An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0143
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a subsidence damage claim made by the Complainants on a home insurance policy, which the Provider has declined to admit for payment. The Provider subsequently voided the policy for non-disclosure of previous cracking issues with the property.

The Complainants' Case

The Complainants' home insurance policy was incepted with the Provider on **1 October 2015**. The Complainants' property had previously been insured with a third party provider (the "previous provider") from **1994**, up to the date of inception of the policy with the Provider in October 2015. The Complainants state that they first noticed cracks in one of the rooms in the property during redecoration in **2009** and they state that same were filled. Again, in **2012**, a room in the property was painted and the Complainants state that there was a slight plaster crack at this time, which was filled. The Complainants state that they made no claims in relation to these cracks or in relation to any other incidents under their home insurance policy with the previous provider.

In **2016**, the Complainants state that they asked a builder to attend at the property as a crack had appeared between the window and the floor in the lounge and they asked the builder to fix and repair this crack. Pursuant to the advice of this builder, the Complainants

consulted an engineer to attend and inspect the property in or about **early July 2016**. This engineer advised the Complainants that there may be possible subsidence on the property and that they should report the claim to the Provider, which they did on **25 July 2016**.
The Complainants state that, despite the cracks, they were not (and could not have been) aware of the subsidence issues in relation to the property until in or about **July 2016** when these were identified by their consulting engineer. The Complainants state that they are not professional engineers and could not be assumed to have any particular knowledge of the structural integrity of the property or of the building trade. The Complainants therefore say that these subsidence issues came to light during the currency of the Provider's insurance policy and therefore that they acted properly and correctly in notifying the Provider of these issues on **25 July 2016**.

A loss assessor was appointed on behalf of the Provider and a representative of the loss assessor attended the property on **10 August 2016** with the Complainants' engineer present. The Complainant's state that, in light of the fact that the Provider's policy was incepted on **1 October 2015**, less than 10 months prior to the reporting of the incident, the loss assessor for the Provider advised the Complainants that they should notify the previous provider of the situation at the property.

The loss assessor for the previous provider appointed a consultant engineer who attended the property and carried out his own inspection on **7 December 2016**. This engineer stated that he was satisfied that a subsidence event had occurred and agreed a scope of repairs with the Complainants' engineer.

The loss assessor for the Provider reverted to the Complainants on **14 October 2016** stating that the Complainants' claim was declined because the *"loss pre-dates your current insurance policy held with the Provider which was incepted in October 2015"*. The loss assessor for the Provider instructed the Complainants to refer the claim to their previous provider.

The Complainants submit that the Provider was incorrect, based upon the evidence before it, to fix the Complainants with specialist knowledge that the Complainants could not reasonably be expected to have held, regarding the damage to property, as well as to conclude that the damage to the property pre-dated the inception of the Provider's policy.

The Complainants state that they received a declinature letter for the claim from the representative of the loss assessor on **14 October 2016**. However, the loss assessor for the Provider subsequently contacted the Provider on **6 April 2017** requesting that the file relating to the Complainants claim be re-opened as the previous provider was dealing with the Complainants' claim but was seeking a contribution of costs from the Provider under the Insurance Federation of Ireland Subsidence/Heave/Landslip "Change of Insurer" Claims Agreement ("the subsidence agreement"). On **7 April 2017**, the Provider re-opened the Complainants' claim.

