An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0142
Sector:	Insurance
Product / Service:	Car
Conduct(s) complained of:	Claim handling delays or issues Premium rate increases
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant holds a motor insurance policy with the Provider. The Complainant sustained damage to her vehicle on **23 January 2018** from a collision with a gate on a third party's property. The Complainant notified the incident to the Provider on **25 January 2018** and the cost of the repairs was paid for under her policy. The Provider indicated to the Complainant that it may be possible to recover the costs of the claim from the property owner's insurer. However, the Provider closed the claim and did not recover any monies from the property owner.

The Complainant's Case

The Complainant explains she informed the Provider that an automatic gate which was controlled by an individual in a private property impacted her car causing damage as she was leaving the property. The Complainant states the Provider's claims handler confirmed that the damage sustained to her car was consistent with her description of the incident. In the meantime, the Complainant states that the claims handler told her to obtain the home insurance details of the property owner which she did and forwarded to the Provider.

The Complainant states that she was led to believe from her conversations with the claims hander *"… that the claim could be retrieved through the woman's home insurance."* The Complainant says she was conscious that her motor insurance was due for renewal at the end of **March 2018** and that she explained this to the claims hander. The Complainant states that she kept in regular weekly contact with the claims handler *"… regarding the woman's home insurer and had progress been made."*

The Complainant explains that her car insurance renewal came through and the quote was almost double the previous premium amount. The Complainant states *"… they said its car insurance going up."* The Complainant states that her husband's insurance was similar to the previous year which did not make sense to the Complainant. The Complainant says she had no choice but to renew her insurance policy as she had an open claim and no other insurer would provide a quote. The Complainant advises that she was unable to get in contact with the claims handler and later discovered that this individual had left the claims handling entity.

The Complainant has also set out her communications with the property owner's insurer. In **May 2018**, the Complainant explains that the new claims handler contacted her and advised that a loss adjuster on behalf of the property owner's insurer had attended the property to examine the gates and found no fault with the gates. The Complainant explains that she requested a copy of the loss adjuster's report but was told that it was marked private and confidential by the property owner's insurer.

The Complainant explains that:

> *"My complaint is that my insurer did not protect my interests led me to believe it was straight forward process for them to retrieve from the woman's home insurance what had been paid out on my behalf to get car repaired. Also did not make aware the process and how long it could take so I could have took steps to get gate assessed privately which I would have done immediately after the accident."*

The Provider's Case

The Provider explains that the incident was first notified to it on **25 January 2018**. The Provider states that within a period of 12 days, the Complainant's vehicle had been assessed and repaired, and the Provider was in receipt of an invoice for payment.

The Provider states the incident was the subject of a liability dispute between the Complainant and the property owner, where the Complainant maintained that the property owner's gates were malfunctioning. The property owner's insurer was notified one day after receipt of the relevant details and it was subsequently contacted on a number of occasions in order to obtain updates and to attempt to expedite a response.

The Provider states that it has enclosed details of its communications with the property owner's insurer in its Schedule of Evidence. The Provider states that it is unable to offer any comment regarding any delay on the part of the property owner's insurer as this is beyond the Provider's control.

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The Provider states that the Complainant was kept fully informed in respect of the progress of her claim, as and when updates were available from the property owner's insurer. The Provider says that it accepts that communication could have been more explicit within the early stages of the claim in terms of the claims process the property owner's insurer would follow and the likelihood of securing recovery. In consideration of this, the Provider advises that it is offering compensation in the sum of €500 and a refund of the excess paid by the Complainant in the amount of €250.

The Provider advises that the property owner's insurer appointed a loss adjuster to inspect the gates and it was found that they were maintained and functioning correctly. The property owner's insurer refused access to the investigation report but confirmed on **9 May 2018** that the Provider may organise an inspection of the gates. The Provider states that it is unable to organise an inspection of third party property without appropriate authorisation from the property owner or the insurer.

The Provider also says, with regard to the difficulties which the Complainant encountered in contacting the original claims handler, that the claims handler was working for an entirely separate entity and it is unable to offer any commentary in that respect.

The Complaint for Adjudication

By letter dated **21 May 2020**, this Office wrote to the Complainant explaining that it could not investigate the insurer's decision not to pursue the property owner's insurer in respect of the costs of the Complainant's insurance claim. The letter also explained that this Office could not investigate a complaint in respect of the increase in the Complainant's insurance premium.

Accordingly, the complaint is that the Provider provided a poor level of customer service to the Complainant.

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.

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A Preliminary Decision was issued to the parties on **29 March 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.

