An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0326
Sector:	Insurance
Product / Service:	Other
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, trading as a dental surgery, held a **Business Insurance Policy** with the Provider. The policy term in which this complaint falls, is from **14 February 2020** to **13 February 2021**. This complaint concerns the Provider's decision to decline the Complainant's business interruption claim.

The Complainant's Case

The Complainant notified the Provider on **10 April 2020** of a claim for business interruption losses as a result of the temporary closure of his dental surgery for three weeks, due to one of his staff testing positive for COVID-19 and the rest of the staff self-isolating as close contacts, in accordance with health measures announced by the Government at the time to help curb the spread of the coronavirus.

In making such a claim, the Complainant relied upon the following 'Business Interruption Section Extensions' wording at pg. 52 of the **Business Insurance Policy Document**:

> ***6. Notifiable Disease***
>
> *The insurance by this Policy will extend to include loss resulting from interruption or interference with the Business carried on by the Insured at the Premises in consequence of:*
>
> 1. *(i) any occurrence of a Notifiable Disease at the Premises …*

> *(ii) any discovery of an organism at the Premises likely to result in the occurrence of a Notifiable Disease …*
>
> *which causes restrictions on the use of the Premises on the order or advice of the competent authority.*

Following its claim assessment, the Provider's Loss Adjuster wrote to the Complainant's Representative on **24 June 2020** to advise that it was declining the claim because the restrictions on the use of his Premises were not brought about as a direct result of an outbreak of the Notifiable Disease at the Premises but was instead brought about by national considerations resulting from the COVID-19 global pandemic including in particular, the requirements of social distancing and public concerns.

The Complainant's Representative emailed the Provider's Loss Adjuster on **6 July 2020** to complain about this declinature, as follows:

> *"The* [Provider] *policy clearly covers Loss from interruption to the business resulting from a* [sic] *occurrence of a notifiable disease.*
>
> *The policy is clearly triggered considering the fact that an employee tested positive as per HSE test results sheet provided. This is not just an employee displaying symptoms but an actual occurrence as required under the policy.*
>
> *Your principles* [sic] *decision to refuse indemnity relies upon*
>
> > *"restrictions on the use of the Premises by the competent authority was not brought about as a direct result of an outbreak of the Notifiable Disease at the Premises. The closure on any view was not caused by an outbreak of a Notifiable Disease at the risk premises…rather it was brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns".*
>
> *This is wholly inaccurate. If your principles* [sic] *statement above were correct, the figures enclosed showing management accounts from Jan 2020 to May 2020 would reflect no distinction between March April or May as your principles* [sic] *assertions maintain that the national considerations were the cause of the loss and these considerations were in play before and after the occurrence. It is abundantly clear that the occurrence coincides with a vast drop in turnover thus proving that the loss is derived from the occurrence as is insured".*

Following its review, the Provider advised the Complainant in writing on **13 July 2020** that it was standing over its position to decline indemnity in this matter.

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The Complainant later emailed the Provider on **7 January 2021**, as follows:

> *"My practice remained open during the lockdown announced in mid March 2020. I continued to see urgent and emergency cases throughout the lockdown. Therefore, the suggestion in your letter of 13th July 2020 that the closure of my practice was "brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns" is factually incorrect. My practice was opened until my nurse tested positive for Covid-19. The practice was closed for 3 weeks as a result of the outbreak and reopened in late April 2020. The closure was directly linked to the outbreak of Covid-19 at my premises.*
>
> *I am aware of the policy wording which states that the closure must be on the order or advice of the competent authority. Again, the closure was based on the advice of the HSE and the Dental Association. The advice of the HSE was for all close contacts with Covid-19 suspected / confirmed cases to self isolate for a period of 2 weeks. After the 2 week period the nurse who tested positive was still displaying symptoms so the advice from the GP was to continue isolation for a further week. I contacted the Dental Association and they offered the same advice.*
>
> [The Provider's] *refusal to accept liability for this loss has caused significant stress over the last 8 months. Your refusal to deal with the facts of my case are concerning as dental practices were permitted to remain open during the initial lockdown for emergency cases. As detailed above the closure was directly linked to the positive case of Covid-19 and was based on the advice of the HSE".*

Following its review, the Provider issued the Complainant with its **Final Response** dated **2 February 2021** wherein it advised that it was standing over its position to decline indemnity in this matter.

