An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0166
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Premium rate increases Complaint handling (Consumer Protection Code) Failure to provide no claims bonus/ inaccurate no claims bonus Maladministration Payment of 3rd party claim Documents mislaid – renewal of policy
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint relates to a motor insurance policy held with the Provider and the Complainant is dissatisfied with the investigation into a road traffic accident by the Provider and the manner in which the claim from a third party against the Complainant arising from this road traffic accident was settled by the Provider.

The Complainant's Case

The Complainant, in both his Complaint Form and subsequent correspondence with this Office, states that he was driving his taxi at approximately 01.15am on **23 March 2014** on a main road approaching a junction. The Complainant asserts that he was in the process of turning right at the junction when another taxi ignored a stop sign, sped through the junction and stopped suddenly. The Complainant states that this resulted in a slight side-by-side impact between the two vehicles.

The Complainant states that he was interviewed by two members of An Garda Síochána at the time of the incident in question and provided a further statement to an investigator for the Provider on **28 March 2014** at the location of the incident in question.

On **7 April 2014**, the Complainant states that he received a letter from the Provider stating that it had completed its investigation and it was satisfied that the Complainant was not liable for the incident. The Complainant further states that the Provider stated at this time that it would fully defend the third party's claim against the Complainant.

The Complainant states that sometime later in **mid-2015** he received a letter from the Provider stating that it had settled the case against him and had paid out €20,324.26 to the third party. The Complainant asserts that when he contacted the Provider, it would not provide him with a breakdown of this pay-out to the third party for data protection reasons.

The Complainant's solicitor received a letter from the Provider in relation to the matter on **8 September 2015.** The Complainant states that the Provider questioned his credibility in this letter and referred to the content of the letter which stated that evidence proved that the Complainant had hit the third party's vehicle from the rear and further stated that he admitted to the investigator for the Provider that he had a blind spot at the time of the incident in question. The Complainant contacted the Provider to query the veracity and validity of the contents of this letter and states that he received a subsequent letter on **4 February 2016** from the Provider. This letter of **4 February 2016** stated that the letter of **8 September 2015**, which the Complainant said brought into question the Complainant's credibility and stated that he admitted to having a blind spot, was incorrect and an error on the part of the Provider. The Complainant states that the letter of **4 February 2016** also addresses the issue of damage being done to the rear of the third party's vehicle stating that the term damage was used *"in a very vague sense"* given that an engineer's report stated that damage was done to the rear passenger wheel arch and that it was never the intention of the Provider to imply that this was a front to rear collision. The Complainant asserts that the Provider apologised for all three errors he says it made in the letter of **8 September 2015,** in its letter of **4 February 2016**.

As a result of this letter of **4 February 2016**, the Complainant enquired with the Provider as to its rationale for justifying the settlement made to the third party in the claim against the Complainant given the aforementioned errors. In response to this, the Complainant states that the Provider sent him a letter dated **7 February 2017** which contained extracts from the statement the Complainant made to the investigator for the Provider on **28 March 2014**. The Complainant asserts that there were sentences included in that statement that he had never said and he requested a copy of his full statement. The Complainant states that on **13 February 2017** he received from the Provider a typed copy of his statement. The Complainant states that this typed copy of his statement is incorrect in a number of material respects. On **15 February 2017**, the Complainant requested a copy of the original statement which he had signed on **28 March 2014** and was told by the Provider that this had been destroyed for data protection reasons.

The Complainant claims that his annual insurance premium with the Provider has increased in each of the three years subsequent to the incident in question (**2015-2017**), amounting

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to a total extra charge on his premium of €8,882. The Complainant states that this increase is due to the claim against him by the third party and, in particular, the deficiencies in the investigation and settling of this claim by the Provider.

The Complainant seeks compensation in relation to the increases to his annual premia, in addition to compensation for his treatment by the Provider since the incident in question occurred.

The Complainant, in correspondence with this Office, has also stated that the mishandling of the third party's claim against him by the Provider has exacted a significant emotional as well as a financial toll on him, effecting both his physical and mental health and causing difficulties in his marital relationship.

