APPROVED **[2020] IEHC 538**

THE HIGH COURT

2019 No. 286 MCA

IN THE MATTER OF AN APPEAL UNDER SECTION 64 OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN ACT 2017

BETWEEN

UTMOST PANEUROPE DAC

APPELLANT

AND

FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

RESPONDENT

AND

W.

NOTICE PARTY

JUDGMENT of Mr. Justice Garrett Simons delivered on 10 November 2020

NO REDACTION REQUIRED

INTRODUCTION

1. This matter comes before the High Court by way of a statutory appeal against a decision of the Financial Services and Pensions Ombudsman ("***the Ombudsman***"). The decision of the Ombudsman concerned the manner in which an insurance provider had processed a claim pursuant to a group income protection scheme ("***the scheme***" or "***the policy***"). The complaint was made by the insured party against the insurance provider which now administers the scheme, Utmost Paneurope ("***the insurance provider***").

2. In brief outline, the insured party has a complex medical history and had been the subject of specific exclusions at the time of her entry into the scheme in 2006. The insurance provider subsequently declined a claim made pursuant to the scheme in 2016 on the basis that the insured party's inability to work was not attributable to a non-excluded illness.

3. The insured party then made a complaint to the Ombudsman, and the Ombudsman upheld the complaint in full. The Ombudsman directed the insurance provider to admit the claim from a particular date, and to make payments from that date into the future. This direction was subject to a rider that the insurance provider remained entitled, in accordance with the policy provisions, to further review the claim at any time in the future. The insurance provider has appealed the Ombudsman's decision to the High Court.

4. The threshold which must be met before the High Court will interfere on a statutory appeal is discussed in detail presently. For introductory purposes, it is sufficient to note that the impugned decision must be vitiated by a serious and significant error or a series of such errors.

5. The two principal issues for determination by this court on the appeal are as follows. The first is whether the Ombudsman erred in determining that the insurance provider had placed too great an emphasis on an attempt to decline cover. The second is whether the remedy prescribed under the terms of the impugned decision is erroneous.

MEDICAL HISTORY

6. In order to understand properly the issues which fall for determination on this appeal, it is necessary first to refer briefly to the insured party's medical history. It should be emphasised that this is done solely to provide context for the dispute which has now arisen. It is neither necessary nor appropriate for this court to make any findings of fact in this regard.

7. It is common case that the insured party suffers from fibromyalgia. It is also common case that the insured party is excluded from making a claim in respect of this illness. This is because when the insured party was admitted to the group income protection scheme in November 2006, she was subject to a number of "member specific" exclusions, and these are defined in such a way as to exclude claims related to fibromyalgia. (See letter of 22 November 2006 to the insured party).

8. The insured party also suffers, to some extent, from rheumatoid arthritis. The precise extent of this illness, and its implications for her ability to work, had been a matter in controversy during the course of the processing of her claim.

9. The insured party has been examined by three consultant rheumatologists. She had attended two of these consultants in 2016, having been referred to them by her general practitioner. The key findings in their respective reports are set out

below. The insured party had subsequently been examined by a third consultant in December 2016 at the request of the insurance provider as part of the processing of her claim.

10. The first report in time is that of Dr. Lee. This report is dated 22 April 2016 and had been included as part of the claim submitted to the insurance provider on 8 June 2016. Insofar as relevant, the report reads as follows.

> "There are no clinical evidence of active Rheumatoid Arthritis despite a raised CCP Ab. Her current clinical presentations and features are more in consistent with that of Fibromyalgia. I have commenced her on Lyrica starting at a low dose of 25mg·nocte for the first week to be increased to 25mg bd maintenance. I have also advised her to consider Cognitive Behavioural Therapy if needs be. Given the positive CCP Ab, I will see her for follow up in 2-3 months with repeat FBC, FSR and CRP."

11. The insurance provider made an initial decision to decline the claim on 29 July 2016. The insured party exercised her contractual right of appeal. As part of her appeal, a report from a second consultant rheumatologist, Dr O'Connell, was included. This report is dated 28 September 2016. The relevant part of the report reads as follows.

> "Thanks for your letter. With regards to our diagnosis I would regard there being a number of different issues going. It is our feeling that you probably do have rheumatoid arthritis though thankfully it is relatively early. This appears to be causing at least some of the pains in your hands, feet, knees and other joints. It can be associated with marked morning stiffness. In your case it is not associated with marked swelling in the joints but it does have positivity for the anti CCP Antibody and a moderately raised ESR and CRP. Rheumatoid factor is negative. You also have a fair deal of widespread muscular pain with poor sleep and have had bladder problems, a chest pain which thankfully has turned out to be non-cardiac, general fatigue which may in part be related to the rheumatoid and part to the generalised pain and a number of other symptoms."

12. There is then a paragraph setting out medication which it is unnecessary to repeat here. The report then concludes as follows.

> "I hope this can help clarify symptoms for your insurance agent. I do believe that rheumatoid arthritis is a significant component of your problems but not the only one. I am hoping for a steady improvement over the next few months."

13. It is necessary to break off from the chronology here to explain that a subsequent report had been prepared by Dr. O'Connell in 2018. This subsequent report is dated 18 May 2018, and had been submitted as part of the procedure before the Ombudsman. For ease of exposition, the relevant portion of this report will be set out below, albeit out of sequence.

> "I wish to confirm that you carry a diagnosis of rheumatoid arthritis. This diagnosis was made in 2016. It is based on positive anti CCP antibodies, in a history of inflammatory arthralgias involving the small joints of your hands, your feet, your knees and other sites and the presence of typical synovitis in a number of small joints in your hands and feet. Physical exam has confirmed that this is the non-deforming type of rheumatoid arthritis but it has required treatment from cortical steroids and you are currently being treated with a mixture of medications including the disease modifying drug hydroxychloroquine. To the best of my knowledge I can find no reports of rheumatoid arthritis being diagnosed before 2016. Other features supporting this diagnosis due to a raised ESR on a number of occasions and a raised CRP. I hope this information clarifies the situation for you with regard to rheumatoid arthritis and I am very happy for it to be used as you see fit."

14. Returning to the events of 2016, the insurance provider had, as part of the contractual appeal, requested that the insured party attend a third consultant rheumatologist, Dr. Howard, for the purposes of an independent medical examination. Dr. Howard prepared a very detailed report. The report appears to be undated but is based on a medical examination which took place on 14 December 2016. The conclusions are stated as follows.