The Complainant sets out his complaint in the **Complaint Form** he completed, as follows:

> *"I operate a dental practice…The practice remained open during the initial Covid-19 lockdown announced in March 2020. During this lockdown I continued treating emergency / urgent cases.*
>
> *On the 1st of April 2020 one of my key dental nurses displayed symptoms of Covid-19 and she contacted her local GP who arranged for a Covid-19 test. Unfortunately the test result was positive and I obtained a copy of the test result dated the 6th April 2020. As I, along with all the other staff, were close contacts of the positive case, I had no option but to close the practice for at least 14 days to allow us all self-isolate.*
>
> *The staff member who was Covid positive contacted me at the end of the 2 week period to advise she was still displaying symptoms. At this stage the decision was taken to close the practice for a further week to reduce the risk to my other staff and patients.*

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The decision to close the practice was based on the advice of the HSE and NPHET for all close contacts to self-isolate for a period of at least 14 days.

At the end of the 3 week isolation period the practice reopened. Thankfully the practice remained open throughout the remainder of the pandemic in 2020. However, the practice closed again in January 2021 after another staff member tested positive for Covid-19.

After the initial outbreak in April 2020, I notified my Broker who in turn notified my Insurers [the Provider]*. There was no immediate engagement by* [the Provider] *so I made the decision to appoint a Public Loss Assessor…*[The Provider] *were provided with details of my claim including the positive test result, copy of management accounts, and a claim for loss of gross profit due to the 3 week closure …*

I was confident the claim would be honoured based on the wording of my policy as I closed the practice following a confirmed case of Covid-19 at the premises and based on advice from the HSE and NPHET.

The loss adjusters appointed by [the Provider] *issued a letter declining the claim ... The basis for the declinature was that the closure was related to the national considerations rather than an outbreak of Covid-19 …*

My Public Loss Assessor issued a complaint to [the Provider] *contesting their findings on the 6th July 2020 … in summary* [my Loss Assessor] *states that the basis of the declinature is incorrect as the closure was directly linked to the confirmed case. The complaint response from* [the Provider] *was issued on the 13th July 2020 maintaining their initial position.*

The Public Loss Assessor recommended at this point that I engage a Solicitor to deal with my claim considering [the Provider's] *position which he did not agree with. I was not in a position to engage a Solicitor due to the financial strain on the business caused by the closure in April* [2020]*.*

Over the coming months I considered my position in relation to the claim and I decided to issue a further complaint to [the Provider]*. The reason for this complaint was to highlight that they were not considering the details of my claim. The initial declinature letter and subsequent complaint response stated:*

> *"The closure on any view was not caused by an outbreak of a Notifiable Disease at the risk premises…rather it was brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns".*

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The above position taken by [the Provider] *was factually incorrect as dental practices were permitted to remain open for the treatment of urgent / emergency cases during the lockdown. All correspondence received from* [the Provider] *and* [its Loss Adjusters] *made reference to a staff member displaying symptoms of Covid-19. There seemed to be a reluctance from them to acknowledge the confirmed case despite them receiving the positive test result in April* [2020]*. My complaint was issued to* [the Provider] *on the 7th January 2021 (exact date to be confirmed) and I received a detailed response on the 2nd February 2021.*

The response from [the Provider] *did acknowledge that a staff member tested positive and that the advice was for all close contacts to isolate as a result. However they maintained their position that the policy would not cover my loss as I have not provided any information that confirms the competent authority placed restrictions on the use of your* (sic) *premises as a result of this occurrence.*

I maintain the position that the practice could not open during the self-isolation period as all staff, including myself, were close contacts.

