An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0006
Sector:	Insurance
Product / Service:	Household Buildings
Conduct(s) complained of:	Claim handling delays or issues Disagreement regarding Settlement amount offered
Outcome:	Partially Upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants are the owners of an investment property which suffered fire damage in **May 2011** due to cars parked on and around the property being set alight. The Complainants made a claim under their insurance policy in respect of the damage caused by the fire. To handle their claim, the Complainants engaged the services of the Provider, an insurance claims handler against which this complaint is made. The Complainants are dissatisfied with the level of service they received from the Provider.

The Complainants' Case

The Complainants state that they are not happy with the manner in which the Provider dealt with their claim. The Complainants state that when they raised their concerns with the Provider they were not taken seriously. They state that they are still trying to resolve their claim. The Complainants submit that if the Provider did its job *"… we would not still be trying to sort out and re-instate our property 5 years later."* The Complainants further ask *"… why are we at a loss and our property still not re-instated. [The Complainants' insurance company] acknowledged that claim was not dealt with properly and are still trying to resolve it."*

The Complainants state that they want compensation from the Provider for *"… not doing the job they were paid to do * The money we lost due to being unable to work as we had to sort out the property ourselves (loss earnings) * Stress + continued inconvenience [the Provider] has put us through."*

The Complainants have made extensive submissions in support of their complaint and also in response to the Provider's submissions. Owing to the length of these submissions, I have set out the main aspects of the Complainants' submission below.

The Complainants state that there was a fire at the property in **May 2011**. Following the fire, the Complainants contacted their insurance broker to allow their broker to notify their insurer of the fire. The Complainants state that their insurer recommended the Provider to deal with the claim on their behalf. The Complainants state that they contacted the Provider and were subsequently advised that one of its personnel would be handling their claim. The Complainants state that the Provider inspected the property on **25 May 2011** in order to advise as to the extent of the works required to re-instate the property and prepare a claim summary. The Complainants state they were advised that *"… the whole house internally would need to be cleaned and then painted [and] the external of the premises would need to be painted."* The Complainants state they were advised that the landscaping and driveway would be covered by the policy. The Complainants were also advised that the insurer would need to attend the property to assess the damage done to the garage roof. The Complainants state they were advised that the rental income on the property from the date of the fire until the property was fully re-instated would also be covered by the policy, and were again advised of this on **7 June 2011**. The Complainants state they were also advised that they would be reimbursed for the temporary repairs they carried out to the property. They state that during the Provider's visit, the Provider's claims handler *"… was going around noting the damage to the property and also the contents that were damaged in a notebook. To date we have never seen this list."*

The Complainants state that they discussed fees with the Provider's claims handler before they decided to engage the Provider to manage their claim. The Complainants state: *"We agreed a fee 8% (of the total claim) to discharge [the Provider's] professional fees, [the claims handler] said that the apportionment of the fees breakdown was – 2% payable by us and the further 6% would be paid by [the insurer] as [the Provider] would be supervising the work."* The Complainants state that they also discussed with the claims handler that the Provider was not to submit their claim to the insurer until they had reviewed what was being submitted. The Complainants states that *"[t]his was not done as we heard nothing from [the claims hander] until we received an e-mail outlining our offers …"*

The Complainants state that they were advised by the Provider that the insurer would not be able to attend the property until the following week. In the meantime, the Complainants decided to try to clean the property due to the level of smoke and soot contamination caused by the fire. The Complainants state that the insurer's loss adjuster attended the property on **1 June 2011** and carried out an inspection. The Complainants were advised that the insurer's builder would assess the damage to the garage roof and a further inspection would be carried out to the property by a restoration company. The builders together with the Provider attended the property on **7 June 2011** to assess the damage. The Complainants state they were advised that the whole garage roof would need to be replaced and refer to the scope of works in this regard. The restoration company also attended the property on the same day with the Provider present.

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The Complainants state that the First Complainant received a call from the Provider on **13 June 2011** to enquire as to whether the First Complainant had received an email outlining the two claim options. The First Complainant states that he confirmed seeing the email but pointed out to the Provider that a claim was not to be submitted to the insurer without it first being discussed with the Complainants to ensure that nothing had been omitted. The First Complainant states that the Provider then advised him that the claim had been agreed and that one of the claim options had to be chosen. The First Complainant states that he advised the Provider that he was not happy that the claim was agreed as this was contrary to the Complainants' instructions. The Complainants then set out a number of issues surrounding their claim that were brought to the Provider's attention by the First Complainant during this conversation. In particular, the Complainants state that the Provider advised that they were not covered in respect of rent as the property was not deemed uninhabitable. The Complainants state that this is in direct contradiction of a report prepared by the insurer which states the property was uninhabitable. The Complainants state they requested that the Provider get it in writing from the insurer that the property was uninhabitable. Within 10 minutes, the Complainants state the Provider contacted them to inform them that the insurer would not state this in writing. The Complainants point out, referring to an email between the Provider and the insurer dated **13 June 2011**, that the Provider did in fact have it in writing that the property was uninhabitable. The Complainants also state that the Provider told them that they were not covered in respect of the landscaping. The Complainants further state that the Provider made no attempt to get an independent builder's quote and that they had to organise an independent landscaping quote themselves.

At this stage of the process, the Complainants state they were very unhappy with the way their claim was being handled and felt they were being misinformed and misled. The Complainants received quotes from their independent builder and landscaper and they also obtained advice from an independent assessor. The Complainants state that their assessor reviewed the options presented by the Provider and *"[h]e could not believe the way [the Provider was] handling the claim or the way we were being treated by them."*

The Complainants state that on **8 July 2011** they phoned the Provider to discuss the manner in which their claim was being handled. They requested that another individual from the Provider attend the property to see the condition it was in. The Complainants state that the Provider refused to do so and they found this person to be *"rude and belligerent."* The Complainants state that the Provider attended to property on **15 July 2011** and that they found this claims handler to be *"unapproachable, evasive and rude"* and *"… he would not give straight answers …"* The Complainants detail the issues discussed with the Provider at this meeting in their submissions.

