An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0336
Sector:	Insurance
Product / Service:	Whole-of-Life
Conduct(s) complained of:	Loading on policy for medical conditions/family history
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, now age 77, incepted a unit-linked whole of life protection policy with the Provider on **16 May 1997**, which at that time provided him with life cover in the amount of IR£50,000 (€63,487) for a monthly premium of IR£65.10 (€82.66).

The Complainant's Case

As at **March 2017**, the Complainant's policy was providing him with life cover in the amount of €119,334 for a monthly premium of €337.27 (including 1% Government Levy).

The Complainant received correspondence from the Provider in **March 2017** advising that following a policy review, the premium would need to increase to €447.26 a month in order to maintain the policy benefit until the next review date in May 2022.

In this regard, the Complainant sets out his complaint, as follows:

> *"*[The Provider] *are not providing me with how they come to the charges they are charging me.*
>
> *In 2012, three premium payments were missed because of a bank error. I was not informed of this till much later. To cover the arrears, my* [premium] *payment increased until arrears were cleared and were to revert to original amount. This did not happen and have* [skyrocketed] *since.*

Earlier this year (2018), I was notified my premium was increasing to over €400 a month, which I couldn't maintain. So in order to keep my policy and not lose everything I had paid in, I had no option but to freeze my policy at €100,000 [life cover] *with a premium of €322 a month"*.

The Provider's Case

Provider records indicate that the Complainant incepted a unit-linked whole of life protection policy with the Provider on **16 May 1997**, which at that time provided him with life cover in the amount of IR£50,000 (€63,487) for a monthly premium of IR£65.10 (€82.66). The Provider sent the Complainant the policy documentation on **6 June 1997**, which included the policy schedule and the Policy Conditions booklet. Indexation was selected at the outset but no longer applies, as it was removed at the Complainant's request on **30 March 2017**.

The life cover benefit as at **16 July 2019** was €100,000 for a monthly premium of €322.78 (inclusive of 1% Government Levy), with a positive fund value of €2,147.65.

The Complainant's policy is subject to periodic reviews in accordance with Condition 9, '**Regular Policy Reviews'**, of the applicable Policy Conditions booklet, which provides, *inter alia*, at pg. 9, as follows:

> *"9.1 We will review your policy at least once every five years. The purpose of the review is to ensure that the premiums you are paying are sufficient to meet the cost of providing your chosen benefits until the end of the period of cover.*
>
> *9.2 We will inform you of the results of the review and recommend to you any change in the premium required".*

The commencement date of the policy was 16 May 1997. The initial policy review was carried out on the tenth anniversary of the policy on **27 March 2007**, with subsequent reviews carried out every five years since, on **27 March 2012** and **25 March 2017**.

2007

Following the first scheduled policy review in March 2007, the Provider says it wrote to the Complainant on 27 March 2007 advising that the then monthly premium of €122.07 was sufficient to maintain the then level of life cover of €93,804 for the next five years, when the next policy review was scheduled to take place.

2009

The Provider notes that its collection for the **December 2009** monthly premium of €141.29 was returned unpaid by the Complainant's bank on 16 December 2009. It made a second attempt to collect this premium on 21 December 2009, but this too was returned unpaid by the bank on 5 January 2010.

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2010

As a result, the Provider says that it wrote to the Complainant on **6 January 2010** to inform him that it had been unsuccessful in collecting the monthly premium and to request that he contact it to arrange payment. The Provider sent a further letter to the Complainant on **25 February 2010** advising that all further premium collections were being suspended due to the unpaid premium, in accordance with the policy conditions.

The Provider says that it next received a written instruction from the Complainant dated **29 July 2010** when he instructed the Provider to bill him for all outstanding premiums in September 2010, that is, the premiums due from December 2009 to September 2010 inclusive. The Provider attempted to collect these outstanding premiums on 21 September 2010 but was unsuccessful. As a result, the Provider wrote to the Complainant on **12 October 2010** to advise that all premium collections were suspended due to the unpaid premiums, in accordance with the policy conditions.

