An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0248
Sector:	Banking
Product / Service:	Credit Union Loan
Conduct(s) complained of:	Dissatisfaction with customer service
Outcome:	Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant and his late wife held separate share accounts with the Provider. When the Complainant's wife passed away in September 2016, the Complainant requested the payment of the Provider's death benefit insurance. This was refused by the Provider on the basis that the balance of the deceased's share account was €5.87 on her death and, consequently, her account did not meet the terms of its death benefit insurance scheme which required a minimum balance of €300.

The Complainant states that his late spouse could not be given direct access to funds due to a diagnosed and documented medical condition and that the balance of her account was deliberately kept at a minimum as a result. The Complainant states that the balance of his own account was over €4,000 held jointly in shares and represented a combination of their savings. He argues that the account in his name contained joint savings and the balance was above the required minimum to qualify for the death benefit insurance scheme. The Complainant is further aggrieved and upset by the manner in which his claim was addressed by the Provider which he found cold and business-like.

The Provider has apologised for its apparent lack of empathy in previous correspondence but asserts that it is satisfied that the terms and conditions of the death benefit insurance scheme have been correctly applied. It further states that there is no evidence of there ever having been a joint account situation at any time.

The Complainant's Case

In an undated letter to the Provider, the Complainant states that he was upset upon receipt of the Provider's response to his ongoing query regarding his late wife's account. He stated that he thought that the two-line letter was very cold and business-like given the nature of the situation and was totally at odds with the ethos of the Provider being a family friendly association that is there for the community. He stated that his late wife suffered acutely from a disability that meant they could not allow her easy access to funds as there was a high potential that this would exacerbate her condition. She was also diagnosed and treated for other medical issues so the family could not risk putting her life in further danger and so it combined their savings into the Complainant's account to prevent her doing this. He states his belief that the least the Provider could do for a long-standing and loyal customer is to honour its pledge to contribute to the expenses when one of the members passes away. He states that despite several health issues, his late wife's life was cut tragically short in an unrelated incident and while he does not expect the Provider to be aware of all the details, he states that he felt that even an acknowledgement of this event would have been appropriate in the harsh two-sentence response he received. He returned the cheque for €5.87 sent to him.

In a letter of complaint to the Provider dated 11 July 2017, the Complainant states that he was not satisfied with the Provider's response which simply outlined the criteria for payment (ie €300 balance in the account) but did not address or take into account the circumstances that were already outlined to it with regard to his deceased wife's condition. He states that the current balance of €4,660 in shares was a combination of both of their savings, but could not be directly available to his late wife for reasons also disclosed. He reiterated his dissatisfaction with the manner in which his case has been handled, from what he regarded as the "*initial abrupt communication*" right up to the most recent letter. He states that he does not believe that he or his situation have been treated seriously by the Provider. He states that he and his wife were and are customers of the Provider for a considerable amount of time and in that context, are not being treated with respect, in relation to the issue.

The Complainant registered a formal complaint dated 30 July 2017 due to the abrupt and insensitive manner in which the Provider dealt with his enquiry regarding his entitlement to death benefit arising from the passing of his wife. He states that the balance of his account represented both of them and exceeded the minimum balance required to access the benefits. He states that the arrangement was necessary due to his late wife's medical condition.

By email dated **25 January 2019**, the Complainant noted his surprise that the Provider's representative, Q. was still involved in the matter due to the abrupt manner in which she had responded to his original query. In relation to the verbal agreement that he states that he had with the Provider's CEO and Q. he states that he called into the Provider and spoke to the CEO about his wife's passing and what was required to avail of the funeral expense

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insurance. He states that he was reassured by the CEO that "*it all would be taken care of*" when he sent a copy of the death certificate.
The Complainant states that this discussion was later followed up by a telephone call from Q. to reiterate that the matter would be sorted once he got the death certificate into them. He states that he then went about obtaining the required documentation which was forwarded to them. He then received the two line response and a cheque for €5.87. He states that it is high time for honesty as everyone involved knows that it is not what was implied, when he was told that the matter would be taken care of. He states that he was a member of the Provider for nearly 50 years and he really expected to be treated a lot better than this.

