Decision Ref: 2020-0306

Sector: Insurance

Product / Service: Household Buildings

Conduct(s) complained of: Disagreement regarding Settlement amount offered

Outcome: Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint concerns a fire damage claim under a house insurance policy. The complaint relates to the way in which the Provider made reductions (and retained payments) for underinsurance / wear and tear, on a total loss claim due to the fire damage. The loss assessor representing the Complainant states that the retention of funds pending validation of works was outside of normal practice.

The complaint for adjudication is that the Provider acted incorrectly and unreasonably when retaining a large percentage of the agreed settlement amount, until the reinstatement of the property was completed.

The Complainant's Case

The Complainant's home was extensively damaged by fire in the summer of 2016. A claim was presented to the Provider for fire damage repairs on a full reinstatement basis. The Complainant's loss assessor states that during the course of settlement talks with the Provider's Loss Adjuster, it was established that the property was underinsured and a deduction for underinsurance would have to be made to the reinstatement settlement for wear and tear.

The Complainant's loss assessor states that in such a situation, the policy will not pay for the full reinstatement cost of the building and approximately €14,000 was deducted from the settlement by the Provider. The Complainant's loss assessor states that this was accepted by the Complainant, but the Provider's assertion that it was entitled to hold

retention of €55,000 until all repair works were completed was not accepted by the Complainant. The Complainant's loss assessor states that this retention was subsequently held by the Provider until all works were completed in late March 2017.

The Complainant's loss assessor states that his client signed the acceptance form in November 2016 under protest in order to trigger the release of the initial upfront payment as he had no other option but to embark on repairing his home. The Complainant's loss assessor states that the single issue in dispute here is the Provider's assertion that even though they are not paying for full reinstatement, they could still somehow insist on retaining a large portion of the settlement figure.

The Complainant's loss assessor sates that it is his view and also the view of the Complainant that once a deduction for underinsurance has been made, the policy reverts from one of reinstatement, to one of indemnity. The Complainant's loss assessor states that the sole reason for holding retention is to ensure full replacement, as new, of all repairs. The Complainant's loss assessor states that in this case, insurers have not paid full reinstatement and hence cannot hold retention pending reinstatement. The loss assessor asserts that this is the accepted practice in the marketplace and complies with insurance case law.

The Loss assessor states that in his opinion, an indemnity policy settlement endeavours to place the policyholder back in the position they were in immediately before the loss occurred. The loss assessor states that a reinstatement policy is sold on the basis of putting the policyholder in a better position after reinstatement than they were in prior to the loss. The loss assessor states that this is the basis for the condition requiring the policyholder to actually fully reinstate as new and to have adequate insurance cover to do so.

The Complainant's loss assessor states he has many examples of recent previous cases with the Provider where, following adjustments for underinsurance, the balance of the settlement has been paid in full to the clients which he states was in keeping with market practice. The loss assessor states that he does not understand why this practice should not apply in this case.

As regards a resolution, the Complainant's loss assessor states that the retention monies have now been released by the Provider as the Complainant has reinstated the property as best he can. The loss assessor states however, for many insureds in this position, they would struggle financially to complete repairs and as such, the holding of retention would place further financial hardship on them.

The Complainant's loss assessor states that a reinstatement policy is only an extension to the basic indemnity policy. The benefit of this extension is subject to certain conditions, one of which is having a building sum insured adequate to cover full reinstatement. The Complainant's loss assessor states that in this case, the Provider decided the Complainant did not comply with this condition. The loss assessor states that consequent upon this, the Provider was incorrect in retaining monies pending full reinstatement. The

/Cont'd…

Complainant states that this is an accepted principle of Insurance Law and has been breached by the Provider, in his opinion.

The Complainant is seeking the following:-

- The cost incurred arising from extra borrowings arising from failure to release all monies from indemnity settlement.

- The Provider to be instructed that in cases where the conditions outlined in their policy for full reinstatement cover are not met by their policyholder, the policy will revert from one of reinstatement, back to the base indemnity cover.

The Provider's Case

The Provider's positon is that it believes that it has dealt with the Complainant at all times in an entirely appropriate and reasonable manner, and that his claim presented to it for losses arising as a consequence of the fire that occurred in his home was handled honourably and fairly and entirely in accordance with the terms and provisions of the applicable policy of insurance.

