An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0349
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Claim handling delays or issues Dissatisfaction with customer service Failure to consider vulnerability of customer
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This complaint concerns a house insurance policy.

The Complainants' Case

The Complainants' property was the subject of flood damage due to burst water pipes on **02 March 2018**. It is stated that the Provider paid a settlement sum to the Complainants on 1 May, 2018, closing the claim with regard to material damage at the property.

The complaint submitted by the Complainants, through their representative, concerns the alleged actions of the Provider and its loss adjuster. The Complainants state that the Provider "*procrastinated processing of this claim*". When the Complainants' representative contacted the Provider regarding the delay, it is stated that it was indicated to him that "*there was a queue*" and that the claim would be dealt with in order. The Complainants also queried the "*higher than normal retention*" figure, when settling the final insurance sum. The Complainants' representative states that he informed the Provider that the first Complainant was a "*vulnerable customer under the Consumer Protection Act*". The Complainants say that the Provider, through its loss adjuster, did not accept this.

The first Complainant also states that on the 11 April 2018, he received a phone call from the Provider's loss adjuster, suggesting that he deal directly with him and not through the appointed representative, as had been agreed previously by the Complainants.

The Provider's Case

The Provider apologised to the Complainants in its final response letter dated 27 April 2018. It agreed that *"its service provided fell short of the standard we set ourselves"*. The Provider, through its loss adjuster, has also stated that they

> "*were not aware that these were vulnerable customers, and this was never suggested to* [them]. *We met with* [the first Complainant] *only on our inspection. He advised us on that date that he was suffering from the flu but nothing else* [was] *provided to suggest the insured to be vulnerable customers*".

The Provider agreed to settle the claim "*based on the full amount claimed*".

The Complaint for Adjudication

The complaint is that the Provider:

1. Through its loss adjustor failed to deal with the Complainants' house insurance claim in accordance with the provisions of the Consumer Protection Code 2012 (as amended);

2. Failed to deal with the Complainants' house insurance claim in a timely manner;

3. Failed to accept that the first Complainant was a vulnerable customer under the Consumer Protection Act and has in fact, implied that the Complainants' representative's statement regarding this information was "*false and misleading*".

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.

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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 4 October 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 an additional submission from the Complainants' representative, the final determination of this office is set out below.

Legislation

Section 2(2) of the ***Consumer Protection Act 2007*** (cited by the Complainants' representative) provides as follows:

> *2) In this Act, "the average consumer " has the meaning assigned to it in the Directive, and when applied in relation to a particular commercial practice or product of a trader—*
>
> *…*
>
> *(b) if the commercial practice or the product is a practice or product that would be likely to materially distort the economic behaviour only of a clearly identifiable group of consumers whom the trader could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, the expression shall be read as "the average member of that vulnerable group".*

Section 41 of the ***Consumer Protection Act 2007*** provides as follows:

> *(1) A trader shall not engage in an unfair commercial practice.*
>
> *(2) A commercial practice is unfair if it—*
>
> *(a) is contrary to one or both of the following (the requirements of professional diligence):*
>
> *(i) the general principle of good faith in the trader's field of activity;*

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(ii) the standard of skill and care that the trader may reasonably be expected to exercise in respect of consumers,

and

(b) would be likely to—

(i) cause appreciable impairment of the average consumer's ability to make an informed choice in relation to the product concerned, and

(ii) cause the average consumer to make a transactional decision that the average consumer would not otherwise make

.

(3) In determining whether a commercial practice is unfair under subsection (2), the commercial practice shall be considered in its factual context, taking account of all of its features and the circumstances

Chapter 12 of the ***Consumer Protection Code*** provides as follows:

"vulnerable consumer" means a natural person who: a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties).

Chapter 3 of the ***Consumer Protection Code*** provides as follows:

Where a regulated entity has identified that a personal consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the regulated entity.

Analysis

In essence, this complaint concerns the manner in which the Complainants' insurance claim was processed by the Provider and it focuses on the issues of delay and the failure to recognise the first Complainant as a vulnerable person. The insurance claim itself was resolved between the parties when the Complainants' representative accepted the Provider's settlement offer on their behalves.

Whilst the Complainants' representative, in response to the Preliminary Decision of this office, has made it clear that he believes that the claim settlement was not a satisfactory one, the FSPO has noted that the Complainants elected, via their representative, in May 2018, to accept the Provider's proposal to settle their claim at €5,334.50, which applying the

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policy excess of €600, gave rise to a payment of €4,734.50. I also note that although the Complainants' representative has, in response to the Preliminary Decision of this office, made additional comments regarding the original retention amount (which he considered to be punitive) it is clear that when the Complainants settled the claim with the Provider via their representative, the figure was paid in full at the beginning of May 2018, without any retention applied, in accordance with the claim settlement agreed between the parties.

1. Delay

The loss in this instance was suffered on 2 March 2018. The claim was notified on 7 March 2018. An inspection of the property took place on 12 March 2018 as agreed between the parties. The Provider states in its response to this office that the claim was accepted on 13 March 2018. Thereafter, the Complainants provided estimates for repairs on 14 Mach 2018. Subsequent to this point in time, there was a delay prior to payment finally being made to the Complainants on 2 May 2018.

