An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0125
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Complaint handling (Consumer Protection Code) Dissatisfaction with customer service Results of policy review/failure to notify of policy reviews Poor wording/ambiguity of policy Maladministration (life)
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns the Provider's administration and communication on a Whole of Life Policy taken out in 1990. The Complainants submit that the policy premiums have increased with the last several policy reviews, and that they now find themselves in a position where maintaining their current level of life cover under the policy is beyond their means.

The complaint is that the Provider acted incorrectly and unreasonably in relation to the administration of the policy, in particular in relation to the policy reviews, and regarding the substantial increase of premiums.

The Complainants' Case

The Complainants' position is that they understood their policy to be a *"Life Policy With Savings Whole of Life"*. They state that they were unaware that the policy would be reviewed in later years, and did not know that their premiums could increase on foot of the reviews.

The Complainants assert that they telephoned the Provider to complain about the *"review system"* and that the Provider's position did not change after their call. They note that they have paid nearly €50,000 in premiums since their policy's inception in 1990, which is more than the present life assured sum of €37,000.

The Complainants state that the Provider has offered them a *"Policy Guaranteed Whole of Life Premium"* of €465 per month, but that this amount is *"out of the question"* as they cannot afford to pay it.
They ask that the Provider *"be reasonable"* and maintain their life cover at a more affordable premium.

The Provider's Case

The Provider explains that the Complainants have a '[redacted] Account', which is a unit-linked, open-ended protection plan, designed to provide flexibility in relation to the ability to vary the level of Life Cover on the plan:

> *"For example, people might require more life cover when they are raising a family, however then wish to reduce this level of cover in later years when they have fewer commitments."*

The Provider submits that reviews are a feature of the Complainants' [redacted] Account, and that this is detailed in the policy's terms and conditions. The Provider states that the Complainants' [redacted] Account is subject to "*regular Plan Reviews….. when we check whether your regular payment is sufficient to maintain the cost of the life cover, until the next scheduled Plan Review date*".

The Provider submits the following explanation as to how the Complainants' policy operates:

> *"It is more beneficial for payments on an open-ended plan to be set for a certain period (i.e. ten or 20 years) and then to conduct a review on a regular basis to see whether the payments are still sufficient to cover the cost of the plan's Life Cover…… Open-ended plans, like your [redacted] Account, will be subject to reviews at regular intervals, but, as it is not a fixed-term plan, it can be continued indefinitely throughout your lifetime, irrespective of [the Life Assured's] age or state of health."*

The Provider states that the cost of Life Cover is linked to the mortality rate, which increases substantially at older ages. It further states that the cost of Life Cover reflects this, and so the level of payment increases required in respect of maintaining such cover *"can be extremely substantial"* into older age.

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The Provider notes that had the Life Assured died during the earlier years of the Complainants' [redacted] Account that the Provider would have been committed to paying a Life Cover claim.

The Complaint for Adjudication

The Complaint is that the Provider acted incorrectly and unreasonably in relation to the administration of the policy, in particular in relation to the policy reviews, and regarding the substantial increase of premiums.

The Complainants are unhappy that the policy premiums have increased with each policy review. The Complainants submit that they were *"not aware"* that their policy would be reviewed in later years and that their premiums would increase after each review. The issue for investigation and adjudication is the Provider's failure to correctly and reasonably administer the policy, in particular in regard to policy reviews, as well as its failure to communicate in a clear and transparent way with the Complainants regarding the cost of maintaining benefits, changes to their [redacted] Account and the policy fund value in the period from 2002 onwards.

Section 51 (5) of the ***Financial Services and Pensions Ombudsman Act 2017*** states that:

> *"(a) conduct that is of a continuing nature is taken to have occurred at the time when it stopped and conduct that consists of a series of acts or omissions is taken to have occurred when the last of those acts of omissions occurred, and*
>
> *(b) conduct that consists of a single act or omission is taken to have occurred on the date of that act or omission"*.

Consequently, the FSPO is satisfied that the conduct complained of, regarding ongoing policy reviews, falls within the jurisdiction of this Office.

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.

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

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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 5 April 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.

Evidence

[redacted] Policy Document

Paragraph 2 – DEFINITIONS

"(o) The 'Policy Review Date' means the tenth anniversary of the Date of Commencement of the Assurance and thereafter each fifth anniversary thereof provided that where the Life Assured or the older of the Lives Assured has attained age 70 and the Policy shall have been in force for not less than ten years the Policy Review Date shall mean each anniversary of the Date of Commencement of the Assurance".