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

Background and Chronology

The Complainant reported the incident the subject of this complaint to the Provider by telephone on **25 January 2018**, 2 days after the accident. The Complainant described the incident to the First Claims Handler. The First Claims Handler indicated that the best option for the Complainant would be to put the cost of the repairs on her policy and let the Provider attempt to recover the costs from the property owner. The First Claims Handler stated that the Provider would pursue the property owner's insurer (the **Insurer**) directly.

The Complainant indicated that she would give the property owner a copy of the repair quote to see what her reaction would be and if the Complainant did not make any progress, the Provider could pursue the matter. Towards the end of the conversation, the First Complainant asked if it would be best if she contacted the property owner when she received a repair quote. The First Claims Handler agreed with this and explained that the Provider would write to the property owner directly. The Complainant asked if the Provider would *have to go legal*.

The First Claims Handler advised that if there was liability on the part of the property owner then the Insurer would have to pay the claim. The First Claims Handler also explained that it may be a case that the property owner might be willing to pay for the claim privately without involving the Insurer and the Complainant would only really know that, once she contacted the property owner. The Complainant then advised that she would request the property owner's insurance details.

Separately, the First Claims Handler advised the Complainant that there was a €250 excess on her policy and the Provider would also seek to recover this from the Insurer. The First Claims Handler explained that the Complainant's claim would not affect her *No claims bonus*. The First Claims Handler advised the Complainant that its assessor would also need to inspect the vehicle.

By email dated **25 January 2018**, the Provider provided the Complainant with the contact details of her dedicated claims handler. Later the same day, the First Claims Handler advised the Complainant that an engineer had been appointed to inspect her vehicle and that the engineer would be in touch with the Complainant within 24 hours. The vehicle was inspected on **26 January 2018** with the relevant repairs being carried out **2 February 2018**.

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The Complainant forwarded details of the third party property owner's Insurer to the First Claims Handler on **29 January 2018**. On **30 January 2018**, the First Claims Hander contacted the Complainant to explain that her hire car was ready to collect and that he had also contacted the Insurer but the Insurer was unable to find a policy associated with the policy number provided by the Complainant. The Complainant confirmed the policy number again. The First Claims Handler telephoned the Complainant on **31 January 2018**, to advise that he had spoken to the Insurer and that the matter was being looked into.

On **7 February 2018**, the Second Claims Handler wrote to the Complainant by email advising that the Provider was in a position to make an offer of €1,366.13 in settlement of her claim. The Complainant telephoned the First Claims Handler on **19 February 2018** to enquire as to whether the Insurer had been in contact with the Provider. The First Claims Handler explained that he had not heard back from the Insurer and if he did not hear anything by the middle of the week, he would follow-up with the Insurer.

While there was previous contact with the Insurer on **30 January 2018**, it appears that the First Claims Handler sought to recover an outlay amount of €1,454.42 from the Insurer on **22 February 2018**. The Insurer responded the same day advising that its investigation was still on-going and it was not in a position to comment on liability. A follow-up email was sent by the First Claims Handler on **5 April 2018**. This was followed by telephone calls with the Insurer in **April** and **May 2018**.

The First Claims Handler telephoned the Complainant on **13 March 2018** to inform her that he had not heard from the Insurer and that it may be the case that the Provider would need to seek legal advice. The Third Claims Handler telephoned the Complainant on **1 May 2018** to advise that the Insurer had received a copy of the loss adjuster's report but the Insurer still had to review the report. Later that evening, the Insurer informed the Provider by email that it was not in a position to reimburse the claim outlay or the Complainant's policy excess as its loss adjuster found no fault with the gates and that the gates were properly maintained. In response to this, the Third Claims Handler requested a copy of the loss adjuster's report or, alternatively, facilities to inspect the gates.

The Third Claims Handler emailed the Complainant on **2 May 2018** with the following update:

> *"With reference to this matter and our conversation today.*
>
> *Having reviewed the correspondence received from [the Insurer] I note that it is mark[ed] as private and confidential so unfortunately I cannot provide a copy. I can advise that they have disputed liability in this correspondence and state that a loss adjuster attended the scene on their behalf. We are advised that the loss adjuster examined the gates and found no fault with the gates or the sensors and states that they were maintained to an adequate standard. They have advised of their intention to defend any claim taken against their client.*
>
> *As discussed, I have responded by requesting a copy of their report and will update you once I hear from the handler."*

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During a call on **3 May 2018**, the Complainant indicated that the best course of action was to stop pursuing the Insurer in respect of her claim and close the case. The Third Claims Handler explained that as the Provider paid out on the claim, it reserved the right to pursue the Insurer in respect of the claim. The Third Claims Handler explained it may be appropriate to wait and see if the Insurer would share the loss adjuster's report and that the Provider would need to consider the possibility of recovering from the Insurer. In response to a question from the Complainant, the Third Claims Handler advised that legal action may need to be considered but if it was a case that it was not economic to pursue the matter, the case may be closed. However, the Provider would have to investigate the prospect of recovery further.