By email dated 19 February 2019, the Complainant highlights the Provider's acknowledgement that he would be taken care of when the death benefit was received. He argues that there can be no doubt what was implied with this comment. He further argues that the statement itself might be a verbal contract.

The Provider's Case

The Provider's CEO responded to the Complainant's letter of complaint of 11 July by letter dated 20 July 2017. In this, the Provider sincerely apologised for the apparent lack of empathy in any of its previous correspondence. Upon a review of the claim, however, the Provider stated that it was satisfied that the terms and conditions of the death benefit scheme had been correctly applied. The Provider stated that having regard to the Complainant's own understanding of the balances in the Complainant's account in his sole name being a combination of joint savings, the Provider has had no evidence of this ever being the case and the circumstances would not allow any claim on behalf of his late wife on this account. The CEO stated that he genuinely sympathised with the Complainant and the family on the sad and tragic loss of the Complainant's wife and empathised fully with the circumstances. He further stated that all benefit schemes must be governed by certain terms and conditions and the Provider was merely adhering to these. He provided the Complainant with his mobile telephone number if he wished to contact him further.

By letter dated 22 August 2017, the Complainant was informed that his complaint to a further complaints committee was unsuccessful. It noted that the Complainant's account was clearly a sole account and there was no evidence of there ever having been a reference to a joint account situation at any time. The complaints committee accepted his dissatisfaction with the manner in which the claim was dealt with and added its apologies to those already submitted by the Provider. It also expressed its condolences on the tragic loss of the Complainant's wife. The committee stated that his claim had been treated with the utmost respect and understanding but the facts that exist must govern the outcome previously outlined: that his late wife's claim for death benefit was clearly excluded from the terms of the death benefit insurance scheme.

In response to queries raised by this Office, the Provider set out the terms and conditions of its death benefit insurance scheme which states that the insurance for 2016 would be covered by the Provider, provided that qualifying members:

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> "*have a minimum of €300 in their share account on 31/12/2015. Any member who does not have this amount in their share account can still avail of the cover by calling into one of our offices paying premium themselves*."

The Provider states that the member (ie the Complainant's late wife) did not meet the qualifying condition of a €300 minimum balance since November 2009. The Provider states that since the minimum of €300 to qualify for the death benefit insurance scheme was introduced in October 2009, it has not been changed.

In response to a query as to whether the Complainant had discussed his spouse's circumstances or their accounts with the Provider at the local branch before she passed away, the Provider states as follows:

> "*No discussion as regards the savings/shares/joint accounts, only previous discussion as regards deceased borrowing issues*."

The Provider states that the qualifying terms and conditions for its death benefit insurance scheme are in its view clear, and "*serve the principles of purpose well*". It argues that the Complainant's claim falls outside the terms and conditions. It further states that there is no situation in which it would rely on an informal arrangement when dealing with a request involving a sole account being converted to a joint account. Such requests are governed by legal and regulatory obligations. It states that it respects and adheres to such obligations without exception.

The Provider states that its complaints officer, Q. called the Complainant following receipt of his letter to apologise for any upset that might have been caused as a result of the two line response referred to. This was followed up with letters of 28 June and 22 August 2017. The Provider notes that the apology was not in relation to the factual nature of the contents but rather the apparent lack of empathy and the consequential upset caused to the Complainant. The Provider states that it did not do anything deliberate or otherwise that would represent poor treatment of a member in a vulnerable condition.

The Provider states that the amount of the death benefit insurance payable once all qualifying criteria are met, is €1,300. It confirms that the criteria set out in this policy do not allow for the payment of any partial death benefit payments. The Provider notes that a goodwill payment was proposed as an ex gratia payment which was an effort to balance the Complainant's expectations and disappointments.

By email dated **16 January 2019**, the Provider confirmed that the proposed ex-gratia payment for the Complainant was €500. By email dated 2 February 2019, the Provider's CEO states that his initial response that *"it all would be taken care o*f" was totally misunderstood as the Provider deals with requests from members on many issues regularly and this always involves requesting backup material before processing and the matter being taken care of. He states that "*there should be no sense of completion or approval assumed on that basis*". The CEO stated that the ex-gratia payment offered was on the basis of the Provider's genuine empathy with the family at the time and it has apologised for the insensitive reply to the invalid death benefit claim.