At that time, there was a positive fund value on the Complainant's policy which enabled the life cover under the policy to be maintained until such time that this fund value eroded, in accordance with Condition 5, '**Paying Premiums'**, of the Policy Conditions booklet, which provides, *inter alia*, at pg. 7, as follows:

> *"5.4 The policy value which is built up from premiums will be used to pay the charges as they arise …*
>
> *5.5 We will allow you 30 days from the date that the premium is due to pay it. If the premium is not paid by then, the following terms apply: …*
>
> - *If there is a positive policy value, the benefits will continue. We will deduct policy charges from your policy value every month. The benefits will continue until your policy value is zero. The policy and all benefits will cease from the date that your policy value cannot pay the policy charges"*.

2011

In this regard, the Provider says that it wrote to the Complainant on **17 May 2011** to advise that the policy would remain in force for a further 14 days only from the date of the letter, as the fund value was no longer sufficient to maintain the cost of the policy and its benefits.

Following this letter, the Complainant met with Mr B., an Insurance and Investment Manager on **30 May 2011** and signed a quotation on the same day to reinstate the policy with a monthly premium of €250.70 (excluding 1% Government Levy) for a reduced life cover benefit of €93,500. The Provider originally advised this office in July 2019, that this premium amount was calculated on the basis that it incorporated the outstanding premiums which were due from December 2009 totalling €2,633.13 (and included the annual increases due to indexation). When pressed by this office to explain this, bearing in mind that the fund value had been stated to have been used to sustain those premium payments, the Provider confirmed in July 2020 that this was not in fact correct.

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The Provider says that the Complainant also signed a new direct debit mandate on 30 May 2011 in order to facilitate the collection of future premiums. The Provider agreed to waive the requirement for a Declaration of Health, as would ordinarily be required in such circumstances, and the policy was reinstated on **10 June 2011**. A confirmation letter was sent to the Complainant on 10 June 2011 stating the revised monthly premium of €253.20 (including 1% Government Levy) and the life cover benefit of €93,500.

The Complainant then telephoned the Provider on **15 June 2011** to ask that the premium collection date from his bank account be changed from the 16th to the 25th of every month. As the collection process for the premium due in June had already commenced, this request was not processed until 8 July 2011, upon receipt of confirmation that the June premium had been returned unpaid from the Complainant's bank. The Provider rebilled for both the June and July premiums on 29 July 2011 and these were collected successfully.

The Provider notes that its collection for the August 2011 monthly premium was returned unpaid by the Complainant's bank on 25 August 2011. It made a second attempt to collect this premium on 31 August 2011, but this too was returned unpaid by the bank on 8 September 2011. As a result, the Provider wrote to the Complainant on **9 September 2011** to inform him that it had been unsuccessful in collecting the monthly premium and to request that he contact it to arrange payment. The Provider sent a further letter to the Complainant on **27 October 2011** to advise that the policy would remain in force for a further 14 days only from the date of the letter and the policy subsequently lapsed 14 days thereafter.

2012

The Provider says that a meeting took place on **3 January 2012** between the Complainant and Ms. R., an Insurance and Investment Manager. Following this meeting, the Provider emailed Ms. R. on **5 January 2012** with two options to present to the Complainant in order to reinstate the policy and address the arrears, as follows:

1. Pay the outstanding policy premiums amounting to €1,266 (5 months premiums @ €252.20 per month, including 1% Government Levy). This figure did not include the monthly premium that would be due on 16 January 2012.

2. Pay an increased monthly premium of €261.66 (excluding 1% Government Levy) which incorporated the outstanding premiums.

The Complainant chose the second option and signed the quotation on **10 January 2012**. He included a handwritten note instructing the Provider, as follows:

> *"I wish to proceed with this level of cover of €93,500 at a premium of €261.66 p/m. Please amend my direct debit date to the 22nd of each month"*.

