An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0020
Sector:	Insurance
Product / Service:	Critical & Serious Illness
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant incepted a Term Life Insurance policy with the Provider on **15 July 2014**, which provided life cover in the amount of €207,780 and serious illness benefit up to €75,000 for a term of 20 years, for a monthly premium of €34.01 (including 1% Government Levy).

The Complainant's Case

The Complainant, a hairdresser, was certified as unfit to work since **27 April 2016** and submitted a specified illness claim to the Provider in **June 2016** under the 'Loss of Independence – permanent and irreversible' benefit, wherein she detailed her illness as

> *"Loss of Independence - Cervical Dystonia (constant spasms in my neck + shoulder). Power has been lost in my right arm, fibromyalgia, which leads to inflammation of all joins + neck"*.

Following its assessment, the Provider initially declined this claim by correspondence dated 21 September 2016 but on appeal, it admitted the claim and paid the Complainant the full €75,000 serious illness benefit on **7 March 2017**.

The Complainant is, however, dissatisfied with the way the Provider treated her throughout its claim assessment and appeal process and sets out her complaint, as follows:

> *"In June 2016, I began the process of making a claim to* [the Provider] *on my Serious Illness Policy under Loss of Independence. From the very beginning, I was told lies. I was also treated very badly by* [Provider] *staff.*
>
> *The level of additional medical information that my GP had to give and the correspondence he had to deal with from* [the Provider] *despite the medical evidence being there from the very outset.*
>
> *When* [the Provider] *told me by phone that my claim was refused they lied about my Doctor's report, stating that Loss of Independence was not mentioned, when clearly it was.* [The Provider] *also said at this point that they had spoken to my Neurologist, which they had not.*
>
> *Several times I was lied to over the phone and many times my calls were not returned, despite promises made.*
>
> *Crucial calls went missing when I requested recordings …*
>
> [The Provider's] *Chief Medical Officer deemed my condition permanent in Oct 2016. Yet I was subject to a visit from an Occupational Therapist from Bristol coming to visit my home and even after that I was subjected to surveillance on my home by Private Investigators. This was very frightening for a sick woman living with her daughter in a secluded place in the depths of winter. The claim was only settled in March 2017 after I went the legal route.*
>
> [The Provider] *also lied about* [its] *own Neurologist.*
>
> [The Provider] *insulted me by not believing me and put me through a very stressful ordeal. All of this made my condition worse"*.

In addition, in her email to this Office dated 16 January 2019, the Complainant submits, *inter alia*, as follows:

> *"If the Provider had its work done from day one I wouldn't have had to get stressed. To this day* [the Provider] *never got a neurologist to see me. It's the only thing I asked for. My neurologist is a great man and specialises in dystonia. It is the worst pain a human being has to endure and cripples a person. How dare they treat me like this and insult my conditions. Lies, lies and more lies is all I got from this company…My doctor from day one said I had loss of independence"*.

The Complainant submits that *"my medical condition was made much worse by the stress* [the Provider] *caused me by not acknowledging the seriousness of my condition a lot sooner"* and as a result, she is seeking from the Provider *"financial compensation…for aggravating my condition + making my life hell"*.

/Cont'd…

The Complainant says that the Provider provided her with a poor level of customer service throughout its assessment of her specified illness claim.

The Provider's Case

Provider records indicate that the Complainant incepted a Term Life Insurance policy with the Provider on **15 July 2014**, a policy designed to provide a lump sum payment during the policy term in the event of death or of a diagnosis of a specified illness, which are listed and defined in the policy terms and conditions that the Provider issued to her on 18 July 2014.

The Complainant contacted the Provider on **31 May 2016** to register a specified illness claim under the 'Loss of Independence – permanent and irreversible' benefit and completed a Specified Illness claim form on 3 June 2016, wherein she detailed her illness as

> *"Loss of Independence - Cervical Dystonia (constant spasms in my neck + shoulder). Power has been lost in my right arm, fibromyalgia, which leads to inflammation of all joins + neck"*.