The Complainants state that the Provider did not furnish them with a breakdown of the offers made by the insurer or provide clarity in respect of certain amounts and what these related to. Referring to a phone call between the Provider and the First Complainant following an email dated **3 August 2011**, the Complainants state that having requested a breakdown of the figures the First Complainant was told *"to do the maths".*

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The Complainants state that during this conversation the builder's quote was also queried as the new quote was over €2,000 less that the original quote. The Complainants submit that the Provider stated that in the original quote the builder quoted for something twice.

In a further telephone conversation with the Provider on **3 August 2011**, the Complainants state they were informed that the insurer would not improve its previous offer. The Complainants were unhappy with the current offer and asked if they could accept the first option/offer and do the work themselves. The Complainants state that the Provider advised that the alternative offer had been retracted and was no longer available. Referring to an email dated **20 July 2011**, between the insurer and the Provider, the Complainants state that they still had the option to carry out the works themselves. The Complainants state that the Provider advised that the insurer was *"fed up that this claim had been going on so long and that [the insurer] was losing patience …"* The Complainants state that the Provider's claims handler *"… said it was 'no skin off my nose' whether we took the offer or not, but my advice to you is to take the offer (during these conversations [the claims handler] was shouting, rude, aggressive, argumentative and unprofessional)."* Further to this, the Complainants state that the claims handler *"… said that '[the insurer] don't care about you', and that if we decided to go legal this could go on for a year and during this time you will not be paid for loss of rent."* The Complainants submit that in light of these matters and other matters set out in their submissions *"… we felt we had no choice and, so under extreme duress it was arranged [the insurer's] builders to start works."*

The Complainants contacted their insurance broker and advised it that they were not happy with the way the Provider handled their claim. The Complainants state that the broker requested their files from the Provider and these were supplied on **6 January 2012** without photographs. It was not until **15 March 2012** that the Provider confirmed that it had given the Complainants their full file. The Complainants have reviewed the files provided to them and have identified a number of issues which predominantly relate to re-instatement work that was not carried out.

The Complainants submit that the insurer *"… lost control of the claim from the beginning. [The insurer] only sent a representative to the property after a lengthy delay. [The Provider] did not fight enough on our behalf, or represent us in a professional manner. [The Provider] just agreed (without discussing with us) the first offer that [the insurer] sent to them."*

In a further submission, the Complainants state that they never saw or agreed a scope of works despite asking for it on numerous occasions. In respect of the options forwarded to them by the Provider, the Complainants state:

> *"• The first option was [the insurer's] builder … carrying out the repairs, we were not happy with this as he wasn't doing all the work required to reinstate the house.*
>
> • *The second option the amount for building repairs was obviously not enough. We had sourced alternative quotes for what it would cost to get the job done properly. The 50% retention was also excessive."*

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The Provider's Case

The Provider states that it was appointed by the Complainants on the recommendation of their insurance broker to act on their behalf in relation to the fire damage to their rental property which occurred in **May 2011** as a result of a car being set alight in the driveway to the property. The Provider states that its sole function was *"… to compile, submit and negotiate a settlement under the terms of their insurance contract."* The Provider submits that this was set out in the terms of business document sent to the Complainants with its letter of engagement dated **25 May 2011**.

The Provider states that in the height of the recession, a number of insurance companies were opting to re-instate properties to try and contain costs. The Provider states that the insurer had the power to do this under the terms of the Complainants' policy. Once the insurer did this, the Provider submits that *"… we had very little power to negotiate, as Insurers were in control of the builder, and any shortcomings with the scope of work carried out thereafter was outside our control."*

The Provider states that it initially called to assess the damage to the Complainants' property on **25 May 2011**. At this assessment, the Provider took an inventory and photographs of the loss and damage and documented a scope of repairs. The Provider states that it met with the insurer's claims adjuster to agree the scope of damage and subsequently submitted a statement of claim.

The Provider states that the insurer *"… in accordance with the terms of the policy wording and with the complainant's agreement, opted to reinstate the damage by using the Insurer's preferred contractor to carry out the repairs …"* The Provider states that the sum of €3,000 was paid directly to the Complainants to indemnify them for contents, cleaning and two months' loss of rent which was deemed to be the period necessary to complete the works. The settlement offer also included the insurer agreeing to pay the Provider's fee in the sum of €1,600. The alternative offer was a cash settlement for the amount the insurer's contractor was prepared to do the work for and not pay the Provider's fee, with a retention of 50% of the value of the work and the balance to be payable on production of VAT invoices on the completion of the repairs. The Provider states that these options were initially communicated to the Complainants on **13 June 2011**. The Provider states that the First Complainant confirmed by telephone on **11 August 2011** that the Complainants were *"… reluctantly agreeable to accept the reinstatement option …"*

The Provider states that it received a telephone call from the Complainants' insurance broker on **3 January 2012** requesting a copy of their file. The Provider states that it was unclear as to what the Complainants were unhappy with and why they were requesting a copy of the file. A reply was then issued enclosing a copy of the Complainants' file on **5 January 2012**. The Provider received an email from the broker on **7 January 2012** indicating that the Complainants thought the Provider had not sent the full file and that it may be trying to hide something. The Provider states that it replied the same day to ascertain the Complainants' query and also offered to assist the Complainants in taking the matter up with the insurer if there were valid reasons for reviewing the claim/work reviewed.

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The Provider states that it was then asked on **13 January 2011**, for a copy of photographs of the damage. The Provider advises that it was somewhat concerned that the photographs sent to this Office as part of the complaint file were copies of copies and would appear darker making the fire/smoke damage appear worse than it was.

