An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0172
Sector:	Banking
Product / Service:	Repayment Mortgage
Conduct(s) complained of:	Failure to process instructions Complaint handling (Consumer Protection Code) Dissatisfaction with customer service Failure to process instructions in a timely manner Maladministration (mortgage)
Outcome:	Substantially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainants held a mortgage loan agreement with the Provider which was due to mature in **November 2018**. The loan was subject to interest only repayments during its term, with the capital balance falling due at the end of the term of the loan. To provide for the repayment of the capital balance, the Complainants incepted a policy of insurance with a financial service provider (the **Insurer**) which was also due to mature in **November 2018**. However, the surrender value of the policy was not received by the Provider until **January 2019**.

The Complainants' Case

In their Complaint Form, the Complainants state, as follows:

> *"Pursuit by* [the Provider]*, as assignee of an endowment policy from* [the Insurer] *of €90,045 from us while simultaneously responding to* [the Insurer's] *requests to provide them with documentation.*
>
> *Failure of both to interact with each other in a timely fashion.*
>
> *Stress and medical intervention an outcome.*
>
> *Pl. see attached letter of 25/9/19 and enclosures …"*

In the Complainants' letter to this Office dated **25 September 2019**, the Complainants explain that their complaint relates to an endowment policy in respect of a mortgage loan taken out with a predecessor of the Insurer in **November 1998** which was assigned to the Provider and due to mature in **November 2018**. The Complainants say that they have always made their mortgage loan and endowment policy repayments on time and had initiated contact with the Insurer and the Provider, but these entities failed to engage with one another in a timely fashion.

The Complainants say the Provider put them under severe pressure by issuing heavy handed correspondence around Christmas **2018** and at a time when the Complainants were sending documents to the Insurer which the Provider had failed to supply. The Complainants say the Provider was seeking repayment of the loan (with threats) of over €90,000 despite its Complaints Department stating in a letter of **14 February 2019** that it was aware this money was to be received through the Insurer. The Complainants advise they had to engage solicitors to act on their behalf and the Complainants themselves put enormous time into this matter.

The Complainants say that retrieving their data from the Provider was unduly slow due to errors on the part of the Provider. The Complainants say the Provider did not have the courtesy or professionalism to advise them when the Insurer had transferred the proceeds from the policy. The Complainants say this caused a lot of stress for the Second Complainant and that the Provider was aware of this.

The Complainants continue their letter by setting out the background to the policy. The Complainants explain that they first contacted the Provider and the Insurer on **11 October 2018** to try to ensure the smooth conclusion of the matter. Referring to correspondence from the Provider, the Complainants say the loan was due to mature on **30 November 2018**. The Complainants say their contact in **October 2018** seems to have been the impetus for any action commencing in respect of the policy. The Complainants submit that the Provider and the Insurer should have engaged with one another in a timely fashion to ensure matters were finalised on time. The Complainants say that several attempts were made to get a balancing figure of the shortfall amount between the outstanding loan balance and the policy value as the Complainants would need to make up the shortfall.

In a telephone call on **29 November 2018** and prior to the loan becoming due, the Complainants say they were advised that the Insurer had not remitted the surrender value of the policy to the Provider, apparently despite repeated requests from the Provider. The Complainants say they were *"… given to understand that* [the Provider] *was very understanding that we were dependent on* [the Insurer] *making payment to them …"* and that the Provider had sent the requisite documentation to the Insurer which would be in touch with the Complainants, if required. The Complainants explain that this call concluded with them being of the opinion that the source of the delay rested with the Provider and the Insurer.

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On **13 December 2018**, the Complainants say they received a letter from the Provider dated **7 December 2018** in an envelope postmarked **12 December 2018** which did not display much understanding of the Complainants' position. Describing the letter, the Complainants say it spoke of repossession, imposition of charges and surcharges and the engagement of solicitors, if necessary, at a minimum cost of €5,000. The Complainants say the tone of this letter was set in its heading which highlighted in bold and capital letters in places that the situation was urgent, requiring immediate attention, their loan account was in the Mortgage Arrears Resolution Process and referenced the consequences of not co-operating. The letter also pointed to potential adverse consequences for the Complainants' credit rating. The Complainants say this letter was unanticipated for several reasons, including:

- their proactive efforts to ensure matters were concluded on time,
- the Complainants' call to the Provider on **29 November 2018**,
- the Insurer's email of **29 November 2018** advising it was awaiting documentation from the Provider.

The Complainants say the above letter also spoke of them having missed (for the first time in 20 years) a payment of €37 on **6 November 2018**. The Complainants explain that the Standing Order was cancelled on the advice of the Provider during a telephone call on **11 October 2018**. The Complainants says they received a letter dated **9 November 2018**, advising of a missed payment. The Complainants say that as at **11 October 2018**, it was immaterial to them when the final payment was due as they assumed that the Insurer would pay the Provider on time and that they stood ready to immediately pay the shortfall balance, as they had advised the Provider.

The Complainants say they wrote to the Provider by registered post on **17 December 2018** advising that the fault did not lie with the Complainants, they were going to engage a solicitor, they were not going to complete the Standard Financial Statement provided by the Provider and a request was made for call recordings and correspondence. The Complainants say they also advised the Provider how utterly reprehensible it was, that it would date a letter of such importance a full six days in advance of posting it. The Complainants say that although they rescinded any authority for the Provider to communicate with them by telephone, they received a telephone call from the Provider on **3 January 2019** seeking clarification regarding their data subject access request.

They Complainants say the Provider's acknowledgment letter of **24 December 2018** committed that the complaint would be *"thoroughly and fairly"* investigated. The Complainants say they appointed and met with their solicitors on the first available opportunity in early **January 2019**, and complied immediately with their advice to cease direct contact with the Provider. The Complainants also refer to a solicitor's letter sent to the Provider and the Insurer on **30 January 2019**.

The Complainants say they received a letter dated **14 February 2019** from the Provider in response to their complaint. The Complainants say they find the Provider's response utterly unsatisfactory, even unclear/insufficiently transparent and duplicitous in places.

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The Complainants say this letter fails to acknowledge some key issues and falls well short of the standard the Provider sets in its letter of **24 December 2018**. The Complainant say it is apparent that:

- the Insurer and the Provider failed to liaise with one another in a timely fashion,
- the Insurer appears to have engaged meaningfully only late in the day notwithstanding the Complainants' contact beginning on **11 October 2018**,
- the Provider behaved in a heavy-handed and unprofessional manner,
- the Provider did not reference the fact that the policy was assigned to it,
- the loan was drawn down on **19 November 1988** yet in some instances the Provider sought full repayment on **6 November 2018**.

The Complainants set out a number of issues they have with the Provider's complaint response letter over two pages of their letter to this Office, under nine bullet points.

The Complainants say that they have been proactive in their efforts to have everything regarding their loan concluded on time, something which was not reciprocated. The Complainants say the telephone call to the Provider on **11 October 2018** seems to have been the impetus for the Provider, but not the Insurer, to commence engagement with one another. The Complainants wish to reiterate that, as made clear to the Provider in the initial telephone call, at all times, the Complainants stood ready to repay whatever balance was required to meet the shortfall between the loan balance and the surrender value of the endowment policy.

The Complainants say the Provider wrote to them on **20 December 2018** seeking identification documentation before releasing personal data and that call recordings would constitute a disproportionate request which it would not be obliged to respond to under the relevant data protection legislation. The Complainants says the Provider offered to provide recordings of telephone call where the Complainants would provide the date and time.