In this regard, Section 4.7, 'Full Payment Specified Illness Conditions', of the applicable Term Life Insurance policy booklet provides, *inter alia*, as follows:

> *"We will make a full payment for specified illness cover if the life assured is diagnosed as having a specified illness*.
>
> *A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, the life assured has: …*
>
> - *been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below …*
>
> ***27. Loss of Independence – permanent and irreversible***
>
> *Plan definition:*
>
> *The permanent and irreversible loss of the ability to function independently which is defined as:*
>
> 1. *Permanent confinement to a wheelchair, or*
>
> 2. *being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or*
>
> 3. *being permanently unable to fulfil at least three of the following activities unassisted by another person:*

/Cont'd…

- *The ability to walk 100 metres unaided.*
- *The ability to get into and out of a motor vehicle unaided.*
- *The ability to put on, take off, secure and unfasten all necessary garments and any braces, artificial limbs or other surgical appliances.*
- *The ability to feed oneself once food and drink has been prepared and made available.*
- *The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained.*
- *The ability to climb stairs without the assistance of special aids*
- *The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.*

4. *or suffer from severe and permanent intellectual impairment which must,*

   a. *result from organic disease or trauma, and*

   b. *be measured by the use of recognized standardized tests and*

   c. *have deteriorated to the extent that requires the need for continual supervision and assistance of another person.*

The diagnosis must be confirmed to the satisfaction of the professional opinion of [the Provider's] *Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.*

In all of the above permanent means that, even with the best treatment available, the life assured is not expected to recover. The condition must continue for at least six months following diagnosis before the benefit can be claimed".

As part of its claim assessment, the Provider arranged for the Complainant to attend for an independent medical assessment with a Specialist in Occupational Medicine, Dr J. on 11 July 2016. In the resultant report dated 11 July 2016, Dr J. advised, *inter alia*, as follows:

"It is my opinion, based on assessment of this lady, that she is not currently medically fit for work. In my view she will currently experience difficulties dressing and washing herself as well as to manage her bowel and bladder functions with an adequate level of personal hygiene. In my view, [the Complainant] *will experience difficulties performing these activities as a result of cervical dystonia with torticollis and associated pain.*

/Cont'd…

> *It is also my opinion that walking a distance of 100 metres, getting in and out of a vehicle and to climb stairs would also aggravate her symptoms. However, although* [the Complainant] *is currently unable to fulfil the majority of the activities as listed in your referral form, I am unable to state at present that* [the Complainant] *has permanently lost the ability to fulfil three of the listed activities.* [The Complainant] *is aware of further treatment options, including a pain management programme, cognitive behavioural therapy, as well as surgical intervention. Although* [the Complainant] *is currently clearly unwell, I am, regretfully, unable to support this claim at present"*.

In addition, the Provider had requested on 15 June and received on 24 June 2016, a medical report from the Complainant's GP, Dr B., which noted some previous medical history that had not been disclosed to the Provider at the time the Complainant had applied for her policy. This matter required further investigation, as it could potentially have affected the Provider's decision to accept her application for cover from the outset. As a result, it was necessary for the Provider to return to Dr B. on three occasions - 25 July, 24 August and 8 September 2016 - in order to obtain the exact information it required. Whilst the Complainant states that her GP was dismayed at the level of correspondence received from the Provider, Dr B. did not contact the Provider himself to express any such concerns.

The Provider also had regard to correspondence from the Complainant's treating Consultant Neurologist, Dr P. dated 5 May 2016, wherein he advised, as follows:

> *"As you know* [the Complainant] *has cervical dystonia with torticollis. I note she has recently been seen by* [Dr F.]. *She does not feel the recent treatment has been helpful. It is difficult to judge, Botulinum toxin treatment is notoriously difficult and especially in the context of dystonia. Outcome measures are highly variable and patients have different views of the pros and cons of different aspects of it (pain, cosmetic result, etc.) I have pointed out that it may be too early to judge the effect. She feels she is in a lot of pain and has not been out of bed for weeks.*
> *She may be rushing to judgment on the treatment at too early a date"*.