Paragraph 20 – POLICY REVIEW

"At each Policy Review Date the Company's Actuary will:

(a) Determine the maximum Guaranteed Minimum Death Benefit and Ancillary Benefits the company is willing to allow under the Policy until the next following Policy Review Date and in determining the said maximum Guaranteed Minimum Death Benefit and Ancillary Benefits, the Company's Actuary will inter alia have regard to the Accumulated Fund on the Said Review Date future operations and Premiums under the Policy and then current mortality and morbidity rates. If on a Policy Review Date the Guaranteed Minimum Death Benefit or the Ancillary Benefits under the Policy exceed the permitted maximum as determined by the Company's Actuary then the Guaranteed Minimum Death Benefit or the Ancillary Benefits under the Policy exceed the permitted maximum as determined by the Company's Actuary then the Guaranteed Minimum

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Death Benefit or the Ancillary Benefits as appropriate will be reduced to the said maximum or at the option of the Proposer(s) the amount of Premium payable in the future will be increased to such amount as the Company's Actuary shall determine.

(b) Review the limits and charges specified in paragraphs 2, 3, 5, 16, 17, 19 and adjust any he deems necessary."

'You and Your [redacted]' Leaflet
(Issued to the Complainants 14 February 2002)

"The progress of your Account including your policy fee is reviewed initially after 10 years and subsequently every 5 years (yearly after age 70)……. The purpose of this review is to reassess in the light of conditions at the time the relationship between your chosen level of life assurance and your contribution….. As a result of this review you may need to either increase your contribution or reduce your life assurance to a more sustainable level".

"As you grow older the likelihood of suffering a serious illness or dying increases. Insurance premiums are calculated on the risk of an event happening and as a result, as you grow older, insurance costs increase significantly.
When the cost to maintain your life cover reaches a stage where it is greater than your regular payments, this difference is made up from your policy fund (policy savings).
If this policy fund runs out (as in stage 3 above), in order to keep your level of cover, you would need to increase your payments."

Correspondence from policy reviews

2002 Review
Letter from the Provider to the Complainants dated 14 February 2002

"We can advise you that at the moment your payments are enough to maintain your current level of life cover until your next review date, which is 1 January 2008".

The policy's nil value is not included in this policy review letter to the Complainants.

2007 Review
Letter from the Provider to the Complainants dated 30 November 2007

"As your current premium will be insufficient to maintain your current level of cover from 01/01/2008 to 01/01/2013 we would ask you to look carefully at the options available to you with effect from 01/01/2008. The options will require either an increase in your payments or a decrease in your level of benefits".

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The policy's nil value is not included in this policy review letter to the Complainants.

2012 Review

Letter from the Provider to the Complainants dated 1 December 2012

> *"From 1 January 2013, we anticipate that your payments will not be enough to maintain your benefits. We would ask you to look carefully at the options available to you to maintain your plan to 1 September 2014. The options will require either an increase in your payments or a decrease in your level of benefits".*

This review notes that the *"Current value"* is *"€0.00"*.

2015 Review

Letter from the Provider to the Complainants dated 2 July 2015

> *"We anticipate that your payments will not be enough to maintain your current level of benefits from 1 September 2015. It is therefore necessary to make some adjustments to your plan.*
>
> *a) You can increase your payments in order to maintain your current level of benefits*
> *b) You can reduce your level of benefits in line with the payment you are making*
> *c) You can reduce your level of benefits by a smaller amount for an increased payment"*

This review notes that the *"Current value"* is *"€0.00"*.

2016 Review

Letter from the Provider to the Complainants dated 4 July 2016

> *"We anticipate that your payments will not be enough to maintain your current level of benefits from 1 September 2016. It is therefore necessary to make some adjustments to your plan.*
>
> *a) You can increase your payments in order to maintain your current level of benefits*
> *b) You can reduce your level of benefits in line with the payment you are making*
> *c) You can reduce your level of benefits by a smaller amount for an increased payment"*

This review notes that the *"Current value"* is *"€0.00"*.

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2017 Review

Letter from the Provider to the Complainants dated 4 July 2017

> *"We've carried out your latest review and your current payments and any fund value you've built up are no longer enough to keep your current level of cover"*.

The Provider offers the Complainants two options:

> *"Continue with your existing* [redacted] *Account: This means you will have to change your payments or level of cover on your plan. Your plan will be reviewed again in 2018 and the cost of your cover may increase again.*
> *Change to a Guaranteed Whole of Life cover plan with no reviews: This means you can get up to €30,000 life cover (or your current life cover amount if it's less than €30,000) and your payment is guaranteed not to increase for the rest of your life"*.

This review notes that the *"Current Value at 4 July 2017"* is *"€0.00"*.

