rate of increase in pension | 4.0% | 4.0% |
| Inflation | 2.0% | 2.0% |

9 FINANCIAL COMMITMENTS

There are no capital commitments for capital expenditure at 31 December 2008.

10 CONTINGENT LIABILITIES / LEGAL ACTIONS

At the 31 December 2008 an appeal to the Supreme Court has been made by a Financial Service Provider against a High Court judgement which considered matters following a decision made by the Ombudsman. The Ombudsman is defending this action. The Ombudsman also has an appeal himself to the Supreme Court in another case. There are other normal appeals before the High Court which the Ombudsman is also defending. No provision, other than the costs incurred by the Bureau has been made in the Financial Statements, as the financial consequences of any litigation, if any can not be determined at this stage.

11 COUNCIL MEMBERS – DISCLOSURE OF INTERESTS

The Council adopted procedures in accordance with guidelines issued by the Department of Finance in relation to disclosure of interests by Council members and these procedures have been adhered to in the period. There were no transactions in the year in relation to the Council's activities in which the Council members had any beneficial interest.

12 APPROVAL OF FINANCIAL STATEMENTS

The Financial Statements were approved by the Financial Services Ombudsman on 2 April 2009.



part:five

Case Studies

PART V

CASE STUDIES

Insurance agent drove a customer to an ATM cash point to secure sale of policy- action condemned by Ombudsman, €1,520 premiums returned as well as €1,500 compensation

A sister complained on behalf of her sixty year old farmer brother, who lives alone. She stated that as his reading and writing ability was not great he preferred her to deal with how he was treated by two insurance sales people as it was causing him a great deal of distress. In essence the complaint was about feeling annoyed after the purchase of two health illness protection policies from two representatives of an Insurance Company who called to him at his home in October 2007. The complaint was that he was given false information, purchased the policies and paid for them on the spot, because he was forcibly led to believe that if he did not do so, his existing medical insurance cover with a third party health insurer would be insufficient for his needs. When it was realised a short time later that he was misled he applied to the Company to cancel the policies and received a full refund of the premium amounts paid-€1,520. After the Ombudsman commenced to investigate the matter a more specific complaint was subsequently made that one of the Company's representatives had driven him over twelve miles to the nearest ATM cash point in order to procure the necessary cash to pay the balance; this was done under duress while the other representative stayed behind in the house until his return.

The Company advised the Ombudsman that it was limited in its investigation of the Complainant's grievances as he was unwilling to meet with any representative of the Company, and accordingly it was unable to conclude that its representatives had misled the Complainant. The Company had nevertheless cancelled the policy in accordance with the Complainant's request and issued him with a full refund. The Company also stated that its representatives had understood that the Complainant was happy to be driven to the local ATM but that nevertheless, such a type of situation was not good practice and it was the Company's policy to discourage such actions on the part of its representatives. The Company indicated that it was not satisfied that the agents were operating within the Company's rules, and that a formal warning would be

issued to them. In recognition of this fact, the Company offered an *ex gratia* payment of €1,000 to the Complainant.

Whilst acknowledging that the Complainant had received a full refund of the premiums paid, nevertheless the Ombudsman expressed serious concern that in circumstances where it appeared that one of the Company's representatives was undergoing in-field training and supervision, the more experienced agent considered it appropriate to leave his co-agent in the Complainant's home while he drove the Complainant to a cash point over a dozen miles away, in order to procure more cash. The Ombudsman found that such action was entirely inappropriate, irrespective of whether the Complainant's consent was given at the time. The Ombudsman also stated that *discouragement* of such an action on the part of an agent, by the Company, was not sufficient as such action must in no uncertain terms be unreservedly prohibited.

The Ombudsman found that the agents of the Company acted in a highly improper manner, the policy was inappropriate to the needs of the Complainant anyway and in all circumstances the complainant could not comprehend what he was purchasing. Whilst noting that the Complainant was not out-of-pocket, given the refund of premiums already received, he directed the Company to pay an award of €1,500 to the Complainant also for the distress caused. The Ombudsman has brought this disgraceful sales practice to the attention of the Financial Regulator also.

€7,500 lost from old age pensioner's bank account by fraudulent ATM withdrawals

An old age pensioner opened a deposit account with a bank and placed her life savings of €7,500 in the account. She stated in evidence that although she said she did not want one, the bank official dealing with her lodgement insisted that she must take an ATM Card. A PIN was subsequently sent to her in the post and she put it with the ATM Card. Six months later her Card was stolen. Subsequently over a period of eleven days €700 a



day was withdrawn from her account until the account was empty. The bank refused to accept any responsibility for the loss because it had not been notified that the Card had been stolen.

In arriving at his Findings, the Ombudsman accepted that the Complainant did not want a Card, had never used it and had made no transactions on the account since it was opened. A bank's primary duty is to protect depositors' money. The Ombudsman took the view that the sudden pattern of withdrawals should have alerted the bank that something was wrong. The bank's system did not pick up on this, no enquiries were made and the withdrawals continued day after day until the money was gone.

The Ombudsman held that the bank could not be found to be at fault for the fraudulent withdrawals on the first two days but should be held liable for the subsequent withdrawals and he directed that the bank credit the customer's account with the sum of €6,100.

The account opening and fraudulent withdrawals in this case occurred in 2006 but the complaint was not made to the Ombudsman until 2008. The Ombudsman, after making findings in 2006/7 on similar type complaints, had raised with banks in 2007 his concerns about protection for elderly and vulnerable depositors and he requested them to put in place fraud preventative measures. He welcomes the fact that these have or are being put in place as this complaint clearly indicates the need for these improved measures to be not alone in place but above all to be operating effectively.

€70,000 compensation for bad investment advice loss of €110,000

Arising from the proceeds of a sale of a house, a couple who had a lump sum of €135,000 available, looked for advice at a meeting in the office of an investment broker. As a result of this meeting, the Complainants invested €110,000 in a five year insurance 'wrap around' investment Bond. The investment in question was a complete failure and the Complainants lost the entirety

of their investment. The Complainants said that they had made it clear to the broker that what they wanted was a low risk investment. The broker agreed that it had categorised the Complainants as 'low risk' investors but that the Complainants had said they would accept some risk.

The Ombudsman found that the Complainants knew there was some risk that their capital was not 100% guaranteed and that they were attracted to this particular Bond because of the attractive dividends promised. In fairness to the broker, the Ombudsman was satisfied that it had, in good faith, regarded the Bond as low risk based on what had been told to it by the Bond issuer. However, the Ombudsman said that as financial advisor, the broker was obliged to do more than merely accept at face value the representations of those with a commercial interest in marketing this Bond. Furthermore, the Ombudsman found that the 'reasons why' letter drawn up by the broker to be flawed. The letter noted that the Complainants' requirements would be met by lodging €24,000 in a deposit account and recommended that €111,000 be placed in the Bond which it described as 'a secure investment'. In the reasons why letter to the Complainants, the broker said 'the Bond is simple, straightforward and transparent in how it works. While it is not 100% risk-free several major financial houses would have to default before the Bond would be in danger ... therefore it is extremely unlikely that there is any issue with your capital investment'. The Ombudsman considered the foregoing passage from the reasons why letter to be extraordinary in that it totally understated the level of risk associated with this Bond, and that it was imprudent and ill-advised of the broker to present the Complainants with a risk analysis couched in this language. It amounted to a breach of duty of care.

In general the Ombudsman considered that the evidence disclosed in the case established a failure by the broker to discharge its professional duty and failed to deliver the level of professional service that the Complainants were reasonably entitled to expect. In deciding on a remedy the Ombudsman considered that while the broker should pay financial compensation to the Complainants, nevertheless the evidence showed that the Complainants knew that the Bond in question was not 100% guaranteed and therefore must be considered

to have accepted a degree of risk. In the circumstances the Ombudsman directed the broker to pay compensation to the Complainants in the sum of €70,000.

The broker has appealed the Ombudsman's finding to the High Court

€325,000 specified illness cover directed to be paid and application of Insurance Company's 'loss of independence' test criticised

The Complainant's specified illness policy provided life cover of €325,000, and independent (as distinct from accelerated) specified illness cover of €325,000. The complainant who had been seriously injured in a horrific accident, in which his two friends died, complained that the insurers would not pay him the lump sum benefit he felt he was due.

The insurers took the view that the Complainant did not qualify for benefit under the heading of 'Loss of Independence'. The Company indicated that whilst the Complainant's injuries limited his physical capacity and his intellectual ability had been reduced as a result of the accident, nevertheless in its opinion, the Complainant did not satisfy the test in the policy document for loss of independence, either on the physical front, or on the basis of intellectual impairment.

The evidence considered by the Ombudsman showed that following the accident the Complainant had suffered a post-traumatic amnesic state for a period of 6 days. His first recollection was from a time almost a week after the accident, and his behaviour in hospital was erratic, showing concern for matters relating to his business, but being unable to retain any detail in relation to the chronology of his day, i.e. who had visited him etc. The Complainant's injuries had left him unable to bend, preventing him from sitting or standing in one position for any length of time, making it immensely difficult for him to move from a standing position to a lying down position and he complained of suffering pain to his groin when moving from a sitting position to

standing. The Complainant had reduced mobility and pain in his left arm, causing pain when lifting. He had paraesthesia in the fingertips of his left hand, though it was noted that he was right hand dominant. He had episodic sternal pain and stiffness in his big toe (which had been broken) which appeared to affect his ability to balance. The evidence also recorded that the Complainant suffered frequent nightmares and panic attacks; he continued to suffer severe effects of post-traumatic stress disorder while psychological therapy had been discontinued as it had proved emotionally difficult for him.

In coming to his Finding the Ombudsman considered the following matters

- ❖ *The test set out in the policy document for loss of independence, was firstly considered on a physical basis. The test specified that for a policyholder to satisfy the test, he/she was required to be permanently unable to carry out three of the six activities listed. The Ombudsman indicated a concern that such a test might well prove to be unfair as the tasks listed, e.g. 'walk 100 metres', offered no indication of an acceptable timeframe, it failed to indicate whether the walking surface should be flat and even, similar to interior flooring, and indeed it did not specify whether the use of a crutch or walking aid was acceptable for the purpose of 'passing' such a test. In the particular circumstances of the case, however, the Ombudsman did not consider it necessary to make any finding specifically in relation to this physical test.*
- ❖ *The Ombudsman found that the Company's own assessor had reported that the Complainant 'failed' in the test of being able to 'put on or take off all necessary items of clothing' albeit that he could dress himself in a basic sense and could 'get by' in doing without socks and wearing slip-on shoes. The assessor had also reported to the Company that in her opinion the Complainant 'failed' in the test of being able to 'wash yourself all over', owing to his inability to bend and reach below thigh level; various washing aids had been recommended to assist the Complainant in that*



regard, together with regular visits to a podiatrist, as the Complainant could not reach his toes. The Ombudsman did not accept the Company's opinion in those circumstances that the Complainant was 'able' to complete these two tasks.

- ❖ In addition, the Ombudsman found that it was unreasonable of the Company to form the opinion that the Complainant could 'climb stairs' when the medical report to hand recorded that the Complainant had difficulty with negotiating even the single step to enable him to use his own shower (preferring instead to use the opportunity, when driven to the gym, to use the floor level showering facilities). The evidence recorded that the Complainant had taken to regularly sleeping downstairs, rather than negotiating the stairs in his home; he had reported having fallen on occasion when trying to do so. Indeed the Complainant's assessor had remarked that the Complainant's descent of the stairs in his own home was 'unsafe'. The Ombudsman found in those circumstances that the Complainant met the criteria in the policy document for "loss of independence" on a physical basis, insofar as he was unable to carry out three of the six tests listed.
- ❖ In relation to the test for intellectual impairment, the definition in the policy document was again considered, and in addition, consideration was given to the explanation offered by the policy document 'In Simpler Terms' (noting that the policy had been awarded the 'crystal mark' for honesty and clarity, by the Plain English Society). The policy explanation, in simpler terms, referred to the need for 'continued supervision and help of another person' and advised that with regard to the standard tests for measuring elements of brain function (such as awareness of time and place, language, behavioural changes, personality changes, concentration and short and long term memory loss) if a policyholder failed such tests then he/she would be likely to have difficulty with everyday activities such as handling basic household finances, taking prescribed medication and being able to answer the 'phone and take a

message. The Ombudsman noted that these were precisely the problems which the Complainant faced on a daily basis, owing to the significance of his cognitive deficits as diagnosed. His mother and sister were providing ongoing and continued support to him in relation to his financial affairs, his mother needed to arrange his medication in a weekly medication box and whilst the Complainant was capable of answering the 'phone and taking a message, his short term memory loss was such that he was unlikely to later remember that he had done so.

The Ombudsman also reviewed and was highly critical of the Company's Final Response Letter to the Complainant rejecting his complaint. It stated that in order to meet the definition of loss of independence on the ground of intellectual impairment, the Company would expect an inability on the part of the Complainant to use a computer, to use a mobile phone and to arrange social meetings. In circumstances where no such inabilities were referred to in the policy document itself the Ombudsman held that it was highly inappropriate of the Company to introduce this additional test in the course of assessing the Complainant's claim. Furthermore the Ombudsman stated that such minor tasks were capable of completion by any average pre-teenage child, and could not in any way be indicative of a capacity for independent living.

The Ombudsman therefore decided that the Company ought to have admitted the Complainant's claim on the basis of loss of independence, both on the physical and also on the intellectual impairment front. Accordingly the Company was directed to admit the Complainant's claim for specified illness benefit of €325,000.

€250,000 investment in a geared property fund was unsuitable and was to be refunded

The Complainant was annoyed because she maintained she was never advised in the course of her discussions with the representative of an investment intermediary Company that an insurance firm's UK Geared Property

Fund recommended to her was 'high risk' and her investment of €250,000 had significantly fallen in value by over €100,000 in a year.

