An tOmbudsman Seirbhísí Airgeadais agus Pinsean

Financial Services and Pensions Ombudsman

Ombudsman's Digest of Legally Binding Decisions

Volume 1 - Published January 2019

Contains summaries and case studies based on decisions issued between 1 January and 31 December 2018

Contents

The Financial Services and Pensions Ombudsman (FSPO)

The FSPO was established in January 2018 by the ***Financial Services and Pensions Ombudsman Act 2017.*** The role of the FSPO is to resolve complaints from consumers, including small businesses and other organisations, against financial service or pension providers.

We provide an independent, fair, impartial, confidential and free service to resolve complaints through either informal mediation or formal investigation and adjudication.

When a consumer is unable to resolve a complaint or dispute with a financial service or pension provider they can refer their complaint to the FSPO.

We deal with complaints informally at first, by listening to both parties and engaging with them to facilitate a resolution that is acceptable to both parties. Much of this informal engagement takes place by phone. In 2018, we resolved approximately 2,300 complaints through this informal mediation process.

Where these early interventions do not resolve the dispute, the FSPO formally investigates the complaint and issues a decision that is legally binding on both parties, subject only to an appeal to the High Court. The Ombudsman has the power to direct a provider to pay compensation of up to €500,000 to a complainant. He can also direct that a provider rectify the conduct that is the subject of the complaint. There is no limit to the value of rectification he can direct.

During the formal investigation of complaints, documentary and audio evidence, and other material, together with submissions from the parties, are gathered by this office and exchanged between the parties. Following detailed consideration of all of the evidence and submissions made, a preliminary decision is issued to the parties and they are advised that certain limited further submissions can be made prior to the issuing of a legally binding decision.

The financial service or pension provider must implement any direction given by the Ombudsman in his legally binding decision. The FSPO issued 234 legally binding decisions in 2018.

At the date of publication, one financial service provider had not carried out the direction of the FSPO, given in a 2018 decision, to pay €1,450 in compensation to a complainant. It is very rare that a provider fails or refuses to implement a legally binding direction of the FSPO, and the Ombudsman finds such actions completely unacceptable. Accordingly, he has commenced enforcement proceedings in the courts to ensure that the direction is implemented and that the complainant receives their compensation.

Publication of FSPO Decisions

Section 62 of the ***Financial Services and Pensions Ombudsman Act 2017,*** provides the FSPO with the power to publish legally binding decisions in relation to complaints concerning financial service providers. The legislation provides that decisions should be published in a manner that ensures that a complainant is not identified by name, address or otherwise and a provider is not identified by name or address. Publication must also comply with Data Protection legislation and regulations.

The legislation also provides the FSPO with the power to publish case studies of decisions relating to pension providers, but not the full decision.

The purpose of this document is to provide a summary of some of the 2018 decisions and to provide guidance on how to access the full text of all published decisions. Decisions relating to financial service providers are published in full but anonymised to protect identities. Case studies are provided for decisions relating to pension providers.

To provide the maximum possible access to the Ombudsman's decisions we have created an online database of Legally Binding Decisions. This can be accessed at www.fspo.ie/decisions. This database holds the full text of all of the Ombudsman's decisions in relation to financial service complaints published since January 2018. Information on how to access decisions and search for areas or decisions of specific interest is included on Page 7 of this Digest.

In 2018, we resolved the majority of complaints, approximately 2,300, through mediation. However, a substantial number of complaints also required formal investigation and adjudication.

234 legally binding decisions issued in 2018

We issued 234 legally binding decisions. In the case of 127 decisions, the complaint was upheld to some extent, while 107 were not upheld. A detailed analysis of all complaints dealt with by this Office will be provided by the Ombudsman in his Annual Review of 2018, which he will publish in March 2019.

The FSPO published 228 decisions in January 2019. As the legislation does not provide the power to publish decisions relating to pension providers, three decisions relating to pension providers that were issued in 2018 are not published. Case studies of these three decisions are included in this Digest. A further two of the 2018 decisions were under appeal to the High Court at the time of publication in January 2019. These two decisions will be not be published pending the outcome of those appeal processes. In addition, one decision where the content of the decision is so distinctive that, even when anonymised, it would risk identifying the parties has not been published.

In addition to publishing the full decision, this Digest includes a short summary of a selection of 27 of the 2018 decisions. Some details within the case studies referenced in this Digest, such as names and locations, have been altered in order to protect the identity of the complainants. It is important to keep in mind that these are only short summaries. Interested parties are encouraged to read the full text of the decisions. Each case study relating to a complaint against a financial service provider includes a link to the full text of the decision.

Message from the Ombudsman

I am very pleased to publish the legally binding decisions made by the Office of the Financial Services and Pensions Ombudsman, during 2018, in respect of complaints against financial service providers.

The powers available to me are extensive and my decisions are legally binding on both parties, subject only to an appeal to the High Court. This means that a provider must implement any direction made in my decisions.

This is the first time that such decisions have been published. I very much welcome the initiative taken by the Minister for Finance and the Oireachtas to provide me with the power to publish decisions. I believe that publishing these decisions enhances the transparency and understanding of the powers of the office and of the service we provide. This is something we are very committed to constantly improving.

I also believe that the publication of these decisions will play an important role in providing enhanced protection for consumers, as these decisions should be of assistance to consumers and their advocates and also to financial service providers, in both avoiding and resolving disputes.

As can be seen from the decisions published, our adjudications dealt with a very broad range of complaints relating to insurance, banking, credit facilities, investments and pensions. In the 127 decisions where the complaint was upheld, substantially upheld, or partially upheld, the remedies directed were wide-ranging. These included directing providers to rectify the conduct complained of, by reinstating insurance policies, admitting insurance claims for payment, correcting credit ratings and/or paying compensation.

One of the key objectives of our Strategic Plan 2018 – 2021, *Enhancing the Customer Experience*, is to improve communication and engagement with the public. Publication of these decisions is an important step in achieving this and will, I believe, contribute to an enhanced consumer protection framework.

I am very conscious of the impact of the work of this office on the daily lives of consumers. The importance of resolving a contentious dispute, that is negatively affecting a person's life, cannot be overestimated. I am so grateful to all my colleagues for their hard work and commitment in providing a fair, impartial, independent and transparent service.

I feel the importance of our work was very well captured by a letter we received from a complainant in December 2018, which is reproduced anonymously on Page 36 with the complainant's permission.

I am confident the publication of these decisions will help to improve the quality of services and protections available to consumers of financial services and pension products.