As a result of their claim being declined by the Provider, the Complainants state that they engaged the services of a loss assessor to look into the matter on their behalves. The Complainants' loss assessor sent an email to the Provider on **19 April 2017** referencing the

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subsidence agreement, of which the Provider is a signatory. This subsidence agreement contemplates situations whereby, given the nature of the damage in question i.e. subsidence, it would often not be possible for an insured, or a provider, to say with any real certainty the date at which loss to the insured's property occurred. This subsidence agreement therefore provides for the sharing of losses between providers depending upon which scenario best fits the circumstances of the loss. The Complainants submit that "Option 3" of the subsidence agreement should apply to the Complainants' claim:

> *"…Every Insurer subscribing to this Agreement undertakes to deal with such claims in the following manner:*
>
> *Option 3: Where the Date of Notification is more than eight weeks but less than one year from the date of inception of the current Insurer's policy, any claim shall be accepted and dealt with by the Insurer to whom notification is given and the Cost of Settlement shared equally between the two Insurers. The handling Insurer shall keep the other Insurer advised of material developments, including the original reserve and any revision. Contributions shall be paid within 21 days of settlement subject to full details being supplied with supporting documentation (to include apportioned VAT invoices in respect of fees incurred on behalf of both Insurers). Interim contributions will not be collected for sums less than £5000"*

The Complainants point towards the fact that the previous provider was happy to proceed with the claim based on "Option 3" of the subsidence agreement and that this would result in the costs of the remedial works to the property being borne on a 50/50 basis by the previous provider and the Provider, against which this complaint is made. The Complainants estimate that the total cost of these repairs is €12,023.60 based on a quotation from their consultant engineer, therefore amounting to a liability of €6,011.80 falling to the Provider. The Complainants, in further submissions to this Office place emphasis on the fact that "Option 3" of the subsidence agreement states that it is the "date of notification" and not the date of loss that triggers the operation of the subsidence agreement.

On **25 April 2017** the Complainants' loss assessor submitted two documents to the Provider's loss assessor. The first document was a letter from the Complainants' original engineer and the second was a report by the engineer engaged by the previous provider compiled on **7 December 2016**. The loss assessor sent these documents to the Provider for review on **8 May 2017**.

The Provider subsequently wrote to the Complainants on **3 July 2017** stating that it was cancelling the Complainants' policy back to the inception date of **1 October 2015** and referred the Complainants' back to their previous provider in relation to the damage on the property.

On **14 July 2017**, the loss assessor for the Complainants emailed the Provider, attaching a letter dated **13 July 2017** which requested that the Provider review the Complainants' claim and while this review was occurring it requested that the Complainants' insurance policy with the Provider be reinstated. On **17 July 2017**, the Provider confirmed to the loss assessor

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for the Complainants that the Complainants' claim would be reviewed and pending the outcome of the review, the Complainants' insurance would remain in force.

However, on **1 August 2017**, the Provider wrote to the loss assessor for the Complainants advising that the decision to cancel the Complainants' insurance policy remained and the policy was cancelled by the Provider on **14 August 2017**. On **17 August 2017**, a letter confirming the cancellation together with a cheque for the full refund of the premium, was issued to the Complainants by the Provider.

The Complainants submit several points in respect of the cancellation of the policy.

Firstly, the Complainants submit that the formal refusal of their claim on **14 October 2016** by the Provider amounts to an affirmation of the Complainants' policy of insurance and that, by affirming the policy, the Provider has waived any rights it may have had to void the policy for non-disclosure or misrepresentation. The Complainants state that the Provider is therefore estopped from cancelling the policy.

Secondly, the Complainants submit that the Provider ignored provisions of the Insurance Federation of Ireland's Code of Practice on Non-Life Insurance ("IFF code of practice"), particularly Clause 3 therein which states:

> *"3. CLAIMS*
> *(a) An insurer will not repudiate liability to indemnify a policyholder:*
>
> *…*
> *(i) on grounds of non-disclosure of a material fact which a policyholder could not reasonably be expected to have disclosed;"*

Thirdly, the Complainants submit that there is no evidence to confirm that the Provider adhered to its own policy wording in giving the Complainants 14 days' notice that the Provider was cancelling the policy. The Complainants submit that this has exposed the Complainants to significant hardship and anxiety.

