An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0088
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Automatic renewal Complaint handling (Consumer Protection Code) Dissatisfaction with customer service
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant had a motor insurance policy with the Provider which was due for renewal in 2017. The Complainant contacted the Provider in advance of the renewal date and made it clear that he did not want to renew his policy. The Provider failed to cancel the policy, the policy was automatically renewed and a payment was debited from the Complainant's bank account. The Complainant contacted the Provider when he realised the policy had been renewed despite his express instructions.

The Complainant's Case

The Complainant states that he informed the Provider that he did not want to renew his insurance policy with them, however the Provider, despite his express instructions, renewed the policy and sent him an insurance disk. The Complainant states that he rang the Provider to state that he had not taken out a policy with them and to make a complaint. The Complainant states that the Provider's agent was somewhat unhelpful, however, eventually, the agent conceded that they would not hold him to the policy. Further issues arose in relation to the repayment of the direct debit. The Complainant states that the Provider told him that it would only agree to the cancellation of the policy but that it "*would not consider it to have not been sold as a policy*". The Complainant states that this is unacceptable and sharp practice. The Complainant states that he sought an offer of amends but he received no response.

The Complainant's belief is that the Provider acted intentionally, when it did not register his complaint, as a complaint; he believes that this was to avoid officially noting a complaint.

The Complainant is seeking (i) confirmation that he did not take out an insurance policy with the Provider, (ii) a written apology and (iii) a "*fine*" levied against the Provider for mis-selling of a financial product.

The Provider's Case

The Provider confirms that the Complainant informed its agent that he didn't want to renew his policy. This instruction wasn't honoured and the Complainant's policy rolled over on the renewal date and a direct debit payment was taken. The Provider accepts that this shouldn't have happened and states that it was a result of human error. The Provider states that this is not how it expects its staff to behave and that corrective action has since been taken.

The Provider states that when the Complainant became aware of the renewal he raised it as a complaint and the complaint was escalated to a Supervisor. The Provider states that the issue was resolved, the policy was lapsed from the renewal date and the direct debit amount was refunded.

The Provider accepts that when the Complainant contacted it about the issue it was not initially raised as a complaint, and there was no apology made or gesture of goodwill offered. The Provider accepts that this was an error made by the individual handling the matter. The Provider states that it has increased monitoring and training for all complaints.

The Provider has made a written apology to the Complainant and has offered the Complainant €250 as a gesture of goodwill.

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.

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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 16 July 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.

An additional submission was received from the Complainant on 20 July 2018, contending that the Preliminary Decision contained an error of fact. A copy of the said submission was sent to the Provider on 24 July 2018 offering an opportunity of 10 working days to comment on the contents, but the Provider declined to comment. Following the consideration of the additional submission from the Complainant, the final determination of this office is now set out below.

In reaching my decision I have had regard to the following provisions of the Central Bank's Consumer Protection Code:-

"3.3 A regulated entity must ensure that all instructions from or on behalf of a consumer are processed properly and promptly.

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10.7 A regulated entity must seek to resolve any complaints with consumers.

10.8 When a regulated entity receives an oral complaint, it must offer the consumer the opportunity to have this handled in accordance with the regulated entity's complaints process.

10.9 A regulated entity must have in place a written procedure for the proper handling of complaints. This procedure need not apply where the complaint has been resolved to the complainant's satisfaction within five business days, provided however that a record of this fact is maintained. At a minimum this procedure must provide that:

a) the regulated entity must acknowledge each complaint on paper or on another durable medium within five business days of the complaint being received;

b) the regulated entity must provide the complainant with the name of one or more individuals appointed by the regulated entity to be the complainant's point of contact in relation to the complaint until the complaint is resolved or cannot be progressed any further;

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c) *the regulated entity must provide the complainant with a regular update, on paper or on another durable medium, on the progress of the investigation of the complaint at intervals of not greater than 20 business days, starting from the date on which the complaint was made;*

d) *the regulated entity must attempt to investigate and resolve a complaint within 40 business days of having received the complaint; where the 40 business days have elapsed and the complaint is not resolved, the regulated entity must inform the complainant of the anticipated timeframe within which the regulated entity hopes to resolve the complaint and must inform the consumer that they can refer the matter to the relevant Ombudsman, and must provide the consumer with the contact details of such Ombudsman; and*

e) *within five business days of the completion of the investigation, the regulated entity must advise the consumer on paper or on another durable medium of: i) the outcome of the investigation; ii) where applicable, the terms of any offer or settlement being made; iii) that the consumer can refer the matter to the relevant Ombudsman, and iv) the contact details of such Ombudsman.*

…

10.12 A regulated entity must undertake an appropriate analysis of the patterns of complaints from consumers on a regular basis including investigating whether complaints indicate an isolated issue or a more widespread issue for consumers. This analysis of consumer complaints must be escalated to the regulated entity's compliance/risk function and senior management."

It was very clear from the call on **03 April 2017** that the Complainant was seeking a revised quote and that he was <u>not</u> looking to renew his policy. He clearly said that he did not want to go ahead with the quote because the policy premium had increased by such a significant amount and, despite request, the agent was unable to tell him why his premium had increased so much. There was no lack of clarity in this call; it was clear that the Complainant wanted to cancel the policy.