Ger Deering

Financial Services and Pensions Ombudsman

January 2019

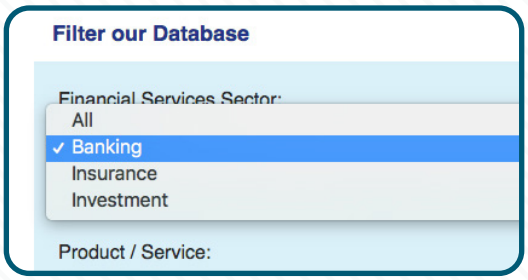
How to search our decisions on **www.fspo.ie**

Accessing our database of decisions

Our database of legally binding decisions is available online at www.fspo.ie/decisions.
To refine your search, you can apply one or a number of filters.

1 Applying **filters** to narrow your search

To filter our database of decisions, you can firstly select the relevant sector:



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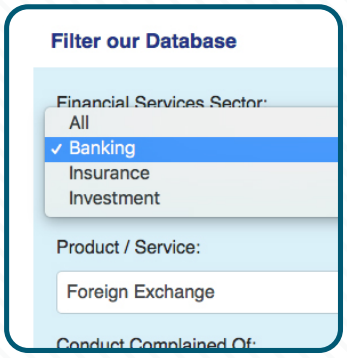
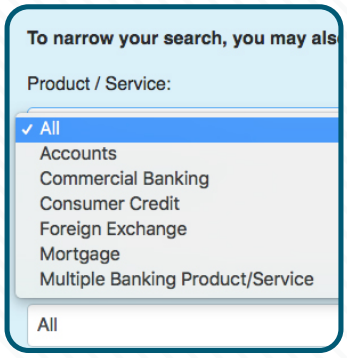
Having filtered by sector, the search tool will then help you to filter our **decisions** further by categories relevant to that sector such as:

- product / service
- conduct complained of

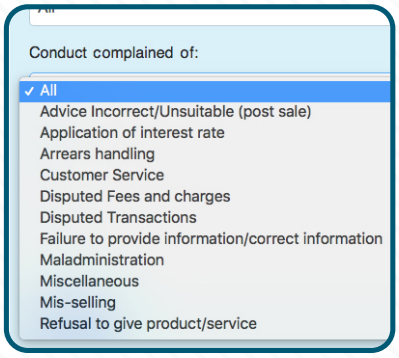
✓ **Sector**



✓ **Product / Service**



✓ **Conduct complained of**



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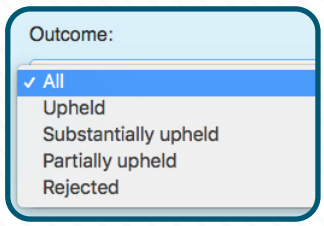
You can also filter our database of decisions by year, and by the outcome of the complaint, i.e. whether the Ombudsman Upheld, Substantially Upheld, Partially Upheld or Rejected the complaint.



Once you have found the decision you are looking for, click **View Document** to download the full text in PDF.

Summaries and **case studies** based on decisions issued between 1 January and 31 December 2018

- Banking
- Insurance
- Investment
- Pensions

Sector:
Banking

READ THE FULL DECISION HERE

Decision Reference: 2018-0223

Engagement with customers who were in arrears on a mortgage loan

In 2006, Susan and Fergus took out a variable rate 25-year mortgage to purchase a buy-to-let property, which was not their family home. Until about 2011, the couple met their mortgage repayments but when their financial circumstances changed, they began to experience difficulties in servicing this mortgage as well as that of their family home. They re-structured the mortgage on their family home.

Following a series of misunderstandings and miscommunications between the couple and the lenders, in January 2014, Fergus was informed that the mortgage account had been moved to the legal department of the Arrears Support Unit and that the couple had been classified as 'non-co-operating'. The Ombudsman later found this decision was unreasonable and it likely had a significant, unfavourable impact on the manner in which the lender subsequently dealt with the borrowers.

A third party acted on behalf of the couple in negotiating an action plan and, in June 2014, informed the lender that the couple intended to sell the property to clear outstanding arrears. In November 2015, Susan and Fergus reached 'sale agreed' on the property. After much difficulty getting the redemption figures from the lender, their solicitor contacted the lender in January 2016, to inform it that the sale was complete and to outline that a small shortfall would remain after the sale proceeds were applied to the loan.

In late January, Fergus contacted the lender looking to get a response to the solicitor's letter. He explained how the buyers were getting anxious and wanted to move in. The customer service agent then informed Fergus that the lender intended to appoint a receiver to the property. Fergus was understandably shocked at this news and expressed his concern to the agent, highlighting how the lender had provided no support during what was a difficult situation.

The agent also stated that the receiver would have to sell the property and that the lender would then engage with the couple regarding the residual balance.

Half an hour later, Fergus called the Arrears Support Unit again, this time speaking to a different agent. This agent informed him that it had 'been in the receivership process for 12 months' and dealt with Fergus in a highly dismissive manner. Fergus questioned why the lender had released the redemption figures and allowed the sale to proceed if a receiver was going to be appointed.

The Ombudsman noted that it was most unreasonable that having engaged in the challenging process of selling a property, Fergus was then informed that a receiver had been appointed 12 months before that. However, in reality, this process had only been considered, not actioned and it appears the lender later tried to misrepresent what the agent had said on the matter during the call. The Ombudsman found that it was unacceptable that the lender did not admit this mistake.

The Ombudsman also found that the Arrears Support Unit legal department adopted an obstructive approach and treated the couple in an unreasonable and unjust manner.

The Ombudsman concluded that Susan and Fergus were caught in an impossible situation where the lender was slow to engage its legal remedies, such as the appointment of a receiver, but was dealing with the couple's attempts to reach an agreement as though they were non-co-operating borrowers against whom legal remedies had commenced.

The Ombudsman upheld the complaint and directed the lender to pay a sum of €90,000 in compensation to the couple.

Decision Reference: 2018-0130

READ THE FULL DECISION HERE

Communication of the impact of interest rate increases on a term-loan

In July 2007, Ronan took out a loan of €40,000 to be repaid over ten years. Approximately 17 months before the expiry of the loan, the bank sent Ronan a letter stating that the remaining repayments would not be sufficient to clear it by the expiry date due to increases in interest rates over the term of the loan. In order to clear the loan, he would be required to pay a further €11,088.12.

When signing for the loan, Ronan believed it was a fixed term loan at a rate of 8.1%. It was actually a variable rate loan on which the interest rate increased to 11.4%. Ronan also believed that if any sums were due, they should have been added to his repayment as they arose, rather than being demanded at the end of the loan.