On **23 May 2012**, the Provider received an email attaching a list of items that the Complainants passed to their broker on **20 May 2012** *"'wondering if you could pass this list onto [the Provider] and get his comments on the items listed?'."* The Provider states that it replied on **5 June 2012**. The Provider states that it offered to meet with the Complainants on two separate occasions in **2012** to try and find out what issues the Complainants were raising with their broker and to assist if possible but this offer was not taken up.

A written complaint was received by the Provider on **24 April 2013**. The Provider states that it spoke with the insurer and it advised that additional works were carried out at the Complainants' request – the garage was converted into a living room and a door was opened though the garage into the hall. The Provider states that a full and formal response was made on **30 May 2013** advising that any shortcomings complained of were the responsibility of the insurer and their appointed contractor. The Provider states that it was not contacted again by the Complainants.

The Provider states that following receipt of a formal notification of the complaint to this Office on **23 November 2016**, it tried to contact the building contractor to obtain a formal statement but this company had gone out of business. The Provider also tried to contact the individual it had dealt with from the insurer but he had left the company. The Provider states that it is its understanding that the insurer engaged a third party *"… to handle a complaint against them in 2013 and that [the insurer] have in the intervening period made a further payment in compensation for any shortcomings in the work carried out by their contractor."*

The Provider submits that it carried out its role as set out in the letter of engagement and as per its terms of business. The Provider does not believe it failed to discharge its duties and it was *"… never instructed by [the insurer] or by the complainant[s], to supervise repairs; it was never discussed with either party, and we were never engaged to carry out this function."* The Provider states that it was never appointed to supervise the works to the property and its role ceased when the Complainants agreed to allow the building contractor to carry out the repair works. The Provider states that *"[s]ince the complaint was made we made contact with [the insurer] and met with [the insurer's third party complaints handler] … [The insurer] paid out a further €16,480.00 to the complainant[s] with an additional offer to re-do the single storey roof repair again. We note that this includes an item of €3,500.00 for landscaping works to replace trees and shrubs in the front garden, which [the building contractor] agreed to do as part of the repair work. …"*

The Provider further states that it has no control over what the insurer noted in its file and if the Complainants have suffered a loss then it was due to the negligence of the insurer's building contractor and not the fault of the Provider. The Provider submits that the outcome for the Complainants after the Provider discharged its functions was unsatisfactory *"… but they are trying to visit this upon [the Provider] who are not the correct party …"*

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In its submissions to this Office, the Provider has identified certain aspects of the Complainants' initial submissions and sought to address these. In essence, the Provider states that when it first met with the Complainants to assess the extent of the repair works, its claims handler was offering his opinion as to the extent of the work requested and that the policy document would need to be checked to determine the level of cover offered by the Complainants' policy. The Provider further states that the conversation in respect of the manner in which fees were to be apportioned did not take place and neither did the Complainants instruct it not to submit a claim to the insurer without the Complainants reviewing it first.

The Complaint for Adjudication

The complaint is that the Provider failed to perform the services agreed to be carried out in respect of the Complainants' insurance claim.

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.

A Preliminary Decision was issued to the parties on 13 November 2019, outlining my preliminary determination 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 issue of my Preliminary Decision the Complainants made a further submission under cover of their letter to this Office dated 3 December 2019, a copy of which was transmitted to the Provider for its consideration.

The Provider has not made any further submission.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

I stated in my Preliminary Decision that "*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.*"

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In the Complainants' post Preliminary Decision submission dated 3 December 2019, they submitted: "*You state that you have clearly considered the evidence and submissions and are satisfied that the submissions and evidence furnished do not disclose a conflict of fact. Your interpretation of the evidence is flawed as there is a conflict of facts throughout your preliminary decision*." The Complainants have quoted part of a sentence from my Preliminary Decision. Whether deliberately or in error, they have omitted the second and key section of the sentence they are quoting from. What I actually stated, as repeated above, was: "*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 did not state that there were no conflicts of fact, as indeed there are. What I stated was that I did not believe an Oral Hearing would assist in the resolution of these conflicts of fact.

Notwithstanding the Complainants' request for an Oral Hearing, I remain 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.

Having considered the Complainants' additional submission and all of the submissions and evidence furnished to this Office, I set out below my final determination.

The Complainants are dissatisfied with the level of service they received from the Provider in terms of its handling of their insurance claim. There are a number of aspects to this complaint. First, the Complainants submit that the Provider was retained not only to prepare, negotiate and settle their claim but also to supervise the re-instatement works to their property. Second, the Complainants state that the Provider did not do an appropriate job in negotiating and settling their claim, misrepresented and misinformed them, and did not follow their explicit instructions. Third, the Complainants state that the Provider spoke to them in an unprofessional manner.

The First Aspect of the Complaint

Letter of Engagement

The Provider has supplied a letter of engagement in evidence dated **25 May 2011** and addressed to the Complainants. The letter states as follows:

> *"We write to confirm our instructions to act on your behalf in the preparation, negotiating and settlement of your claim in the above matter and enclose herewith our standard Terms & Conditions of Business for your attention.*
>
> *Our fees will be 8% of the value of settlement. We require payment of our fees when you receive your initial settlement cheque from Insurers.*
>
> *…*

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<u>We enclose herewith a Mandate for your signature and return to [the Provider] at your first convenience.</u>

We will keep you informed of all developments in the claim but in the meantime if you have any queries please do not hesitate to contact us. …"

Terms of Business

The Provider's terms of business state:

"The terms of business set out below provides the basis on which [the Provider] will provide Loss Assessing services to you.

We are appointed by you to act on your behalf in relation to assisting you with your claim, we recommend you seek competitive quotations for the necessary work so that you will know what the actual cost needed to effect re-instatement will be.