The Provider's Case

The Provider accepts that the Complainant was involved in an incident with another motor vehicle on **23 March 2014**. The Provider states that an investigator for the Provider met with the Complainant at the location of the incident on **28 March 2014** and took a statement from the Complainant in relation to the incident. The Provider also produced evidence in respect of enquiries that it states were made to the members of An Garda Síochána on duty at the time of the incident which revealed that no statement from them in relation to the incident was forthcoming.

The Provider states that at that point in time, further to a review of the available evidence by a claims handler for the Provider, the Provider believed that the third party was the sole cause of the road traffic accident and that the third party's claim against the Complainant would be fully defended. On **7 April 2014** this viewpoint was communicated to the Complainant over the telephone and the Provider followed up that communication with written correspondence to the Complainant confirming this.

Subsequent to this correspondence with the Complainant, the Provider states that it received correspondence from the third party's insurance company which contained the third party's account of events and images of both of the vehicles involved in the road traffic accident taken almost immediately post-accident. On the basis of this correspondence, the Provider states that it reviewed its decision concerning liability of the incident. The Provider states that on **14 April 2014**, the Provider discussed the updated position with the Complainant over a number of phone calls and emailed the post-accident images to him asking that he review them and respond to the third party's claim that he was liable. The Provider claims that this email states that the post-accident images furnished by the third party's insurance company left the Provider with a difficulty defending the claim on behalf of the Complainant. The Provider also states that during the phone calls on **14 April 2014**, the Complainant was informed that the best outcome that can be hoped for, given the lack of independent witnesses and/or lack of CCTV footage of the incident in relation to the incident, was a 50/50 split in liability between the third party and the Complainant.

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The Provider states that on **15 June 2015**, a representative of the Provider settled the third party's claim against the Complainant with solicitors for the third party for a figure of €20,324.26. The Provider states that the Complainant was informed of this settlement in a letter sent to him on **19 June 2015**.

The Provider admits that the letter sent on **8 September 2015** by the Provider to the Solicitor for the Complainant was poorly worded and has apologised for the contents of this.

In relation to the statement given by the Complainant on **28 March 2014** to the investigator for the Provider, the Provider admits that it has destroyed the original statement and states that this was for data protection purposes and has apologised to the Complainant for any miscommunication that may have occurred during the taking of this statement. In the interests of completeness, the Provider has requested that the Complainant provide a rectified version of this statement and has stated that it will amend its records as to the content of this statement.

The Provider further acknowledges that during its original communications with the Complainant it stated that it would be defending the third party's claim against the Complainant fully. However, the Provider maintains that due to the information received from the third party's insurance company the Provider changed its decision to fully defend the third party's claim against the Complainant. The Provider further maintains that having considered all of the evidence provided and the claim file in full and in order to mitigate the payments made under the Complainant's policy, its decision to settle the third party's claim against the Complainant for the sum of €20,324.26 was correct in all the circumstances.

In respect of the increases in the Complainant's insurance premia, I note that in correspondence sent from the Provider to the Complainant dated **9 March 2015**, the Provider makes a number of points relevant to an insured's no claims bonus and the effect which a claim against an insured by a third party, even if unsubstantiated, can have on a no claims bonus. The Provider states that even in circumstances where the Provider successfully challenges a third party's claim against an insured, the insured's no claim bonus will still be affected as the bonus is awarded where no claims are made. It states that in the particular claim concerning the Complainant, if the claim was fought, it is likely that it would have remained an active claim on the Complainant's account for longer and would have cost more to defend than it would have to settle. Therefore, the Provider states that even if the claim had proceeded to trial and a Court had dismissed the claim, the Complainant's no claims bonus would still have been affected. The Provider has also stated that general rates for motor insurance have increased over the period of time during which this complaint arose and that the Complainant had a second active claim against his policy from an incident which occurred in **September 2014**. The Provider states that these factors, coupled with the Complainant's accident history, are major contributing factors for the rise in the Complainant's premia. At each occasion when the Complainant has had to renew his premium, the Provider states that it has reduced the amount initially sought after discussions with the Complainant.

Finally, the Provider acknowledges that it has breached section 7.16 of the Consumer Protection Code 2012 which states:

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"A regulated entity must, within ten business days of making a decision in respect of a claim, inform the claimant, on paper or on another durable medium, of the outcome of the investigation explaining the terms of any offer of settlement"

The Provider states that it breached this provision of the Consumer Protection Code 2012 when it made a decision to make a without prejudice settlement offer to the third party and where that decision was not communicated to the Complainant until after a settlement had been reached. The Provider has apologised to the Complainant for this breach.