The Complainants submit they find it utterly unfair that the Provider can operate a policy of not accepting emails whilst not being readily able or perhaps, more accurately, unwilling to supply call recordings where a dispute arises. Such an approach disadvantages any individual dealing with the Provider. The Complainants refer to a letter from the Provider dated **14 February 2019**, where the Provider cited selected aspects of telephone calls with the Complainants, which would seem to suggest that the Provider can access the Complainants' call recordings. The Complainants suggest that the Provider may be adopting a strategy of obfuscation in relation to such requests. At a minimum, the Complainants say that if the Provider is to persist with its policy of refusing to transact by email, it should be obligated to forewarn customers at the outset of each telephone call of the potential issues arising in relation to record retrieval should a dispute subsequently arise.

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In respect of a letter received from the Insurer dated **13 February 2019** in response to a letter from the Complainants' solicitor dated **30 January 2019**, the Complainants say the Insurer advised that most of the points raised were matters for the Provider as assignee. The letter acknowledges there was a delay on the part of the Insurer in issuing maturity papers for which they offered an *ex gratia* goodwill payment of €250. The Complainants note that maturity papers apparently issue, in normal course, four weeks in advance of maturity and, as a result, the telephone call to the Insurer on **11 October 2018** was timely. The Complainants quote from the final paragraph of the Insurer's letter as follows:

> *"As we had a Notice of Assignment we were obliged to deal with* [the Provider] *for this maturity encashment. Papers were issued on 9th November and we then had to await receipt of all of the claim requirements, which were received on 10th January, 2019."*

The next section of the Complainants' letter to this Office deals the Provider's response to their data subject access request.

In respect of their credit rating, the Complainants say that it seemed for a period there had been consequences for their credit rating in that the Provider informed them that it would contact the Irish Credit Bureau and the Central Credit Register. The Complainants say they wish to know the nature of such correspondence and they want an assurance that any adverse correspondence relating to them has been fully retracted and will not have potentially negative consequences in the future. The Complainants say they flagged their concerns to the Provider but suspect these may have been ignored.

The Complainants explain that much of their Christmas in **2018** was spent hiring a solicitor, preparing a brief and going over files to check and re-check what could have gone wrong and *"Scare family and relaxation time was written off."*

The Complainants say that while the blame rests between the Provider and the Insurer, the Provider's letter of **7 December 2018** caused the Second Complainant absolute consternation and distress, ruined the Complainants' Christmas and severely impacted the Second Complainant's health, while causing the First Complainant significant disquiet and worry, and a knock-on effect on their children.

The Complainants say that neither they nor their solicitors were advised that the loan had been paid off on **21 January 2019** until the Provider's letter of **14 February 2019** and thus, unnecessarily and unprofessionally prolonged the stress which the Second Complainant suffered and compounded a situation completely outside of the Complainants' control.

The Second Complainant describes the impact the Provider's conduct had on her beginning with the letter of **7 December 2018**. The Second Complainant says this letter had a huge impact on her and she found it intimidating. It was full of legal jargon and consequences of what was going to happen if the Complainants did not engage with the Provider, and the whole emphasis of the letter was that the situation arose because of the Complainants, which was not the case.

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The Second Complainant says the letter contained instructions which, in the language used, appeared to be orders to provide details of the Complainants' financial circumstances and if they did not, *"financial hellfire and damnation"* would ensue. The Second Complainant says payments have always been made on time and never missed. The Second Complainant says the letter was sent:

> *"to put the fear of God into the recipient and it certainly succeeded in my case, it was accusatory and demanding in tone. It in particular caused me great distress with the following sentence*
>
> *'*[The Provider] *registers information on your payment history with the Irish Credit Bureau (ICB) based on current operational and reporting procedures'*
>
> *as I had recently taken out a loan - this caused me to have a panic attack as I was afraid that loan was going to called in - all €11,000 and I did not have the financial means to repay it …"*

The Second Complainant says the Provider's letter gave the strong indication that it had the unquestionable power to do whatever it wanted without a second thought for the consequences of its customers.

The Second Complainant continues, as follow:

> *"Throw Christmas into the equation, our son who at that time was in his Leaving Cert year, the fear that the papers had not been passed between* [the Provider] *and* [the Insurer]*, at that stage the final payment between* [the Insurer] *and* [the Provider] *hadn't been made, not then having the deeds of our house which we had paid for over the last 20 years, the personal and private information that was held by* [the Provider] *but was subsequently "lost", my fear that my loan was going to be recalled, the amount of time and effort put in by* [the First Complainant] *to the detriment of family life into trying to defend ourselves against this onslaught by* [the Provider]*, it has put a huge strain on us all but in particular, me, that letter really got under my skin and caused me sleepless nights, panic attacks, raised blood pressure and strained relationships which resulted in being prescribed Xanax (anxiety) and Lansoprazole to aid with the excess stomach acid that the stress was causing – I am still taking Lansoprazole.*
>
> *And it is still ongoing as we now have to stand up for ourselves for the appalling treatment we have received both at the hands of* [the Provider] *and by* [the Insurer]*, it is still eating into our family life."*

The Complainants also refer to GP correspondence in respect of the Second Complainant.

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In respect of the Provider's dispute resolution process, the Complainants submit that if the manner in which their complaint was handled reflects the Provider's general approach to complaints, they find it heavily biased towards the Provider, unprofessional and not fit for purpose from a customer perspective.

The Complainants say entities that purport to be professional should be capable of doing better than deploying intimidating approaches when entirely inappropriate. The Complainants say the fact that, over the years, they made all due payments but stood accused, exacerbated the Second Complainant's concerns and her blood pressure as well as other negative health effects (none of which were pre-existing). The Complainants say the impact of the Provider's thoughtless, unprofessional approach is particularly reprehensible and it did not have the decency to advise the Complainants in a timely fashion that the loan had been paid. Exerting this type of unwarranted pressure on an individual or family especially in circumstances where they are blameless, the Complainants say, is something that could potentially end in tragedy.

The Complainants have set out a table containing a list of the costs they are claiming in respect of the conduct described in their letter with updated figures being provided by letter dated **11 August 2020**:

Item	**Amount - €**
Solicitor's fees	*5,000.00
GP visits	150.00
Medication	**19.23
Incidentals (postage, travel to solicitor's office, printing)	50.00
Time spent on correspondence (15 full day equivalent, but over unsociable house, weekends, night, Christmas season)	***????
Time spend – Second Complainant – on correspondence (unsocial hours)	***????
Stress, anxiety, disquiet	****????

[Asterisks are those of the Complainants.]

The Complainants say that in the event of a dispute with the Provider, its refusal to accept emails and the delays involved in getting call recordings severely disadvantages a customer. The Complainants say that a supposed administrative error on the part of the Provider resulting in the Complainants not receiving all call recordings, added to an already cumbersome process. The Complainants say that the practice of posting letters with short timelines for action, particularly in or approaching holiday periods, and well after they are dated, is unacceptable.

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The Provider's Case

The Provider explains that on **18 October 2017**, the Complainants' mortgage loan provider (the original lender) wrote to the Complainants to advise that it was entering an agreement to transfer a portfolio of loans, including the Complainants' mortgage loan, to the Provider with a proposed transfer date of **15 December 2017**.

On **19 October 2017**, the Provider says it received correspondence from the Insurer addressed to the Complainants' original lender. The Provider says correspondence dated **25 September 2017** and forwarded from the original lender, provided confirmation that an insurance policy review letter had issued to the Complainants on the same date. The Provider says the letter issued by the Insurer to the Complainants noted the loan repayment date as **6 November 2018**.