Updates were sought by the Complainants or their representative on 17, 22, 26 and 29 March 2018. The Provider states that the reason for the delay at this point in time, was due to the number of claims that had arisen from a very significant storm that struck the country in February/March 2018 (the 'Beast from the East').

A settlement offer was eventually made available on 29 March 2018. There followed certain interactions between the Complainants' representative and the Provider's loss adjustor regarding the amount of the offer and certain technicalities attaching, including the amount of 'retention' to be withheld pending the completion of the works. In the course of these interactions, the Provider's loss adjustor sought a detailed breakdown of the Complainants' builder's estimate to include "*measurements and rates per measurements used*". The Provider also highlighted that "*a number of rooms were included for works which were not shown to us on inspection and would suggest this to be the difference in prices*". The Complainants' representative responded in the following terms:

> *The estimate is a market estimate and its format is commensurate with what is in the market place. The builder's estimate stands as it is.*

In respect of the foregoing, I take the view that the Provider's request for a detailed breakdown was a reasonable request. The Complainants' representative's refusal to furnish those details is something of a mystery, and in my opinion is not a reasonable position to adopt. This clearly contributed in part to some of the delay. A further source of delay was the inability on the part of the Provider's loss adjustor to contact the Complainants' builder.

An improved settlement offer was made on 13 April 2018. This offer was not formally accepted or declined by the Complainants initially as they were insisting on a letter of apology from the Provider's loss adjustor. A further improved offer was then advanced and accepted on 1 May 2018.

I am satisfied that there was certain delay attributable to the Provider in the matter. The claim was processed fairly promptly initially, insofar as the claim was accepted within one

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week of notification. The process of the quantification of the claim was where the delay occurred. In this regard, there was certainly a delay by the Provider's loss adjustor from 14 March 2018 to 29 March 2018. I do not however view this delay as in any way egregious, not least given the fact of the recent passing of an unusually violent storm with the associated run of claims arising therefrom.

The balance of the period between 29 March and payment being made on 2 May related to two matters. The first was a circa two-week period in which the Provider's loss adjustor sought a detailed estimate from the Complainant's builder. The second arose as the Complainants sought an apology before engaging with the improved offer made available on 13 April 2018.

I am not satisfied that either of these two circa two-week delays in April 2018 can be said to have resulted from any objectionable conduct on the part of the Provider. The first was contributed to, in significant part, by the Complainants. The second was a matter of choice by the Complainants. The Complainants' complaint with the Provider was resolved by way of the provision by the Provider's loss adjustor of a written signed apology. In the circumstances, I am not satisfied that anything further is warranted and, accordingly, I am not in a position to uphold this aspect of the complaint.

2. Vulnerable Person

The Complainants' representative states that on 30 March 2018 he emailed the Provider's loss adjustor informing it that the first Complainant should be considered a vulnerable person. The Provider's loss adjustor replied the same day querying the basis for same. The Complainants' representative reverted as follows:

> [The first Complainant] *has a broken back and is a vulnerable customer*.

The Provider's loss adjustor responded in turn as follows:

> [The first Complainant] *did not have a broken back on our inspection and from our inspection would not constitute a vulnerable customer. The attempt to classify them as vulnerable customers is questionable.*

The statement that the first Complainant had a broken back is the only basis indicated in the evidence, on foot of which the Complainants contend to qualify as vulnerable customers. Though there is a reference in a letter written on behalf of the Complainants by their solicitor dated 9 April 2018 to the provision of medical evidence supporting the diagnosis, the FSPO has not been furnished with any such evidence. The letter of 9 April 2018 in fact refers to a "*back injury*" and does not make any express reference to a 'broken back'.

It is not in dispute however, that the first Complainant was present for the inspection of the property on 12 March 2018 with the Provider's loss adjustor. It does not appear to be disputed that the first Complainant omitted to make any reference to having suffered a broken back and that the first reference to this came on 30 March 2018. The first Complainant conceded in a phone call on 4 April 2018 that he was not wearing a back brace

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on 12 March 2018 in the course of the inspection. Quite apart from this, it appears clear that the first Complainant was fully capable of interacting with the Provider's loss adjustor regarding the claim, on 12 March 2018 (and in the course of multiple phone calls on different dates) and was not inhibited in that regard by any back injury.

In the circumstances I am not satisfied that any injury which the first Complainant may have had to his back was of such a nature as to render him particularly vulnerable because of any physical infirmity or incapacity. On the evidence available to me, it would seem that the first Complainant was entirely capable of engaging with the Provider's loss adjustor. Additionally, it is clear that the Provider was not informed of any alleged vulnerability until late in the process. I might note, in any event, that the first Complainant had the benefit of advice from his own professional loss assessor (the Complainants' representative). I might also note that, even if it had been appropriate to classify the Complainants (or either of them) as vulnerable customers, I am not satisfied that the Complainants have established that the Provider engaged in any unfair practices as regards the Complainants, or that the Complainants were denied any reasonable arrangements and/or assistance.

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 am not in a position 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

30 October 2019

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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.