An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0215
Sector:	Insurance
Product / Service:	Term Insurance
Conduct(s) complained of:	Maladministration
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to the Provider's error in incorrectly debiting €7,033.18 from the Complainant's bank account over a period of approximately 4 years and crediting that money to the plan of another person.

The Complainant's Case

On approximately the 21st September, 2010, the Provider issued a life insurance policy in the form of *"keyman cover"* **("the Policy")** to a company of which the Complainant was a director, with the Complainant named as the life assured. At the same time, the Provider issued similar policies to the other three directors of the company **("the Policies")**. The monthly premiums were debited from the company's bank account.

In approximately autumn 2012, the company directors decided to transfer ownership of the Policies to each individual director. By letter dated the 6th October, 2012, the Provider informed the Complainant's advisor what was required in order to make the relevant alterations and enclosed draft deeds of assignment.

By Deed of Assignment dated the 24th September, 2012 **("the Deed")**, ownership of the Policy was transferred from the company to the Complainant.

The Complainant submitted the Deed and a direct debit mandate to change the bank details from which the premiums ought to be debited from those of the company, to those of the Complainant's personal bank account. No other director provided bank details to the Provider so that the Provider could continue the payments on their respective policies by debiting their personal bank accounts.

Through an error, the Provider incorrectly applied the Complainant's bank details to all currently *"in force"* plans that had previously been debited from the company. As a result, the Complainant's bank details were applied to one of the other Policies and one payment of €431.276 and 46 payments of €143.52 (together totalling €7,033.18) were incorrectly debited from the Complainant's bank account between approximately the 1st November, 2012, and the 1st September, 2016, and credited to his co-director's policy.

By letter dated the 9th October, 2012, the Provider stated that the assignment had been made but made no reference to the new manner of payment of the premiums. Details of the Policy including the Complainant's monthly payment were sent directly to the Complainant prior to the change in ownership in July, 2011 and 2012 and after the change in ownership, in July 2013, 2014, 2015, 2016 and 2017, none of which mentioned the payments which the Complainant was making in respect of his co-director's policy.

In approximately September 2016, the Complainant discovered that his personal bank account was being debited for an amount exceeding the premiums due on his Policy and instructed his agent to phone the Provider in that regard. It emerged during that phone call that the Complainant had paid premiums of €143.52 on a policy in the name of a third party since September 2012. The Provider undertook to look into the matter and to send the details of the third party payment to the Complainant but it was agreed that the Complainant was due a refund if it transpired that he shouldn't be paying those premiums.

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On the 14th September, 2016, an agent of the Provider **"the Provider's agent"** phoned the Complainant and noted that an error had been made, that his bank details had been added to the account of a third party and that €7,033.18 had been paid by the Complainant in error and that it would be refunded.

The Complainant sought compensation; although the Provider asked the Complainant to suggest a figure the Complainant declined to do so and sought an offer from the Provider. The Provider undertook to make the refund and revert with an offer.

By letter dated the 15th September, 2016, the Provider's agent noted that the matter was under investigation by the Provider, enclosing a copy of the Provider's complaints guide and advising that he would be contacted in relation to the complaint.

By letter dated the 17th September, 2017, although he did not apologise to the Complainant or offer compensation, the Provider's agent confirmed in writing that the amount incorrectly debited as "*an overpayment on your plan"* would be credited to his account and available to him within four working days.

On the 20th September, 2016, the Provider's agent phoned the Complainant to inform him that the refund had been made and offered compensation of €250. The Complainant found that offer insulting, particularly given the breach of trust which had occurred. He refused again to make a suggestion of what he would accept but noted that he would consider any reasonable offer. The Provider's agent pressed the Complainant to contact him with a figure in compensation which he could put to his manager.

By letter dated the 21st September, 2016, the Provider's agent set out a breakdown of the payments that were incorrectly debited, but offered no apology or compensation therein.

By letter dated the 6th October, 2016, the Provider apologised for the delay in replying to complaint but noted that the investigations would completed by the 26th October, 2016.