> "IMPRESSION
>
> I feel that [the insured party] has evidence of fibromyalgia on examination today and I think this is the main contributing factor to her current symptoms. She also has positive blood tests for rheumatoid arthritis and her blood work does show systemic inflammation. She does not however have any gross swelling of any of her joints and her clinical picture would fit with the very early stages of rheumatoid arthritis. She has been started on a mild disease modifying medication Plaquenil and she feels that there has already been some improvement in her joint symptoms with this and one would anticipate that the localised pain in her hands and feet would improve further with ongoing use. She may well require a stronger disease modifying medication in the future and I think she is only at the early stages of rheumatoid arthritis and it is difficult to predict how symptomatic she may be in the future.
>
> I do not consider her to be permanently disabled from work. Her symptoms are currently improving with treatment of both fibromyalgia and rheumatoid arthritis. She is having a new issue with diarrhoea with some borderline incontinence with this and there may be further adjustments needed to her medication to correct this problem. My recommendation would be that she would be considered disabled from work for the next two months but at that point I feel she should be able to return to her previous activities.
>
> [The insured party] does not feel that this is the case; I get the sense that she feels somewhat overwhelmed looking after her two children and her daughter with special needs in addition to her full-time employment but I do not feel that her condition warrants her to be considered as disabled into the future."

15. On receipt of this report, the insurance provider raised a specific query with Dr. Howard by email dated 19 January 2017. Given the significance which the Ombudsman has attached to this query in his decision, it is necessary to set out the query, and the consultant's response, in full. The relevant part of the email of 19 January 2017 reads as follows.

> "I note that [the insured party's] main issue preventing her from working is in relation to her Fibromyalgia. If we take the Fibromyalgia out of the picture (Given that this was specifically excluded at underwriting stage for this claimant),

> would it be reasonable to deduce that her rheumatoid arthritis is not severe enough to prevent her from working at present?"

16. The consultant's response is set out in a letter dated 24 January 2017 as follows.

> "Many thanks for your correspondences regarding [the insured party]. I found her to have evidence of fibromyalgia and she had very mild early rheumatoid arthritis. She did not have a significant degree of rheumatoid arthritis and I do not feel that this by itself was enough to render her disabled from work."

17. The insurance provider's decision on the internal appeal cites Dr. Howard's detailed report, and then states as follows.

> "We asked Dr Howard if your symptoms of rheumatoid arthritis alone (given that fibromyalgia is excluded) would render you unfit for work and his reply is as follows:
>
> '*I found her to have evidence of fibromyalgia and she has very mild early rheumatoid arthritis. She did not have a significant degree of rheumatoid arthritis and I do not feel that this by itself was enough to render her disabled from work.*'
>
> Given the outcome of the Independent Medical examination, I regret to advise that your appeal has been unsuccessful and our decision to decline based on policy exclusions remains unchanged."

18. This decision-letter is dated 17 February 2017.

OMBUDSMAN'S DECISION

19. Before turning to examine the Ombudsman's decision, it is necessary first to explain one peculiarity of the decision-making process as follows. The practice of the Ombudsman is to circulate a "preliminary decision" to the parties prior to his issuing a "legally binding decision". (For the purposes of this part of the judgment, these will be referred to as "***the preliminary decision***", and "***the final decision***", respectively). The parties are afforded an opportunity to make further submissions in respect of the preliminary decision within a period of 15 working

days. Such submissions must, however, be confined to one or more of the following: the submissions must seek (1) to advance an additional point; (2) to point out an error of fact; or (3) to point out an error of law.

20. The preliminary decision had been circulated under cover of letter dated 14 May 2019. The central finding as *per* the preliminary decision had been as follows (at page 14).

> "I conclude from the evidence submitted that there was an overemphasis by the Provider to quantify the impact that the two medical conditions had on the Complainant's ability to work and in doing so to unreasonably and unfairly find that the excluded condition predominated, thereby preventing payment of benefit to the Complainant."

21. The insurance provider made a comprehensive submission in response to the preliminary decision. In particular, objection was made that the Ombudsman had "weighed and evaluated" the medical evidence.

22. The final decision issued on 15 July 2019. The final decision is a comprehensive document, running to some seventeen pages. The content of the various medical reports (including, relevantly, the reports prepared by the three consultant rheumatologists) are fairly summarised. The final decision also correctly identifies that the insurance provider would be entitled to decline the claim by reference to the exclusions under the policy in certain circumstances. This is stated as follows (at page 11).

> "The Complainant's membership of the scheme was conditional on her acceptance of certain exclusions. The effect of the exclusions is to limit the Provider's obligations under the policy and also the Complainant's entitlement to the benefits provided by the policy. The Provider is entitled to decline a claim once the Complainant's symptoms and medical condition comes within these exclusions. To receive the benefits provided for under the policy the Complainant must demonstrate that her symptoms and condition were covered by the policy and were not excluded."

23. The point is made (at page 12) that in order for the claim to be approved, the insured party would have to meet the definition of "disability" under the policy. (The definition requires that an insured party's inability to perform the material and substantial duties of their normal insured occupation is *as a result of* their illness or injury). This is summarised as follows in the final decision (at page 12).

> "For the Complainant's claim to be approved she must come within the meaning of disability as defined in the policy. While she may have demonstrated that she was suffering from rheumatic arthritis (a condition not excluded by the policy) that alone may not satisfy the definition attributed to disability by the policy. The policy makes clear that the condition must be of such a degree that it prevents the Complainant from performing the material and substantial duties of her normal insured occupation."

24. The final decision also acknowledges that the claim is complex on account of the insured party's medical diagnosis. This is stated as follows at page 13.

> "What makes this claim complex is that the Complainant has had a diagnosis of a number of ailments and has been classified by specialists as having other ailments, some of which the Provider consider are excluded by the policy for cover. It can be clearly seen from the submissions that there was a difficulty in deciding whether the coverable ailment (Rheumatoid Arthritis) was the ailment (on its own) that was preventing the Complainant from working. This difficulty on the part of Provider is evident from the questions it had to put to the appointed specialist. What is also evident is that there is some overlap of symptoms of both the excluded ailments (for example the symptoms of Fibromyalgia) and the covered ailment (the symptoms of Rheumatoid Arthritis)."