During the call on **27 April 2017** the Complainant clearly said to the Provider's agent that he would be making a complaint to the FSO in relation to this issue. It is clear from this call that the Provider's agent did not accept that the Complainant had been wronged. The Provider's agent attempted to resolve the mistake and agreed to cancel the policy and repay the premium. The Complainant states that he was looking for an offer of amends as this was unacceptable and he stated that if there was no offer of amends, he would refer the matter to the FSO.

On **22 May 2017** the Complainant contacted the Provider stating that he had received the cheque for the incorrectly deducted premium and stating that he had not received an apology or recognition of wrongdoing and that the matter had not been treated as a complaint. The Complainant stated that he would refer the matter to the Ombudsman if it was not resolved. The Provider responded on **24 May 2017** stating that the matter had

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been escalated to a complaint. However, the Complainant did not receive confirmation of his complaint within 5 working days and the Complainant had to contact the Provider again on **13 June 2017** and again on **26 June 2017** seeking an update and advising that the matter would be referred to the FSO. It was only on the **10 July 2017**, after the Complainant had made a complaint to the Ombudsman, that the Provider responded to the complaint.

The renewal of the insurance policy despite express instructions not to renew, was contrary to Section 3.3 of the Consumer Protection Code, as the Provider failed to process properly and promptly, instructions from the Complainant. I accept that the Provider made a human error as it appears the phone call of 3 April 2017 was not recorded on the Provider's call log. The Provider's agent was helpful in correcting the mistake and ensuring that the policy was cancelled and the Complainant was refunded. However, the Provider's agent did not apologise for its action or offer amends as requested by the Complainant.

In the response to the complaint which issued on 10 July 2017 the Provider apologises for the delay in investigating this complaint stating that the complaint wasn't "*correctly referred*". The Provider accepts that a complaint was raised on 27 April 2017.

In relation to a breach of provision 10.7 of the Consumer Protection Code, I disagree with the Provider's contention that "*the issue at hand was resolved on the day it was identified"* Certainly, the Provider did fix the mistake it had made, by cancelling the policy and refunding the premium. However, the Complainant had at all times requested an apology/amends and this was not given on the 27 April 2017; consequently the Complainant was certainly not of the same opinion as that of the Provider, that the matter had been resolved.

In breach of provision 10.8 of the Consumer Protection Code the Provider failed to offer the Complainant the opportunity to have the complaint handled in line with the complaints process. As a result of this failure the Provider was in breach of Provision 10.9 of the Consumer Protection Code and it was left to the Complainant to repeatedly ask what progress was being made on his complaint. It appears that it was not until the Complainant escalated his complaint to the FSO that the complaint was addressed. The Complainant's commitment must be commended. What is more, if the Provider did believe, in error, that the complaint had been resolved on the 27 April 2017 the Provided failed to show evidence to this Office of where the Provider recorded the fact that a complaint had been made and that the complaint had been resolved within five days, such that the written complaints procedure for handling complaints would not apply.

The failure to register a complaint as a complaint, even where it is substantially resolved on the day the complaint is made, makes provision 10.12 of the Consumer Protection Code less effective and unfortunately creates the impression of an attempt to side step the Code.

More recently, in addition to the offer of amends which the Complainant had originally sought, the Complainant has suggested that *"At the heart of this matter is that the insurance provider in a manner or form designed to entrap a consumer in an insurance*

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policy in an entirely inappropriate manner and as such strategy as a whole is an aftermath to the principles of consumer protection and appropriate insurance requirements of insurance under requirements and obligations of consumers to have insurance policies and provide to act appropriately in this jurisdiction. Given the serious nature of an individual's insurance history even aside from any claims made on any policy, I believe it is of supreme importance that the position of the policy that [the Provider*] purported to take out in my name be annulled from its inception as opposed to simply being cancelled to find otherwise fundamentally alters my insurance history in an unjust manner and could potentially mitigate against me in respect of future policies of insurance I might seek to take out."*

I accept however, that the renewal occurred owing to human error, notwithstanding the very clear instructions of the Complainant on 3 April 2017. I do not accept in that regard that the renewal occurred as a result of a deliberate action on the part of the Provider to tie the Complainant into a policy of insurance for the following year, which he did not require.

I note that the record has been corrected by the Provider which confirmed that "*The issue was resolved, the policy lapsed from the renewal date and a refund was organised. Although the issue was resolved, this wasn't handled as a complaint, and there was no apology made, or gesture of goodwill offered. This was an error made by the individual handling the case."*

In circumstances where the records of the Respondent Provider confirm that the policy was not renewed with effect from the renewal date, and the premium refund to the Complainant was actioned, I do not accept that the Complainant has been prejudiced in any way, in relation to any future policies of insurance.

For the reasons set out above however, in relation the Provider's handling of the Complainant's complaint, and on the basis of the evidence outlined, this complaint is upheld.

Conclusion

- My 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)(g)***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to review its practice relating to recording of complaints, as complaints, where such complaints are resolved to a Complainant's satisfaction within five working days and in particular where resolved on the day the complaint is made. I also direct the Provider to pay €500 by way of compensation to the Complainant for any loss, expense or inconvenience caused as a result of the conduct complained of, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider, and I also direct that interest is

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to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION
AND LEGAL SERVICES

9 August 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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.