The Provider submits that in the context of the complaint now made, at all times in the presentation of the claim, it was represented that the Complainant intended to carry out the full reinstatement works claimed for and ultimately agreed. The Provider states that at no time was a "walk away' sum or lump sum "non — reinstatement' settlement sought by the Complainant or his loss assessor. The Provider's position is that the claim was always one presented on the basis that full reinstatement would definitely take place. The Provider states that this was how the loss was presented, adjusted and settled.

The Provider states that in normal circumstances, the significant under-insurance arising would have resulted in a major reduction in the Complainant's claim to reflect the "average" arising. This, the Provider states that this would normally have resulted in the claim being reduced to an amount of around €112,000.00.

The Provider states that, in accordance with the applicable policy wording, it only applied a reduction of 7.5% to the gross agreed Buildings reinstatement claim of €188,191.84 to reflect normal wear and tear. This, the Provider states, resulted in a net agreed "Buildings" reinstatement sum of €174,076.00, a reduction of €14,114.00. The Provider states that this was regarded as being a fair and reasonable reduction. The Provider states that such reduction was reached by agreement and consensus with the Complainant's loss assessor and the Provider's loss adjuster, and was not a source of dispute.

The Provider states that the various elements of the claim presented were agreed without dispute by the parties at a total sum of €268,979.00, including contents and

/Cont'd…

alternative accommodation. The Provider states that an interim payment of €30,000.00 was paid at the outset, and that it immediately paid a further sum to the Complainant of €183,179.00 to enable the required reinstatement works to advance. The Provider states that it indicated its intention to hold a retention of €55,800.00, pending the agreed full reinstatement works taking place.

The Provider states that the Complainant's loss assessor indicated that the Complainant disputed the Provider's entitlement to hold a retention, but that, under protest, the Complainant would proceed to carry out the agreed reinstatement works and reserve his position on the matter.

The Provider submits that at no time whatsoever was it suggested by the loss assessor that the holding of such retention was going to cause any detriment, hardship, prejudice or financial loss of any description whatsoever to the Complainant in the carrying out of the required reinstatement works. The Provider states that at that time, it was never once suggested by either the loss assessor or the Complainant that the holding of such retention in any way might hamper or undermine the Complainant's ability to carry out the agreed reinstatement works.

The Provider states that the Complainant then carried out the required reinstatement works and the retention of €55,800.00 was paid immediately by the Provider to the Complainant when this was confirmed by the loss adjuster. The Provider's position is that the Complainant's claim, as agreed, has, therefore, been paid in full.

The Provider states that the complaint made on the Complainant's behalf by his loss assessor relates solely the loss assessor disputing of the Provider's entitlement to have held a retention in the circumstances that arose.

The Provider states it believes that the loss assessor's belief that the Provider was wrong not to pay the full, agreed claim before the agreed reinstatement works had been carried out, is entirely misplaced and incorrect.

The Provider submits that the Insurance Policy is very simple, clear and specific on the point.

The Policy states —

> *"We will settle claims by either repairing, replacing or reinstating property or by making a payment or stage payments.*
>
> *Under this policy stage payments can be made where a portion of the claim payment will be retained by us until the works are completed.*
>
> *When these works have been completed and supporting invoices and receipts or any additional evidence we may reasonably request have been*

/Cont'd…

provided to us to confirm the total cost incurred the full agreed sum will be paid".

The Provider states that the loss assessor suggests that if the full amount of an agreed reinstatement sum is not paid, that is, to reflect wear and tear, as provided for in the policy, it, in some way, transforms the policy. The Provider states that the loss assessor refers to it "reverting to an indemnity policy'. The Provider submits that it has no idea what authority the loss assessor is relying upon for what it describes as such an extraordinary proposition. The Provider states that the contractual relationship between the Complainant and the Provider is dictated by the applicable policy wording and, in this respect, the applicable wording is clear and specific and has direct application to exactly the situation that arose, that is, *a .. portion of the claim payment [was] retained by [the Provider] until the works [were] completed'.*

The Provider states that the loss assessor also makes reference to "accepted practice in the market place and ... insurance case law', but that no elaboration is made to support such sweeping statements. The Provider states that it has no knowledge of any such suggested "market practice". The Provider states that it does not know what "insurance case law" the Complainant's loss assessor is referring to. The Provider submits that the practice of insurers holding retentions pending agreed reinstatement works being completed is, however, well established. The Provider states that at all times, the Complainant's claim was presented, considered and adjusted on the basis that the Complainant intended to carry out the required reinstatement of his home.

