An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0128
Sector:	Insurance
Product / Service:	Other
Conduct(s) complained of:	Rejection of claim
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant, a limited company trading as an indoor activity centre, hereinafter 'the Complainant Company', held an insurance policy with the Provider.

The Complainant Company's Case

The Complainant Company temporarily closed its business on **15 March 2020** following a recommendation from its industry group Play Activity & Leisure Ireland, hereinafter 'PALI', which stated, as follow:

> *"Following advice from the Dept of Health, the Dept of Business and* [the then Minister of State for Housing and Urban Development] *we as your PALI committee are recommending that centres within our group close during this COVID-19 virus. One of the stipulations from the Dept of Health was that children of school age do not mix in any social settings. Having weighed up everything and listened to how all sports clubs and classes associated with children are closing, we feel it is best for our types of business to follow suit.*
>
> *This is going to be such a difficult time for all of us and its unprecedented what has happened but we need to do what it right for the safety of all children and adults that they may be in contact with".*

In this regard, the Complainant Company's Broker subsequently received an email from the Chief Executive of PALI on **25 March 2020** to clarify, as follows:

> *"As Chief Executive of PALI it was very important that we received the correct information in regards to closing our businesses. On March 12th* [2020], [the Taoiseach] *announced that all schools, creches and childcare facilities were to close their doors from 6pm that evening. As a group we are a facilities (sic) whose customer base is largely children.*
>
> *On Friday March 13th I rang the Dept of Finance and the HSE for clarity on whether we should close. We felt we were the same classification but needed clarity. Both the Dept of Finance and the HSE recommended we close immediately. In fact, the HSE called out bullet points asking did any of them represent our types of business. One of them was, "if children are in a similar setting to a classroom/school environment then they should be closed". Obviously in all our centres children play together, sit down together to eat party food in large groups, do activities together, etc.*
>
> *Following on from this I then called* [the then Minister of State for Housing and Urban Development] *and he reiterated the point that we should be closed. A press release was drafted and issued to all PALI members, All members closed their doors"*.

The Complainant Company's Broker notified the Provider on **19 March 2020** of a claim for business interruption losses arising from the temporary closure of the Complainant Company's business on 15 March 2020 for a period, due to the outbreak of coronavirus (COVID-19). In this regard, in its subsequent email to the Provider on **24 March 2020**, the Complainant Company's Broker submitted, *inter alia*, as follows:

> *"*[The Complainant Company] *had no option* [but] *to comply with the HSE instructions as to do so would recklessly endanger both employees and customers and potentially compromise their Employers and Public Liability cover".*

In making such a claim, the Complainant Company relied upon the '**<u>Property – Business Interruption (Office)</u>**' section of its insurance policy wording that states at pg. 22, as follows:

> *"**What is covered*** ***We** will insure **you** for **your** financial losses and any other items specified in the schedule, resulting solely and directly from an interruption to **your business** caused by: …*
>
> *Public authority*
>
> *5. **your** inability to use the **office** due to restrictions imposed by a public authority during the **period of insurance** following: …*
>
> *b. an occurrence of a **notifiable human disease**."*

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On **25 March 2020,** following its assessment, the Provider declined the Complainant Company's claim by way of email to the Complainant Company's Broker.

The Complainant Company submitted a complaint to the Provider by email on **2 April 2020** regarding its decision to decline indemnity.

The Provider emailed the Complainant Company's Broker on **26 May 2020** and the Complainant Company itself on **2 June 2020** to advise that following the completion of its internal appeals process, it was standing over its decision to decline the claim.

The Complainant Company sets out its complaint in the **Complaint Form** sent to this Office, which it completed in April 2020, as follows:

> *"There is no ambiguity in the wording of the cover and there are no applicable exclusions*. [The Provider] *have incorrectly and unreasonably refused my claim …*
>
> *That refusal of my claim…states that the Public Authority cover can only be triggered following certain specific occurrences, all of which must happen either in the vicinity of or at the insured premises. Those are not the terms in the wording of my policy. That statement may be applicable to food poisoning on the premises under section 5(c) or vermin at the premises under section 5(e) but is incorrect in relation to section 5(b) as there is no such limitation in the policy wording in relation to restrictions imposed following an occurrence of a notifiable human disease.*
>
> *It also appears obvious to me from the four page* [Business Insurance FAQs – COVID-19 document] *dated 23rd March issued by* [the Provider] *with their declinature that they are adopting a strategy of blanket refusal of all claims relating to Covid-19, regardless of the specific wording of individual policies such as mine. The second page of that* [document] *states that business interruption cover responds to insured physical damage, but that limitation does not appear in the wording of my policy. That* [document] *also states that pandemics are not covered. In my case there is no such exclusion in the wording of my policy.*
>
> *While that* [Business Insurance FAQs – COVID-19 document] *does include one sentence stating that each claim is different and depends on the terms and conditions in the policy documentation, almost all of the replies by* [the Provider] *on the third page of that document refute the existence of cover in the absence of physical damage to insured property. That is both incorrect and illogical in my case.*
>
> *Take for example the cover at 5(a) which relates to restrictions imposed by a public authority following a murder or suicide and that obviously does not relate to physical damage to insured property. The limitation of insured damage is written in bold at sections 1 to 4 on page 22* [of the policy document] *but not at section 5(b). It is my understanding that terms and exclusions cannot be imported into a policy by an insurer after the event.*

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> *It is also my complaint that* [the Provider] *are non-compliant with the…guidance issued by the Central Bank by letter of 27th March 2020 to the CEO's of insurance companies.*
>
> *I also contend that* [the Provider] *are in breach of the spirit and clear wording of* [Chapter 10, 'Complaints Resolution', of the Central Bank of Ireland's Consumer Protection Code 2012]
> *…*
>
> *I have rent and rates and VAT and other overheads so I could be facing liquidation and possibly personal insolvency as a result of* [the Provider's] *refusal of the cover for which I specifically paid for, business interruption. This is an extremely stressful situation. I cannot escape the conclusion that* [the Provider] *intend to drag this matter out and grind me down …*
>
> *My complaint…is that there is a sole issue involved here which is* [the] *interpretation of the plain English in the cover provided at section 5(b) on the 22nd page of the policy. The wording on that page also highlights in bold print what is not covered, being terrorism and liquidation/receivership. That would have been the place to highlight the exclusion of pandemics if the cover at section 5(b) on notifiable diseases was to be so delineated, but no such limitation appears in my policy wording.*
>
> *This claim has been mal-administered by* [the Provider] *from the outset…I am not seeking any ex gratia payment nor any other indulgence from* [the Provider] *over and above the insurance cover for which I paid, as reflected in the wording of the policy. Neither by spirit nor by word are* [the Provider] *honouring the terms of my insurance. In my view they are flaunting the guidelines issued by the Central Bank* [of Ireland] *to act honestly, fairly and professionally in the best interests of consumers".*

As a result, the Complainant Company seeks for the Provider to admit and pay its claim for business interruption losses and in this regard, the Complainant Company submits, as follows:

> *"I am insured for business interruption of €70,000. At this stage it's impossible to quantify the losses ensued by our business closure as we will not know the effects of it until we are directed by government to reopen and until we can see consumer confidence resume, which may take many months after this"*.

The Complainant Company's complaint is that the Provider wrongfully declined to admit and pay its claim for business interruption losses, as a result of its temporary closure due to the outbreak of coronavirus (COVID-19).

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The Provider's Case

Provider records indicate that the Complainant Company held an insurance policy which was a premises specific policy of insurance with two modules, namely, '**Property – Contents (Office)**' and '**Property – Business interruption (Office)**'.