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By phone calls dated the 14th October, 2016, the Provider's agent stated that he had reverted to his team leader and could now offer €700 in compensation. The Complainant was equally disappointed with this offer and complained about the Provider's failure to deal with the matter in an appropriate way by considering or even enquiring about the circumstances of the Complainant or the effect this had on him and to make a reasonable offer (which, he claimed, he would likely have accepted). The Provider again pressed the Complainant to suggest an amount he would accept in compensation, which he could take to his superiors.

Upon questioning from the Provider's agent, the Complainant confirmed that €1,000 would not be acceptable even if it was offered. The Complainant made clear that he would need an offer well in excess of €1,000 and asked that the Provider not revert to him, unless it had a meaningful offer.

By letter dated the 21st October, 2016, the Provider apologised to the Complainant for the substantive error and explained that the error was due to human error in applying the Complainant's bank details as received with his direct debit form, to the plan of other customer and noted:-

> *"I apologise for this error and regret any concern that we have caused. As an apology for our error I offered you €1,000 during our telephone conversation on 14 October 2016, however you advised that you did not want to accept our offer".*

The Complainant was advised that a complaint could be made to this office if this was not acceptable to him.

By letter dated the 15th November, 2016, the Complainant sought an explanation as to how the offer of €1,000 was calculated. By letter dated the 22nd November, 2016, the Provider once again apologised for the error and noted that:-

> *"Having reviewed the case with my manager we felt that due to the length of time that we were incorrectly collecting payments from your bank account and the total*

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> *amount that was collected in error, that an offer of €1,000 along with a full refund of €7,033.18 would be satisfactory as an apology for our error"* [emphasis added].

The letter closed by referring the Complainant to this Office, should he remain dissatisfied.

The Complainant complained to this Office and by letter dated the 15th November, 2017.

The Complainant does not believe that the Provider had made a sufficient offer of compensation in this matter in light of the illegal nature of the payments, the fact that the error was not discovered by the Provider and could have continued indefinitely, the failure to clearly explain how the error occurred or how the offers of compensation were calculated and the severe financial hardship he experienced during the time of the illegal deductions.

He is also extremely dissatisfied about how the matter was handled by the Provider. The Complainant believes that the Provider should pay at least €7,000 in compensation.

The Provider's Case

The Provider maintains that it has dealt with the Complainant in a just, fair and reasonable manner.

In response to an enquiry from this office, the Provider noted as follows:-

> *"[t]he background to this administrative error, which led to the over-deduction was the Complainant, along with a number of other individuals were Directors of a Company [name of Company] that up to September 2012 was paying for each of the Directors' Keyman Cover life assurance plans from the Company's bank account.*
>
> *In October 2012 the Provider received a number of Deeds of Assignment to transfer the legal ownership of any current "Keyman Cover" life assurance plans from the Company to the individual Directors in question. In the Complainant's case a Direct Debit Mandate Form was also received by the Provider, giving details of the Complainant's personal bank account and an instruction to continue collecting the premium for his plan, but from his personal bank account. No other individual Directors' personal bank details were provided in order to continue the payment by debiting their personal accounts after the change of ownership.*

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When updating the bank details on to the Provider's systems for individual plans, there are two possible options. One is to update the individual plan with the new bank details (Separate tab). The other is to combine the new bank details to all plans that have previously been linked to the plan being updated (Combined tab). The Combined tab option is usually used when an individual customer has multiple plans that need to be debited from the same new bank account.

Unfortunately when the Complainant's personal bank details were being updated on the Provider's systems the "Combined" option tab was used in error and this resulted in the Complainant's bank details updating to any currently inforce plans that had previously shared the same Company Bank Account details.

As all but one of the other Director's plans were cancelled by November 2012 the Complainant's bank account was debited for one remaining Director's life assurance plan up to September 2016, when this matter was brought to the Provider's attention by the Complainant".

It notes that it accepted responsibility for the *"administrative error"* which caused the deductions, that it immediately refunded the relevant amounts and apologised for the maladministration and offered compensation, culminating with an offer of €1,000. The Provider notes that:-

"It is regretful that the Complainant felt that this amount was not a satisfactory level of compensation under the circumstances. However the Provider believes that its final offer is proportionate and commensurate with the error made. The Provider therefore believes it has dealt with this matter in what it considers to be a just, fair and reasonable manner".

