An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0295
Sector:	Insurance
Product / Service:	Other
Conduct(s) complained of:	Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This Complaint is a sole trader and her complaint relates to a business insurance policy.

The Complainant's Case

The Complainant's relevant insurance period under the policy was from **02 August 2015** to **01 August 2016**. The Provider has refused to indemnify for an injury claim under the Complainant's Business Insurance policy as noted in its Final Response Letter dated **15 September 2017**. The injury claim was made by the Complainant's employee. The Provider refused to indemnify the Complainant due to late notification of the circumstances leading to the claim.

The Complainant explains that an employee informed her of a fall and possible injury to herself, while working in the business premises around the middle of **2015**. The Complainant drove the employee home and suggested she *"attend hospital and get an x-ray".* The Complainant says she was advised the following day that the x-ray was clear. The Complainant admits to not informing the Provider of the incident, as she *"thought nothing further of the incident"* and had no indication that the employee would pursue a Personal Injury claim, at that time. The Complainant states that had the employee informed her within legislative time limits, she would have informed the Provider of the incident.

In early **2017** the Complainant became aware of the employee's intention to submit an injury claim. The Complainant says she was dealing with some personal family issues

during 2017, saying it was a stressful time and she could not always deal with her correspondence. She states that she received communications from the Personal Injuries Assessment Board which she forwarded to her Broker in May 2017. The Broker reported the incident to the Provider on **17 May 2017**. The Complainant says she made herself available to assist with the Provider's investigation, and believes the Provider *"was not prejudiced by the late notification".*

The Complainant submits, in her full submissions further arguments through her third party representative. The Complainant's position is that the Provider *"cannot rely"* on the late notification of the incident, to reject a claim on the policy or *"avoid liability".* The Complainant maintains that she did not receive sufficient notice of a claim, from the employee.

The Complainant's position is that the Provider was able to carry out a full investigation of this incident. The Complainant says there were no changes made in the area where the employee alleged that she had slipped and fallen. The Complainant submits that this is evident from the report that was prepared by her Loss Adjustors dated the **08 September 2017** and submitted to the Provider. The Complainant states she raised an issue about a leak in the roof which was the responsibility of the Landlords which may have been a contributing factor. The Complainant submits the investigator who prepared the report has stated in his report *"however it is not possible to confirm if the said repairs have prejudiced investigations, given that it is yet to be confirmed that the said leak resulted/contributed to the incident"*.

The Complainant states that the issue as to whether the leak in the roof could have contributed to the incident is a matter that could be investigated further and ascertained as to when the repairs to the roof were carried out.

The Complainant states that in the investigators report there is reference to an employee who brought the matter of the incident to the attention of the Complainant not being available at the time of the investigation for interview as she had left her employment with the Complainant. In response the Complainant states there is no doubt that if required this employee could have been interviewed at a later date for her recollection as to what occurred at the time of this alleged incident. The Complainant's position is that the issue of prejudice is clearly relevant to indemnification under this policy of insurance, and says, it is respectfully submitted that the Provider has not been prejudiced in carrying out a full investigation.

The Complainant states that the policy documents are not written in plain English and in most cases are difficult for the general public to read and understand. The Complainant submits that the Provider has referred to a document entitled "features and benefits" and says, if you look at the paragraph headed employers liability this document states that if a policy holder is required by law to pay compensation for bodily injuries to an employee in the course of their employment that the policy of insurance provides protection for this. The Complainant states it does not go on to say that there is an obligation on the policy holder to notify the Provider of any event which may give rise to a claim.

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The Complainant wants the Provider to indemnify the claim under the '*Business Insurance Policy'.*

The Provider's Case

The Provider points out that the period of late notification concerning this claim is **in excess of 20 months** and the Provider is firmly of the view that the application of the Policy terms is not unreasonable. The Provider states there is no requirement on the Provider to demonstrate that its position has been prejudiced as a result of the late notification of the claim. The Provider's position is that compliance with the Policy terms and conditions is a condition precedent to the operation of the policy in question and the Provider notes that the vast majority of general insurance policies on the market contain a notification requirement. The Provider states that the policy condition imposes a duty on an Insured to report any occurrence which may give rise to a claim under the Policy.

The Provider says it does not require that an Insured should make a determination or judgement as to who is legally responsible or whether an injured party is likely to proceed to make a formal claim for compensation.