Having fully considered the medical information before it, the Provider wrote to the Complainant on 21 September 2016, as follows:

> *"I regret to inform you that we are not in position to admit this claim. The claim was assessed against the definition of Loss of Independence – permanent and irreversible in your terms and conditions …*
>
> *I note from the medical evidence we have received from your GP* [Dr B.] *that your condition has not progressed to the extent to limit your physical capacity as outlined by the definition … Also your consultant* [Dr P.] *has confirmed that all your treatment options have not yet been explored. We also note that you are to attend a neurosurgeon to discuss other treatment options. Therefore, the permanency of your condition has not yet been established.*
>
> *It is for this reason we are unable to admit your claim at this time"*.

/Cont'd…

The Provider is satisfied that it declined the Complainant's specified illness claim based on the evidence provided by the appropriate medical professionals at that time, in accordance with her policy terms and conditions.

The Complainant telephoned the Provider on 23 September 2016 to appeal its decision and advise that she had recently attended her Consultant Neurologist Dr P. in August.

As a result, the Provider wrote to Dr P. on 1 October 2016 seeking an updated medical report. The Provider notes, however, that the ensuing report from Dr P. dated 10 October 2016 did not confirm the permanency of the Complainant's condition but instead advised that with further Botulinum toxin treatment, her condition, which *"is a symptomatic + disabling condition with variable response to treatment"*, could *"possibly"* improve.

In addition, as part of its appeal assessment, the Provider carried out surveillance of the Complainant for the purpose of claim verification from 29 January to 3 February 2017. The Provider also arranged, with the Complainant's consent, for an independent home assessment to be conducted by an independent Occupational Therapist on 30 January 2017. The fact that this Occupational Therapist travelled from the UK has no relevance to the Complainant's complaint and the costs for this visit were met by the Provider. The Occupational Therapist's report concluded that the Complainant should not be permanently disabled by her condition and as such, a number of appropriate rehabilitation treatments were suggested that might improve her disability. As these treatments however, were not easily accessible to the Complainant as she lived in a remote area and was unable to drive, the Provider made the decision to pay her claim, even though the 'Loss of Independence – permanent and irreversible' definition as set out in the policy terms and conditions was not met.

To clarify, the Provider fully assessed the Complainant's claim and despite the medical evidence from the relevant medical professionals not proving a permanent loss of independence as defined in the policy terms and conditions, the Provider admitted her claim on appeal and paid the Complainant the full €75,000 serious illness benefit on 7 March 2017.

The Provider notes that the Complainant is mistaken when she states that the Provider's Chief Medical Officer, *"deemed my condition permanent in Oct 2016"*. Instead, it was the opinion of the Chief Medical Officer in October 2016 that whilst her diagnosis of cervical dystonia was a permanent condition, it was not at that time disabling to the point where the Complainant satisfied the policy definition for 'Loss of Independence – permanent and irreversible', as cited above.

The Provider is satisfied that as demonstrated through its correspondence and telephone calls, the Complainant was kept very much informed about the claims process and the requirements needed to assess her claim. The Provider notes that it is not unusual within the industry for especially technical claims of this nature to take a number of months if not longer to assess and reach a decision. In addition, medical information came to light during the assessment of the claim that had not been disclosed by the Complainant to the Provider in her original application. This non-disclosure delayed the assessment of her claim, as the Provider had to refer back to her GP on a number of occasions.

/Cont'd…

The Provider received a significant number of telephone calls from the Complainant during the assessment of her claim. Whilst it is standard practice to record telephone calls to and from its Customer Service Team, the Complainant on a number of occasions requested to speak with members of the back office claims and senior/executive management team. In this regard, not all back office telephone lines have a recording facility. In addition, the Provider can on occasion suffer technical issues and this can cause some calls not to record. The Provider has furnished the Complainant with all telephone call recordings that it has in relation to this matter and having listened to these recordings, it is satisfied that its staff acted professionally and tried to assist and explain the status of her claim on each occasion.

