An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

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| **Decision Ref:** | 2020-0419 |
| **Sector:** | Insurance |
| **Product / Service:** | Farm & Livestock |
| **Conduct(s) complained of:** | Rejection of claim – partial rejection |
| **Outcome:** | Upheld |

## LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint relates to the Complainant's claim under his Farm Insurance Policy arising from damage caused during a fire which occurred [month redacted] 2015 and which spread to three sheds in the Complainant's farmyard.

## The Complainant's Case

The Complainant has held a Farm Policy with the Provider since in 1999. The Complainant maintains that he always understood his policy to cover all the various farm buildings on the farm. The Complainant has described the annual attendance at his farm by the Provider's local representative, an employee of the Provider, at the time of each renewal of the policy, including in [month redacted] 2015. Upon this attendance in [month redacted] 2015, the Complainant advised that no new farm buildings had been constructed in the previous year and, following the attendance, the policy was duly renewed.

Unfortunately, one morning in [month redacted] 2015, one of the Complainant's hay sheds began to burn, requiring the attendance on site of multiple units of the local fire brigade. The fire spread to three farm buildings in total. Ultimately, two sheds were irreparably damaged, and the content of hay in one of them was destroyed. In due course, the Complainant made a claim on the policy. At this point, the Complainant states that the Provider advised him that one of the sheds which had been damaged, a shed which will be referred to as the "Disputed Shed", was not actually covered on the policy and that consequently, the Complainant would not be entitled to compensation in respect of the total value of his loss albeit that a certain amount was paid over.

Thereafter, the Complainant engaged extensively with the Provider including his submission of an internal appeal/complaint, which was rejected. At this point the Complainant indicated his intention to complain to the, then, Financial Services Ombudsman, which, according to the Complainant, precipitated a meeting with a representative of the Provider. In the course of this meeting, the Provider made "*an offer of €25,000 to settle the claim*", that figure, according to the Complainant, representing half the amount that he contends was the insured value of the Disputed Shed and to which he argues he was entitled. The Complainant states that, as his "*family were under financial strain*" and, as he needed the money to purchase bedding for his cattle, he accepted the offer "*under duress*". In his submission, the Complainant states that he accepted the offer "*under duress due to being under financial strain as a family as a result of [the Provider's] delay in dealing with the loss*".

In addition to the foregoing, in the course of the same meeting, the Complainant maintains that he requested the Provider to pay a bill of approximately €6,400 (€6,335 in exact terms) in respect of a contractor who had assisted with dealing with the aftermath of the fire. The Complainant states that the Provider's representative said that he would "*do his best*" but no payment has ever been made.

The complaint is that the Complainant made a claim on his insurance policy in respect of the Disputed Shed which, he maintains, was wrongfully declined by the Provider. The Complainant seeks payment of the balance to which he claims he was entitled on the policy, €25,000, together with approximately €6,400 (€6,335) relating to the contractor, resulting in a total of €31,400.00 (€31,335).

**The Provider's Case**

The Provider maintains that the Disputed Shed was not covered on the policy and, therefore, the Complainant was not entitled to compensation in respect of damage to it. The Provider claims that, notwithstanding this, the Complainant accepted a "*goodwill ex gratia contribution*" towards his loss which, in the Provider's letter to the Complainant referring to the matter, the Provider notes that the Complainant was "*happy to accept to finalise the matter*".

The Provider seeks to rely also on the argument that from the inception of the policy, a building described as a "2.5 span slatted unit" was listed on the schedule and that the sum insured was increased on that building in November 2006, rather than the addition of a new building.

The Provider also argues that at the time of the November 2006 amendments to the schedule of insured buildings, construction of the Disputed Shed had not been completed. The Provider relies on a receipt submitted by the Complainant relating to the purchase of some of the materials used in the construction of the Disputed Shed which bears a date in December 2007. It argues that it would not have insured a part-completed building.

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**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 29 October 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.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

**Matters for consideration**

There are two matters for consideration, the substantive complaint is that the Provider has wrongfully declined to make full payment in respect of the Complainant's loss arising from the destruction of the Disputed Shed caused by the fire in 2015.

The second aspect of the Complainant's complaint, as set out in his complaint form, is that the Provider has wrongfully declined to pay the Complainant's claim for the sum of €6,335, that being the cost incurred in hiring a contractor to remove burning debris from the vicinity of the Complainant's farmyard in the aftermath of the fire.

