An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0008
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Claim handling delays or issues Delayed or inadequate communication Dissatisfaction with customer service Dissatisfied with 3rd party claim
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a motor insurance policy the Complainant held with the Provider.

The complaint is that the Provider incorrectly paid out on a third party claim without informing the Complainant that a claim had been made, which resulted in the Complainant losing one years no claims bonus and accepting the Provider's renewal quotation as an alternative to a higher premium with a new insurance company as there was an open claim.

The Complainant's Case

The Complainant submits that on 7 August 2015 a third party reversed into her car in the carpark of a supermarket. The Complainant submits that she immediately informed the Gardaí and the Provider. The Complainant submits that she proceeded to make a claim against the third party, and the Provider sent an assessor to take a statement from her and view the damage to her vehicle.

The Complainant submits that she was advised by the Provider that she was not at fault, and if she wished to proceed with a claim against the third party she should contact their insurance company. The Complainant states that as the Provider advised her that she was not at fault, "*I undertook the repair of my car at my own cost and did not proceed to make a claim on the third parties insurance. I had assumed the matter was finished with as advised by [the Provider]*".

The Complainant submits that when she received her renewal notice from the Provider she noticed that there was an open claim on the policy. The Complainant submits that she immediately contacted the Provider and was informed that it had paid out a claim from the third party without informing her that a claim had been made, and despite the Provider informing her that the incident had not been her fault. The Complainant states that "*As it was so close to my insurance policy ending with [the Provider] it left me with an open claim therefore binding me to stay with [it] or have to pay a higher premium with a new insurance company as the claim was still open*". The Complainant submits that she has lost a years no claims bonus as a result of the Provider's actions.

The Complainant states that she is seeking the following:

> *"1. I would like for the decision to be overturned in my favour as initially advised by [the Provider].*
>
> *2. I want my 1 years no claims bonus back.*
>
> *3. I want reimbursement for the elevated insurance premium I am now paying. 1. Due to [the Provider] not closing the claim before the end of my policy 2. Due to me having a claim on my driving history."*

The Provider's Case

The Provider submits that the Complainant and a third party were involved in a collision at a supermarket carpark on 7 August 2015, and both maintain that they were not at fault. The Provider submits that the Complainant chose not to pursue a claim under her policy.

The Provider states, in its final response letter dated 29 July 2016, that "*I see that we failed to keep you informed of our decision to settle 60% of the Third Parties claim on 19th July 2016 and I apologise for this error*".

The Provider submits that its solicitors had been arguing an apportionment of liability on a 50/50 basis. The Provider submits that the third party solicitors, however, would not agree to this apportionment on the basis that their client had commenced their manoeuvre before the Complainant commenced hers.

The Provider submits that when it considers the viability of contesting a claim in court it has to be very aware of the legal costs incurred in doing so. The Provider submits that legal costs can be up to 60% of the claim value and all of these costs are paid for under the Complainant's policy.

The Provider states that "*Having considered the economic pragmatics of this case we found that it was more economical to settle the claim allowing a further 10% in favour of the third party because this 10% was financially lower than the legal costs to be incurred in contesting a 50% share of liability in court without any guarantee of success. If we were to fail in our effort to achieve a 50% sharing in court we would then be responsible for 100% of all legal*

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costs; ours and the Third Parties, whereas we have now paid just 60% of their much reduced legal bill".

The Provider's delegated authority states that "*We have a duty to our Principle to protect their interests and determine both coverage and indemnity based on the merits of each claim and we find in this matter that the economic pragmatics of the case pointed to settlement on a partial fault basis as liability was in dispute and there were no witnesses nor CCTV footage to corroborate either version of events*".

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 20 February 2018 outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

The issue to be determined is whether the Provider incorrectly paid out on a third party claim without informing the Complainant that a claim had been made, which resulted in the Complainant losing one years no claims bonus and accepting the Provider's renewal quotation as an alternative to a higher premium with a new insurance company as there was an open claim.

The Provider submits that in line with Section "*3.2 Claims*" under "*Section 3: General Conditions*" of the policy terms and conditions it may take over and carry out in the name of the Insured legal proceedings to defend or settle any claim and it will decide how any

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proceedings are carried out or how any claim is settled. The Provider submits that Section 3.2 of the policy terms and conditions states the following:

"3.2 Claims

B. We may do the following:

i. ***We*** *may take over and carry out in* ***Your*** *name (or that of any person defined as an* ***Insured Person*** *under Section 2 – Definitions of this policy) legal proceedings to defend or settle any claim, or to prosecute in* ***Your*** *name (or the name of another person) any claim for* ***Our*** *own benefit.* ***We*** *will decide how any proceedings are carried out or how any claim is settled."*

The Provider submits that it denied liability on the basis of the Complainant's advices and on the basis of the Engineers Report which, although supported the Complainant, could be interpreted in support of the third party version of events. The Provider submits that solicitors for both parties had been arguing an apportionment of liability initially on a 50:50 basis. The Provider states that "*However, the Third Party Solicitors would not agree to apportionment as they were insistent that their client had commenced their manoeuvre before [the Complainant] had commenced hers. The Solicitors appointed by ourselves advised that should this matter proceed to Court it would turn in to a "she said, he said" scenario and there was no guarantee of success. There was no CCTV footage or witnesses either available or brought forward*".