The Provider points out that the '**Important Notes'** section of the quotation advised, *inter alia*, as follows:

> *"Your plan will be reviewed every five years, to make sure your premium is sufficient to pay for your benefits until the end of your period of cover"*.

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The Provider says that it once again agreed to waive the requirement for a Declaration of Health and the policy was reinstated on 17 January 2012. A confirmation letter was sent to the Complainant on **17 January 2012** stating the revised monthly premium of €264.27 (including 1% Government Levy) and the life cover benefit of €93,500.

The Provider notes that the Complainant states in his complaint that, *"In 2012, three premium payments were missed because of a bank error"*. The Provider has no record of there being three missed premiums in 2012 due to a bank error. The Provider does have a record of a premium missed in February 2012 and a letter was sent to the Complainant on 9 March 2012 requesting that he contact the Provider to arrange payment. In this regard, the Complainant visited the Provider offices on **28 March 2012** and paid the premiums due for February and March 2012.

In addition, the Provider says that it sent a further letter to the Complainant on **6 June 2012** as it had been unsuccessful in collecting the May 2012 premium.

The Complainant telephoned the Provider on **2 July 2012** and instructed it to rebill for the outstanding premium. The Provider cannot comment on why any premiums were missed but if the Complainant believes that these premiums were missed due to a bank error, the Provider respectfully submits that this is a matter between the Complainant and his bank.

The second scheduled policy review took place in **March 2012**. In light of the changes that had been made to the policy in January 2012, two months earlier, the then monthly premium of €261.66 (excluding 1% Government Levy) was deemed sufficient to maintain the policy and its benefits for another five years, when the next review was scheduled to take place. The Provider wrote to the Complainant on 27 March 2012 to inform him of the outcome of this review.

2017

Following the third scheduled policy review in **March 2017**, the Provider wrote to the Complainant on 25 March 2017 to advise that if he wished to sustain the then level of life cover of €119,334 until the next review in 2022, the monthly premium would need to increase from €337.27 (excluding 1% Government Levy) to €447.26 (excluding 1% Government Levy). The level of life cover and the premiums had increased each year due to indexation.

At this point, the premium arrears that the Complainant had accrued from August 2011 to December 2011 inclusive and which had been spread out and added to each monthly premium due over the period from January 2012 to the next policy review date, were fully repaid, and the premium amounts now quoted as part of this March 2017 review were based solely on the level of cover held at the time. Ms. R., an Insurance and Investment Manager, telephoned the Provider on **30 March 2017** to discuss the Complainant's options following this policy review. Following this call, the Provider furnished the Complainant with a further quotation based on the lower level of life cover of €100,000 for a reduced premium of €322.79 per month (including 1% Government Levy), with indexation removed from the policy. The Complainant signed this quotation and returned it to the Provider on 19 April 2017. He included a handwritten note instructing the Provider, as follows:

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"Please alter my policy to €100k life cover over 5 years".

A confirmation letter was sent to the Complainant on 19 April 2017 stating the revised monthly premium of €322.78 (including 1% Government Levy) and a life cover benefit of €100,000.

The Provider sent the Complainant a '*Guide to your reviewable protection policy'* document on 10 August 2017 to remind him of the features of his policy and it trusts that he found this guide helpful in further explaining why periodic policy reviews are carried out and why premium increases occur.

Accordingly, the Provider is satisfied that at all times it correctly administered the Complainant's life protection policy in accordance with the policy conditions.

The Complaint for Adjudication

The Complainant's complaint is that the Provider has failed to administer his life protection policy appropriately and that it has also failed to furnish him with a clear and justifiable reason for the premium increases sought.

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 **14 September 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.

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In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

The complaint at hand is that the Provider failed to administer the Complainant's life protection policy appropriately and that it also failed to furnish him with a clear and justifiable reason for the premium increases sought.

In this regard, the Complainant incepted a unit-linked whole of life protection policy with the Provider 23 years ago, on 16 May 1997. At that time this policy provided him with life cover in the amount of IR£50,000 (€63,487) for a monthly premium of IR£65.10 (€82.66).