The Provider notes, however, that when it wrote to the Complainant on **19 October 2016** enclosing a recording of these calls, the Provider in error included two telephone call recordings on the disc from two other Provider customers. By way of an apology for this, the Provider offered the Complainant a €250 customer service award. The Complainant rejected this offer and as an alternative requested that the Provider make a prepayment to her of her life cover benefit in the amount of €207,780, which the Provider was not agreeable to. In this regard, the Provider notes that its offer to the Complainant remains open for her to accept. For information purposes, the Provider handled the issuing of the other customers' phone calls to the Complainant, through its data protection process and both customers were duly contacted about what had happened.

Finally, the Provider is satisfied that at no time was the Complainant lied to about the status of her claim or the information that it had received, in order to assess it. It is very regrettable that the Complainant feels this way, especially in light of her claim having been paid, despite not meeting the permanency definition as set out under the 'Loss of Independence – permanent and irreversible' in the policy terms and conditions. In this regard, the Provider fully assessed the Complainant's claim, and despite the medical evidence from the relevant medical professionals not proving a permanent loss of independence as defined in the policy terms and conditions, the Provider nevertheless admitted the claim on appeal and paid the Complainant the full €75,000 serious illness benefit on 7 March 2017 and it is satisfied that it provided her with appropriate customer service throughout its claim assessment and appeal process.

The Complaint for Adjudication

The complaint is that the Provider provided the Complainant with a poor level of customer service throughout its assessment of her specified illness claim.

/Cont'd…

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 23 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 additional submissions from the Complainant, the final determination of this office is set out below.

The Complainant incepted a Term Life Insurance policy with the Provider on **15 July 2014,** which included a serious illness benefit up to €75,000 in the event of a diagnosis of a specified illness as listed and defined in the policy terms and conditions

The Complainant, a hairdresser, was certified as unfit to work since 27 April 2016 and submitted a specified illness claim to the Provider in June 2016 under the 'Loss of Independence – permanent and irreversible' benefit, wherein she detailed her illness as

> *"Loss of Independence - Cervical Dystonia (constant spasms in my neck + shoulder). Power has been lost in my right arm, fibromyalgia, which leads to inflammation of all joins + neck"*.

Following its initial assessment, the Provider declined the claim by correspondence dated 21 September 2016 but on appeal, it admitted the claim and paid the Complainant the full €75,000 serious illness benefit on 7 March 2017.

The Complainant is, however, dissatisfied with the way the Provider treated her throughout its claim assessment and appeal process and she submits that

/Cont'd…

> *"From the very beginning, I was told lies. I was also treated very badly by* [Provider] *staff"* who *"insulted me by not believing me and put me through a very stressful ordeal. All of this made my condition worse"*.

The Complainant complains of *"the level of additional medical information that my GP had to give and the correspondence he had to deal with from* [the Provider] *despite the medical evidence being there from the very outset"*. In this regard, the Provider, in line with standard industry practice and as part of its claim assessment, wrote to the Complainant's GP, Dr B. on 15 June 2016 seeking a medical report and history. I note from the documentary evidence before me that the information the Provider then received from Dr B. included some previous medical history that had not been disclosed to the Provider at the time the Complainant had applied for her policy, mainly relating to cholesterol. In my opinion, it is understandable that the Provider then sought to further investigate this matter, as this nondisclosure could potentially have affected its decision to accept the Complainant's application for cover from the outset. As a result, it was necessary for the Provider to revert to Dr B. on three further occasions - 25 July, 24 August and 8 September 2016 - to obtain the information it required.

Having listened to a recording of the telephone call in question, I am satisfied that in its call on 29 July 2016 the Provider explained clearly and in detail to the Complainant why it was seeking further information from her GP, that is, the possibility of nondisclosure at the policy application stage and the potential consequences of same, and I note that the Complainant indicated that she understood this.