25. The final decision, having discussed the correspondence between the insurance provider and the consultant rheumatologist in January 2017, goes on then to state a conclusion (at page 14) to the effect that there had been an overemphasis on quantifying the impact that the two medical conditions had on the insured party's ability to work.

> "I conclude from the evidence submitted that there was an overemphasis by the Provider to quantify the impact that the

> two medical conditions had on the Complainant's ability to work and in doing so to unreasonably and unfairly find that the excluded condition predominated, thereby preventing payment of benefit to the Complainant."

26. This is the same conclusion which had been reached in the preliminary decision.

27. As noted earlier, the insurance provider had raised an objection, in its submission on the preliminary decision, to the effect that the Ombudsman had "weighed and evaluated" the medical evidence. This objection is addressed in detail by the Ombudsman in the final decision. Specifically, an *additional* three pages of text, over and above that which had been contained in the preliminary decision, are dedicated to this objection. The Ombudsman is at pains to emphasise that he is not weighing or evaluating the medical evidence nor questioning the efficacy of the chief medical officer's report. See pages 16 and 17 of the final decision as follows.

> "The Provider in its post-Preliminary Decision submission of 5 June 2019 submits that I have weighed and evaluated the medical evidence and that I have implied that the report of its Chief Medical Officer is deficient or incorrect in some fashion, and it questions whether it is appropriate that I comment and/or form a view on the efficacy of its CMO's report. I would point out that I have not questioned the efficacy of the CMO's report however, I do have concerns the basis on which the Provider has arrived at its decision in circumstances where all of the reports and communications place considerable emphasis on the Complainant's diagnosis of Fibromyalgia. It is evident to me that throughout all of the claims process and assessment, very considerable emphasis was put by the Provider on the diagnosis of fibromyalgia. The same level of scrutiny and consideration does not appear to have been given to the diagnosis of rheumatoid arthritis and the effect it has on the Complainant's ability for work.
>
> Having regard to all of the above I uphold this complaint and direct that the Provider admit the claim from the date of the expiry of the deferred period and make payments from that date, into the future. The Provider remains entitled, in accordance with the policy provisions, to further review the claim at any time in the future."

28. The formal conclusions of the Ombudsman are then set out as follows at page 17 of the final decision.

> "Conclusion
>
> My Legally Binding Decision pursuant to Section 60(1) of the Financial Services and Pensions Ombudsman Act 2017, is that this complaint is upheld on the grounds prescribed in Section 60(2) (b) and (g).
>
> I direct pursuant to Section 60(4) of the Financial Services and Pensions Ombudsman Act 2017, that the Respondent Provider admit the claim from the date of the expiry of the Deferred period and make payments from that date, into the future.
>
> The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision."

29. To assist the reader in understanding the precise legal basis for the final decision, the relevant provisions of section 60(2) are set out below.

> (2) A complaint may be found to be upheld, substantially upheld or partially upheld only on one or more of the following grounds:
>
> […]
>
> (b) the conduct complained of was unreasonable, unjust, oppressive or improperly discriminatory in its application to the complainant
>
> […]
>
> (g) the conduct complained of was otherwise improper

30. As discussed presently, it is significant that the final decision is not grounded on a finding that the conduct complained of was contrary to law (subsection 60(2)(a)).

DETAILED DISCUSSION

OMBUDSMAN'S JURISDICTION

31. The Ombudsman's jurisdiction to consider and determine complaints is created by Part 5 of the Financial Services and Pensions Ombudsman Act 2017 ("***the FSPO Act 2017***"). Unless otherwise stated, all references below to a section of an Act are intended to refer to the FSPO Act 2017.

32. The statutory regime is broadly similar to that which had applied to the financial services ombudsman under the Central Bank Act 1942 (as amended). The latter office has since been dissolved and its functions transferred to the financial services and pensions ombudsman (referred to throughout this judgment as "***the Ombudsman***"). The establishment date under the FSPO Act 2017 is 1 January 2018.

33. The Ombudsman's jurisdiction to consider and determine complaints in respect of the conduct of a financial service provider is extensive (section 44). The Ombudsman can consider not only complaints made in respect of the provision of a financial service, but can also consider complaints in respect of conduct involving an *offer* to provide a financial service, or involving the *failure* to provide a particular financial service requested by the complainant. In such circumstances, the Ombudsman has jurisdiction to uphold the complaint on the grounds, *inter alia*, that the conduct complained of was unreasonable, unjust, oppressive or improperly discriminatory in its application to the complainant.

34. The Ombudsman's jurisdiction is thus not confined to circumstances where there is a contractual relationship between the financial service provider and the complainant. Indeed, the complaint might be precisely that the financial service

provider *refused* to provide a particular service, with the consequence that no contract was ever entered into between the parties.

35. The Ombudsman appears to enjoy what might be described as a hybrid jurisdiction, whereby he may adjudicate not only on contractual disputes, e.g. where a complainant alleges that the conduct of a financial service provider in refusing to honour a claim is in breach of contract, but may also make determinations and direct remedies in respect of conduct which, while not contrary to law, is found by the Ombudsman to be "unreasonable" or "unjust".

36. The statutory regime governing the Ombudsman's statutory predecessor, the financial service ombudsman, had entailed an equally broad jurisdiction. The nature of the jurisdiction under the former legislation was commented upon as follows by the Supreme Court in *Governey v. Financial Services Ombudsman* [2015] IESC 38; [2015] 2 I.R. 616 (at paragraphs 39 and 40 of the judgment).

> "Thus it may be seen that, while the F.S.O. [Financial Service Ombudsman] is given a jurisdiction to consider, and if appropriate to find substantiated, complaints which involve issues based purely on questions of legal rights and obligations, the jurisdiction is much broader than the determining of such legal questions. It is absolutely clear that the F.S.O. retains a jurisdiction to find a complaint substantiated even though there has been no breach of the legal entitlements of the complainant.
>
> It is also clear from the provisions of s. 57CI(4) [of the Central Bank Act 1942] that the range of remedies which can be imposed by the F.S.O. in the event that a complaint is substantiated are wide and go beyond (but do include) the form of redress which might be available in the case of someone whose legal rights have been interfered with."

37. The judgment of the Supreme Court in *Governey* goes on then to reference a provision of the Central Bank Act 1942 (as amended) which permitted the financial services ombudsman to decline to investigate a complaint where there is an alternative and satisfactory means of redress in relation to the conduct

complained of. The equivalent provision under the FSPO Act 2017 is to be found at section 52(1)(d) as follows.