On **4 December 2017**, the Provider says a member of its Customer Service Department placed an unsuccessful call to the Complainants to discuss the pending maturity of the loan in **November 2018** and to query whether the Complainants had a plan as to how they would fund the monies that would be due on maturity. The Provider says correspondence subsequently issued to the Complainants on the same date, in which it was confirmed that the loan was due to expire on **30 November 2018** and the letter requested that the Complainants contact the Provider to discuss the status of the loan.

On **12 December 2017**, the Provider says the First Complainant contacted its offices on receipt of its letter of **4 December 2017**. During this call, the Provider says its agent confirmed the basis of the letter was to ascertain if the Complainants had a repayment plan in place to meet the monies that would become due on the expiry of the loan which its agent quoted as **30 November 2018**. During the call, the Provider says the projected value of the endowment policy was discussed as well as the Complainants' ability to meet the full amount due.

On **18 December 2017**, the Provider says the original lender wrote to the Complainants to confirm that with effect from **15 December 2017**, all legal rights and agreements relating to the loan account had been transferred to the Provider.

On **29 March 2018**, the Provider says a member of its Customer Service Department placed an unsuccessful call to the First Complainant. The Provider says the basis of the call was to re-confirm that the Complainants had a viable plan in place to meet the liability due once the loan reached maturity. On the same day, the Provider says the First Complaint returned its call and re-confirmed that the endowment policy as well as a further cash payment was available to meet the outstanding liability.

On **30 May 2018**, the Provider says correspondence issued to the Complainants in which it was stated that the term of the loan was due to expire on **30 November 2018** and the outstanding balance as at that date would become due and owing. The letter also stated that:

> *"Now is the time to check what you need to do to ensure that you will have the funds available to repay your mortgage"*.

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On **24 August 2018**, the Provider says a member of its Customer Service Department placed an unsuccessful call to the First Complainant and the basis of the call was to re-confirm that the Complainants had a viable plan in place to meet the liability due, once the loan reached maturity. On **26 September 2018**, the Provider says a further call was placed to the First Complainant to discuss the impending maturity of the loan. However, the First Complainant expressed his reluctance to continue the call as he had concerns as to the legitimacy of the call.

On **11 October 2018**, the Provider says the First Complainant contacted its offices to discuss the impending maturity of the loan. During this conversation, the Provider says the First Complainant informed its agent that the loan was an endowment mortgage loan and the majority of the proceeds to redeem the loan would be received from the Insurer and any shortfall in the balance owing would be paid directly by the Complainants. The Provider says its agent informed the First Complainant during this conversation that the next payment due on **6 November 2018** would be for the full amount outstanding. The Provider says its agent proceeded to advise the First Complainant to cancel the direct debit with his bank in order to ensure an application for the full monies due would not be placed and that the First Complainant needed to contact the Insurer with regard to the upcoming encashment of the policy. The Provider says its agent proceeded to offer the First Complainant details of the policy number as well as the Insurer's contact number in order to aid the First Complainant in his efforts to contact the Insurer. The Provider says it was also agreed that its agent would contact the Insurer.

On the same day, the Provider says its agent placed a call to the Insurer and confirmed that the policy was due to expire on **6 November 2018** ad it was agreed that the Insurer would issue the documentation to the Provider which would outline the information that was required to encash the policy.

On **22 October 2018**, the Provider says its agent placed a call to the First Complainant to ensure that the direct debit had been cancelled as previously discussed. The Provider says its agent confirmed that although he had spoken with the Insurer on **11 October 2018**, the Provider was still awaiting receipt of the documentation which the insurer had undertaken to send. The Provider says its agent confirmed that he would endeavour to contact the Insurer on **26 October 2018** if the information remained outstanding. However, the Provider says its agent advised that he could not offer an opinion as to how long it would take the Insurer to release the funds. The Provider says it acknowledges that its agent quoted the maturity date as **30 November 2018**, however, assurances were offered to the First Complainant during this call that in the event the funds were not received once the loan reached maturity or even 30 days after the maturity date, the Provider would bring this issue to the attention of its Credit Committee to request that there would be no impact to the Complainants' credit rating.

On **24 October 2018**, the Provider says its Customer Service Department cancelled the direct debit on the loan account to ensure no application was placed on **6 November 2018** for the outstanding loan balance that would become due on that date, and on **30 October 2018**, correspondence issued to the Complainants to confirm that the loan was due to expire on **30 November 2018**.

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The Provider says the outstanding balance as at that date was confirmed as €99,780.72 and it was also outlined in the letter the importance of ensuring *"you have the necessary repayments in place to repay the balance owing at the end of the mortgage term."*

On **6 November 2018**, the Provider says the final monthly instalment was billed and the sum of €99,823.10 became due and owing, and as no corresponding payments were received, it was recorded as an arrears balance. The Provider says that as it received no correspondence from the Insurer to progress the Complainants' encashment of the policy, its agent placed a number of calls to the Insurer on **8 November 2018**. During these conversations, the Provider says it agents stated that documentation had not yet been issued to which the Insurer responded that the request would be marked as a high priority. However, it was estimated that it could take up to 10 days for the relevant documentation to be issued. The Provider says it was also confirmed that this documentation would issue to the Provider, the Complainants and their broker.

On **9 November 2018**, the Provider says correspondence issued to the Complainants in accordance with its obligations under Provision 9 of the Code of Conduct on Mortgage Arrears (**CCMA**). On **14 November 2018**, the First Complainant contacted the Provider in respect of the issuing of the letter of **9 November 2018** and to confirm that he had transferred payments of €5,000 and €4,000 by way of electronic fund transfers in reduction of the outstanding balance on the loan. The Provider says its agents subsequently explained that as the due date for the repayment of the loan was **6 November 2018**, its letter of **9 November 2018** was automatically issued in accordance with the Provider's obligations under the CCMA. The Provider says the letter was issued in sole recognition of its obligations under the CCMA and was of an informative nature as to the status of the account. The Provider says that its agent proceeded to confirm that if the funds were received by **30 November 2018**, there would be no impact on the payment profile recorded with the Irish Credit Bureau. The Provider says the First Complainant also received assurances that the funds he had transferred should be allocated to the loan account in the coming days. The Provider says that its agent further confirmed that the documentation from the Insurer had yet to be received and, as such, it was agreed that a further call would be placed to the Insurer.

The Provider says that during this conversation its position on email communication was discussed with the First Complainant in which it was explained that the Provider could not support this facility. The Provider advises that it does not support email communication because it does not deem it to be a secure form of communication.

The Provider says its Customer Service Department contacted the Insurer on **14 November 2018** and was advised that documentation had been sent to the Provider, the policyholders and the broker on **9 November 2018**. The Provider says a follow-up call was placed to the First Complainant the same day to inform him of this and, in anticipation of the loan being redeemed, a vacate mortgage checklist was issued for the Complainants to complete and return.

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On **16 November 2018**, the Provider says the First Complainant contacted it to confirm receipt of documentation from the Insurer but its agent advised that no correspondence had been received by the Provider and it was agreed that a copy of the correspondence would be sent by the First Complainant to the Provider. The Provider says its agent made references to her previous interactions with the Insurer and offered the First Complainant assurances that once the relevant documentation was received, she would review it as a matter of urgency.

On **19 November 2018**, the Provider says it received correspondence from the First Complainant which enclosed a letter from the Insurer dated **9 November 2018**. The Provider says that outlined in this letter was confirmation that the policy was assigned to the Provider and the actions that needed to be taken in order to 'close the investment'. This letter also enclosed emails exchanged between the Insurer and the First Complainant.