I am also satisfied that the policy application documentation clearly advised the Complainant as to the importance of disclosing all material facts. In this regard, I note from the documentary evidence before me that the Provider sent the Complainant a copy of her application for cover on 15 July 2014, which included a copy of all questions asked and answers provided on her application and which advised at pg. 4, as follows:

> *"**Important – Telling*** **[the Provider]** ***about material facts***
>
> *We now need to ask you about your health. The answers you give will be used to access your request for cover. If you do not give us true and complete information, or withhold any facts or details, any future claim on this plan may not be paid. If this were to happen it could have a severe financial impact on you or your family. If you are not sure whether something is relevant, you should tell us anyway"*.

Similarly, I note that the Provider wrote to the Complainant on 18 July 2014 when her policy commenced, to remind her that its decision to accept her for cover had been based on the information that she had provided in her application.

In particular, I note that the Provider advised in its correspondence, as follows:

> *"**Your health details***

/Cont'd…

Our decision to accept you for cover is based on the information you provided in either your paper or online application form. It is important that you take note of the following:

- *It is important that you have told us all relevant information that is likely to influence the assessment and acceptance of your application.*
- *You must carefully review your answers to the health questions to make sure they are correct (attached)*
- *If any recorded details are incorrect or if there has been a change in the health of the life covered between the date you applied for cover and the date we accepted your application, you must let us know in writing immediately"*.

It was the Complainant's own nondisclosure when applying for the policy, that necessitated the Provider to write to her GP on a number of occasions seeking information. Given the circumstances, I consider that these requests were reasonable and necessary in order for the Provider to fully assess the Complainant's specified illness claim, by ensuring that her policy, in light of the nondisclosure, had been incepted on the correct terms. After investigating this nondisclosure in full, I note that the retrospective underwriting decision made by the Provider, was to leave the original standard rate underwriting decision in place.

In addition, the Complainant complains that

> *"when* [the Provider] *told me by phone that my claim was refused they lied about my Doctor's report, stating that Loss of Independence was not mentioned, when clearly it was"*.

In this regard, the Provider rang the Complainant on 21 September 2016 to advise that it had declined her specified illness claim, and I note the following exchange:

> Agent: *Well, according to your GP, you're able to walk 100 metres, you're able to get in and out of a car, maybe with some discomfort but unaided. You do need assistance dressing and undressing and washing but you can feed yourself, you can climb stairs without the assistance of special aids and you can manage bowel and bladder functions. Now also an important part of that definition is that you have to be permanently unable to fulfil them, so at the moment your GP is saying that you do have symptoms at the moment but that all your treatment options have not yet been explored …*

The Complainant's GP, Dr B. completed a Medical Certificate questionnaire for the Provider on 21 June 2016, and I note the following questions and his answers:

> *"**Question 13:***
> ***Is the level of impact of this illness considered to be permanent or is improvement anticipated?***
> *Unknown*

/Cont'd…

Question 14:
Please describe the course of the illness since the diagnosis and its impact on the claimant's life?
Marked impact and deterioration in quality of life and loss of independence".

Whilst the Complainant is correct that in June 2016, her GP used the term *"loss of independence"* in completing this report, I am satisfied that he did not use it in the context of confirming that there was a permanent and irreversible loss of independence and in this regard, he indicated in his answer to the previous question that he did not know at that time, whether the impact of the illness on the Complainant, that is, a deterioration in her quality of life and loss of independence, was permanent or whether improvement was anticipated.

In addition, the Complainant complains that during this telephone call on 21 September 2016 the Agent also advised *"they had spoken to my Neurologist* [Dr P.]*, which they had not"*. Having listened to a recording of this telephone call, I note the following exchange:

Agent: *Yes, well* [Dr P.] *has said that all your treatment options have not yet been explored, there's further Botox injections to happen, that you, he has noted that you may attend a neurosurgeon to discuss further options. Therefore our Chief Medical Officer has decided that the permanency of your condition hasn't been established yet. You know, there is further treatment options out there, so at the moment in time we're not able to admit your claim …*

Complainant: *So have ye been in contact with, with* [Dr P.]*?*

Agent: *Yes, we have been in contact, yes, sorry, we got reports from your GP that included reports from* [Dr P.] -

Complainant: *But have you been talking to* [Dr P.]*?*

Agent: *No, we don't, we don't speak to the doctors. We get reports –*

Complainant: *Ok, well you actually took me that* [Dr P.] *said about a neurosurgeon – the last day -*

Agent: *I'm sorry, in his report, so, sorry, just to stop you there…*

… sorry, I may have used the wrong terminology ….