> 52.(1) The Ombudsman may decline to investigate, or discontinue an investigation of, a complaint where, in the opinion of the Ombudsman—
>
> […]
>
> (d) there is or was available to the complainant an alternative and satisfactory means of redress in relation to the conduct complained of […]

38. The judgment in *Governey* then continues as follows (at paragraph 42).

> "I draw attention to these provisions for the purposes of observing that the range of issues which the F.S.O. can investigate and the range of remedies available go far beyond the type of case which can be brought to a court as a result of an alleged breach of legal rights or failure to meet legal obligations. But the remit of the F.S.O. does, potentially, include cases which involve (and may only involve) the establishment and determination of such rights and obligations and the payment of compensation for loss in respect thereof. Obviously, some cases might be such as could be considered hybrid with some issues involving legal questions but others involving the general reasonableness of the course of conduct between the relevant financial institution and the complainant. However, there are some cases where the sole, or virtually only, issue raised by the complainant may be one which is based on an assertion of legal rights. Such cases are, of course, within the jurisdiction of the F.S.O., and it is for the F.S.O. itself to decide whether to determine them. However, it is important to record that the F.S.O. does not have an obligation to determine by adjudication a complaint where the substance of the matters complained of is that a relevant financial institution has acted unlawfully in its dealing with the complainant and where, therefore, exactly the same issues of legal rights and obligations could be brought before a court. The legislation, therefore, permits, but does not require, the F.S.O. to deal with such complaints, being cases which are, in reality, matters which might otherwise be pursued by an appropriate form of court proceedings before whatever court might have jurisdiction to deal with the issues concerned."

39. (I will return to consider another aspect of the judgment in *Governey* at paragraph 49 below).

40. The relevance of all of this to the present case is as follows. The Ombudsman's position is that the essence of the decision under appeal is that the insurance provider had not properly or reasonably analysed the claim because of the emphasis which it placed on the exclusion condition. There is no express finding in the decision to the effect that, in declining the claim, the insurance provider had acted in breach of contract or otherwise contrary to law.

41. Put shortly, the decision is now characterised as one entailing a finding of unreasonable conduct, rather than a breach of contract. (See paragraph 58 below).

HIGH COURT'S APPELLATE JURISDICTION

42. The High Court's appellate jurisdiction is provided for under section 64 of the FSPO Act 2017 as follows.

> 64.(1) A party to a complaint before the Ombudsman may appeal to the High Court against a decision or direction of the Ombudsman.
>
> […]
>
> (3) The orders that may be made by the High Court on the hearing of an appeal under this section include (but are not limited to) one or more of the following:
>
> (a) an order affirming the decision or direction of the Ombudsman, subject to such modifications as it considers appropriate;
>
> (b) an order setting aside that decision or any direction included in it;
>
> (c) an order remitting that decision or any such direction to the Ombudsman for review with its opinion on the matter;
>
> (d) such other order in relation to the matter as it considers just in all the circumstances;
>
> (e) such order as to costs as it thinks fit;

> (f) an order amending the decision or direction of the Ombudsman, as the case may be.

43. As appears, the right of appeal is stated in general terms, and the High Court has very extensive powers as to the disposal of the appeal. In contrast to other similar legislative regimes, such as the Freedom of Information Acts, the appeal is not confined to an appeal on a point of law.

44. Notwithstanding that the right of appeal under the current legislation, and its statutory predecessor Part VIIB of the Central Bank Act 1942 (as introduced in 2004), are stated in general terms, the courts have consistently held that the appeal is not intended to take the form of a re-examination from the beginning of the merits of the decision appealed from.

45. The leading authority in this regard is the judgment of the High Court (Finnegan P.) in *Ulster Bank Investment Funds Ltd v. Financial Services Ombudsman* [2006] IEHC 323 ("***Ulster Bank***"). Having carefully considered a number of judgments addressing the nature of statutory appeals, the former President of the High Court observed that it was desirable that there should be consistency in the standard of review on statutory appeals. The threshold for a successful appeal was then stated as follows.

> "[…] To succeed on this appeal the Plaintiff must establish as a matter of probability that, taking the adjudicative process as a whole, the decision reached was vitiated by a serious and significant error or a series of such errors. In applying the test the Court will have regard to the degree of expertise and specialist knowledge of the Defendant. The deferential standard is that applied by Keane C.J. in *Orange v The Director of Telecommunications Regulation & Anor* and not that in *The State (Keegan) v Stardust Compensation Tribunal*."

46. The passage from the judgment of the Supreme Court in *Orange Ltd v. Director of Telecoms (No 2)* [2000] IESC 22; [2000] 4 I.R 159 relied upon reads as follows (at pages 184/85 of the reported judgment).

> "In short, the appeal provided for under this legislation was not intended to take the form of a re-examination from the beginning of the merits of the decision appealed from culminating, it may be, in the substitution by the High Court of its adjudication for that of the first defendant. It is accepted that, at the other end of the spectrum, the High Court is not solely confined to the issues which might arise if the decision of the first defendant was being challenged by way of judicial review. In the case of this legislation at least, an applicant will succeed in having the decision appealed from set aside where it establishes to the High Court as a matter of probability that, taking the adjudicative process as a whole, the decision reached was vitiated by a serious and significant error or a series of such errors. In arriving at a conclusion on that issue, the High Court will necessarily have regard to the degree of expertise and specialised knowledge available to the first defendant."

47. The standard of review posited in *Ulster Bank* has been applied consistently by the High Court to appeals in respect of both the former and the current statutory regime. The approach has also been endorsed by the Court of Appeal in *Millar v. Financial Services Ombudsman* [2015] IECA 126 and 127; [2015] 2 I.R. 456; [2015] 2 I.L.R.M. 337.

48. There are two refinements to the standard of review which are potentially relevant to the issues which arise in the present case. The first concerns the level of deference to be shown to a determination of the Ombudsman on a question of law. The Court of Appeal confirmed in *Millar* that the High Court, in hearing an appeal, should not adopt a deferential stance to a decision or determination by the Ombudsman on a "pure" question of law. The judgment went on to hold, however, that the complaint in that case presented a mixed question of law and

fact. The position is put as follows by Finlay Geoghegan J. at paragraphs 15 and 16 of her judgment (page 480 of the Irish Reports).