However, before turning to address either aspect of the complaint, it is necessary to deal with a matter that has arisen in the course of the investigation of the complaint, that being whether or not the Complainant accepted a lesser amount than that which he asserts is the sum insured in relation to the disputed building, in full and final settlement of his claim.

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**Discussion on the €25,000 *ex gratia* payment**

Following the fire, when the Provider initially considered the Complainant's fire damage claim, it asserted that the Disputed Shed was not a covered building. It agreed a settlement of approximately €64,000 in respect of the buildings that it accepted were covered on the policy.

The Complainant maintained throughout the process his understanding that the Disputed Shed was covered by the policy and that it had been added to the list of buildings covered by the policy when the Provider's local representative visited his farm in November 2006. Following representations to the Provider's Head Office by its local representatives, the matter came before the Provider's *ex gratia* committee and an *ex gratia* payment, of €25,000, to the Complainant was approved.

An employee of the Provider met with the Complainant and his wife and offered €25,000 which the Provider submits, was accepted in full and final settlement of all claims in respect of the consequences of the fire. The Complainant agreed to accept the payment and at that meeting says it was also agreed by the Provider's employee that it would 'look at' payment of a further disputed element of the claim, namely the costs incurred in hiring a contractor to remove the burning hay from the vicinity of the farmyard and dwellings in the days after the fire.

In his submissions, the Complainant asserts that on account of his straightened financial circumstances, resulting from the fire, he *"under duress"* accepted the payment. He now argues that such acceptance was not an acceptance in full and final settlement of his claim.

It should be noted that, in circumstances such as the present case, parties to a dispute are free to reach a settlement at any stage prior to its conclusion, as indeed is frequently the case in court proceedings. However, there are a number of essential requirements that must be present in order for a valid agreement to compromise to have been reached.

a. There must be consideration;

b. There must be an identifiable agreement;

c. The agreement must be complete and certain;

d. There must be an intention to create legal relations, and

e. Any formalities required must be observed.

I will deal with each requirement in turn.

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a. The requirement here is that there must be some benefit accruing to one party corresponding with some detriment to the other. In the present instance, the Provider submits that it agreed to pay the amount of €25,000 to the Complainant and that in return the Complainant, at the meeting which took place, said he would forbear from taking further action regarding the matter in dispute. Thus, the requirement that there be valid consideration would appear to have been satisfied.

b. In many instances, an agreement to compromise will be obvious from the exchange of correspondence between the parties or from the terms of a written compromise agreement. None of these exist in the present case.

   It would appear from the evidence submitted that the *ex gratia* payment being offered was put to the Complainant at a meeting with the Provider's employee, in the Provider's local office, on or about 11 March 2016. The subsequent letter from the Provider dated 13 April 2016, with which the cheque was enclosed, did not refer to the detail of the discussion that had taken place at that meeting, but instead referred to *"representations"* having been made on the Complainant's behalf by the Provider's named employee and the Provider having agreed to make the payment. The Complainant does not appear to have been asked to confirm his agreement to the compromise, nor was any confirmatory letter or email sent to him immediately after the meeting. The Provider's employee, who apparently conducted the meeting has indicated that the Complainant was advised to take some time to consider the proposal. No evidence of any further communication with the Complainant concerning the *ex gratia* proposal in the time between the meeting on 11 March 2016 and the issue of the letter and cheque on 13 April 2016 has been furnished by the Provider.

c. Even where it is possible to construe an agreement from the parties' negotiations and communications, the agreement might not be sufficiently clear or certain to enable it to be considered a valid compromise. In the present instance, the Complainant describes the meeting that took place in the Provider's local office on 11 March 2016. However, it is not clear if there was a meeting of minds as to whether the payment that the Provider agreed to make represented a full and final settlement of all outstanding claims arising from the fire in 2015.

   Two issues are relevant to my consideration of this element of what would comprise a valid compromise of the dispute. The Complainant refers to an *"an offer of €25,000 to settle the claim"* and the letter enclosing the cheque states that it is provided *"in respect of Settlement of claim*". This points to a valid agreement.

   However, on the other hand, the second of the issues that I consider relevant relates to the nature of the agreement by the Complainant to accept the Provider's offer of payment.