The Complainant Company's Broker notified the Provider on **19 March 2020** of a claim for business interruption losses as a result of the Complainant Company's temporary closure on 15 March 2020.

Following its assessment, the Provider wrote to the Complainant Company's Broker on 25 March 2020 to advise that it had declined the claim, *inter alia*, as follows:

> *"… whilst there is additional cover under the Public Authorities section of* [the] *policy for mandatory closures by a Public Authority this cover only applies to a mandatory closure order issued by a Public Authority which specifically applies to the insured's premises and which has arisen as a result of an occurrence of a notifiable human disease at the insured's premises. This situation has not occurred and therefore this cover has not been triggered".*

On **2 April 2020**, the Provider received a complaint, from the Complainant Company by email, regarding its decision to decline indemnity.

Following the completion of its internal appeals process, the Provider emailed its final response letter to the Complainant Company on **2 June 2020**, setting out in detail its reasons for declining the business interruption claim, as follows:

> *"Many policyholders including you consider that the policy wording should trigger cover. We disagree. The policy wording is clear and unambiguous. It does not provide cover for pandemic risk where restrictions and measures imposed are in response to the global pandemic and are of national and general application for the purposes of protecting public health and have resulted in a very significant economic slowdown. To assist in understanding the scope of cover under the Policy we set out below an explanation of the relevant clauses in the Policy.*
>
> ***Business Interruption cover***
>
> *In the first instance, the business interruption cover is provided as part of the policyholder's Property insurance, and the core business interruption cover provided by our business insurance policies responds to physical property damage at the insured premises resulting in the business being unable to trade.*
>
> *The COVID-19 pandemic itself and the different Government measures taken to mitigate its impact do not typically involve damage to property. We note that you have confirmed that you do not dispute this position.*

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In limited circumstances, the Policy provides cover where there is no damage to the policyholder's property (as set out in the "What is covered" section of the Business Interruption section of the Policy). The cover that can be triggered without property damage is set out in the "Public Authority" section [of] *the Policy (clause 5(b)). However, for there to be cover, all the policy terms and conditions must be met.*

The policy is only triggered if the financial losses (and any other items specified in the schedule) result solely and directly from an interruption of the business caused by an insured peril referred to in the "Public Authority" clause. Such interruption must therefore be the ***sole and direct*** *cause of the loss. The happening of the event in and of itself is not sufficient to trigger cover for financial losses. Financial losses suffered as a result of the slowdown in economic activity, the restrictions, the social distancing and other safety measures do not result solely and directly from an insured peril. Where there is on any view more than one cause of the losses, cover is not triggered under the Policy …*

1. *As you note the Insurance Product Information Sheet states that cover includes "financial losses resulting solely and directly from your inability to use your business premises due to restrictions imposed by a public authority following an outbreak of an infectious disease that must be notified to the local authority". This reflects the cover as set out in the insuring clause of the Business Interruption section of the policy.*

In the first instance, you appear to be misreading the insuring clause by disregarding the words at the start of the clause which operate as a stem for the entire clause (and which are reflected in the Insurance Product Information Sheet).

The stem of the insuring clause provides:

> *"We will insure you for your financial losses and any other items specified in the schedule, resulting solely and directly from an interruption to your business..."*

As we have explained above, the Policy is only triggered if the financial losses (and any other items specified in the schedule) result "solely and directly" from an interruption of the business caused by the occurrence of an insured peril referred to in the "Public Authority" section of the insuring clause.

In the circumstances which arise at present the financial losses which the policyholder has suffered do not result solely and directly from an interruption to the business caused by the occurrence of an insured peril. The financial losses are caused wholly or partly by the economic slowdown and the general restrictions imposed by the government and the safety measures adopted by the public. Those restrictions and measures are in response to the global pandemic and are of national and general application for the purposes of protecting public health and have resulted in a very significant economic slowdown.

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Accordingly, even if the policyholder's business had remained open it would in any event have suffered these financial losses as a result of the slowdown in economic activity, the restrictions, the social distancing and other safety measures. Accordingly, the financial losses claimed do not result solely and directly from an insured peril. As set out above, as there is clearly more than one cause of the losses, cover is not triggered.

It is also clear from the Business Trends clause in the policy that special circumstances or business trends affecting the policyholder's business would in any event be taken into account assessing any amount paid even if cover applied, which it does not. The clause makes clear that if covered, the amount paid must reflect as near as possible the result that would have been achieved if the restriction had not occurred. The losses which the policyholder would have suffered had the premises being (sic) open would not in any event have been recoverable …

2. *The Public Authority cover (clause 5(b)) is triggered where the financial loss results solely and directly from an interruption caused by the policyholder's inability to use the insured premises following one of five specific events, one of which is restrictions imposed by a public authority following an occurrence of a notifiable human disease.*

Whilst COVID-19 is a notifiable human disease, no occurrence of COVID-19 resulted in restrictions being imposed by a public authority on the policyholder's business …

3. [The Provider] *is not relying on a policy exclusion to decline cover, rather as set out above, it is our position that cover is not triggered under the policy.* [The Provider's] *policy wording does not provide cover for pandemics in the circumstances which have arisen and therefore it was not necessary to exclude such risks.*

4. *We have not been provided with a copy of an instruction by the HSE to the policyholder to close its operations at the same time as schools and creches. The note sent by PALI to its members makes a clear recommendation that centres within the group closes during the COVID-19 virus. The reason provided for this recommendation is the stipulation by the Department of Health that children of school age do not mix in any social settings:*

> *"Having weighed up everything and listened to how all sports clubs and classes associated with children are closing we feel it is best for our types of business to follow suit. This is going to be a difficult time for all of us and its unprecedented what has happened but we need to do what is right for the safety of all children and adults that they may be contact with".*

Having considered the supporting documentation provided in your correspondence, there has not been an occurrence of an insured peril, i.e. an occurrence of COVID-19 which resulted in restrictions being imposed by a public authority on policyholder's business.

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Rather it is clear that the decision to close the policyholder's premises was *taken in response to the social distancing and public health measures introduced by the government. For the avoidance of doubt, it is not necessary for us to determine whether the closure was mandatory or voluntary in order to reach the conclusion that cover is not triggered.*

We also note your comment that there is no limitation in the Policy wording requiring the occurrence of a notifiable disease to be at/on the premises. We have explained above that you cannot read the description of the insured peril in isolation from the stem of the insuring clause. The clause when read as a whole does make it clear that it will respond to cover financial loss as a result of an interruption to the policyholder's business due to restrictions imposed by a public authority following an occurrence of a human notifiable disease. While COVID-19 is a notifiable human disease, no occurrence of COVID-19 resulted in restrictions being imposed by a public authority on the use of the premises. The Policy does not cover the occurrence of pandemics such as COVID-19 in the circumstances which arise at present where the restrictions imposed are national and of general application and there is no connection with the premises. Therefore there has not been an occurrence of an insured peril as required to trigger cover under the Policy.

We note your comment that the policyholder will always have the legal benefit if the policy does not reflect the intent of the insurer. The wording in the insuring clause is clear and unambiguous. The ordinary and natural meaning of the words is clear from the insuring clause and when read in light of the policy as a whole as set out in the preceding paragraph. It is clear that cover is not triggered …

The claim

In summary, based on the information you have provided in support of the claim, there has not been an occurrence of COVID-19 which resulted in the public authority imposing restrictions on use of the premises. In these circumstances, there has not been an occurrence of a notifiable human disease which falls to be covered under the Policy. Independently of this, the financial losses the [Complainant Company] *has suffered do not result solely and directly from an interruption to its business caused by an insured peril. Additionally, the aforementioned restrictions, safety measures and economic slowdown result in there being more than one cause of the loss it is experiencing so that the Policy does not provide cover. Furthermore, there is no ambiguity in the Policy wording"*.