With 17 months remaining on the loan, Ronan was given three options by the lender: continue monthly repayments until the loan was repaid in full; increase repayments so the loan would be repaid by the date of expiry or repay all outstanding amounts on the date of expiry.

Ronan made a number of calls to the lender and his branch between February and March 2016 but technical issues meant the complaint was not dealt with substantively until more than three months after it was made. Various failures in customer service also arose in the wake of the complaint.

The bank eventually provided further detail in May 2016 outlining reasons for the shortfall. The reasons given were an increase to interest rates, variances in payment scheduling and late or missed payments. Ronan had never been late with or missed any payments. Later that month a further letter gave details of the interest rate changes and referred to advertisements in the national press highlighting them.

The lender argued that the terms of the loan stated that the interest rate may vary and that notice was provided in national newspapers and in annual statements that the interest rate had increased.

While the Ombudsman accepted that the terms and conditions made it clear that the interest rate was variable, he was not satisfied that the increases in interest rates were adequately communicated, particularly given that an increase in the interest rate of a variable loan is arguably the most significant event concerning the loan.

The Ombudsman was unconvinced that a newspaper advert is still an appropriate method of communicating and pointed out the difficulty of a customer inspecting newspapers daily for ten years to establish the interest rate applying to their loan. He also found that these advertisments were small and unclear on details. The references to the increases in the annual statements amounted more to confirmation of a rate increase which had been in effect for several months and did not comprise sufficient notification of a change in the interest rate.

The Ombudsman found it was unreasonable to demand the additional payment so late in the life of the loan, given these failures to notify the interest rate increases. He suggested that repayments could have been increased by the lender, or Ronan could have been given this option, around the time that interest rates initially rose, within the first year.

In any of these circumstances, Ronan would have come to understand at an early stage that he had signed up to a variable rate loan and he may well have taken steps to address the matter.

The Ombudsman substantially upheld the complaint as he found the conduct of the lender to be unreasonable. Accepting that Ronan was on notice of the increase for the last 17 months of the loan, and therefore should make some contribution to the shortfall, he directed the lender to significantly reduce its demand from €11,088 to €2,000. In addition, he directed that no further interest was to apply to any amount above the original loan sum. The lender was also directed to ensure that the arrangement would not adversely affect Ronan's credit rating.

Decision Reference: 2018-0115

READ THE FULL DECISION HERE

Service provided by a debt management agency

In order to manage her mortgage debt, Olivia, who was having difficulty paying her mortgage, engaged a debt management agency. After eleven months, she cancelled this contract as she was dissatisfied with the service. In bringing her complaint to the Financial Services and Pensions Ombudsman, she sought a refund of the €1,450 she had paid for the service.

Her central complaint was that apart from the initial proposal letter, the agency failed to negotiate with the bank to seek better repayment terms on her behalf. In response, the agency claimed that it had completed the standard financial statement with the bank, followed it up and undertaken numerous phone calls and discussions with the bank. The agency concluded that Olivia's bank would not agree to restructure or write down her mortgage and that, for that reason, the agency advised her of alternative options, including personal insolvency or bankruptcy.

However, of all the communication the agency claimed to have undertaken, it only supplied proof of two identical letters sent to Olivia's bank with 'a proposed new monthly payment' of €425 and the 'proposed re-structure options' as well as follow-up letters. Considering the evidence before him, the Ombudsman found that the agency had breached its own terms of business by failing to negotiate with its client's bank to attempt to agree repayment terms. Furthermore, the Ombudsman deemed that he had not seen any evidence to illustrate that the bank had said that it would not agree to a long-term restructuring.

Indeed, evidence submitted by Olivia showed repeated calls from the bank to the agency requesting a completed standard financial statement and supporting documentation. Furthermore, the call log did not state that the bank would not agree to a restructuring agreement but rather that it was awaiting documentation. The Ombudsman therefore considered that the agency incorrectly informed Olivia that restructuring was denied.

The second dimension of Olivia's complaint was that the agency had submitted incorrect repayment figures to her bank. She stated that the agency had informed the bank that her proposed monthly repayments were €425 rather than the €450 she was in fact paying. She further submitted that the agency failed to communicate to the bank that her ex-husband was now paying €140 per month towards the mortgage repayments.

The agency defended this by stating that it had assisted Olivia by ensuring that her ex-husband started paying €140 monthly towards the mortgage (under a separate arrangement with him). On Olivia's monthly payments, the agency stated that €425 represented the amount available after deducting their fee and that after this was reduced by €25, Olivia was then able to pay €450.

The Ombudsman noted that the agency had underestimated the amount the bank was receiving per month by €165 and that this figure was of utmost importance in terms of shaping the bank's view of whether the mortgage was sustainable. He concluded that the agency breached its duty of care to Olivia by submitting incorrect figures to the bank or not updating them when it became clear the repayments had increased.

The Ombudsman upheld Olivia's complaint and directed the agency to pay compensation of €1,450 to Olivia.

At the date of publication, the debt management agency had not carried out the direction of the Financial Services and Pensions Ombudsman. This is very rare and has been deemed unacceptable by the Ombudsman, who has commenced enforcement proceedings in the courts to secure the €1,450 compensation directed for Olivia.

Decision Reference: 2018-0163

READ THE FULL DECISION HERE

Reporting of credit rating to the Irish Credit Bureau

Simon took out a loan in 2009, which he believed he had paid off in May 2013. He received no communication to the contrary from his lender but when he received his credit check record from the Irish Credit Bureau (ICB), it indicated that the loan had been 'written off' and Simon realised that there were a number of inaccuracies recorded in his credit history.

Two incorrect addresses were recorded and the letter 'B' was noted on his report, which indicates that he could not be located by the lender. However, the lender has acknowledged that this was a mistake as payments from Simon continued to be paid by direct debit during this period.

Although both parties agree that Simon missed four monthly payments, with the last of these occurring in March 2012, upon viewing his ICB record, Simon discovered that nine missed payments were noted. The Ombudsman found that the increased number of recorded missed payments from four to nine was not clearly or adequately explained or properly documented.

The provider continued to collect the monthly payments while the account remained in arrears, with the consequence being that there were further payments due which would require manual payment after the direct debit instruction had expired.

In May 2013, Simon noted from his bank statement that he had made a direct debit payment to the loan account with the note that it was a 'final payment'. Simon left the direct debit active until October 2014, but no further direct debits were taken by the lender.

Due to the recording of incorrect addresses, the lender failed to contact Simon to inform him that his loan had not been fully paid off and that there was an outstanding balance that needed manual payment.

