Decision Ref: 2020-0165

Sector: Insurance

Product / Service: Other

Conduct(s) complained of: Rejection of claim - late notification

Outcome: Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to the refusal by the Provider to indemnify the Complainant pursuant to a claim under its insurance policy.

The Complainant's Case

The Complainant is a construction company and entered into an insurance policy with the Provider against which this complaint is made, which began on **14 January 2016**.

The Complainant submits that on **22 July 2016** an incident took place wherein an employee of the Complainant was struck by a moving roof truss and fell to the ground. The Complainant states that it reported the incident to its insurance broker (hereinafter referred to as the 'third party provider') on **28 July 2016** by telephone but *"due to oversight details were not notified to the* [Provider]*"*. The Complainant submits that it received a letter in **January 2017** from a solicitor acting for the injured party to the **22 July 2016** incident. This letter was forwarded by the Complainant to the third party provider on **9 January 2017** and the third party provider in turn forwarded the letter to the Provider's claims representative on **13 January 2017**.

The Complainant contends that a loss adjustor was appointed to investigate the incident on **7 March 2017** and that the Complainant paid a policy excess of €1,000 at the request of the Provider on **24 March 2017**. By way of letter dated **15 November 2018**, the third party provider acting on behalf of the Complainant contends that the Provider led the Complainant to believe that it was dealing with the claim by accepting the policy excess.

The claims representative for the Provider informed the third party provider in **May 2017** that *"based on the late notification,* [the Provider was] *not in a position to offer indemnity under the policy"*.

By way of letter dated **3 January 2019**, the third party provider, on behalf of the Complainant, submitted that it was fully accepted that an innocent error occurred on behalf of the third party provider but did not accept that this prejudiced the Provider in any way in its investigation of the claim. It submitted that all data/witnesses were and are still available for interview and contended that time clearly was not of the essence in relation to the investigation of this incident as the loss adjustor appointed by the claims representative for the Provider did not investigate the matter for 3 months post notification of the claim. This letter further submits that:

> *"Repudiation of a liability policy is an extremely serious development and should only be invoked in the case of fundamental policy breach/non-disclosure. In this case it was far from fundamental in that no negative consequences ensued".*

The Complainant submits that it complied with the claim notification requirement *"by virtue of notifying* [the third party provider]*"*.

The third party provider, on behalf of the Complainant, made a number of submissions to this Office in relation to the dispute. It stated that the condition precedent in relation to the claims procedure relied upon by the Provider was *"anti-consumer"* and had been outlawed in the United Kingdom. It further stated that the Provider has not acted honestly, fairly, professionally, in the best interests of its customers or with integrity. The third party provider also stressed that the delay in notification did not prejudice the Provider in its investigation of the incident. The third party provider also stated that the use of the phrase: *"may give rise to a claim"* in the condition precedent is subjective and open to interpretation and that *"every policyholders view on this 'may' be different"*. The third party provider further submitted that the collection of the excess by the Provider is in itself a *"confirmation of cover"*.

Ultimately, the Complainant wants the Provider to deal with the claim by the Complainant's employee pursuant to the insurance policy between the parties.

<u>The Provider's Case</u>

The Provider states the reason it refused indemnity in respect of this matter is that the Complainant did not fulfil the claims notification requirements contained within the policy within the "Claims Procedure" section.

/Cont'd…

This section states that:

> *"on the discovery of any circumstances or event which may give rise to a claim under this policy it shall be a Condition Precedent to Liability that* [the Complainant]*:*
>
> 1. *Shall immediately give written notice to Us or Our appointed claims representatives*
>
>   *(a) of any circumstances which may give rise to a claim and/or claims being made against you and for which there may be liability under this Policy."*

In its final response letter dated **1 March 2018** the Provider stated that the above clause acted as a condition precedent to liability. Therefore, the Provider submits that as a matter of law, there is no insurance cover in force unless or until the condition is met.

The Provider accepts that the third party provider received a phone call from the Complainant on **28 July 2016** in relation to an incident involving one of its employees and due to an oversight on the part of the third party provider, the details were not notified to the Provider until **13 January 2017**.