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By letter dated 22 February 2019, the Provider's CEO explained the context of his statement that the matter 'would be taken care of' as follows. He states that the Complainant presented at reception enquiring as to what was required to make a death benefit insurance claim in relation to his wife, who had recently passed. He states that standard requirements in the case of a claim were communicated to him, dealing with the application and processing of same by its insurance body which administers the scheme. He states that the Complainant was advised that on the furnishing of these requirements, the application would be taken care of. He states that there was no inference that the claim would be settled but rather that the application would be dealt with. He states that the claim as submitted to the insurance body clearly falls outside the scope of the scheme. The CEO again acknowledges and accepts that it sent a less than sensitive response letter which the Provider is genuinely sorry and embarrassed by, as explained on several occasions to the Complainant. He states that the Provider is once again offering an ex-gratia payment of €500 but that "*if not accepted this offer would have to be withdrawn and the process of adjudication be initiated*."

The Complaints for Adjudication

The complaint is that the Provider wrongfully failed to pay death benefit insurance on the passing of the Complainant's wife and further demonstrated poor customer service and complaint handling in dealing with his request.

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 12 July 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.

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Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The Complainant's wife sadly passed away in 2016. The Complainant applied to the Provider for the payment of a death benefit insurance claim that he understood was available to all members of the Provider upon their deaths. No application form has been furnished to me and it is unclear whether the application was made orally. The letter that he received in response dated 27 May 2017 was in the following terms:

> "*Dear [the Complainant].*
> *Regarding your late wife's account please find attached cheque for €5.87, this account is now closed.*
> *Trusting this is to your satisfaction.*
> *Yours sincerely,*
> *[Q.]*"

The Complainant reverted to Q. setting out his frustration and upset upon receipt of the letter, which he regarded as cold and business-like. He requested that the Provider would honour its pledge to contribute to the expenses of a deceased member. He further indicated that an acknowledgement of the sudden passing of his wife would have been appropriate. He continued as follows:

> "*When I contacted [the Provider], I was asked to try and obtain the official death certificate in order to get this matter closed. After a lot of effort, I managed to get the certificate and send onto the credit union only to receive a two line response and a cheque for €5.87 with no reference whatsoever to the payment of death benefit. My complaint is not solely centred around whether or not we receive death benefit but rather about the poor treatment of customers who are already in a vulnerable condition*."

In letter of response dated 28 June 2017, Q. apologised for her letter of 27 May 2017 which she stated "*was not intended to cause any upset*." The letter went on as follows:

> "*I would like to outline the criteria regarding the Death Benefit insurance (Funeral Expenses) here in [the Provider], this is also outlined in our annual AGM booklet.*
>
> - *All members must have €300.00 in their account on the last day of the year ie 31/12/2016 to qualify for the DBI, once the [Provider] are in receipt of a Death Certificate we submit a claim to [the insurer].*
>
> *Unfortunately, the above was not the case with your late wife []'s account as she did not have this amount in her account, therefore she did not qualify for the Death Benefit Insurance.*
>
> *I trust this clarifies the situation for you, should you wish to discuss the above, please give me or [MC] a call*."

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The complaint was then escalated to the CEO of the Provider in the correspondence set out above.

Turning first to the issue of the death benefit insurance, I have been furnished with the relevant portion of the AGM booklet which set out the terms and conditions of the death benefit insurance scheme in 2016 for members of the Provider. The terms of the scheme were as follows:

> "*The purpose of Death Benefit insurance is to provide basic cover to members, to the value of €1300 towards the cost of their funeral expenses.*
>
> *All members are eligible for this cover provided they have joined the [Provider] before the age of 70 and are in good health at the time of joining.*
>
> *The cost of this insurance for 2016 will be covered by the [Provider] provided qualifying members have a minimum of €300 in their share account on 31.12.15. Any member who does not have this amount in their share account can still avail of the cover by calling into one or (sic) our offices and paying the premium themselves. If you would like further information on Death Benefit insurance, our staff will be delighted to assist you*."

I note the Provider's contention that the €300 minimum qualification amount was introduced in October 2009 and has not been changed since. I am therefore proceeding on the basis that information as to the €300 minimum was notified to the Complainant and his wife or was otherwise made available to them.