Fourthly, the Complainants state that the Provider has cancelled its policy on the basis that the property was not in a good state of repair. In respect of that point, the Complainants state that the policy does not contain a general condition that the property must be in a good state of repair and furthermore, even if such a condition did exist in the policy, the property was exceptionally well maintained. The Complainants, in a further submission to this Office received on **16 August 2018**, stress that the engineer for the previous insurer stated that in his expert opinion, the property was in *"good repair"* and *"well kept"* at the time of his inspection.

The Complainants also submit that the Provider has flouted the Central Bank's Consumer Protection Code 2012, in particular sections **2.1, 2.2, 2.8, 2.10, 2.12** and **7.15**, which state:

> *"A regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it:*

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2.1 acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;
2.2 acts with due skill, care and diligence in the best interests of its customers;
…
2.8 corrects errors and handles complaints speedily, efficiently and fairly;
…
2.10 ensures that any outsourced activity complies with the requirements of this Code;
…
2.12 complies with the letter and spirit of this Code.
…

7.15 A regulated entity must ensure that any claim settlement offer made to a claimant is fair, taking into account all relevant factors."

The Complainants state that it is not plausible for the Provider to contend that, in the context of the manner in which it handled the Complainants' claim and the subsequent cancellation of the policy, it has fulfilled the requirements contained within the referenced provisions.

The Complainants say that the Provider should be held to account in respect of the consequences of its policy cancellation and that this Office should correct the wrongful repudiation of the Complainants' claim and the wrongful cancellation of the Complainants' policy.

The Provider's Case

The Provider states that when the Complainants notified it of their claim on **25 July 2016**, it appointed a loss assessor and this loss assessor carried out an inspection of the property **on 10 August 2016.** Given that the Complainants' policy was only in force for less than 10 months, the Provider states that the loss assessor requested a timeline of events from the Complainants' engineer in relation to the cracking that had previously occurred.

The Provider states that an email sent by the Complainants' engineer on **11 October 2016** stated:

"In 2003 the Complainants redecorated the room by professional painter that is the room where the major crack in the ceiling and gable wall exist. They have no recollection of any cracking having to be filled in the wall or the ceiling at that stage.

They first noted ceiling cracks in the summer of 2009. At that stage they were filled in before decorating. There was no evidence of a crack between the ceiling and the wall or at the window.

In 2012 the room was painted; the ceiling crack was filled in and a crack was developing between the ceiling and the gable wall.

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The crack from the window in this room to ground level only appeared in the last 12 to 24 months."

Based on the above information, the Provider states that the claim was declined by its loss assessor on **14 October 2016** because the loss pre-dated the current insurance policy held with the Provider, which was incepted in **October 2015**. The Provider states that the damage would not have been covered as it occurred prior to inception.

The Provider submits that it was not until it agreed to the request to reopen the Complainants' claim in **April 2017** that the full extent of the actual damage to the property became known to it. As a result of the re-opening of this claim, the Provider states that its loss assessor sought a copy of the engineer's report that had been prepared for the previous provider dated **7 December 2016**. The Provider submits that said engineer's report states:

"In 2012, new cracks developed and the extent of the cracking was significantly greater. They [in reference to the Complainants] *also noted a significant crack over the window on the southern gable which had never been there previously."*
…
In summary, as a result of a leak on the external drains in the front southern corner this has caused rotational and differential movement on the building which would appear to be ongoing for the last 5 years and has been getting progressively worse more recently."

The Provider states that based on the above and given that the cracking occurred on two separate occasions prior to inception of its policy, it simply cannot accept that substantial cracks of the nature outlined in the engineer reports would be considered as part of regular wear and tear to the property or that the date of loss occurred post-inception of the policy of insurance. The Provider states that the proposal form signed by the Complainants as part of their policy of insurance stated that:

"If you are in any doubt as to whether or not certain information is material then it should be disclosed."

