Decision Ref:	2021-0055
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Maladministration Failure to provide product/service information Failure to process instructions
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to the Complainant's Motor Insurance policy, purchased through the Provider which is a Broker.

The Complainant's Case

The Complainant states that she had been with the Provider for *"many years"*. Following the policy coming up for renewal in **October 2018**, she raised concerns with the Provider regarding the administration of the policy and the accuracy of the policy documentation issued to her over the previous two to three years. The complaint also concerns the suggested poor customer service, complaint handling, and maladministration shown by the Provider in respect of the Complainant's Motor Insurance policies.

The Complainant submits that she had previously purchased *"third party fire and theft"* motor insurance policies through the Provider. The Complainant states that on **27 January 2015** she increased the policy to *"fully Comprehensive"* cover, as she had changed her car. The Complainant maintains that she continued to renew the policy from that point forward on the understanding that her policy was fully comprehensive.

The Complainant says her motor insurance policy was always due for renewal in or around **25 October** each year. It is stated that the Provider contacted her in **September 2018** regarding the renewal of her policy. The Complainant states that she spoke with the Provider on **18 September 2018** and was assured that her the policy was *"fully comprehensive".*

The Complainant says she had been speaking to a Provider employee the previous week, who had told her the policy was *"third party fire and theft".* She also says that the Provider said it was a *"clerical error in their office",* and that the 2018 renewal was *"fully comprehensive".*

The Complainant states that it was only when she enquired about a windscreen replacement, in or around **September 2018**, did she become aware that the Provider's *"error"* which revealed that her motor insurance cover was indeed limited to *"third party fire and theft".* The Complainant is very annoyed about being given wrong information and also wants the Provider to clarify start and finish dates on her policies along with clarifying the correct policy number on her motor insurance policies for the renewals from 2015 to 2018.

The Complainant refused the Provider's offer to pay for the windscreen repair; she says she paid for the repair herself and on **3 October 2018,** the Complainant sought a new policy via an alternative Provider.

The Provider's Case

In its Final Response Letter dated 18th October 2018 the **Provider** confirms that the Complainant did increase the policy to *"Comprehensive cover"* on **27 January 2015.** The Provider goes on to explain that when the Complainant's insurer suddenly left the market in **July 2016,** it issued a letter to the Complainant, on **29 July 2016** inviting her to arrange alternative insurance cover.

The Provider says that the Complainant contacted the Provider on **3 October 2016** regarding *"third party fire and theft"* cover. The Provider says that the Complainant *"opted for third party fire and theft, which it duly set up at that time".*

The Provider says its **13 September 2017** renewal notice, which cited comprehensive cover, *"was a clerical error and that the cover was third party Fire & Theft".* The Provider says it "*offered the option to go to Comprehensive, but* [the Complainant] *settled for Third Party Fire & Theft"*. It cites premium costs as a factor in the Complainant's decision to opt for a reduced level of cover.

The Provider says that when the Complainant notified it of a windscreen claim in **September 2018,** it clarified that the insurance cover was not comprehensive and accepted that the renewal notice had stated 'comprehensive' in error. As a gesture of goodwill, the Provider says it advised the Complainant that it would *"offer* [the Complainant] *a renewal premium for €380.00 for comprehensive cover through* [the Complainant's] *current insurer".*

The Provider also says that on **2 October 2018,** *"as a gesture of goodwill it did offer to pay for* [the Complainant's] *windscreen".* However, as the Complainant was not renewing her motor insurance policy through the Provider, it advised that it was *"not liable for* [the Complainant's] *policy for the current year through another broker".*

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The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration, insofar as it:

1. Failed to provide clarity to the Complainant as to what Motor Insurance cover was in place on her policies, between 2016 and 2018;

2. Renewed the Complainant's comprehensive motor insurance policy in 2016 and 2017 as Third Party Fire & Theft, against her wishes;

3. Failed to keep the Complainant's motor insurance cover consistent, leaving the Complainant unclear regarding her insurance cover level and her insurance cover period;

4. Issued incorrect renewal documentation to the Complainant, which she can no longer rely on.

The Complainant wants the Provider to pay compensation. *"I have lost my fully comp policy and had to start a new policy with a new company costing over €590.00 and had to pay for the new window for the car".* The Complainant says that this matter has also caused a lot of *"hassle"* and inconvenience to her.

