An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0009
Sector:	Insurance
Product / Service:	Retail
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns an insurance policy taken out by the Complainants in relation to a business of which they were directors. The insurance policy was incepted on 25 September 2014 and expired on 24 September 2015. The complaint relates to the Provider's decision to refuse indemnity for an employer liability claim, relating to an incident which occurred on 12 May 2015, which gave rise to a personal injuries claim by a third party, a former employee of the Complainant's business.

The Complainants' Case

The Complainants submit that they took on a self-employed business consultant on 12 May 2015, and an incident occurred on 25 May 2015. The Complainants submit that approximately four weeks after the consultant commenced working for the business, he became an employee of the business up until 1 November 2015 when he reverted to a self-employed business consultant up until 18 March 2016. The Complainants submit that when the consultant departed it was not a pleasant process and "*a string of threatening emails/texts followed*".

The Complainants submit that they subsequently received correspondence from the Injuries Board to advise that the former employee was planning to take a personal injury case against them for the incident that occurred on 25 May 2015. The Complainants submit that

upon receipt of this correspondence all correspondence was sent to their broker and the Provider.

The Complainants submit that they received an email from the Provider dated 8 November 2016 advising that it would not cover the claim, as the incident was not reported at the time. The Complainants state that they "*advised that with any incident we would assess the situation as and when it happens, ie. A child falling off a stool or a chef cutting their finger. The same assessment was done with [named former employee] as there was no suggestion that this would result in a claim. [Named former employee] is a disgruntled former employee who's only objective is to try and extort from our business. Furthermore [named former employee] has lied in his injuries report to the Injuries Board*".

The Provider's Case

The Provider states that there has been a "*serious breach of Policy Conditions, arising from the late notification of the incident to us. The [business] is now under new management, therefore our investigations have been prejudiced… As a consequence, we regret to advise that we are not prepared to provide an indemnity under the Policy and will take no further action in this claim*".

The Provider states that "*The insured was fully aware of the accident both at the time it occurred and also in the following March when he was in email communication with the injured Claimant. At both of these times he was still in control of the premises and should have reported the matter to his insurers to allow them to investigate the matter and assess the extent of the liability if any or gather evidence on which to defend the case. If the case was one for settlement then there could have been earlier engagement with the claimant in order to resolve the claim at a lower cost*".

The Complaint for Adjudication

The complaint is that the Provider has wrongfully refused to indemnify the claim.

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 Complainants were 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 on 8 January 2019, 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 Provider submits that it declined cover in respect of an Employers Liability claim arising from an accident on 12 May 2015 but which was not reported to it until 17 June 2016. The Provider submits that the insured was aware of the accident at the time it occurred but did not report the matter to it or his insurance broker. The Provider states that "*Furthermore he was aware that the claimant was taking action in respect of the accident through email correspondence from the claimant to the insured on 21st March 2016. By the time the accident was reported to [the Provider] the insured was no longer running the business at the location where the accident happened and our position with regard to carrying out investigations was prejudiced*".

The Complainants have submitted a copy of an email from the business's former employee dated 21 March 2016, which I note states, among other things, the following:

> *"[Albeit] an insurance matter for you to consider, I will also seek compensation for a permanently disfigured toe for which I have the report from the medic I sought assistance from on the evening of the occurrence along with photos."*

I have also been provided with a copy of a letter to the first Complainant from the Injuries Board dated 7 June 2016 regarding notification of a claim from the former employee of the business.

The first Complainant submits that he was there at the time of the incident, and after questioning the former employee on numerous occasions, he was told that he was fine. The first Complainant states that "*I had no logical reason to suspect that [the named former employee] would ever make a claim as a result of this incident. I had understood that he was not injured, did not require any medical attention, did not take any time off work, and it was clear that he accepted all culpability for the incident itself*". The first Complainant also states that "*it is important to note that the PI Summons received on behalf of [named former employee] discloses no injury of any kind*".

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The first Complainant states "*It is also worth noting that minor incidents would happen quite regularly. These would range from a child falling off a stool, to a chef cutting their finger. An assessment would be made at the time given the feedback from the individual*". The first Complainant also states "It would be prohibitive to contact the insurance company/broker on every minor incident that happened within the business".