The Complainant stated that

- ❖ *In December 2006, she was a recently retired teacher, and she sought advice from the Company on investment options for a lump-sum of €85,000. On the basis of the Company's advice, she invested her lump-sum in a With-Profits Fund, which offered a guarantee on the 10th anniversary of the investment and she had no complaint about that investment.*
- ❖ *However in the course of her discussions she told the Company's representative that she had been approved for a loan of €250,000 to be mortgaged on her family home, as she had been thinking of purchasing an apartment in Paris. She was unsure of this strategy however as she felt that the returns might not justify the cost of the borrowing involved. On the basis of the Company's advice thereafter, the Complainant invested the €250,000 borrowed monies- €85,000 initially and €165,000 a week later- in December 2006, in a Geared Property Fund.*
- ❖ *By August 2007, following discussions with an accountant friend she understood that investment of borrowed monies in a Unit Linked Fund presented a serious risk as the returns after annual charges and exit taxes were unlikely to exceed the cost of borrowing, and therefore on balance, such an investment was more likely to result in a loss, than a profit. It was only then she understood that investment in a Geared Property Fund was very high risk, but this was not explained to her at the time the recommendation was made by the Company.*
- ❖ *She sought to have the original amount of the investment returned to her and to be recouped interest on her borrowings since December 2006.*

On the other hand the Company stated that

- ❖ *In December 2006 it carried out a financial review of the Complainant's affairs to enable it to advise her. The Complainant's decision to borrow the sum of €250,000 was made, before she ever sought investment advice, and the Company had no part in the arrangements for the borrowing.*
- ❖ *The Complainant had prior experience of investment in property, as she already owned a property in the South of France, and her arrangements for the borrowing indicated to the Company that:*
 - *The Complainant was willing to borrow to invest and was willing to invest in property.*
 - *The Complainant was willing to appreciate the risks associated with investment in property using borrowed funds and was willing to invest for the long-term.*
- ❖ *Diversification into a mix of retail, office and industrial properties would represent a better proposition than investment in a single residential property in a single location in France. It advised the Complainant that the Geared version of the U.K. Property Fund was about to close and an explanation was given as to the difference between Geared and Un-geared Funds. The risk factors associated with gearing and how an investment of €250,000 would give exposure to €500,000 of an investment, albeit with increased risks was explained. It also pointed out that borrowing within the Fund was non-recourse and that her exposure would therefore be limited to the amount invested.*
- ❖ *It believed that both the Complainant's investments were fundamentally sound. These were taken out for the medium to long-term and the question of whether the advice given was good or bad, would only be answered with the fullness of time.*

In investigating the case the Ombudsman noted that while the financial review carried out by the Company in December 2006 identified the Complainant's risk tolerance as 'medium', it was therefore unclear how the



Company formed the opinion that the Geared Property Fund was an attractive proposition to her, as an investment because

- ❖ *The published Investment Fund Fact Sheet (showing performance figures to 30 June 2006), made it clear that whilst the Property Fund carried a risk profile of 'medium', the Geared U.K. Property Fund nevertheless carried a risk profile of 'medium to high', as the gearing element, i.e. the exposure to double the growth potential of the sum invested, meant that, conversely, the risk involved would be higher.*
- ❖ *The financial review certainly showed that the Complainant was comfortable financially, in the sense that there was very little in the way of a mortgage remaining on her family home, which had a substantial value, and she had a comfortable income from her pension and supplementary 'grind' work. It was nevertheless strange, in the Ombudsman's opinion, that the Company formed the opinion that an individual reliant for the most part on pension income, was a suitable candidate for the investment of a substantial sum of borrowed money, in a product which carried a risk profile which was higher than the risk tolerance recorded for her.*

The Ombudsman considered in detail the terms of the suitability statement for the Complainant's investment, which had been included in the Company's papers (and which he noted was not signed by the Complainant). The copy of the document furnished to his office by the Complainant was dated by the Company's representative as January 2007, a month after the initial investment instalment of €85,000 and 3 weeks after the second investment of €165,000. The suitability statement recorded that the Geared Property Fund was suitable for the following reasons:-

- ❖ *'You can afford to invest for a 5 year period. You wish to invest in an asset class with potential for strong capital appreciation that lacks the volatility associated with equity markets. The U.K. Geared Property Fund has a gearing ratio of 1:1 which allows you to increase your exposure and potential return.*

- ❖ *You are prepared to take on board the risks associated with investment in property. The cost of borrowing within the Fund is reasonable, i.e. Euribor plus 1% and the lending within the Fund is on a non-recourse basis.'*

The Ombudsman was somewhat at a loss to appreciate why these features of the Bond made it suitable to the Complainant's circumstances because

- ❖ *The Complainant's 'capacity' to raise borrowings on an interest only basis, mortgaged on her family home, did not equate with such a step necessarily representing prudent action, nor did this capacity in itself, make the product suitable to her situation. The advice that this particular asset class 'lacks the volatility' associated with equity markets was, in his opinion, nothing short of disingenuous; the 'gearing' of the investment was such that property market movements were magnified, and consequently, the effects of market movements on the investment were more volatile, both on the positive and indeed also on the negative fronts.*
- ❖ *The suitability statement advised that the cost of the borrowing was reasonable, but the Company's file gave no indication of any computation carried out in the course of the Company's advice, to establish the level of growth which would be required by the investment, to enable the Complainant's investment to show any profit after (i) the payment of interest charges on the borrowings and (ii) payment of the 1.5% annual fund management charge, in addition to the exit taxes.*

Furthermore the Ombudsman was also surprised and concerned that although the Complainant met with the Company's representative in early December 2006, when the 'Agreed Financial Priorities for Immediate Action' were recorded in the financial review as 'Rabo deposit – wants to invest for real growth over the long-term to age 65', nevertheless no action was then taken to proceed with the Complainant's investment in the recommended With Profits Policy, as a priority. Instead, the €85,000 then available to the Complainant was invested 9 days later in the Geared Property Fund.

Approximately 2 weeks later when the Complainant's borrowings became available, an additional sum of €165,000 was invested in a similar fashion, and it was not until mid January 2007 that the Complainant's initial financial priority was put into effect, with the investment of €85,000 long-term in the With Profits Policy. This may be explained by the Company's comment in its December 2007 response letter to the Complainant, that *'the geared version of this Fund was about to close'*.

As regards the Company's suggestion that the question of whether the advice given was good or bad would only be answered in the fullness of time, the Ombudsman did not accept this. An investment product maturing at a loss does not of itself indicate that advice given to proceed with an investment in that product was bad advice. Such a product might well indeed have been ideally suited to the investor's circumstances and requirements, but might have failed to perform as anticipated. Conversely, simply because in the fullness of time a product shows significant growth, does not in itself indicate that the product was suitable to the investor if, e.g. the risk level involved was unsuitable, or if indeed the investment timeframe was not suited to that investor's circumstances. What are appropriate at the point of sale are really what matters and not a pious hope for possible success in the future.

Having considered the evidence before him, the Ombudsman was of the opinion that the investment product recommended by the Company i.e. the Geared Property Fund Investment, was simply not suitable to the Complainant's circumstances. She was retired from work, supplementing her pension income with income from lodgers and by carrying out some *'grinds'* work, but she did not have large amounts of money available to put at high risk. The Ombudsman also stated that there is a world of difference between a person making their own bad investment decisions, and a person being advised to invest in an investment by a Financial Service Provider which is not suitable and which carries substantial risks. He also held that there is a different risk level between investing in a single property and investing in a Geared Property Fund.

Accordingly he directed the Company to reimburse the Complainant the sum of €250,000 which she invested in December 2006. He also held that the interest charged

to the Complainant on her borrowings since December 2006 was really a matter for herself as she was willing to and did drawdown those funds.

Though the finding of the Ombudsman was appealed to the High Court by the Company the Ombudsman was informed later that the appeal was withdrawn by the Company.

€1m investment in bond was worthless but complaint not upheld

A man who sold land and buildings for €2,700,000 sought investment advice from an investment intermediary. As a result of the advice, he invested €1,000,000 in a Bond. He lost the entirety of his investment when the Bond in question became worthless. He brought a complaint to the Ombudsman to have his investment restored to him on the grounds that he had been misled by the Provider as to the true nature of the Bond and that, in effect, the Bond had been miss-sold.

The Ombudsman's investigation revealed that prior to engaging with the intermediary two banks had already furnished proposals to the complainant which involved an investment in managed funds. The complainant was not happy with these proposals and he wished the intermediary to look at other options to provide his income requirements. The Complainant had told the intermediary that he wanted to have an annual income from the investment of approximately €80,000 over a 5-7 year period and that the capital sum be returned to him on maturity. The Ombudsman was satisfied on the evidence that during the discussions with the complainant, the intermediary had stated clearly that it would not be possible to achieve this objective by simply investing the money in traditional deposit-type accounts and that it would be necessary to explore other options. In the event, the intermediary recommended that 63% of the Complainant's funds be invested in high yielding deposit accounts with another bank and that the remaining 37% be invested in an insurance type investment Bond.



The intermediary suggested the fatal Investment Bond to the Complainant and provided him with a copy of the brochure in respect of it. The Ombudsman found as a fact that the Complainant knew that there was an element of risk to his investment in this particular Bond. However, the Complainant insisted that he was never properly advised as to the nature of the risk attaching to the Bond. Nevertheless, the Ombudsman noted that in the application form (which was completed by the Complainant) he acknowledged and understood *'that there is a risk that the price of the fund falls to zero and hence I receive nothing back'*. On the other hand, the intermediary included a statement which said *'the Bond offers investors a return of their invested capital after seven years'*. The Complainant alleged that the intermediary was negligent in recommending that over a third of his €2,700,000 capital was to be invested in this particular Bond.

The Ombudsman said it was understandable that the Complainant should feel aggrieved about the entire loss of his investment. The investment had been an unmitigated disaster. But the question for the Ombudsman was whether the evidence in the case established a breach of duty of care on the part of the intermediary in giving the overall investment advice? The Ombudsman noted that the Complainant had elected of his own volition to invest in a product that he knew had some risk which he had freely chosen to accept while also investing in high yielding deposit accounts. Having considered all the evidence, the Ombudsman found that this was not a case of mis-selling of an investment product as the Complainant knew and signed up to an element of risk even, however remote the possibility, a risk of total loss. While in retrospect the investment advice turned out in the end to have been very bad advice indeed, with disastrous consequences for the investor, nevertheless the evidence taken as a whole did not show negligence or breach of duty on the part of the investment intermediary.

Overdraft facility not requested by person receiving 'Social Welfare' benefit

A bank customer who was on weekly 'Social Welfare' benefit of €185 got into debt which he claimed was as a

result of getting an overdraft facility of €1,000 which he did not request and that his Social Welfare benefits had been wrongfully appropriated by the bank to repay the debt on the overdraft. In the course of the investigation the bank acknowledged that it had been unable to locate any application for the overdraft facility but insisted that an overdraft would not have been set up on the account without an instruction from a customer.

Nevertheless, the fact was that overdraft facilities had been put in place and while the Ombudsman acknowledged that the Complainant had drawn down the money and made use of it, the fact remained that he had been given a credit facility which he had not applied for and had got into debt as a result.

In apportioning blame, the Ombudsman held that the bank was 60% responsible for what had happened and he therefore directed that the bank should write off 60% of the outstanding debit balance (€600) on the account.

Incorrect bogus non resident account notification which led to a subsequent tax settlement of €200,000 merits only €12,500 award

A couple, whose names were submitted by the bank to the Revenue Commissioners (pursuant to Section 908 of the Taxes Consolidation Act 1997) as bogus non-resident account holders, complained to the Ombudsman that they had no such account. They further complained that as a result of the bank's notification, a Revenue investigation followed which found that there was a liability to income tax on the part of the Complainants which liability was discharged in settlement with the Revenue of €200,000 and the Complainants' names were published in the Defaulters' List.

The Complainants sought a refund of the €200,000 and compensation from the bank as a result of public humiliation being suffered after being named in Revenue's defaulters list. They claimed that the false information about the bogus non-resident account was the cause of the Revenue enquiries which resulted in

€200,000 having to be paid over to the Revenue in arrears and penalties.

The Ombudsman found as a matter of fact that the Complainants had never had a bogus non-resident account and that the bank had been negligent and in breach of duty to its customers in supplying this incorrect information and that the customers should be compensated for this lapse.

However, the Ombudsman did not consider that the amount of compensation in the case should be pitched at a level that would be sufficient to reflect the extent of the distress that had been experienced by the Complainants in being publicly named as tax defaulters or the loss of €200,000 in tax arrears. An important point in this case was that the Complainants had a substantial undisclosed liability to the Revenue Commissioners which was not caused by any breach of duty on the part of the bank. Rather it was caused by failure and irregularities in the Complainants' own tax affairs.

As a matter of public policy the Ombudsman expressed again his publicly stated view that in assessing a fair level of compensation he will not compensate anyone for tax unpaid, concealed or understated and/or for any distress caused by being published in Revenue's defaulters list.

He directed that €12,500 compensation instead should be paid by the bank for negligently naming the Complainants as bogus non-resident account holders when this was not in fact the case and especially for the way the Bank dealt with the matter over a lengthy period after the customers raised the issue.

Lost house title deeds merits €47,000 compensation and €20, 000 in legal fees

A boundary dispute arising between neighbours in 1989 led to the Complainants finding out that they were at a grave disadvantage in the dispute. This was because when they sought sight of the Deeds of their mortgaged property to help their case, the bank which was holding

the Deeds could not find them. In fact the bank had lost them. As a result, the Complainants became involved in what they accurately described as '*an ongoing saga*' with the bank, extending over a period of 20 years and ending only when the Deeds in question were found by the bank in 2008. It appears that when the branch concerned was undergoing extensive refurbishment the missing Deeds were located behind filing cabinets.

The Ombudsman felt that the manner of the finding of the Deeds itself cast a measure of doubt over the adequacy of a bank's efforts over 20 years to effectively and thoroughly search for the said Deeds to treat the matter with the urgency that it undoubtedly deserved.

The matter was made worse in the Ombudsman's view because, in a letter to the Complainants as late as February 2007, the bank told the complainants that the bank did not have the Deeds and that the branch in question had never received them in the first place. The Ombudsman felt that perhaps the only satisfactory feature of this sorry episode was that the Deeds had now been located, the bank accepted full responsibility for what happened and apologised to the Complainants in writing from Head Office.

There can be few more serious issues to homeowners than an inability to prove legal ownership of their property whenever it becomes necessary to do so. It was abundantly clear that the Complainants had spent considerable time, energy and money in attempting to locate their original documents and extricate themselves from this nightmare. The Ombudsman was satisfied that the lamentable facts of the case disclosed a grave breach of duty on the part of the bank, which breach of duty entitled the Complainants to substantial compensation because of the consequences for them over a period of 20 years.