… another staff member tested positive for Covid-19 on the 7th January 2021. Considering the position taken by [the Provider] *on this claim I contacted the HSE after the second confirmed case. I spoke to* [named redacted] *who is a Public Health Doctor with the HSE. When I provided the information of the confirmed case (confirmed case on 7th January 2021) she acknowledged that the practice should be closed as per the extract from her email below:*

> *"*[The Complainant] *contacted me this morning outlining the situation in his practice regarding COVID 19. One staff member has been diagnosed with COVID 19. Two further employees have reported symptoms consistent with COVID 19 and have been sent for COVID testing. A risk assessment was carried out and as a result it is not possible for the practice to be staffed and will need to remain closed while all necessary COVID protocols are followed to ensure a safe working environment for staff and patients".*

A second claim was reported to [the Provider] *following the confirmed case in January 2021. Insurers reverted with several other queries in relation to this claim but they did offer settlement and that claim has been concluded.*

I emailed [the Provider] *again after the second claim was paid to check if their position on the initial claim had changed. The circumstances of both positive Covid-19 cases at the practice are identical. The only difference on the second claim was that I contacted the HSE to confirm their advice was indeed to close to reduce the risk to any further outbreaks at the practice. On the initial claim I did not obtain this advice in writing but I was satisfied that my actions were in line with the advice from the HSE and NPHET. I would highlight that it is not a condition of the policy that the advice needs to be in writing …*

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In summary, I am submitting this complaint to your office on the following grounds:

1. The initial repudiation of the claim by [the Provider's Loss Adjusters] *did not deal with the circumstances of my claim. Following the complaint by* [my] *Loss Assessor on the 6th July 2020* [the Provider's] *response again failed to acknowledge the circumnutates of my case and the reason for the repudiation was factually incorrect. The closure was not brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns.*

2. After I reiterated that the basis of the declinature was incorrect they are now denying liability on the basis that I have not provided evidence that a competent authority placed restrictions on the use of the premises. I believe that I acted in accordance with the advice of the HSE and NPHET by closing the practice while all staff self-isolated following the confirmed case of Covid-19 at my premises".

The Complainant seeks for the Provider to admit his claim for business interruption losses and in this regard, when he submitted his **Complaint Form** to this Office, the Complainant calculated his **April 2020** loss as **€26,239.10 (twenty six thousand two hundred and thirty-nine Euro and ten Cent)**

The Provider's Case

The Provider says that the Complainant's Representative emailed it on **10 April 2020** to advise that the Complainant had closed his dental surgery for three weeks due to an occurrence of COVID-19 at his surgery.

The Provider says that the Business Interruption Notifiable Disease Extension provides cover where there is an outbreak of a disease at the Premises causing an interruption or interference with the Business carried out at the Premises. The Provider says that in order for this Extension to apply, there must be an outbreak of the Notifiable Disease at the Premises and that the closure of the Premises is brought about on the advices of the component authority as a result of the outbreak at the Premises and that this directly results in a verified financial loss.

The Provider says that upon receipt of the business interruption claim from the Complainant's Representative in **April 2020**, it wrote to the Complainant on **28 April 2020** requesting the date of the occurrence of the Notifiable Disease at the Premises or when it was first brought to his attention; the date on which the restrictions by the competent authority were put in place; the period of the restrictions and copies of any notices or relevant documents in support of the claim.

The Provider says that it received no evidence from the Complainant as part of his claims documentation that the premises was closed on the orders or advices of the component authority as a result of an outbreak of COVID-19 at the Premises.

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The Provider says that the closure was instead brought about by the national considerations resulting from the COVVID-19 global pandemic including in particular, the requirements of social distancing.

The Provider says that following its claim assessment, its Loss Adjuster wrote to the Complainant's Representative on **24 June 2020** to advise that it was declining the claim, as follows:

> *"After conducting a careful review of* [the Complainant's] *claim and considering all the information they have provided, our Principals have concluded that this claim is not covered under the policy. The cover, provided under the Notifiable Disease Extension of your Policy, operates only where there is loss resulting from interruption or interference with the business as a result of any occurrence of a Notifiable Disease at the Premises, which causes restrictions on the use of the Premises on the order or advice of the competent authority.*
>
> *In this case, a staff member at the Premises may have displayed symptoms of Covid-19 but the restrictions on the use of the Premises by the competent authority was not brought about as a direct result of an outbreak of the Notifiable Disease at the Premises. The closure on any view was not caused by an outbreak of a Notifiable Disease at the risk premises…rather it was brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns".*

The Provider notes that the Complainant's Representative emailed the Provider's Loss Adjuster on **6 July 2020** to complain about the claim declinature.