The Provider notified the Complainants on 26th July 2017 that their next review date would be 1 September 2018.

<u>Other Correspondence</u>

Complainants' submission of July 2018

> *"[Our* [redacted] *Account] was switched to term rates in 2002. Who authorised it… we did not know about it"*.

Provider's submission of August 2018

> *"It should also be pointed out that the Complainants made a number of withdrawals from their fund in the early years, which had a direct impact on the long term sustainability of their policy…. This meant that by 2002 as a result of the withdrawals and the increasing cost of cover, there was no cash value remaining nor was there any expectation that the policy would accumulate further cash surplus due to the increasing costs…. It was for this reason that the Provider took the decision to switch the policy…. to the cheaper Term Rates, which in the long run would be more advantageous to the Complainants."*
>
> *"The Complainants' independent brokers were aware of the lack of a Policy Value following two separate queries to the Provider's Customer Services in July 2005 and May 2006".*

Complainants' submission of August 2018

Regarding the abovementioned queries from the independent broker to the Provider's Customer Services in July 2005 and May 2006, the Complainants' state that the

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information relayed during the calls *"should have been sent to us, the life assured and the policy owner"*. The Complainants also state that the Provider *"broke the terms and conditions of this policy"*.

Provider's submission of September 2018

The Provider clarifies that it did not:

> *"alter the basic nature of the 'whole of life' aspect of [the] policy but rather applied cheaper life cover (Term) rates in order to make [the Complainants'] 'whole of life policy' more affordable in the long run. This was clearly to the Complainants' advantage but it also had the effect or removing any possibility of the policy accumulating a surplus value…… How the policy is administered in relation to this aspect is solely at the discretion of the Provider and there was no onus on it to inform the lives assured of this alteration"*.

Complainants' submission of September 2018

The Complainants reiterate that the information relayed to the independent broker in 2005 and 2006 should have been conveyed to them by the Provider. They also state *"we have paid into this policy over €50k for a sum assured of €37k"*.

2008 Statement issued to the Complainants in August 2008

> *"Current protection value of your fund at 5 August 2008: €0.00"*.

2009 Statement issued to the Complainants in August 2009

> *"Current protection value of your fund at 28th July 2009: €0.00".*

2010 Statement issued to the Complainants in July 2010

> *"Current value of your fund at 2 July 2010: €0.00".*

2011 Statement issued to the Complainants in July 2011

> *"Current value of your fund at 4 July 2011: €0.00".*

2013 Statement issued to the Complainants on 2 July 2013

> *"Total fund value at 2 July 2013: €0.00."*

2014 Statement issued to the Complainants in July 2014

> *"Plan Review: A review of your play payments and benefits confirms that your payments are sufficient to cover the cost of your benefits at this time….. We will continue to check your payments each year to ensure your payments are sufficient."*
>
> *"Total Value at 2 July 2014: €0.00."*

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2015 Statement issued to the Complainants in July 2015

"Total fund value at 2 July 2015: €0.00."

2016 Statement issued to the Complainants in July 2016

"Total fund value at 4 July 2016: €0.00."

2017 Statement issued to the Complainants in July 2017

"Total fund value at 4 July 2017: €0.00."

Analysis

The policy which is the subject of this complaint was incepted on **1st September 1990** and is a unit-linked, open-ended protection plan purchased by the Complainants through an independent intermediary. The Provider is not responsible for any alleged acts or omissions of the independent intermediary in relation to the sale of the policy in 1990. The policy has the benefit of being a 'whole of life' policy, as long as the premiums continue to be paid and the Complainants can support the cost of the policy benefits. The main benefit of a unit-linked protection contract is that it affords the policyholder the opportunity to pay a premium in the early years that more than covers the cost of the life cover benefit, with the balance of the premium remaining invested in the designated investment fund. This allows the policyholder to build up a fund that is accessible at all times, or can help to supplement the cost of the premium paid in future years, allowing the policy benefits to be maintained.

On this basis, the policy document provides for ongoing "reviews" in order to establish if the premium being paid is sufficient to maintain the policy benefits to the next scheduled review date.

I would note that even though a unit-linked whole of life policy allows the policyholder, in the early years, to build up a fund value over and above what is needed to pay for the life insurance, this is generally dependent on the performance of the fund. It can be the case that, after a number of years, the policy will have little or no cash value. Such policies are not intended to be savings plans. Where withdrawals are made from the fund by the Policyholder, this will have an impact on what fund value is available thereafter. I note the Provider's confirmation that two withdrawals were made by the Complainants in 1994 and 1996 and the Complainants' acknowledgement of this.