1. *[The Provider] will assess/compile, prepare, submit and negotiate your insurance claim with your Insurer or their appointed loss adjuster. We will not agree settlement of your claim without your consent. We will use our best endeavours to represent your interests at all times and act on your behalf as though we were the insured party.*

2. *…*

3. *…*

4. *[The Provider] is authorised to offer broad-based advice in relation to your policy cover, endorsements, exceptions and exclusions. We will use our best endeavours to highlight all matters that may be in your best interests to guarantee a successful outcome. Any settlement offer however, is subject to the terms and conditions of the insurance policy and the adequacy of the sums insured, etc.*

5. *[The Provider] will seek to represent details of your loss or damage in a fair, reasonable and professional manner, in order to maximise the settlement outcome. …"*

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Correspondence and Further Submissions

In its Final Response letter dated **30 May 2013**, the Provider states:

> *"… Firstly I would like to point out that we were never engaged to supervise the repair works our function was to agree a scope of works as Insurers were putting their own network builder in to carry out repairs. [The Provider's claims handler] in his email to you date 13th June gave you the two options showing the settlement amount if you were to carry out the work yourself using your own Contractor versus using [the insurer's building contractor]. We do not have any control over how [the insurer] allocate payment but it was an arrangement that was entered into with [the insurer] if their builder was engaged and it would appear to have made sense from an economical perspective as our fee was being covered by them and not you as would normally be the case."*

Enclosed with the Final Response letter was a list of items queried by the Complainants in which the Provider had inserted its comments.

In an email from the insurer's third party complaints handler to the Provider dated **6 March 2017**, the complaints handler states:

> *"As outlined, we were instructed by our Principals to deal with an issue which had arisen with the contractor appointed by their staff member to undertake repairs to the subject property.*
>
> *…*
>
> *From our meeting [with] the Policyholder we were informed there was work that the contractor was meant to carry out and had been paid for, which was not in fact completed. …"*

In an email to this Office dated **5 April 2017**, the Second Complainant states:

> *"… We feel that this claim was not handled properly from the beginning. One of the main reason (sic) why the claim did not seem to be handled properly was that, after we agreed the fees structure with [the Provider] where we were only to pay 2% and the remaining 6% was to be paid by [the insurer] (the insurance company) for supervision. It then appears that when [the Provider] and [the insurer] discussed the claim they came up with 2 options where we were to choose one of them, it was quite evident that these options were to benefit [the insurer] and [the Provider] as they were pushing for [the insurer's] builder to do the works. [The insurer] gets to use his builder (for his own reasons) and [the Provider] gets his fees for supervision only if [the insurer's] builder carries out the works. If we were to carry out the works ourselves [the Provider] knew he would only be getting paid 2% by us and nothing from [the insurer]."*

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In an email written by the insurer's complaints handler dated **18 January 2018**, it states in respect of the Provider's fees:

> *"3/The term 'Professional Fees' are defined in the Property Owners Policy. The fees that [the insurer] paid of 1600euro based on the final report from [the insurer's loss adjuster] was for Professional Fees in the Supervision of the Reinstatement."*

In an email dated **24 January 2018** between the insurer and its claims handler, the claims handler states:

> *"In relation to the €1,600 paid to [the Provider] by [the insurer] prior to my involvement, I understand form [the insurer] this was for professional fees in relation to supervision of reinstatement of repairs."*

In the course of their submissions dated **1 February 2018**, the Complainants refer to the definition of professional fees in the insurer's property owners' booklet.

This definition states as follows:

> *"… means architects', surveyors', consulting engineers' and legal fees necessarily and reasonably incurred with the Insurers' consent in the reinstatement of the Property Insured directly consequent upon its Damage by an event insured hereby* ***but not for the preparation of any claim****. …"* [My emphasis]

In the Complainants' submission dated **1 February 2018**, they state that the Provider was claiming professional fees of 10% in the claim summary submitted to the insurer and not the agreed 6%. The Complainants state that these professional fees were for the supervision of the reinstatement works to the property.

In a submission to this Office dated **31 January 2019**, the Provider states that the 10% professional fee is not for its services as contracts of insurance do not cover claim preparation costs. This fee is for the separate engagement of supervising surveyors, architects, engineers and the like.

The Provider further submits that it *"… would never agree a fee of 2% unless the claim exceeded €1,000,000.00 in value. As set out in our terms of engagement letter the fee agreed was 8% of the settlement amount this would never have been split as suggested by the Complainants."*

In a submission to this Office dated **14 February 2019**, the Complainants state that the Provider *"… have confirmed they made an arrangement for professional fees of 10%, which was agreed between [the Provider] and [the insurer] if [the insurer's] contractor carried out the works. This arrangement ensured [the Provider] received maximum fees of 10% instead of 2% agreed between [the Provider] and [the First Complainant]."*

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In a submission to this Office dated **1 March 2019**, the Complainants refer to a definition of professional fees contained in their policy booklet as: *"Definition of Professional Fee as per policy book is – Supervision for the reinstatement of the property."*

Analysis

In determining the first aspect of the complaint it is necessary to ascertain the terms upon which the Provider was engaged by the Complainants. It is the Provider's position that it sent a letter of engagement to the Complainants dated **25 May 2011** enclosing its terms of business and mandate for the Complainants to sign. The basis of the agreement contained in the letter of engagement and the terms of business is that the Provider was being retained to prepare, negotiate and settle the Complainants' insurance claim and that its fee for these services would be 8% of the settlement amount. In addition to providing these services, it is the Complainants' position that the Provider also agreed to supervise the re-instatement works.

The Complainants have made four main points in support of their position. First, it was verbally agreed between the parties when they met at the property on **25 May 2011** that the Provider would supervise the re-instatement works. Second, the claim summary submitted by the Provider lists *Professional Fees* as 10%. Third, the definition of *Professional Fee* in the Complainants' policy includes supervision of reinstatement works. Fourth, there is correspondence between the insurer and third parties referring to supervision on the part of the Provider.

Dealing with the first point, I accept that the Complainants agreed a fee of 8% with the Provider. This fee is consistent with the fee contained in the letter of engagement and the type of service being offered in that letter. However, according to the Complainants, this fee was to be apportioned between the Complainants and the insurer.