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 **10 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.

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Following the consideration of an additional submission from the Complainant, the final determination of this office is set out below.

Certain accepted facts are not in dispute between the parties. The Complainant incepted a 'third party fire and theft' policy via the Provider for the period 25 October 2014 to 24 October 2015.

In **January 2015**, this policy was changed to a comprehensive-cover policy at the Complainant's request with the period of insurance ending on 24 October 2015. This comprehensive-cover policy was renewed in October 2015 with the policy was intended to be effective from 25 October 2015 to 24 October 2016.

By way of letter dated **29 July 2016**, the Provider wrote to the Complainant to advise that the underwriter had gone into liquidation and that alternative cover would be required. This letter noted that the Provider did not have a contact number for the Complainant and requested that she contact the office urgently.

In a submission to this office after the Preliminary Decision, the Complainant pointed out that "that the Provider had "***stated that they did not have my number, but you can clearly see it written on page 8 of the pdf on the 29/07/2016 letter they sent out to me.***" I note in that regard that the letter in question indeed has some very feint and illegible handwriting in the top right quadrant, which includes an identifiable "~~086~~" which had been struck through. The additional digits or letters appearing below however, are entirely illegible.

I am disappointed to note that the Provider, having been given a copy of the Complainant's comments in that regard however, elected to make no further submission or observation, such that it has neither denied nor agreed with the Complainant's suggestion that the copy letter in question displays her telephone contact details.

From July 2016, there are certain conflicts between the parties as to what transpired. The Complainant has provided copies of emails which she maintains she wrote to the Provider on **3 August 2016** in response to the letter of **29 July 2016**, noting that she had been unable to get through to the Provider's office on the phone, giving her phone number details, and requesting a call back. The email is addressed to the email address cited in the letter of 29 July 2016. The Provider however disputes receiving this email.

Matters seem to have lain dormant thereafter for a period until **October 2016**. It would seem that the Complainant may have been uninsured until then, dating back to July 2016. The Provider states that, on **3 October 2016**, the Complainant "*came back to us*", by way of phone call, and at that point, it presented certain options to the Complainant.

In its letter dated 18 October 2018, the Provider states that it proposed a comprehensive policy costing €607 or a third-party fire and theft policy costing €425, either of which would be reduced by €85, which had been refunded from the policy with the liquidated insurer.

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These figures also appear in handwriting on a copy of the letter of 29 July 2016 supplied to this office by the Provider. The figures are however inconsistent with the statement from the director of the Provider dated 15 June 2020 which refers to advising the Complainant of a figure of €550 for the comprehensive policy and €445 for the third-party fire and theft policy. An optional €20 charge for breakdown assistance and legal cover may go some way to explaining this anomaly.

In any event, the Provider maintains that the Complainant opted for the third-party fire and theft policy and, indeed, the Complainant appears, on **3 October 2016**, to have signed a proposal form requesting a third-party fire and theft policy. A new policy was incepted, and a policy schedule was sent to the Complainant noting the policy was 'third party fire and theft' and describing the period of cover as 3 October 2016 to 2 October 2017.

The following year, the Provider issued a policy renewal letter dated **19 September 2017**. This renewal letter set out figures and expressly stated that the cover was 'comprehensive'. The Provider states that the reference in the renewal notice to 'comprehensive' cover was a "*clerical error*". The Provider states that it apprehended this error some short time later and it says that on **10 October 2017**, it brought the matter to the Complainant's attention.

I note that the Provider's letter of 18 October 2018, a year later, states as follows on the matter:

> *We advised that there was a clerical error and the cover was Third Party Fire and Theft, we offered you the option to go Comprehensive but you settled for Third Party fire and Theft as it was over €100 less. We renewed the policy per instruction and issued schedules along with certificate and disc.*

There does not appear to be any written record of this advice at that time, and the Complainant disputes that she was advised of anything on this day. On the same day (i.e. 10 October 2017) the policy was renewed from 3 October 2017 to 2 October 2018 on a third-party fire and theft basis.

The following year, the Complainant suffered a broken windscreen in or around early September 2018 and she phoned the Provider looking to see if her policy would cover a replacement. The Complainant was advised that the policy would not cover a replacement, as it was third-party fire and theft cover only.