The Provider submits that information about these cracks, in particular, the *"significant crack"* mentioned in the engineer's report of **7 December 2016** is something that the Complainants should have disclosed to the Provider prior to inception of the policy as it is something which the Provider would consider to be a material fact. Furthermore, the Provider states that the Complainants signed a home proposal form when they entered into their policy of insurance with the Provider and this form contained a declaration of truth which reads:

"I/We declare that:
(a) The property is in a good state of repair and it will be so maintained at all times"

The Provider states that given the cracks to the property it viewed the property as not being *"in a good state of repair"* as had been declared in the home proposal form.

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The Provider further states that had it been aware that the property suffered damage of this nature prior to inception of the insurance policy, it would never have entered into a contract of insurance with the Complainants for this risk address. For all of the above reasons, the Provider states that it proceeded to void the Complainants' policy from its inception date on **1 October 2015** and as a result of this, it argues that no valid policy of insurance ever existed.

In relation to the notice period required to be given by the Provider to cancel the policy, the Provider states that a Notice of Cancellation letter was issued to the Complainants on **3 July 2017** in line with the following terms and conditions of the policy:

> *"6. You may cancel the policy at any time by giving us written notice. We may cancel the policy (or any section) by giving you 14 days' notice by registered post to your last known address."*

The Provider states that the Complainants' policy was set to cancel after 14 days which was the **17 July 2017**. However, the Provider states that following the request from the Complainants' loss assessor to review the claim, the Provider made the decision to reconsider the pending cancellation and the policy was not cancelled on **17 July 2017**. The Provider states that the claim was then reviewed again on **1 August 2017** and the decision to cancel remained. The Provider states that it then issued a fresh notice of cancellation letter to the Complainants on **1 August 2017** and the Complainants' policy was subsequently cancelled on **14 August 2017** with a full refund of premiums paid being sent to the Complainants.

Furthermore, the Provider acknowledges that it is a subscriber to the subsidence agreement but disagrees with the Complainants' contention that it did not abide by the subsidence agreement's terms. The Provider notes that the subsidence agreement contains a section which states:

> *"ii. Nothing in this Agreement shall prevent any Insurer from voiding a policy for fraud, non-disclosure or misrepresentation, or from relying otherwise on any policy term or condition except that late notice alone shall not prevent the operation of this Agreement. When one Insurer specifically excludes all or part of the damage, this Agreement will apply only to that part of the damage covered by both policies."*

The Provider states that as the policy was deemed null and void there was therefore no policy in force to cover this claim, and the Provider was not obliged to contribute to this loss.

In respect of the issues raised by the Complainants in respect of the IIF code of practice, the Provider states this section of the code is only relevant to the handling of claims and that the Complainants' claim could not be dealt with as there was no valid policy of insurance in force to cover the loss. It places emphasis on the fact the Complainants' policy was cancelled due to a breach of policy terms and conditions and in that way, no valid policy of insurance ever existed.

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The Provider further submits that it is satisfied that it complied with the general principles of the Consumer Protection Code.

In relation to section 2.1 of the Consumer Protection Code 2012, the Provider states that it has acted honestly, fairly and professionally in the best interests of the Complainants. It points to the fact that even though the Complainants' policy was only in force for just under 10 months, it registered the claim and appointed a loss adjuster to ensure that the matter was investigated. The Provider further points to the fact that when the initial decision to cancel the Complainants' policy was made, it accepted a request from the loss assessor for the Complainants to review the matter further and agreed to leave the Complainants' insurance cover in place while the review was being carried out.

In relation to section 2.2 of the Consumer Protection Code 2012, the Provider states that it has acted with due skill, care and diligence in the best interests of the Complainants. It asserts that it exercised this skill, care and diligence by ensuring that it had as much information as possible to hand before making the ultimate decision on the policy cancellation.

In relation to section 2.7 of the Consumer Protection Code 2012, the Provider states that as the policy was sold through a broker it cannot comment on the sale of the insurance product, however it is fully satisfied that the documents it supplied to the Complainants at the time the insurance policy was entered into, alerted the Complainants to their duty to disclose all material information and the consequences of failing to do so.