In their submissions dated **1 March 2019**, the Complainants state that *"… there was a third party present for the discussions …"* that took place in respect of the Provider's fees. At the time I issued my Preliminary Decision, this third party had not been identified and the Complainants had not furnished any statements prepared by this person.

The Complainants have submitted in their post Preliminary Decision submission of 3 December 2019, "*we have <u>never</u> been asked to provide details from this individual, however we have attached a signed statement from them detailing what they witnessed*." In this regard I would point out that it is a matter for the Complainants themselves to submit any supporting documentation which they consider to be relevant to the investigation of the complaint. It is not the role of this Office as an impartial adjudicator of complaints, to seek out certain particulars of evidence from the Complainants.

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The Complainants have now submitted a statement signed on 27 November 2019 by a named third party, which details as follows;

> *"I [REDACTED] confirm that I was at the property [REDACTED] on the day of _____ _____25th May 2011_____. I was present for and witnessed the discussion between [the First Complainant] and [the Provider's representative] regarding the payment of fees. And how it was to be divided. [The Provider's representative] said that their standard fees were 8% of the claim amount. [The Provider's representative] suggested that to keep [the First Complainant's] cost down that he would only pay 2% and [the Provider] would then submit to the Insurance company for supervision to cover the remaining 6%."*

The statement provided supports the Complainants' position that it was agreed between the parties that the Provider's fee would be apportioned. Having considered the statement submitted, I note that it was prepared some eight years and six months after the discussion in question took place in May 2011 and cannot reasonably be considered to constitute contemporaneous evidence of that conversation. In any event, assuming that the Provider's representative and the First Complainant did agree during this discussion that the Provider's fee would be apportioned between the Complainants and the insurer, any such verbal agreement was not binding on the parties in circumstances where it proposed to bind a third party, the insurer, who had not yet been made aware of or agreed to the proposal regarding the apportionment of the Provider's fee.

In terms of the second and third points, the submissions advanced by the Complainants suggest that they have misunderstood what *Professional Fees* in the claim summary actually refer to. First, the Provider's fee was not incorporated into the claim summary. It was a separate and distinct fee and calculated on the basis of the settlement amount. I am satisfied that the basis of calculation was clear from the correspondence exchanged between the parties during the assessment of the claim. Second, it is important to note that in the context of the contractual relationship between the Complainants and the Provider and the services provided pursuant to that contract that this relationship was not governed by definitions contained in the Complainants' insurance policy. These definitions are not relevant to determining the type of the services to be provided by the Provider. Furthermore, the Complainants have not made any arguments to the effect that the definitions contained in their policy were incorporated into their contract with the Provider. While the Complainants have relied on the definitions contained in the policy document to inform their interpretation of their agreement with the Provider, the definition of *Professional Fee* which I have referred to above, specifically excludes fees relating to the preparation of a claim.

The Complainants also place reliance on correspondence from the insurer's third party claims handler to the insurer. I do not consider the views expressed by third parties as to their understanding of the agreement are relevant in determining what was agreed between the Complainants and the Provider.

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It is important to note that the parties to the agreement were the Complainants and the Provider. While the insurer was involved in the assessment and settlement of the claim, the insurer was not a party to this agreement. In any event, there is no correspondence in the period immediately following the settlement of the claim and during which the works took place which suggest that the Provider was to supervise the re-instatement works and neither is there any evidence to demonstrate that the insurer required the Provider to supervise the various works.

The Complainants deny having received the Provider's letter of engagement and accompanying documents. I note that the Provider has not provided this Office with a copy of the document signed by the Complainants and neither has the Provider submitted any correspondence or offered any evidence to show that a signed mandate was sought or received from the Complainants. In my Preliminary Decision I did not accept that the Complainants signed and returned the mandate; however, as the letter is correctly addressed to the Complainants, I accepted it was likely that the letter was sent by the Provider.

The Complainants submit in their post Preliminary Decision submission of 3 December 2019: *"… If this letter was in fact sent/posted – Where is [the Provider's] correspondence following this up if they did actually send it? The Insurer would also have requested and required a copy of this document for their records (this is common practice for data protection). Why was this letter not followed up? Why is it not mentioned in any subsequent email correspondence?" Also it needs to be considered when we asked for the full files from [the Provider] this letter was* ***not*** *enclosed, in fact it was only brought to light after mediation. [The Provider's] convenient "finding" of this letter is questionable at the very least, and rather convenient for them, however the acceptance by the FSOB that this letter was posted is quite disturbing."*

In circumstances where the Complainant disputes receipt of the letter of engagement and accompanying documents in May 2011 and the Provider does not hold a copy of the signed mandate which was purportedly sent to the Complainants, I am proceeding on the basis that the signed mandate was not sought or received from the Complainants. I remain of the view that it is likely, on the balance of probability that the letter of engagement was sent by the Provider. In this regard I am mindful of the fact that the Complainants met with the Provider's representative for the first time on 25 May 2011, being the same date that the letter of engagement and accompanying documents purportedly issued to the Complainants. As detailed above, the Complainants' submission that a fee of "*8% of the claim amount*" was agreed during a discussion with the Provider's representative on that date is consistent with the letter of engagement which details that the Provider's fees will be *"8% of the value of settlement*".

With regard to the Complainants' submission that the Provider did not furnish a copy of the letter of engagement at the time the Complainants requested a copy of the full file in January 2012. I note that the Provider's email to the insurance broker dated 5 January 2012 detailed that in response to this request it had provided "*a copy of the relevant parts of our file in relation to the above*".

/Cont'd…

The Provider's email to the insurance broker dated 9 January 2012 further detailed that *"any other documents on our file are hand-written notes, a copy of the policy schedule from yourselves, and letters to the insured. There is nothing else relevant or otherwise apart from what was already sent to you and indeed, we are not obliged to release any part of our file, particularly if it is going to be used against us."* This would suggest to me that in responding to the Complainants' request for a copy of their file in 2012, the Provider did not include copies of letters already issued to the Complainants.

