An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0044
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a motor insurance policy.

The Complainant's Case

The Complainant held a motor insurance policy with the Provider, with a family member listed as a named driver on this policy.

The Complainant had two claims during the 2016/2017 period of insurance. The first, claim number xxx52, related to an accident on **6 October 2016**, with Ms X. identified as the third party. The second, claim number xxx31, related to an accident on **4 November 2016** in which the third party was never identified.

In its letter to the Complainant dated **27 September 2019**, the Provider advised, as follows:

> *"It emerged from our investigation that there was a significant mistake made when handling these claims which possibly impacted* [the First Complainant's] *ability to explore other insurance markets for your motor insurance since your renewal in July 2017.*
>
> *We discovered that we had inadvertently paid* [Ms X.'s] *insurers under claim number xxx31, having mistaken her for the Third Party in this claim. It was not our intention to concede liability or make a payment to this Third Party as we considered her at fault for the accident (claim xxx52). When we discovered this error, we immediately corrected our records by moving the payment to the correct claim and began the process of recovering the money. This has led to a long dispute with* [Ms X.'s] *insurers which is still ongoing. Unfortunately, the claim file must remain open whilst these negotiations continue.*

In consideration of this substantial error we have reviewed your 2017 and 2018 renewal calculations and confirm we are refunding you some premium for both years.

In 2016 your policy was arranged on a 1 year earned No Claims Discount, transferred from a previous policy in [the Complainant's] *own name. We also allowed an introductory discount for other driving experience. At renewal 2017 we disallowed the driving experience discount due to the claims. You also lost your earned no claims discount when we applied the step-back no claims discount protection which was included in your policy. We now agree to apply the step-back no claim discount protection to the combined earned no claims discount and introductory discount. This means we revised the 2017 discount percentage from 0 years to 3 years and the 2018 discount from 1 year to 4 years. We have also removed any claims loading that had been applied. This resulted in a refund of €798.92 on your 2017 renewal and €937.95 on your 2018 renewal. These amounts will be processed immediately and will be refunded to you through your insurance intermediary …*

We also recognise how distressing this situation has been for you and wish to offer you €500 in compensation for out lapse in service. This is in addition to the premium refunds".

In this regard, the Complainant sets out her complaint in the Complaint Form she signed on **20 January 2020**, as follows:

"I had a crash in 2016 which was not my fault. My insurance company paid for other person that was in the wrong, [their] *car to be fixed. But her insurance company paid me €9,000 then my insurance company closed the case then when I phoned they reopen it, as I knew I was not at fault …*
I just want all the overpayments I have paid to this insurance company as I [know] *I was not at fault".*

In a handwritten note to the Provider on file, it is submitted by and/or on behalf of the Complainant, *inter alia*, as follows:

"*For a start, we are not happy with the final outcome, even though it was successful.*

The payments they have worked out + come up with are undervalued and have left us short at the end of the day!

Our family situation has also suffered from [the Provider's] *negligence + incompetence…and when I say this, I mean* [the Complainant] *suffers from anxiety and her dose has been increased from 100mls a day up to 150mls a day.*
Plus how could a big insurance [company] *make a big mistake like this and you think 500 euro for all the stress you have caused* [the Complainant] *and for your mistake is enough …*
… and for all the taxi fare [the Complainant] *has had to pay as for your company's incompetence*".

/Cont'd…

The Provider's Case

The Provider position is as set out in the passage from the letter of **27 September 2019** reproduced above, namely that it has acknowledged a "*substantial error*" and that it has sought to reimburse the Complainant for the loss stemming from the error and, additionally, to provide further compensation in the amount of €500.

The Provider acknowledges that it made an erroneous payment in respect of Ms. X. (the third party in Claim xxx52) to Ms. X.'s insurance company, in the amount of €1,740.59 under the Claim Reference xxx31. The Provider later discovered that Ms. X. was not the third party in this incident and removed the payment which has since been allocated to the correct file reference xxx52. The Provider notes that the payment is still erroneous insofar as it did not intend to pay the third party under Claim Reference xxx52 as it considered the third party to be liable for the incident. The Provider has confirmed that it is seeking recovery of the erroneous payment in question from the third party insurers, along with the cost of its vehicle damage outlay under Claim xxx52.

The Provider says that although the payment was erroneous, it cannot be removed from its records. The payment was made from the Complainant's insurer's claim fund and the Provider cannot expunge the payment from the records as it can only "contra" the payment if and when the money is recovered from the third party insurers.

The Complaint for Adjudication

The Complainant's complaint is that the Provider failed to properly administer her motor insurance policy by incorrectly settling a claim, as a result of which she suffered inconvenience and loss.

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.

/Cont'd…

A Preliminary Decision was issued to the parties on **1 February 2021**, 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.