In relation to section 2.8 of the Consumer Protection Code 2012, the Provider submits that the complaint in relation to this matter was handled speedily, efficiently and fairly in line with this provision.

In relation to section 2.10 of the Consumer Protection Code 2012, the Provider submits that this provision is not applicable to this dispute.

In relation to section 2.12 of the Consumer Protection Code 2012, the Provider states that it treats the cancellation of any insurance policy very seriously and this is not something that it does lightly. The Provider notes that it did review the claim at the Complainants' request in order to be fair and reasonable and states that although the overall outcome was not the resolution the Complainants were seeking, it is satisfied that it acted within the letter and spirit of the Code throughout.

In relation to section 7.15 of the Consumer Protection Code 2012, the Provider submits that settlement proposals were not considered in this case, as the policy was deemed null and void from inception. Therefore, it submits, no claims payment could be made.

The Provider accepts that a subsidence event occurred on the property due to an escape of water and it asserts that this damage to the property clearly started before the date of inception of the Complainants' policy on **01 October 2015**. The Provider states that the previous provider is the appropriate policy provider to cover this loss in full.

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The Complaints for Adjudication

The complaints for adjudication in this matter are firstly, that the Provider wrongfully declined the Complainants' claim for subsidence damage to the Property and secondly, that the Provider subsequently wrongfully cancelled the Complainants' home insurance policy. The Complainants say in that context that the Provider failed to adhere to the IFF code of practice and the Consumer Protection Code 2012.

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 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 **25 March 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below. Both parties continue to be considerably at odds, not only in relation to the merits of this complaint, but also as to the manner in which certain judgments of the court should be interpreted.

The documentary and audio evidence submitted to this Office has been examined and, in my opinion, this evidence clearly establishes that, on the first occasion when the Provider declined the Complainants' claim, it did so based on the Complainants' engineer's email of October 2016 which disclosed two instances of cracking to the property which had occurred in **2009** and **2012** respectively. As these instances of cracking to the property pre-dated the inception of the Complainants' insurance policy held with the Provider, which was incepted

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in **October 2015**, I take the view that it was appropriate for the Provider to decline the claim at that time.

Subsequently, upon review of the claim, a copy of the engineer's report that had been prepared for the previous provider, dated **7 December 2016**, was at that stage, made available to the Provider and crucially, this report established that the crack in **2012** was *"significant"*. I note in that respect that the report in question included the following:

> *"In 2012, new cracks developed and the extent of the cracking was significantly greater. They* [in reference to the Complainants] *also noted a significant crack over the window on the southern gable which had never been there previously."*

I accept that even allowing for the Complainants' lack of engineering/building knowledge, they were, or certainly should have been, aware that such cracks were material facts for the purpose of their insurance policy proposal to the Provider; consequently whilst the Complainants may well not have formed any understanding as to the cause of the cracks, nevertheless the occurrence of those cracks should have been disclosed at the time when they were proposing to the Provider for insurance cover. In this regard, I note that the Complainants accept in their complaint that they noticed cracks in both 2009 and 2012.

I further note that the proposal form signed by the Complainants as part of their policy of insurance, set out the following:-

> *"**Declaration of Truth***
>
> *If any of the information shown on this Proposal Form requires clarification or is incorrect, please provide full details using an additional sheet. Unless otherwise disclosed, I/we declare that:*
>
> *(a) the property is in a good state of repair and it will be so maintained at all times …*
>
> ***The details on this proposal form are based on the information supplied to us. All relevant information likely to influence the acceptance or assessment of this quote must be disclosed by you to us. Relevant information includes, for example, your previous claims history. If you are in any doubt as to whether or not certain information is material, then it should be disclosed. If you do not do so, your insurance cover may not protect you in the event of a claim, the policy may be cancelled and you may encounter difficulty purchasing insurance elsewhere. You should also be aware that failure to have property insurance in place could lead to a breach of the terms and conditions attaching to any loan secured on that property.***
>
> ***Your quotation may be revised if the information on this Proposal Form differs from that originally supplied.***