The Provider states that the loss assessor makes reference to the Provider "... using false statements to influence policyholders in their decision as to whether to bring a case to the Ombudsman".

The Provider's response is that this is entirely wrong and states that if one reads the applicable correspondence relied upon by the loss assessor, the Provider was making reference to the fact that the principle of the holding of retentions by insurers has been considered and upheld in the past. The Provider states that it has also been subjected to rigorous scrutiny by the Central Bank, and found to be an acceptable claims practice.

The Provider states that the loss assessor also makes reference to how the Provider has dealt with recent, previous cases in which, following adjustments for under-insurance, the balance of a settlement is paid in full. The Provider's response is that it deals with each and every individual claim on its own, specific, unique merits. The Provider states that it

/Cont'd…

does its utmost to meet the specific requirements and needs of individual policyholders in whatever given claims situation arises. The Provider states that in some cases, retentions are not held by the Provider and individual considerations apply to individual cases.

The Provider states that the loss assessor seeks to rely upon a suggested "further financial hardship" that may be placed on "many insureds". The Provider states that the assumed interests of such notional insureds should not form the basis of any consideration by the FSPO of the Complainant's complaint.

The Provider submits that it is its firm position that if any policyholder of the Provider indicated to it that how it was handling his/her claim resulted in them inappropriately suffering "further financial hardship", the Provider would most certainly consider any representations made and do its utmost to minimise this occurring. The Provider's positon is that this did not arise at all in the Complainant's situation, and no suggestion was made, for instance, that the sum retained should be a lower amount or that it should be "split' into a number of stage payments as the reinstatement works were undertaken.

The Provider reiterates that if it had been suggested at any time in its consideration of the claim that the agreed reduction to reflect wear and tear was likely to impact adversely in any way on the Complainant's ability to reinstate his home, or that the holding of the retention, as per the policy wording, was going to have adverse implications for such reinstatement by the Complainant, the Provider would have looked favourably on any representations made.

The Provider submits that, to the best of its knowledge, particularly as it has never been suggested otherwise, the holding of the retention did not impede, in any way, the Complainant's ability to ensure all required, agreed reinstatement works took place without issue or difficulty.

The Provider states it would never wish the holding of a retention to cause any hardship in itself for a policyholder. The Provider states that it would never wish to compound the difficulties already faced by a policyholder presented with the problems and stress that the circumstances giving rise to the claim in the first place would have already caused.

The Provider submits that even now, in the loss assessor's formalised complaint on behalf of the Complainant, no suggestion is made that the Complainant was prejudiced, let alone even inconvenienced, in any way whatsoever by the Provider's approach to his claim. The Provider states that concerned that it had, perhaps, inadvertently caused any such possible prejudice or hardship to the Complainant, it asked to meet with him to

/Cont'd…

understand fully his grievance with the Provider. The Provider states it was stated by the loss assessor that the Complainant would not meet with the Provider.

The Provider states that it believes that the Complainant's claim has been dealt with entirely, fairly and appropriately and in keeping with the clear, specific policy wording provided for in the Policy issued by the Provider.

The Provider states that it believe that it has been very honourable in all its dealings with the Complainant and that he has been treated most fairly and reasonably by the Provider.

Some of the Provider's and the Complainant's loss assessor's further comments

The Complainant's loss assessor's submission of 25 June 2018

The Complainant's loss assessor submits that the Provider has stated that the Complainant appears to have accepted that he suffered no financial loss, hardship or prejudice. The loss assessor states that this view held by the Provider on the basis of the previous response is a complete misconception. The loss assessor states that he clearly set out that the Complainant only had one home and therefore had to reinstate it. The loss assessor states that as the Provider was not obliged to pay for full reinstatement the Complainant had to make up the additional amounts himself. The loss assessor states that the Provider was aware of this and the fact that the Provider insisted on retaining such a large portion of the settlement put the Complainant in a position where he not only had to pay the difference between the basic indemnity amount agreed with the Provider and the cost of reinstatement, but had to find the additional funds with respect to the retained amount. The Complainant's loss assessor submits that this put the Complainant under unnecessary and unjustifiable financial hardship. The loss assessor states that the mere fact that the Complainant had to use his own money/borrowed money to carry out/complete repairs prior to payment of retention clearly indicates a financial loss having been suffered as opposed to a full upfront payment being made by the Provider.