The Provider submits that it is entirely reasonable that a Policyholder who is seeking indemnity under the terms of a policy will put his/her insurer on notice of any incident that may give rise to a claim in order that a full and timely investigation can be carried out and any resulting claim managed effectively. The Provider states that the policy condition is clear and unambiguous in that the Policyholder is obliged to report any occurrence which may give rise to a claim under the policy. The Provider says that the timely notification of an incident is in no way a burdensome condition; a letter/email or a telephone call to the Provider following the alleged incident was all that was required.

The Provider submits that where there is no delay in notification of an incident which may give rise to a claim, incidents of this nature are investigated promptly to ensure that all/any witnesses and relevant parties are identified and their details recorded. The Provider says that during such an investigation all information and statements are gathered while the event remains clear and foremost in the memory of any witnesses or other connected parties. The Provider's position is that it lost its opportunity to do so in this case.

The Provider submits that it is beyond question that a person's recollection of events, dates or times may be seriously impaired by the passage of time. The Provider states that in this particular case, the claim investigator confirmed that a staff member who first brought the reported incident to the attention of the Policyholder in **2015** was not available at the time of the meeting on **26 August 2017** as this party had since left her employment with the Policyholder. The Provider says it is also noted that property repairs were carried out on an area of the roof possibly relevant to this claim between the loss date and when the claim was reported to the Provider.

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The Provider states that the claim was reported to the Provider on **17 May 2017** and the deadline for the Insured/Insurers to reply to the Personal Injuries Assessment Board (PIAB) notice of claim was **20 May 2017**. The Provider submits it is therefore highly unlikely and unrealistic that an Insurer would have adequate time to fully investigate an incident such as this and determine liability in a period of 3 days.

The Provider submits that, it is relevant to note that there would be serious implications if claims could be admitted under a liability policy at any point in time regardless of late notification. The Provider states that in such a scenario, the Provider could have no certainty on its exposure or financial liability and could not adequately reserve in line with its requirements under the Central Bank's reserving requirements. The Provider states that its ability to effectively set prices and assess risk would be removed if there was no requirement upon policyholder to notify incidents which may give rise to claims as they occur.

The Provider states that in addition, a *"Features & Benefits"* document was issued along with annual renewal papers and this document outlined a summary of the covers available, the main features, benefits and restriction which apply to the Policy. The Provider states that the document outlines the condition to notify the Provider promptly of any claims or incident that may give rise to a claim.

The Provider states that there is an obligation on all Policyholders to familiarise themselves with the terms of their Policy and in this regard, the Complainant ought to have been aware of their responsibility to provide notification of this loss to the Provider in a timely manner. It is the Provider's position that if the Complainant had been in any doubt they were free to contact the Provider to seek advice or clarification.

The Provider states it was entitled to refuse cover even in circumstances where it has not been prejudiced as the Complainant's duty to notify the Provider of the possibility of a claim *"forthwith"* was a condition precedent to the provision of an indemnity in this case. The Provider submits it is clear that the Complainant failed to notify the Provider *"forthwith"***.**

The Provider draws attention to first paragraph of "features and benefits" document which it says clearly states that the document is a "summary" of the cover applicable under the Policy and that *"this document is not meant to replace the full policy terms and conditions."* The Provider states it clearly states that the terms and conditions included in the Policy document should be read in conjunction with the Policy Schedule.

The Provider submits that the requirement to notify the Provider promptly of any claims or incidents which may give rise to a claim is outlined under the heading *"Important Notes on our Business … Policy".*

The Provider states that as is suggested by the title of the *"Features & benefits"* document it is not intended nor logical or feasible that the full policy terms and conditions could be outlined in a three page document and the Provider says it rejects the argument made by the Complainant in this respect.

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In response to a query from this office as to when there was first notification from any party of the leaks to the property, and the incident that occurred, the Provider stated:

> *"In response to your query, we can confirm that the Provider was not made aware by any party of leaks to the risk property and the incident which occurred prior to 17 May 2017".*

Timeline of events

Mid 2015: Date of alleged incident at the Complainant's premises.

20 February 2017: PIAB issue notice of claim to the Complainant.

17 May 2017: First notification of claim to Provider by email from Complainant's broker.

22 May 2017: Claim handler discusses claim with Complainant's Insurance Broker and confirms Provider reserves its position due to late notification.

22 May 2017: Provider issues letter reserving its rights

23 May 2017: Provider instructs Claims Investigator to carry out a without prejudice investigation.

30 June 2017: Claims Investigator unable to complete claim investigation, Provider appoints a different Claims Investigator.