The first Complainant states that:

> *"The indemnifier is adopting an 'ala carte' attitude to the stated ground of refusal for indemnity i.e. saying that they wanted to inspect the accident site and interview witnesses, but they never made any offer to do so.*
>
> *Further whereas the indemnifier originally claimed that a failure to notify post 12th May 2015 was the reason for non-indemnification; they later did a 180 on this and instead placed great significance on non-notification post the email of 21st March 2016 which was of course some 10 months after the fact and of course any inspection that could have been carried out at that time was meaningless.*
>
> *I would have been more than happy to make myself available for interview, since I was the only other person present, however this was never requested at any stage during my communications with [the Provider]."*

Policy terms and conditions:

Pages 3 and 4 of the policy terms and conditions set out, among other things, the following:

> *"CLAIMS CONDITIONS*
> *…*
>
> *2. On the discovery of any circumstance or event which may give rise to a claim under this Policy the Insured shall*
> *(A) notify the Company in writing forthwith*
> *…*
> *(E) within 30 days… after the circumstances or event or of the expiry of the Indemnity Period or such further time as the Company may allow at his own expense deliver to the Company*
> *(1) full information in writing of the claim*
> *(2) details of any other insurance relating to the claim*
> *(3) all such business books documents proofs information explanation and other evidence as may be reasonably required…*
> *(4) if demanded a statutory declaration of the truth of the claim and of any matter connected with it*
>
> *3. No claim under this Policy shall be payable unless the terms of Claims Condition 2 have been complied with*
> *…*

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> *11.* ***APPLICABLE ONLY TO LIABILITY INSURANCE***
> *Every letter claim writ summons and process in connection with the event shall be forwarded to the Company immediately on receipt. The insured shall also give the Company written notice immediately the Insured has knowledge of any prosecution or inquest in connection with any occurrence which may give rise to liability under this Policy"*

A policy of insurance can be described as an agreement between an insured and an insurance company whereby the insured agrees to pay a premium, and the insurance company agrees to provide indemnity in the event of certain insured perils. However, this arrangement is subject to a number of terms and conditions, which govern the relationship between the parties. Each party has rights and responsibilities and the obligations of both the insured and the insurer are set out within the insurance policy.

As noted above, the claims conditions set out in the policy document expressed certain obligations that the Complainants were required to comply with, and, in particular, the following:

> *"2. On the discovery of any circumstance or event which may give rise to a claim under this Policy the Insured shall*
> *(A) notify the Company in writing forthwith*
> …
> *11. Every letter claim writ summons and process in connection with the event shall be forwarded to the Company immediately on receipt"*

Significantly, these obligations were expressed to be a "*condition precedent*" to the Provider's liability, within the general conditions of the Policy. In practical terms, this had the effect of making the Provider's liability to make any payment under the policy **conditional** upon the Complainants having done or complied with all that was required of them under the Policy.

I note Austin J. Buckley's observation on this issue, that:

> *"Where the submission of particulars within a specified time is a condition precedent, failure to submit particulars within the time specified relieves the insurer of liability and a subsequent submission of the particulars does not entitle the insured to indemnity"*[1]

He goes on to note that:

> "*to sustain repudiation it is not necessary for insurers to prove that there interests have been prejudiced"*[2]

I have considered the issue of prejudice, briefly, below.

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[1] Buckley, *Insurance Law*, 2nd ed. Thompson Round Hall, 2006, p 201
[2] *Ibid*, p 202

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Prejudice

I am satisfied that it is not necessary for the Provider to establish that it has been prejudiced by the late notification. Nevertheless, I am of the opinion, that in only becoming aware of the claim at a remove of some 12 months after the event, it is somewhat inevitable that the Provider's position in defending any claim made by the injured party was indeed affected, even if only insofar as the opportunity to inspect the locus of the incident.

I am conscious of the difficult position, which the Complainants find themselves in, and accept that the failure to notify the Provider within a reasonable time and/or forward on the correspondence received may well have been an oversight or misunderstanding. However, it is the case that the provision of cover under an insurance policy is determined by the Policy Terms and Conditions which both parties are bound by. I must also, therefore, be conscious of the fact that the Provider has, through no fault of its own, found itself at a potentially significant disadvantage in defending any claim in the circumstances, where it was not informed of the particulars of the event within a reasonable time, or "forthwith", to refer to the wording of the Policy, nor indeed was the email from the former employee to the first Complainant dated 21 March 2016 highlighting the potential of taking a claim submitted to the Provider immediately on receipt. Having failed to involve the Provider at these earlier stages, I do not believe that it would be reasonable to oblige the Provider to deal with the matter at this remove.

Overall, I am of the view that the Provider has not acted unreasonably in acting in accordance with its Policy Terms and Conditions, regarding its decision not to provide policy indemnity for the employers liability claim. As the evidence before me discloses no wrongdoing on the part of the Provider, this complaint is not upheld.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 January 2019

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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
(ii) shall not be identified by name, address or otherwise,
(iii) 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.