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The Complainant explains that he did so on the understanding that the Provider would 'look at' the payment of a further €6,400 to cover the cost of the removal of the smouldering hay from the location of the fire. This introduces an element of conditionality into the acceptance. The internal file note dated 18 October 2016, furnished by the Provider, shows that the Complainant had continued to raise the matter of the payment of the contractor's bill up to that time.

Further, the email dated 14 March 2016 in the Provider's submissions refers to the Complainant agreeing to accept the *ex gratia* payment if the Provider agrees to then release the amount of the covered claim that it had withheld by way of retention, pending the completion of the works and the submission of confirmation thereof. This too introduces a degree of conditionality, even if different from that recounted by the Complainant.

Either way, I am satisfied that the acceptance by the Complainant of the €25,000 was conditional on the Provider then doing either one of these two things. This 'conditionality' leads me to the conclusion that the Provider clearly knew that, at that time, the matter was not fully resolved.

I accept that the Provider made the *ex gratia* payment in the hope that the matter might be resolved, but on the evidence before me, I cannot accept that the agreement to do so was complete and certain.

d. In relation to the intention to create legal relations between the parties, I will address this requirement in conjunction with requirement 'e.' below, as in the context of the settlement of an insurance claim, I consider that the intention to create legal relations is inextricably linked with insurance industry practice and the 'formalities' that go with it.

e. Insofar as the requirement for the observation of formalities is concerned, certain types of contract, such as contracts in relation to the transfer of land or to guarantees, are required by law to be evidenced in writing. There is no legal requirement to reduce the settlement of an insurance claim to writing and, the Provider argues that its letter dated 13 April 2016 to the Complainant fulfils the requirements sufficiently to bind the Complainant to his acceptance of the ex gratia payment.

While there may be some merit in that argument, there are other factors which I must consider. As this aspect of the decision concerns the validity of the compromise of an insurance claim, it is also necessary to look at the normal operating practices within the insurance industry. In relation to the type of agreement argued for by the Provider, it is standard insurance industry practice, when making such compromise agreement to secure written confirmation that the payment being made is accepted by the recipient, in full satisfaction and final settlement of all claims arising from the event in question.

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The Provider did not follow that practice in making the *ex gratia* payment in this instance, even though the internal email dated 8 April 2016, furnished as part of the Provider's response to the complaint, contains the following instruction to the Provider's claims handler;

> *"Can you please arrange for payment, along with an acceptance letter for the client to sign stating that he accepts this amount in respect of full and final settlement of this claim to be sent to [named employee and local office] and he will get the client to sign the acceptance form and issue him with payment."*

The Provider has not been able to explain why the matter was not dealt with in line with this instruction, though it accepts that, for whatever reason, it did not obtain from the Complainant such an acceptance letter, at any stage in the process concerning the payment of the €25,000.

It relies on its letter to the Complainant on 13 April 2016, but, as I have noted at b. above, I do not consider that this letter fully reflects the circumstances of the payment.

In this regard also, it should be noted that, in December 2015, when the Provider agreed payment of the claim in respect of the buildings which it accepted were insured, it followed the standard insurance industry practice and obtained the Complainant's acceptance of the settlement figure, in respect of the damage to the buildings that it was not disputed were covered under the policy. The Acceptance Form that was signed by the Complainant at that time signalled acceptance of the payment that would be made in respect of the buildings that were agreed were covered by the policy, but specifically excluded the *"claim that may be being pursued"* in respect of the disputed building.

The foregoing also, in my view, points to the Provider's clear awareness of the need to make 'watertight' any agreement that might be reached. In light of this, I am of the view that, while the Provider may have intended that the *ex gratia* payment would resolve the matter, the manner of its execution, as described above leads me to the conclusion that it should not be considered a valid compromise agreement.

In those circumstances, I will now turn to consider the substantive elements of the Complainant's complaint, regarding whether the 'Disputed Shed' was, or was not, covered by the Complainant's Farm Policy and, whether the contractor's costs should also have been covered by his policy.

**Whether the Disputed Shed was covered by the policy**

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There is much confusion regarding the descriptions of various farm buildings in the Complainant's farmyard, not least on the part of the Provider which, on its own case, misdescribed (by reference to the size) a number of buildings on the Complainant's policy. The Complainant has provided detailed submissions inclusive of photographic material in support of his contentions as to which building is which, and as to what building should have been, but was not insured. This material is persuasive in relation to a number of the points which the Complainant makes.