The Provider submits that when it considers the viability of contesting a claim in court it has to be very aware of the legal costs incurred in doing so. The Provider submits that legal costs can be up to 60% of the claim value and all these costs are ultimately paid for under the Complainant's policy. The Provider states that "*Having considered the economic pragmatics of the case we found that it was more economical to settle the claim allowing a further 10% in favour of the third party because this 10% was financially lower than the legal costs to be incurred in contesting a 50% share of liability in court without any guarantee of success. If we were to fail in our effort to achieve a 50% sharing in court we would then be responsible for 100% of all legal costs; ours and the Third Party's, whereas payments have been made of a much-reduced legal bill*".

I would point out that one of the main conditions in all motor insurance policies is a Subrogation clause. Subrogation allows an Insurance Company to take over and either contest or settle a claim on behalf of the insured. This means that if a third party submits a claim against the policyholder or other insured stating that the policyholder damaged their vehicle or they incurred personal injuries following an incident with the policyholder, the Insurance Company may decide, under its subrogation rights, to settle the case. Insurance Companies generally do not need the permission of the insured to do this under the terms of the subrogation clause.

Both the Complainant and the Provider are bound by the terms and conditions of the policy document. I must accept that the Provider was entitled, pursuant to the terms and conditions of the motor insurance policy, to settle the claim.

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In relation to the attachment of liability, it must be noted that this Office cannot make a decision on the question of liability in a road traffic accident. Similarly, the Provider cannot determine liability, but can only form a view based on the evidence presented, and exercise its discretion to deal with a claim accordingly.

The Complainant submits that when she received her renewal notice from the Provider she noticed that there was an open claim on the policy. The Complainant submits that she immediately contacted the Provider and was informed that it had paid out a claim from the third party without informing her that a claim had been made, and despite the Provider informing her that the incident had not been her fault. The Complainant states that "*As it was so close to my insurance policy ending with [the Provider] it left me with an open claim therefore binding me to stay with [it] or have to pay a higher premium with a new insurance company as the claim was still open*". The Complainant submits that she has lost a years no claims bonus as a result of the Provider's actions.

Provision 7.21 of the Consume Protection Code 2012 (the CPC 2012) provides that:

> *7.21 Where the policyholder who is a consumer is not the beneficiary of the settlement the policyholder must be advised, on paper or on another durable medium, by the regulated entity, at the time that settlement is made, of the final outcome of the claim including the details of the settlement. Where applicable, the policyholder must be informed that the settlement of the claim will affect future insurance contracts of that type.*

The Provider submits that the decision to settle the third party claim on a 60:40 basis was not conveyed to the Complainant until 29 July 2016. The Provider submits that it has apologised for not keeping the Complainant informed of its decision to settle on a 60:40 basis at the time the decision was made on 19 July 2016. The Provider states that "*in line with our complaint feedback procedure we are continually reviewing actions taken and whether any improvements could be made in corresponding with claimants/Policyholders. We are also constantly reviewing and improving documentation and communication with Claimants/Policyholders and acknowledge in this case that we could have provided the Policyholder with an update on the decision made on the 60:40 split on the Third Party Claim on the 19th July 2016 sooner than the 29th July; albeit that we do not have an obligation to do so under the CPC*". The Provider submits that settlement of the claim was made on 31 August 2016 following agreement as to apportionment of costs. The Provider submits that, in line with Provision 7.21 of the CPC 2012, it issued a letter on 31 August 2016 to both the Complainant's Broker and also by e-mail to the Complainant's partner advising of the final settlement.

The Provider has submitted a copy of its letter dated 31 August 2016 to the Complainant's Broker. I note that this states, among other things, the following:

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"Please note that the claim has been settled in the sum of €2,390.14, broken down as follows:

Claim costs	*€ 320.60*
Third party property damage	*€1,062.44*
Third Party Legal Costs	*€ 578.10*
Our Legal Cost	*€ 429.00*

We are obliged to inform you that claim payments made under your client's policy may affect future insurance contracts of this type. Please note that 'claim costs' do not in their own right affect no claim bonus entitlements."

The Provider submits that it was not in a position to close the claim prior to expiry of the Complainant's policy on 27 July 2016. The Provider submits that a decision to settle on a 60:40 basis was only made on 19 July 2016 and the claim was only finally settled on 31 August 2016. The Provider states that "*The claim on [the Complainant's] driving history is not in itself in dispute and as such would remain declarable to any potential new Insurer regardless of whether at fault or otherwise therefore, the claim cannot be simply dealt with on an ab initio basis as [the Complainant] desires*".