> "I agree with the trial judge that where the Ombudsman has made a decision or determination on a pure question of contract law which forms part of the finding under appeal, that the court should not adopt a deferential stance to the decision or determination on the question of law. This follows from the statutory scheme applicable to the Ombudsman and the judgments in *Orange Ltd v Director of Telecoms (No.2)* [2000] 4 I.R. 159 and *Ulster Bank Investment Funds Ltd v Financial Services Ombudsman* [2006] IEHC 323 and those following. Section 57CK(1) expressly permits the Ombudsman, at his own initiative, to refer a question of law to the High Court. The relevant deferential stance on appeal as explained by Keane C.J. in *Orange* at p.185 is that "…the High Court will necessarily have regard to the degree of expertise and specialised knowledge available to the [Ombudsman]." With respect to the Ombudsman he does not have expertise or specialised knowledge, certainly relative to the High Court, in deciding questions of law.
>
> However, it does not appear to me that it follows from this conclusion that as put by the trial judge where the appeal is taken against a finding of the Ombudsman which includes a decision on the question of a contractual construction that the High Court is required "to examine afresh" that issue in the course of the appeal. Rather the correct position is that the general principles set out in *Ulster Bank Investment Funds Ltd v Financial Services Ombudsman* still apply to the determination of the appeal save that the High Court in considering a decision of the Ombudsman on a pure question of law will not take a deferential stance to that part of the finding. […]"

49. Similar sentiments have been expressed by the Supreme Court in *Governey*, albeit on a provisional basis only in circumstances where the application before that court was merely an application for leave to appeal. See paragraph 44 of the reported judgment as follows.

> "There may well be a case for affording deference to the view which the F.S.O. [Financial Services Ombudsman] takes as to, for example, the unreasonableness of lawful conduct on the part of a financial institution. But it does not necessarily follow that a court is bound to afford similar deference to the F.S.O. on its view of the law or the application of the law to

> facts which task is, after all, one of the core functions to be found in the administration of justice."

50. The second refinement to the standard of review concerns the assessment by the Ombudsman of medical evidence. The High Court (Binchy J.) observed in *Baskaran v. Financial Services and Pensions Ombudsman* [2019] IEHC 167 that the Ombudsman is not a medical expert whose function it is to adjudicate on conflicts of medical opinion. Whereas these observations were made in the context of a discussion of whether or not an oral hearing had been required, they may nevertheless have implications for the standard of review on appeal. The rationale underlying curial deference is that the High Court should defer to the expertise of the statutory decision-maker. This rationale is, self-evidently, confined to decisions and determinations made in respect of matters which fall within the decision-maker's area of expertise.

51. More generally, it appears to have been accepted by the Ombudsman—in the context of the decision under appeal—that insofar as medical evidence is concerned his function is not to comment on or form an opinion as to the nature or severity of an insured party's illness. (See page 11 of the final decision, discussed further at paragraph 60 below).

52. Finally, an issue arose during the course of the hearing before me as to the implications of the judgment of the High Court (Hedigan J.) in *Smartt v. Financial Services Ombudsman* [2013] IEHC 518. Counsel on behalf of the Ombudsman submitted that the "serious and significant error" test implies that the standard of review is whether there was evidence before the Ombudsman which allowed him to come to the decision that he did. The following passage at paragraph 14 of the judgment in *Smartt* is cited in support of this proposition.

> "[…] Thus, in my view, the FSO [Financial Services Ombudsman] had before him and relied upon relevant evidence upon which he could rely in coming to the decision he did. That is the test. It is not for this Court to either agree or disagree with his finding as long as it is one reasonably based upon the evidence before him."

53. With respect, the submission reads too much into the above passage. It is clear from the earlier part of the judgment in *Smartt* that Hedigan J. was not purporting to establish a different test than that posited in *Ulster Bank*. The passage at paragraph 14 of the judgment in *Smartt* has to be seen in the context of the judgment as a whole.

54. At all events, the judgment in *Ulster Bank* expressly states that the deferential standard to be applied is that of Keane C.J. in *Orange v. Director of Telecommunications Regulation*, and not that in *State (Keegan) v. Stardust Compensation Tribunal* [1986] I.R. 642. The standard of review applicable on an appeal is, therefore, more exacting than the test of administrative unreasonableness applicable in judicial review proceedings. (The relevant passages from *Ulster Bank* and *Orange* have been set out at paragraphs 45 and 46 above).

(1). WHAT DID THE OMBUDSMAN ACTUALLY DECIDE?

Submissions of the parties

55. There was much debate at the hearing before me as to what precisely has been determined by the Ombudsman in the final decision. Leading counsel on behalf of the insurance provider, Ms. Kelley Smith, SC, observed that notwithstanding that the Ombudsman had identified the following four issues for adjudication (at page 4 of the final decision), it is not apparent as to what findings, if any, the

Ombudsman made in respect of each of these issues. The four issues identified by the Ombudsman are as follows.

> "The Complaint for Adjudication
>
> The complaint for adjudication is that the Provider wrongly declined the Complainant's initial claim; wrongfully declined the Complainant's claim on appeal; did not deal with the Complainant's appeal correctly; and that the policy which the Provider provided to the Complainant was not suitable for the Complainant."

56. Counsel submitted that the only issue which is expressly addressed in the final decision is the third, namely whether the insurance provider had dealt with the appeal correctly. Counsel says it is unclear as to how the Ombudsman resolved the first and second issues. The fourth issue, i.e. the suitability of the policy, is simply not addressed at all, and, in any event, would be a matter for the different entity which admitted the insured party to the scheme in November 2006.

57. In response, counsel for the Ombudsman, Mr. Francis Kieran, submitted that the essence of the Ombudsman's decision is that the insurance provider had not properly or reasonably analysed the claim because of the emphasis which it placed on the exclusion condition. Counsel very properly acknowledged that he was bound by the terms of the decision, and could not add to the decision. Counsel also acknowledged that it is not possible to point to any particular paragraph in the decision where the Ombudsman holds that the insured party's inability to work is attributable entirely to rheumatoid arthritis.

58. Counsel drew attention—both in his written submissions (§37 to §39) and in oral argument—to the fact that the Ombudsman made no finding that the insurance provider's conduct was "contrary to law" for the purposes of section 60(2)(a) of the FSPO Act 2017. It is accepted that an insurer would act contrary to (contract)

law where it declined a claim that actually fell within the terms of an insurance policy. In that instance, a complaint could be upheld under section 60(2)(a).