06 July 2017: Claims Investigator confirms appointment to Complainant's Insurance Broker.

07 July 2017: Claims Investigator emails Complainant with documentation required prior to inspection.

26 August 2017: Claim investigator attended Complainant's premises.

15 September 2017: Provider issues letter confirming declinature of claim

Policy Conditions

The following Policy Conditions are relied upon by the Provider:

> ***General Conditions and Exceptions***
>
> ***"3. Due Observance and Fulfilment:*** *The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured and the truth of the statements and answers in the said proposal shall be conditions precedent.*

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10. Claims: *In the event of any occurrence which may give rise to a CLAIM UNDER THIS POLICY:*
(a) The Insured shall forthwith notify the Company in writing with full particulars.
(b) Every letter, claim, legal proceedings including writ, civil bill, civil summons or other notice and every correspondence, communication or notice from the Personal Injuries Assessment Board (PIAB) shall be notified and forwarded unanswered to the Company immediately on receipt".

"Features & Benefits" document

"Important Notes on our Business ..Policy

Policy Conditions
A number of conditions apply to your policy These are detailed in full in the Policy' Document and include the requirement to take all reasonable steps to safeguard your property and all other people from loss or damage; the condition to notify us promptly of any claims or incident that may give rise
to claims and the condition of average"

The Complaint for Adjudication

The Complaint is that the Provider has (i) not been *"prejudiced"* by the Complainant's late notification of a potential claim, arising from an incident at the business premises in mid-2**015**, and (ii) incorrectly declined to indemnify under the Complainant's Business Insurance claim.

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

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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 **12 August 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, my final determination is set out below.

Analysis

Most insurance contracts have a term which obliges the Policyholder to promptly notify the Insurance Company once there is the possibility of a claim arising.

The case law concerning such clauses recognise that the purpose of early notification is twofold. First, it is intended to enable Insurer to investigate potential claims at the earliest possible opportunity, before the trail of evidence goes cold, and to take, or require the person insured to take, such steps as Insurer thinks appropriate to minimise liability under the policy.

Therefore, the early notification of an occurrence is vital in respect of the operation of the terms and conditions of the insurance policy. Here the policy states at section 10 that:-

> *"In the event of any occurrence which may give rise to a CLAIM UNDER THIS POLICY:*
> *(a) The Insured shall forthwith notify the Company in writing with full particulars.*
> *(b) Every letter, claim, legal proceedings including writ, civil bill, civil summons or other notice and every correspondence, communication or notice from the Personal Injuries Assessment Board (PIAB) shall be notified and forwarded unanswered to the Company immediately on receipt".*

This condition is with a view to enabling the Provider to move quickly in order to assess whether the incident is going to progress to a claim, and to establish the cause through site inspection and enquiry. In this instance the Provider was not informed "forthwith" or indeed within any reasonable timeframe of the incident having occurred and it was unable therefore to make a timely and full determination in relation to the cause, as a result of the elapse of time.

While I accept that the Complainant had other concerns to prioritise at the time, I note that there was a delay from **February 2017** to **May 2017** before the notice, in relation to the actual claim, that the Complainant received was passed to her broker and ultimately to the Provider.

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From a review of the evidence and submissions, it is clear that the Complainant was aware of the incident very shortly after it occurred, had accompanied the employee to the hospital, had received sick certificates from the employee for a number of weeks after the incident, and had discussed reduced hours of a lighter nature with the employee as a result of the incident. However, despite all this the Complainant took no action to notify the Provider until some 20 months after the incident, by which time the employee's claim had proceeded, for some considerable length of time, to the Personal Injuries Assessment Board.

The Complainant was engaged in the running of a business and ought reasonably have been aware of the *potential* for a claim to be initiated arising out of this incident, requiring a timely notification of the incident to the Provider. This would be so, even if it was felt that the business was not in any way responsible for the incident, or if it did not consider the employee would be likely to make a claim. In the circumstances, I accept that the Complainant should have notified the Provider of the incident in question in a reasonable time period after the incident occurred.

I accept, the Complainant's failure to notify the Provider of the incident in question within a reasonable period after the incident had occurred amounted to a breach of General Condition 10, of the policy, quoted above.

I accept that the Provider was entitled to act in accordance with the terms and conditions of the policy in question by refusing to provide an indemnity to the Complainant arising out of the claim in question. Therefore, I do not uphold the complaint.

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.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

03 September 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,

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(ii) a provider shall not be identified by name or address, and

ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.