The Provider submits that the Complainant's policy had Step Back No Claims Discount protection which is detailed under "*Section 5: No Claims Discount Protection*", which states the following:

5.3 Step Back No Claims Discount

*If **You** have this cover, **Your** existing **No Claims Discount** entitlement will be reduced in accordance with the table below if a claim arises during any **Period of Insurance.***

Pre-Claim NCD	***Post Claim Step back NCD***
5 year	*3 year*
4 year	*2 year*
3 year	*1 year*
2 year	*0 year*
1 year	*0 year*

***Step Back No Claims Discount** protection protects the number of years in respect of which a discount is allowed, and the percentage value of the discount only. **Your** premium may still increase.*

*Any payment **We** make for fire or theft claims under Section 7 – Loss of or Damage to **Your Car**, or windscreen claims under Section 9 – Windscreen and Windows will not affect **Your No Claims Discount.**"*

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The Provider submits that the policy does not benefit from a fully protected bonus. The Provider states that *"[the Complainant], at inception, stated that she had 6 years earned No Claim Bonus with [another Insurance Company]… and this was the basis on which the policy was issued via Electronic Data Interchange (EDI) with [the Broker]. Documentation was retained by [the Broker] in line with the terms of the EDI Delegated Authority Agreement. The Post Claim Step back NCD was issued at 3 years in line with the above table*".

The Provider goes on to state that "*However, we would point out that the documentation provided to [the Broker] by [the Complainant] from [the Complainant's previous Insurance Company] only confirmed 4 claim free years not the 6 years declared and as a result we would have been entitled to reduce the Post Claim Step Back NCD to 2 years and request Additional Premium due for the differential bonus. The premium differential would have been 10% in this case. Please note that we have elected not to do either of these in order to avoid exacerbating the situation*".

Having carefully considered all of the evidence before me, I must accept that at the time the Complainant's policy was up for renewal there was an open claim on the policy which would affect future motor insurance contracts. As set out above, the Provider was entitled, pursuant to the terms and conditions of the motor insurance policy, to settle the claim. As the Complainant did not have "*Fully Protected No Claims Discount*" cover on her policy, the "*Step Back No Claims Discount Protection*" resulted in her losing one years no claims bonus.

In relation to the Complainant's complaint regarding the information given to her by the Provider, and its failure to notify her regarding the third party claim, I am of the view that there was a lapse in service on the part of the Provider. I note that the Provider's contemporaneous notes regarding a telephone conversation between the Complainant and its representative on 16 October 2015 state the following:

> *"[The Provider's representative] spoke with [the Complainant] – [The third party Insurers] are denying liability to her*
> *[The Provider's representative] advised of option to claim comp, [the Complainant] does not wish to do so*
> *She may appoint solicitor to pursue recovery*
> *Asked that we advise if any [third party] correspondence or if our position re liability changes"*

I note that the "*Diary Note*" attached to the Provider's contemporaneous notes of 16 October 2015 states "*KEEP INSD ADVISED IF TP CLM RECEIVED*". It is apparent from the evidence before me that the Provider, as at 16 October 2015, was denying liability.

I note that the Provider submits that it received a letter from its solicitors on 24 May 2016 setting out that they had been unable to contact the Complainant, and having reviewed the file were of the opinion that settlement on a 50/50 basis should be attempted. I note that the Provider's solicitors' letter dated 24 May 2016 stated, among other things, the following:

> *"I have endeavoured to contact the Insured by telephone and email but have had no response to date.*

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…

In all the circumstances, particularly where I have been unable to get proper instructions from your Insured I would recommend we approach the other side with an offer settling on a 50/50 basis and I look forward to your instructions in this matter."

The Provider's solicitors emailed the Provider on 22 July 2016 stating, among other things, that "*As you are aware this matter has settled on 60/40 basis*". The Complainant's partner telephoned the Provider on 27 July 2016 querying the open claim on the Complainant's policy and the Provider's representative advised that "*We have made the decision that we will try and settle it 60/40*". I note that the Provider subsequently queried the legal costs in relation to the claim with their solicitors, and closed the claim on 31 August 2016.

While I note that the Provider's solicitors advised the Provider that they attempted to contact the Complainant, it is disappointing that the Provider did not contact her, as requested, to inform her of developments with regard to the third party claim and its change in position regarding liability. Furthermore, given the circumstances, I am of the view that the Provider should have notified the Complainant as soon as a settlement had been reached, on 19 August 2016.

To mark the Provider's lapse in service, I direct the Provider to make a compensatory payment of €400.00 to an account of the Complainant's choosing within 35 days.

Consequently, it is my Legally Binding Decision that this complaint is partially upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider make a compensatory payment of €400.00 to an account of the Complainant's choosing within 35 days.

- Pursuant to ***Section 60(6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, where the amount is not paid after the expiry of the 35 days as set out above.

- Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the expiry of the 35 days as set out above to notify this office in writing of the action taken or proposed to be taken in consequence of the said direction outlined above.

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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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 March 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) in accordance with the Data Protection Acts 1988 and 2003.