There does not appear to be a dispute between the parties as to whether the account held in the sole name of the Complainant's deceased wife held the minimum €300 required for the scheme, as of December 2015. An account statement relating to the Complainant's late wife's share account with the Provider has been furnished in evidence. The balance of the account as of January 2009 was €394.19. By 7 November 2009, the balance was €230.19. The balance dropped below €200 in December 2009 and was never again above €200. Various small payments in and out of the account were made over the next six years, with the lowest recorded balance of €1.55 occurring in September 2011. While the balance on 1 January 2015 was €20.81, by December 2016 the balance of the account was €5.87. The account was closed in May 2017 and a cheque in the sum of €5.87 sent to the Complainant.

It appears that the share account of the Complainant's late wife was never at a level where she would qualify for the death benefit insurance scheme after the minimum qualification amount was introduced in October 2009. Insofar as the complaint concerns a refusal to pay death benefit insurance on basis of the account held in the sole name of the Complainant's late wife, I am satisfied that the account in question fell outside of the scheme as the balance of the account did not reach the minimum qualifying amount. I have not been convinced that the Provider fell into error in this regard, or has acted unreasonably or unfairly in refusing to pay funeral expenses under the insurance scheme as regards the account of the Complainant's late wife.

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The Complainant has stated that the balance of the account held in his own name in fact represents the joint savings of the Complainant and his late wife. He argues that as this account represents both of them, and exceeds the minimum balance required to access the death benefit insurance, the benefit should be paid. The Complainant explains that due to a documented medical condition, it was dangerous to allow his late wife access to funds and so he and his family had made a decision to hold the savings in an account in his sole name. The Complainant does not furnish any detail as to whether, or when, he claims that the balance of his late wife's account was transferred to his account, or detail any discussion he had with the Provider as regards his account containing joint assets from any particular date. For its part, the Provider has stated that no such discussion ever took place and that the Complainant has made available no evidence to support an argument that the account in his name was, in effect, a joint account.

The Provider has stated that the balance of the account in the Complainant's sole name was €3,010.21 as of September 2016. The question is whether this was a sole account or a joint account.

I fully accept the sincerity of the Complainant's belief and understanding that the proceeds of his account represented the joint savings of him and his late wife. I also accept his concerns and those of his family, that his late wife should not have ready access to funds owing to her medical condition. The difficulty is that this understanding, though genuinely held, appears to have been an informal family understanding rather than anything approaching a legal agreement which was communicated to and agreed with the Provider. The account in question is not and was not held in the joint names of the Complainant and his wife, but in the sole name of the Complainant. There does not appear to be any record of any indication having been given to the Provider that the contents of the account should be treated as joint assets, rather than the sole assets of the Complainant. Indeed it would appear that the Complainant and he alone, had access to the relevant account. If the Complainant's late wife had sought access the relevant account during her lifetime, she would not have been entitled to do so. These circumstances lead me to the inevitable conclusion that the account was not a joint account in the legal sense, whatever the informal family understanding in relation thereto.

While I have the utmost sympathy for the Complainant for the circumstances he finds himself in, I am of the view that there would need to have been a more formal agreement with the Provider as regards the joint ownership of the proceeds of the relevant account, for an argument to be made out that would entitle the Complainant's late wife to access to the death benefit scheme. I appreciate that this will be disappointing for the Complainant and I understand that he feels that his loyalty and that of his wife, to the Provider for a period of 50 years ought to entitle them to payment of death benefit expenses. I am satisfied, however, that the claim made by the Complainant on behalf his late wife, falls outside the terms and conditions of the relevant scheme and, therefore, that the Provider was entitled to decline to make the relevant payment.

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Turning to the more recent argument of whether there was an agreement by the Provider to meet the claim upon the production of the death certificate, again I appreciate that the Complainant's understanding of the commitment made by the Provider's CEO to 'take care' of the matter, was to the effect that the death benefit payment would be made upon his production of the death certificate. The CEO has stated that this was not the impression that he attempted to convey and was merely a commitment to ensure that the application would be processed on the Complainant's behalf, by sending it to the relevant insurers.