The Provider originally declined the Complainant Company's claim for business interruption losses on the basis that the policy was not triggered and there was no available cover for the Complainant Company's claim under the policy.

The Provider said that the commercial object of the Complainant Company's insurance policy was to provide cover for financial losses arising from business interruption which results solely and directly from damage to the insured premises, or where the insured is unable to use the insured premises, in certain specified instances only.

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The Provider said that the response of the policy is also fact specific to the type of business. However, generally and in limited circumstances, the policy responds in respect of the public authority section of the policy where a notifiable human disease occurs at the insured premises which results in a consequential and specific order from a public authority as a result of which an insured is unable to use the premises. The Provider said that the policy did not insure against all of the economic consequences of a pandemic but the consequences of an inability to use the insured premises as a result of a restriction imposed by a public authority arising from, that is, after, an occurrence at the premises.

The Provider also said that the essence of the cover provided by the policy, so far as material, was against specified mandatory actions by public authorities, which had the effect of interrupting the policyholder's business. It stated that the policy did not respond to customers' non-attendance at the business, nor did it provide cover against the reasons underlying those mandatory actions, or beyond the scope or in the absence of those mandatory actions.

The Provider said that the claimed financial losses must result solely and directly from the policyholder's inability to use the premises. If the financial losses claimed arose from any other source, including in combination with an insured peril, the losses were not covered. It says that the business trends clause of the policy, which applied where the losses would have been suffered in any event, supported the interpretation that the cover was not triggered in the context of a pandemic where, by reason of the pandemic, the losses would be suffered anyway.

The Provider said that the policy stated that financial losses resulting solely and directly from an interruption of the Complainant Company's business caused by the occurrence of specific insured perils were covered. These specific insured perils were listed at the '**Property – Business Interruption (Office)**' section of the applicable policy document, at pg. 22, as follows:

> *"**What is covered*** ***We** will insure **you** for **your** financial losses and any other items specified in the schedule, resulting solely and directly from an interruption to **your business** caused by:*
>
> *Financial losses from insured damage*
>
> *1. **insured damage** to **property**:*
>
> *a. insured under any Property section of this **policy**, other than Equipment breakdown; or*
> *b. insured elsewhere, but not under this **policy**, provided the **damage** occurred whilst the **property** was contained in the **office**;*

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Denial of access

2. ***insured damage*** *to property in the vicinity of the* ***office*** *which prevents or hinders* ***your*** *access to the* ***office****;*

Suppliers

3. ***insured damage****, other than* ***damage*** *caused by* ***flood*** *or* ***earth movement****, arising at the premises of one of* ***your*** *suppliers operating and based in the European Union, other than water, gas, electricity or telecommunications services;*

Public utilities

4. *failure in the supply of water, gas, electricity or telecommunications services supplied by a supplier operating and based in the European Union to the* ***office*** *for more than 24 consecutive hours caused by* ***insured damage****, other than* ***damage*** *caused by* ***flood*** *or* ***earth movement****, to any land based premises of the supply authority or the terminal feed to* ***your office*** *or* ***business premises*** *or to underground pipes or underground cables conveying such services from the supply authority to* ***your*** *premises.*

Public authority

5. ***your*** *inability to use the* ***office*** *due to restrictions imposed by a public authority during the* ***period of insurance*** *following:*

   a. *a murder or suicide;*
   b. *an occurrence of a* ***notifiable human disease****;*
   c. *injury or illness of any person traceable to food or drink consumed on the premises;*
   d. *defects in the drains or other sanitary arrangements;*
   e. *vermin or pests at the premises.*

Equipment breakdown

6. ***insured failure****".*

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The Provider said that it was satisfied that the insured peril of the policyholder's inability to use its premises due to restrictions imposed by a public authority following an occurrence of a notifiable disease, read in the context of the policy as a whole, and the insured perils in the above section of the policy, supported the interpretation that the notifiable disease had to be at the policyholder's premises and had to be followed by a restriction imposed by a public authority hindering access to the premises, as a result of which the policyholder was unable to use its premises.

It was the Provider's position that this situation had not occurred in this instance, insofar as there had been no restriction on the use of the premises by the Complainant Company imposed by a public authority following an occurrence of a notifiable disease at the premises; therefore the policy had not been triggered.

The Provider noted that the Complainant Company's activity centre closed on **15 March 2020** and the claim was notified to the Provider on **19 March 2020**. Statutory Instrument No. 121/2020 – Health Act 1947 (Section 31A – Temporary Restrictions) (Covid-19) Regulations 2020, hereinafter 'S. I. No. 121/2020', was introduced on **8 April 2020**, that is, after both the closure of the Complainant Company's premises and the notification of the claim.

In this regard, the Provider noted that there was no closure order made in respect of the Complainant Company's premises and that rather, that the Complainant Company closed following a recommendation from its industry group, PALI, to its members, prior to the introduction of S. I. No. 121/2020. Therefore the Provider said that the said instrument could not have led to the closure.

The Provider stated that, as a result, it was satisfied that the business interruption clause was not triggered as no insured peril had occurred. It also maintained that even if an insured peril had been triggered (which it denied) the policy only provided cover for financial losses which occurred *"solely and directly"* from an interruption to the policyholder's business as a result of an insured peril.

The Provider said that the use of the words *"solely and directly"* made clear that the policy did not respond where there were multiple causes of financial loss. The Provider noted that there had been a number of causes of the financial losses sustained by the Complainant Company, which as a result gave rise to the policy cover not being triggered by this notification.

In this regard, the Provider considered that the restrictions, the slowdown in economic activity, the social distancing and any other safety measures, were all individual reasons for the reduction in the Complainant Company's income, but none of which created an inability on the Complainant Company's part to use its premises, as these were taking place independently of and prior to the introduction of S. I. No. 121/2020 (which itself was after the closure of the Complainant Company's activity centre).

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The Provider said that whilst as a matter of generality, the restrictions, the slowdown in economic activity, the social distancing or any other safety measures arose as a result of the outbreak of the coronavirus, and the social consequences thereof, nevertheless these arose independently of S. I. No. 121/2020, insofar as there was a slowdown in economic and social activity occurring before the introduction of this instrument. As a result, the Provider was of the position that the Complainant Company would have sustained financial losses in the period of imposed public confinement, in any event, as customers were already staying at home as a result of the government guidelines, rules and regulations and were not participating in normal economic and social activity at that time.

The Provider maintained that even if policy cover was triggered, which it denied, it noted that the aforesaid restrictions, slowdown in economic activity, social distancing and any other safety measures, were all matters which it would be entitled to consider as part of the special circumstances or business trends affecting the Complainant Company when calculating the amount of any losses payable under the policy, in accordance with the business trends clause of the policy. In this instance, in light of the COVID-19 pandemic and the disruption to economic activity caused by it, the Provider submitted that the losses suffered by the Complainant Company would have been sustained in any event, had it remained open.

In addition, the Provider noted that the policy did not provide cover in respect of national or global pandemics, as this was not listed as an insured peril. In this regard, the Provider submitted that as a matter of objective interpretation of the policy, it was not the intention of the underwriters or of the Complainant Company itself, that the policy would cover pandemics. For that reason, the Provider stated that it was satisfied that it was not necessary for the policy to specifically state that pandemics were excluded from cover in order for pandemics not to be covered by the policy.