The Provider says that on **20 November 2018**, a member of its Customer Service Department contacted the Insurer to ensure the accuracy of the completion of the form. The Provider says tht a point to note during this call is that its agent queried if she had to return the letter of release or the deed of assignment, to which it was confirmed that the deed of assignment was to be provided. The Provider says on the same day, its agent requested the deed of assignment from its off-site storage facility. On **22 November 2018**, the completed mortgage vacate checklist was received and the Provider also received the deed of assignment from its storage facility. Due to the urgency of the Complainants' request, the Provider says its agent completed the relevant documentation and sent it to the Insurer the same day, enclosing a copy of the deed of assignment and policy documents dated **7 April 2006**. Also on **22 November 2018**, the Provider says its agent placed a call to the First Complainant requesting that he provide the Insurer with a certified copy of proof of address and identification. The Provider says it also offered assurances that she was returning the relevant documentation to the Insurer.

On **29 November 2018**, the Provider says the First Complainant contacted its office to enquire if any progress had been made with the Insurer regarding the finalisation of the claim. The Provider says its agent confirmed that it had not received any further communication from the Insurer subsequent to the correspondence issued on **22 November 2018**. The Provider says it was agreed that the First Complainant would contact the Insurer to enquire as to the status of the claim. The Provider says the First Complainant discussed his concerns as to what the consequences would be, if payment was not received by **30 November 2018**, to which the Provider's agent stated *"we are fully understanding of the situation you are in"* and that the Provider would be in contact with the Complainants with regard to any updates. The Provider says it was agreed that a redemption statement would be issued to the Complainants which was issued on **29 November 2018**.

On **30 November 2018**, the Provider says the First Complainant contacted its office to confirm that he received email communication from the Insurer acknowledging that it had received correspondence from the Provider on **27 November 2018**, and that the original policy documents were still outstanding and the remaining documentation was being reviewed by the Insurer.

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The Provider says the First Complainant also explained that the Insurer would be in communication with the Provider directly regarding this matter. The Provider says it acknowledges that during this conversation its agent informed the First Complainant that the final payment was due to be received on **30 November 2018** and the redemption amount due on that date was also discussed during the call.

On **7 December 2018**, the Provider says correspondence issued to the Complainants which advised that an arrears position remained outstanding on the loan account for a period of 31 days and that the loan was being treated under the Mortgage Arrears Resolution Process (**MARP**). The Provider says it also provided a copy of the MARP booklet. The Provider says this letter was sent in accordance with Provision 23 of the CCMA. The Provider says that while it can appreciate the Complainants' urgency on receiving this letter, given the efforts to contact the Insurer and to progress the encashment of the policy, it is obliged to issue this letter due to the arrears position that had remained outstanding on the account for a period of 31 days. Notwithstanding this, the Provider says it recognises that further efforts could have been made on **29 November 2018** to advise the Complainants of its obligations under the CCMA with regard to issuing written communications in respect of arrears when the First Complainant queried the consequences of non-payment of the monies that were due.

Also on **7 December 2018**, the Provider says it received correspondence from the Insurer dated **30 November 2018** which outlined the Insurer's request for the original policy documents and the original deed of assignment, as only copies of these had been received. The letter advised that in the absence of one or both of these documents, a lost policy declaration and indemnity form would need to be completed. The Provider says the letter also confirmed that once the relevant documentation was provided *'the claim can be processed without delay.'*

On **11 December 2018**, the Provider says a member of its Customer Service Department contacted the Insurer, acknowledged receipt of its letter and confirmed that the Provider would forward the original policy documents to the Insurer, however, the deed of assignment previously provided was the original. The Provider says it was agreed with the Insurer during this call that the Insurer would review the documentation submitted and contact the Provider with an update. On the same day, the Provider says that a representative of the Insurer contacted its officers and confirmed that the Insurer did receive the original deed of assignment and that when this was received, the documentation was copied which led to confusion as to whether the original had been received. The Provider says its agent outlined the urgency of the claim and it was agreed that a request would be sent to the relevant personnel within the Insurer to review the claim as quickly as possible. The Provider says a copy of the original policy document was sent to the Insurer on **12 December 2018** by way of registered post.

On **18 December 2018**, the Provider says it received the Complainants' letter of **17 December 2018**, in which the Complainants expressed dissatisfaction at the content of the Provider's letter of **7 December 2018** and the level of service received.

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On **20 December 2018**, the Provider says correspondence issued to the Complainants in which its requested information in order to proceed with the data subject access request. On **24 December 2018**, the Provider says correspondence issue to the Complainants which acknowledged their letter of **17 December 2018** and also confirmed that a full investigation of the complaint raised would be completed. On **31 December 2018**, the Provider says it received correspondence from the Complainants in which they enclosed copy certified copies of their proofs of identification and which also contained a request for call recordings.

On **2 January 2018**, the Provider says it received correspondence from the Insurer which stated that the documentation received was a Life Quote and a policy review, and not the original policy schedule and deed of assignment. The Provider says the actions it needed to take in order to comply with the Insurer's request were also outlined. On the same day, the Provider says its agent contacted the Insurer and confirmed that it had received the Insurer's letter of **21 December 2018**. The Provider says the Insurer advised that the documentation received was in relation to 2006 and 2014; however, the policy had been originally taken out in 1988. The Provider says its agent proceeded to state that she had previously received assurances from the Insurer that the original deed of assignment had been received. The Provider says the call was subsequently highlighted to a supervisor in the Insurer who agreed to review the ongoing claim queries and revert with an update.

The Provider says a representative of the Insurer contacted the Provider's offices on **2 January 2019** and advised that her review had concluded that there appeared to have been a miscommunication between the Claims Team and the Contact Team within their offices and to ensure the accuracy of the information requested, the original file would be recalled. The Provider says the Insurer confirmed it would contact the Provider on **3 January 2019** with an update, however the Insurer requested that the Provider complete a lost declaration form with regard to the policy documents to which the Provider's agent responded that the Provider had supplied the documentation available. The Provider says the Insurer proceeded to state that the original document would have been sent from the Original Lender and for the purposes of completeness, the Insurer required the Provider to complete the relevant form.

On **3 January 2019**, the Provider says the Insurer spoke with its agent and confirmed that while the Insurer was in possession of the deed of assignment, it was in the name of the Original Lender and this assignment ended in **December 2017** after which the Provider was subsequently named as the policyholder. The Provider says the Insurer required the original deed of assignment in the Provider's name. The Provider says its agent stated that she had dealt with a number of previous claims and this was the first time this had been requested. In response to this, the Provider says the Insurer stated the easiest resolution was to complete the last policy declaration and indemnity form with regard to both the policy document and deed of assignment in order to progress matters. On the same day, the Provider says correspondence issued to the Insurer, enclosing the completed form as requested.

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On **8 January 2019**, the Provider says it received correspondence from the Insurer in which it acknowledged receipt of the lost policy declaration and indemnity, however it was referenced that the form was not witnessed. The Provider says on **9 January 2019**, the amended form was sent to the Insurer.

The Provider says that on **16 January 2019**, a member of its Customer Service Department followed up with a call to the Insurer in respect of the progress of the claim. The Provider says its agent was advised that the claims handler dealing with the claim was not in the office and requested that the agent contact the Insurer on **17 January 2019**.