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> ***Declaration*** *– I/We declare that the statements and particulars given in this proposal are, to the best of my/our knowledge and belief true and complete and that this proposal will form the basis of my/our contract with [Provider]. I/We agree to the terms as per the Terms of Business of [Intermediary]. I/we confirm that I/We am/are giving my/our permission for the information provided in this form to be used for the purposes set out in the Data Protection Section above."*

In my opinion, these details on the proposal form clearly emphasised the importance of disclosing, at the time of entering into the insurance policy, any information material to the risk to be covered.

In the context of the occurrence of these cracks, and in particular the "significant" crack in 2012, it is unclear whether the property could correctly have been described as being in a *"good state of repair"* at the time the insurance policy was entered into. Whatever one's view as to whether or not the property was in a "*good*" state of repair (and I take the view that such terminology creates considerable difficulty with achieving certainty of opinion) I am satisfied that the issues with the cracks in question should have been disclosed to the Provider, as material to the Policy risk.

The Provider voided the policy back to the point of inception, i.e. to 1 October 2015, on the basis that the Complainants had failed to disclose a material fact (and also that the property was not in a state of *"good repair"* when the policy with the Provider was entered into).

I accept that the notices of cancellation of the Complainants' policy issued to the Complainants on **3 July 2017** and **1 August 2017** were both issued correctly and properly and that the Complainants received the necessary 14 days' notice prior to the ultimate cancellation of their policy on **14 August 2017**. I therefore find that the Provider did not act wrongfully in declining the claim and subsequently voiding the policy of insurance on the basis of non-disclosure of material facts, in relation to these cracks having appeared in 2009 and 2012.

The Complainants argue that the Provider was estopped from cancelling the policy due to the fact that it had admitted the claim under the policy and declined it on **14 October 2016**. I do not accept this argument. The evidence supplied to this Office clearly establishes that it was only at the point where the claim was reviewed, subsequent to the initial decision to decline the claim, that the Provider received the full information in relation to the nature and timescale of the damage to the property and it was on the basis of this 'new' information that the Provider then made the decision to cancel the policy.

The Complainants also maintain that the Provider breached the subsidence agreement and that "Option 3" referred to above, should apply to the circumstances outlined. In my opinion however, the Provider was not bound by the subsidence agreement due to the fact that the policy entered into with Complainants was void from the date of inception due to the material non-disclosure by the Complainants, as set out above.

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Indeed, it is noted that under Section 3 "Claims" of the IFF Code of Practice which the Complainants suggests has been breached by the Provider, it is clear that an insurer shall not repudiate liability to indemnify a policyholder "*on grounds of non-disclosure of a material fact which a policyholder could not reasonably be expected to have disclosed*". In this instance however, I am satisfied that the Complainants ought reasonably to have disclosed the existence of the cracks which appeared in the fabric of the building in 2009 and more significantly in 2012, at the time when they proposed for cover with the Provider in October 2015.

Furthermore, I note that the subsidence agreement, of which the Provider is a signatory, contemplates situations whereby, given the nature of the subsidence that has occurred, it would often not be possible for an insured, or a provider, to say with any real certainty the date at which subsidence damage to the insured's property occurred. In the Complainants' case, while the exact date the subsidence occurred may not be known with certainty, it clearly occurred prior to the inception date of the Complainants' policy with the Provider, possibly in **2009** with the emergence of a crack in the property but certainly by **2012** with the presence of the significant cracking to the walls of the property.

In my opinion, the Complainants' argument that it is the date of notification, as opposed to the date of loss, which is important, is misplaced, as the rationale underlying the subsidence agreement is that an insured must notify its provider of damage when it becomes aware that the damage exists. Therefore, an insured cannot simply ignore damage to a property which he or she is aware of, or ought to be aware of, and then make a notification to a subsequent provider, at a later date.