The Provider said that, in relation to its handling of the Complainant Company's claim, it was notified by the Complainant Company's Broker on **19 March 2020** of a claim for business interruption losses. Following its assessment, the Provider wrote to the Broker on **25 March 2020** to advise that it had declined this claim. The Provider then received a complaint from the Complainant Company by email on **2 April 2020** and it replied on the same day, advising that a final response would issue within 40 working days, that is, by **3 June 2020** (allowing for the Easter and May bank holidays). The Provider later advised on **8 May 2020** that its final response would issue by **22 May 2020**.

The Provider says that as part of its internal appeals process, the Provider sent a 'Claim Notification: Business Interruption' questionnaire to the Complainant Company's Broker on **13 May 2020**, the answers to which were needed in order to complete its internal appeals process. The Provider acknowledges that the Broker returned this questionnaire on **20 May 2020** but due to an oversight, the receipt of this was not registered on its filing system, resulting in the Provider informing the Complainant Company on **22 May 2020** that it would not be in a position to provide a final response until it received the completed questionnaire. The Broker returned the completed questionnaire on behalf of the Complainant Company again, on **26 May 2020**.

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Following this, the Provider says that it emailed the Complainant Company's Broker later on **26 May 2020** with its internal appeals response letter and then emailed the Complainant Company itself with its final response on **2 June 2020**, each advising that the Provider was upholding its decision to decline the claim.

The Provider notes that throughout late March and early April 2020, it received a large number of enquires in relation to its business interruption policies of insurance. In order for it to deal with these enquiries fairly and in as efficient a manner as possible, the Provider drafted the '***Claim Notification: Business Interruption***' questionnaire, which was only finalised shortly before **13 May 2020** and was sent to the Complainant Company at the first available opportunity.

The Provider expressly denies that its internal review process was a sham or a delaying tactic, as suggested by the Complainant Company in its complaint papers. In accordance with the Central Bank of Ireland's Consumer Protection Code 2012, the Provider is obliged to investigate complaints within a specified time frame. The Provider said that it was satisfied that it had complied with all of its obligations under the Code, within the time allowed therein.

In conclusion, the Provider acknowledged that it is unfortunate that due to the COVID-19 pandemic, businesses such as that of the Complainant Company, suffered a loss of income as a result of the pandemic itself and subsequently as a result of steps taken by the Government. However, the Provider submitted that it was never intended that the Complainant Company's insurance policy would respond to such circumstances.

As a result, the Provider stated that it was satisfied that it was entitled to decline the Complainant Company's claim for business interruption losses as the policy was not triggered by the circumstances of the claim. For the reasons set out, the Provider submitted that there was no basis upon which the Complainant Company's complaint against it can be substantiated.

Having adopted that position at all material times during 2020, nevertheless, on **4 February 2021**, the Provider advised the Complainant Company's broker that arising from the decision of the UK Supreme Court in *Financial Conduct Authority v Arch Insurance (UK) Limited & Ors*, on 15 January 2021, the Provider had undertaken a review of the Complainant Company's business interruption claim, and having done so, cover for the claim was confirmed, subject to the policy terms and conditions.

The Complaint for Adjudication

The complaint is that the Provider wrongfully declined to admit and pay the Complainant Company's claim for business interruption losses as a result of its temporary closure in March 2020, due to the outbreak of coronavirus (COVID-19).

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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 Company 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 **3 November 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. Following the consideration of additional submissions from the parties, received in the period between November 2020 and April 2021, the final determination of this Office is set out below.

In concluding this adjudication, I was conscious that after the Preliminary Decision had been issued to the parties, the submissions made available to this Office on behalf of the Provider, by way of letter dated **25 November 2020,** had referenced a High Court decision in the U.K. involving the Financial Conduct Authority and a number of insurers. It was noted that subsequently, in **January 2021**, the Supreme Court in the U.K. delivered Judgment on appeal in that matter. For that reason, I wrote to the Provider on **1 February 2021**, to invite it to update its submissions, to take account of the Supreme Court Judgment, if it wished to do so. The Provider's submission followed thereafter and the Complainant Company also responded offering further commentary regarding the issues arising.

I note that the Complainant Company originally made a complaint to the Provider, regarding the Provider's decision to decline the Complainant Company's claim for recovery of business interruption policy benefits, as a result of its temporary closure in **March 2020**, due to the outbreak of coronavirus (COVID-19). In the Complaint Form submitted to this Office, the Complainant Company indicated its opinion that the Provider *was "in breach of the spirit and clear wording of"* its obligations under Chapter 10, '**Complaints Resolution'**, of the Central Bank of Ireland's **Consumer Protection Code 2012**. The Complainant Company in fact suggested that the Provider's internal review process was a sham or a delaying tactic, which I note has been firmly denied by the Provider.

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I am satisfied, having considered the documentary evidence before me, that the Provider processed the Complainant Company's complaint, in accordance with its regulatory obligations under CPC. Thereafter, as the Complainant Company remained dis-satisfied, it brought its complaint to the FSPO in **April 2020**, in accordance with its entitlements and it is the investigation of that complaint, which has led to this Decision.

Insofar as the substantive complaint is concerned, that the Provider wrongfully declined to admit and pay the Complainant Company's claim for business interruption losses as a result of its temporary closure in March 2020, due to the outbreak of coronavirus (COVID-19), I note that the Complainant Company trades as an indoor activity centre and has a customer base that is mostly children. The Complainant Company at the relevant time held an insurance policy with the Provider and the policy schedule detailed the business, as follows:

> *"Activity Centre to include: Indoor Karting (**%), Lazer Tag Paint Ball (**%), Archery (**%), Airsoft (**%), Lazer Maze / Lazer Pigeon Shooting (<**%), X-Box Room / Simulation Room (<**%)".*

On **19 March 2020**, the Complainant Company's Broker notified the Provider of a claim for business interruption losses, as a result of its temporary closure on **15 March 2020** for a period, following the announcement of Government restrictions due to the outbreak of coronavirus (COVID-19) and a recommendation from its industry group Play Activity & Leisure Ireland (PALI).

On **25 March 2020**, following its assessment, the Provider wrote to the Complainant Company's Broker to advise that it had declined the Complainant Company's claim, and advised, amongst other things, that:

> *"… whilst there is additional cover under the Public Authorities section of our policy for mandatory closures by a Public Authority <u>this cover only applies to a mandatory closure order issued by a Public Authority which specifically applies to the insured's premises and which has arisen as a result of an occurrence of a notifiable human disease at the insured's premises</u>. This situation has not occurred and therefore this cover has not been triggered."*
>
> [underlining added for emphasis]

I note that the Complainant Company then submitted a complaint to the Provider by way of email on **2 April 2020** regarding its decision to decline indemnity. Following its internal appeals process, the Provider emailed the Complainant Company's Broker on **26 May 2020** and then the Complainant Company itself on **2 June 2020,** to advise that it was standing over its decision to decline the claim.

The Complainant Company states in the Complaint Form it completed for this Office, as follows:

> *"My complaint…is that there is a sole issue involved here which is* [the] *interpretation of the plain English in the cover provided at section 5(b) on the 22nd page of the policy"*.