The Provider submits that this 175-day gap between the incident occurring and the notification of its occurrence to the Provider *"cannot objectively and reasonably be termed immediate"*. It goes on to state that the Complainant notifying the third party provider of the incident cannot amount to notification of the Provider as no aspect of claims representation is delegated by the Provider to that third party provider. The Provider states that while it does not, as a matter of law, have to show that it has been prejudiced to decline cover for the incident, the delay in the reporting of the incident to the Provider meant that a proper investigation into the incident was not possible given that *"crucial elements of the system of work in place and the causative elements were irretrievably lost"*. The Provider states that this view is supported by legal advice received on this point.

In response to the Complainant's letter of **13 February 2019**, the Provider makes a number of points. It states that whether circumstances *"may"* give rise to a claim against an insured involves an objective test in law and cites the case of <u>*HLB Kidsons v Lloyd's Underwriters [2008] Lloyd's Rep IR 237*</u>, wherein it was stated that *"…a circumstance which may result in a claim"* is one which:

> *"…objectively evaluated creates a reasonable and appreciable possibility that it will give rise to a loss or claim against the assured"*

It goes on to say therefore that it must be *"at least possible that a claim will result"* (<u>*Rotherstrasse Assurance Plc v Collyear [1999] Lloyds Rep IR 6*</u>) from the incident in question, even though the possibility is well below 50% and that there must be *"a real as opposed to fanciful risk of insurers having to indemnify the insured"* (<u>*Aspen Insurance UK Limited v Pectel Limited [2008] EWHC 2804 (Comm)*</u>).

/Cont'd…

Against this legal background, the Provider submits that the incident of **22 July 2016**, was a circumstance that may give rise to a claim against the Complainant.

In relation to the assertion by the third party provider that the type of condition precedent contained within policy is *"anti-consumer"* and *"has been outlawed in the UK"*, the Provider submits that the policy is subject to Irish law and jurisdiction and therefore the basis of the UK/English position is irrelevant. The Provider goes on to state that, in any event, the third party provider's assertion regarding UK law is incorrect and that the relevant UK legislation does not apply to conditions precedent (as in this complaint) which regulate simple notification of circumstances that may give rise to a claim, or notification of an actual claim.

The Provider states that the request it made for payment of the excess in the matter was standard and did not amount to an unequivocal confirmation that any rights that might arise out of the investigation were being waived in advance nor did it amount to a promise to return the excess if the claim was ultimately adjudged not to be covered. The Provider also claims that, as a matter of law, a breach of a condition precedent cannot be waived through waiver by affirmation and cites the case of *Kasmar Villa Holidays plc v Trustees of Syndicate 1243 [2008] Lloyd's Rep IR 125* in that regard.

In response from a query from this Office in respect of its obligations pursuant to provisions 2.1, 2.2, 2.12 and 4.1 of the Consumer Protection Code 2012 (as amended), the Provider stated that it was satisfied that its general claim handling arrangement and the specific actions taken in relation to this matter were taken in compliance with the Consumer Protection Code. It stated that it was satisfied that the final decision reached by it in this matter was fair and reasonable having regard to the policy wording, applicable law and the circumstances of the complaint. It also stated that the wording of the claims procedure is not hidden in any way, is clear & in plain English and is in no way unfair or misleading.

The Complaint for Adjudication

The complaint for adjudication is that the Provider has wrongfully refused to indemnify the Complainant in respect of a claim made under the Complainant's insurance policy.

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.

/Cont'd…

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 22 January 2020, 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 parties made the following submissions:

1. Letter from the Complainant to this Office dated 11 February 2020.

2. Letter from the Provider to this Office dated 6 March 2020.

3. Letter from the Complainant to this Office dated 16 March 2020.

Copies of the above submissions were exchanged between the parties.

Having considered these additional submissions and all of the submissions and evidence furnished to this Office by the parties, I set out below my final determination.