It is appropriate to point out that the cost of providing the policy benefits increases as the life assured gets older. Usually, the accumulated fund diminishes the impact of the increasing premium required at each review date. However, if the premium level and the fund value together cannot maintain the policy benefits until the next review date, some

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action needs to be taken (either the premiums are increased or the sum assured is reduced). If the fund value has been completely exhausted, the level of the premium increase required may be significant. It is for the Provider's actuaries to calculate in each such instance, the correct level of premium which must be paid to sustain the level of cover in place.

A policy review provides the Provider with an opportunity to realistically assess how the policyholder's needs are being met. Furthermore, a policy review should give the Provider the information to furnish the policyholder with an up to date picture of the level of cover chosen and provide an indication as to how long the premium and policy fund is likely to sustain that cover. Such reviews are important, as they allow the Provider to liaise with the policyholder with regard to what, if any, action needs to be taken. This is important for the policyholder.

In this case, in 2002 when the Complainants' policy fund had been exhausted, the Provider took the decision to switch the Complainants' [redacted] Account from 'Product Rates' to less expensive 'Term Rates' which are set for a specific term, usually over a five year period. This *"less expensive"* rate meant that no changes would be needed until *"the next scheduled review in 2008"*. The Complainants accepted the recommended premium increases in the years 2007, 2012, 2015 and 2016. At their policy review in 2017, the Provider offered them a *"New Policy Guaranteed Whole of Life Premium"* as one of the options available, which would have guaranteed them life cover of €30,000 for a monthly premium of €465 with the premium fixed for the duration of the Life Assured. The Complainants declined this offer and chose to maintain their policy benefit of €37,103 for a monthly premium of €297.62. They submit that they cannot afford to pay a higher premium and that they are in *"an awful position"*.

The [redacted] Policy Document clearly states that policy reviews apply from the tenth anniversary onwards. It also states that once the Life Assured turned 70 years of age, policy reviews would take place yearly, on the anniversary of the policy's inception. I note that the first review of the Complainants' policy took place in 2002, twelve years after the policy's inception and two years after the first review was due (due, it seems, to an administrative oversight on the part of the Provider).

The Provider acknowledges that the Life Assured turned 70 years of age in 2003, meaning that policy reviews should have taken place yearly from that point on (with the first yearly review due in September 2003). The Provider's decision to switch the Complainants' policy to *"the cheaper Term Rates"* in 2002 led to the next review date being set for 2008, instead of 2003. As a result, several annual reviews of the Complainants' policy were circumvented.

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I note that neither the Provider's decision to switch the Complainants' [redacted] Account to *"Term Rates"* in 2002, nor the circumvented policy reviews up to 2008, were communicated to the Complainants by the Provider. The Provider submitted the following regarding the switch to Term Rates:

> *"How the policy is administered in relation to this aspect is solely at the discretion of the Provider and there was no onus on it to inform the lives assured of this alteration"*.

I cannot agree that there was *"no onus"* on the Provider to inform the Complainants of this change. While I accept that a Provider does not have to notify a policyholder in advance of altering the annual charges made for mortality rates, I do consider it reasonable that a Provider would communicate at the earliest opportunity, be that at policy anniversary date or at review stage, that it has made a significant alteration to the policy by switching from 'Product Rates' to 'Term Rates' and of the effect of this alteration on the policy. Whilst this alteration occurred prior to the Central Bank of Ireland publishing its Consumer Protection Code in 2006, nevertheless I believe the Provider should have notified the policyholders of this important change, and explained to them why it was being implemented.

The Provider concedes that, following the 2008 policy review, the next scheduled review date was again set for a further five year period, rather than for one year, as per the policy terms and conditions. The Provider states that *"the reason for this oversight may have been due to the fact that the [redacted] Account had been switched to Term rates in 2002, which have an automatic 5 year term"*. This oversight was not corrected until 2013, when yearly policy reviews commenced – ten years after they had been due to begin. Whilst this may have been to the advantage of the Complainants in some respects, nevertheless it masked the manner in which the policy was designed to be administered.

The Complainants submit that they were not aware that the policy would be reviewed in later years and that the premiums could increase. I note however that this information was clearly stated in the Policy Document, and, as a copy of this document was submitted by the Complainants I am satisfied that they were on notice of the contents and they had the opportunity to review it.