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In this regard, I note that the '**Property – Business interruption (Office)**' section of the applicable insurance policy wording states, at pg. 22, as follows:

> *"**What is covered*** ***We** will insure **you** for **your** financial losses and any other items specified in the schedule, resulting solely and directly from an interruption to **your business** caused by:*
>
> *Financial losses from insured damage*
>
> *1. **insured damage** to **property**:*
>
> *c. insured under any Property section of this **policy**, other than Equipment breakdown; or*
> *d. insured elsewhere, but not under this **policy**, provided the **damage** occurred whilst the **property** was contained in the **office**;*
>
> *Denial of access*
>
> *2. **insured damage** to property in the vicinity of the **office** which prevents or hinders **your** access to the **office**;*
>
> *Suppliers*
>
> *3. **insured damage**, other than **damage** caused by **flood** or **earth movement**, arising at the premises of one of **your** suppliers operating and based in the European Union, other than water, gas, electricity or telecommunications services;*
>
> *Public utilities*
>
> *4. failure in the supply of water, gas, electricity or telecommunications services supplied by a supplier operating and based in the European Union to the **office** for more than 24 consecutive hours caused by **insured damage**, other than **damage** caused by **flood** or **earth movement**, to any land based premises of the supply authority or the terminal feed to **your office** or **business premises** or to underground pipes or underground cables conveying such services from the supply authority to **your** premises.*
>
> *Public authority*
>
> *5. **your** inability to use the **office** due to restrictions imposed by a public authority during the **period of insurance** following:*
>
> *a. a murder or suicide;*

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*b. an occurrence of a **notifiable human disease**;*
c. injury or illness of any person traceable to food or drink consumed on the premises;
d. defects in the drains or other sanitary arrangements;
e. vermin or pests at the premises.

Equipment breakdown

*6. **insured failure**.*

What is covered *1. **We** will not make any payment for any interruption to **your business** directly or indirectly caused by, resulting from or in connection with **terrorism**.*

*2. **We** will not make any payment under this section if **your business** is discontinued permanently or if a liquidator or receiver is appointed".*

The policy defines a notifiable human disease as

"Any human infectious or human contagious disease, an outbreak of which must be notified to the local authority"

I note that on **20 February 2020** the Minister for Health signed Statutory Instrument No. 53/2020 – Infectious Diseases (Amendment) Regulations 2020, to include the coronavirus (COVID-19) (SARS-Cov-2) on the list of notifiable diseases. It is accepted by the parties that there was no occurrence of COVID-19 at the Complainant Company's premises.

The Provider declined the Complainant Company's claim because it concluded that to meet the policy criteria for the insured peril of the policyholder's "*inability to use [its premises] due to restrictions imposed by a public authority following an occurrence of a notifiable human disease*", in the context of the policy as a whole and the insured perils in the business interruption section of the policy, it would have been necessary for the occurrence of the notifiable disease to be at the policyholder's premises and to result in an order imposed by a public authority specific to that premises, thereby hindering access, and giving rise to the policyholder being unable to use the premises.

The relevant policy wording is, as follows:

*"**What is covered*** ***We** will insure **you** for **your** financial losses and any other items specified in the schedule, resulting solely and directly from an interruption to **your business** caused by:*

…

/Cont'd…

Public authority

5. ***your*** *inability to use the* ***office*** *due to restrictions imposed by a public authority during the* ***period of insurance*** *following:*

   a. *a murder or suicide;*
   b. *an occurrence of a* ***notifiable human disease****;*
   c. *injury or illness of any person traceable to food or drink consumed on the premises;*
   d. *defects in the drains or other sanitary arrangements;*
   e. *vermin or pests at the premises"*

[underlining added for emphasis]

Having considered the matter in detail, I am of the opinion that there is nothing in this policy wording indicating that the occurrence of a notifiable human disease must be at the policyholder's premises, in order for the insured peril at 5.b. to operate. In this regard, I am conscious of the use of the term *"at the premises"* in the wording of 5.e. (*"vermin or pests at the premises"*) which clearly indicates that the vermin or pests must be at the insured premises, in order for that particular insured peril to operate. Likewise the wording of the peril identified at 5.c. makes it clear that the injury or illness of any person must be traceable to food or drink consumed "*on the premises*". There is no such wording however within the cover identified at clause 5.b.

In that context, I take the view that the absence of the words *"at the premises"*, or some similar term of the same meaning, in the wording of 5.b., results in the reasonable interpretation of the plain meaning of the words, that there is no such stipulation that the notifiable disease must be at the premises, in order for the insured peril at 5.b. to operate.

I am satisfied that if it had been the intention of the underwriters, that the occurrence of a notifiable human disease must be at the policyholder's premises, in order for the particular insured peril at 5.b. to operate, it would have been open to the underwriters to have specified that particular requirement, just as they chose to do, for the perils at 5.c. and 5.e.; in this instance however the underwriters did not do so.

As I am of the opinion that there was nothing in the applicable policy wording indicating that the occurrence of a notifiable human disease must be at the policyholder's premises, in order for the insured peril at 5.b. to operate, I am therefore satisfied that the insured peril at 5.b. was the policyholder's inability to use its premises, due to restrictions imposed by a public authority, following an occurrence of a notifiable human disease. I accept the Complainant Company's contention in that regard, that this is the position, on a plain English interpretation of the policy wording. As a result, I take the view that the Provider's

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suggestion that for cover to operate, the notifiable disease had to occur at the insured premises, was misconceived, and contrary to the plain meaning of the policy words.
I am conscious of the Provider's position as outlined in its Final Response Letter of **2 June 2020**, that:

> *" The policy is only triggered if the financial losses ... result solely and directly from an interruption of the business caused by an insured peril referred to in the "Public Authority" clause ...*

The Provider stated in summary, in its letter that

> *" ... there has not been an occurrence of an insured peril, i.e. an occurrence of Covid-19 which resulted in restrictions being imposed by a public authority on the policyholder's business. Rather it is clear that the decision to close the policyholder's premises was taken in response to the social distancing and public health measures introduced by the government".*
>
> [underlining added]

It seems to me in that respect that the Provider failed to recognise that "*the social distancing and public health measures introduced by the government*" which it has referred to in that letter, themselves constituted "restrictions" imposed by a public authority, following an occurrence of a notifiable human disease, independently of any specific closure order imposed.

I take the view that there is nothing within the particular policy clause under "*Public Authority*" at number 5, that requires the "*restrictions imposed by a public authority*" to be either (i) by way of a specific closure order, or indeed (ii) to be restrictions which are policyholder specific, as opposed to more general restrictions imposed, in the context of the occurrence of a notifiable disease. I am satisfied accordingly that the Provider's approach to assessing the Complainant Company's claim, was incorrect and unreasonable, when it adopted the position that for cover to be available it was necessary for an occurrence of Covid-19 to have occurred at the Complainant Company's own premises thereby resulting in restrictions being imposed by a public authority specifically on the Complainant Company's business.

I note that the Complainant Company's indoor activity centre closed on **15 March 2020**, following a recommendation from its industry group, PALI, to its members. The Provider has submitted that the Complainant Company did not close on 15 March 2020, because of restrictions imposed by a public authority. The Provider maintained that therefore, the claim circumstances did not meet the criteria for the insured peril at 5.b., that is, that the policyholder's inability to use its premises must be due to restrictions imposed by a public authority following an occurrence of a notifiable human disease.

I do not accept the Provider's position in that regard, that the Complainant Company did not close on 15 March 2020, due to restrictions imposed by a public authority. I am mindful that, on **12 March 2020**, the Government directed the closure from 6pm that day of museums,

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galleries, tourism sites, schools, crèches, childcare and higher education facilities, to minimise physical contact between children and young people.

The Government urged all pupils and students from pre-school to third level, to practice social distancing and to avoid meeting up. I am also mindful in that regard, of the exhortations of An Taoiseach, that "*businesses [were] to take a sensible and level-headed responsible approach"* in the context of the Government guidelines, including the required implementation of social distancing. I consider that it was appropriate in such circumstances for each individual business to assess its ability to continue trading, within the confines of those Government guidelines.