On **17 January 2019**, the Provider says its agent placed a call to the Insurer and it was advised that the date of completion of the claim was **16 January 2019**, the claim would be reviewed as a matter of urgency and funds should be released by **18 January 2019**. The Provider says it also issued correspondence to the Complainants to advise that the complaint was still under investigation.

The Provider says on **21 January 2019**, it received a cheque in the amount of €90,046 from the Insurer which represented the full surrender value of the policy.

On **28 January 2019**, the Provider says a review of the loan account was completed in which authorisation was received to waive the balance outstanding which accrued on the account due to the delay in funds being received from the Insurer. The Provider says that a request was also sent to the Irish Credit Bureau to ensure there was no impact on the relevant payment profile. The Provider says that as part of its complaint investigation in **February 2019**, it was determined that there was no negative impact to the Complainants' payment profiles recorded with the Irish Credit Bureau and the Central Credit Register. The Provider says a Final Response letter issued on **15 February 2019**.

The Provider advises that during the investigation of the loan account in **October 2020**, it was noted that an amendment was sent to the Central Credit Register on **5 November 2019** in which the Provider requested an amendment of the payment profile recorded for the Complainants' account. The Provider says it is important to note that a remediation project commenced in **October 2019** when it was determined that a number of accounts, including the Complainants', did not reflect the late allocation of payments for the period **March 2018** to **November 2019**. The Provider says the amendment requested that the profile record a late payment for **November 2018**, and *"the reasoning for this amendment was that the profile should have been impacted for November 2018 as the billing fell due on 6 November 2018 and the full monies due were not received until 21 January 2019."*

The Provider says it recognises that assurances were given it its letter of **14 February 2019** that no negative impact would be recorded with the Central Credit Register or the Irish Credit Bureau. Therefore, the Provider says it has sent a request to the Central Credit Register to ensure the full profile codes as clear.

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The Provider says it received confirmation from the Central Credit Register on **12 November 2019** that the Complainants' profile had been updated. In respect of the assurances given by the Provider on **14 February 2019**, it says that definitive clarification was not provided to the Complainants if any impact had been recorded at that time.

The Provider says it also notes that subsequent to receiving the redemptions funds on **21 January 2019** and prior to **14 February 2019**, it did not offer the Complainants assurances that the funds had been received. The Provider says that although it is disappointed that its Customer Service Department did not take steps to advise the Complainants of the redemption of the loan account, it was not its responsibility to confirm that the policy with the Insurer had been encashed.

The Complaint for Adjudication

The complaint is that the Provider was guilty of maladministration, insofar as it failed to engage with the Insurer, in a timely manner, to facilitate the redemption of the loan, and it proffered poor communication and poor customer service and complaints handling.

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 Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **10 May 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

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I note that the original lender wrote to the Complainants on **4 December 2017** to inform them that the loan was due to expire a year later on **30 November 2018**. During a telephone conversation on **12 December 2017**, the Provider's agent (acting for the original lender at that time) advised the First Complainant that the loan was due to expire on **30 November 2018** and queried whether he had a plan in place regarding the payment of the loan.

On **5 May 2018**, the Provider wrote to the Complainants to notify them of the pending maturity of their loan, as follows:

> *"We are contacting you to remind you that the term of your mortgage loan account above (mortgage) is due to expire on 30/11/2018.*
>
> *In line with the terms and conditions of your mortgage, you agreed to make repayments on an interest only basis for the full term of the mortgage. This means that no capital balance is being repaid by you during this time and once the term expires, the outstanding balance will become due and owing.*
>
> *You will need to ensure you have sufficient funds to repay the loan before or on the expiry date outlined above. …"*
>
> [underlining added for emphasis]

The First Complainant telephoned the Provider on **11 October 2018**, in respect of the pending maturity of the policy and the loan. The First Complainant queried whether the Provider would contact the Insurer regarding the policy, to which the Provider's agent responded that the Provider would not and that the First Complainant would need to contact the Insurer. However, later in the conversation the Provider's agent said the Provider would *"contact them here on our side."* The First Complainant was also advised to cancel his direct debit for November as the full outstanding payment would be called for. The Provider's agent advised that the direct debit would also be cancelled on the Provider's side.

The Provider's agent then telephoned the Insurer on **11 October 2018** noting the policy was due to mature on **6 November 2018** and queried the process for issuing funds. The Insurer's agent advised that documentation would issue to the Provider and there was *"a reminder with Alterations"* and that the documentation was *"going out in the next few days."*

On **30 October 2018**, the Provider wrote to the Complainants to notify them of the maturity of their loan, as follows:

> *"We are contacting you to remind you that the term of your mortgage loan account above (mortgage) is due to expire on 30/11/2018.*
>
> *In line with the terms and conditions of your mortgage, you agreed to make repayments on an interest only basis for the full term of the mortgage. This means that no capital balance is being repaid by you during this time and once the term expires, the outstanding balance will become due and owing.*

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> …
> *It is important to ensure that you have the necessary repayment arrangements in place to repay the full balance owing at the end of the mortgage. We would strongly urge you to review these arrangements with your broker or financial adviser to ensure that they are sufficient to repay the balance owing at the end of your mortgage term."*
>
> [underlining added for emphasis]

On **22 October 2018**, the Provider telephoned the First Complainant to advise him that it had contacted the Insurer and that the Insurer was due to send documentation regarding the policy. The Provider's agent advised the First Complainant that the loan was not due to mature until **30 November 2018** and if there were funds outstanding after that point, the Complainants would still have a further 30 days before there would be any potential impact on the Complainants' account and there would be no impact on their credit rating.

The Provider telephoned the Insurer on **8 November 2018** and explained that the Provider was expecting forms regarding the expiry of policy. The Provider's agent queried whether the relevant forms had been issued and the Insurer's agent responded that there was a *task open* to issue maturity options. The Insurer's agent asked if the Provider wished for this to be prioritised to which the Provider's agent responded in the affirmative. This call appears to have unexpectedly terminated and the Provider's agent telephoned the Insurer again and raised the same query. On the second call, the Insurer's agent advised the Provider's agent that the forms had not been issued yet, but there was a task with the Alterations Team to have them issued and they would be marked as a high priority.

By letter dated **9 November 2018**, the Provider wrote to the Complainants to inform them that they had recently missed a payment on their loan due on **6 November 2018**. The letter also advised that it was issued pursuant to Provision 9 of the CCMA.

The First Complainant telephoned the Provider on **14 November 2018**, for an update on the progress being made with the Insurer and to query a letter he had received the previous day regarding a missed payment on the loan as he had been advised to stop the direct debit during a pervious conversation with one of the Provider's agents. In respect of the direct debit, the Provider's agent advised that the direct debit was due on **6 November 2018** and once the account was cleared by the maturity date of **30 November 2018**, the Complainants' credit rating would not be affected.

The Provider's agent advised the First Complainant *"under the code of conduct"* the Provider was obliged to issue the letter in question which are generated automatically. The Provider's agent also told the First Complainant that one of the Provider's agents had been speaking with the Insurer on **8 November 2018** and that documents would be issued to the parties. The Provider's agent advised the First Complainant that it would contact the Insurer that day for an update. Towards the end of the call, the Provider's agent confirmed the First Complainant's contact details and the First Complainant asked if the Provider had an email address for him. In response to this, the Provider's agent explained that the Provider did not correspond externally using email.

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The Provider telephoned the First Complainant on **14 November 2018**, to advise him that one of the Provider's agent had spoken with the Insurer who advised the documentation had issued to the Provider, the Complainants, and the Complainants' broker on **9 November 2018**. The Provider's agent advised the First Complainant that this documentation had yet to be received and as soon as they were received, they would be actioned.