The provider then decided to move the account to its internal bad debt department, which led to the letter 'W' (written off) being incorrectly recorded on Simon's credit report. When Simon discovered this in October 2015, he made a payment of €116.12 to settle the account, after being assured by the provider that his credit report would be updated; yet two months later this still had not occurred. The lender admits it did not instruct the responsible internal team to correct his ICB record. Only in summer 2017 was the 'W' removed from his credit file. The Financial Services Ombudsman found the delay in correcting Simon's record unreasonable.

In his analysis of Simon's case, the Ombudsman noted the serious consequences that a negative ICB credit rating can have on an individual and found the behaviour of the lender to be irresponsible and its reporting of incorrect credit history on Simon to be most unreasonable and careless.

The Ombudsman upheld Simon's complaint and directed the provider to pay €7,000 in compensation to Simon. The Ombudsman also directed the provider to correct Simon's ICB record and ensure that the file cessation date for his negative record is January 2019.

Decision Reference: 2018-0090

READ THE FULL DECISION HERE

Blocking of a company bank account following a dispute between its directors

In February 2010, Mark and Tim, the two directors of a company, both signed an agreement which stated that in order to carry out a transaction or give an instruction to their company's bank, only one of their two signatures was needed. However, in June of that year, Tim wrote to the bank requesting that this be revised so that both directors' signatures would be necessary on all transactions.

Following receipt of this letter, the bank wrote to both Mark and Tim, advising that the account had been 'blocked to all debit transactions pending receipt of a new mandate agreeable to all parties'. Following a series of letters, the bank deemed that the mandate signed in February was inoperable.

The complaint was made by one of the company directors, Mark, who argued that on receipt of Tim's request, without giving prior notice to the company secretary or the board of the company, the bank blocked the account, which prevented the transfer of money and had a catastrophic effect on the company.

In examining the complaint, the Ombudsman investigated whether the bank acted correctly and reasonably.

The Ombudsman found that in a situation in which an account holder requests changes to the operation of a bank account where there is a dispute with another holder of that same account, the bank should be cautious. He found that by blocking all debit transactions, the bank acted reasonably and prudently in protecting the funds in the account.

The Ombudsman also found that the mandate both directors signed in February 2010 meant the bank should act on all instructions from any one of the signatories and that, therefore, the instruction to stop all payments out of the account that Tim gave was rightly actionable. He also found that the bank reasonably and prudently communicated the blocking of all debit transactions to Mark, Tim and the secretary of the company.

In examining the complaint, the Ombudsman concluded that the bank had found itself in the centre of a dispute between the two directors, which ultimately took five years and a High Court case to resolve. The Ombudsman stated that the disagreement between Mark and Tim was their responsibility to resolve and that until they found a resolution, the bank had no choice but to suspend the operation of the company's bank account.

The account remained on hold until August 2015, at which time Tim had resigned from the company and a new mandate was received. The bank then lifted the block on the account.

The bank does acknowledge that it did not comply with the correct 20-day response timeline in respect of investigating Mark's complaint in February 2015. The bank offered €500 in compensation to Mark for this error and the Ombudsman felt this was sufficient compensation.

On the basis that the offer of €500 remained available to Mark, the Ombudsman did not uphold the complaint.

Decision Reference: 2018-0002

READ THE FULL DECISION HERE

Underpayment of credit card debt

Pavel acquired a credit card in 1998 and made the necessary payment on the card each month until October 2012, when he accidently underpaid the account by €19. At the beginning of November, after calling the lender to advise that he would make the payment, he paid the €19, together with the late fee charge of €15.

Following the missed payment, the lender deemed the account to have fallen into arrears and, on 30 October, placed a restriction on the use of the credit card. Pavel was unaware of this and was therefore shocked when his card was declined in a shop. He was informed by the lender that the card had been withdrawn and would not be reinstated.

Pavel states that since the card was blocked in 2012, when the balance outstanding stood at €14,166, he has paid €15,250 towards the outstanding balance. However, due to approximately €9,000 of that being interest, this has only reduced the balance by €6,250.

Pavel's complaint was, that the lender unreasonably blocked his account as a result of a small underpayment; secondly, that after blocking his card, the lender unreasonably charged a very high interest rate and thirdly, that the lender dealt with Pavel in an unacceptable manner.

Addressing the first part of the complaint, the lender claimed to have sent a letter to Pavel on 11 October to advise him that the account was in arrears and that a spending restriction would be placed on the account if payment was not received to cover the overdue amount within ten days. However, Pavel did not receive the letter and the lender provided no copy of the letter in the evidence submitted to the Ombudsman.

The Ombudsman found that the lender's failure to fully maintain its records constituted a breach of compliance with the Consumer Protection Code 2012 and also noted that the lender did not comply with the Consumer Credit Act 1995 by clearly stating what was required to remedy the situation.

Regarding the blocking of the credit card, the Ombudsman found that while the lender was entitled to do so based on the terms and conditions of the account, it was disproportionate and unreasonable when the underpayment was just €19 and there was no evidence of previous arrears on the account. Furthermore, the Ombudsman found that the lender failed to comply with European Communities (Payment Services) Regulations 2009 by not unblocking Pavel's credit card once he had paid it off.

Pavel noted that since October 2012, he had not missed any payments and that despite the withdrawal of his credit card, he is still charged a very high interest rate. The Ombudsman found that although the lender's decision to block Pavel's card was unreasonable, it was entitled, due to the terms and conditions, to charge the same interest on the account when it was blocked as when it was active.

Pavel complained that he was left on hold for over 25 minutes when he tried to contact the lender and that he had been dealt with in an unacceptable manner. The Ombudsman concluded that while this was not ideal, exceptionally high call volumes can lead to delays. In addition, while the Ombudsman noted a delay in providing Pavel with his original credit card agreement, he could find no intentional wrongdoing in this regard. He also noted that he could find no evidence that the lender had dealt with Pavel in an unacceptable manner.

The Ombudsman substantially upheld Pavel's complaint and directed the lender to pay €10,000 in compensation. He also directed that the lender remove any adverse reports on Pavel's Irish Credit Bureau (ICB) record.

Decision Reference: 2018-0066

READ THE FULL DECISION HERE

Security and identification requirements of a bank

Robert opened a bank account in 1986. By 2016, he held only a very small amount of money in it and had not carried out any transactions for a number of years. Following the amendment of the Criminal Justice (Money Laundering and Terrorism Finance) Act, 2010, Robert's bank was required to satisfy itself of a customer's true identity and address.

Due to this, the bank wrote to Robert explaining this requirement and asked him to provide relevant documentation. It warned that in cases in which it could not obtain the necessary documentation, it would be required, by law, to cease providing services and would have to close the account.