The Complainants also state in their post Preliminary Decision submission of 3 December 2019 that "*we do not and never have had a contract implied or otherwise with [the Provider]. For a contract to be recognized under law we would have had to sign and return their mandate/letter of agreement … due to the fact that we neither received or signed the mandate or discharged [the Provider's] fees, effectively no contract exists*". I do not accept that in order for a contractual relationship to exist between the parties that there was any mandatory requirement on the Provider's part to obtain the signed mandate from the Complainants. Notwithstanding whether the Provider's initial letter of engagement and accompanying documents was issued to the Complainants or not, it is clear from the supporting correspondence and documentation supplied in evidence that the Provider was instructed by the Complainants to act on their behalf in relation to the insurance claim in exchange for a fee. What is in dispute between the parties is the Provider's alleged failure to carry out the services that were agreed upon in relation to the insurance claim.

Taking these matters into consideration and the correspondence and documentation outlined above, I do not accept that the Provider was retained to supervise the re-instatement works to the Complainants' property. Therefore, having come to this conclusion, I accept that the Provider's contractual obligations in terms of the service it was retained to provide to the Complainants ended on the settlement of their claim during **August 2011**.

In light of this, I do not accept that the Provider was responsible for supervising the manner in which the re-instatements works were carried out.

The Second Aspect of the Complaint

General Insuring Clause

The Provider has provided an extract from the Complainants' insurance policy relating to the payment of claims under the policy:

> *"… the Insurers hereby bound shall by payment, or at their option by reinstatement or repair, indemnify the Insured to the extent hereafter described in respect of loss, destruction or damage, accident or Injury occurring during the Period of Insurance subject to the limits, terms, conditions and exclusions contained herein or endorsed thereon."*

/Cont'd…

Settlement of the Complainants' Claim

In an email dated **1 June 2011** from the insurer to the damage restoration company, the insurer requests a survey and report on the property. This email states in respect of the Provider that:

> *"… The loss assessor, [the Provider], is also seeking complete decorative finishes throughout the property although in my view this is not warranted. In addition the property is in a poor state of repair with many of the rooms not decorated, damaged or defaced."*

This email suggests that the Provider was trying to get the insurer to indemnify the Complainants to a high level in respect of the decorative finishes in the property. I note that the Complainants have made a number of handwritten comments in respect of certain aspects of this email however, none of these relate to the conduct of the Provider.

By email dated **7 June 2011**, the Provider sent a claim summary to the insurer. The Complainants' claim is summarised on the first page of the claim summary as follows:

> *"Summary*
>
> | | | |
> |---|---|---|
> | *Demolition and Preparation* | *5* | *12,351.00* |
> | *Reinstatement* | *10* | *17,666.00* |
> | *Subtotal* | *11* | *30,017.00* |
> | *Preliminaries and Insurance @ 10%* | *12* | *3,001.70* |
> | *Subtotal* | *13* | *33,018.70* |
> | *Professional Fees @ 10%* | *14* | *3,301.87"* |

The insurer received a report from the restoration company on **10 June 2011**. While this report does not categorise the property as uninhabitable, it recommends *light decontamination* for the inside of the house. The report further states:

> *"As it was requested, no provision has been made for decontamination of any of the contents, however, we included for the aqueous decontamination of the steps of the stairs."*

In an email to the Provider dated **13 June 2011**, the insurer states:

> *"Report herewith.*
>
> *As you will glean from the content smoke damage was largely confined to garage, utility & hall stairs and landing with only light levels of smoke contamination with soot deposits present. Accordingly, we remain of the view that the property has not been deemed uninhabitable and as such insured is not entitled to compensations for loss of rent.*

/Cont'd…

We have already outlined settlement proposals and perhaps you could confirm acceptance of same to conclude."

In response to this email, the Provider writes (on the same date) that:

"[The report] doesn't say anything about the house being habitable.
It does say there is soot contamination throughout the house though. If we can get one month €1,200.00 paid to the Insured I think we can get it closed. The tenants have not paid any rent to the landlord since the incident. As a part of the house is unusable i.e. the garage, the property is not in the same condition as when the tenants first rented the dwelling therefore they are entitled to refuse to pay rent."

The insurer then offered to *"… pay €600 on top of the €1,900 to get it over the line."*

The Provider was also in contact with the First Complainant on **13 June 2011**. In the first of two emails, the Provider outlines two settlement offers:

"Offer if Insurers builders carries out repairs:

[Restoration company] clean down €1,900 (paid directly to you)
[The Provider's] fee €1,600 (paid directly to [the Provider])

Offer if you were to carry out repairs:

Building repairs	*€14,755.00*
[Restoration company]	*€1,900.00*
Net	*€16,655.00*
Less retention of 50%	*€8,327.50*

Settlement now due €8,327.50
[Provider's] fee 8% -€1,332.40
…

Speaking with the builder … he advised he would be willing to do additional work for you incl landscaping and velux windows if you wanted covered in his price."

In the second email the Provider outlines the scope of works. Following this, by email dated **15 June 2011**, the First Complainant requested a copy of the report prepared by the restoration company. The First Complainant also queried whether he should get a quote for the re-instatement works from an independent builder. In response to this, by email of the same date, the Provider advises that it cannot get a copy of the report as the insurer appointed the restoration company. The Provider also advises that *"… a second quote would be fine but bear in mind they will only pay the same amount as their builder as he can carry out the works for that amount."*

/Cont'd…

The Provider acknowledges that it did in fact have this report at the time of the Complainants' request and this was an oversight on its behalf. The Provider further states that it had nothing to gain by not sharing this report and that it was subsequently given to the Complainants.

By way of facsimile message dated **15 July 2011**, the First Complainant forwarded to the Provider a builder's quote, a landscaping quote and list of contents.