In arriving at a measure of compensation the Ombudsman took into account that legal fees, in the amount of €20,000, incurred by the Complainants in trying to get the matter rectified had been paid by the bank since the case was brought to the notice of his office. There were further small legal costs incurred since then and the Ombudsman directed that the bank should also meet those costs.



Finally the Ombudsman directed that a further €30,000 in compensation as well as paying off a loan of €17,000 taken out in 2000 to redeem their mortgage should be paid to the Complainants. This was to take account of the loss, inconvenience and distress which they had undoubtedly suffered over a period of 20 years arising from the bank's negligence in the matter.

€60, 000 losses on CFD stock broking account not upheld

An investor who opened a Contract for Difference (CFD) account with a firm of stockbrokers lost approximately €60,000 in 36 transactions over a period of fifteen months. He brought a case to the Ombudsman claiming that the losses were due to bad advice and mismanagement of his account by the firm of the stockbrokers.

The Ombudsman was satisfied from his investigations that all 36 transactions complained of were undertaken on the Complainant's behalf based on pre-trade consultation in each case with the Complainant, and the ultimate decision on whether to buy, sell or hold the stock rested at all times with the Complainant and the stockbrokers acted only on his instructions in each case. The Ombudsman found that the portfolio was diversified across various sectors and was exposed to well regarded stocks. A stockbroker may recommend shares to a client and those shares may fall sharply in value but this does not necessarily establish negligence or breach of duty on the part of the stockbroker. In this particular case the Complainant chose to sell his stock himself when the losses had mounted up. However, the Ombudsman noted that even at the time that the Complainant finally exited his positions the stockbroker was of the view that there was value in those particular stocks. Indeed the stockbroker had price targets for these stocks that were well above the levels at which the Complainant chose to exit his positions by selling these stocks. The evidence did not establish that there was any failure by the stockbroker in the overall management of the Complainant's account.

In the Ombudsman's opinion it is abundantly clear that in certain instances stockbrokers may be liable to compensate their clients for trading losses which occurred if negligence is found. However, the threshold of liability is relatively high. There must be cogent evidence to demonstrate failure to discharge an acceptable level of professional service. The mere fact that shares which were recommended later fell in value is not evidence of a breach of duty.

In this case the Complainant incurred significant losses through CFD trading but this is a risky kind of trading and the Ombudsman was satisfied on the evidence that the Complainant was fully aware of the risks involved. On the totality of the evidence the Ombudsman found no negligence on the stockbroker's part, or that it failed to provide an acceptable level of professional service to the Complainant in this case and the complaint was rejected.

€1,850 repaid for €4,300 of credit and debit card transactions in a foreign nightclub

The Ombudsman receives a growing number of complaints following transactions on credit cards occurring when people are in nightclubs and especially overseas. Customers have a responsibility to be protective of their cards and PIN numbers but providers must also have appropriate fraud prevention measures in place. Each complaint is considered on its individual merit by the Ombudsman with many being rejected.

A night out on the town while on a business trip to Brussels had an unforeseen consequence for a Cardholder when he received his Credit Card and Debit Card statements at the end of the month. The Cardholder had been to a nightclub in Brussels and stated that he had *'a few beers and paid for two dances at the club at €50 each'*. He got an unpleasant surprise when he received his Credit Card statement as it showed payments on the premises of €2,550 and on his Debit Card deductions were shown at €1,750, the night therefore costing him €4,300. He claimed he was the victim of a Credit Card fraud and that the bank should be responsible for the loss.

The bank stated that the Complainant was responsible for the loss because he must have revealed his PIN numbers to the fraudsters who used his own Cards in combination with these PIN numbers to carry out the fraudulent transactions. Furthermore, the bank did not accept that the Complainant's PIN numbers were fraudulently copied but rather were negligently revealed by himself, the bank pointing to the fact that there were no unsuccessful PIN attempts in or around the disputed transactions.

The Ombudsman's investigations revealed that the bank was correct in stating that each of the disputed transactions was carried out by way of a Chip & PIN transaction. The evidence also strongly suggested that for a period of time the Complainant's Cards were not in his possession (the Complainant himself believed that his wallet was stolen from him and subsequently replaced) and his statement to the Belgian police bore this out.

A review of the audit trail revealed that all the transactions were made during the timeframe while the Complainant was in the nightclub. The audit trail also revealed that two Credit Card transactions for €50 each took place at 02:75 and 03:16. A transaction for €2,350 took place at 03:28. In respect of the Debit Card, a transaction of €450 took place at 02:37 and two fraudulent transactions for €850 each took place at 02:48 and 03:21. The question which the Ombudsman had to consider was whether the fraud detection system should have intervened sooner to prevent the transaction of €2,350 which came only 12 minutes after the second €50? It was a significant amount of money to be spent at 3:28 a.m. in such a location and was also inconsistent with the small amounts of the previous transactions.

The Ombudsman felt that clearly a balance must be drawn between a system which protects customers on the one hand, and which, on the other hand allows them the use of their Credit Card without undue inconvenience. Taking this consideration into account and finding that there were circumstances in these particular transactions which ought to have given cause for alarm and fraud preventative measures to commence, the Ombudsman felt that the bank should refund a portion of the transactions.

The Ombudsman directed the bank to refund €1,850 in total - €850 in respect of the Debit Card transactions and €1,000 in respect of the Credit Card transactions. The complainant's rather expensive night out cost him €2,450.

Review of transcript of phone call regarding unauthorised credit card transactions of €6,700 while on honeymoon results in full refund

A Credit Cardholder who went on honeymoon to South Africa discovered on his return that the honeymoon had cost him €6,700 more than he had bargained for. This was because his Card had been debited with a number of transactions which he claimed he did not incur or authorise.

It turned out that the bank's fraud detection system had identified transactions taking place in South Africa that were unusual when compared with the Complainant's previous pattern of spending, furthermore the transactions in question were carried out in a region where the bank had previously experienced fraud. The next day a security watch was placed on the account until the bank could verify the transactions with the Complainant. The Complainant telephoned the bank the next day complaining that he was having some difficulty negotiating with his Card. The bank explained that a security watch had been placed on his Card pending confirmation of transactions. The bank stated that during the call the Complainant stated 'yes' after each transaction was mentioned, thereby indicating that the transactions were indeed his own. The Complainant refuted this. Clearly this telephone call was of pivotal importance in resolving this dispute.

The Ombudsman, in the course of his investigation, obtained a transcript of the said telephone call. The operator went through approximately 12 cash withdrawal transactions with the Complainant and at no time during the said telephone call did the Complainant clearly state that these transactions were not his. The Complainant said in evidence that the operator was



confusing and was talking about transactions in Euro which he did not recognise. The Ombudsman accepted that the operator in question would only have had the Euro transaction amounts available to her but at no time during the telephone call did the Complainant state explicitly that any of the transactions were not his. However, there was plenty of room for confusion, for example, in relation to an attempt to withdraw €428 in Capetown the Complainant said *'it wasn't approved; yeah I wonder if I made that one, yeah'*. After that the Complainant said to the operator *'how much is used in it in the last couple of weeks €200 is it'* and the bank operator said *'around that yes'*. The Ombudsman came to the conclusion that the exchanges on the said telephone call were not so explicit as to amount to the Complainant positively verifying every disputed transaction.

The Ombudsman found that the telephone operator should have canvassed the possibility that the Complainant's Card had been skimmed. She did not do so. The Ombudsman also considered that it was somewhat unrealistic of the bank to demand of the Complainant that he should have expressly denied certain transactions allowing for the fact that he was away on honeymoon and would have been spending money in varying amounts at different places.

The crucial question was really, whether the bank was at fault in lifting the security watch which had been placed on the account and which led to the 'phone call? In the Ombudsman's opinion, the answer to this question was a hesitant 'yes'. In the circumstances, although it was a close call, the Ombudsman came to the conclusion that the loss should lie with the bank. The Ombudsman directed that a total of €6,700 should be refunded to the Complainant.

€74,000 directed to be refunded to solicitor who was defrauded when year old cheque for €111,000 was cashed and paid out on by bank

A gullible solicitor who was defrauded of more than €111,000 by one of his clients brought a case against his

bank alleging that his bank had been negligent and should make good his loss.

What happened was that the solicitor drew a cheque for €111,568 on his firm's client account and sent it to the client to an address in England. A year later the client 'phoned the solicitor and said that he had moved to Spain and that the cheque had only just reached him and that when he had tried to lodge it, it was refused for being more than six months old. The solicitor then said to his client that he would send the amount by electronic transfer and the client should then destroy the stale cheque, which he said he would do. The electronic transfer was duly made to a bank in Spain. However, six days later the original cheque was presented again and was duly paid by the bank in Dublin. The solicitor knew nothing of this and no more was heard from the client. It was not until twelve months later that the solicitor discovered on reviewing his books that the cheque had been cashed. He blamed the bank but the Ombudsman noted that he himself had never asked for any 'stop' to be placed on the cheque. He had foolishly and naively trusted his client to scrap the cheque and this trust had been betrayed.

The issue the Ombudsman had to decide was whether the bank had been negligent in paying out on a stale cheque. The Bills of Exchange Act 1882 which governs these matters does not require that cheques should be dated at all. However, it has long been the accepted practice and custom of banking that a bank will refuse to pay on a cheque which is more than six months old. In this case the evidence was that the cheque had been presented for payment with a date more than twelve months old and if normal banking practice had been applied, the cheque would not have been paid. The Ombudsman came to the conclusion that in paying out on the out-of-date cheque, the bank failed in its duty of care to his client, the Complainant.

However, the Ombudsman also noted that notwithstanding the bank's failure, the Complainant himself had a well recognised duty to mitigate his loss and he had failed to do this on a number of occasions, e.g. he had instructed his client to destroy the cheque rather than requesting that it be returned to him before making the electronic payment and he could also have placed a stop on the cheque, but he failed to do it. The

Ombudsman felt that it was incumbent also on the solicitor to note that his client was not resident in the State and that therefore even greater care should have been taken. The Complainant failed to ensure that the cheque was taken out of circulation and also failed to inform the bank of the situation and gave instructions for an electronic transfer for the same amount without explaining the background circumstances to the bank.

There was also the matter that the bank sent out monthly statements to the Complainant which clearly showed that the cheque had been paid. The question was whether there was a duty imposed on customers to check their statements and report any irregularity to the bank? The law is clear that there is no such duty at common law. However, the Terms & Conditions of the current account for sole traders and partnerships provided by the bank states clearly *'on receipt of account statements the customer should check all transactions and report any discrepancies to the bank immediately'*. The Ombudsman was satisfied that this customer was bound by this term of the contract.

In arriving at a remedy, the Ombudsman was satisfied that the bank failed in its contractual obligations to the Complainant when it paid the cheque, that this was also a breach of general banking practice and indeed the bank's own Code of Practice. To that extent the bank must be held liable in principle for the sum paid out. However, this failure had to be counterbalanced by the Complainant's duty to mitigate his loss and the Ombudsman found that the Complainant had, on a number of occasions, failed to do this. This was surprising considering his professional status.

Apportioning responsibility therefore, the Ombudsman found that the Complainant should be held responsible for one-third of the loss and the bank for the remaining two-thirds. He provided a remedy accordingly by directing that the bank pay the sum of €74,379 to the Complainant. The Ombudsman further stated (though it was not his concern) that the fraudulent client should be pursued for the monies wrongfully obtained and if the Complainant recovered the proceeds of the cheque paid incorrectly by the bank then the Complainant must, both in law and in conscience, return €74,379 to the bank.

Fall of €13,500 in €100,000 investment after only one year merits an award of €3,000

A couple complained that their retirement lump-sum investment of €100,000 in an Insurance Bond in February 2007 had fallen in value by €13,500 after just one year. They had a long standing and fruitful relationship with the Company. They complained that when seeking investment advice from the Company in 2007, they had made clear their requirements of (i) security (ii) a return to supplement their pension payments and (iii) an ability to withdraw funds without penalty, if they needed access to their money before the recommended investment term had elapsed. The Complainants said that they proceeded to make the investment as they were told by the Company that the product was secure, offering a return better than a deposit account.

The Company advised that the investors had undertaken a focused Financial Review in February 2007 and had confirmed that they understood that the investment was for the longer term and would be subject to investment risk and would fluctuate in value. The Company said that the Complainants were willing to invest in equities as well as other asset classes, in order to achieve the required growth in their investment.

The Ombudsman following his detailed consideration to the documentary evidence available arising from the parties' discussions in February 2007, including the Financial Review was critical of the Company's sales process, in a number of respects. He found that the *'focused Financial Review'* referred to show no evidence of any particular focus on issues such as the level of acceptable investment risk, or preferred investment term. He noted that the company's own understanding of the precise risk tolerance of the Complainants was confused and had led to incorrect information issuing initially to the Complainants, after they had complained to the Company. He also expressed significant dissatisfaction with the Company's practice of providing essential information as regards the features/elements attaching to various different risk categories, by way of pages on the screen of a lap-top or a desk-top computer, in paragraphs printed in a size which made it more difficult, in his opinion, for a potential investor to absorb the information in question.



The Ombudsman was also severely critical of the terminology used by the Company to classify risk, categories which included '100% Growth' and '100% Active Growth', which the Ombudsman found carried connotations only of the positive, without any real sense of an alert to the risk involved that negative growth could result in significant loss in value. The Ombudsman also found that the *Reasons Why Document*, was inadequate in respect of its contents and he indicated that these aspects of the Company's sales process and sales documentation which he had highlighted in his report, required the Company's urgent attention.

However on the particular facts before him, and in particular on the Complainants' own evidence, the Ombudsman found that in February 2007 the Complainants had understood that the suggested investment could rise or fall in value, but that they had taken the view that, on balance, on a historical basis, the investment was 'safe' and had elected to accept the risk involved, with a view to the potential reward. The Ombudsman noted, in addition, that after the investment had been made, the documentation issued by the Company to the Complainants had reminded them that the investment was designed for the longer term and that the capital and the return were not guaranteed.

The Ombudsman found in those circumstances that the Complainants were not entitled to the full €13,500 loss when they cashed in the investment after a period of one year only. Nevertheless, in circumstances where the Company's documentation had been confusing and lacking in clarity, he directed the Company to make a compensatory payment of €3,000 to the Complainants which they were pleased with.