In an attempt to comply with this request, Robert supplied a copy of his driver's licence. However, he only supplied the photo page of the licence and no expiry date was visible. Furthermore, the address on the driver's licence did not match the address on the account statement.

The bank wrote to Robert in November 2016 to request a 'more clearly visible copy of the photographic identification'. While the Ombudsman agreed that ideally the bank should have identified that the missing expiry date was the precise reason for this request, he concluded that this issue was clarified in a subsequent letter which Robert received before making his complaint.

After receiving the letter, Robert called the bank and asked to be put through to the document verification unit but was informed that it didn't take customer calls. Robert became frustrated with the agent after having to repeat some information and asked to speak to someone more senior. What followed with the second agent was an exchange in which Robert demanded to be told the precise basis and justification for his account being chosen as one which required documentation to be provided. He stated that if the bank was asking this of every customer, it was wasting a lot of money out of 'laziness'.

He also asked what risk analysis had been carried out to identify his account as one that posed a risk for money laundering/terrorist financing.

In December, the bank issued its final response letter, again stating that it is required to confirm the identity of all customers. In March, it sent another letter, requesting the documentation and warning that if it was not received the account would be closed without further notice.

The Ombudsman found that the bank's request for documentation confirming every customer's identity and address not already on file was a reasonable way to comply with the regulation and that there was no evidence to suggest that the bank believed Robert to be involved in any illegal activity.

While the Ombudsman described it as 'regrettable' that the bank ultimately placed a block on Robert's account, it was a measure it was entitled to take.

The Ombudsman concluded that while the bank's request may have created inconvenience for customers, it is a consequence of compliance with measures designed to prevent money laundering and funding of criminality. Ultimately, the overarching objective of the procedures and legislation is to protect customers and the public from criminality.

The Ombudsman did not uphold Robert's complaint.

Decision Reference: 2018-0137

READ THE FULL DECISION HERE

Role of bank in the transfer of money to an alleged fraudulent account

Pharma Inc., a company offering pharmaceutical services had a number of patents in place but in order to exploit these patents, it required the sourcing of major external investment of at least €25million. To raise this money the directors of Pharma Inc. organised a bank loan which would be paid directly to a third party financial services company as a security deposit for an investment of €25million.

However, following this, no investment was forthcoming from the third party and the security deposit that was funded by the bank loan was never recovered. The parties to whom the money was paid are currently subject of a police investigation and it is alleged that fraudulent activity took place. The events have been highly damaging for Pharma Inc. and it has not traded since these events. Prior to this event, over €13million had been invested into the company and it planned to create up to 150 jobs.

The complaint the Financial Services and Pensions Ombudsman considered did not concern the alleged fraud but rather the assertion by Pharma Inc. that the bank in question failed to exercise sufficient due diligence in the transfer of money to the third party. The complainant states that the bank was unequivocally involved in the detail of the transaction and prepared and presented a payment instruction for the company that ignored the escrow related protections included in documents in the bank's possession.

On the other hand, the bank states that it outlined to the company that it had a number of concerns on the structure of the proposed transaction and queried a number of issues. Given its concerns, the bank outlined an alternative, safer form of payment by suggesting a bank guarantee by way of a letter of credit type facility from the bank's trade finance department. According to the bank, this would have provided greater protection as the guarantee would only have been paid on confirmation that the third party financial services company had complied with their part of the transaction by raising the investment.

However, this alternative payment option was not acceptable to the third party and Pharma Inc. sought that the funds be paid upfront through a bank loan. The bank then wrote to the company setting out the loan offer with special conditions, which reflected its concerns, including written confirmation from the company that they had received independent legal and financial advice on the transaction. The directors of Pharma Inc. signed their acceptance of these conditions and the money was transferred.

The Ombudsman found that it was clear that the bank was concerned that the transferred money was apparently going to be in the third party financial services company's control. The stipulation in the agreement that an escrow account be created would, if properly set up, have provided protections for the company. However, the bank's suggested solution did not have the agreement of the third party. The Ombudsman found the bank's condition that the company take legal and financial advice on the agreement to be prudent.

The complainant pointed out that while all the relevant account details from the third party financial services company were included, the actual name of the account was missing. However, the Ombudsman found that the complainant does not highlight how its inclusion would have changed the outcome.

The Ombudsman came to the conclusion that the bank had fulfilled its obligations and did not uphold the complaint.

READ THE FULL DECISION HERE

Decision Reference: 2018-0027

Opening of bank account

Anne entered into a Loan Agreement for €2000 with a bank in July 2015. This was to be repaid through 51 weekly payments of €41.22. Anne suggested that due to errors on the bank's part, the loan fell into arrears, was referred to a debt collection agency and ultimately led her credit rating being adversely affected.

In September 2015, Anne received a letter from her bank stating that her account was due to change from a Student Account to a Graduate Account. She rang the bank to advise that she was remaining in college and would like her account to remain as a Student Account. The bank has acknowledged that although it agreed, this was not actioned at the time, and her account was converted automatically to a Graduate Account in error. As it could not convert the account back, it opened a new Student Account for her. This was done without Anne's consent or knowledge. The original account, now a 'Graduate Account' remained open, with its original account number.

Shortly after this, Anne had also sought to restructure her loan from €41.22 a week to approximately €80.00 per month and visited her branch in order to arrange this. Records in relation to what was agreed at this meeting are unclear.

After receiving notification that the loan had fallen into arrears, and ultimately was to be handed over to a debt collection agency, Anne contended that, without her knowledge, these loan repayments had been coming out of the 'new' account that the bank had opened, and, as a result, 'bounced' as her salary was not being paid into that account. The Ombudsman believes there is a degree of misunderstanding on Anne's part. Although the bank did open a new account, there is no evidence that it set up a direct debit on that account to make repayments toward the loan.

The Ombudsman found the opening of a new account by the bank without Anne's knowledge or consent to be quite extraordinary conduct. Whatever the perceived benefit of this decision, he found it was entirely inappropriate for the bank to have taken such action, without consulting Anne first.

Nonetheless, the Ombudsman did not consider the bank could be held responsible for the arrears which accrued; rather, the majority of these arose as a result of Anne's attempted loan restructure.

Misunderstandings arose from the parties' discussions at the meeting around the loan restructure and although a lack of records on the bank's part is unhelpful, it should have been clear to Anne, from even a cursory look at her statements, that no money was leaving the account for loan repayments. When the first repayment for the new arrangement, as Anne understood it, did not leave her account from the outset or in the weeks and months that followed, she bore some level of responsibility to follow up on this with the bank.

