Decision Ref:	2019-0104
Sector:	Insurance
Product / Service:	Commercial
Conduct(s) complained of:	Delayed or inadequate communication Maladministration Mis-selling (insurance)
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to an agreement with an Insurance Brokerage company and alleged maladministration and poor customer service.

The Complainant's Case

The Complainant Company engaged the respondent Provider as an insurance broker for the purposes of, amongst other things, securing public and employers' liability insurance. The Complainant states that in June 2012, it took out a public and employers' liability insurance policy through the respondent Provider. The insurance was provided by [a third party Insurance Company]. When this policy lapsed, a second policy was taken out in 2014 on the same terms and basis as the previous policy.

The Complainant states that in October 2015, [the Insurance Company] cancelled this policy ab initio. The Complainant states that the respondent Provider informed it that the reason the policy had been cancelled was that a director of the Complainant Company, [Mr B], was also a director of other businesses which had not been disclosed either to the insurance company or to the respondent Provider. In addition, the Complainant states that the

respondent Provider explained that the policy was also cancelled due to what it states was the non-disclosure of material facts in relation to a previous claim.

The Complainant states that when the respondent Provider had requested a list of other directorships held by [Mr B], it was informed that he was only a director of the Complainant Company. The Complainant states that at no time prior to this enquiry was it asked about any directorships.

In addition, the Complainant states that at the time the policy was taken out, the respondent Provider was advised that a claim was being made against the Complainant Company by an individual and that this individual had previously submitted another claim against [Mr B] under his own personal policy in his capacity as the sole owner/landlord of the premises where the Complainant Company operates the business.

In addition to the foregoing, the Complainant states that since the policy was cancelled on 6 October 2015, the Complainant has received very poor customer service and has been "fobbed off" on a continuous basis. The Complainant states that the respondent Provider has provided poor customer service and communication throughout.

In addition, the Complainant states that the respondent Provider never advised of a complaints procedure or of the Ombudsman's role in dealing with complaints/issues.

The Provider's Case

The Provider rejects the allegations made against it by the Complainant. In particular, the Provider denies that there was a lack of communication between the Provider and the Complainant or that the Provider "fobbed off" the Complainant. In relation to the cancellation of the policy, the Provider states that the Complainant had been asked questions in relation to the claim against [Mr B] and that the Provider acted appropriately based on the answers given to it by the Complainant. The Provider disputes that that it did not appropriately or properly inform the Complainant of its own complaints procedures. The Provider also states that it spent a lot of time and effort working on behalf of the Complainant with the insurance company in order to resolve the ongoing issue.

A Preliminary Decision was issued to the parties 7 December 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.

Following the issuing of my Preliminary Decision, both parties made further submissions as follows:

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1. E-mailed letter from the Complainant to this Office dated 9 January 2019.

2. E-mailed letter from the Provider to this Office dated 23 January 2019.

3. E-mailed letter from the Complainant to this Office dated 6 February 2019.

4. E-mail from the Provider to this Office dated 11 February 2019.

5. E-mailed letter from the Complainant to this Office dated 25 February 2019.

6. E-mailed letter from the Provider to this Office dated 11 March 2019, a copy of which was transmitted to the Complainant for her consideration. However by e-mail dated 11 March 2019, the Complainant advised this Office that she did not wish to add anything further.

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.

In its post Preliminary Decision submission of 6 February 2019, the Complainant had requested that an Oral Hearing be held by this Office. However, having reviewed and considered the submissions made by the parties to this complaint, including the various post Preliminary Decision submissions, 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.

While the parties engaged in considerable correspondence and exchange following the issuing of my Preliminary Decision, I did not find anything in these submissions which would constitute an additional fact, error of fact or error of law in relation to my Preliminary Decision.

Having considered these additional submissions, together with the significant amount of supporting documentation furnished by both parties, I set out below my final determination.