The Provider has stated that as a gesture of goodwill and in recognition of the shortcomings of the Provider in the handling of this incident, the Provider is agreeable to paying the Complainant a sum of €2,500.

The Complaints for Adjudication

The complaint for adjudication is that the claim by the third party was dealt with improperly by the Provider, was incorrectly settled by the Provider, ultimately resulting in the increase of the Complainant's insurance premia, the poor handling of the complaint and the wrongful destruction of the original statement of the Complainant.

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.

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 17th 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

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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, the Complainant made a further submission by e-mail dated 9th May 2019, a copy of which was transmitted to the Provider for its consideration. The Provider did not make any further submission.

Following the consideration of the additional submission from the Complainant, my final determination is set out below.

The Complainant has stated that the third party's claim against the Complainant was dealt with improperly by the Provider and was incorrectly settled by the Provider.

When two parties (an insured person and an insurance provider) enter into a motor policy it forms a legally binding contract between them. The relationship between both parties is then governed by the terms and conditions of the policy contract. I must therefore take into account the terms and conditions of the policy when determining the merits of the complaint.

One of the main conditions in most motor insurance policies is what is known as a Subrogation Clause. Subrogation allows an Insurance Company to take over and either contest or settle a claim on behalf of the insured person. This means that if a third party submits a claim against the policy holder or other insured stating that the policy holder damaged their vehicle or they incurred personal injuries following an incident with the policy holder, the Insurance Company may decide, under their subrogation rights, to settle the claim. Where a Subrogation Clause is included in a contract of insurance, the Insurance Company does not need the permission of the insured to settle the claim.

I have examined the Complainant's policy of insurance (contract) with the Provider and I note it contains the following Subrogation Clause at Page 13:

> **1. Claims Procedure**
>
> In connection with any injury loss or damage which may give rise to a claim under the policy:
> …
>
> The Company is entitled to take over and conduct the defence or settlement of any claim, and to pursue any claim for its own benefit in the name of any person insured. However, the Company does not have to do so.

This Clause allowed the Provider to take over any claim against the Complainant under the policy.

However, under the Consumer Protection Code it is a requirement that once a claim is settled against a third party the policyholder must be informed in writing of the final outcome of the claim and the final settlement figure.

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In relation to the attachment of liability for the accident I cannot make a finding on the question of liability in a road traffic accident as this is not within my legal jurisdiction. Similarly, the Provider cannot determine liability, but can only form a view based on the evidence presented, and exercise its discretion to deal with a claim accordingly. The appropriate forum for such a determination is a court of law.

I note that the Provider made its initial assessment that the Complainant was not liable for the claim after considering the Complainant's initial statement and a report of an investigator for the Provider who met the Complainant at the location of the incident on **28 March 2014**. I further note that the Provider subsequently changed its decision relating to liability, primarily based on the information furnished to it by the insurance company for the third party and also based on the lack of independent witnesses and/or lack of CCTV footage available in relation to the incident. I must accept that given the Subrogation Clause referred to above, the Provider was entitled to re-assess its position in relation to the assessment of liability when new evidence comes to light.

That said, I find the communication with the Complainant, or lack thereof, to be unreasonable. Firstly, the Provider told the Complainant that it would not be admitting the claim and then changed its stance without informing him.

There is a discrepancy pointed out by the Complainant between the Complainant's recollection of the contents of the original statement given by the Complainant and the typed version of the statement as put forward by the Provider. The Provider has apologised to the Complainant for any miscommunication that may have occurred during the taking of his statement and has stated that it will amend its records to reflect the content of the rectified version of the statement as provided by the Complainant. I have no reason to doubt the Complainant's version of what happened. However, even if I accept the contents of the original statement were as stated by the Complainant, the Provider would still have been entitled to make the decision in the manner in which it did to settle the third party's claim as against the Complainant.

However, I am very concerned about the Provider's conduct in destroying the Complainant's original signed statement.