The Ombudsman also drew the Financial Regulator's attention to his concerns about the sales documentation and risk categorisation as it may also apply to other investors.

Reduction from 50% to 20% in no claims bonus for minor car damage was too harsh and Ombudsman directs it to be reduced to 5% and only for one year

This complaint, from a lady in her mid 70s, stemmed from the loss of her no claims bonus as a result of a third party claim against her motor insurance policy following a road traffic accident. The Complainant acknowledged that she bumped into the back of the third party's car but denied that she had caused any damage, contending that the damage claimed must have predated the accident as evidenced by her own undamaged vehicle. The repair cost for the other car was €850. As a result the Complainant's No Claims discount was reduced from 50% to 20%.

On examination of the submissions made, the Ombudsman was satisfied that the Company had acted in accordance with the subrogation clause contained in the policy document, which permitted the Company to take over and defend or settle any claim made against the Complainant's policy, and further permitted the Company the discretion to decide how any claim was to be settled. The papers showed that the claim had been assessed promptly and that the third party vehicle had been inspected by the Company's suitably qualified motor engineer who determined that there was damage consistent with the incident in question.

However the Complainant maintained that an inspection of her car would have supported her case that she was not responsible for the damage. The Company indicated that it would not normally be necessary to do this unless she herself had submitted a claim for damage, which in this case she had not done. Furthermore the Company said it had no evidence that the Complainant had made a request for her vehicle to be inspected but she strongly maintained otherwise.

In the circumstances of the case, the Ombudsman found that the damage was quite slight and the sum for repairs not significant. He also took account of the Complainant's age, her genuine belief that no damage was caused and he was satisfied that she had contacted the Company to inspect her car. He felt that the loss of

30% on the No Claims Discount was rather harsh to say the least and accordingly he reduced the loss to 5%, to be applied for one year only.

Allegation of €35,000 Investment Bond fraud against a foreign broker merits an award of €25,000 by an Irish insurance company

In 2001 the Complainant, while living abroad, invested €35,000 with an Irish based Insurance Company through a Broker (the Broker did not fall within the Ombudsman's jurisdiction as he was based in South Africa). The Complainant stated that the Broker had *fraudulently* encashed the policy in 2003. The Complainant argued that the Company was some way to blame for the loss of his monies. The Company denied any responsibility for the loss. It was alleged that the Broker submitted a fraudulent instruction to the Company requesting liquidation of the funds to a bank account, which he had opened in the name of the Complainant, by using an altered passport and copies of utility documents. The Broker was said to have then proceeded to control the dispersion of the funds, mostly to his own bank account, but also to two other parties, to whom it was said, it appeared to have owed monies.

The Complainant questioned the ease with which the Broker managed to submit invalid and improperly certified '*signature bearing*' passport documentation, the lack of verification or confirmation correspondence to them as clients at the time of the *fraudulent* encashment and the apparent disregard for the safe keeping of the, *fraudulent*, documents. The Complainant's argument was that these alleged irregularities indicated that whatever procedures the Company had in place at the time, had failed him. The Complainant stated that as a result of the Company's failures, he was robbed of his investment without his knowledge.

Having examined all the evidence the Ombudsman pointed out that the general position where an investor devolves the handling of affairs to an independent advisor is that the advisor would deal directly with the

Company and instruct it regarding the investment (this would include the receipt of all correspondence connected with the investment from the Company and transferring of same to the investor). A Company and its agents would adhere within reason to the instructions of that Independent Advisor. The Complainant here appointed, in writing, the Broker to handle his investment and deal with correspondence relating to same on his behalf. A certain amount of trust was placed in the broker by all the parties concerned. The Ombudsman found that a number of parties had dealings with the investment in question but from what was alleged there was only one main wrongdoer i.e. the Broker. While checks and balances may frustrate a fraudster in his/her activities, there are circumstances where prevention of such activities may prove near impossible and unfortunately, this appeared to be one such case.

When the Ombudsman contacted the Company regarding the safeguards it had in place against fraud the Company specifically stated it was not at fault. However having regard to the particular circumstances of the case, the Company offered to make an *ex gratia* award of €25,000 in full and final settlement of the dispute. The Ombudsman felt that the Company's offer was fair and reasonable and €25,000 was paid to the Complainant.

PRSA charging structure and complaint handling by the Company was highly unsatisfactory- €14,000 award and refund of premiums

The Complainant effected in May 2006 a PRSA commencing on 1 July 2006. The monthly premiums were initially €1,000, later increased to €1,500 while a single premium of €13,950 was also paid into the account in July 2006. The Complainant received a Statement of Account as at 30 June 2007 from the Company specifying a total of €31,000 paid into the account, but with an account value of only €17,500. The Complainant was very unhappy with the performance and the charging structure of the PRSA which he alleged



was changed by the field sales agent from what was originally agreed. The PRSA was made 'paid-up' in September 2007 as the Complainant stopped paying premiums.

The Complainant complained to the Ombudsman in January 2008. He was very unhappy with how the Company was dealing with his concerns from July 2007 after he asked the Company for the option to have the charges changed back to what was agreed or to have the premiums transferred to another provider. When informed by the Company that the Revenue Commissioners would only sanction a transfer of the current value of the PRSA on the grounds that the 'cooling off' period had expired, the Complainant maintained that he never had been offered a 'cooling off' period.

The Company on the other hand submitted that it found nothing untoward in the sales or advice process. Regarding commission paid, the Company maintained that its commission rates were market standard. The Company also submitted that it approached the Revenue Commissioners to allow the Company to refund in full all contributions made, but that this was declined. It stated that its offer in November 2007 to the Complainant to reverse the commission on the single premium was not acceptable to the Complainant.

The Company files submitted and reviewed by the Ombudsman however indicated that the Compliance Department had acknowledged in correspondence to both the Revenue Commissioners and the Complainant that the charges were not explained to the Complainant. The Ombudsman therefore stated that he found it difficult to reconcile the Company's submission, that nothing untoward was found in the sales process, with the earlier position taken by its Compliance Department that the charges were not explained to the Complainant.

With regard to the manner in which the complaint was handled by the Company, the Ombudsman found that the level of service provided to the Complainant was unacceptable. He also found that the Company had not provided a satisfactory explanation to either the Complainant or his office as to why the charging structure of the PRSA was changed from that which was discussed at the sales meeting in May 2006.

It was also evident to the Ombudsman that the Complainant had spent a considerable amount of time corresponding with the Company since his initial complaint arose in July 2007 and he noted that he was anxious to set up a new pension arrangement as he had a further €10,000 to invest in same. Taking account of all the circumstances the Ombudsman directed in July 2008 that the following amounts be paid to the Complainant:-

- ❖ *€7,500 for poor service in dealing with the Complainant both at the point of sale and at later stages while €6,556 of commission earned was to be refunded also.*
- ❖ *A refund of premiums which had been paid but the Company had to take account of the fact that the Revenue Commissioners had certain restrictions regarding full refunds.*
- ❖ *Interest was to be paid at the rate of 4% from September 2007 when the monthly premiums stopped.*

The Financial Regulator's Consumer Protection Code which came into force on 1 July 2007 details how complaints should be properly addressed by companies. As the Company's actions, in dealing with the complaint after it was made July 2007, was not of the highest standard the Ombudsman decided to refer this matter to the Financial Regulator as there may be other instances with this Company where similar situations could have arisen.

Sale of €20,000 assurance policy did not meet sale guidelines- €5,000 award

The Complainant proposed for life cover (€20,000) on his wife in 2004. The Complainant's wife sadly died in March 2007. The claim for death benefit under the policy was declined by the Company and the policy was voided for non-disclosure of a medical condition. The Company had offered to return the €400 paid in premiums.



The Complainant was sold the policy by a Company representative who called to the Complainant's home in April 2004. His son and a neighbour were in the house at that time and also met the representative. The Complainant's wife was upstairs in the bedroom reading and did not meet the Company representative until she was called downstairs by her husband to sign the proposal form. It was argued that perhaps given their maturity (early sixties) the policyholders trusted that the information the Company representative sought from them was all the information that was required. They were said to have answered the questions asked and signed the form where they were told to sign. There was no dispute that the Complainant's wife had a significant health history.

The Ombudsman noted that the Complainant and his wife signed the application form which included a declaration to the effect that they had read and understood the 'Important Notes' and that to the best of their knowledge and belief, all the statements made in the proposal were true and that they did not withhold any material information. The declinature of this claim rested on the fact that the Complainant's wife's **full** medical history had **not** been revealed under medical questions set out on the application form. The consequence of a non-disclosure on the application was clearly set out in the declaration signed by the policyholders i.e. rejection of a claim.

However the Ombudsman noted that if the Company's representative had done all that was required of him i.e. made sure that the person to be insured (the Complainant's wife) was asked the questions set out on the proposal form, the situation may have been different. The Company admitted that the sale did not appear to have been completed in accordance with the guidelines laid down for its representatives.

Because of the non disclosure, the Ombudsman could not uphold the claim for benefit under the policy but having regard to how the policy was sold he directed the Company to pay an award of €5,000 instead of returning the €400 premiums paid.

This case again highlights the importance of everybody reading over a document before signing same but above all for sales personnel to be clear and precise on all

matters. It is the responsibility of the person/s seeking insurance to read the information on the application to ensure it is correct before signing. If an insured person/s fails to disclose circumstances which would have influenced the decision of the insurance company in fixing a premium or in determining whether or not to accept the risk, the insurance company has an arguable case to decline liability under the policy.

Permanent Health Insurance benefit confusion resolved and €91,000 arrears paid

The Complainant submitted a claim to a Company under a Group Permanent Health Insurance Scheme which was paid from 1998 until September 2002. The Complainant disputed the Company's decision to cease benefits and numerous letters of correspondence arose between both parties. He complained to the Ombudsman in July 2007 about the matter.

The Complainant confirmed that after the cessation of benefits in September 2002, he was obliged to work part-time. The Company requested financial evidence of the Complainant's income earned since he started part-time working, but the Complainant was unable to meet these requests, as the income earned by him was submitted to the Revenue Commissioners as part of his wife's tax returns. The Company agreed to use 50% of the declared income earned for the part-time job in order to calculate the benefits payable.

The Company offered in December 2007, when the Ombudsman was dealing with the complaint, to reinstate the Complainant's proportionate benefit and backdate it to September 2002. The Complainant was dissatisfied with the Company's offer, was disappointed with the delays in receiving benefits, felt that he was being mistreated by the Company and wanted interest to be paid on the arrears.

The Ombudsman noted that there was some confusion on the Complainant's part regarding the overall proportionate benefit payable. However having examined the detailed breakdown of the Company's



settlement offer the Ombudsman was satisfied that the Complainant's claim was correctly assessed in accordance with the policy terms and that the offer was fair and reasonable.

The Ombudsman did have some concerns regarding the length of time taken by the Company to assess the claim and the resultant inconvenience caused to the Complainant. He awarded a once-off payment of €500 to the Complainant in view of this.

Following the Ombudsman's finding the Company in July 2008 paid the arrears of €91,000 and confirmed that benefits would be paid on a monthly basis going forward. The Ombudsman also pointed out to the Complainant that it was at the Company's discretion to review this claim in the future by way of medical assessment in accordance with the policy conditions.

Personal Accident Benefit definition was not clear - 50% benefit to be paid as a result

The issue which arose in this complaint was the whether the Company was entitled to decline the Complainant's claim for Personal Accident Benefit, on the grounds that the circumstances which resulted in the Complainant's injury did not meet the criteria of accident under the policy. The Complainant submitted that, while lifting a box of tiles he felt a sharp pain in his back and numbness in his leg, resulting in an acute disc bulge with bilateral sciatica and limitation of movement in his spine.

On the other hand, the Company argued that it did not accept that the injury was as a result of an accident and that an injury resulting from the lifting and carrying of the box of tiles was the consequence of a deliberate action and was not the result of an accident. Whilst accepting that the injury was the unforeseeable result of a deliberate act, the Company stated that it did not accept that that the deliberate act of lifting and carrying tiles constituted an accident.

The policy in question provided that entitlement to 'Personal Accident Benefit' arises due to '*an accident*' and the '*bodily injury*' occurred '*through accidental means*'. In this regard, the Ombudsman took account of the policy wording and the level of guidance it provided in the event of a claim being submitted under the 'Personal Accident' section. The Ombudsman also examined the definitions provided in the policy. From the evidence submitted, there was no definition of 'accident' or 'accidental means' contained in the policy documentation.

The Ombudsman held that the inclusion of such a definition would have provided more clarity as to the level of cover under the policy and avoided confusion when the claim was submitted. Taking into account the overall circumstances of this dispute, the Ombudsman directed the Company to pay the Complainant 50% of the benefit that would have been paid had the claim been admitted.

Travel Insurance

(A) DEFINITION OF 'RELATIVE' / 'STEP-PARENT'; OMBUDSMAN DIRECTS 75% REFUND OF €1,100 CLAIM

The Complainant planned a holiday for August 2007 and purchased a travel insurance policy for same in April 2007. Her stepfather became ill in July 2007 and sadly passed away shortly afterwards. The Complainant cancelled her holiday as a result and submitted a claim to the insurance company amounting to €1,100. The Company rejected the claim, stating that while the policy did provide cover for the death or illness of a 'relative', a step-parent was not included under the definition of 'relative'.

The Ombudsman noted the close relationship between the Complainant and her step-father as her step-father had been married to her mother for 35 years. He also considered the meaning of 'relative' as defined in the policy. Of particular note was the policy's reference to 'parent' without specifically mentioning 'step-parent'.



The Ombudsman considered the normal, everyday meaning of step-parent, as well as dictionary definitions of same, and whether 'parent' could be taken to include 'step-parent'.

Taking into account the overall circumstances of the case and the possible confusion that could arise from the policy definition of 'relative', the Ombudsman directed the Company to pay 75% of the claim submitted.

(B) CANCELLATION OF HOLIDAY DUE TO PRE-EXISTING ILLNESS MERITS 50% AWARD OF STG£1,500

The complainant had purchased in September 2006 a holiday for August 2007 and had also taken out holiday insurance. The issue for determination in this dispute was whether the Company was entitled to decline the Complainant's claim for the cancellation of her holiday - Stg£3,000 - on the grounds that the primary cause of the Complainant's father's death, heart disease, was a pre-existing condition suffered prior to the policy issue date, the Complainant having failed to disclose the pre-existing medical condition to its Medical Pre-Screening Company.