I am satisfied from the evidence, that the Complainant Company's closure of its indoor activity centre, was effected in order to comply with the Government's guidelines at that time. Given the specific direction to schools, crèches, pre-schools and further and higher education settings, effective 6pm on Thursday 12 March 2020, I accept that it was reasonable for the Complainant Company to have interpreted this instruction from Government as applying also to its business, given that it trades as an indoor activity centre, with a customer base of mostly children, and taking account of the Government directions to comply with social distancing requirements.

Had it not closed as it did, on 15 March 2020, I believe that the Complainant Company would have been open to significant criticism for failing to heed the Government's directions, given that its business provided a location for children to meet up indoors, and to interact in ways which in mid-March 2020, were contrary to the concept of "social distancing".

In my opinion, if the Complainant Company's indoor activity centre had remained open at that time, it seems likely to have represented an incentive for children and young people, to behave in a non-socially distanced way, thereby breaching the restrictions which the Government had imposed. Indeed, the Complainant Company's industry body, having sought guidance from a number of reliable Government sources, made clear its recommendation to its members to close, being mindful that "*all sports clubs and classes associated with children*" were required to close, in light of that Government instruction.

A number of months after the events that have given rise to this complaint, the Government developed a somewhat more sophisticated system, designed to ensure a greater degree of clarity regarding the consequences of guidelines and restrictions imposed, by way of a framework of designated "levels", unveiled through a "***Living With COVID***" plan, the details of which are subject to variation by the Government, from time to time, as the need arises.

I believe however that it is only fair to be mindful that the closure of the Complainant Company's indoor activity centre, occurred at the very outset of what has been an unprecedented health emergency for the Country, with guidelines including restrictions on movement being imposed by the Government in a manner which was considered to be unparalleled, and individuals and businesses being called upon to do the right thing. It is in that context that I view the Complainant Company's decision to close its business of an

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indoor activity centre with a customer base of mostly children, as a decision which was correctly taken by it, to adhere to the guidelines which the Government had announced.

Accordingly, I do not accept that the Complainant Company should be prejudiced in some way, because it is now arguable that it closed its premises some days before being more unequivocally required to do so, by the further Government restrictions announced on 25 March 2020 (directing the closure of non-essential retail businesses and facilities effective from 26 March 2020). I am of the opinion that it would be unjust and unreasonable if the Complainant Company's claim were to be prejudiced because it was viewed by the Provider as having precipitously closed its premises on 15 March 2020, ahead of the Government announcing further restrictions on 25 March 2020.

I note that the Central Bank of Ireland's Expectations of Insurance Undertakings in Light of COVID-19 correspondence to Insurers, dated **27 March 2020** states, amongst other things, as follows:

> *"The Central Bank is of the view that where a claim can be made because a business has closed, as a result of a Government direction due to contagious or infectious disease, that the recent Government advice to close a business in the context of COVID-19 should be treated as a direction."*

I note that since the Preliminary Decision of this Office was issued to the parties, both have referred to the "***COVID-19 and Business Interruption Insurance Supervisory Framework***" published by the Central Bank of Ireland on **5 August 2020**. This framework document post-dates the decision of the Provider to decline the Complainant Company's claim, and I am unconvinced that it can have any direct bearing on the adjudication of this complaint which concerns the conduct of the Provider in the period between March 2020 and June 2020.

For the reasons outlined above, I am satisfied that there is nothing within the Complainant Company's applicable policy wording indicating that the occurrence of a notifiable human disease was required to be at the policyholder's premises, in order for the insured peril to operate. Moreover, I accept that it was appropriate for the Complainant Company to have closed its indoor activity centre on 15 March 2020, in response to the Government's guidance that children and students from pre-school to third level, should practice social distancing and avoid meeting up and, in that context, that all schools, crèches, pre-schools and further and higher education settings were to close, from 6pm on Thursday 12 March 2020 (to minimise physical contact between children and young people, in order to curb the spread of COVID-19, a notifiable human disease).

I am satisfied therefore that, following that closure of the indoor activity centre in those circumstances by the Complainant Company, the Provider ought to have admitted its claim under the policy for business interruption losses, for assessment of benefit, in accordance with the policy provisions applying, to enable it to expeditiously progress the assessment of the Complainant Company's claim under the insured peril at 5.b., for the period from **15**

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March 2020, being the date when it closed its business, in recognition of the Government restrictions.

Since the Preliminary Decision of this Office was issued to the parties in **November 2020**, indicating the intention of this Office to uphold the complaint on the basis which is outlined above, both parties have made additional submissions. The Provider has indicated that simply because, arising from the UK Supreme Court decision in the FCA case, it has now elected to confirm cover for the Complainant Company's claim, subject to policy terms and conditions, nevertheless, this should not be taken to be an acknowledgement that the Provider wrongfully or unfairly declined the Complainant's claim when it originally declined it in March 2020, or when it confirmed that declinature on appeal, in June 2020.

The Provider says in that regard that the UK Supreme Court has provided legal clarity regarding the contractual interpretation of certain clauses. It says that although, in light of the UK Supreme Court decision in the FCA litigation, it is no longer relying on certain arguments which were previously made, it nevertheless takes the view that the failure of this Office to address those previously relied upon arguments within its Preliminary Decision on 3 November 2020, constituted an error of law.

The Provider has also offered its opinion of an additional error of law by this Office, in proposing to uphold the complaint on the grounds prescribed at section 60(2)(b) and (g) of the Act when in the opinion of the Provider, in truth the finding is one of contractual interpretation, which the Provider maintains is "*provided for in section 62(2)(a)"* (presumably section 60(2)(a)).

The Provider also maintains that the Preliminary Decision of this Office wrongly characterised the Provider's reasons for declining cover, thereby constituting an additional error of fact. I do not however accept this, for the reasons outlined above.

The Provider has also made submissions regarding the stated intention of this Office to direct an additional compensatory payment by the Provider to the Complainant in the sum of €5,000 (entirely separate from any policy benefits)

> "*as a result of the Provider's disappointing approach to this claim, and its unsatisfactory failure to recognise the claim as one which is clearly covered by the plain meaning of the policy words*."

The Provider maintains that contrary to the view of this Office (that the plain meaning of the words made the cover position clear) rather, in its opinion the issues raised within the policy were complex. It has referred in that respect to the comments of the UK courts in the FCA litigation, and indeed to the comments of McDonald J. in the FBD test case when he referred to "*considerable complexity and novelty*" in the questions of contractual interpretation" which were put before him in that particular matter.

The Provider also takes issue with the intention indicated by this Office to direct the Provider to make an interim payment of €25,000 to the Complainant Company, pending

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the completion of the assessment of the claim, notwithstanding that it has also confirmed that it is the usual practice of the Provider to make interim payments "*and this will also occur in this situation, if it is appropriate.*"

Finally, the Provider has submitted that the FSPO should discontinue its investigation on the basis that in **February 2021**, the Provider confirmed that the Complainant Company's claim was covered, subject to policy terms and conditions.

The Complainant Company also made submissions to the effect that the level of compensation directed by this Office in the sum of €5,000 was disappointingly low, given "*the public policy dimensions of the particular matter*". The Complainant Company has suggested that substantially additional compensation should be directed by the FSPO and it also maintains that the complaint should be upheld under Section 60(2)(d) of the Act, on the basis that

> "*the conduct complained of was based wholly or partly on an improper motive, an irrelevant ground or an irrelevant consideration*".