The Complainants also maintain that the Provider has flouted numerous sections of the Central Bank of Ireland's Consumer Protection Code 2012. However, noting the reasons outlined by the Provider and listed above, in my opinion, the Provider was not in breach of the CPC 2012.

In relation to section 2.1 of the CPC 2012, I find that the Provider acted honestly, fairly and professionally in the best interests of the Complainants in this matter. The Provider registered the Complainants' claim and appointed a loss adjuster to ensure that the matter was investigated. When the initial decision to cancel the Complainants' policy was made, the Provider accepted a request from the loss assessor for the Complainants, to review the matter further and agreed to leave the Complainants' insurance cover in place while the review was being carried out. In relation to section 2.2 of the CPC 2012, I find that the Provider acted with due skill, care and diligence in the best interests of the Complainants. The Provider exercised this skill, care and diligence by ensuring that it had as much information as possible to hand before making the ultimate decision on the policy cancellation. In relation to section 2.7 of the CPC 2012, I take the view that the documents the Provider supplied to the Complainants at the time the insurance policy was entered into, alerted the Complainants to their duty to disclose all material information relating to the property and the consequences of failing to do so.

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In relation to section 2.8 of the CPC 2012, I am of the opinion that the complaint in relation to this matter was handled speedily, efficiently and fairly by the Provider. I also take the view that there is no evidence available that the Provider breached Section 2.10 of the CPC 2012. In relation to section 2.12 of the CPC 2012, I note that the Provider did review the claim at the Complainants' request in order to be fair and reasonable and that it acted within the letter and spirit of the Code and, in addition, given the manner in which the claim was dealt with, section 7.15 of the CPC 2012 did not arise.

Finally, whilst the Complainants contend that the Provider breached Clause 3 of the IFF's code of practice, given this Office's acceptance that the Complainants failed to disclose a material fact which they would reasonably have been expected to have disclosed, when incepting the policy of house insurance, namely the cracking which had previously occurred to the property, for the reasons outlined above, I do not find that the Provider has breached Clause 3 of the IFF code of practice.

In coming to this conclusion, I am mindful of the decision in *Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199.* The Supreme Court stated that the test for materiality is:

> *"...a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and if so, in determining the premium which he would demand. The standard by which materiality is to be determined is objective and not subjective."*[1]

I have also had regard to the High Court decision of *Earls -v- The Financial Services Ombudsman & Anor [2015] IEHC 536*, where the court carried out a detailed analysis of previous case law on non-disclosure and the principles to be applied. From this decision it is clear that this Office should not proceed on the basis that if a material fact was not disclosed then, *ipso facto*, there has been a breach of the duty of disclosure. Rather, in the Court's opinion, this may not always be the case, as the duty arising for an insured in this regard, is to exercise a genuine effort to achieve accuracy using all reasonably available sources, so that, eg. if the form of questions asked in a proposal form might limit the duty of disclosure arising, such an issue would require consideration.

Furthermore, this High Court decision pointed to the fact that materiality falls to be gauged by reference to the hypothetical prudent proposer for insurance. The Court held that the arbiter must also give consideration to what a reasonable insured would think relevant and relevance in this particular context is not determined by reference to an insurer alone.

In this instance, I am satisfied that whatever argument might be raised as to whether the cracks which appeared in 2009 would have been considered material be a hypothetical prudent proposer for insurance, I am in no doubt that the significant crack in 2012, would have been considered material by such a hypothetical prudent proposer for insurance, and consequently should have been disclosed to the Provider by the Complainants, at the time of the policy inception.

[1] Kenny J, Chariot Inns Ltd v Assicurazioni Generali spa [1981] IR 199

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In light of the entirety of the foregoing, and in the absence of evidence of wrongdoing by the Provider or conduct within the terms of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** that could ground a finding in favour of the Complainants, I do not consider it reasonable to 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

14 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.