As a result of indexation, by 26 March 2017 the Complainant's policy was providing him with life cover in the amount of €119,334 for a monthly premium of €337.27 (including 1% Government Levy).

Following a policy review in March 2017, the Provider wrote to the Complainant to advise, *inter alia*, that the monthly premium would need to increase to €447.26 in order to maintain the policy benefit until the next review date in May 2022.

I note that the '**Introduction**' section of the applicable Policy Conditions booklet that the Provider issued to the Complainant on 6 June 1997 when he incepted his life protection policy, provides, *inter alia*, at pg. 3, as follows:

> *"It is important that you read the policy conditions set out in this document. They form the legal agreement between you and* [the Provider] *…*
>
> ***Policy Overview – How the policy works** …*
>
> - *Every five years, we will review your policy to check whether the benefits are appropriate to your needs and that the premium level is enough to meet the cost of providing the benefits in the future. We will increase your premium if it is not enough to meet the cost of providing you with the benefits"*.

In this regard, 'Condition 9, '*Regular Policy Reviews'*, of this booklet provides, *inter alia*, at pg. 9, as follows:

> *"9.1 We will review your policy at least once every five years. The purpose of the review is to ensure that the premiums you are paying are sufficient to meet the cost of providing your chosen benefits until the end of the period of cover.*
>
> *9.2 We will inform you of the results of the review and recommend to you any change in the premium required. An increase in the premium level may be required because:*
>
> - *you may have altered the type of amount of cover, and who is covered on your policy*

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- *you may not have paid the premiums when they were due*

- *we may have changed the table of rates used to calculate charges for death benefits and other benefits or we may have increased other policy charges".*

I am therefore satisfied that the Complainant's life protection policy provides for policy reviews to be carried out by the Provider.

In addition, Condition 5, '**Paying Premiums'**, of the Policy Conditions booklet provides, *inter alia*, at pg. 7, as follows:

> *"5.4 The policy value which is built up from premiums will be used to pay the charges as they arise. This fund is used to smooth premium payments. Your policy value is likely to reduce in the later years of your policy because the cost of providing you with your benefits becomes more expensive as you get older".*

The Complainant's policy is a flexible unit-linked whole of life protection plan, providing life cover payable in the event of death. With policies of this nature, the cost of providing the life cover increases according to the age of the policyholder and this cost depends on a number of factors, including gender, age and current mortality rates.

As a person grows older, the cost of providing life cover increases as the age-related risk to the insured is greater. A positive policy value may be built up in the earlier years when the cost of the life cover is less than the premiums, but where the cost of life cover in later years becomes higher than the premium amount, the built up fund subsidises this difference. In due course, the fund is exhausted, resulting in the need for a policy review, which recommends either an increase in premium or a reduction in life cover.

Policy reviews are an integral part of a unit-linked whole of life policy. The purpose of these reviews is to assess whether the value of the policy and the on-going premium payments will be sufficient to sustain the cost of life cover until the next review date. The premium calculation takes into account, *inter alia*, the level of life cover provided and the age of the life assured, hence it may be necessary for the policyholder to make an additional provision to maintain the level of life cover by way of an increased premium. Alternatively, the policyholder may choose to maintain the life cover by increasing the premium. The setting of a premium following a policy review is the prerogative of the appointed actuary, which this office will not interfere with.

The Complainant's policy commenced on 16 May 1997. The policy conditions state that the Provider *"will review your policy at least once every five years"*. I note from the documentary evidence before me that the first policy review was not carried out until the tenth anniversary of the policy on 27 March 2007.

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However, given that the Provider wrote to the Complainant on 27 March 2007 advising that the then monthly premium of €122.07 was sufficient to maintain the then level of life cover of €93,804 for the next five years, I am satisfied that the policy would have also passed a review on the fifth anniversary of the policy in March 2002, if one had taken place at that time. As a result, I am satisfied that the Complainant was in no way financially disadvantaged by the Provider's failure to carry out a policy review at that time.