According to the Complainant, no post mortem was carried out at her mother's request, the on-call GP noting the cause of death on the death certificate as cardiac arrest. It was stated that, whilst the hospital specialist and the GP who initially referred her father to the hospital both confirmed to her that her father's death was directly related to the brain tumour, and that the most probable cause of death would have been a blood clot on his lungs based on swelling of her father's legs days before his passing, this could not be proven as no post mortem was carried out

The Company on the other hand submitted that it was a policy condition that in order for cover to be accepted in relation to pre-existing medical condition, an insured must at inception of the applicable policy, contact its medical pre-screening company and disclose any pre-existing medical condition and/or material facts relevant to the insured or a relative. According to the Company, it

based its decision on the medical evidence as submitted and the information provided stated that the Complainant's father's primary cause of death was due to heart disease, with a secondary cause of death as a brain tumour. It submitted that the primary cause of the Complainant's father's death was a pre-existing condition suffered prior to the policy issue date.

In the context of this complaint, the section of the Complainant's policy entitled 'Pre-Existing Medical Conditions' specified that if an insured person was aware that a relative had received any form of medical advice, treatment or medication for any heart or circulatory related condition then the insured person must contact the Medical Pre-Screening company in order to arrange cover for that condition. It also stated that failure to advise the Medical Pre-Screening company of a pre-existing medical condition would result in claims not being paid.

The medical evidence indicated that the Complainant's father, who had heart disease since 2005, did have a pre-existing medical condition which the Complainant failed to advise to the Company's Medical Pre-Screening company. The effect of the Complainant's failure to disclose her father's pre-existing medical condition was that this material fact would entitle the Company to decline a claim under the policy. However the evidence submitted to the Ombudsman - from the Complainant's father's GP and the treating hospital - indicated that the medical condition which caused the Complainant to cancel her holiday in July 2007, and which subsequently gave rise to the claim for the cancellation of the holiday, was mainly her father's brain tumour, the symptoms of which only commenced in June 2007.

While accepting that the Company had justifiable grounds for refusing the claim on the grounds of non disclosure nevertheless the Ombudsman taking into account all the circumstances of the case and bearing in mind what was fair and reasonable, found that the Complainant was entitled to 50% of the benefit payable under the policy in respect of the cancellation of the holiday.



Provider was entitled to alter inpatient only medical insurance cover

The Complainant had an Inpatient only medical insurance policy with a Health Insurance Company. The Complainant acquired the stand alone policy so as to ensure that she would have adequate maternity cover. The policy provided unlimited coverage for routine maternity and unlimited coverage for complications of childbirth.

At renewal the Company introduced limits on maternity benefits. The Company further provided maternity cover only as an optional extra which had to be taken out together with outpatient cover. The Complainant argued that the Company had breached the implied condition of utmost good faith in altering the terms of cover at renewal. Further the Complainant argued that twelve months' notice of these changes should have been provided so as to enable policyholders to maintain continuity of cover for such benefits should they decide to move to an alternative insurance provider.

The Ombudsman found that the renewal of an annual non-life insurance policy constitutes a new contract for both parties involved. Insurance Companies are entitled to assess the risk involved and alter the terms of the contract upon renewal. It was further noted that the policy document itself included a clear condition allowing the Company to reassess and change cover terms at renewal. In regard to the notice period the Ombudsman found that the Company in this instant case had complied with the requirements of the Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007 in relation to the applicable time periods. Further the Company had in this instant case allowed the Complainant an additional sixty day period to review the details of the renewal terms. Accordingly the Complaint was not upheld.

Medical Expenses Insurance complaint not upheld due to Pre-Existing Condition Waiting Period

The Complainant purchased a health insurance policy in January 2004. He was 52 at the time of purchasing same. The Complainant's policy contains a 'pre-existing condition waiting period'. This means that a set amount of time has to pass before the Company pays for claims relating to conditions that existed before taking out the insurance. The length of the 'pre-existing waiting condition period' depends on the age of the policyholder at the time of purchasing the insurance.

In February 2007 the Complainant claimed under the policy for expenses relating to arthritis. The Company declined the claim, stating that the Complainant had suffered from arthritis before purchasing the policy. The Company stated that the 'pre-existing condition waiting period' had to elapse before cover could be granted for treatment relating to arthritis. The Complainant disputed the Company's decision.

The Ombudsman referred to the 'pre-existing waiting period' in the policy documentation. He noted that the Complainant was 52 at the time of buying the cover and therefore a 5 year 'pre-existing condition waiting period' applied to the Complainant's policy. The Ombudsman examined the medical evidence submitted and concluded that the Complainant had suffered from arthritis since 2002. This was a relevant factor and the Ombudsman decided that the Complainant's arthritis was a 'pre-existing condition' and the waiting period would apply to claims for arthritis. The Ombudsman found that as the policy was taken out in January 2004, the waiting period would expire in January 2009.

While the Ombudsman was very mindful of the medical expense incurred by the Complainant, he found that the Company was correct in declining the claim on the stated grounds.

Daughter led the Company to believe that she was making €90,000 investment solely on her own behalf and not on behalf of her 92 year old mother

In March 2007, following discussions with the Company's advisor, a teacher in her mid 40s placed €60,000 in an insurance investment fund and also commenced a fortnightly contribution from her salary. She had had a long standing satisfactory investment relationship with the advisor. The money had been in a low interest earning deposit account and she wanted a higher return. Two months later she placed another €30,000 in the investment. However early in 2008 she notified the Company that she had never been told that her capital would be at risk, and she was shocked that the investment had fallen significantly in value. The Complainant maintained that the Company had been advised in 2007, that the money being invested was her 92 year old elderly mother's - she was her only child- and that any investment risking that money would be unsuitable. She also maintained that she had been given to believe that the return would be subject to market conditions, but that the capital lump-sum itself would be safe. The Complainant said that she had never been told about any cooling-off period and she advised that the money was now required for her mother's care. She sought to have her losses made good by the Company.

The Company however maintained that the manner, in which the investment policy would operate, had been clearly explained to the Complainant in 2007 and that, in fact, the advisor's handwritten notes bore this out. The Company stated that the chosen investment term of 17 years had been selected to coincide with the commencement in university of the younger two of the Complainant's children, though the money could be accessed at any time, without penalty. The Company also vehemently refuted the Complainant's suggestion that she had said that it was her elderly mother's money. The Company indicated that had any such suggestion been made in 2007, the Company would have met with the Complainant's mother herself, in order to discuss her requirements in relation to an investment.

The Ombudsman found that in March 2007, whatever the original source of the funds, the Complainant was

essentially treating those funds as her own, and had proceeded on her own behalf to make the investment decision. The suggestion that the money belonged to the Complainant's elderly mother was simply not borne out by the evidence. All the documentation completed identified the Complainant as the client and the two lump-sums invested had been drawn respectively from the Complainant's own bank account and her joint account with her husband. He was satisfied on the evidence before him that the Complainant led the Company to believe that she was making the investment solely on her own behalf.

The Ombudsman also found that it was clear from the evidence that after both investments in March and May 2007 respectively, the Complainant had been issued with correspondence offering her a 30 day cooling-off period during which she could cancel the investment.

The Ombudsman noted that the Financial Health Check carried out in March 2007 recorded that whilst the Complainant advised of a 'low' risk tolerance in relation to pension, her risk tolerance for savings was, by way of comparison, 'moderate'. The investment strategy chosen by the Complainant, according to the Financial Health Check, was 'medium risk' for 100% of the investment monies. The Ombudsman also noted that the Complainant stated that she believed at all times that her capital would not be at risk and that it was only 'benefits' which would fluctuate in value, i.e. the return, as distinct from the capital lump-sum. She admitted nevertheless that *'historically, these funds had never dropped, had always performed well and had positive projected returns'*. It seemed therefore to the Ombudsman that the Complainant's belief that the Fund was 'safe', may have stemmed from the historical performance figures, notwithstanding the explanation in the product brochure that the selection of a 'median' investment strategy *'provides the potential for better returns and involves a medium level of risk'*, as opposed to the selection of a conservative strategy (offering low risk) or an adventurous strategy (involving the 'highest level of risk'). The Ombudsman found, on the basis of the information in the documentation provided to the Complainant that she ought reasonably to have understood that the Plan she had selected would not operate, as she was now suggesting, just like a bank account, except that her return might be higher. In

essence the policy she had chosen exposed the money invested to a medium level of risk, in accordance with the 'Median' investment strategy she had selected.

The Ombudsman did not uphold the complaint but indicated that if the Complainant's financial circumstances had changed since 2007, and she now required access to the funds invested, it was a matter for her alone to decide whether to encash the policy sooner than had originally been intended, and crystallize her losses. Otherwise she should consider whether to remain invested for the longer term in the hope of recovering those losses.

SSIA roll over complaint not upheld

The complainant commenced an equity-based Special Savings Incentive Policy with an Insurance Company, from April 2002. He complained in 2008 that he had always believed that the Policy would end after a five year period, in April 2007, when the Government contributions would cease. At the end of the SSIA period in April 2007, however, the Complainant's Policy was rolled over by the Company and his monthly contributions continued. The Policy then subsequently fell in value and the Complainant argued that the Company should pay him the differential in value, for the loss he had sustained after April 2007.

The Company pointed out that the Complainant had selected an open-ended investment Policy in April 2002, with a recommended investment term of 5-7 years. The product brochure had carried an investment warning that the capital was at risk and that the value of the Policy could fall as well as rise. The Company pointed out that when the Revenue Declaration had been sent to the Complainant for signature in January 2007, he had been reminded in writing that the Policy would continue, unless he contacted the Company to arrange otherwise.

The Ombudsman found that in addition to the warnings given to the Complainant in 2002 that the Policy was designed for a period of 5-7 years, the Company had

also in January 2007, written to the Complainant to advise that notwithstanding the end of the SSIA timeframe, the Policy would continue, with ongoing monthly contributions, unless the Complainant advised the Company otherwise in writing.

Having considered the evidence, the Ombudsman found that the Complainant ought reasonably to have been aware of the position with regard to the Policy and the complaint against the Company was not upheld.

Investment loss not upheld as proper notification to transfer funds was not given

The Complainant sought compensation for €8,000 losses incurred as a result of the Company's alleged failure to transfer investment funds amounting to €131,000 at a specific time. The Company stated it did not receive a precise instruction to transfer the funds. This complaint essentially was whether a particular email constituted an instruction to act and transfer funds.

The Complainant stated that in April 2007 he discussed with the Company the possible movement of three investment funds. Later he met with a Company representative in September 2007 and he accepted a recommendation for two funds. The Complainant stated that the representative asked him to email an instruction and that he did this the following day. At a later date in October 2007 when the Complainant discovered that the transfer had not taken place he noted his funds had dropped significantly in value. The Complainant stated that he immediately sent an email to the representative in question requesting that the transfer be made at the rates pertaining in September 2007. The Complainant stated that he had given both a verbal and an emailed instruction, as requested by the representative.

The Company stated that the wording of the Complainant's email of September 2007 did not constitute a specific instruction to transfer funds. The Company stated that the email was a request for a valuation, that the Complainant would consider his position and decide on a course of action after he

received the valuations requested. The Company stated that its standard terms and conditions, which issue with each new investment, precluded emailed instructions and that the Complainant had experience in the transfer of funds and the requirement for a signed document as conclusive proof of an individual's intentions.

The email under scrutiny asked for an evaluation for two funds which the Complainant wanted to move to two different funds. In it the Complainant stated he understood that there were *'no new entry charges but that tax on profits (if any) will apply'*, he asked *'for the valuations when available and documentation when completed'* and finished by stating *'I will consider my situation when this is complete.'*

The Ombudsman noted that the Complainant had made withdrawals of funds on two previous occasions in recent years, on these occasions he had given a written signed instruction to transfer funds and the Company had requested and received from the Complainant the appropriate signed form before effecting the withdrawals. The Ombudsman noted that the policy provisions required notification in writing of any withdrawal by the policyholder and/or completion of *'the relevant form'*.

The Ombudsman on reading the email concluded it was not a valid instruction to transfer funds particularly as it stated *'I will consider my situation when this is complete'*. He found that it was reasonable of the Company to interpret this email as a request for valuations upon receipt of which the Complainant would consider his position in relation to his desire to transfer funds.

Charges applied to investment bond were correct

The Complainant invested €220,000 in an investment bond with an Insurance Company in 2000. She decided to cash in her investment in 2008 and received approximately €243,000. The Complainant stated that the return on the investment was below her

expectations, particularly in the context of the charges applied by the Company during the term of the investment. The Complainant also referred to the policy documentation and promotional literature issued by the Company, stating that it was misleading as to the possible return on investment.

In reaching a finding on the case, the Ombudsman examined the documentation issued by the Company and considered whether it was clear regarding the investment being made and the level of risk attached. Particular attention was paid to the policy documentation referring to investment performance, the nature of investment being made and when bonuses may / may not be paid. The Ombudsman also considered the extent to which charges were explained in the documentation and whether said charges were clearly detailed.

The Ombudsman found that the policy documentation was clear and explained the risk involved. He also found that the charges applied by the Company were clearly explained, were properly applied and he did not uphold the complaint.

Encashment value of policy had to be based on the value when written notification to cancel was received and not on a previous value given over the phone

The policy giving rise to this complaint was a Mortgage Protection Policy and the Complainant's view that she was entitled to rely on a policy valuation provided over the telephone. While the term of the mortgage loan was 15 years the Mortgage Protection Policy was a Whole of Life Policy which had the potential to continue after the end of the mortgage loan term.

In February 2008 the Complainant contacted the Company by telephone regarding the Policy. The Complainant was advised that as the Policy was a Whole of Life Plan it would continue until a written cancellation request was received. The Policy Conditions stated that a written request was needed to encash the policy.



During the telephone call the Complainant was quoted a current policy value of €20,160. This value was based on the latest price available for the fund on that day. The written request to encash the policy was not received until March 2008; the Complainant then received a value based on the unit price available on that date. Regrettably the Unit Price had fallen since February 2008 and consequently the value of the policy on encashment amounted to €19,900. The Company had explained that the fall in the Unit Price was solely due to a fall in the equity markets in the intervening period.