The fact is that the original map of 1999 and the original description and numbering has changed over the years with the construction of additional buildings, but without revised farmyard plans having been prepared by the Provider's local representative as part of a survey process. In circumstances where it is asserted by the Complainant that the Provider's employee visited the farm each year in relation to the renewal of the policy, I consider the absence of revisions a serious omission. In effect, it would permit any error made early in the lifetime of the policy to be continued and exacerbated throughout the years the policy was in force, if the only question asked by the Provider's employee at each renewal was whether there had been any new buildings constructed in the past year, and in circumstances where no proper inspection, survey or mapping was carried out.

This is most obvious arising from the changes made to the schedule in 2002 and where no new farmyard plan was prepared to show the precise location of the revisions. Recordings of a number of calls have been provided in evidence and I have considered the content of these calls.

In considering the extent to which the Provider had a responsibility to survey the farmyard and buildings at each renewal or at all, I have reviewed the submissions, including the call recordings furnished by the Provider and am satisfied that, though not specified in the policy terms and conditions, the Provider's practice was that an employee visits the farmyard and surveys the buildings at the very least when additions are proposed. Specifically, I am referring to a telephone conversation that took place between the Complainant and a member of the Provider's local office staff on 20 August 2015 at 12.12pm. During that call the Complainant explained that a shed that was in existence for about 15 years had been *"missed"* and that he wanted to put it on cover. The Provider's employee explained that in order to do so the Provider would, "*have to get the rep to call out"* the purpose of which was, *"to have a quick look at it and put it on cover."*

**<u>Submissions by the parties</u>**

a) The Complainant's arguments in relation to the visits to his farm by the Provider's employee and his understanding that all buildings were covered.

The Complainant has maintained from the very outset, and consistently throughout the investigation of his complaint that the Provider's local representative visited his

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farm each year at renewal and that he 'walked' the yard and was familiar with it, having purchased livestock in a personal capacity from the Complainant. The Complainant argues that he relied on the Provider's local representative to ensure that all of his buildings were properly and adequately insured. He argues also that he was assured by the Provider's employee that this was the case.

In the Provider's response to the complaint, it relies on a denial by the local representative that his visits were consistent throughout the lifetime of the policy and also on his assertion that he was, *"not aware of the [Disputed Shed] prior to the fire"*. The Provider, in its engagement with the Complainant and in its submissions to this office has clearly accepted the account given to it by its local representative, that he did not attend the Complainant's farm annually, did not walk the farm every year and that he was not aware of the existence of the Disputed Shed.

This conflict has largely been resolved by the content of a telephone conversation which took place on the day of the fire between the Provider's local representative and a member of its Head Office claims staff. Of particular note is the call took place at 9.10 am on the morning of the fire in 2015. During the call the local representative raised the issue that there might be a problem with underinsurance of the buildings on the Complainant's farm. When asked by the Head Office employee whether the Complainant was aware of this potential underinsurance, the local representative answered that he was not.

Further, the local representative asked that a particular local loss adjustor be appointed to deal with the claim on the basis that he would be better placed to deal with any issue involving under insurance. These comments point to a degree of familiarity with the buildings on the Complainant's farmyard that undermines the assertions by the Provider's local representative that he was unaware of the Disputed Shed and that he had not visited the farm regularly.

I note with concern that the note of that telephone call taken by the Provider's Claims Department employee does not accord with the entirety of the conversation, especially where the Claims Department employee asks whether there had been reviews since the inception of the policy. The note says that there were, *"no reviews or inspections carried out since inception"* whereas, the call recording establishes that in answer to the question about reviews since inception, the local representative answers that, *"there would have been regular review meetings"*.

As part of the Provider's submissions, it has furnished a statement from its local representative which deals entirely with his visit to the Complainant's farm on [date redacted] 2015 when he dealt with the renewal of the policy immediately prior to the fire.

It does not address the nature or extent of his prior visits to the farm other than in the following context where he says;

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> *"I regret not insisting on walking the farm that evening <u>as I do on all farm revisions</u> but the conversation that [the Complainant] was leading was a cost reduction one but I'm sure had I picked up the missing shed he would have insured it".* [My emphasis added]

The indication by the local representative that he 'walks the farm' on all revisions suggests that at some point between 2006 and 2015, he ought to have conducted a proper inspection/survey of the buildings, especially in light of the number of revisions that had already been made, such as for example at the 2002 renewal when no new drawings were prepared by the local representative.