The Ombudsman was satisfied that the bank did not act unreasonably in referring the loan to a debt collection agency and although it would have been entitled to submit Anne's account to the Irish Credit Bureau (ICB), records show it did not and it cannot be held accountable for any negative credit rating.

Overall, the Ombudsman was of the view that it was inappropriate and unacceptable for the bank to have opened a new account without Anne's knowledge or consent. Furthermore, he found that in the course of its dealings with her, it failed to comply with certain obligations pursuant to the Consumer Protection Code, 2012, particularly with regard to record keeping. These actions did not, however, give rise in any way to the accrual of arears.

The Ombudsman partially upheld the complaint, directed that the bank pay Anne €3,750 in compensation and referred the bank's conduct to the Central Bank for its consideration.

Decision Reference: 2018-0024

READ THE FULL DECISION HERE

Extension of credit by a moneylender

Andrea became a customer of the lender in 1998 and in the years that followed, took out a relatively large number of loans, including nine in the period between 2010 and 2013. Andrea presented her case to the Financial Services and Pensions Ombudsman with two distinct but related complaints. While, in some instances, the Ombudsman can only investigate complaints up to six years from the date of the conduct giving rise to the complaint, because this complaint concerns continuing conduct, the complaint was within jurisdiction.

The first element of Andrea's complaint was that the lender had allowed her to take out a new loan before an existing loan had been fully discharged on a number of occasions. Secondly, Andrea submitted that old loans were discharged using credit from new loans.

Dealing with the first element of Andrea's complaint, it stated that there was no requirement to only allow a customer one consumer credit loan at a time.

On the second issue, it stated that the customer must receive the full amount of the loan in their hand and that if an agent were to withhold any amount, this would be a breach of Section 99 of the Consumer Credit Act 1995 (CCA). While the lender argued that it was unclear whether or not the agent Andrea dealt with had withheld funds, on three occasions a previous loan was repaid in close proximity to the issue of a new loan. The lender argued that while this might suggest a withholding of funds, it was not evidence of refinancing.

The lender further argued that if funds had been withheld, it would have been to Andrea's benefit as it would have kept her weekly repayments to a manageable level by avoiding the need to service two loans concurrently.

Subsequently, in its final response letter, the lender, without any admission of liability, accepted that these three loans might have been issued in breach of Section 99 and arranged to clear her outstanding balance.

Analysing the complaint, in relation to the first issue the Ombudsman found that there is nothing to prevent the lender issuing more than one loan to an individual at the same time, provided they can demonstrate they can afford it. Reviewing the evidence, the Ombudsman considered that Andrea had confirmed to the lender that the weekly repayments were affordable for her.

In response to the second part of the complaint, the lender argued that Andrea had been unwilling to discuss her complaint with it but that they were confident that the agent would have provided her with the full funds of the loan. However, given that they could not confirm this as the agent was no longer available for interview, they acknowledged that there may have been a breach of the CCA and on that basis, made a goodwill offer to Andrea. This offer consisted of the clearing of her outstanding balance of €585 and a payment of €70.

The Ombudsman concluded that the evidence is highly indicative of a breach of Section 99 of the Consumer Credit Act 1995 and partially upheld the complaint. He found that compensation of €70 was not sufficient and directed the lender to make a compensatory payment in the sum of €500 to Andrea, in addition to the clearing of the outstanding loan balance of €585.

Decision Reference: 2018-0079

READ THE FULL DECISION HERE

Access to bank services on equal terms

Jack holds a student current account with a bank. He asserts that the bank is not complying with its obligations under the Single European Payments Area (SEPA) Regulation 260/2012 whereby payment service providers are obliged to offer services to all SEPA accounts on equal terms. Jack notes that the bank requires the use of a particular form of security device to add new payees but that this requirement is waived for domestic transfers up to €300 when using the mobile app. As this security device is not required when the destination is an Irish account, Jack argues that this differentiation is a breach of the SEPA regulation.

Jack also argues that this hinders full competition of account providers as his bank's policy renders transferring even small amounts of money to non-Irish accounts so cumbersome that would-be switchers are discouraged from using any bank not registered in Ireland. Jack requested that the Ombudsman clarify that the bank is obliged to provide non-discriminatory services to all SEPA accounts. Acknowledging the fact that the subject of his complaint had not caused him any financial loss, he did not seek any form of financial redress.

In reaching his decision, the Ombudsman noted that it was not appropriate for his office to consider hypothetical arguments in relation to potential ramifications of a particular policy as applied by a regulated financial service provider. Consequently, he would not offer any view as to whether the policy of the bank is or could be contrary to law or be anti-competitive as applied to other, unidentified individuals or financial institutions.

The Ombudsman noted that SEPA does not cover payments via mobile phone but merely applies to credit transfers and direct debits. SEPA established a technical platform so that a payment service provider which offers domestic credit and debit payment transactions can provide these services on an EU-wide basis, ensuring that payment schemes are inter-operable.

While SEPA mandates that each payment system is technically interoperable with others inside the EU, it makes no reference to security arrangements that can be applied to the processing of customer instructions. In fact, it confirms that a payment service provider must ensure that the payer gives consent for a relevant payment.

The Ombudsman therefore concluded that the bank was entitled to require the use of the security device for some but not all of its credit transfers.

Furthermore, the Ombudsman concluded that by opening an account with the bank and agreeing to its terms and conditions, Jack had agreed to comply with the security measures and authentication processes required of him by the bank in relation to the processing of individual transactions.

The Ombudsman did not uphold the complaint.

Decision Reference: 2018-0105

READ THE FULL DECISION HERE

Mortgage application cash back offer

Lorraine and Conor applied to the bank for a mortgage in April 2016. The bank had introduced an offer which provided applicants with a payment of €2,000 towards professional fees. This was available to those who drew down their mortgage loans between 3 October 2016 and 31 December 2016. The couple intended to avail of this offer.

Lorraine and Conor were also considering changing their car and getting a car loan. During a meeting with a mortgage consultant in April, Lorraine and Conor reported that they had asked whether this would affect their mortgage application. According to the couple, the mortgage consultant told them that once they received their mortgage approval in principle, they could 'do what (they) like'. The bank denied that such a statement was made.

The couple completed the bank's home loan application form and signed it in April 2016. In July, the bank sent Lorraine and Conor a loan offer of €164,000. The Ombudsman was satisfied that the couple did not have an obligation in this instance to indicate that they had a future intention to take out a car loan as they were not asked a specific question about future loans in the application.

That loan offer expired and on 10 October 2016 the couple's solicitor wrote to the bank advising that they would likely want to draw down on loan funds in the first half of December. On 25 October, Lorraine and Conor entered into a 4-year car finance agreement with another credit institution for a total of €20,718.98. The following day, the bank issued the couple a new loan offer.