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Included in the documentation supplied in evidence is the signed agreement and terms of business entered into between the Complainant Company and the Provider on 3 July 2012. Contained within the body of the terms of business document is a section entitled "Complaints Procedure".

This states as follows:

Complaints Procedure

The company has a written procedure in place for the effective consideration and handling of complaints. Any complaints should be addressed in writing to the managing director, [Provider].

Each complaint will be acknowledged by us within five working days of receipt, updates will be advised in intervals of not more than 20 working days, we will endeavour to resolve the complaint within 40 business days and findings will be furnished to you within five working days of completion of the investigation. In the event that you are not entirely satisfied with the firm's handling of and response to your complaint, contact may be made with the Irish brokers Association, 87 Merrion Sq, Dublin 2 and ultimately you have the right to complain to the Financial Services Ombudsman, Third floor, Lincoln House, Lincoln Place, Dublin 2.

One aspect of this complaint is the complaint that the respondent Provider has "never advised of the complaints procedure or the Ombudsman's role in dealing with complaints". It appears from the foregoing, the Complainant Company was furnished with documentation at the time of entering into the agreement with the respondent Provider that clearly sets out the Provider's complaints procedure and the Complainant's right to complain to the office of the Financial Services Ombudsman (as it then was). Accordingly, I do not uphold this aspect of the complaint.

The public and employers' liability insurance policy was first taken out in July 2012. The Provider has furnished this office with its internal contemporaneous notes relating to the Complainant Company. Amongst other things these notes show that on 27 May 2012, a note was taken that the Provider was approached by [Mr B] with regard to business for which he wanted to obtain a quote on. It is noted that this is his wife's business which he is not involved in. It is further noted that [Mr B] outlined that "*someone is claiming off him as landlord of the building*". The note goes on to record that the Provider enquired as to who the claimant was but that not much information was furnished other than it was a member of the public. This note records that the Provider sought clarification if the claimant had anything to do with the business being quoted for and that the response given that it had not. A later note dated 30 May 2012, notes that a quote was received from [the Insurance Company] but that it was sent back to referral on a few things such as correct occupation and the claim against the landlord. This note also records that the Provider rang the [the Insurance Company] helpdesk to seek advice on answering the questions and to query the claim "*in terms if it's okay to proceed or if what will happen if all parties to contribute a claim*". It is noted that [the Insurance Company] had no problem with the notification and were happy to proceed with cover. The policy then commenced on 9 July 2012.

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In addition to the foregoing, this office has been provided with the diary entries which show diary entries by the Provider and on behalf of [the Insurance Company].

These entries show that on 29 May 2012 the Provider referred the quote to the insurance company and noted that there was an outstanding claim against the landlord of the building that the Complainant Company uses. It is noted that "*there is no connection to the claim with this company proposed".*

This was noted again on 31 May 2012 and again on the day when the policy commenced on 9 July 2012.

The policy was then renewed the following year. The documentation provided shows that the Provider wrote to the Complainant about renewing the policy again in 2014. It appears that this letter was either overlooked or not received by the Complainant. In any event the internal notes and documentation show that the Provider discovered that the policy had lapsed and contacted the Complainant. The Complainant agreed to get cover again and when the Provider contacted [the Insurance Company] it stated that it could not resurrect the old policy but it would set up a new policy. I note that the Provider had advised that the previous policy had notes attached to it including a note relating to a claim against the landlord of the Complainant Company's office. It is noted that [the Insurance Company] said that this was no problem and then the Provider contacted the Complainant to clarify a couple of matters including asking about the claim against [Mr B]. I note that the Provider asked if there had been any developments in relation to this claim. The Complainant responded that there were not. These details were inputted and the policy was created.