The Complainant also indicated that it found the position adopted by the Provider in challenging the terms of the Preliminary Decision of this Office, and in the Provider's suggestion that the investigation should be discontinued, to be *"intimidating*". It added that

> *"This demand by [the Provider] is not only unfair and unjust but has no basis under the provisions of section 52 of FSPO Act. Many financially distressed policyholders are frightened by insurers at the current time and nothing is being done to restore public trust by the adversarial manner in which [the Provider] are continuing to act."*

The Provider has pointed out that it is unwilling to comment on anecdotal hearsay and it has urged this Office to disregard the submissions of the Complainant Company that do not refer to its own specific circumstances.

The Complainant Company submitted that, in order to counter the prejudice caused by the Provider to its business survival prospects, it had found itself obliged to borrow "*from friends, family and the bank*" to secure the cash flow which it believes should have been available to it under the policy when it made its claim, in early 2020. The Complainant Company's directors have also referred to being "*in massive arrears of rent and all of this is really hard to take*".

In considering this complaint, I am cognisant of the provisions of the ***Financial Services and Pensions Ombudsman Act 2017*** ("the Act") which prescribes at ***section12(11)*** that

> *"… the Ombudsman, when dealing with a particular complaint, shall act in an informal manner and according to equity, good conscience and the substantial merits of the complaint without undue regard to technicality or legal form."*

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In those circumstances I do not consider it necessary or indeed appropriate in the conclusion of this adjudication, to examine and comment on the details of certain arguments which the Provider had previously raised but which it has more recently confirmed it is no longer seeking to rely upon.
I am also conscious that in considering whether this complaint should be upheld, pursuant to the provisions of ***section 60(2)*** of the Act, I should be mindful that those provisions are identical to the then equivalent provisions of ***s.57CI(2)*** of the ***Central Bank and Financial Services Authority of Ireland Act 2004,*** which was the governing legislation of the Financial Services Ombudsman, details of which came under the scrutiny of Mr. Justice Hogan (of the High Court at the time) in *Koczan v FSO [2010] IEHC 407.*

Hogan J., having referred to the powers given to the Financial Services Ombudsman, and in advance of quoting from those same provisions, observed:-

> "*The Ombudsman's task, therefore, runs well beyond that of the resolution of contract disputes in the manner traditionally performed by the Courts. It is clear from the terms of s.57BK(4) that the Ombudsman must, utilising his or her specialist skill and expertise, resolve such complaints according to wider conceptions of* ex aequo et bono *which go beyond the traditional limitations of the law of contract. This is further reflected by the terms of s.57CI(2) …"*

Likewise, some time later Hogan J. in *Lyons and Murray v FSO and Bank of Scotland plc, Notice Party HC[2011/22MCA]* commented upon the decision of McMahon J. in *Square Capital Limited v FSO [2009] IEHC407, [2010] 2I.R.514,* noting that:-

> "*One may venture the suggestion that Koszan and Square Capital represent classic examples of the kind of complaints which the Oireachtas intended would be investigated by the Ombudsman, since they relate to instances of unfair dealing and perhaps even forms of sharp practice for which the ordinary judicial system and the law of contract may provide no adequate remedy*."

I am also conscious of the recent comments of Hyland J. of the High Court on **19 February 2021**, in ***Danske Bank A/S v FSPO and Moore, [2020 121 MCA],*** when she addressed an argument from the Appellant Bank to the effect that, where there was no illegality identified by the FSPO in the conduct of the Appellant, this Office was not entitled to uphold the complaint which had been made. I note that in dismissing that argument, Hyland J. referenced the decision of Simons J. of the High Court in ***Utmost Pan Europe DAC v FSPO [2020] IEHC 538*** (which is the subject of an appeal but has yet to be determined by the Court of Appeal).

Having considered the matter, Hyland J. concluded that:

> *"… this argument fails to recognise the import of the jurisdiction being exercised by the respondent under s.60(2)(b) and (g) of the 2017 Act, which respectively permit him to uphold a complaint on the basis that the conduct was unreasonable, unjust, oppressive, or improperly discriminatory in its application to the complainant or that the conduct complained of was otherwise improper. Having regard to this*

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jurisdiction, it was open to the respondent to uphold the complaint under s.60(2)(b) and (g), irrespective of whether the appellant had acted in accordance with law.

Even where the complainants had signed up to the mortgage documentation and where the appellant had no black letter duty under statute, or "soft" law obligation under a regulatory standard, to give information in a specific form as to the redemption of the tracker mortgage and the inability to return to a tracker rate under the new mortgage, the respondent was still entitled to find an ambiguity and lack of clarity in the information provided. In short, the statutory scheme and the case law on same make clear that the mere absence of a breach of law does not immunise a financial services provider from a finding of unreasonable and improper conduct under s.60(2)(b) and (g)."

Accordingly, having considered the matter at length, and for the reasons outlined above, it is my Decision, on the evidence before me that the complaint should be upheld.

Although I am in no doubt that some very complex arguments of contractual interpretation have been analysed by the Court in Ireland, and indeed by Courts in other jurisdictions also, I believe that it is nevertheless appropriate in this instance to accept the Complainant Company's contention that the policy wording in this particular instance was clear, on a plain English reading.

Accordingly, whatever arguments the Provider may have considered it appropriate to raise in Court litigation, regarding the extent of cover under certain policies and/or the calculation of benefits (in advance of the clarity that certain court judgments have since brought about) the Provider's failure in this instance was its failure in March – June 2020, to recognise that the Complainant Company's claim met the policy requirements of Clause 5.b., such that I am satisfied that the Provider ought to have admitted the claim in early 2020.

I take the view that the Provider's failure to admit the claim for calculation and ultimate payment of policy benefits, was contrary to the contractual provisions in place between the parties and was also unjust and unreasonable within the meaning of Section 60(2)(b) and was otherwise improper within the meaning of Section 60(2)(g) of the governing legislation of this Office. On the evidence before me therefore, I consider it appropriate to uphold the complaint on that basis.

Although the Provider submitted on 23 February 2021, that the FSPO should discontinue its investigation, because it has, since February 2021, confirmed that the Complainant Company's claim is covered, subject to policy terms and conditions, I do not accept that it is appropriate to discontinue the investigation of this complaint. Not only is it the position that the Complainant Company has not withdrawn the complaint, it has in fact indicated a firm desire for the adjudication of the complaint to be concluded by this Office. Moreover, I am satisfied that the basis on which the Provider has suggested that this complaint investigation should now be discontinued, is not an appropriate basis for the discontinuation of this

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investigation, whether pursuant to ***section 52*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** or otherwise.

In concluding the investigation however, I believe that it is appropriate to note the changed position of the Provider regarding the Complainant Company's claim, albeit that unfortunately for the Complainant Company, this change of position occurred almost a year after the claim was originally declined.

I am mindful in that regard of the Provider's legal obligations under the contract, and its regulatory obligations under the Central Bank of Ireland's Consumer Protection Code, to act honestly, fairly and professionally in the best interests of its customers in its dealings with them. I take the view that, in this instance, the Provider did not act fairly or reasonably in its dealings with the Complainant Company in the assessment of the claim for benefit payment, made by the Complainant under its insurance policy in May 2020.

I do not accept the Provider's submission that this Office has wrongly characterised its reasons for declining cover; I take the view that the Provider's failure to recognise that the Complainant Company met the specific required policy criteria (regardless of whether its losses were concurrently caused or contributed to by other consequences of the occurrence of Covid-19) was unreasonable and unjust, and constitutes conduct which falls within the provisions of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***. I would note however that, on the evidence before me, I do not accept the Complainant Company's argument that s.60(2)(d) of the Act, is an appropriate ground for upholding the complaint, in this instance.