I note that the subsequent policy reviews were carried out every five years as scheduled, in March 2012 and March 2017.

In this regard, following the scheduled policy review in March 2012, I note that the Provider wrote to the Complainant on 27 March 2012 to advise, *inter alia*, as follows:

> *"Based on the current assumptions* [the policy] *should continue to provide valuable protection benefits until the end of the period of cover".* [Emphasis added]

The words underlined above, were in my opinion regrettable as they were likely to confuse, given that the protection benefits were available only until the next policy review in 2017. When this arose, 5 years later, in March 2017, I note that the Provider wrote to the Complainant on 25 March 2017 to advise, *inter alia*, as follows:

> *"A policy review is a checkpoint on your policy that we do every 5 years. At this checkpoint we determine if your premium and policy value together are enough to cover the cost of your chosen level of benefits until your next review.*
>
> *The results of your review indicate that if you wish to sustain your current level of benefits to the next review date in May 2022, you must* ***increase your premium from €337.27 to €447.26*** *per month.* ***We will apply this change to your policy on 16/05/2017 if we do not hear from you*** *to ensure that your chosen level of cover remains in place".*

This policy review also presented the Complainant with the option to reduce his life cover benefit from €119,334 to €106,505 whilst maintaining the then premium level at €354.14 per month.

I note that following discussions with Ms R., an Insurance and Investment Manager, the Complainant opted on 19 April 2017 to reduce his level of life cover to €100,000 for a reduced premium of €322.79 per month (including 1% Government Levy), with indexation removed from the policy.

As part of his complaint, the Complainant submits as follows:

> *"To cover the arrears, my* [premium] *payment increased until arrears were cleared and were to revert to original amount. This did not happen and have* [skyrocketed] *since …*

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> *So in order to keep my policy and not lose everything I had paid in, I had no option but to freeze my policy at €100,000* [life cover] *with a premium of €322 a month"*.

I note that the Complainant did not pay the monthly premium from August 2011 to December 2011 inclusive.

Following a meeting with Ms R., an Insurance and Investment Manager on 3 January 2012 and in order to reinstate the policy and address the outstanding premiums, the Complainant signed a quotation on 10 January 2012. This was for him to pay an increased monthly policy premium of €261.66 (excluding 1% Government Levy) up from the previous premium rate of €250.70 (excluding 1% Government Levy) until the next scheduled review date in March 2017. I note that the 'Important Notes' section of this quotation advised, *inter alia*, as follows:

> *"Your plan will be reviewed every five years, to make sure your premium is sufficient to pay for your benefits until the end of your period of cover"*.

As a result, the repayment of the unpaid premiums from August 2011 to December 2011 inclusive totalling €1,266 (5 months premiums @ €252.20 per month, including 1% Government Levy) were spread out over the period until the next scheduled policy review in 2017. When this took place, in March 2017, I note that the Provider wrote to the Complainant on 25 March 2017 to advise, *inter alia*, as follows:

> *"The results of your review indicate that if you wish to sustain your current level of benefits to the next review date in May 2022, you must* ***increase your premium from €337.27 to €447.26*** *per month"*.

At that time, the arrears that the Complainant had accrued from August 2011 to December 2011 had been cleared. As a result, the premium level the Provider was quoting as part of this March 2017 review, was based solely on the level of cover held at the time by the Complainant, who was in his mid 70s. In this regard, as I have stated above, the setting of a premium following a policy review is the prerogative of the appointed actuary and it is not a matter for the FSPO to modify it.

The Complainant states, *inter alia*, as follows:

> *"*So *in order to keep my policy and not lose everything I had paid in, I had no option but to freeze my policy at €100,000* [life cover] *with a premium of €322 a month"*.

At each policy review, the Provider will determine what life cover can be maintained by the current level of premium and what premium increase is required to maintain the current life cover, until the next scheduled policy review date. This inevitable increase in the premium, as the Complainant continues to age, is unwelcome, but the policy offers the Complainant continuing cover without specific medical loading, as long as he continues to maintain his premium payments.