The loss assessor suggests that the Complainant has continued to be prejudiced by this matter. The loss assessor submitted correspondence the Complainant received informing him that his premium with the Provider has been increased by 83% from the previous year (noting that the previous year's premium was after the claim had been made and settled) and he is unable to move to a different insurance provider as there is an ''active claim" on his policy.

The Complainant's loss assessor states that the Provider states he did not "deal with the fundamental legal position that the relationship between the Complainant and the Provider is first and foremost governed by the actual applicable policy wording in place." The loss assessor states that he found this rather confusing as it considers that it dealt at length with the wording of the policy and reiterate that it is its contention that the wording of the policy provides that stage payments can only be made where the Provider is paying for reinstatement. The Complainant's loss assessor states that as the

/Cont'd…

amount the Provider was obliged to pay the Complainant was not dependent on the work being "complete", which it states is the only condition allowing the Provider to make stage payments under the policy, the Provider was not entitled to make stage payments in this case. The Complainant's loss assessor states that the Provider paid the Complainant the absolute minimum he was entitled to receive which was for the ''loss and damage" incurred to his home and this amount could not have been reduced further by the Provider had the Complainant failed to reinstate the property. The loss assessor states that the assertion by the Provider that it is absolutely entitled to retain monies until the full cost of reinstatement works are incurred / completed without having paid for said full reinstatement is plainly illogical and places unjustifiable financial hardship on a policy holder without getting anything in return from the Provider.

The Complainant's loss assessor states that it rejects the Provider's assertion that the examples provided to demonstrate the market practice are notional or abstract cases. The Complainant's loss assessor states that the cases he referred to, are real cases, some of which are the Provider's own policyholders and at a very minimum demonstrate a prejudice in the way the Complainant's claim was handled. The Complainant's loss assessor states that in bolstering this assertion, he would point out that the example he gave was also in respect of the Provider policy, but yet no retention was held in that case. The Complainant's loss assessor states that the limited details provided for these examples was due to instruction from the Ombudsman regarding data protection, but if the Provider wish to waive this in relation to examples where it was on cover the loss assessor can provide any details required.

As regards the Provider's assertion that it deals with "every individual claim on its own specific, unique merits", the Complainant's loss assessor states that the Provider has not once, despite being repeatedly being asked to do so, said why they held a 30% retention in this claim. The Complainant's loss assessor questions why was it that the Provider needed to retain such a percentage, and what the basis was for retaining this amount. The Complainant's loss assessor states that considering that the Provider was obliged to pay for the "loss or damage", the Complainant suffered, "no more, no less, how can the Provider justify retaining anything". The Complainant's loss assessor questions what the "specific unique merits" of the Complainant's case were that necessitated putting more financial pressure on him.

The Complainant's loss assessor states that the Provider appears to be suggesting that the Complainant never raised an issue with the amount of retention being held, and that this assertion *is blatantly shocking*. The Complainant's loss assessor provided two correspondence with the Provider, which he asserts clearly outline disagreement with the Provider's decision to withhold any portion of the settlement. The loss assessor states that it would not be logical for him to make representations to the Provider on the amount of retention to be held when, in the first place, he disagreed wholly with the notion that retention should be held at all.

The Complainant's loss assessor states it is incredulous based on the extent of correspondence on file where it made representations on the Complainant's behalf

/Cont'd…

about the holding of a retention that the Provider would make the statement that it "would most certainly have considered and taken on board any representations made". The loss assessor states that the fact is, the Provider was well aware that the Complainant disputed the handling of his claim and did not once seem to be interested in the "specific requirements and needs" of the Complainant, as the Provider continuously claims.

The Complainant's loss assessor asserts that the Provider has not followed either the wording or logic of the Policy or established norms or principles in the insurance industry in this case. The loss assessor states that this has resulted in the Complainant suffering financial loss, prejudice and offence.

The Provider's response of 28th June 2018

The Provider states that it appreciates that the Complainant would have had to find additional funds in respect of the uninsured element of his losses. The Provider states that it has never been suggested that the retention, so impugned by the Complainant's loss assessor, held by the Provider has given rise to any such hardship in itself.

The Provider submits that certainly, at no time, either in the presentation of the Complainant's claim by the loss assessor, at the time of settlement or afterwards, has it ever been indicated that the holding of the retention in itself would or did cause hardship, and no representations to this effect were ever made to the Provider.