However, in December 2016, the couple received a phone call from the bank informing them that their new car loan had shown up on a credit report and that a reassessment of their application would need to take place. Ultimately, a new mortgage loan offer was issued in January 2017, meaning that Lorraine and Conor missed out on the window to benefit from the bank's cashback offer.

In their complaint to the Ombudsman, Lorraine and Conor wanted the bank to pay them €2,000 towards professional fees as well as compensation of €1,000 for stress and €750 towards rent that they had to pay the landlord arising out of the delay drawing down the mortgage.

In his analysis of the complaint, the Ombudsman observed the stark conflict between the parties' understanding of what had been said at the April meeting. However, he was satisfied that because this discussion was superseded by subsequent events, the precise terms of that conversation were not determinative of the complaint. The Ombudsman pointed to a 2012 High Court judgment which ruled that borrowers could not rely on discussions that took place prior to formal documentation being executed in order to argue that what was in the signed documentation did not reflect the agreement of the parties.

Examining the 'letter of offer' dated 26 October 2016, the Ombudsman noted that it required the borrower to make full disclosure to the lender of all information relating to the borrower. As the bank was not informed of the car finance agreement Lorraine and Conor had just entered into, he found that the information supplied to the bank by the couple was no longer complete and accurate when they signed the new loan agreement on 16 November 2016. Therefore, he found that it was reasonable for the bank to reassess the mortgage application in light of the new car loan.

The Ombudsman found that ultimately the delay was caused by the bank's discovery of the couple's new car loan and that it was acceptable for it to reassess their mortgage application as a result. In addition, he found that it carried out this re-evaluation within a reasonable period.

The Ombudsman did not uphold the complaint.

Decision Reference: 2018-0159

READ THE FULL DECISION HERE

Closed account and old account book balance

In October 2015, Colm contacted the bank in question with a photocopy of a deposit passbook, which showed a remaining balance of IR£10,500 as of February 1980. Colm requested the bank to pay him the euro equivalent of this balance.

The bank contended that deposit passbooks only served as a memorandum of transactions and do not constitute proof that the account remained open. The bank explained that transactions are permitted without production of a passbook and that entries in the passbook did not necessarily reflect the true balance of the account; rather the bank's own records displayed the true details.

The Ombudsman noted that the bank had conducted thorough searches in Colm's name, as well as variations of it, in addition to numerous addresses which he had resided at over the years. It also searched for two variations of his account number, with one taken from the passbook and a second sent by Colm's representative.

The bank then proceeded to check the oldest copies of its 'balance microfiche' records and also attempted to locate the account by way of 'ledger microfiche'. During its search of the latter, it found that in its earliest records, which dated to 1 November 1984, there was no record of the account. From this the bank concluded that Colm's account had been closed before that date.

The bank also searched its 'history cards', recalling 19 boxes of cards from the original branch, and the safe of the branch was checked for old manual transaction ledger books. Noting that one of the three transactions marked in Colm's passbook had taken place in a different branch, the bank contacted that branch to see if it had the microfiche dating back to that period, but it did not.

Following this, the bank contacted its Dormant Accounts Unit. It had no record of Colm's account. As Colm had originally held the money in a branch of the bank in the UK, the bank also contacted the UK business centre which now operates that business, but no record of the account was found.

In concluding, the Ombudsman noted that while the bank had not produced any evidence of a withdrawal of Colm's monies, it had no obligation to retain documentary records relating to particular transactions after six years, or six years after the date on which it ceased to provide a product to a customer.

While the Ombudsman accepted that the passbook entries showed that Colm held an account with the bank in 1980 and that the last entry showed a balance of IR£10,500, he was satisfied that the passbook was not, in the absence of further evidence, conclusive as to the status of the account. Rather, what Colm's passbook illustrated was a snapshot in time, with it being entirely possible that the balance listed was withdrawn without the passbook or transferred to another account.

Therefore, the Ombudsman concluded that the balance of probability suggested that the account was closed, or that the money had been transferred by Colm on a date prior to 1984, and that, for this reason, it had not been possible to locate any details of this account. The Ombudsman found that it simply was not possible to say, in the absence of any further evidence, what occurred, given that the balance displayed dated from almost 40 years ago.

The Ombudsman did not uphold the complaint.

Sector:
Insurance

READ THE FULL DECISION HERE

Decision Reference: 2018-0178

Administration of a whole of life policy

George passed away in 2015. When his family contacted his insurance company to notify them, they were informed that he had encashed his policy in August 2014 for €1,100 and no longer had life insurance.

They learned that after paying premiums for 31 years to his whole of life insurance policy, George was told his premium was to increase by over 100% in order to cover costs of continued insurance with a guaranteed death benefit of approximately €101,000.

George had felt the premium increase was outrageous and unaffordable and had looked for options to reduce it whilst ensuring death benefit for his wife. Following liaison with the insurer, George had felt his only option was to apply for a new Lifelong Cover policy, and then cancel his existing policy. However, he was unlikely to ever be approved for this, and was subsequently refused it.

His family contended that he was badly advised in respect of his options by the insurer and that options to which he was entitled, including conversion to another whole of life plan or remaining on his existing policy at a lower death benefit, should have been explained better to him.

The family also argued that the insurer had a responsibility to better manage the funds over the life of the policy and questioned why previous reviews of the policy had failed to mention the pending 'fiscal cliff' his policy was going to fall off, instead choosing only to tell him when the money had all but run out.

The Ombudsman found that there were major lapses by the insurer in relation to how it administered the policy over the years, in particular by not carrying out scheduled reviews. As a consequence, George lost the opportunity to exit the policy earlier when in younger and healthier circumstances when he may have been able to avail of alternative cover.

The Ombudsman also found that when the matter of the substantial premium increases became an issue the insurer failed to set out the full options available to George at that time.

The Ombudsman accepted that ultimately George had taken the action of cancelling the policy himself and that the policy had provided him with cover for over three decades. However, considering all of the circumstances the Ombudsman found that the most suitable remedy was a substantial compensatory payment.

The Ombudsman substantially upheld the complaint and directed the insurer to pay George's estate €50,000.

Decision Reference: 2018-0180

READ THE FULL DECISION HERE

Loss of No Claims Bonus following an incident with an uninsured driver

After an uninsured driver drove into his vehicle, Paul reported the incident to his insurer, with whom he had a commercial vehicle insurance policy. Speaking to a customer service agent working for the insurer, Paul verified that his no claims bonus (NCB) would not be affected. He also contacted the Motor Insurance Bureau of Ireland (MIBI) to ensure that this would be the case.