In those circumstances, I would consider it appropriate, to direct the Provider to rectify the conduct complained of, by immediately admitting the Complainant Company's claim for business interruption losses with effect from **15 March 2020**, for an expeditious assessment of the benefit payment to be made, in accordance with the terms of the policy. I note however that earlier this year, almost a year after it first declined the Complainant Company's claim, the Provider admitted cover for the claim in question.

Accordingly, a direction of that nature is no longer necessary, since the Provider wrote to the Complainant's broker on **4 February 2021,** confirming cover, and since the Provider's legal representative confirmed to this Office on **23 March 2021** that the Provider is "*unequivocally and unambiguously confirming that it is providing cover*", subject to policy terms and conditions, which the solicitors have advised means that "*the adjustment process and other terms of the policy remain operative*".

I have also noted that it is abundantly clear from the Provider's solicitors' communications with this Office, that whatever the position originally adopted by the Provider in March 2020, the "*trends clause*" within the Complainant Company's policy is not relied upon by the Provider. I note that as recently as on **15 April 2021**, the Provider's solicitors confirmed to this Office that:

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> *"Contrary to assertions made by the Complainant Company in its submissions, many policyholders with the Provider have received interim payments having engaged in the adjustment process. There has been no application of the trends clause in the course of that process and consequently, the complaints of the policyholder in that regard are misconceived."*

I also note that the Provider has indicated that it is not seeking to prolong the claim adjustment process, but it advised on 23 March 2021 that "*the Complainant Company has refused to partake in the contractually mandated adjustment process",* and it noted that *"Other Covid-19 business interruption claimants who have engaged with the process are already being adjusted and interim payment will likely begin to be issued this month".*

The question which arises therefore is what directions this Office should now make, to take account of the up to date position of the parties. It is important for the Complainant Company to be aware that, now that the Provider has belatedly confirmed cover for its claim, in order for that business interruption claim to be expeditiously advanced towards full settlement and payment, by agreement of the relevant figures, the Complainant Company must engage with the nominated agents of the Provider dealing with that adjustment process. The complaint to this Office is an entirely separate matter, and it is not the role of the FSPO to undertake the required and very normal claim adjustment process which ensues when a policyholder seeks to claim benefits arising from an insured peril, which is covered by a policy held.

Neither is it the role of this Office to in some way seek to "punish" or "sanction" a provider, in the event that the conduct of such a provider is found to have been wrongful, within the meaning of ***section 60(2)*** of the ***Financial Services and Pensions Ombudsman Act 2017***. The analogy sought to be drawn by the Complainant Company, to the actions of an apprehended shoplifter is, in my opinion, entirely misconceived and inappropriate.

The Provider takes issue with the proposed direction of this Office referred to within the Preliminary Decision, to require the Provider to make an advance payment of benefits to the Complainant Company, pending the conclusion of the assessment/adjustment process to calculate the final benefit figure to be paid (although it has confirmed that it is in fact the practice of the Provider, to make interim payments, where it considers it appropriate). Although I am mindful that the turnover of the Complainant Company in the period up to February 2020, was over €500,000, whereas the turnover for the following 12 months up to February 2021, was a fraction of that figure, it is not a matter for this Office, in the course of this particular investigation, to calculate the Complainant Company's losses which now fall to be recovered, by way of the claim it made under the policy in March 2020. These losses will be assessed by the Provider in accordance with the required adjusting processes, but it will be important for the Complainant Company to note that this calculation of benefit payment due will inevitably be delayed, if it refuses to actively engage with this process.

I am mindful that it will be appropriate for the relevant turnover figures to be examined during that claim adjustment process. Whilst the Provider has confirmed that it does not

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seek to rely on the trends clause within the policy, nevertheless, I am cognisant of the comments of McDonald J in the FBD test case when he said:

> ***" …***
> ***236****. I do not believe that the approach advocated by FBD is correct. It seems to me that, in applying the trends and circumstances provisions of s.3 of the FBD policy, one must exclude the effects of the insured peril from the calculation. In the absence of clear language to the contrary, it would be contrary to the nature of an insurance policy as a contract of indemnity, to allow the effects of the insured peril to reduce the payment to be made to an insured who has the benefit of cover for that peril. As the FBD submissions acknowledged, the purpose of the trends and circumstances clause is to ensure, in so far as reasonably practicable, that the adjusted figures reflect the financial results which, but for the occurrence of the peril, would have been achieved during the subsistence of the peril. For the reasons previously discussed in paras. 227 to 229 above, this approach seems to me to be applicable whether the losses were proximately caused by the events within the relevant 25 mile radius or by a combination of the events within and beyond that radius …"*

Accordingly, in recognition of the fact that almost a year elapsed before the Provider confirmed cover, and being mindful that this claim assessment may take further time to finalise, even if the Complainant Company now elects to engage swiftly, and noting that the Complainant Company was insured at the relevant time under the particular "*business interruption*" peril for a maximum figure of **€70,000**, I consider it appropriate to direct the Provider (unless it has already done so, in accordance with its stated practice of making interim payments) to make an advance payment of policy benefits to the Complainant Company, of **€25,000**, pending the calculation of any further interim payments or the final benefit figure payable.

Whilst the Complainant Company has suggested that this advance benefit payment should be doubled, owing to the period which has elapsed since the preliminary decision of this Office was issued on **3 November 2020**, I don't accept this. The Preliminary decision of this Office anticipated that the claim adjustment process might well have concluded by the time the legally binding decision would be issued, and I do not accept that the Provider is solely responsible for the fact that the adjustment process has not yet been advanced closer to payment, following the email to the Complainant Company's broker on 4 February 2021, confirming cover for the claim.

Since the preliminary decision was issued to the parties on 3 November 2020, I also remain of the position that it is appropriate to direct the Provider to make a compensatory payment to the Complainant Company in the sum of €5,000 (entirely separate from any policy benefits which are payable under the policy). This compensatory payment is directed, to take account of the inconvenience which the Complainant Company suffered throughout a particularly difficult period, as a result of the Provider's disappointing

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approach to this claim, and its unreasonable failure in early 2020, to recognise the claim as one which was clearly covered by the plain meaning of the policy words.

I have noted the Complainant Company's suggestion that

> "*There are good reason why the Houses of the Oireachtas in 2018, increased the compensation limit that the FSPO can award from €250,000 to €500,000 in addition to upholding a complaint and we suggest that the full jurisdiction is exercised."*

I do not however consider it appropriate to direct a compensatory payment in the amount suggested by the Complainant Company, as the evidence before me, in my opinion, does not warrant a compensatory payment of that level.

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) and (g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** and noting that the Respondent Provider has now confirmed cover for the Complainant Company's claim for business interruption losses (as a result of its temporary closure in March 2020, due to the outbreak of coronavirus (COVID-19)) I direct the Provider to make an advance payment of policy benefits to the Complainant Company, in the sum of **€25,000** (unless it has already done so) pending the conclusion of the assessment/adjustment process to calculate any remaining benefit figure payable to the Complainant Company on foot of this claim..

- In addition, to redress the inconvenience caused to the Complainant Company by reason of the delay of almost a year, before the Provider confirmed cover for the claim, I direct the Provider to make a compensatory payment to the Complainant Company in the sum of **€5,000**, to an account of the Complainant Company's choosing, within a period of 35 days of the nomination of account details by the Complainant Company to the Provider.

- I also direct that interest is to be paid by the Provider on the said advance payment of policy benefits and on the compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said nominated account, within that period of 35 days from the date of nomination.

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- 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

5 May 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.