I note that the Provider accepts that the original statement made by the Complainant and signed by him was destroyed in February 2017, and the Provider asserts that this destruction was for data protection reasons. I am at a loss to understand why the Provider was required to destroy the Complainant's statement for data protection reasons. In any event, the destruction of the original statement by the Provider was not in keeping with sections 11.5(f) and 11.6 of the Consumer Protection Code 2012, which state:

> *"11.5 A regulated entity must maintain up-to-date records containing at least the following:*
> *…*
> *(f) all documents or applications completed or signed by the customer*
> *…*

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11.6 A regulated entity must retain details of individual transactions for six years after the date on which the particular transaction is discontinued or completed. A regulated entity must retain all other records for six years from the date on which the regulated entity ceased to provide any product or service to the consumer concerned"

This statement was taken in March 2014 and the CPC requires that such records are to be maintained for a period of six years. The failure to comply with the provisions of the Code in this regard is wholly unacceptable.

Furthermore, the Complainant has asserts that the language used in the typed version of his statement is not language that he would normally use and he is clear that it differs from the statement he gave to the Provider's investigator. I accept the Complainant's assertion in this regard. Further, having examined the statement provided by the investigator and the typed statement that the Provider purports to have been given by the Complainant, I note there is a remarkable similarity between both the language and content of both statements.

The Provider has given no explanation as to why there should be any difference between the signed statement given by the Complainant and the typed version available on the file and provided to this Office.

I am of the view that the letter sent by the Provider to the Complainant's solicitor on **8 September 2015** was poorly worded and included inaccuracies and errors, for example questioning the Complainant's credibility and stating that he admitted to having a blind spot. The Provider accepts that this letter contained inaccuracies and errors and was very poorly worded and that these inaccuracies and errors caused considerable distress to the Complainant. I note that a Claims Handler on behalf of the Provider did apologise to the Complainant for the content of this letter both over the phone on **21 January 2016** and through written correspondence on **4 February 2016.** The errors and inaccuracies in the letter of **8 September 2015** and the delay in apologising for this, is not in keeping with the requirements of section 2.8 of the Consumer Code of Conduct 2012 which states that a regulated entity must ensure that in all its dealings with customers and within the context of its authorisation it *"corrects errors and handles complaints speedily, efficiently and fairly"*. This failure to comply with the requirements of the Code is most disappointing, in respect of both the inaccuracies and errors in the letter and the failure to acknowledge and apologies for these inaccuracies and errors, between **8 September 2015** and **21 January 2016**.

The setting of premia by an insurance provider is a matter of commercial discretion for the Provider and therefore does not fall within the jurisdiction of this Office. Therefore, the amount of premia charged does not form part of this investigation and adjudication.

However, I note that even had the Provider successfully challenged the third party's claim against the Complainant, the Complainant's no claim bonus would still be affected as the bonus is awarded only where no claims are made against an insured's policy.

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Finally, it is accepted by the Provider that it breached section 7.16 of the Consumer Protection Code 2012 when it made a decision to make a without prejudice settlement offer to the third party and this decision was not communicated to the Complainant until after a settlement had been reached. I note that the Provider has apologised to the Complainant for this breach.

As the Provider was acting on behalf of the Complainant, it was entitled to change its view on the assessment of the liability of the incident in question on foot of new information and evidence in relation to that incident. The Provider was further entitled to settle the third party's claim against the Complainant.

In assessing the manner in which the Provider handled the third party's claim against the Complainant, I find that the Provider has not acted reasonably, particularly in its destroying of the Complainant's signed statement in in its poor communications.

These were failings in the manner in which the Provider dealt with the third party's claim against the Complainant and the Complainant's subsequent complaint relating to this, and failures to comply with sections 2.8, 7.16, 11.5 and 11.6 of the Consumer Protection Code 2012 by the Provider, as outlined above.

I note that an offer of €2,500 was made by the Provider to the Complainant in recognition of the shortcomings in its handling of the claim. I do not believe this compensation is at all sufficient to compensate the Complainant for the inconvenience caused.

For the reasons outlined above, I substantially uphold this complaint and direct the Provider to pay a sum of €7,500 in compensation for the inconvenience caused to him.

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Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld on the grounds prescribed in ***Section 60(2) (b), (f) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €7,500 for the inconvenience caused to him to an account of the Complainant's choosing within a period of 35 days of the nomination of account details by the Complainant to the provider.

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

17 June 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.