Findings of the court

59. Having carefully read and reread the decision, and having had regard to the submissions of counsel on both sides, I have concluded that the decision is narrowly drawn. The rationale of the decision is confined to a finding that the conduct of the insurance provider was unreasonable and improper insofar as it emphasised the excluded illness, i.e. fibromyalgia. The decision is thus directed to the conduct of the insurance provider in assessing the claim. The decision cannot be read as entailing a finding that the insurance provider had acted in *breach of contract* by declining the claim. Had a finding to this effect been made, then the decision would have been grounded on subsection 60(2)(a) ("*the conduct complained of was contrary to law*").

60. This understanding of the decision is consistent with the express statement (at page 11 of the final decision) as follows.

> "For the purpose of assessing this complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the medical evidence submitted."

61. As discussed earlier (at paragraphs 31 and onwards), the Ombudsman appears to enjoy what might be described as a hybrid jurisdiction, whereby he may adjudicate not only on contractual disputes, e.g. where a complainant alleges that the conduct of a financial service provider in refusing to honour a claim is in breach of contract, but may also make determinations and direct remedies in

respect of conduct which, while not contrary to law, is found by the Ombudsman to be "unreasonable" or "unjust". In the present case, it seems that the Ombudsman chose to determine the complaint on the latter basis alone.

62. As an aside, it should be noted that the judgment of the Supreme Court in *Governey v. Financial Services Ombudsman* observes that the Ombudsman does not have an *obligation* to determine by adjudication a complaint where the substance of the matters complained of is that a relevant financial institution has acted unlawfully in its dealing with the complainant and where, therefore, exactly the same issues of legal rights and obligations could be brought before a court. These observations were made in the context of a discussion of the statutory discretion of the Ombudsman to decline to investigate, or discontinue an investigation of, a complaint (now to be found at section 52(1)(d) of the FSPO Act 2017). They are nevertheless of interest in that they tend to confirm that the Ombudsman is not *required* to adjudicate on allegations of breach of contract.

(2). IS FINDING VITIATED BY SERIOUS AND SIGNIFICANT ERROR?

Submissions of the parties

63. The insurance provider has challenged the Ombudsman's finding that there had been an "overemphasis" on its part on quantifying the impact of the two illnesses upon the insured party's ability to work, and on the excluded illness, i.e. fibromyalgia. Counsel submits that—both as a matter of contract law and under the Central Bank's Consumer Protection Code—an insurance provider must endeavour to verify the validity of a claim received. An insurance provider, when it receives a claim, is entitled to look at its policy terms and conditions and to interrogate whether the claim is covered. Here, a significant and unusual aspect of the insured party's cover were the member-specific exclusions. Fibromyalgia

was clearly excluded, and the insured party would only be entitled to make a valid claim in respect of rheumatoid arthritis if that illness resulted in "disability" as defined under the insurance policy.

64. In response, counsel for the Ombudsman reiterates that the High Court, in exercising its statutory appellate jurisdiction, is not entitled to carry out an examination of the complaint afresh. In his written legal submissions (at §47), counsel has identified seven matters which it is said support the Ombudsman's finding that there was an "overemphasis" on quantifying the impact of the two illnesses upon the insured party's ability to work, and on the excluded illness, i.e. fibromyalgia.

Findings of the court

65. For the reasons which follow, I have concluded that the approach of the Ombudsman to his assessment of the insurance provider's conduct in its processing of the claim (and, in particular, the appeal) was erroneous in law; that the legal errors were serious and significant; and that the decision is invalid as a result.

66. The starting point for any proper assessment of the "reasonableness" of the processing of the claim should have been the terms of the relevant code of conduct applicable to the insurance provider. This is the objective standard against which the "reasonableness" of the conduct falls to be considered in the first instance. Here, the relevant code of conduct is the *Consumer Protection Code (2012)* published by the Central Bank of Ireland. Clause 7.6 provides as follows.

> "7.6 A regulated entity must endeavour to verify the validity of a claim received from a claimant prior to making a decision on its outcome."

67. This clause is recited in the Ombudsman's decision (at page 10), but there is no discussion of its implications. In particular, it is nowhere explained in the decision why it is that the insurance provider's conduct in processing the claim should be regarded as inconsistent with its entitlement to verify the validity of a claim.

68. In assessing whether the conduct of the insurance provider was "reasonable", it is also appropriate to have some regard to the underlying contract of insurance itself. Whereas the mere fact that conduct is in accordance with the terms of the contract does not necessarily mean that the conduct is "reasonable"—conduct may be unreasonable even if it is lawful—the terms of the contract are nevertheless relevant. Here, the insured party had been subject to a number of member-specific exclusions at the time of her admission to the scheme in November 2006. It is common case that one legal consequence of these exclusions is that the insured party was not entitled to make a claim, under the group income protection scheme, in respect of fibromyalgia. It has never been suggested that this exclusion was improper.

69. The entitlement to claim under the scheme was also confined to circumstances where the contractual definition of "disability" had been met. That definition requires that an insured party's inability to perform the material and substantial duties of their normal insured occupation is *as a result of* their illness or injury. Accordingly, in order for the insured party in the present case to succeed in her claim, it would be necessary for her to establish, first, that she was unable to work, and, secondly, that that inability is as a result of a non-excluded illness.

70. The insurance provider was entitled, under clause 7.6 of the *Consumer Protection Code (2012)*, to verify the validity of the claim received from the insured party

prior to making a decision to admit the claim. This entitlement has not been properly acknowledged in the decision of the Ombudsman. This is a serious and significant error of law.

71. The criticisms made of the insurance provider by the Ombudsman are unjustified. The principal criticism made centres on the correspondence between the insurance provider and the consultant rheumatologist who had been nominated to carry out an independent medical examination of the insured party. See page 16 of the decision as follows.

> "I am also concerned that the appointed Consultant Specialist was asked by the Provider a very pointed question that contained information that went beyond that which would reasonably and fairly be considered necessary for what the Provider was asking its specialist to consider. That is, the Provider specifically highlighted for consideration that one of the medical conditions, was a medical condition that was excluded by the Provider at underwriting stage. While it may have been stated for background information, I consider that the question could have been asked without that information."