Following its review, the Provider wrote to the Complainant's Representative on **13 July 2020** to advise that it was standing over its decision to decline the claim, as follows:

> *"I understand your complaint surrounds our decision to decline your claim for business interruption due to Covid-19 restrictions.*
>
> *We received notification of your claim on the 10th of April, 2020. On the 28th of April, we wrote to you requesting information to support your claim.*
>
> *The cover, provided under the Notifiable Disease Extension of your Policy, operates only where there is loss resulting from interruption or interference with the business as a result of any occurrence of a Notifiable Disease at the Premises, which causes restrictions on the use of the Premises on the order or advice of the competent authority. The Indemnity Period is from the date on which the restrictions on the Premises are applied for a maximum period up to three months, and is subject to a limit as noted in your Policy.*

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In reviewing your claim I note that a staff member at the Premises may have displayed symptoms of Covid-19 but the restrictions on the use of the Premises by the competent authority was not brought about as a direct result of an outbreak of the Notifiable Disease at the Premises. The closure on any view was not caused by an outbreak of a Notifiable Disease at the risk premises…rather it was brought about by national considerations resulting from the global pandemic including in particular, the requirements of social distancing and public concerns …

Our position is that as with all claims we must be bound by the terms and conditions of your insurance policy. Having completed my review, our decision to decline your claim is correct and no cover can be provided".

Following receipt of a further complaint from the Complainant and its subsequent review of the matter, the Provider wrote to the Complainant on **2 February 2021** to advise, among other things, that:

"In reviewing your claim, I understand that your practice was closed for a period of 3 weeks due to an employee testing positive for Covid-19 and the advice from the HSE was that all close contacts was to isolate. I note that you have not provided any information that confirms the competent authority placed restrictions on the use of your premises as a result of this occurrence.

The cover, provided under the Notifiable Disease Extension of your Policy, operates only where there is loss resulting from interruption or interference with the business as a result of any occurrence of a Notifiable Disease at the Premises, which causes restrictions on the use of the Premises on the order or advice of the competent authority. The Indemnity Period is from the date on which the restrictions on the Premises are applied for a maximum period up to three months, and is subject to a limit as noted in your policy.

Our position is that as with all claims we must be bound by the terms and conditions of your insurance policy. Having completed my review, our decision to decline your claim is correct and no cover can be provided".

The Provider notes that the HSE and NPHET issued self-isolation guidelines for national consideration and says that while the Complainant was following these guidelines, there was no direct advice from the HSE or any other competent authority to the Complainant that the business should be closed as a result of an outbreak of COVID-19 at his Premises.

The Provider notes that the Complainant made a second business interruption claim in **January 2021** due to the closure of his dental surgery from **8 January** to **16 January 2021**. The Provider notes that the claim documents submitted included written confirmation from the HSE advising the Complainant to close the business as a result of a COVID-19 outbreak at the premises. The Provider says that as there was also a verified financial loss, all three aspects of the criteria for the Business Interruption Notifiable Disease Extension were satisfied and the Complainant's **January 2021** claim was therefore admitted by the Provider and paid in the amount of **€14,159.29**.

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In relation to the **April 2020** claim, the Provider says that if the Complainant had provided evidence that his business was closed as a result of HSE advices following an outbreak of a Notifiable Disease at the Premises and that this resulted in a verified financial loss, then the Provider confirms that it would have accepted liability and admitted the claim.