Finally, during that telephone conversation on the morning of the fire in 2015, the matter of the history of the policy was discussed. The local representative informed the Head Office employee that he had done the initial inspection in 1999 and been involved with the policy since then. He also said that there had been regular review meetings with the Complainant.

In circumstances where the Complainant described the various attendances by the local representative of the Provider in great, almost minute detail, and where no detailed account was furnished by the Provider of the local representative's visits to the Complainant, other than in [month redacted 2015, shortly before the fire and, where the recorded telephone call leads me to believe that there were *"regular reviews"*, I am satisfied to accept the Complainant's evidence on this aspect of the matter.

b) The Complainant's arguments regarding the accuracy of the descriptions of each of the buildings in his farmyard.

Much emphasis has been placed by the parties on the various maps and drawings furnished in evidence. The policy was incepted in 1999 and the schedule of farm buildings were subject to considerable change between then and the fire in 2015. Notwithstanding that however, no revised plan of the farmyard was prepared, prior to November 2006. That 2006 plan appears to follow the line of the only previous plan, being the original in May 1999. This is in spite of the revisions made to the buildings in 2002, when no new plan was created.

That there are inconsistencies and unresolved discrepancies between how the Complainant describes the buildings and how they are described in the Schedule is clear. The recorded telephone call on 20 January 2016 deals extensively with this issue and I have found the Complainant's arguments during this lengthy telephone call to be highly informative and very persuasive.

I am satisfied, having reviewed the entirety of the parties' submissions and arguments that on the evidence before me, there was for some time, most likely from the inception of the policy, a degree of misdescription of the insured buildings. There appears also to have been an absence of clarity as to the evolution of the layout of the Complainant's farmyard and the buildings therein during the lifetime of the policy. This

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led to the situation whereby the information transmitted by the Provider's local representative to its Head Office regarding the buildings to be insured was flawed. In the final analysis, it led to the dispute about the Disputed Shed, but also to the realisation that a second building, known as the 'bull pen' where the Complainant argues he kept his most valuable animal, not being listed on the schedule as being insured.

Having considered carefully the contents of the telephone call from the Provider's local representative to its Head Office on the morning of the fire in 2015, I am satisfied that he then realised that there were likely to be 'issues' with the buildings insured and certainly the sums insured.

The Provider, throughout its submissions has argued that it is the responsibility of an Insured to make certain that the correct buildings are insured for the right amount. Indeed this position was summed up, quite succinctly, by the Provider's employee who dealt with the Complainant's complaint, during a telephone call on 20 November 2015, when she said to the Complainant, *"your property is your responsibility".*

In circumstances where the Provider accepts a proposal and grants cover solely on the information furnished by an Insured, I might accept the Provider's assessment of the situation.

However, the difference that arises in the present set of circumstances is that the Provider's local representative visited the Complainant's farm at the outset, in May 1999 and, I am satisfied that he did so regularly, during the lifetime of the policy.

The Provider's local representative prepared whatever maps were required as well as the information for transmission to the Provider's Head Office. He was effectively the Provider's inspector or surveyor of the risk and as such had a duty to ensure that all the information given to the Provider's Head office was accurate. Indeed during the telephone calls referred to above that took place on the morning of the fire in 2015, the Provider's Head Office employee referred to the visits by the local representative as *"inspections"*. As the local representative attended in the capacity of an employee of the Provider, the Provider must bear responsibility for any shortcomings in his work.

I consider that the role of the Provider's local representative, in carrying out inspections or surveys of the site and in preparing the required plans of the farmyard, including the 2006 plan, together with his ongoing involvement with the renewal of the policy is such that it creates a duty to take all reasonable steps to ensure the accuracy of the schedule of buildings covered as well as, insofar as is possible, the adequacy of the sums insured.

In the absence of the local representative having this role of inspector/surveyor, there would be little reason for his conducting such site visits annually or at all, unless requested to do so by either the Provider's head office or by the Complainant and, no evidence has been furnished to suggest that either was the case.

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c) The Provider's argument that the building in question had not been added to the Schedule of covered buildings in November 2006, as the structure had not been completed at the time.

In this regard, the Provider relies on the argument that, at the time of the visit to the Complainant's farm by its local representative in November 2006, the building had not been constructed. It cites as evidence the receipt furnished by the Complainant to show that certain of the materials used in its construction were not purchased until late in 2007.