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The Complainant may of course wish to explore other options, e.g. a term assurance limited to a specific period of time. It would however, be preferable for the Complainant in my opinion to ensure that the policy continues to be in place, until such time as he either puts an alternative policy into place or decides that he no longer requires the cover in any event.

Finally, in its Final Response Letter to the Complainant dated 1 May 2018, I note that the Provider stated, *inter alia*, as follows:

> *"You applied for a [product redacted] policy in April 2011 but cover was declined. Therefore you decided to adjust the benefit on this policy and bring the level of cover down to €98,000…the policy was revived in June 2011 with billing commencing that month"*.

In this regard, in his note to this Office dated 17 July 2018, the Complainant submits, as follows:

> *"The part relating to me applying for a [product redacted] for me and my family in April 2011 never happened. This is the first I have heard of it. The fact that this "Application" is around the same time as the missed premiums leads me to believe* [the Provider] *have me mixed up with someone else. My policy does not allow for this"*.

However, I am satisfied from the documentary evidence before me that the Complainant met with Mr B., an Insurance and Investment Manager on 15 April 2011 and signed an application for a *[product redacted]* contract for life cover in the amount of €150,000, for a term of 15 years on that date. As part of this application and at the request of the Provider, the Complainant underwent a tele-interview with a nurse on 18 April 2011. I note that based on the medical information then made available, the Provider was not in a position to offer the Complainant the cover sought and it wrote to him on 17 May 2011 to advise, as follows:

> *"Thank you for your recent application for a* [Provider]*, [product redacted], requesting Lump Sum on Death Benefit of €150,000 over a term of 15 years.*
>
> *Following careful consideration by our Chief Medical Officer, we regret that we are unable to offer you cover"*.

At that time, I note that the Complainant had not paid any premium in respect of his whole of life protection policy since December 2009. Having been refused this application for a fixed term life policy on 17 May 2011, the Complainant then met again with Mr B. on 30 May 2011 and signed a quotation on that day, to reinstate his whole of life protection policy with a monthly premium of €250.70 (excluding 1% Government Levy) for a life cover benefit of €93,500. This was a reduction from the life cover amount of €108,591 stated in the Annual Statement sent to the Complainant on 17 May 2010. Indeed, I note that the Provider permitted him to do this, without a Declaration of Health, as normally required.

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Whilst the Complainant suggests that *"my policy does not allow for this"*, I note that the 'Introduction' section of the Policy Conditions booklet provides, *inter alia*, at pg. 3, as follows:

> *"You can ask to increase or reduce the benefits at any time as your needs change. If you wish to change the policy details, we will work out your revised premium"*.

In this regard, I note that the Complainant also chose to reduce the level of life cover once again, in April 2017.

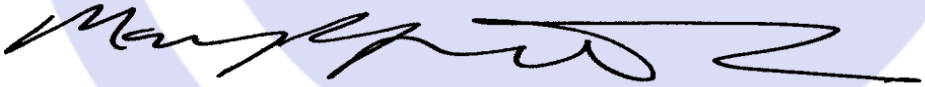
Having considered the evidence before me, I am of the opinion that the Provider adopted a more than fair approach in reinstating the Complainant's policy on 10 June 2011 and again on 17 January 2012 after it had lapsed due to the non-payment of premium, without the Provider requiring him to complete a new Declaration of Health on those occasions. This is of particular significance, given that the Provider had previously declined to provide the Complainant with a separate fixed term life policy in May 2011, due to the medical information that he had made available as part of that application process in April 2011, for it enabled the Complainant to ensure that he continued to have life cover in place.

Having reviewed the matter in its entirety, on the basis of the evidence available, including the contractual provisions of the policy in place, I am satisfied that in carrying out the policy reviews in March 2007, March 2012 and March 2017 the Provider administered the Complainant's life protection policy in accordance with the policy conditions.

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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

6 October 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.