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

Analysis

The Complainant in this matter was involved in an accident on **6 October 2016** which she maintains was the fault of the driver of the other car involved in the collision. This proposition would appear to be accepted by the Provider, and indeed the Complainant makes reference to being "*paid*" €9,000 by other driver's insurance company, which appears to be a reference to compensation for personal injuries (and an inherent acknowledgment of either full or partial liability).

Notwithstanding this position, the Provider (which is the Complainant's insurer) inadvertently and in error paid out for the material damage to the other driver's vehicle. The Provider identified this error (two years after the event it would seem) and brought the matter to the attention of the Complainant. In doing so, the Provider accepted that it had made a "*substantial error"* and it has sought to reimburse the Complainant for the loss stemming from the error and, additionally, to provide further compensation in the amount of €500.

In the circumstances, and in particular where the Provider has accepted a significant failing, I consider it appropriate to examine the adequacy of the compensation offered to the Complainant by way of redress. The Complainant views the compensation offered as inadequate and "*undervalued"*. In her Complaint Form, she seeks the reimbursement of the "*overpayments"* paid to Provider. The Complainant also refers to taxi expenses which she was forced to incur. The Complainant has not however explained or quantified any losses she claims to have incurred as a result of the Provider's actions.

The redress offered by the Provider can be analysed in two parts. In the first part, there is the reimbursement of portions of the insurance premiums paid over two years in circumstances where those premiums were inflated due to the loss of the Complainant's 'no claims bonus' and the mistaken disallowance of the Complainant's 'driving experience discount'. This reimbursement amounted to €1,736.87. I am entirely satisfied that this was an appropriate component of the overall compensation calculated by the Provider. I am equally satisfied that the calculations themselves appear to be in order and in this regard the Provider has, in its response to this office, supplied a detailed breakdown of the calculation in respect of which the Complainant has not made any comment.

/Cont'd…

The Complainant, in terms of this first aspect of the overall compensation, should be put back to the position she would have been in, had it not been for the Provider's mistake and the consequent hike in insurance premium. This, I understand the Provider to have done, and I do not propose to interfere with this element of the redress. Insofar as the Complainant has sought the return of "*the overpayments [..] paid to*" the Provider, I understand this aspect of the redress to already fully address this matter. The Complainant does not criticise this figure or suggest that it undervalues the 'overpayments'. It is also worth noting that a certain increase to the premium was inevitable, in light of the 4 November 2016 accident, for which the Complainant accepted liability.

The second part of the redress offered by the Provider is compensation for distress, inconvenience and expense (other than the financial loss attributable to inflated premiums). The Provider has offered the Complainant €500 under this heading but this was refused. The Provider has confirmed that this offer remains open for acceptance.

There is limited detail or evidence put before this office by the Complainant regarding her losses and inconvenience other than the claim for 'overpayments' to the Provider; there is simply a reference to "*all the taxi fares*". I understand this to refer to taxi costs incurred as the Complainant was compelled to cancel her insurance policy, when it fell for renewal in July 2019 as she could not afford to maintain the policy, thereby losing the use of her car. No estimate of this cost has been provided.

In addition, there is an undetailed reference to the anxiety and stress suffered by the Complainant. The 14 phone recordings furnished by the Provider in evidence provide little detail other than the Complainant's clear exasperation and distress. There is however a reference in a call of 14 August 2019 to difficulties the Complainant has experienced caring for her father (in the absence of being able to afford motor insurance) the need for her to take time off work to drop her children to school, and the general negative impact and inconvenience on family life.

I have no doubt that the increased insurance premiums caused significant difficulties for the Complainant. I have no difficulty in accepting that this caused inconvenience and distress, although the accident itself and the injuries suffered as a result (there is a reference in a phone call of 9 November 2018, two years post-accident, to the need for surgery arising from the accident) were likely also a source of anxiety and inconvenience. I can equally appreciate that the level of the premium may have forced the Complainant to surrender her insurance policy.

However, I am particularly concerned with the amount of time that it took the Provider to notify the Complainant of its error, having identified it. The relevant accident occurred in October 2016. The incorrect pay-out to the third party driver was made 5 months later on **27 March 2017**. (The Provider's response to question 4 posed by this office refers to the date 27 March 2018, however this seems to be an error, by reference to the timeline supplied in response to question 3.)

/Cont'd…

According to the Provider's timeline document supplied in response to question 1, the Provider thereafter emailed the third party's insurer on 4 July 2017 indicating that it had

> "*confused this file with another one and advised Third Party Insurers to close their file.*"

Notwithstanding having identified the problem (or a significant anomaly, at least) at this point in time, the true position was not notified in writing to the Complainant until 27 September 2019, more than two years later, even though an "*administrative error*" was acknowledged in an earlier phone call of 9 November 2018, when the Complainant indicated that she wished to make a complaint). I note that the initial reaction of the Provider was to invite the third party's insurer to close its file, rather than to investigate further or indeed to seek to recoup the payment made, in order to reinstate the Complainant's policy to the correct position. I take the view that this was an abject failure on the part of the Provider.