The Complainant accepts that the Disputed Shed had not been completed at that time. He has explained that the slatted tank had been constructed and, in the course of the telephone call with the Provider on 20 January 2016 set out a very clear and detailed explanation of the circumstances of the visit by the Provider's local representative, the reasons for it, the work then going on in relation to the welding of the ironwork and the confirmation by the Provider's local representative that he would add it to the Schedule. I acknowledge that the Provider, had it been informed by its local representative that the building was not then complete, might not have been prepared to provide cover in respect thereof.

d) The Provider's argument that the building described as a 2.5 span slatted tank/straw shed had been listed on the schedule of buildings since 1999 and, could not therefore have been added in November 2006.

The Provider's position is that the amendment made in November 2006 was to increase the sum insured on a 2.5 span slatted/straw shed that had been on the schedule since 1999 and not the addition of the new building contended for by the Complainant. It argues that the sum insured on the existing building was increased to €50,000 from €15,000 and that this is reflected in the drawing prepared by its local representative.

This argument is undermined by the counter arguments made by the Complainant and also by the unreliability of the plans and the building descriptions referred to earlier.

To counter this argument by the Provider, the Complainant has maintained that it would have made no sense for him to increase the sum insured on a building already on the schedule, which he states was halved in size. He also states, and this has not been challenged, that this building does not fit the specification of what comprises a 2.5 span structure.

He explains that a 'span' in agricultural building terms has a specific meaning, equal to 15 feet and 9 inches and that this building, so described since 1999 is not of that dimension, being 28 feet. He argues also that the only alteration to that building was to reduce its size, and that this would certainly not justify any increase in the sum insured.

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Furthermore, during the investigation of this complaint, the Complainant submitted an engineer's report which states that there was only one 2.5 span slatted tank on the farmyard, that being the one adjacent to the now destroyed 'Disputed Shed'.

Having considered all of the large volume of evidence submitted by the parties in support of their respective positions, I accept that, in light of his dealings with the Provider's representative, the Complainant was justified in his belief that his farm buildings were all correctly insured under his Farm Policy with the Provider.

Therefore, I uphold this element of the complaint.

I will now deal with the second element of the Complainant's complaint, concerning the matter of the contractor's invoice and the Provider's decision not to reimburse the Complainant with the amount involved, that being €6,335.

In his complaint form and accompanying submission wherein he expanded on the detail of his complaint, the Complainant set out this element of his complaint as being;

> *"[w]e also requested they pay a bill of €6,400 (actual amount €6,335) to [named contractor], a contractor who assisted with the fire and its ruins. [The Provider's named employee] said he would do his best to get this paid also but to date no payment has been made."*

The Complainant says that this statement was made by the Provider's employee during the course of the meeting at which the offer of €25,000.00 was advanced, when the Complainant says that he requested that the Provider also satisfy an invoice raised by a subcontractor in the amount of c. €6,400 (€6,335).

It should be noted also that in his complaint form, when setting out the outcome desired, the Complainant included this amount in the total redress sought, that being €25,000 plus €6,400.

Notwithstanding that the Complainant sought redress in that amount in his complaint form, the Provider made no reference to this element of complaint in its initial formal response to the complaint to this office. It was only when this office sought further information regarding a number of other aspects of the complaint that the Provider submitted its reasons for excluding this item of outlay from the initial claim.
The Provider, in its submissions, has argued that;

> *"They fell outside the scope of the policy. The Shed was not insured and we did not agree to the contractor's fees as they were working under the instruction of the fire brigade therefore they should have billed them. Also works they carried out in the days after the fire were not agreed and would not have been covered under the policy".*

On examining the entirety of the material submitted by the Provider, I find this reasoning or explanation does not appear elsewhere in its submissions. The only other reference to

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this element of the complaint and the reason for the decision to decline payment of this amount appears in the report prepared on 11 December 2015 by the loss adjustor appointed by the Provider to deal with the claim. It indicates a different reason for the decision to decline to pay this amount to the Complainant. It states;

> *"Also whereas it was accepted that the insurance on each building under sections 1 and 2a of the policy extended to include costs and expenses necessarily incurred by the insured with the consent of the company in:-*
>
> *d) Removing debris,*
> *e) Dismantling and/or demolishing,*
> *f) Shoring up or propping*
>
> *The liability of the Company under this clause of the policy in respect of any item, shall in no case exceed the sum insured and as we had allowed the full sum insured under the buildings heading for the 2 x 3 span hay barn, no payment was allowed for the extra emergency costs incurred."*

As can be seen therefore, the loss adjustor's reasoning does not appear to accord with the reasons given by the Provider in its submission to this office.