72. The relevant correspondence has already been set out at paragraphs 14 to 16 above. For ease of reference, the email of concern to the Ombudsman is repeated below. It will be recalled that this email had been sent to the independent medical examiner following upon receipt of his detailed report.

> "I note that [the insured party's] main issue preventing her from working is in relation to her Fibromyalgia. If we take the Fibromyalgia out of the picture (Given that this was specifically excluded at underwriting stage for this claimant), would it be reasonable to deduce that her rheumatoid arthritis is not severe enough to prevent her from working at present?"

73. Contrary to the findings of the Ombudsman, this correspondence was entirely proper. The query raised was legitimate, and one which the insurance provider was entitled to pursue with the independent medical examiner. The claim could not be properly assessed without some attempt being made to quantify the relative

impact that the two medical conditions had on the insured party's ability to work. It would have been artificial not to explain the relevance of the question to the independent medical examiner.

74. The Ombudsman's criticism of the correspondence of January 2017 is difficult to understand given that he appears to have had no objection to the initial letter of instruction sent on 12 December 2016 to the consultant rheumatologist who was to carry out the independent medical examination. The Ombudsman describes that letter as "clear and objective". Yet that letter had stated that the insured party was claiming benefits with respect to symptoms of rheumatoid arthritis and fibromyalgia; had set out the member-specific exclusions; and had expressly stated that the claim had been declined on the basis of the exclusions. There is no qualitative difference between the two letters, yet only one found disfavour with the Ombudsman.

75. (The suggestion, which was made in the written submissions, that the insurance provider appeared keen to attempt "to nudge" the consultant "in a particular direction" is unsubstantiated and should not have been made. No such suggestion is made in the Ombudsman's decision itself. Nor was it ever put to the insurance provider by the Ombudsman that the provider was attempting "to nudge" or otherwise improperly influence the independent medical examiner, and the provider never had an opportunity to respond to such an allegation.)

76. The other incidents relied upon in the Ombudsman's decision in support of the purported finding of unreasonable conduct on the part of the insurance provider are even less convincing. The first in time is an internal email dated 27 July 2016. The author of the email records that he found it "perplexing" that the insured party had not been declined entry into the income protection scheme in 2006 given her

(medical) history. Crucially, however, the email goes on to acknowledge that she had been accepted into the scheme with multiple exclusions. The content of this email is wholly unexceptionable, and it was unreasonable for the Ombudsman to draw any adverse inference from it.

77. The second incident is the omission from the decision-letter of a reference to a right of internal appeal. I address this at paragraph 82 below.

78. The third incident is one which actually *postdates* the insurance provider's decision-making process. The Ombudsman seeks to rely on the content of the written submission made by the insurance provider in response to his preliminary decision of 14 May 2019. In particular, the Ombudsman seizes upon a statement to the effect that the insurance provider took the decision to decline the claim as the provider had been advised that the insured party had an illness which was specifically excluded. The Ombudsman points out, correctly insofar as it goes, that the issue is whether or not the diagnosis of rheumatoid arthritis was of sufficient severity to prevent the insured party from working. Put otherwise, the insurance provider would not have been entitled to decline cover simply because the insured party suffered from an excluded illness, i.e. fibromyalgia, had it been the case that the cause of her disability was a covered illness, i.e. rheumatoid arthritis.

79. With respect, however, the inference that this distinction was lost on the insurance provider is untenable. Similarly, the sentence seized upon by the Ombudsman does not expose a "difficulty" with the insurance provider's approach. Rather, it is obvious on any fair reading of the insurance provider's written submission *in toto* that they were fully alive to the critical importance of identifying which illness was the cause of any inability to work. Indeed, the sentence seized upon

by the Ombudsman follows a lengthy quotation from the insurance provider's chief medical officer which states that the diagnosis is fibromyalgia, and not any active form of arthritis.

80. The Ombudsman's written legal submissions purport to identify a number of *additional* matters which were not expressly relied upon in the Ombudsman's decision. For reasons similar to those stated by the High Court (Hyland J.) in *Jackson Way Properties Ltd v. Information Commissioner* [2020] IEHC 73, the Ombudsman's decision must stand or fall on its own terms: subsequent elaboration should not be required and is impermissible.

81. In summary, the Ombudsman's approach evinces serious and significant errors of law in that it purports to make a finding that the conduct of the insurance provider was unreasonable without any attempt to measure that conduct against the relevant code of conduct; and then draws unsubstantiated inferences from certain correspondence.

82. Indeed, the only aspect of the *Consumer Protection Code (2012)* which is discussed in the decision is the obligation, at clause 7.20, to notify a claimant of any internal procedure.

> "7.20 A regulated entity must provide a claimant with written details of any internal appeals mechanisms available to the claimant."

83. The insurance provider's initial decision on the claim did not refer to the right to an internal appeal, but the right of appeal is clearly set out in the group income protection scheme. At all events, the insured party availed of her right of internal appeal within time, and thus cannot be said to have been prejudiced by the omission of a reference to the right to an internal appeal in the decision-letter of 29 July 2016.

(3). REMEDY DIRECTED BY OMBUDSMAN

Submissions of the parties

84. The insurance provider has also challenged the decision on the ground that the remedy directed by the Ombudsman was invalid. Counsel submits that whereas the legislation provides for a wide range of remedies (section 60(4)), the Ombudsman does not have *carte blanche* as to what remedy he imposes. This is especially so where a remedy has been imposed without analysis, without description, and without reason. The effect of the remedy imposed is to direct the insurance provider to recognise a contractual claim which has not been upheld by the Ombudsman in his decision. Counsel submits that, putting it at its most neutral, this is counterintuitive. It is further submitted that the cost of complying with this direction could run to in excess of €400,000 in circumstances where the income protection scheme contemplates that cover will be paid until the insured party reaches the age of retirement in 2039.

85. Insofar as the rider to the direction is concerned, counsel submits that it is inoperable. (It will be recalled that the rider is to the effect that the insurance provider remains entitled, in accordance with the policy provisions, to further review the claim at any time in the future). The insurance provider has already determined, on the basis of the medical evidence, that the claim is inadmissible. This determination has not been gainsaid by the Ombudsman's decision. Counsel asks rhetorically what change in circumstances or other factor is the insurance provider to take into account when reviewing the claim, in circumstances where the insurance provider considered that cover was appropriately declined in the first instance?