The Ombudsman found that the encashment value sought by the Complainant was not possible, as an encashment value based on a unit price prevailing before the receipt of the written encashment request and confirmation of the release of the Bank's assignment would also have to be in accordance with the policy provisions. To do otherwise, the Company would not be administering the Policy uniformly as between all policyholders. The Ombudsman held that the encashment request received by the Company was given effect to in accordance with the policy conditions.

Other cars insurance cover did not extend to cover commercial vehicles

The Complainant effected a motor insurance policy with the Company in November 2005. In February 2007 the Complainant was involved in a Road Traffic Accident involving a third party. She was driving an Isuzu Trooper at the time of the accident, which was insured in her father's name under a commercial policy with a third party insurance company. The accident was reported to the Company, but following investigation the Company declined to provide indemnity under the Complainant's policy on the grounds that the "Driving of Other Cars" extension of the Complainant's policy does not extend to cover commercial vehicles.

The Complainant however, was adamant that she was covered under her motor insurance policy. She believed that there was an onus on the Company to make the Insured fully aware of the extent and scope of the cover

being provided, but it failed to do so in this case, and should therefore be obliged to provide indemnity. She also regarded a section of her insurance certificate to be misleading. She felt that it showed that she was insured to drive her own vehicle registration number, as well as any motor car being driven by the Insured provided such vehicle did not belong to him/her and was not hired to him/her under a hire purchase agreement. She submitted that as the Isuzu Trooper was not owned by her or hired to her under a hire purchase agreement, she verily believed that she was covered under her policy to drive it.

The Ombudsman found that the Company did adequately inform the Complainant of the extent and scope of the cover being provided by means of policy documentation and that it would have been prudent for the Complainant to contact the Company directly, had she concerns regarding the extent of cover under her policy. He also found that the terms of the policy document, insurance certificate and proposal form must all be considered in this case, and not merely the insurance certificate. The completed proposal form clearly indicated that third party cover would be operative in respect of any private motor car only being driven by the Complainant, provided that such vehicle did not belong to him/her and was not hired to him/her under a hire purchase agreement. The policy document also clearly highlighted that the "driving of other cars" provision extended to private motor vehicles only. It was noted that the Isuzu Trooper in question was insured as a commercial vehicle with the third party insurance company.

The Ombudsman stated that the fact remained that the vehicle that the Complainant was driving on the date of the accident, which had no rear seats, rear passenger doors or rear windows could not be categorised as a private motor car. He found therefore that the Company had correctly declined indemnity in accordance with the policy terms in this case.

Travel insurance

(A) LOSS OF MONEY AND VALUABLES WHILE MUGGED ON HOLIDAYS

The Complainant bought a multi trip insurance policy. While travelling in South America in September 2005 the Complainant was mugged. A number of items including €1,000 cash were stolen from the Complainant's person. The goods in question were stated to be all of high value.

The Complainant submitted a claim in amount of €4,000 to the Company in November 2005. The Company requested proof of ownership. The Company stressed that such proof could include, the receipt, the warranty or the instruction documentation associated with an item, chargers or accessories for electric and electronic goods, the box or certificate associated with jewellery, bank statements showing the purchase or withdrawal of foreign currencies, or photographs showing the claimant wearing the stolen items.

The Complainant confirmed that she had exchanged the Euro for foreign currency at her local bank branch in Ireland but did not submit proof of this. The Complainant confirmed with the Company in March 2008 for the first time that she could not for various reasons submit any proof of ownership to the Company in relation to any of the goods stolen.

In this instant case the Ombudsman considered the amount of the claim, the lack of proof of purchase for any item claimed, as well as the clear and unambiguous wording of the policy document in relation to the proof of purchase requirement. Further to this consideration had to be taken of the lengthy delay on the Complainant's part in corresponding with the Company. The Complaint was not upheld.

(B) LOST BAGGAGE COMPLAINT AND A DELAYED BAGGAGE SITUATION AROSE

A claim by the Complainant under her travel insurance policy for 'lost baggage' was assessed by the Company as a claim for 'delayed baggage', but subject to a maximum payment of €130.

The Complainant's luggage had been misplaced when the Complainant inadvertently took another person's suitcase upon alighting from the air coach at Dublin airport. She travelled to South Africa with the wrong suitcase, while her own suitcase in turn was taken to Canada. The Complainant was not reunited with her own suitcase until she returned to Ireland some three weeks later.

The Ombudsman noted that the policy offered indemnity to the insured in the event of lost or damaged personal baggage. In the case of lost baggage, the policy made a distinction between the temporary loss of baggage and the permanent loss of baggage. Baggage which was lost for more than 12 hours was considered delayed (subject to a maximum payment of €130) unless it was never recovered, in which case it was considered 'permanently lost', and assessed as such with a maximum payment of €2,750.

Although the Complainant's luggage was not returned to her until she came back from her trip, thereby being significantly delayed, the facts were that she was aware of its location during her holiday and the luggage did not prove to be permanently misplaced or lost. In these circumstances the Ombudsman found that the Company had acted reasonably in assessing the Complainant's claim under 'delayed baggage', subject to a maximum payment of €130.

Naive bank official facilitated an 'interfering neighbour' to improperly deal with elderly peoples' account- €1,200 awarded

An elderly couple, a brother and sister, had a joint deposit account with a balance of approximately



€106,000 at a Bank branch in a provincial town. The monies in the account came from renting out land to a neighbour. The brother was 78 years of age and had become deaf while his sister was 85 and in hospital.

A strange tale unfolded when a complaint was made to the Ombudsman by the brother, after his sister died. He alleged that when the sister was gravely ill in hospital, a third party (a friend and neighbour of the couple) approached the Bank branch and suggested that the Complainant's name be removed from the joint account so that the account would solely be in the sister's name as that is what the sister allegedly wanted. The neighbour - who allegedly had tried to rent the land - had approached an official of the Bank who helpfully explained how this could be accomplished and then furnished the third party with documents which each of the account holders were to sign. The Complainant said that while visiting his sister in hospital, both of them signed the documents under duress which were authorisations to turn the account into the sole account of the sister and that a draft for €55,000 was to be issued in favour of the Complainant at the same time.

In response to the Ombudsman's investigation the Bank stated that the transaction was entirely legitimate and had been carried out in the proper way with valid signatures. The Bank stated that it had at all times acted in good faith and had no reason to think that the Complainant's signature was obtained under duress. The Ombudsman, however, took the view that, having regard to the age and infirmities of the account holders, the Bank was under a particular duty of care to them and ought to have contacted the account holders themselves, rather than acting on the instructions of an interfering third party. The Ombudsman accepted that the Bank official involved in this transaction had acted in good faith but had been naive to the point of negligence. Furthermore the Bank had in effect discussed its customers' business with an interfering third party; had explained the steps to be taken to change the account and had facilitated the said change. The Ombudsman found the actions of the Bank official to be highly irregular and unsatisfactory. The official apparently knew all three individuals.

The Ombudsman decided that the most appropriate remedy to do justice in the case would be to regard the change in the account as being invalid because of duress

and he so found. He directed the Bank to reinstate the joint account and to lodge the Bank draft (which had not been cashed) for €55,000 to the said account, the entire proceeds of which the Complainant was now entitled to by right of survivorship. In addition, the Ombudsman awarded €1,200 to the Complainant in compensation for the Bank's negligence and failure of duty and requested that a letter of apology should also be sent.

Husband who met with the Bank and signed what purported to be his wife's signature costs bank €52,000

A husband and wife who had recently sold property invested €100,000 in a Property Fund which then fell sharply in value. At the time of the complaint being made the investment was worth only €68,000. The Complainants alleged that the Bank was negligent in selling them this particular investment which was not the type of investment which they had wanted. The Complainants were 69 and 70 years of age respectively.

The Ombudsman's investigation showed that the Bank had set out a range of possible investments for the Complainants to consider. The Complainants chose the disputed investment. The Ombudsman was satisfied that the investment was correctly described as "*medium risk*". The Complainant stated that he had not wanted this type of investment and instead he had wanted only a short term investment. The Ombudsman however was satisfied from the evidence that the husband had not made any such thing clear to the Bank which had provided a brochure, prospectus and Terms of Business to the Complainants. The Ombudsman noted that it was clearly pointed out that the value of the investment could fluctuate and that an investor might not get back the full amount invested. The husband had conducted the business and the Ombudsman was satisfied that of his own volition the husband had knowingly decided to invest on behalf of his wife and himself in something which did not have capital security. The Ombudsman found no failure of duty of care by the Bank in respect of the suitability of this investment for the husband.

The Ombudsman however discovered that the position in regard to the wife was quite different. This was because the evidence disclosed that only the husband met with the Bank and that the husband had signed the documents on behalf of his wife who was not present. An internal note of the meeting made by a Bank official stated that the husband "*signed the application on behalf of both parties*". The Bank was asked to account for this and stated in reply that the person who wrote it had left the Bank. The Ombudsman found this to be unsatisfactory. He would have expected that the Bank would possess clear records establishing conclusively that the second named Complainant had signed the application form for her 50% interest in this investment and that she had made an informed decision in regard to the investment. No such records were forthcoming from the Bank. The Ombudsman stated that it was not sufficient to state that the official concerned had left the Bank as it should be in a position to produce meticulous, clear records demonstrating unequivocally that the wife had signed the forms in the presence of a Bank official and had been made aware of the features of the investment.

In conclusion the Ombudsman was satisfied that the husband knew the true nature of the investment. He also found as a fact on the balance of probability that the husband knew that the investment was not capital guaranteed and that its value could fluctuate. The Ombudsman found that the Bank was not guilty of any wrongdoing or breach of duty insofar as the husband was concerned.

The Ombudsman did consider that a breach of duty had been established in relation to the wife's application for the investment. The Bank had failed to follow satisfactory procedures to ensure that the wife signed the application form in question and had made the investment on a fully informed basis and this aspect of the complaint the Ombudsman found to be justified.

By way of remedy the Ombudsman decided that half the sum invested was to be regarded as belonging to the wife. He therefore directed that €50,000 must be returned to her and since this money could have earned about 4% interest in the twelve months since the investment was made, he directed the Bank to pay to the wife the sum of €52,000 in return for 50% of the investment in the Bank's Fund made by the Complainants.

€50,000 award following delayed review of Unit Linked Whole of Life Policy-systemic problem in 1,800 other cases also identified by Ombudsman

The dispute in this case related to a Company's administration of a unit linked whole of life policy, which had been taken out in 1988, in particular the Company's actions relative to the policy review where serious delays had arisen. The policyholders, in their late 60s, were medical professionals paying premiums in excess of €780 a month since 1999 for substantial life cover. In order to maintain their existing level of cover the Company informed them in September 2006 that the premiums were to increase to €2,000 a month in 2007. They were understandably upset and sought a return of over €60,000 of premiums already paid since 1999. The Company acknowledged that there had been errors in its administration of the policy but would not return the premiums.

The evidence reviewed by the Ombudsman indicated that the Company:

- ❖ carried out the first scheduled review in 1999, one year after its due date in 1998
- ❖ did not apply the default option, to automatically increase the premiums, when the complainant did not contact the Company regarding the options put forward by the Company in 1999.
- ❖ neglected to carry out the second scheduled policy review five years later in 2004, and
- ❖ quoted an incorrect fund value following a request for same by the complainants in 2007.

It was the Company's argument that despite its errors the Complainants remained on full cover and had a valid claim been made on the policy, full benefits would have been paid. The Ombudsman then considered the following further submissions made by the Company to him after he raised certain matters



- ❖ External legal advice as to the validity of the contract and the Company's obligation to pay the protection benefits in the event of a claim.
- ❖ Evidence showing that the protection benefits were reinsured with an external provider and that the Company continued to pay the reinsurance premiums for the highest level of protection benefits even after the failure to implement the reviews.
- ❖ The Company agreed that the policyholders had experienced inconvenience as a result of poor administration and considered €15,000 as appropriate compensation.
- ❖ The Company considered that the policyholders were not disadvantaged by its failure to carry out the reviews as the Complainants were held on higher level of benefits despite paying premiums which were inadequate for that level of cover.

The Ombudsman noted that the effect of the errors was cumulative and great inconvenience and frustration had undoubtedly been caused to the policyholders. He considered that it was disingenuous for the Company to expect the Complainants to merely accept that the full level of benefits would have been paid. Having met with the Company and having reviewed all of the Company's submissions (legal opinion etc) the Ombudsman accepted however that the evidence supported the Company's argument that it would have paid out full benefits had a claim arisen.

While the strict legal position may well have been that a return of premiums paid since 1999 would not be the most appropriate remedy for such poor administration, the Ombudsman stated that great inconvenience had been caused, the people had not been given an opportunity to consider alternative options even in 2004 and indeed any trust that the Complainants had in the Company's handling of their policy was lost because of the errors. Therefore, he considered that a substantial compensatory award was called for in this case. In coming to this conclusion, he had particular regard to the high level of cover that the Complainants sought to insure and the substantial premium that they were paying the Company to provide the cover and to

properly manage their policy. He also held that the Complainants' current ages of 65 and 69 years meant that finding alternative cover at the current level and at premiums of €780 a month would be difficult if not impossible to obtain. Accordingly the Ombudsman directed the Company to pay the Complainants €50,000 instead of the €15,000 it had offered.

The Company at the Ombudsman's request reviewed its records and discovered that it had failed to carry out a contractual review prior to the 10th anniversary of approximately 1,800 other Whole of Life policies. The Company indicated that it was remedying the matter and that it had informed the Financial Regulator. A copy of the Ombudsman's decision was forwarded by him to the Financial Regulator for any action it considered needed to be taken on this identified serious issue.

Bank's threatening letter debacle costs it €4,000

A customer who held a mortgage with a Bank was told that his mortgage repayments would now have to be made by a different method. The Complainant was advised that all direct debits, standing orders and other payments would be automatically changed and that the Complainant was not required to take any action at all.

However, it turned out that the Bank made a number of errors as a result of which the Complainant's mortgage fell into arrears. Although this arrears situation was entirely the fault of the Bank, the Complainant began receiving letters from the Bank demanding immediate payment of arrears of €6,000. The Complainant paid the arrears by cheque but two months later the same thing happened again, generating more letters. The Complainant then had had enough, changed his mortgage to another bank and subsequently brought a complaint to the Ombudsman against the first Bank.