The Provider also telephoned the Insurer on **14 November 2018** to query whether encashment documentation had been issued. The Insurer's agent advised that a maturity options form was issued to the Provider, the Complainants and the broker on **9 November 2018**. The Provider's agent also confirmed the address of the Provider to which the form was sent.

The First Complainant telephoned the Provider on **16 November 2018**, to see if the Provider had received the relevant documentation from the Insurer. The Provider's agent advised the First Complainant that it did not appear that any correspondence had been received from the Insurer. It was agreed during this call that the First Complainant would send a copy of the Insurer's letter he had received, to the Provider.

The First Complainant wrote to the Provider on **16 November 2018**, enclosing a copy of a letter dated **9 November 2018** received from the Insurer regarding the maturity of the policy. This letter advised that the 'Maturity Options' regarding the policy had been issued directly to the Provider. I note that on the documents forwarded by the First Complainant, the Insurer did not appear to require the original policy document, but it required certain identification documentation and the original deed of assignment.

The Provider telephoned the Insurer on **20 November 2018** with a query regarding the completion of the Surrender Form. It was confirmed by the Insurer's agent that the original deed of assignment was required by the Insurer.

On **22 November 2018**, one of the Provider's agents telephoned the First Complainant to advise that she was sending the completed claim form to the Insurer. The Provider's agent also advised the First Complainant that the Provider had yet to receive correspondence from the Insurer regarding the expiry of the policy. The Provider sent a completed Surrender Form to the Insurer under cover of letter dated **22 November 2018**.

During a call on **29 November 2018**, the First Complainant queried what would happen if the money from the policy was not received by the Provider before the maturity of the loan. I note that in the course of this conversation, the Provider's agent advised the First Complainant that the Provider understood the situation. The First Complainant telephoned the Provider on **30 November 2018**, to inform the Provider that he received an email from the Insurer where it outlined that it had received documentation from the Provider, but the original policy document was outstanding and the documents received were being reviewed.

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The Insurer wrote to the Provider on **30 November 2018** (which appears to have been received on **7 December 2018**), as follows:

> *"In order to process the maturity, we require the following:*
>
> 1. *The Original Policy Documents. Alternatively, if the document had been mislaid please complete the enclosed Lost Policy Declaration and Indemnity form and have same witnessed by a third party …*
> 2. *Original Deed of Assignment to* [the Provider]*. Unfortunately, we only received a copy of this document. If this document has been mislaid please complete the enclosed Lost Policy Declaration and Indemnity form and have same witnessed by a third party …*
>
> *…*
> *On receipt of the above requirements, the claim can be processed without delay. …"*

The Provider wrote to the Complainants by letter dated **7 December 2018** as follows:

> *"We are writing to you to inform you that your mortgage loan account (mortgage) … has been in arrears for 31 days or more.*
>
> *We are sending you this letter in accordance with our obligations under Provision 23 of the Central Bank of Ireland's Code of Conduct on Mortgage Arrears 2013 (the Code). …*
>
> *Please note that:*
>
> - *Your most recent arrears started on 06/11/2018.*
> - *0.00 repayments have been missed at the date of this letter.**
> - *The total monetary amount of repayments missed at the date of this letter is €90,054.64.*
> - *The total monetary amount of arrears at the date of this letter is €90,054.64.*
>
> *…*
>
> *Therefore, your mortgage is now being dealt with under the Mortgage Arrears Resolution Process …*
>
> ***Talk to Us***
> *Your case had been assigned to our Arrears Support Unit (ASU) who will be your dedicated arrears contact during the MARP. You can contact the ASU at …*
>
> ***Urgent action required***
> *If your missed payments is simply due to an oversight and you are not currently experiencing financial difficulties, please bring your mortgage up to date immediately. …"*

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This letter also requested that the Complainants complete and return a Standard Financial Statement, explained the importance of engaging with the Provider and the concept of 'not co-operating' and also advised of the potential adverse credit reporting that may arise.

One of the Provider's agents telephoned the Insurer on **11 December 2018** and explained that she had sent documentation to the Insurer on **22 November 2018** and received a letter from the Provider the previous Friday (**7 December 2018**) requesting further documents. The Provider's agent advised the Insurer's agent that she had the original policy document which she said she would send to the Insurer. The Provider's agent also queried the Insurer's position that the original deed of assignment had not been provided, stating that the original had been sent to the Insurer. The Insurer's agent advised the Provider's agent that having checked the system notes that the documents received were copies and not originals. The Provider's agent stated that it was not copies that were provided. Later the same day, the Insurer's agent telephoned the Provider's agent and advised that original documentation had been received. The Provider wrote to the Insurer on **11 December 2018**, enclosing the requested original life policy.

The First Complainant wrote to the Provider on **17 December 2018** expressing his dissatisfaction at the Provider's letter dated **7 December 2018** which was received on **13 December 2018**, and the impact it had had on the Second Complainant. The First Complainant also requested, amongst other matters, that the Provider refrain from contacting the Complainants by telephone. The First Complainant also requested an explanation regarding arrears accruing on the loan account on **6 November 2018**. The letter also contained a data subject access request. The Provider wrote to the First Complainant on **24 December 2018** acknowledging his letter of **17 December 2018** as a complaint. The Provider issued a Final Response letter on **14 February 2019**.

The Insurer wrote to the Provider on **21 December 2018**, as follows:

> *"Unfortunately the documentation recently received was a Life Quote and a Policy Review not the original Policy Schedule and original Deed of Assignment as requested."*

The letter continued by repeating the contents of the Insurer's letter of **30 November 2018**. I note from the Provider's date stamp that this letter does not appear to have been received by the Provider until **2 January 2019**. That said, **21 December 2018** is likely to have been the last business day before Christmas with **2 January 219** being the first business day of **2019**.

On **2 January 2019**, the Provider telephoned the Insurer on foot of a letter received by the Provider stating that the original documentation had not been received even though it was confirmed to the Provider on **11 December 2018** that the original documentation had been received. The Provider's agent spoke with another of the Provider's agents who advised that she would check the documents sent by the Provider to ascertain whether these were original documents.

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I note that following this, the Insurer's agent telephoned the Provider to advise that there appeared to be a mix up between its Contact Team and its Claim Team when processing the claim and that the file was being recalled to confirm whether the documentation received from the Provider was the original documentation and whether the Lost Policy Declaration was still required. The Insurer advised the Provider's agent that the documents received were a quote from 2006 and a review from 2014, and the original documents were dated 1988. The Insurer's agent advised that either the original policy document from 1988 or a Lost Policy Declaration was required.

The Insurer's agent spoke with the Provider's agent on **3 January 2019**, who advised that the original deed of assignment to the Original Lender had been received, but that the assignment to the Original Lender was closed off the Insurer's system in **December 2017** and it was replaced with an assignment to the Provider. The Provider's agent explained that generally with these types of claims it would send the original deed of assignment from when the policy was taken out. The Insurer's agent explained because the assignment was transferred to the Provider, the Insurer required the original deed of assignment to the Provider. The Insurer's agent advised that the simplest thing to do would be for the Provider to complete a Lost Policy Declaration in respect of the original policy documents and the deed of assignment.

The Provider wrote to the Insurer on **3 January 2019** enclosing a Lost Policy Declaration and Deed of Assignment. On **7 January 2019**, the Insurer wrote to the Provider advising that the Lost Policy Declaration had not been witnessed and requested that the form be witnessed and returned. The Provider acceded to this request, and witnessed form was returned under cover of letter dated **9 January 2019**.