The Provider states that if any such representations had been made, it is most certainly and absolutely the Provider's position, notwithstanding what the loss assessor suggests to the contrary, that the Provider would have considered and taken on board any such representations. The Provider states that it would never wish to cause avoidable financial hardship to a policyholder as a consequence of how a claim was handled or, in particular, in the holding of a retention.

The Provider states that while the loss assessor took exception in principle to the holding of a retention, if there had been any suggestion ever made that the level of retention held gave rise to financial hardship, the Provider would most certainly have considered any representation to that effect. The Provider states that no representation to that effect was made.

The Provider states that it believes the loss assessor is incorrect in its view. The Provider states that it does not regard the loss assessor's views as being relevant in the present instance in which no representations of potential financial hardship being caused by the holding of the retention have ever been raised.

/Cont'd…

The Provider states that it most certainly does not agree that the other case, as presented by the loss assessor, demonstrate a prejudice in the way that the Complainant's claim was handled. The Provider reiterates that each policyholder's claim is considered on its own individual, specific merits, despite the loss assessor not agreeing with this. The Provider considers that the loss assessor is incorrect on the matter.

As regards the loss assessor's view on the holding of a 30% retention and there being "No Justification Forthcoming", the Provider's response is that no suggestion was ever made by the loss assessor at any time that the level of retention held by gave rise to any financial prejudice, hardship, etc. The only disagreement in relation to the holding of a retention was one made in principle, not as to the actual level of retention held. It is the Provider's position that it would have facilitated the Complainant, had representations, in terms of any hardship caused, been made.

As regards the loss assessor's reference to retentions of up to 60% being held, the Provider states that this clearly relates to matters not the subject matter of the present complaint and it does not know what bearing they can possibly have on the Complainant's specific complaint.

The Provider states that the making by the Complainant of the present complaint has had no bearing or relevance whatsoever on the premium charged at renewal, as suggested by the loss assessor.

The Provider states that when renewal of the household insurance policy occurred in July 2017, settlement of the Complainant's claim had not then taken place. The claim was settled subsequent to the renewal in November 2017. The Provider's position is that the premium then charged in 2017 did not reflect any loss of the Complainant's existing 40% no claims discount due to the claim presented by him.

The Provider states that by the time of the 2018 renewal, the claim had been settled and the previous, applicable 40% no claims discount was no longer available, it had been "lost' as a consequence of the claim made. This resulted in a much higher premium being paid. The Provider states that in addition, there was also a standard premium rate change across the entire Provider home insurance portfolio prior to its 2018 renewal season, which was also reflected in the premium charged.

The Provider states that the loss assessor is entirely wrong in his assertion that the increase in premium is as a consequence of their being an "active claim", as suggested by him. No such "active claim" exists. The Provider states that if, as suggested by the loss assessor, the Complainant is unable to move to a different insurance provider, this is not the fault of the Provider, and is a matter entirely beyond the Provider's control. The Provider concludes that as with all its dealings

/Cont'd…

with the Complainant in relation to his claim, the increase in the premium that arose is entirely in accordance with the applicable policy terms.

The Complainant's submission of 9 July 2018

The Complainant's loss assessor made the following comments:

"1) Financial Loss/Hardship Suffered

[The Provider] seem adamant to repeatedly point out that at no time were representations made to [the Provider] that the holding of a retention would cause [the Complainant] financial hardship. We have pointed out that this is completely disingenuous on their part given the correspondence on file and the practical realties of the situation itself.

Further, in our previous submissions we noted that [the Provider] could not have paid [the Complainant] any less than the settlement amount that he ultimately received as [the Provider], at a minimum, were obliged to pay for the "loss and damage" to [the Complainant's] home (regardless of whether he fully reinstated his home or provided receipts to [the Provider]). You will note that [the Provider] do not appear to be contesting this (they have not responded to this assertion at all). This is important, as if [the Provider] accept that they couldn't have paid [the Complainant] any less than they did, then, [the Provider] are accepting that they put [the Complainant] under unnecessary financial pressure without any justification for so doing.

2) Wording [of policy]

We have been quite confused by [the Provider] repeatedly suggesting that we do not believe that the applicable policy wording governs the contractual relationship between [the Provider and the Complainant]. We have set out very clearly in our previous submissions that we do…. We believe that the wording of the … policy only allows for stage payments to be made where [the Provider] are paying for full reinstatement.