The Provider sent a follow-up email to the Insurer on **9 May 2018** which was responded to by the Insurer the same day, advising that it was not in a position to share the report and for the Provider to contact the loss adjuster to arrange an inspection of the gate.

By email dated **17 May 2018**, the Complainant requested an update from the Third Claims Handler. In response to this, on **21 May 2018**, the Third Claims Handler advised that:

> *"… [The Insurer] has come back to me to advise that they are not in a position to share a copy of their report but they are willing to facilitate us in relation to inspection of the gate. I am just waiting further information in relation to this and hope to be back to you shortly."*

Additional information in respect of the gates was sought from the Insurer by the Third Claims Handler by email on **28 May 2018**. On **31 May 2018**, the Insurer advised that it did not have the requested information and it did not have any problem with the Provider inspecting the gates. During a telephone conversation with the Complainant on **5 June 2018**, the Third Claims Handler advised the Complainant that the claim would be closed as there would be difficulty in seeking final recovery.

The Complainant made a formal complaint by email dated **25 October 2018**. This was acknowledged by the Provider on **26 October 2018** and a Final Response letter issued on **12 November 2018**.

Analysis

The Complainant reported the damage to her vehicle to the Provider on **25 January 2018**, repairs were carried out on **2 February 2018** and the claim was settled on **7 February 2018**. In this respect, I am satisfied that the Provider promptly settled the Complainant's claim.

It is the Complainant's position that the Provider led her to believe that it was a straightforward process to recover the costs of her claim from the Insurer. As can be seen from the telephone conversation on **25 January 2018**, the First Claims Handler explained that the Provider would seek to recover the cost of the claim from the Insurer and a discussion took place as to how the Provider would go about this.

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While the Provider accepts that its communication with the Complainant could have been more explicit during the early stages of her claim in terms of the claims process with the Insurer and the likelihood of securing recovery, having considered the communications between the Complainant and the claims handlers, I am not necessarily satisfied that the Provider unreasonably led the Complainant to believe that this would be a straightforward process as suggested by the Complainant in her Complaint Form.

On **9 May 2018**, the Insurer confirmed that it was not in a position to share the loss adjuster's report. The Complainant telephoned the Provider on **17 May 2018** requesting an update in respect of the claim with an update being provided by email on **21 May 2018**. In light of the communications between the Complainant and the Provider prior to **9 May 2018**, I believe that the Provider should have communicated the information it received from the Insurer to the Complainant before **21 May 2018** and there was a certain level of delay on the part of the Provider in this regard.

The evidence shows that the Provider made contact with the Insurer around **30 January 2018** and was in further contact with the Insurer over the coming months in an effort to recover the costs of the claim. The decision was ultimately reached not to seek recovery from the Insurer. This decision was communicated to the Complainant on **5 June 2018** and in the Final Response letter. In the circumstances of this complainant, I am not satisfied that there was any delay or any unreasonable delay in communicating this information to the Complainant.

Further to this, I am satisfied that the Provider kept the Complainant reasonably up to date in respect of her claim and its communications with the Insurer. I am also satisfied that the Provider responded to the Complainant's formal complaint in an appropriate timeframe and to a reasonable standard. I do not however accept the Provider's recent comment that the Complainant's inability to make contact with the first Claims Handler, is not a matter for the Provider. Whilst the Claims Handler was indeed employed by a separate entity, that entity was handling the claim on behalf of the Provider, and the Provider cannot simply maintain that the service level made available in that context, is not a matter for itself. I note indeed, that it is the name of the claims handling entity, which is branded on the insurance policy which the Complainant held with the Provider.

Goodwill Gesture

The Provider made a goodwill gesture in its Formal Response as outlined above. In a further submission dated **8 September 2020**, the Provider repeated this goodwill gesture which totals €750. On the basis of the evidence available, I consider this goodwill gesture to be a reasonable sum of compensation for the customer service failings on the part of the Provider. In these circumstances, on the basis that this offer remains available to the Complainant, I do not consider it necessary to uphold this complaint and it will be a matter for the Complainant to make direct contact with the Provider if she wishes to accept the reasonable compensatory figure which has been offered.

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Conclusion

My Decision, pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017*** is that this complaint is rejected.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

11 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.