The Provider telephoned the Insurer on **16 January 2019** requesting an update on the maturity claim. The Insurer's agent advised that the agent assigned to the claim was not working that day but the claim was in their queue. The Provider telephoned the Insurer the following day, **17 January 2019**, to follow-up with the Insurer regarding the claim. The Insurer's agent advised that the funds should be released by the following day. The Insurer wrote to the Provider on **18 January 2019** enclosing a cheque in the amount of €90,046.00.

Analysis

I have noted that the First Complainant contacted the Provider on **11 October 2018,** almost a month in advance of the expiry of the policy, to discuss its maturity and the repayment of the loan. Following this call, on the same day, the Provider contacted the Insurer regarding the upcoming maturity of the policy when the Insurer advised that maturity documentation would be issued in the coming days. The policy matured on **6 November 2018** and not having received any documentation from the Insurer, the Provider telephoned the Insurer on **8 November 2018** when the Insurer confirmed that the relevant documentation had not yet issued.

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It appears that the Complainants received correspondence regarding the maturity of the policy from the Insurer dated **9 November 2018**, however, based on the evidence presented, no such correspondence appears to have been received by the Provider. To this end and following a conversation with the First Complainant, the Provider telephoned the Insurer on **14 November 2018** when it was confirmed that correspondence had issued to the Provider on **9 November 2018**. It is unclear as to whether this correspondence was ever received by the Provider and the Provider does not appear to have requested it to be re-issued.

However, the First Complainant himself, forwarded the correspondence he received from the Insurer to the Provider on **16 November 2018** and the Provider proceeded to request the surrender value of the policy based on this documentation. Following certain enquiries with the Insurer on **20 November 2018**, the evidence indicates that the Provider returned a completed Surrender Form to the Insurer on **22 November 2018**.

The Insurer wrote to the Provider on **30 November 2018** (which appears to have been received on **7 December 2018**) to advise that it required the original policy documents and the original deed of assignment to the Provider (as only a copy had been received). At this point, it is worth noting that it does not appear to have been stated in the correspondence issued by the Insurer to the First Complainant on **9 November 2018** that the original policy documents were required, only the original deed of assignment. Further to this, I also note that the Insurer's correspondence said 'original deed of assignment', which would tend to imply the deed of assignment to the Original Lender and not necessarily the Provider.

It appears that it was only in the Insurer's letter of **30 November 2018**, that the Insurer first advised that the original policy document and the deed of assignment to the Provider were required. Although it was stated in the Insurer's letter of **30 November 2018** that the deed of assignment to the Provider was the relevant deed, this does not appear to have been fully understood by the Provider until around **3 January 2019** and the Provider instead appears to have relied on the approach it usually took to redemption claims, which was to send the deed of assignment from the date when the policy was incepted.

On **11 December 2018**, the Provider sent what it considered to be the original policy documents to the Insurer but as indicated in the Insurer's letter of **21 December 2018**, the Provider only sent documentation from 2006 and 2014, although the policy had been incepted in 1988. Having considered the evidence and the documentation sent by the Provider purporting to be the original policy documents, it appears that the Provider did not have the original policy documents and the Provider should have been aware of this, particularly if appropriate consideration had been given to the policy related documents it was sending to the Insurer.

A Lost Policy Declaration was sent to the Insurer on **3 January 2019** but the Provider failed to have it witnessed. A witnessed Lost Policy Declaration was subsequently sent to the Insurer on **9 January 2019** with the surrender value of the policy being received under cover of letter dated **18 January 2019**.

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Having considered the evidence, it is clear there were delays in redeeming the Complainants' policy. There was a level of shortcoming and confusion regarding the provision of original policy documents, the correct deed of assignment and the requirement for, and completion of, the Lost Policy Declaration and I am satisfied that the Provider is responsible for some of the delay that arose in respect of redeeming the policy though, I note that it was in regular contact with the Insurer in an effort to progress the surrender of the policy.

I am also of the opinion that the Provider's communication to the Complainants could have been much improved, in order to warn as to the nature of the communications which would be automatically issued, if the payment of the policy proceeds became delayed. I have commented further below in this regard.

The Provider says it received the redemption money on **21 January 2019**. It was 3 weeks later when the Provider advised the First Complainant only, in its Final Response letter dated **14 February 2019** that the funds had been received from the Insurer on **21 January 2019** and applied to the loan account with the remaining balance being waived. I note that the Provider wrote to both Complainants on **7 March 2019**, to advise that in light of the recent settlement of the loan, it had no further interest in the policy. In its Complaint Response, it expressed its disappointment that its Customer Service Department did not take steps to advise the Complainants of the redemption of the loan.

In my opinion, when the Complainants' loan was ultimately cleared, it was reasonable to expect the Provider to have informed the Complainants of this within a short period of this occurring. Disappointingly, the evidence shows that this did not happen in the present case and indeed only the First Complainant was informed, by way of a Final Response letter addressed to him, that the loan had been cleared, with the later indication that the loan had been settled coming a month later, in **March 2019**. It is my opinion that the Provider should have specifically written to both Complainants within days of receiving the redemption funds advising them that the funds had been received from the Insurer, and applied to their loan account (and indeed to advise that the remaining balance was being waived, if this is what the Provider had decided to do at that time).

In its Complaint Response, the Provider goes on to say that it was not its responsibility to confirm that the policy had been encashed. While this may be the case, I am satisfied that the Provider should nonetheless have informed the Complainants about the redemption of the loan, regardless of the source of the redemption funds and I believe that it was unreasonable of the Provider not to have done so, bearing in mind the regular interaction it had had with the Complainants up to that point. I am in no doubt that this additional period of 3 weeks before the Complainants were advised that the large redemption payment had been made by the Insurers, contributed significantly to the inconvenience which they suffered.

The Provider has taken the position that the outstanding loan balance of just over €90,0000 was due from **6 November 2018**. The basis for this position appears to be that this was the billing date for loan repayments.

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Whilst the original loan may have been drawn down on 19 November 1998, the Complainants subsequently entered a mortgage loan agreement with the original lender in **September 2006** for an amount of €120,000. The loan was subject to 143 interest repayments with the capital amount to be repaid in a single instalment at the end of the loan term. The 'Period of Agreement' was stated to be 12 years and 2 months from drawdown with the latest date for drawdown being **28 December 2006**. In the Schedule to the loan agreement it states, in respect of the repayment of the loan, as follows:

> *"You will make interest only payments during the whole loan period so you will still have to repay the original capital amount at the end of the mortgage term. …"*
>
> [underlining added for emphasis]

Section 8 of the General Conditions deals with repayment and states:

> *"8.1 You must repay the Loan by instalments comprising both principal and interest (the "Repayment Instalments") at the intervals specified in the Schedule.*
>
> *8.2 The Repayment Instalments will commence on a date mutually agreed between us, or, in the absence of agreement, on a date specified by us. They will continue thereafter for the Period of Agreement at the intervals specified in the Schedule. …*
>
> *8.4 The last Repayment Instalment shall include the amount of the final balance of the Loan (if any) outstanding after payment of the normal amount of the last Repayment Instalment. The amount, if any, of the final balance will depend on the rates of interest payable during the Period of the Agreement, the number and amount of the Repayment Instalments and other sums received by us."*

I note that in an email from the First Complainant to the Insurer dated **17 October 2018**, he stated that: *"Our mortgage started on 6 November, 1988."* However, as can be seen from the correspondence sent to the Complainants by the original lender and the communications between the Complainants and the Provider, the loan was due to expire/mature on **30 November 2018**.