3) Market Practice Demonstrates Prejudice

We note that in [the Provider's] first submission, [it] asked us to give examples of market practice, when we did so, [the Provider] then said that such market practice did not matter given the applicable policy wording. We have been clear that the market practice (including practice involving [the

/Cont'd…

Provider] themselves) serves to demonstrate how [the Provider's] interpretation of their policy when it came to [the Complainant's] claim was unfair and illogical given how they themselves have handled claims previously and due to the common principles of insurance coverage and the basic rights of policy holders across the insurance industry.

4) <u>No Justification Forthcoming?</u>

We note that [the Provider] have again refused to provide justification for their withholding of a retention of 30% in [the Complainant's] case despite being repeatedly and directly asked to do so. As such, one can only conclude that [the Provider] have failed to provide such justification because they are simply unable to do so in this case. This again indicates that [the Provider's] conduct in handling [the Complainant's] claim was arbitrary and unjustified and put [the Complainant] under undue financial hardship with the only benefit accruing to [the Provider], who held onto their own funds for longer.

With regard to when [the Complainant's] claim was settled we can only point out evidence provided by [the Provider's] own loss adjusters. You will note that [loss adjuster] acting on behalf of [the Provider] recommended final release of retention on 30th March 2017 and [the Complainant] received final payment from [the Provider] on 3rd April 2017. This was some 3 months before his renewal in 2017 and 8 months before [the Provider] said that they settled the claim in November 2017.

In conclusion, we believe that this response together with our previous submission demonstrates that [the Provider] have not followed either, the wording and logic of their … Policy or established norms or principles in the insurance industry in this case. This has resulted in our client suffering financial loss, prejudice and offence".

<u>The Complaint for Adjudication</u>

The complaint for adjudication is that the Provider acted incorrectly and unreasonably by retaining a large percentage of the agreed settlement amount, until the reinstatement of the property was completed.

<u>Decision</u>

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

/Cont'd…

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 **29 July 2020**, 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.

Submissions dated **17 August 2020** and **07 September 2020** from the Complainant, and submissions dated **04 September 2020**, from the Provider, were received by this Office following the issuing of a Preliminary Decision to the parties. These submissions were exchanged between the parties and an opportunity was made available to both parties for any additional observations arising from the said additional submissions. On **14 September 2020**, the Provider advised that it had nothing further to add. I have considered the contents of these additional submissions, together with all the submissions and evidence, for the purpose of setting out the final determination of this office below.

Analysis

The Policy Provisions state —

> *"[The Provider] will settle claims by either repairing, replacing or reinstating property or by making a payment or stage payments.*
>
> *Under this policy stage payments can be made where a portion of the claim payment will be retained by [the Provider] until the works are completed.*
>
> *When these works have been completed and supporting invoices and receipts or any additional evidence [the Provider] may reasonably request have been provided to [the Provider] to confirm the total cost incurred the full agreed sum will be paid".*

It is clear from the parties' submissions that in the presentation and negotiation of the settlement of the claim, it was represented by the Complainant and the Complainant's loss

/Cont'd…

assessor that the Complainant intended to carry out the reinstatement works claimed for. The calculation on how much was going to be paid in respect of the loss was negotiated between the parties (the Provider's loss adjuster and the Complainant's loss assessor) on this reinstatement basis.

Thereafter, the Provider communicated that a proportion of the settlement amount negotiated would be withheld pending completion of the works. This clearly differs from a situation where a *"walk away"* sum or lump sum *"non — reinstatement"* settlement formed part of the discussions. These alternative means of settlement do not appear to have been sought by the Complainant or his loss assessor.

In the Complainant's post Preliminary Decision submissions, it is the Complainant's positon that a *'walk away'* lump sum settlement was discussed with the Provider.

The Complainant remains of the positon that an Insured would have been paid the retention amount even if he had chosen, following agreeing a settlement, not to reinstate the property.

The Provider's submission is that a "walk-away" sum or lump sum "non-reinstatement settlement" did not "form part of the discussions".

It is the Provider's position that had alternatives been suggested to the Provider as regards how the claim should be "settled", they would have been considered. The Provider states that at all times, the claim was presented on a reinstatement basis and that the Complainant had very clearly and specifically indicated his intention to reinstate. The Provider states that this is how the claim was calculated and adjusted and, clearly, had a bearing on its holding of the retention, including the level of retention held.