In an email from the insurer to the Provider dated **20 July 2011**, the insurer states:

> *"[The building contractor] is in the process of preparing his written quotation – the figure quoted is €12,450 which includes all landscaping, replacement carpets (stairs & landing only) decoration of hall, stairs and landing, removal and renewal of roof, facia, guttering & garage door.*
>
> *Also included in this figure is attic to be insulated, external walls, driveway etc washed down with all electrics to be checked and certified along with Waste Disposal.*
>
> *On the assumption our contractor completes the work your prelims will be discharged on the basis of 10% with a further €2,500 to be paid to Insured.*
>
> *If however, insured insists on his own contractors, [the restoration company] will be retained to carry out decontamination and therefore insured will only be entitled to €600 loss of rent. In addition a 50% retention will apply until all works are completed and suitable invoices submitted with Vat numbers for revenue purposes. Your prelims will also require to be reviewed as a consequence."*

By email dated **26 July 2011**, the Provider wrote to the insurer in respect of the building contractor's quotation:

> *"Further to the breakdown & quotation from [the building contractor] in the amount of €12,450.00, could you please email me over your overall summary of final offer to review and revert back to the insured."*

The Provider wrote to the First Complainant by email dated **4 August 2011**, advising him of the final settlement proposal as follows:

> *"As requested, please find attached below the final settlement proposals from the loss adjuster.*
>
> 1. *Building: €12,450 (Paid to Insurance Builder)*
> 2. *Contents & Loss of Rent: €3,000 – net of €500.00 Policy Excess (Paid directly to you)*
> 3. *Assessors Fees: €1,600 (Paid directly to [the Provider] from Insurers)*

/Cont'd…

We have attached a copy of the Insurance Builders final quotation for the works. In addition to this, and as discussed, the following conditions will apply:

1. *This quotation allows cleaning to the driveway. If the cleaning cannot take up all the affected areas, the damaged area will be replaced.*

2. *This quotation allows for stripping the complete roof area, setting aside any undamaged titles for reuse if possible. Should this not be possible, the builder will supply and install new tiling throughout.*

3. *Should the cleaning to the external areas not be sufficient, decoration will be required and included."*

In response to a query raised during a telephone conversation on **3 August 2011**, the Provider sent a further email to the First Complainant on **4 August 2011** in respect of the duration of the works and the external decorative works on the property.

In an email dated **4 August 2011**, the insurer states:

"I have now settled this claim in the sum of €18,480.75 on the basis that [the insurer's builder] completes all works.

The initial amount sought under the Buildings claim was €41,488 with a further €5,000 sought for Contents and €3,600 in respect of Loss of Rent.

The total claim therefore submitted by [the Provider] was €50,008.80.

The building works as agreed with [the builder] inclusive of Vat amounts to €14,130.75 which includes stripping out and encapsulation and decontamination of walls and ceilings etc. This represents excellent value for money as you will note [the restoration company] had sought a figure of 5,974.15 for stripping out, decontamination and encapsulation only!! …"

The insurer prepared a *Final Report on Fire Damage Claim* dated **4 August 2011**. On the second page of this report it states:

"Claim details in the amount of €50,088.00 were submitted by [the Provider] in the form of a bill of quantities. The breakdown was as follows:-

Buildings: €41,488.00
Contents: €5,000.00
Loss of Rent: 3,600.00

/Cont'd…

In relation to the buildings claim the nature of the repairs including demolition and renewal of existing garage roof, ceiling and garage door, facia, soffits and down pipes, electrical installations, complete redecoration of main house, renewal of landscaping and appropriate repairs to all external block work and driveway.

Upon review of same ***we found substantial overstatement both in relation to claimed rates and the scope of the required works****. [The building contractor] subsequently produced an estimate in the sum of €14,130.75 inclusive of Vat for the reinstatement works which include all works recommended by [the damage restoration company] who had earlier quoted €5,974.17 for stripping out and decontamination works only.*

The contents claim was also grossly overstated *with the assessor looking to replace all carpet floor coverings, curtains, bed linen, beds, mattresses and various items of furniture.*

Whilst it is accepted that a number of pairs of curtains would require professional cleaning carpets and furnishings did not sustain significant damage to warrant replacement although the carpet in the hall, stairs and landing would need to be professionally cleaned, if not replaced.

Accordingly, ***following prolonged negotiations*** *this element of the claim was subsequently agreed albeit in the reduced amount of €600 net of €250 policy excess applicable therein.*

The buildings claim was the subject of prolonged discussions*, however****, following a number of heated discussions*** *it was agreed that our nominated contractor would complete all necessary works for the originally figure submitted on the basis that [the Provider] supervise al, (sic) works. This is our view represents an excellent result for Insurers given the initial figure sought and taking into account the costs report of [the damage restoration company].*

The property has been deemed uninhabitable and we have therefore agreed 2 months loss of rent at €1,200 per month in accordance with the existing tenancy agreement. …" [My emphasis]

The Provider wrote to the Complainants on **11 August 2011**, to confirm the settlement of their claim.

In an email from the Provider to the insurance broker dated **5 January 2012**, the Provider explains:

"You will note that our original scope of works proposed was not allowed in full and the insurers opted to re-instate based on their builders quote. The quote from [the restoration company] was deemed to be duplication of works that the builder was capable of doing as the smoke levels in the house were extremely light.

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The decoration to internal surfaces were not deemed to be damaged by the smoke and were disallowed (apart from the hall stairs and landing and utility room). Some areas of the house needed re-decoration due to deterioration caused by the tenants – this would not fall due for consideration although we did seek to try and get it included. …

You will also note that the loss adjuster was not prepared to allow any loss of rent initially, on the basis that he did not deem the house to be un-inhabitable. This was subsequently allowed at 2 months. If the builder took longer to complete the works we may be able to re-visit this aspect, however it there was alterations or improvements to the property this may be very difficult to achieve.