The Ombudsman found that the Bank was entirely responsible for the debacle and noted that the Complainant had not lost any money and that his credit rating had not been adversely affected. Nevertheless, he

found that the Complainant had been put through a great deal of stress and annoyance. In particular in deciding on a remedy, the Ombudsman took account of the fact that the Bank had written to the Complainant stating "*the conduct of your account is totally unacceptable*" when the fault turned out to be entirely that of the Bank. In view of this and in view of the fact that the matter remained uncorrected for five months, the Ombudsman awarded €4,000 in compensation for the Bank's failure and for the distress which occurred.

Bogus non resident account allegedly held by a member of the Gardaí - €2,000 compensation follows as bank at fault

A man received a letter from the Revenue Commissioners asking him to account for a bogus non-resident account held in his name at a branch of a Building Society in the West of Ireland, the Revenue having been notified by the Building Society in accordance with law. This man had never had such an account and he brought a complaint to the Ombudsman seeking compensation for upset, distress and trauma as a result of the Revenue enquiries which he alleged had been facilitated by the Building Society in opening the account in his name. The Ombudsman was satisfied from his investigations that this was not what had happened. It was clear that the person opening the account had the same name as the Complainant and had used an address in London with which the Complainant had absolutely no connection whatsoever. The Building Society had made an error and supplied incorrect details to the Revenue. The Building Society, while admitting to, and regretting the error, said it was no big deal and the matter had been easily cleared up.

The Ombudsman, however, found that the Complainant should never have found himself in this position and that he was fully justified in feeling wronged (all the more so because he was a member of An Garda Síochána where allegations of tax evasion would be particularly distressing). The Ombudsman awarded €2,000 in compensation.

Accountant's unnecessary delay in submitting financial accounts to Insurance Company resulted in the Claimant's Income Protection claim not being assessed.

In 2004 the Complainant received payment under a Serious Illness claim. The Complainant also had Income Protection cover at this time, but did not make a claim under same until 2005. On receipt of the claim the Company gave deadlines as to the receipt of information relative to the claim. Following the late receipt of information in 2007 the Company declined to assess the claim.

From the Ombudsman's investigating officer's initial examination of the evidence it was found to be clear that the Company gave the Complainant ample time to submit information relative to his claim, but unfortunately the Complainant failed to comply with the Company's requirements within the appointed time frame. The policy specifically stated that the refusal or failure to comply with requirements, to the satisfaction of the company, and within such period of time as the company deemed reasonable, would result in the non payment of benefits in respect of the life insured. The initial Finding was that the Company acted within its contractual rights when declining the claim. However, because of the particular circumstances of the case, an award of €2,500 was made.

The Complainant indicated that he was unhappy with the Finding and requested to meet the Ombudsman. As a general rule, Complainants are not met in person during the course of an investigation as most investigations are carried out by documentary evidence, be it in the form of replies to questionnaires or an examination of file. However, there are occasions at final review stage where the Ombudsman, may decide to meet with the parties to either elaborate on certain conditions or where he feels that the person may not be capable of putting their genuine thoughts into writing. Having preliminarily reviewed the matter, he felt that this was an occasion where he would meet the Complainant.



At the meeting the Complainant explained that the real reasons for delay in submitting the claim and the late submission of his financial accounts to the Company were:

- ❖ lack of energy (due to his illness) to pursue the matter at the relevant time
- ❖ his Accountant delayed in preparing the information for the Company.

The Ombudsman noted that his investigating officer was not made aware of these mitigating circumstances prior to the initial Finding having been issued. The Ombudsman did accept that the Complainant had problems with his Accountant in having his financial accounts submitted to the Company even though the accounts had been completed when the Company asked for them; this he felt was a matter that he should have addressed with his Accountant as the Company could not be held responsible for same. While the Ombudsman found that the Company could not be expected to keep a claim file open indefinitely and that there were policy requirements regarding the provision of information, it was his opinion that a person with a serious illness may not have the energy to pursue matters to the fullest within time frames that normally apply particularly where his accountant was a major problem. Accordingly he directed the Company to re-open the claim and assess the Complainant's claim for Disability Benefit in accordance with the terms and conditions of the policy. As well the award of €2,500 originally given under the initial Finding was to stand on the following terms; the Complainant was to receive the greater of (i.e. not both) the benefit payable under the policy (subject to him medically and financially qualifying for same) and, the €2,500 award. In other words the least the Complainant should receive was €2,500.

Loan protection insurance not extended to consolidated loan-bank directed to write off €17,000 of a €23,000 loan

The Executors of the estate of a man who, shortly before he died, obtained a top-up Bank loan for €6,000 which brought his indebtedness to the Bank to €23,000 brought a complaint to the Ombudsman. The earlier indebtedness of €17,000 had been covered by loan protection insurance. However, the new consolidated loan was regarded as an entirely new loan and was not covered by the loan protection insurance which he had enjoyed on the earlier loan. The man died shortly afterwards. His Executors complained to the Ombudsman that because of the consolidation of the loans the new debt of €23,000 was not covered by any loan protection, whereas the earlier loan balance of €17,000 had been covered.

The Bank pointed out in response to the Ombudsman's enquiries that the deceased borrower had stated clearly that he did not want insurance. The Ombudsman found that although the Bank had acted within its rights in consolidating the loan into a new loan of €23,000 without loan protection being in place, it did have an obligation to its customer to point out forcibly that whereas the original loan was covered, the consolidated loan was not (even for the original amount).

The Ombudsman decided that on balance the Bank had failed in its obligation to the deceased customer in allowing him to add the €6,000 extra loan into a consolidated loan for €23,000 with the consequence that the loan protection of the original €17,000 was forfeited. The Ombudsman felt this was grossly unfair and he directed the Bank to write off €17,000 of the consolidated loan, thus reducing the debt owing to the Bank from the estate to €6,000.



€7,500 awarded for partly 'unsuitable' investment advice

A man who had received compensation for a work accident and was on an invalidity pension contacted a Bank in 2001 and enquired about investments for the capital sum he had obtained - €127,000. He had wished to invest in a five year term deposit account but claimed that a member of the Bank staff told him that he would be better advised to invest in a Bond. He accordingly invested in the bond in the hope of a better return but withdrew €52,000 after ten days prior to the issue of the bond. The return on the bond failed to materialise and at the end of the five year period of the Bond the Complainant was advised that he would receive back only the original €75,000 he had invested five years earlier.

The Bank justified the advice on the basis that its customer would have been taken through the Terms & Conditions of the Bond and a copy of the brochure would have been given to the Complainant. The Bank also pointed out that there was a cooling-off period of two weeks during which the Complainant could have changed his mind. On considering these points the Ombudsman took the view that one would have had to have a considerable amount of financial literacy to follow the Terms & Conditions contained in it. The Ombudsman thought that just as a letter had been sent out giving clear and concise calculations for ordinary term accounts, a letter should have been sent to the Complainant in this case and it was not.

The Ombudsman came to the conclusion that it would have been better had the Complainant placed his money in a five year term deposit account. However, he was by no means forced to do so and the Ombudsman felt that the responsibility for the lost opportunity to him should be divided between himself and the Bank with the Bank being responsible for 35% of the loss and the Complainant for 65%. Accordingly, the Ombudsman directed that the Bank should pay the sum of €7,500 to the Complainant for the partly unsuitable advice which had led to the investment he made.

Switch of Medical Plans recommended by the Health Insurer resulted in no cover for cardiac treatment expenses; restoration to original Medical Plan, without a two year waiting period, directed by Ombudsman and €5,000 compensation

In November 2005, the Complainant received a mail-shot from his medical insurer, advising that the Company believed that a change from his current Medical Plan to an alternative Medical Plan, would offer the Complainant and his family health care cover which would be more relevant to their current needs. The mail-shot listed benefits which included a much reduced excess for day-to-day medical expenses, improved maternity benefits, improved cover for dental treatments etc., and advised that in the event of a change to this Plan, the policyholder would no longer have cover in the Blackrock Clinic or Mater Private Hospital. A brochure was enclosed providing full details. The Complainant considered the terms of the mail-shot and on the following renewal date, he proceeded to change to the Medical Plan which had been recommended by the Company.

Almost two years later in July 2007, the Complainant was admitted to Blackrock Clinic for cardiac treatment, but the Company subsequently declined his claim for cardiac treatment expenses, because his Medical Plan did not cover Blackrock Clinic. The Complainant was naturally highly annoyed and he took the view that because of his age profile and that of his wife (49 & 48 respectively in 2005) and because their only child had then been 12 years old, the Plan recommended by the Company in 2005 had not in fact been suitable for them. He felt it was rather a Plan which might be more suitable for a family with a lower age profile. He was also very annoyed that when he sought to change back to his original Medical Plan, he was advised by the Company that he would be subject to an "up-grade clause" which would rule out any cover for cardiac treatments at Blackrock Clinic or Mater Private Hospital for a period of two years, even though at the time of the change of Plan in 2005, he had not been warned by the Company that the change recommended, was in fact a down-grade of cover. The Complainant sought the reinstatement of the original Medical Plan with



retrospective effect, with no penalty or waiting period, together with payment by the Company of his medical expenses which amounted to some €25,000.

The Company advised that whilst it had offered information on the new Medical Plan available, it had not actively advised the Complainant to change his cover, and the information furnished had clearly set out the differences in the cover provided by the Plans. The Company maintained that it was always a matter for the Complainant himself to make the decision, on the basis of the information provided. In those circumstances, the Company considered that it would not be appropriate to reinstate the Complainant's original Medical Plan with retrospective effect.

On the basis of the evidence furnished by the parties, the initial finding by the Ombudsman's Investigating Officer was that although the decision by the Complainant was ultimately one for himself alone, nevertheless, the Company ought not to have directed the particular mail-shot letter to the Complainant in August 2005, as the change of Plan (which the Company advised the Complainant would provide more relevant medical cover to him and to his family) was not in fact a suitable change given the age profile of the family in question. In addition, the Company had not alerted the Complainant to the implications of the change as regards the applicable waiting period, if the Complainant wanted subsequently to revert to the original Medical Plan. The Investigating Officer awarded the Complainant a sum of €5,000 towards his medical expenses and directed the Company to restore the Complainant and his family to the original Medical Plan with effect from 1 November 2007, without the application of any waiting period. Both the Complainant and the Company were unhappy with this finding and both made further submissions on the matter to the Ombudsman. Having considered these submissions, in his Final Decision the Ombudsman stated that:

- ❖ He agreed with the finding that the Complainant must take responsibility for his own decision to embark upon the change in Medical Plan which the Company had offered to him, and he ought to have fully acquainted himself with the relevant information before he proceeded to make the change.

- ❖ The Company ought to have been aware that the type of mail-shot directed to the Complainant could easily persuade a policyholder to proceed with the switch of Plan recommended, on the basis of the Company's "belief" that it would provide more relevant health care; policyholders were likely to trust the Company's belief implicitly, given its high reputation for good service delivery.
- ❖ The Plan which was most relevant to the Complainant and his family was a Plan which was suitable to the entire family circumstances.
- ❖ The mail-shot should have been more explicit in its advice, in respect of the implications of a change of Plan, with regard to the requirement for a waiting period, if the policyholder subsequently wished to change back; he accepted nevertheless that the Company had acted in good faith.

The Ombudsman directed the Company to pay €5,000 to the Complainant but the Complainant be also allowed switch back to his original Medical Plan from November 2007, without the application of a waiting period. He also directed that the Company, for the future, as soon as was administratively possible, should clearly warn a policyholder in writing of the consequences, in circumstances where a change of Plan would give rise to a waiting period condition, if the policyholder subsequently wished to change back.

Lack of clarity as to what was covered under an insurance travel policy-€600 awarded and a review of former claims follows

A claim for the theft of a personal laptop computer was repudiated by an insurance Company. The Company argued that the laptop was not covered, as the circumstances leading to the claim i.e. theft of the laptop, would fall under the policy exclusion i.e. "[the Company] will not pay for loss or damage to computer equipment". However the Ombudsman noted that the policy clearly stated that cover was provided if Personal

Property was lost, damaged or stolen. On a strict interpretation of the policy computer equipment was excluded for cover in all eventualities i.e. loss, damage or theft. However, as the Ombudsman considered that there was lack of clarity in the policy document as to what were personal property and this lack of clarity could reasonably cause confusion an award of €600 was accordingly made by him.

The Ombudsman had concerns that there may have been other claimants over the years that were affected by this lack of clarity in the policy document. In this regard he noted that a previous complaint under this policy against this Company in May 2005 resulted in a finding for another claimant also. In the interim period the Company did not appear to have considered altering the wording of the policy to take account of the identified lack of clarity. The Ombudsman then inquired whether other claimants over recent years were adversely affected with their claims under the particular section of the policy and (if there were any claimants identified), what action the Company were proposing to take with regard to those claimants. The Company advised that it had provisionally identified approximately 800 property claims that had been rejected over the past 3 years. The Company also advised that it was getting the files back from storage and that it intended to reconsider and review them individually. Following this review 4 other claimants were recouped their loss. The Ombudsman commends the Company's action.

The Ombudsman referred the matter to the Financial Regulator for any action it considered needed to be taken.

Award of €15,000 made as Broker did not draw to the Complainant's attention the possibility of increasing her disability cover

A complaint about the payment of disability benefit under the Complainant's Personal Pension Plan was received. The Complainant was unhappy that the level of disability benefit had not increased since the plan commencement (the Complainant having chosen not to index the cover). She stated that it was the responsibility

of the Broker, when reviewing and increasing the pension contributions annually, to have also increased the disability benefit also- the Ombudsman specifically noted that the Complainant had instructed the Broker to have aspects of her pension plan changed, including premium increases, lump sum injections into the plan and fund switches. The Broker argued that no instruction either written or verbal was ever received from the Complainant to have her disability benefit increased.

The Ombudsman noted that when the agency for the personal pension plans was transferred from her corporate pension's adviser to the Broker in April 2003, the Broker issued the Complainant with Terms of Business, which set out the general terms under which the firm would provide insurance and investment business services, and the respective duties and responsibilities of both the firm and the policyholders. On the basis of the evidence submitted the Complainant did not specifically ask for a review of the disability policy on a periodic basis by the Broker. Whilst the Disability Benefit policy did provide for increases in the level of disability benefit, on the basis of the evidence submitted to the office, the Complainant did not at any time elect to increase the amount of the PHI cover under the plan.