Notwithstanding that divergence, and having reviewed the parties' submissions, I am satisfied that the Complainant has furnished an invoice from the contractor, made out to him, in respect of the removal of the debris from the vicinity of the other buildings in the aftermath of the fire. While the statements of the loss adjustor's staff suggest that the contractor operated 'under the direction' of the local fire brigade, there is nothing in those statements to indicate that the fire brigade had hired the contractor to assist it. Indeed, in this regard, the loss adjustor's report indicates also that some of the Complainant's neighbours assisted by drawing water to the site of the fire using their slurry tankers. Therefore, it seems to me to be entirely reasonable that the Complainant would take all necessary steps to remove the smouldering material, away from his other buildings and his farmyard, including the hire of a contractor who had the equipment that was required to do so. Indeed, I consider it would not have been prudent for the Complainant not to have carried out the instructions or advice offered by the fire brigade.

For this reason, I uphold this aspect of the complaint.

Finally, I must comment on the wholly unsatisfactory aspects of the Provider's engagement with both the Complainant and this Office in the investigation of this complaint.

In that context, the following provisions of the ***Financial Services and Pensions Ombudsman Act 2017*** should be noted. ***Section 59(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** provides that;

> *"A person who -*
>
> *…*

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*(c) without reasonable excuse, fails to comply with a requirement or request made by the Ombudsman under this Act,*
*…*

*(d) in purported compliance with a requirement or request referred to in paragraph (c), gives information that the person knows to be false or misleading,*

*…*

*commits an offence and is liable on summary conviction to a class A fine or to imprisonment for a term not exceeding 3 months, or both."*

It should be noted also that ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** provides that;

*"A complaint may be found to be upheld, substantially upheld or partially upheld only on one or more of the following grounds:*
*…*

*(f) an explanation for the conduct complained of was not given when it should have been given;*

I am particularly concerned by the Provider's failure to furnish this office with certain evidence when initially requested to do so. At the commencement of the investigation of the complaint, this office sought copies of recorded telephone conversations. None were furnished and the reason given by the Provider was that it thought that there were, *"no relevant calls in this case".*

When, during the course of the investigation, additional evidence was sought from the Provider by this office, again requesting copies of recorded telephone conversations, it did then furnish copies of sixteen recorded telephone conversations. Not all of these assisted in my consideration of the complaint. However, as outlined above, I found a number of these recorded telephone calls to constitute critical evidence.

I am also concerned about the manner of the Provider's investigation of the conduct of its local representative in circumstances where there were very clear differences between the Complainant's account of the local representative's visits to the Complainant's farm in the years prior to the fire, and the account given by the local representative to the Provider and which would appear to have been accepted with little scrutiny. The only detailed account from its local representative that the Provider has furnished relates to the visit on [month redacted] 2015. A more thorough enquiry in relation to the entirety of the local representative's dealings with the Complainant, specifically in light of the recorded telephone conversations, may have led to a different conclusion on the Provider's part and, perhaps, to a foreshortening of the entire process.

/Cont'd…

I consider that the Provider's conduct in dealing with this complaint has greatly added to the inconvenience suffered by the Complainant in having the matter finalised.

For the reasons outlined in this Decision, I 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 upheld, on the grounds prescribed in ***Section 60(2) (b), (f) and (g).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to pay to the Complainant the sum of €31,335, that being €25,000 in respect of the balance of the sum assured on the disputed building and €6,335 in respect of the cost incurred by him in removing the burning debris from the vicinity of the farmyard.

I also direct the Provider to make a compensatory payment of €15,000 to the Complainant to mark its failure to provide the Complainant with the appropriate level of service in respect of both its dealings with the Complainant at the renewals of the policy prior to the fire in 2015 and also, following his complaint to the Provider, about the manner in which the Provider dealt with that complaint.

The above sums are to be paid into 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.

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**

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**FINANCIAL SERVICES AND PENSIONS OMBUDSMAN**

20 November 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.**