It's the terminology that I use. I shouldn't have said "said" because we didn't actually speak to him, I should have said "it was in his report to your GP"

/Cont'd…

I am therefore satisfied that the Agent promptly clarified for the Complainant that the Provider had not spoken with her Consultant Neurologist Dr P., but rather that the contact it had had with him, was by way of sight of his medical report.

In addition, the Complainant complains that the Provider's Chief Medical Officer

> *"deemed my condition permanent in Oct 2016. Yet I was subject to a visit from an Occupational Therapist from Bristol coming to visit my home and even after that I was subjected to Surveillance on my home by Private Investigators"*.

I note the Provider's position that it was the opinion of its Chief Medical Officer in October 2016 that although the Complainant's diagnosis of cervical dystonia was a diagnosis of a permanent condition, it was not at that time disabling to the point where she would satisfy the policy definition for 'Loss of Independence – permanent and irreversible'.

The difference here is important. Whilst it was accepted that the Complainant's diagnosis was in respect of a permanent condition (in that she will suffer lifelong with that condition), the policy requires a further criterion to be met, in order for a valid 'Loss of Independence – permanent and irreversible' claim, that is, that the loss of independence arising from the condition must itself be a permanent and irreversible loss of independence. In this regard, I am satisfied that it was reasonable for the Provider to conclude from the medical evidence before it, which included reports from her own GP and her Consultant Neurologist, that the Complainant did not satisfy the policy definition of 'Loss of Independence – permanent and irreversible'.

The Complainant appealed the Provider's decision of 21 September 2016 to decline her specified illness claim. I note that as part of its appeal assessment, the Provider carried out surveillance of the Complainant for the purpose of claim verification from 29 January to 3 February 2017. In this regard, I note that surveillance is one of the tools insurers use to fully investigate claims. The Provider also arranged, with the Complainant's consent, for an independent home assessment to be conducted by an Occupational Therapist on 30 January 2017, which I note is reasonable and helpful when reviewing a claim of this nature.

In addition, the Complainant complains that

> *"to this day* [the Provider] *never got a neurologist to see me. It's the only thing I asked for"*.

I am, however, satisfied that there was no onus on the Provider to refer the Complainant for an independent medical examination with a neurologist, when the medical reports provided from her own treating doctors, including the reports from her Consultant Neurologist Dr P. dated 5 May 2016 and 10 October 2016 did not indicate that her condition at that time satisfied the policy definition for 'Loss of Independence – permanent and irreversible'.

/Cont'd…

In addition, the Complainant complains that *"several times I was lied to* [by the Provider] *over the phone and many times my calls were not returned, despite promises made"*.

I note from the evidence before me that there were a number of recorded telephone calls between the Complainant and the Provider, as follows: 31 May, 8 June, 14 June, 30 June, 15 July (two calls), 25 July, 29 July, 25 August, 7 September, 21 September, 23 September, 17 October, 18 October (three calls), 19 October, 20 October 2016 and 6 March, 13 March, 15 March (four calls), 3 April (two calls), 18 April (two calls) and 8 May 2017.

Having listened to the recordings of those telephone calls, the FSPO is satisfied that the different Agents who dealt with the Complainant throughout, were at all times professional, courteous and patient, often in the face of adverse and challenging discourse, and each made great efforts to assist the Complainant by providing her with detailed information initially as to the status of the assessment of her specified illness claim, then her appeal review and later, regarding the various complaints she had made to the Provider.