In that regard, the Provider says it declined the Complainant's **April 2020** business interruption claim because the circumstances of the closure of his premises did not satisfy the criteria set out in the Business Interruption Notifiable Disease Extension, and therefore the relevant policy cover was not triggered.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant's claim for business interruption losses as a result of the temporary closure of his dental surgery for three weeks in **April 2020,** due to one of staff testing positive for COVID-19 and the rest of the staff self-isolating as close contacts, in accordance with health measures announced by the Government at the time, to help curb the spread of the coronavirus.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

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

A Preliminary Decision was issued to the parties on **30 August 2022**, 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 Complainant notified the Provider on **10 April 2020** of a claim for business interruption losses as a result of the temporary closure of his dental surgery for three weeks, due to one of his staff testing positive for COVID-19 and the rest of the staff self-isolating as close contacts, in accordance with health measures announced by the Government at the time to help curb the spread of the coronavirus.

It is important to note that the Complainant's **Business Insurance Policy**, like all insurance policies, does not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that the relevant policy wording in this case can be found in the 'Business Interruption Section Extensions' at pg. 52 of the applicable **Business Insurance Policy Document**, which states:

> ***6. Notifiable Disease***
>
> *The insurance by this Policy will extend to include loss resulting from interruption or interference with the Business carried on by the Insured at the Premises in consequence of:*
>
> 2. *(i) any occurrence of a Notifiable Disease at the Premises …*
>
> *(ii) any discovery of an organism at the Premises likely to result in the occurrence of a Notifiable Disease …*
>
> *which causes restrictions on the use of the Premises on the order or advice of the competent authority.*
>
> [My underlining for emphasis]

"Notifiable Disease" is defined in the **Policy Document**, as follows:

> *Notifiable Disease means illness sustained by any person resulting from:*
>
> *(i) food or drink poisoning or*
>
> *(ii) any human infectious or human contagious disease (excluding Acquired Immune Deficiency Syndrome (AIDS)) an outbreak of which the competent authority has stipulated will be notified to them.*

On **20 February 2020**, the Minister for Health signed ***Statutory Instrument No. 53/2020 - Infection Diseases (Amendment) Regulations 2020*** to include the coronavirus (COVID-19) (SARS-Cov-2) on the list of notifiable diseases.

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The Complainant's dental surgery was one of those essential services that were permitted to remain open during the first COVID-19 'lockdown' period, to provide essential and emergency dental treatment, as was legislated for in ***S.I. No 121/2020 – Health Act 1947 (Section 31A – Temporary Restrictions) (Covid-19) Regulations 2020***.

The Complainant, in support of his April 2020 business interruption claim, furnished the Provider with a **HSE Swabs Report** dated **6 April 2020** and said that this indicates that a dental nurse at his surgery had tested positive for COVID-19. The Complainant said that the dental nurse had begun displaying COVID-19 symptoms on **1 April 2020** and that his decision to close his dental surgery was based on the advice of the HSE and NPHET for all close contacts to self-isolate for a period of at least 14 days.

The onus is on the Complainant, as the insured, to furnish evidence to the Provider when making a claim, of the operation of an insured peril. The insured peril in this case is an *"occurrence of a Notifiable Disease at the Premises…which causes restrictions on the use of the Premises on the order or advice of the competent authority"*.

In order for this insuring clause to have responded to the Complainant's April 2020 claim, I take the view that the Complainant would have had to have furnished the Provider with evidence that there was both an occurrence of COVID-19 at his dental surgery and that as a result of that occurrence of COVID-19 at his dental surgery, the competent authority had placed restrictions on his premises interrupting the carrying out of his business.

In that regard, I accept the Provider's position that if the Complainant had provided evidence as part of his April 2020 claim that his business premises was closed, as a result of HSE advices following an outbreak of a notifiable disease at the premises and that this had resulted in a verified financial loss, as he had done in relation to his January 2021 claim, then it would have accepted liability and admitted the April 2020 claim.

I take the view that, having regard to all of the above, in the absence of such supporting information, the evidence does not support the complaint that the Provider wrongly or unfairly declined the Complainant's April 2020 claim for business interruption losses.

I accept that the Provider was entitled to seek appropriate supporting evidence, which the Complainant did not make available to it. Accordingly, I do not accept that the Provider has been guilty of any wrongdoing and, it is my Decision therefore, on the evidence before me that this complaint cannot reasonably be upheld.

Conclusion

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

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

MARYROSE MCGOVERN
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

26 September 2022

PUBLICATION

Complaints about the conduct of financial service providers

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.

Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.