The Provider has taken the approach that because the loan billed on **6 November 2018** (which also appears to be the last billing date of the loan) that the total balance, including capital, fell due on this date and became payable. However, I do not accept this position and, having considered the matter in detail, it is my opinion, on a reasonable interpretation of the loan agreement and the Provider's communications with the Complainants (which unequivocally stated that the capital balance was due on the maturity of the loan), that the Complainants were only required to make interest repayments during the term of the loan with the capital balance falling due on the expiry of the loan, being **30 November 2018**. In particular, it appears from the loan documentation that the 'last Repayment Instalment' for the purposes of clause 8.4 is the instalment due on the maturity of the loan.

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In the circumstances, I believe on the basis of the loan documentation available, that it was unreasonable and unfair for the Provider to have claimed that the loan fell due on **6 November 2018**. I also believe that the Provider prematurely sought the repayment of the balance outstanding on the loan on **6 November 2018** which did not fall due until **30 November 2018**. I consider the Provider's conduct in this regard to have been unfair, and to have been unjust and unreasonable within the meaning of ***Section 60(2)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017***. The consequences of this approach is that arrears correspondence prematurely issued to the Complainants on **9 November** and **7 December 2018**.

Following on from this, it is my opinion that there should have been no impact to the Complainants' credit rating for the month of **November 2018**, however the evidence suggests that certain credit reporting took place in **November 2018**.

I also note that in its Final Response letter, the Provider indicated that it would write to the Irish Credit Bureau and Central Credit Register to ensure the Complainants were not impacted by the delays associated with the surrender of the policy. In its Complaint Response, the Provider says however, that definitive clarification was not provided to the Complainants as to whether their credit profiles had been impacted. This is disappointing.

It appears that adverse credit reporting was occurring in respect of the Complainants' loan account and this was not brought to the Complainants' attention in the Final Response letter. Further to this, it is not clear how soon after the Final Response letter issued that the Provider sought to update, and updated, its reporting of the loan and neither is it clear when, if at all, the Complainants were made aware of these matters. In addition, there appears to have been a pre-existing and unrelated issue regarding the Provider's reporting of the loan to the Central Credit Register which was not identified at the time of the Final Response letter. It is also unclear whether this should have come to the Provider's attention and been addressed, when investigating its reporting of the loan arising from the delay associated with the surrender of the policy. Therefore, taking the available evidence into consideration, it is my opinion that there were certain significant errors and shortcomings on the part of the Provider when it came to the reporting of the Complainants' loan to the Irish Credit Bureau and the Central Credit Register.

The letters dated **9 November 2018** and **7 December 2018** were issued to the Complainants in respect of arrears on their loan account. These were issued because the billing date for the loan was **6 November 2018** and the Provider regarded the loan balance as being due on that date. However, due to matters relating to the redemption of the policy, redemption funds had not yet been received. During a telephone conversation on **14 November 2018**, the Provider's agent advised the First Complainant that the letter of **9 November 2018** was automatically generated in accordance with the Provider's regulatory requirements. I note that in its Complaint Response, the Provider says that further efforts could have been made on **29 November 2018** to advise the Complainants of its obligations under the CCMA with regard to issuing written communications in respect of arrears when the First Complainant queried the consequences of non-payment of the monies that were due. I agree.

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While I consider these letters to have been prematurely issued, having considered their contents, I am satisfied that the letters were in line with the requirements of the CCMA and, from the Provider's perspective, as it believed that the loan was due and in compliance with its regulatory obligations, it was required to issue such letters. The Provider was nevertheless aware of the Complainants' concerns, given the interactions over the previous weeks. How simple it would have been, in my opinion, to have alerted the Complainants in advance of the communications issuing, in order to significantly reduce the upset and inconvenience which they suffered. It seems that the Provider's familiarity with CCMA notifications is such that it utterly overlooked the distress and concern which might be caused to a recipient in circumstances such as those of the Complainants.

In their letter of **25 September 2019**, the Complainants refer to a gap between the date of the letter of Friday **7 December 2018** and the postmark contained on the envelope enclosing the letter. The Complainants have also provided a copy of this envelope postmarked **12 December 2018**.

In this respect, I consider that the Provider should endeavour to issue correspondence as close to the date of the letter as possible. Engaging in the conduct of posting letters a number of days after they are dated, is unfair and should be avoided.

The Complainants have taken issue with the Provider's decision of not communicating via email. I note that the Provider's reason for this, as explained to the First Complainant, is that the Provider does not support email communication because it does not consider it to be a secure form of communication. While it may be a convenient means of communication for many consumers, the Provider is not obliged to communicate with customers via email. Further to this, the Provider has outlined a legitimate reason for not communicating through email. In this case, the Complainants were able to communicate with the Provider through telephone and by post, which are both reasonable means of communication. As a result, I do not consider the Provider's decision to decline to communicate via email to have been unreasonable and I do not accept that this imposes an obligation on the Provider to forewarn customers that it does not communicate in this manner, as suggested by the Complainants. Nevertheless, this policy makes it all the more important for the Provider to ensure that letters sent by post, are posted on the date identified, on the letter.

The Complainants are dissatisfied with the Provider's investigation of their complaint. In the First Complainant's letter of **17 December 2018**, he raised a number of issues primarily concerning the delay in redeeming the policy and the Provider's letter of **7 December 2018**. This letter also contained a data subject access request.

In their letter of **25 September 2019**, and as part of their complaint to this Office, the Complainants have made a number of points in respect of the Provider's response to their data access request. It is important to note that pursuant to ***Section 44(2)(c)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, a complaint may not be made to this Office where the conduct complained of relates to a matter that is within the jurisdiction of an alternative suitable forum or tribunal. In this instance, the conduct being complained of in respect of the Provider's compliance with the data subject access request, is a matter for the Data Protection Commission, rather than for this Office.

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Turning to the Provider's response to the Complainants' complaint, I note the Provider issued a Final Response letter dated **14 February 2019**, where it set out its investigation of the complaint and its position in respect to the matters raised. While the Complainants are dissatisfied with how the Provider responded to their complaint, I don't accept, apart from the matters discussed above, that there was anything wrong with the manner in which the complaint was responded to.

Goodwill Gesture

In concluding its Complaint Response, the Provider says that:

> *"In order to bring this matter to conclusion and in recognition of the lack of clarification offered to the Complainant with regards the repayment due date falling due on 6 November 2018 even though the maturity date was 30 November 2018, the lack of clarification offered to the Complainant on 29 November 2018 with regards the correspondence he could expect to receive whilst the account remained in arrears and if there was any impact to the payment profile subsequent to our Complaint review and due to the oversight that arose when we amended the CCR on 5 November 2019, we would like to offer the Complainants a sum of €500."*

It is my opinion that the Provider's conduct has fallen below the standard to be reasonably expected of it, in terms of the manner in which it dealt with the Complainants' loan and its part redemption by surrender of the policy. I am not satisfied that the goodwill gesture offered by the Provider constitutes a reasonable sum of compensation for the Provider's conduct or for the significant inconvenience visited upon the Complainants by the Provider's actions and inactions. Accordingly, having considered the matter at length, I believe that it will be appropriate to direct a more significant compensatory payment by the Provider to the Complainants, as outlined below.

I intend to direct the Provider, in that regard, to make a compensatory payment to the Complainants in the sum of €4,000, in order to conclude.

<u>Conclusion</u>

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

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €4,000, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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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 MCGOVERNDEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

1 June 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.