On 6 October 2015, [the Insurance Company] wrote to the Complainant Company notifying it that it had cancelled the insurance policy and was treating it as void ab initio arising out of non-disclosure of claim information. The letter stated that when the Complainant Company applied for insurance cover, it did not disclose the full claim history for all directors involved in the business. [The Insurance Company] later explained that when the policy was first placed with them, in the "refer notes" in their online system they were advised that there was an outstanding claim against the landlord of the premises used by the Complainant Company. [The Insurance Company] explained that they were advised there was no connection with the claim and the Complainant Company. [The Insurance Company] further advised that it was not advised that [Mr B], who this claim was taken against, was a director of the Complainant Company and that this claim was made by an employee of the Complainant Company. In addition, [the Insurance Company] state that they were not made aware of the existence of other companies wherein [Mr B] acted as a director.

It appears from the foregoing that [the Insurance Company] are correct in stating that they were not informed of those factual matters outlined above. This is evident from the internal notes of the Provider and the correspondence between the Provider and the Complainant Company. In addition it is evident from the communications between the Provider and [the Insurance Company]. All of the documentary evidence supports the Provider's position that it furnished [the Insurance Company] with all of the information that was provided to it by the Complainant Company. The documentary evidence shows that the Provider, at the time

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the policy was taken out in 2012, and renewed in 2014, acted cautiously and prudently in relation to the outstanding claim.

It is evident that the Provider asked about the outstanding claim on a number of occasions and was assured by the Complainant Company that the claim was unrelated and had nothing to do with the Complainant Company. According to [the Insurance Company], their investigations revealed that the claim was taken by an employee of the Complainant Company against [Mr B] who is a director of the Complainant Company.

The documentation clearly demonstrates that it was represented to the Provider that the person claiming against [Mr B] was a member of the public. In 2014, the Provider asked whether there had been any developments regarding the previous reported claim against [Mr B], the Provider was advised that there were no developments. In addition, I accept from a review of all the documentation, that it had been represented to the Provider that [Mr B] had no involvement in the Complainant Company and that it was always represented that it was [Mr B's] wife's business.

Accordingly therefore, I do not find any lack of care or wrongdoing on the part of the Provider in relation to the manner in which the policy was taken out in 2012, renewed in 2014. The decision to cancel the policy was a decision made by the insurance company and not the Provider. I accept that the Provider presented to the insurance company all of the information that had been represented to it by the Complainant Company in respect of the pre-existing claim. Accordingly, I do not uphold this aspect of the complaint.

I have carefully examined and considered all of the documentation and communication between the parties since the cancellation of the policy on 6 October 2015, including the post Preliminary Decision submissions. It is clear from the email correspondence between the Complainant and the Provider that the Complainant was extremely frustrated at the apparent lack of progress being made by the Provider with the insurance company. What is also clear, is that the Provider had been making continuous and numerous representations to the insurance company on behalf of the Complainant Company and seeking to get answers to questions as to why the policy had been cancelled. In addition, it is clear that the Provider did make contact with the insurance company on a number of occasions in order to try and explore ways to resolve the matter. It is clear that the insurance company were not going to change their position. That is clearly something that is outside of the control of the Provider in the particular circumstances of this case. It is clear also that the Complainant was frustrated at its point of contact in the Provider ceasing to communicate with her. The Complainant explains that this particular individual, understanding the seriousness of the matter, escalated the matter to the two most senior people of the brokerage. The email correspondence between the Provider and the Complainant Company demonstrates that at a certain point in time there was a changeover in the personnel dealing with the Complainant Company. This appears to be consistent with the Provider's explanation that at a certain point in time the individual who was initially dealing with this in the Provider company, escalated the matter to the two senior partners in the brokerage who then took over the communication with the Complainant Company and the Insurance Company.

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While I accept that the Complainant Company was extremely frustrated at the lack of progress and lack of resolution of this matter, there appears to be a regular and reasonable amount of communication between the Complainant Company and the Provider around this time. This is evidenced by the numerous emails between the parties which have been provided to this Office by both parties. Therefore I do not uphold this aspect of the complaint.

For the reasons outlined above, I do not uphold this complaint.

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

2 April 2019

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.