The purpose of a retention by the Provider of a portion of the monies when reinstatement works are envisaged, is to ensure that the works are "complete". Therefore, on the basis that the claim was presented and negotiated upon by the parties on a reinstatement basis, and all the evidence supports that this was the position, I am satisfied that the settlement, including the retention put in place by the Provider, was in accordance with the policy provisions governing the policy.

That said, I have concerns that the application of a retention is not fully explained in the policy provisions, in particular I would expect the policy provisions to set out how the amount retained would be calculated by the Provider. Such clarity was not evident here.

On 24 October 2013, in an Information Release, the Central Bank published findings from the Household Property Claims themed inspection. In this Information Release it was stated that:

> *"A review of insurers' policy booklets revealed that only one of the insurers clearly describes the practice of retentions in its policy booklet. Insurers have been*

/Cont'd…

> *requested to make clearer their policy on retentions at the time of the product being purchased and again when a claim is instigated".*

With regard to the provision of information to a consumer the Consumer Protection Codes state that a regulated entity must ensure that all information it provides to a consumer is clear and comprehensible, and that key items are brought to the attention of the consumer. The method of presentation must not disguise, diminish or obscure important information.

I consider that a situation where an insurance claim is going to be made to a Provider and the Provider is going to settle the claim on the basis of a retention of a major portion of the claim, is something that a policyholder, or potential policyholder would want to be made reasonably aware of. I consider that this should be communicated clearly prior to the purchase of the policy, and specifically set out in the policy provisions. It should also be communicated again at claim stage.

I believe that greater communication between the parties was merited during the assessment and payment of this claim. The Provider submits that at no time of the Complainant's claim by the loss assessor was it indicated to the Provider that the holding of the retention in itself would or did cause hardship. It is the Provider's position that it would have facilitated the Complainant, had representations been made. I have been provided with no evidence the either the Complainant or his loss assessor did in fact make a case to the Provider that the retention was causing a difficulty for the Complainant.

The loss assessor representing the Complainant, appears to be more interested in the principle surrounding the retention and states that it would not be logical for him to make representations to the Provider on the amount of retention to be held when, in the first place, he disagreed wholly with the notion that retention should be held at all. I do not believe this stance was helpful if in fact the retention was causing hardship for the Complainant, I believe the best course of action would have been to bring this to the Provider's attention.

The Provider states that concerned that it had inadvertently caused possible prejudice or hardship to the Complainant, it asked to meet with him to understand fully his grievance with the Provider. The Provider states that it was informed by the loss assessor that the Complainant would not meet with the Provider. I believe this may have been a missed opportunity to resolve the matter.

I consider that a 30% retention on a house insurance claim, where the Complainant suffered what must have been a devastating loss for him by a fire to his home, and where he communicated that he wanted to reinstate his home to be a very serious matter. There can be no doubt that such a large retention by the Provider, required better communication and explanation by the Provider. I accept that information as to how the particular retention amount was calculated should reasonably be expected to have been provided to the Complainant.

/Cont'd…

I would expect that there would be some scientific or actuarial basis for such retention figures. I accept that the Complainant's objection to the application of the retention was sufficiently drawn to the Provider's attention prior to him agreeing to only accept the initial payment, in order to progress the rebuild. I consider that at that stage, given the large retention amount, the Provider could reasonably have engaged better with the Complainant in relation to the amount to be retained, or the phasing of the works/payments or at the very least provided an explanation as to why such a large retention figure was required.

In my Preliminary Decision I indicated that I was considering bringing this issue to the attention of the Central Bank of Ireland for any action it may deem necessary.

In response, the Complainant indicated he wants the matter brought to the attention of the Central Bank of Ireland. The Provider expressed the view that this is not warranted due to measures it proposes to take.

The Provider states that the concerns and criticisms raised by me in the Preliminary Decision are being taken seriously by the Provider. The Provider has stated that it intends to review the applicable policy wordings in the relevant policies in light of my comments. I welcome this commitment by the Provider.

Furthermore, I note and welcome, the fact that the Oireachtas has recently enacted legislation in this area. The *Consumer Insurance Contracts Act 2019,* came into operation on **1 September 2020**. Section 17.1 deals with the settlement of claims. For these reasons I do not propose to refer the complaint to the Central Bank.

Having regard to all the above, it is my Legally Binding Decision to partially uphold this complaint in respect of the lack of clarity in the policy provisions in relation the calculation and retention on the claim. I direct the payment of €1,500 (one thousand and five hundred euro) 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 partially upheld, on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €1,500, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. 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.

/Cont'd…

- 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

17 September 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.