Noting the Broker's Terms of Business for the review of policies stated - *"With your agreement, we may review the policies you take out on a periodic basis to ensure you are kept informed as to their benefit and to check whether they are still suitable for your needs"* - the Ombudsman felt that it could be argued that it was unclear whether it was the Complainant or the Broker who should instigate a review of the Complainant's policies. He considered that the Broker's documentation should have been clearer as to the Complainant's responsibilities with regard to ensuring that the benefits were adequate to her needs. While it was ultimately the Complainant's responsibility to ensure that the benefits under the disability plan were adequate to her needs, the Ombudsman was also of the view however that the Broker had some responsibility in this regard. Indeed it would have been prudent for him to have at least raised with the Complainant the issue of a review of her policies particularly as the pension plan element was reviewed regularly. Also other aspects of her policy were reviewed annually.



Taking all of the circumstances of the dispute into consideration, the Ombudsman held that a once-off award of €15,000 was called for by the Broker in this instance solely because he did not draw to the Complainant's attention the possibility of increasing her disability cover. As this was not done the Ombudsman also stated that he could not know whether the disability cover would have been increased by the complainant and the award reflected this.

Lost property title deeds merits €3,500 compensation

Customers of a Bank gave a legal charge to the Bank over property which they owned in the U.K. Three years later they asked that the Deeds be forwarded to their solicitor on an accountable receipt in order to facilitate sale of the property. The Deeds could not be found. It seems that the Bank's solicitors in the U.K. lost the Deeds and the proposed sale of the property had to be cancelled. The customers in Ireland had to bear the cost of re-constituting the Deeds.

The Ombudsman decided that although the Irish Bank had not lost the Deeds, the Bank was vicariously liable to these customers for the loss of the Deeds and its consequences. The Ombudsman awarded €3,500 in compensation (this sum to include the cost incurred by the Complainants in having the Title to the property re-constituted).

€3,000 awarded against credit union over loan insurance for a disabled person

A lady who had a loan of €25,000 from a Credit Union had become disabled as a result of an accident and she was then unable to keep up repayments on the loan. The Credit Union did not inform her that her loan was covered by permanent disability insurance. Two years elapsed during which extra interest accrued on the loan. Finally the Complainant herself raised a query on her

own behalf with the Credit Union and the Credit Union confirmed that the loan did indeed enjoy insurance cover. The Credit Union then lodged a claim on her behalf. The insurance company allowed 70% of the claim but repudiated 30%, leaving a balance of approximately €8,000. The Credit Union then lodged an appeal against the partial repudiation. This appeal was rejected. The Credit Union did not furnish the Ombudsman with any explanation of this refusal despite being asked to do so and the Ombudsman could not be satisfied that the application for the insurance and the subsequent appeal had been done properly.

The Ombudsman found that the Credit Union had failed in its duty of care to this member in respect of loan insurance and in the circumstances directed that the Credit Union make a payment of €8,000 by way of credit to the account of the said member.

Incomplete address on motor insurance company records had serious consequences for a teenager after an accident

The Complainant incepted and paid for comprehensive motor insurance in April 2007 costing €2,000 for a smallish type car. She was aged seventeen and later included her brother on her insurance for one day in May 2007 by phone contact at an extra cost of €177 - apparently they were going to a music festival and he was the designated 'non alcohol' driver. The Company stated it issued a letter to the Complainant confirming these details and requesting payment for cover for the Complainant's brother. The Company stated that no payment was received. After attempts to contact the Complainant the Company issued a letter by recorded post to the Complainant in July 2007 requesting payment for the additional driver within 10 days to avoid cancellation of the motor policy with effect from 00.01 hours on 21 July 2007. The Company stated that within the said 10 day period it made numerous attempts to contact the Complainant by phone without success. However on 19 July 2007 the Company stated it made contact with the Complainant and advised her of the outstanding balance and the cancellation date of 21 July

2007 but the Complainant stated that from this conversation she believed she had ten days to pay the outstanding amount.

When the Complainant contacted the Company on 23 July 2007 to report an accident that had happened the previous day she was informed that *"her insurance was cancelled on 21 July 2007"*. The Complainant stated she had no notification of the insurance being cancelled. She stated the Company stated it sent her a registered letter. The Complainant stated that no registered letter was received by her and that the Post office confirmed (on the phone) that *'no registered letters has been sent to the address'*. The Company stated there was no evidence that this letter was returned undelivered to the Company. The Company also stated that as no payment was received it cancelled the Complainant's policy with effect 21 July 2007. A letter confirming the cancellation and the refund due was issued to the Complainant on 25 July 2007. The Company believed it followed all procedures before proceeding with cancellation of the Complainant's policy.

The Ombudsman noted a significant error by the Company in relation to the Complainant's insurance policy as the address used to communicate with the Complainant was seriously inadequate and incomplete and may have contributed to the Complainant not receiving notification of cancellation of her motor policy. The address used by the Company carried no town name just a street name and county. The Ombudsman considered that this may have contributed to letters not being received. However he got confirmation from the complainant's father that she had received her insurance policy and disc before the accident. The Ombudsman considered that the incorrect address details could mean that some letters were delivered while others may not. He also noted that the complainant was making no claim for damage to her own small car but an estimate for €4,200 was submitted as the cost of the damage to the other SUV vehicle.

Due to the address mix up, the precise recall as to what was said on the phone by both parties and taking account of the person's young age and sincerity the Ombudsman on balance directed the Company to pay the Complainant what it considered to be an appropriate amount for the damage caused to the other

vehicle as well €400 for bad customer service. He made the €400 award as he was not satisfied that the complainant had received the other notifications even though she had received the insurance disc and policy in May and had incurred distress and expense since the accident happened. He also asked that the company file regarding the Complainant carry an explanation regarding the circumstances of the cancellation in order to ensure the Complainant has no adverse repercussions when she is seeking motor insurance in the future and the company readily agreed to this. The Ombudsman also suggested to the Company that its internal auditing department review their procedures to ensure that its database had complete and correct addresses for their policy holders.

In coming to his decision the Ombudsman accepted that the Company acted in good faith in cancelling the policy in accordance with its terms and conditions especially when the amount was not paid after two months.

Take reasonable care while on holidays-stolen property claim

A middle aged man travelled to Asia on a two week holiday. Before his departure he decided to purchase a single trip travel insurance policy to cover the duration of his trip in the event of any unforeseen eventualities. Approximately a week into his trip the Complainant had a suitcase stolen from his hotel room. A substantial claim for €3,700 was subsequently submitted to the Insurance Company for the theft of the suitcase and its contents. The case had contained valuable items such as the Complainant's passport, airline ticket and €1,600 cash.

The Insurance Company after assessing the claim repudiated it on two grounds after reviewing a police report, embassy report and CCTV evidence. Firstly the claim was declined due to the fact that the suitcase was stolen by a local woman who was known to the Complainant. Secondly it transpired that prior to the theft the Complainant and this woman were in his hotel room, both had left some time later but afterwards she returned on her own and gained lawful access to the



room. She was later seen leaving the room with his luggage before he returned. The Company stated that this was an apparent lack of care taken by the Complainant for the security of his belongings. Furthermore, the cash was not covered as under the Company terms and conditions there was a requirement that it be held in a 'safety deposit box/safe or on your person'. The Ombudsman after assessing all the submitted documents could not find in favour of the Complainant. While the Ombudsman was in no doubt that a genuine theft had taken place, he was in agreement with the Insurance Company that the Complainant had failed to exercise due care for the safekeeping of his personal items. Allowing individuals access to your personal belongings especially on holidays carries the risk of some unforeseen event taking place which unfortunately resulted in a theft in this instance.

The Ombudsman publishes this matter solely to put the public on notice of the responsibility to safeguard their belongings at all times. An insured person carries responsibility for safeguarding his/her luggage and valuables and must remain vigilant especially when travelling abroad. An insurance claim is not the answer for such negligence.

Cancelled cheque

A customer of a Bank issued a cheque for €4,100 and then tried to have the cheque stopped. The cheque was paid however. The customer claimed that the Bank was negligent in allowing the cheque to be cashed despite his order to stop it. He claimed that a Bank official had said "that cheque is now cancelled". The Ombudsman's investigations revealed that the Complainant had telephoned the Bank at 11:23 a.m. on 7 March and requested that a stop be placed on the cheque which he had issued on 6 March. He said he was given an assurance that this would be no problem and he attended at his branch the following day and filled out the necessary form for stopping a cheque. The Ombudsman's investigations also revealed that the cheque had been issued on 6 March and was cashed at 10:29 a.m. on 7 March at the Complainant's branch, so

that when the Complainant telephoned a stop order at 11:23 a.m. on 7 March, it was already too late.

Even if a Bank official had in fact said "that cheque is now cancelled", such a statement had clearly been made in good faith and had been predicated on the possibility of the funds being retrievable had the said cheque been lodged to an account at the same branch. The Ombudsman found that the onus was entirely on the Complainant to give the stop order before the cheque was cashed and he had not done this. Attending at the branch subsequently and filling out a "stop notification form" could not alter this. The Ombudsman found that there had been no failure or negligence on the part of the Bank and the complaint was not upheld.

Motor Insurance dispute concerning notification of policy cancellation

The dispute arose over the alleged failure of the Company to notify the Complainant that his policy had been cancelled. The Complainant was involved in an accident while he was driving his private motor vehicle. The following day his father reported the accident to the Company only to be told that his insurance policy had been cancelled some four weeks previously, and that the Complainant no longer had cover in place. The Complainant insisted that he had not received any pending cancellation notice nor was he put on notice of the cancellation after it had been carried out. The Company on the other-hand was quite adamant that the Complainant had been advised through different mediums that his policy was cancelled. The Company stated that one of the forms of communication was through a recorded letter advising him that his policy would be cancelled 10 days from the date of said letter.

Having reviewed all the relevant submissions by both parties to this dispute the Ombudsman was satisfied that the Company had in fact informed the Complainant of the cancellation of his motor policy. He found that the Complainant had twice contacted the Company's offices after the date of cancellation and that he was advised on both occasions of the current status of his policy.

However, the Ombudsman noted that the Company had issued the Complainant's final 10 day cancellation letter by regular post and not through recorded post thereby breaching its own policy terms and conditions. He communicated with the Company about this lapse and felt it appropriate to bring this aspect to the attention of the Financial Regulator.

Death certificate determined that personal accident travel insurance was not payable

The insured English female died whilst on holiday in Greece in 2006. The Complainant's solicitors made a 'personal accident' claim under the insured's travel policy. The Company declined the Complainant's claim for accidental death, as it stated the deceased's death was as a result of a heart attack. The Complainant's solicitors argued that the death certificate stated deceased's death was "unascertained". The Complainant's solicitors asked that the Company reconsider its declination of the claim as they could not see how the Company could "have determined that the death was as a result of a heart attack when there was clearly medical evidence to the contrary".

In coming to his Decision the Ombudsman noted that

- ❖ The information recorded in Greece included, *inter alia*, the Death Certificate, postmortem information, the incident report and contemporaneous information from those who observed the Insured being taken from the sea.
- ❖ Information supplied in relation to the insured's death stated "she was dragged from water – tried to resuscitate for 40 minutes... postmortem found the insured had heart attack". The post mortem was carried out on the deceased in Greece.
- ❖ The Greek Death Certificate stated "according to the certificate established by the Forensic MD, the death was caused by a recent infarct of the myocardium". Additionally, the appendix to the Death Certificate stated the "the insured deceased having succumbed to a recent infarct of the myocardium"
- ❖ The UK Coroners Court in December 2006 stated the injury or disease causing death was "Unascertained", and the conclusion reached by the Coroner as to the death was "Open". The UK Coroner's Court in a letter of February 2007 also stated "... (the) unfortunate death was recorded in Greece, therefore no Death Certificate will be issued in England"
- ❖ Though the Complainant's solicitors had argued that the death certificate stated the deceased's death was unascertained in fact it was the Coroner's Court that stated the deceased's death was unascertained but no English death certificate issued.

As the death certificate issued in Greece was clear in its pronouncement that the insured died from a heart attack and having considered all the other evidence submitted the Ombudsman could not uphold the complaint despite having the utmost sympathy for the next of kin.

Insurance Company not responsible for failure of car engine

A car owner claimed comprehensively on his motor policy, when he skidded and damaged his vehicle. He was originally very happy with the repairs undertaken at the repair shop which the insurer directed him to, but some weeks after the repaired vehicle was returned to him, the vehicle simply lost power whilst he was driving and came to a halt. Though the insurer offered to discharge 50% of the cost of the new engine required, the Complainant was unhappy, as he was firmly of the opinion that the original repairs had caused the ultimate engine failure, and he believed that the insurer was responsible because it was the Company which had directed him to the particular repair shop in question. Although the Company had paid the Complainant 50%

of the cost involved, a subsequent engineer's report ruled out the possibility that the fault had been connected to the original repairs. The Company nevertheless advised the car owner that the payment already made could be considered as a goodwill gesture.

The Ombudsman's Investigating Officer noted that the repair shop was not a financial service provider and that, consequently, the office had no jurisdiction to investigate any complaint which the car owner had against the repair shop. It was also found that the repair shop was not an agent of the Insurance Company; it was simply a repair works which the Company approved for the purpose of carrying out work to the vehicles of its insured customers. In addition, if the Complainant was correct in his opinion that the ultimate engine failure had been caused by the repair works, then this would be a matter between the Complainant and the garage, as the insurer would have no part to play in relation to any alleged negligence on the part of the garage in carrying out those repairs. The Investigating Officer found that the Company had acted reasonably in all of the circumstances and the complaint was not upheld.

The Complainant was not happy with this finding and after receiving his appeal the Ombudsman sought further information including a copy of any agreement between the Company and the repair shop. Having considered that documentation, the Ombudsman found that the repair shop had been accepted by the Company onto its panel of recommended repairers, having agreed to certain minimal standards of service levels for the Company's policyholders. The Ombudsman did not accept however that the repair shop was an agent for the insurer as its principal, and he did not uphold the Complainant's grievance in that regard.





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