I am conscious in this regard that on **4 July 2017**, when the anomaly was discovered, the Complainant's policy renewal date was still more than 2 weeks away. It seems to me that the financial disadvantage to which the Complainant was ultimately put by the Provider might well have been avoided, if the Provider had on 4 July 2017 properly examined the "anomaly" which it had noticed by that time.

It was not until **2 May 2018** that a request was made to recoup the payment. The Provider characterises this as the first point in time that it realised its error however it is hard to reconcile this with the email of 4 July 2017. Even if that were to be the case however, again, the overcharging which arose at renewal in **July 2018**, could again have been avoided if the Provider had taken the appropriate steps to properly examine the issues which had arisen and to expedite appropriate corrective steps. It is clear however, that no such corrective action was taken and I note that details of the error which had been made by the Provider were not communicated to the Complainant in writing until **September 2019**. I am mindful that the exasperation and distress of the Complainant is readily apparent during a number of the phone calls both prior to and subsequent to the admission of an administrative error on 9 November 2018. This audio evidence makes clear the level of distress and inconvenience which she was caused.

In the circumstances, there appears to me to have been a wholly unreasonable and extraordinary delay on the part of the Provider in communicating, in any format, the fact of its mistake to the Complainant. This resulted in the exposure of the Complainant to unjustifiably high insurance premiums for a prolonged period together with associated inconvenience and loss, ultimately leading to the Complainant being obliged to make the difficult decision to not seek to renew her motor insurance, owing to the cost involved. I am also mindful that this will have given rise to a break in the continuous period during which she has held motor insurance.

I am also of the view that matters were not moved along, in terms of securing the reimbursement from the other insurance company (by way of litigation, if necessary) in any way close to a prompt enough manner, once the error was eventually acknowledged in May 2018.

/Cont'd…

In this regard, the claim arising from the October 2016 collision, still remained open as of the date of the Provider's response to this office in late June 2020. This delay was one in respect of which the Complainant bears no responsibility and it is a matter which, I am satisfied, the Provider has failed to advance (both initially and subsequently through the failure to ensure the matter was expedited by its solicitors) with the speed, indeed urgency, it merited. Nor was appropriate action taken to ensure that the Complainant would not be prejudiced in the interim.

It is important for both parties to understand that when the FSPO undertakes a formal investigation of a complaint, any such complaint must be considered upon its own individual merits. The Provider has sought to refer to a previous adjudication by the FSPO, on the basis that it is in some manner relevant to the Complainant's situation. References to previous decisions of this office, even if published within the database of decisions available online at www.fspo.ie/Decisions, are of relevance, only when the issues arising are very similar.

What is of relevance in this particular complaint is the situation in which the Complainant found herself as a result of the failures on the part of the Provider to correctly handle the claims processes which arose following 2 road traffic incidents in which the Complainant was involved, in late 2016. I am satisfied in that regard that the compensatory measure offered by the Provider to the Complainant of €500 in respect of the consequences of what it has correctly acknowledged to have been a significant mistake, fell well short of appropriate redress. It is disappointing that the Provider has failed to recognise the level of its failures to the Complainant. I am satisfied that the consequences of the significant mistake might well have been avoided if the Provider had been mindful of its regulatory obligation pursuant to Chapter 2 of the Consumer Protection Code 2012, published by the Central Bank of Ireland, which requires a regulated financial service provider to act honestly, fairly and professionally in the best interests of its customers.

Accordingly, taking into account all of the evidence before me, not least, the very considerable consequences to the Complainant as a result of the Provider's failure to act swiftly when it discovered its mistake, I am satisfied that it will be appropriate to uphold this complaint. In that regard, I take the view that the Provider's conduct falls within the provisions of ***Section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, including having been unreasonable and unjust in its application to the Complainant.

In recognition of the very considerable inconvenience caused by the Provider to the Complainant, I intend to direct the Provider to make a compensatory payment to her in the sum of €8,000, in order to conclude. Accordingly, on the basis of the evidence before me, I am firmly of the opinion that this complaint should be upheld against the Provider.

Conclusion

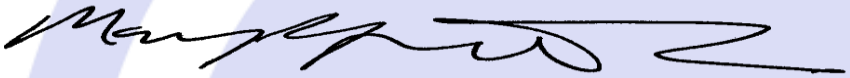
- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is upheld on the grounds prescribed in ***Section 60(2) (b), (f)*** *and* ***(g).***

/Cont'd…

- 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 €8,000, 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.

- 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.



MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

23 February 2021

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.