Regarding those telephone calls that took place from 21 September 2016 onwards, when the Provider advised that it had declined her specified illness claim, it is my opinion that the Complainant adopted an accusatory and confrontational approach to her dealings with the Agents. For example, during some calls the Complainant accused Agents of repeatedly lying to her, on occasion used offensive language (despite being asked to refrain from doing so) and she mocked some Agents by laughing at them or questioning the purpose and/or relevance of their job whilst threatening others with legal action. In this regard, in one particular telephone call on 15 March 2017, I note that the Complainant admitted, *"yes, I am aggressive"*, which I consider to be a fair and accurate summation of her manner at that time.

In addition, the Complainant became concentrated on matters that had no direct bearing on the assessment of her claim, such as the fact that a particular Agent commenced three days annual leave the day after she informed the Complainant that she would complete a full review of her file within 15 working days, or how an Agent could see into the office of her supervisor to know that he was in a meeting when his door was closed (it is a glass-walled office), or wanting to know the gender of the person he was in the meeting with, or why some Agents were prepared to interrupt the supervisor when he was in a meeting whilst others would not, or whether a particular Agent had been on lunch break, at the time the Complainant had been told she was.

Furthermore, it was not always clear to me what exact information it was that the Complainant was trying to ascertain by her chosen line of questioning, yet when asked during the telephone call on 18 April 2017 what her specific query at that time was, she unhelpfully advised, *"I'm not going to clarify anything"*. It is somewhat inevitable that this approach made it increasingly more difficult for the Agents in question to assist the Complainant, though I remain satisfied that each treated her professionally and courteously throughout.

I note from the call recordings that when the Complainant telephoned the Provider on 8 May 2017, the Agent in question advised her, as follows:

/Cont'd…

> *"I have been instructed by management to let you know that we will no longer be taking your calls, so each time you call, our customer service representatives have been informed to terminate your call. So anything that you would like, so issues you would like to raise with us, you can do them in writing but we will no longer be taking calls from you …*
>
> *There's no reason to be given. As I said, we won't be, we won't be engaging with you anymore on telephone calls, and that goes for the whole of* [the Provider] *contact centre …*
>
> *So if you have any other requests, you can send them to me in writing. So I am going to terminate this call at this time, and that will be the last time that we'll be taking your calls from you"*.

This office has considered in detail, the contents of the call recordings. However undesirable a stance it may have been for both parties, I am satisfied that the Provider's eventual decision to refuse to take any further telephone calls from the Complainant was nevertheless a reasonable position for it to adopt, in the circumstances, and henceforth it remained open to the Complainant to communicate with the Provider in writing.

In addition, the Complainant complains that *"crucial calls went missing when I requested recordings"*. It is clear from the evidence before me that the Provider received a significant number of telephone calls from the Complainant. I note the Provider position that whilst it is standard practice for it to record calls to and from its Customer Service Team, the Complainant on a number of occasions requested to speak with specific members of the back office claims and senior/executive management team and that not all back office telephone lines have a recording facility. In addition, the Provider has further advised that it can, on occasion, suffer technical issues and this can result in some calls not recording. In this regard, this Office can only adjudicate on the evidence made available and I note that the Provider advises that it furnished the Complainant with a copy of all telephone call recordings that it has in relation to this matter.

Finally, I note that when the Provider wrote to the Complainant on 19 October 2016 enclosing a recording of these telephone calls, it in error included two telephone call recordings on the disc from two other customers. By way of an apology for this error, the Provider offered the Complainant a €250 customer service award, which in the circumstances I consider to have been a reasonable offer.

I note that the Complainant declined this offer, though the Provider has advised that it remains open to her to accept it. In this regard, I consider it a matter for the Complainant to now advise the Provider directly, in writing, if she wishes to accept it. In that event, she should do so expeditiously, as the Provider is not required to keep that offer open to her indefinitely.

/Cont'd…

Insofar as the Complainant's complaint is that the Provider made a very poor level or standard of customer service available to her, in the course of its assessment of her claim, I am satisfied on the evidence before me that there is no reasonable basis upon which it would be appropriate to uphold that complaint, though I am aware that this outcome is of significant disappointment to the Complainant.

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

9 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.