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 23 November 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, I set out below my final determination.

I believe the error was very serious in nature and warranted an immediate apology from the Provider and a serious attempt to resolve the matter by a person on behalf of the Provider who was authorised to agree a settlement with the Complainant, or at least to recommend a settlement to the Provider.

Despite knowing almost immediately that it had made an error and despite various early engagements with the Complainant, the Provider did not apologise to the Complainant until several weeks later.

Further, and more significantly, the manner in which the Provider sought to resolve the matter with the Complainant did not in my view reflect the seriousness of the error and only seemed to further antagonise him.

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As alluded to several times by the Complainant in the various phone calls between himself and the Provider, while telling him it was trying to resolve the matter to his satisfaction, the Provider was focused on trying to settle the matter at the minimum cost to itself.

Recordings of the phone calls have been provided in evidence. Having listened to these recordings, it is clear to me that the manner in which the Provider sought to minimise the cost of dealing with the matter was a cause of serious irritation to the Complainant.

The whole thrust of the calls was to settle the complaint at minimum cost the Provider rather than recognising and acknowledging the seriousness of the wrong done and seeking to rectify the matter in a fair and reasonable manner.

In these calls, the Complainant makes the very valid point that the Provider made no attempt at any stage to understand or enquire about his circumstances or the impact or implications that removing more than €7,000 from his account without permission had on him.

Indeed, even after he made the point to the Provider, it still did not enquire or seek to establish the impact of its actions.

The Provider's opening offer was a mere €250. Although the next offer was almost treble the initial offer, it was still manifestly insufficient in the circumstances. Further, despite the Provider's assertions in correspondence that it had offered €1,000, this does not accurately reflect what actually happened; €1,000 was never actually offered to the Complainant.

Rather, having unsuccessfully done so by overt questioning on several occasions, the Provider sought to extract a bottom line from the Complainant by enquiring whether €1,000 would be accepted if it was acceptable to the superiors of the Provider's agent.

The positioning of the Provider's agent as a buffer between the Complainant and those who made the relevant decisions and the constant pressing of the Complainant to suggest a

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figure against the background of unreasonable offers, were, in my view, unhelpful and not the best way to seek to resolve the matter.

While the Provider is entitled to negotiate compensation with its customers in circumstances such as the present, given the imbalance of power between it and its customers, it is critical that those discussions/negotiations are carried out in a fair and reasonable manner and by a person with the competence and authority to conduct such matters.

This is the only way to ensure that all customers are treated fairly in such circumstances, irrespective of a customer's own ability to ensure that they are not taken advantage of.

Second, the tone and content of the Provider's letter dated the 22nd November, 2016, is unsatisfactory. Not only does it imply that it should be given some form of credit for giving the Complainant a *"full refund"* (for giving him back his money that was incorrectly removed from his account), it misrepresents the negotiations by asserting that the Provider offered €1,000 to the Complainant when its highest offer was in fact €700.

Third, the Provider did not provide a fulsome explanation for the error until enquiries were made by this Office.

This approach was adopted by the Provider despite the Complainant taking a very calm and reasonable approach in his communications with the Provider.

For the reasons set out above, I uphold this complaint and direct that the Provider pay compensation to the Complainant.

In all the circumstances of this complaint, I do not believe the €1,000 is sufficient compensation. Equally, I do not believe the sum of €7,000 sought by the Complainant is warranted.

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I believe that a sum of €2,500 is fair and reasonable to compensate the Complainant for the loss and inconvenience.

I would strongly advise the Provider to review its approach to dealing with mistakes of this nature and complaints by endeavouring to understand the impact of its actions and by ensuring that customers affected by such mistakes are dealt with by people with the authority to apologise for its actions and make a serious attempt to resolve the matter.

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) (b) and (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 make a compensatory payment to the Complainant in the sum of €2,500, 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.

I also 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***, 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.***

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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

18 December 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.