There was no replacement allowed to the insured's contents beyond cleaning, apart from the stairs and landing carpet which was included for in the builders quote. We did negotiate an allowance of €800 towards cleaning/replacement of contents. €300 was allowed towards temporary works."

Analysis

The Complainants are dissatisfied with the level of service received from the Provider in terms of the settlement of their claim. It is important to remember that when a claim is made under an insurance policy, generally speaking, policyholders are not indemnified in respect of every item claimed for. This is due to the terms and conditions contained in insurance policies. Therefore, when negotiating the Complainants' claim, the Provider was constrained by the terms and conditions of the Complainants' policy and the manner in which the insurer chose to indemnify the Complainants. The Complainants' policy permits the insurer to re-instate/repair in the event of a claim and part of the Complainants' frustrations appear to stem from the fact that the insurer chose to carry out re-instatement work to the property. I accept that the insurer's decision impacted on the Provider's ability to negotiate the Complainants' claim.

It is clear from the correspondence outlined above that there were competing interests between the Provider and the insurer. The Provider wanted to maximise the Complainants' claim while the insurer wanted to reduce the settlement value as much as possible.

This is a matter that the Provider has no control over – it cannot overrule the discretion of the insurer. The insurer noted in an email dated **1 June 2011** that the Provider was seeking *"… complete decorative finishes throughout the property …"* The Provider also submitted an extensive claim summary on the Complainants' behalf. This is not only clear from a review of the claim summary but also from the language of the insurer in its *Final Report on Fire Damage Claim* dated **4 August 2011** outlined above and the words I have emphasised. In an email dated **13 June 2011** the insurer expresses the view that the property was uninhabitable. The Provider questions this in a subsequent email and refers to the fact that the report prepared on **10 June 2011** does not make reference to whether or not the property was habitable.

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The Provider then states that not all of the property was usable and was not in the same condition as it originally was, and the tenants were not obliged to continue to pay rent. The insurer then offered to pay a further €600 in respect of the Complainants' claim. Therefore, I accept that the Provider endeavoured to negotiate and settle the Complainants' claim in a reasonable and competent manner. I do not accept the Complainants' post Preliminary Decision submission of 3 December 2019 that *"there is a clear Conflict of Interest. [The Provider] were not looking after our interests they were looking after their own".*

The Complainants state that it was expressly communicated to the Provider that the Complainants were to review the claim before it was submitted to the insurer to ensure nothing was left out. However, the Provider does not accept it was instructed to do so. While the Provider did not provide a copy of the claim summary to the Complainants for review prior to submitting it to the insurer, the Provider complied with paragraph 1 of the terms of business which states that the Provider would not settle a claim without the Complainants' consent. It appears likely that the Complainants did indicate to the Provider that they be provided with a copy of the claim summary before it was submitted to the insurer. Therefore, I accept that the Provider did not comply with the Complainants' instructions in this regard.

The Complainants advance the point that the Provider misled them and misinformed them as to what would be covered under the policy. I would expect the Complainants to have a reasonable degree of familiarity with the level of cover provided by their policy. Furthermore, having considered the submissions of both parties, I accept the explanation advanced by the Provider (as set out in the *Response Summary* section of its submissions dated **14 December 2017**) to the effect that the policy would have to be checked to determine the level of cover. Therefore, I do not accept that the Provider misled or misinformed the Complainants.

The Provider sent the First Complainant two settlement options on **13 June 2011**. The Complainants have expressed dissatisfaction at the 50% retention however, this is a matter beyond the Provider's control. Moreover, the choice of building contractor is not strictly a matter for the Provider, this again is a matter for the insurer. I note that the difference in the Provider's fees between option 1 and option 2 is €270. I also note that the Provider's fee did not reduce the settlement amount if option 1 was chosen but would have reduced the settlement amount if option 2 was chosen. Furthermore, the Provider also highlighted to the Complainants that should they choose option 1, the building contractor would agree to do some additional work. Therefore, I do not accept that the Provider stood to make any significant gain by the Complainants choosing option 1.

The Complainants indicated to the Provider that they wished to have their own contractors carry out the works (option 2). In a telephone conversation with the Provider on **3 August 2011**, the Provider was asked if it would be possible to accept the first option/offer and for the Complainants to do the reinstatement work themselves. The Complainants state that the Provider advised that the alternative offer had been retracted and was no longer available.

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In an email dated **20 July 2011**, between the insurer and the Provider, the insurer states that *"If however, insured insists on his own contractors …"* This suggests that the possibility of the Complainants using their own contractors may have been open to the Complainant even on **3 August 2011**. However, I accept that the Provider did not make the Complainants aware that this was still an option.

While the Complainants may have expressed to the Provider that they were unhappy with the settlement terms, they ultimately accepted option 1 in settlement of their claim. Therefore, having considered the evidence and submissions of both parties, I do not accept that the Complainants settled their claim under duress.

Therefore, taking the above matters into consideration, I partially uphold this aspect of the complaint.

Third Aspect of the Complaint

The Complainants have set out a number of instances where they assert that the Provider or its agents did not speak to them in a professional manner. The Provider denies this. These instances of unprofessional conduct appear to have been during telephone conversations between the Provider and the Complainants.

There are no recordings of these conversations. Therefore, I do not have an objective source of evidence in respect of this aspect of the complaint. I note that the emails sent by the Provider to the Complainants are drafted in a professional manner. In particular, the emails sent to the First Complainant outlining the settlement offers and subsequent emails. While I accept that the Complainants are unhappy with the manner in which they were spoken to during the telephone conversations with the Provider, I am unable to determine on the basis of the evidence presented in this complaint that the Provider spoke to the Complainants in an unprofessional manner. Therefore, I do not uphold this aspect of the complaint.

For the reasons outlined above, I partially uphold this complaint and direct that the Respondent Provider pay the sum of €1,000 to the Complainants.

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) (b) 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 Complainants in the sum of €1,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

/Cont'd…

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

22 January 2020

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.