I am not, however, satisfied with the Provider's adherence to the policy's terms and conditions relating to reviews, in particular the following:

- The first policy review, due in 2000, was missed due to an oversight, and was not carried out until 2002;
- The next policy review took place five years later, despite the Life Assured having turned 70 years in 2003 which, according to the policy terms and conditions, triggered yearly reviews thereafter;

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- Yearly policy reviews only began to take place in 2013, ten years later than would have been the case if the Provider had adhered to the policy terms and conditions. As a result, several policy reviews had been missed between 2003 and 2013.

I am not satisfied with the Provider's clarity and transparency of communication in respect of the policy as a whole:

- During the first policy review in 2002, the Provider elected to switch the Complainants' [redacted] Account to *"Term Rates"*. The Provider submits that this was *"in the long run….. more advantageous to the Complainants"*. While this may indeed have been the case, I believe that the Provider's decision not to communicate this information to the Complainants meant that they were denied an opportunity to query the reason(s) for the switch. Had they had this opportunity, they might have ascertained, at an earlier point in time, that their policy fund no longer had any value;
- The Provider states that the abovementioned switch was *"clearly to the Complainants' advantage but it also had the effect of removing any possibility of the policy accumulating a surplus value"*. This is important information that the Complainants should have been privy to at the time the change was effected;
- The fact that several policy reviews were not carried out as originally anticipated by the policy terms and conditions was not communicated to the Complainants by the Provider at any time during the thirteen years when annual reviews were due to take place. The Provider has submitted that it *"did not deem it necessary to formally highlight this oversight"*.

When policyholders do not have their plan reviewed when it should be reviewed, this results in the loss to such policyholders of an early insight into the operation and effect of such reviews on their policy. I note the Provider's statement that *"had the review period being (sic) set at one year intervals from 2008 on, the Complainants would have experienced more regular increases each year rather than just the one single increase between 2008 and 2013"*. Whilst this may be accurate, I would posit that had the Complainants experienced more frequent increases they might have also questioned the policy's suitability for their needs at a much earlier stage.

With regard to the provision of information to a consumer, the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear, accurate and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information. Furthermore, a regulated entity must supply information to a consumer on a timely basis.

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The Provider issued annual statements to the Complainants from 2008 onwards. In 2008 and 2009, the statements noted that the "*Current protection value"* of the fund was 0.00 In 2010, 2011 and 2014 the statements noted that the "*Current value"* of the fund was 0.00.

From 2015 onwards, the statements noted that the *"Total fund value"* was 0.00. Having reviewed the statements submitted, I note that the fund value shown on the final page of each statement was not highlighted in any way that would have made it conspicuous to the Complainants, and was described differently on a number of occasions. The Complainants' submission in July 2018 indicated that they were not aware until they received the Provider's formal response from this Office that their policy fund had *"no value"*. I would note that the Provider has submitted that the value of the Complainants' policy fund (i.e. 0.00) was communicated to the Complainants' independent intermediary during telephone calls that took place in July 2005 and May 2006. It would appear that this information may not have been passed on to the Complainants by the independent intermediary, but any such failure is not a matter for the respondent provider.

I consider that the need for the fullest disclosure of information on a policy is particularly required where the cover being provided is life assurance cover. The importance to the Complainants of fully appreciating – at the earliest opportunity – that their policy fund value was nil, was that they would have had the choice at an earlier date, as to whether to continue with the policy or to withdraw from it, and perhaps make alternative arrangements.

Having examined the matter, I believe that there was a continuing failure by the Provider to inform the Complainants clearly and transparently, at the opportune times, as to how their policy was being administered.

While I accept that there was a lapse by the Provider in regard to the administration of the policy reviews and communications with the Complainants, I do not accept that these lapses are sufficient to warrant a direction for the Provider to maintain the benefits as they were and at the current cost, and I acknowledge that the Complainants have had the protection of the policy for many years. I accept that the issue here is one of a requirement for greater and better communication from the Provider regarding the policy administration. For the identified lapses in that regard, I consider that a compensatory payment to the Complainants is merited in this instance.

Having regard to the particular circumstances of this complaint, in particular the failings that have been noted above, it is my Decision that the complaint is partially upheld and I direct the Provider to make a compensatory payment of €15,000 (fifteen thousand euro)

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to the Complainants. The Provider has submitted that the Complainants' policy is currently *"'In Force' and paid to 1 April 2019"*, with life cover of €37,103 on the life of the First Complainant for a monthly premium of €321.75. The Complainants must decide what they wish to do in relation to the cover and premium options that will be offered by the Provider at the next scheduled policy review in September 2019. In considering the options, it would be prudent for the Complainants to seek independent financial advice.

Conclusion

- My Decision is that this complaint is partially upheld, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, 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 make a compensatory payment to the Complainants in the sum of €15,000.00 to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants 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.***

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

2 May 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.**