While there are certain (generally exceptional) situations where oral commitments to make payments can be viewed as legally binding, such commitments must be, amongst other things, expressed clearly and unambiguously. The commitment made by the CEO to take care of the matter must be regarded as ambiguous in that these words were capable of multiple interpretations, including the interpretation placed on it by both parties to the within complaint. I am satisfied that although the Complainant understood the words to mean that the death benefit would be paid, the CEO did not mean for them to be so understood, and merely intended to reassure the Complainant that the application would be processed. The words cannot be interpreted, in my view, as containing a commitment by the CEO that the Provider would make the death benefit payment even if the claim fell outside the terms and condition of the scheme. I am not satisfied that the words used, can be considered as a binding legal commitment to make the relevant payment, nor has any reliance or detriment been shown by the Complainant in relation to it, other than in relation to retrieving the death certificate in support of the claim.

In all of these circumstances, and while conscious of the disappointment of the Complainant in this regard, I cannot upheld this aspect of the complaint concerning the Provider's refusal to meet the claim for the payment of death benefit expenses on the passing of the Complainant's wife.

In relation to the poor customer service complaint, I can readily appreciate the Complainant's upset on receipt of the two-line letter from Q. dated 27 May 2017. It is understandable that the Complainant would feel vulnerable when he had just lost his wife and that the business-like tone of the letter seemed devoid of empathy for his situation. I further cannot understand why this letter did not explain the reason why the Provider had determined that it was not in a position to meet his claim for death benefit. As previously mentioned, it is not clear whether the application for the death benefit payment was made orally or in writing, but, either way, I would expect to see a formal written notification to a customer when a claim was being declined.

To its credit, the Provider immediately apologised to the Complainant for the abrupt tone of its letter of 27 May 2017, both in a letter from its writer, Q. and a further letter from the CEO of the Provider. Indeed this apology has been reiterated on numerous occasions in the course of the investigation of this dispute. In addition, the Provider made an ex gratia offer to the Complainant to pay him the sum of €500 in recognition of the upset caused to him. It further clearly explained the rationale for its decision to decline the claim, in subsequent correspondence.

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I consider that the goodwill sum offered by the Provider in this regard adequately reflects the customer service failings of the Provider in respect of its letter of 27 May 2017. If this offer was still available to the Complainant, it would not be necessary to uphold this aspect of the complaint, on the basis that the Provider quickly and readily apologised for its conduct, repeated this apology on numerous occasions, and made an appropriate offer of compensation to the Complainant.

In its most recent correspondence dated 22 February 2019 however, the Provider stated that it was once again offering the ex-gratia payment of €500 but that "*if not accepted this offer would have to be withdrawn and the process of adjudication be initiated*."

As the offer was not accepted, this office considered it necessary to assume when issuing the Preliminary Decision, that the ex gratia offer had been withdrawn by the Provider and was no longer available to the Complainant for acceptance. On that basis, the parties were advised that it was considered appropriate to uphold the aspect of the present complaint, in relation to the poor customer service experienced by the Complainant owing to the Provider's failure to communicate the decision and rationale for declining his claim for a death benefit payment in respect of his late wife, and for the tone of its communication to him in light of the sudden and recent passing of his wife.

Following the issue of the Preliminary Decision, advising of the intention of the FSPO to direct that a payment of €500 be made to the Complainant to reflect this customer service failing, the Provider advised that

> *"the ex gratia offer of €500.00 is still valid and [the Provider] will be pleased to pay same to [the Complainant] if he is happy to accept same. This may avoid some of the additional actions associated with your office having to formally direct the matter of the payment"*

The Complainant subsequently confirmed that he was *"happy to proceed with this outcome"*

Whilst I note that the Provider in fact since issued payment to the Complainant on 26 July 2019, in the sum of €500, I am satisfied that the payment at that time was made by the Provider, and indeed accepted by the Complainant, on foot of the determination outlined in the Preliminary Decision dated 12 July 2019.

For that reason, noting that the compensatory payment directed in the Preliminary Decision dated 12 July 2019, has already been discharged, I take the view nevertheless, taking into account the Provider's position as quoted above in its communication dated 22 February 2019, that this complaint should be partially upheld.

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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 partially upheld, on the grounds prescribed in ***Section 60(2 (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 €500, 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. It is noted in that regard that the Provider has already taken steps to facilitate the said compensatory payment to the Complainant

- Whilst the payment has been actioned, nevertheless, for completeness sake, 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 the period specified.

- 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

6 August 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.**