86. In response, counsel for the Ombudsman submits that the selection of remedy is a matter within the discretion of the Ombudsman. Even if the Ombudsman were in error—which is denied—this would be an error *within* jurisdiction. The "serious and significant error" test is said to apply equally to the choice of remedy, citing *De Paor v. Financial Services Ombudsman* [2011] IEHC 483. Indeed, it is suggested in the written legal submissions (at §74) that the "significant margin of discretion" afforded by the courts to decisions of the Ombudsman is arguably even wider when it comes to what *remedy* the Ombudsman directs than it is in respect of the Ombudsman's adjudication on the substance of a complaint.

Findings of the court

87. Strictly speaking, it is not now necessary to address the validity of the remedy directed by the Ombudsman. This is because I have held (under heading (2) above) that the Ombudsman erred in concluding that the insurance provider's conduct was unreasonable or otherwise improper. In the absence of a valid finding of misconduct, the question of the imposition of a remedy simply does not arise.

88. Lest I be incorrect on the first point, however, I propose to address briefly the validity of the remedy.

89. It is necessary to distinguish between the threshold question of whether the Ombudsman has, on the basis of his findings on the substance of the complaint, jurisdiction to impose a particular form of remedy; and the subsequent question as to whether the precise form of remedy is reasonable or proportionate in all the circumstances. The concept of curial deference can only properly apply to the subsequent question. If, for example, the Ombudsman has jurisdiction to direct the payment of financial compensation in the particular circumstances of a case,

then the assessment of the precise quantum is something to which deference will be shown. Thus, on the facts of *De Paor v. Financial Services Ombudsman* [2011] IEHC 483, the ground of appeal advanced had been that the *amount* of compensation directed (€850) was simply not sufficient, having regard to the additional and unnecessary distress caused to the appellant/complainant at a time when she was vulnerable and worried on account of her ill health. There was no dispute as to the *jurisdiction* of the financial services ombudsman to direct the service provider to pay an amount of compensation to the appellant/complainant.

90. The question of principle for determination in this appeal is whether, on the assumption that his findings on the substance of the complaint were to have been upheld, the Ombudsman would have had jurisdiction to direct the insurance provider to admit the claim for income protection. For the reasons which follow, the answer to that question is "no".

91. The decision of the Ombudsman was to the effect that the *conduct* of the insurance provider in assessing the claim was unreasonable or otherwise improper. The Ombudsman did not find, *as a matter of contract law*, that the insured party was entitled to recover under the group income protection scheme. The Ombudsman made no finding to the effect that the insured party's inability to work is attributable entirely to rheumatoid arthritis. Yet, the remedy directed was precisely that the insurance provider admit the claim. The practical effect of this was that the Ombudsman treated the claim as if it had been well-founded and that the insured party was suffering a disability (as defined) caused by an illness which came within the terms of the insured risk. With respect, there is no lawful connection between the finding of unreasonable or improper conduct and the remedy actually imposed: it is a *non sequitur*.

92. The decision is not saved by the rider to the effect that the insurance provider remains entitled, in accordance with the policy provisions, to further review the claim at any time in the future. This rider is unworkable for the reasons advanced by counsel on behalf of the insurance provider in her submissions (summarised earlier). In particular, the notion of a *further* review of the claim by the insurance provider is nonsensical in circumstances where the provider has *already determined*, on the basis of the medical evidence, that the claim is inadmissible.

CONCLUSION AND FORM OF ORDER

93. For the reasons set out above, I have concluded that the approach of the Ombudsman to his assessment of the insurance provider's conduct in its processing of the claim (and, in particular, the appeal) was erroneous in law. The legal errors were serious and significant, and the decision is invalid as a result. In particular, the Ombudsman purported to make a finding that the conduct of the insurance provider was unreasonable, without any attempt to measure that conduct against the relevant code of conduct, i.e. the *Consumer Protection Code (2012)* published by the Central Bank.

94. The insurance provider was entitled, under clause 7.6 of the *Consumer Protection Code (2012)*, to verify the validity of the claim received from the insured party prior to admitting the claim. It is nowhere explained in the Ombudsman's decision why it is that the insurance provider's conduct in processing the claim should be regarded as inconsistent with its entitlement to verify the validity of a claim.

95. The proposed form of order is as follows. First, the order will formally record that an extension of time for the bringing of an appeal is granted pursuant to

section 64(2) of the Financial Services and Pensions Ombudsman Act 2017. The appeal was made out-of-time in circumstances where the notification of the decision was initially misfiled within the insurance provider's offices. (See paragraphs 11 to 17 of Mr. Marco Nuvoloni's affidavit). The extension of time is not opposed. Secondly, an order will be made pursuant to section 64(3)(b) of the same Act setting aside the Ombudsman's decision and direction of 15 July 2019 in their entirety. Thirdly, an order is made pursuant to section 40 of the Civil Liability and Courts Act 2004 restricting the publication or broadcasting of the name and address of the insured party (the notice party to these proceedings). This order is appropriate in circumstances where it has been necessary for the purposes of this judgment to set out the notice party's medical history in detail.

96. Insofar as the issue of the costs of these proceedings is concerned, the attention of the parties is drawn to the notice published on 24 March 2020 in respect of the delivery of judgments electronically, as follows.

> "The parties will be invited to communicate electronically with the Court on issues arising (if any) out of the judgment such as the precise form of order which requires to be made or questions concerning costs. If there are such issues and the parties do not agree in this regard concise written submissions should be filed electronically with the Office of the Court within 14 days of delivery subject to any other direction given in the judgment. Unless the interests of justice require an oral hearing to resolve such matters then any issues thereby arising will be dealt with remotely and any ruling which the Court is required to make will also be published on the website and will include a synopsis of the relevant submissions made, where appropriate."

97. The default position under Part 11 of the Legal Services Regulation Act 2015 is that legal costs follow the event, i.e. the successful party is entitled to recover their legal costs as against the unsuccessful party. If the default position were to obtain, then the insurance provider, as the successful appellant, would be entitled

to its costs as against the Ombudsman (such costs to be assessed in default of agreement). In the event that the Ombudsman contends that a *different* form of order should be made, written submissions should be filed on his behalf by 24 November 2020. Any replying submissions on behalf of the insurance provider should be filed by 8 December 2020.

Appearances
Kelley Smith, SC for the insurance provider instructed by Matheson
Francis Kieran for the Ombudsman instructed by Eversheds Sutherland