In relation to the jurisdiction of this Office to investigate the complaint, the Complainant has provided evidence that the annual turnover of the company is less than €3 million per year and that it is not a member of any group of companies. Therefore, it falls within the definition of a consumer for the purpose of taking a complaint to this Office.

I note that the facts of the matter are not in dispute between the parties. All parties accept that the Complainant notified the third party provider of the incident which occurred on **22 July 2016** by telephone on **28 July 2016** and all parties further accept that the third party provider failed to notify the Provider of this incident until **13 January 2017**. This amounted to a delay in notification of 175 days from the time that the incident occurred to the date of notification.

Furthermore, there is no dispute between the parties that there is clause contained within the “Claims Procedure” section of the applicable insurance policy which places an obligation on the Complainant to *“immediately”* give notice of any event which may give rise to a claim to the Provider.

/Cont’d…

In light of this provision, I must accept that a delay of 175 days from **22 July 2016 to 13 January 2017** in the notification by the Complainant to the Provider of the incident amounted to a breach of the claims procedure contained within the insurance policy agreement, albeit that the delay was due to inadvertence by the third party provider. I further accept that, given the background and factual circumstances of the incident, it was one which the Complainant should have been aware *"may give rise to a claim"* in line with the claims procedure.

I believe the fact that the Complainant did report the incident to the third party provider indicated an acceptance that it was an incident that could give rise to a claim.

Furthermore, I accept that while the Provider does not need to demonstrate prejudice to decline to indemnify a claim in circumstances where the claim procedures have not been complied with, the Provider in this matter would be prejudiced in its ability to defend any claim arising from the incident on **22 July 2016** were it obliged to do so. This is because of the inability of the Provider to conduct a prompt and proper investigation of the systems in place and the elements that led to the accident at the location of the incident due to the delay in notification.

The Complainant's representative, in a post Preliminary Decision submission dated **11 February 2020,** states:

> *"It is our submission that the collection of the excess from the Provider was a confirmation of cover and the law in relation to that action has not been correctly applied to the facts at hand".*

I do not agree with the Complainant's representative. I accept that the request for an acceptance of the payment of the excess on the policy did not and does not amount to a confirmation of cover by the Provider. The request for an excess where an investigation into claims of this nature is standard and does not amount to an unequivocal confirmation that any rights that might arise out of the investigation are being waived.

I note the Provider's position that acceptance of the payment of the excess does not amount to a promise by the Provider to return the excess to the Complainant if the claim is ultimately adjudged not to be covered.

However, I believe it would be unreasonable for the Provider not to return the excess in circumstances where it did not admit the claim. I note that the Provider did eventually return the excess of €1,000. I also note that the Complainant has complained that the "*excess was retained for a period of nearly 31 months*". While I find this to be an unreasonable amount of time, I also note the Provider has offered the Complainant a sum of €250 in compensation for this delay. In the circumstances, I find this to be adequate.

In the interest of completeness, I accept that the general claim handling arrangement and the specific actions taken in relation to this matter by the Provider were taken in compliance with the Consumer Protection Code 2012 (as amended).

/Cont'd…

Furthermore, I would point out this Office notes that any legislation/policy or case law from England & Wales is not binding on this Office. Therefore, any submissions raised by the parties to this dispute with reference to the position the English & Welsh courts might adopt to conditions precedent or claims of this nature has been considered in that context.

In light of these facts, and all of the circumstances, I conclude that the refusal of the Provider to indemnify the Complainant in respect of the incident which occurred on **22 July 2016** was not in breach of the insurance policy agreement entered into between the parties. Therefore, in the circumstances of the matter, and pursuant to the relevant policy terms and conditions, I accept that the Provider was entitled to refuse to indemnify the Complainant's claim.

Accordingly, while I understand the loss and frustration the Complainant feels, I must accept that the Provider was entitled, under the terms and conditions of the policy, to refuse to indemnify the Complainant. I cannot hold the Provider responsible for errors or omissions that may have been made by a third party provider.

For the reasons set out above, I do not uphold this complaint.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is rejected.

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

20 April 2020

/Cont'd…

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.