I note that subsequently, less than two weeks later, the 'clerical error' was then repeated again, insofar as a renewal notice issued dated **18 September 2018** which once again referred to comprehensive cover when the policy being renewed was, in fact, third-party fire and theft only. The Complainant states that she contacted the Provider's office upon receipt of this letter and was assured that the renewal quote was for a comprehensive policy, despite her suspicions to the contrary, and despite referencing her phone call to the Provider earlier in the month.

The Provider upon realising that it had repeated its error, offered the Complainant, "*as a gesture of goodwill*", comprehensive cover at a significantly discounted rate. The

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Complainant declined this offer and took her business to another broker. An offer to reimburse the Complainant for the windscreen replacement was also made, but this was not accepted.

I am satisfied that there were a number of failings by the Provider in this matter. The renewal notice sent out in September 2017 was clearly inaccurate. I am not at all satisfied with the Provider's bare reference (in its letter of 18 October 2018) to having advised the Complainant of this error. Notwithstanding that the Complainant has disputed this, the Provider has opted not to provide any further detail or evidence to address this. In reality, such advice should have been made available in writing, in the very clearest of terms, not least as it was correcting a position previously communicated in writing, and certainly no adequate evidence of any correspondence on the issue has been made available to this Office.

The fact that the same 'clerical error' was repeated by the Provider a year later, is a further reason for criticism and it betrays a systems failure on the Provider's part. Again, no explanation has been supplied as to how the error came to be repeated. In the circumstances, and considering also the conflicting advice which the Complainant reports having been given on the phone, I am not at all surprised that the Complainant has been, at various points, very confused as to the level of cover she enjoyed.

The final failing is perhaps the most serious. It would appear that the Complainant may have been uninsured from some point in the period between July 2016 to 3 October 2016. The Provider points to a single letter it sent to the Complainant in this period which I note was dated **29 July 2016** and advised as follows:-

> "*As you may have heard on the radio, your insurance company* [Underwriter] *have gone into liquidation and as we don't have a phone number for you we have been unable to contact you.*
>
> *Please contact our office Urgently in order for us to set up a new insurance policy for you.*"

The Complainant says that she promptly responded to this letter by email (having been unsuccessful in her attempts to make phone contact). Regardless as to the Provider's contention not to have received the Complainant's email of 3 August 2016 (a matter in respect of which I make no determination) and albeit that the Complainant should also have followed up with the Provider, I view it as a most serious failing on the part of the Provider, as a regulated insurance broker, to have failed to make further efforts to ensure that appropriate action was taken on foot of this development, so that its client was adequately insured.

The Provider's advice in the letter of 29 July 2016, was that a new insurance policy was required. As a result it is disappointing that the issue was then simply permitted to drift, and indeed I am conscious that this could have had serious implications for any number of people including the Complainant and it also could have impacted upon the Complainant's ability to secure new insurance.

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Happily, the evidence received from the Complainant does not suggest that these potential exposures came to happen, during the relevant period. The Complainant's recent submission however since the Preliminary Decision was issued to the parties, makes clear her frustration at the level of maladministration and poor service she received from the Provider, during the relevant period, but the Provider elected not to reply any further.

On the basis of the foregoing, I consider it appropriate to uphold this complaint. I am satisfied that the Provider's conduct was unreasonable within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.*** The Complainant has sought compensation either in the amount of the cost of the replacement window screen, or in the amount of the cost of her new 2018-2019 comprehensive policy. The Complainant is not however entitled to compensation on that basis.

In light of the failings by the Provider, outlined above, I consider it appropriate to uphold this complain. Taking account of the very considerable confusion and inconvenience caused to the Complainant, not least in the period between July and October 2016, when it appears that she may even have been uninsured, I consider it appropriate to now to conclude, by directing the Provider to make a compensatory payment to the Complainant in the sum of €1,500 (one thousand five hundred €uro).

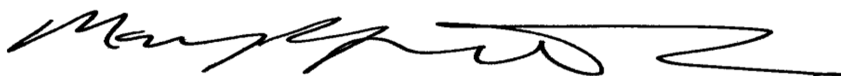
<u>Conclusion</u>

- 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)*** 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 make a compensatory payment to the Complainant in the sum of €1,500, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

- 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

3 March 2021

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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.