However, despite this being logged on the insurer's system, when Paul's policy was up for renewal, he found that his NCB had been reduced from six to two years. Paul discovered that this affected his private car insurance policy, which increased from €600 to €1,000. Paul was unable to obtain a quote from any other provider as his case had not been closed by the insurance company and he was thus forced to pay the higher premium.

Meanwhile, when Paul came to renew his commercial vehicle insurance policy, the quote he received had increased from €600 to €2,600. He spoke with the same agent as before, but this time the agent claimed not to deal with renewals or NCBs and would not accept that what he was telling Paul contradicted what he had told him previously. Paul then rang the MIBI, which confirmed that it had written to the insurance company stating that since Paul carried no liability, his NCB would not be affected.

Upon calling back, the agent still failed to accept this and Paul was directed elsewhere within the company. After failing to receive help from a number of other agents, Paul eventually spoke to an agent who informed him that his NCB had been reinstated to six years but that the insurer could only issue one NCB certificate. When Paul responded by arguing that this was denying him the right to seek insurance from other companies, the agent then stated he would rectify the problem.

Not only was the reduction to Paul's NCB erroneous, leading to a potentially significant increase in the cost of his insurance policies, the Ombudsman also found that the service and information provided to Paul 'fell far short of what a consumer is entitled to' and noted the serious consequences for Paul. The Ombudsman upheld this aspect of the compliant, highlighting the 'annoyance, frustration and distress' caused.

The complaint Paul made to the Ombudsman extended beyond the issues surrounding the NCB and the related poor customer service. Following the incident, Paul's vehicle was valued at €2,200 with a salvage value of €200 which Paul was willing to pay so as to use it for parts. Paul understood that this would be possible following a conversation with the agent, who told him he would be able to keep the vehicle if he wanted. However, the vehicle was later picked up despite his protests and the agent informed him that the company was obligated to take the vehicle. The Ombudsman criticised the conflicting information provided to Paul and also upheld this aspect of the complaint.

In upholding all aspects of Paul's complaint, the Ombudsman directed the insurer to pay €3,000 in compensation to Paul.

Decision Reference: 2018-0186

READ THE FULL DECISION HERE

Rejection of a claim on a mortgage protection policy

In December 2001, Padraig took out a mortgage repayment protection policy. In March 2017, he fell ill and visited his GP, who certified him unfit to work.

A month later, Padraig submitted a claim to his insurance company, citing hypertension as the reason he was unable to work. He accompanied it with a doctor's statement which noted that he had previously suffered from hypertension in 2014 and that he had taken medication known for treating this illness.

At the beginning of May, the insurance company sought Padraig's medical records for the period from the 3 June 2013 to the 3 June 2014. In a phone call with Padraig's wife following that letter, the issue of pre-existing conditions was raised by the insurance company. His wife pointed out that while Padraig had first suffered from the condition in 2014, the policy had been taken out in 2001 and she expressed her fear of running into arrears with the bank.

Soon after, the insurance company phoned Padraig's wife claiming the policy was showing up as being initiated in 2014 rather than 2001 and advised her to contact the bank because the claim would not be approved in time for the next mortgage repayment.

At the end of May, the insurance company wrote to Padraig denying the claim stating that there was 'no medical evidence of a disability'.

On 1 June, Padraig's GP wrote to the insurance company enclosing his blood pressure readings and advising that Padraig was first diagnosed with hypertension in 2008 (still a number of years after the policy was initiated). Subsequently, the GP wrote to them again to confirm beyond doubt that a consultation took place on 23 March 2017.

Despite this, a day later, the insurance company wrote again to Padraig, claiming that there was no medical evidence of hypertension, but also that any condition of hypertension appeared to be pre-existing to the start of his policy.

At this point, Padraig's wife revealed to the insurer that she had had to borrow money in order to pay the mortgage as a result of the failure to meet the claim and highlighted the serious impact it was having on her family.

Padraig's blood pressure readings were provided to the insurance company by his GP again in both June and July, yet Padraig received a further letter once again disputing his condition. Given the information the insurance company had, the Ombudsman found this action by the company 'somewhat inexplicable'.

The Ombudsman summarised that the insurance company had fallen far short of its customer service obligations and had sometimes adopted a dismissive tone with Padraig's wife. He welcomed the apology the insurance company had since sent but stated that it was disappointing that a full investigation by his office was required in order to achieve an apology.

The Ombudsman upheld Padraig's complaint and directed the insurance company to admit and pay the claim and, in addition, to pay a sum of €10,000 compensation.

Decision Reference: 2018-0140

READ THE FULL DECISION HERE

Processing of a motor insurance claim

In January 2014, Seán's Irish registered motorhome was damaged in France by a third party while he was at his place of residence in Australia. In March, his insurance company arranged an inspection and repairs were costed. Initially, when Seán asked whether the motorhome had to be repaired in France, he was told it did. However, a day later the company emailed him to suggest that he bring the vehicle back to Ireland for assessment.

In early May, the vehicle was brought back to Ireland and Seán provided a list of parts and hourly charges from a UK-based motorhome company to his insurance company. Seán attempted to inspect the motorhome later that month but was unable to make contact with the storage location. Eventually, in June, an agent from the insurance company inspected it and sought a repair estimate from a UK-based company. Rather than an estimate, this company provided details of another, Northern Ireland-based company. Seán's insurance company forwarded these details to him and, having returned to Ireland, he brought the motorhome to them himself in September.

On arrival, Seán was told they did not repair motorhomes and he was referred to another third party, also in Northern Ireland. This repair company said they would deal with his insurance company directly and two weeks later, Seán returned to Australia.

Towards the end of October and after failed attempts to contact the repair company directly, Seán's insurance company made contact to say that the repair company would not order the parts until he was in Ireland. Seán explained the sequence of events and even offered to pay for the parts up front. His insurance company said the repair company would contact him directly.

Seán heard nothing from the repair company and made repeated failed attempts to seek a solution from his insurance company over the following 11 months, including visiting the insurance company's branch in person, where he felt he was deliberately avoided.

The company finally responded to his complaint in September 2015, seeking a repair estimate to process the claim, but the repair company failed to produce one and the insurance company could not settle the claim. Eventually a settlement offer was made in February 2016 based on the quotes Seán had given the insurance company himself in May 2014.

Seán believed delays and poor customer service caused him undue stress and financial burden. The insurance company admitted some of its communications did not meet their standards and that it should have done more to obtain a quote, but also argued not all the delays were of their making.

The Ombudsman considered whether the delays could have been avoided by the insurance company and whether their handling of the process and communications reached an acceptable standard. The Ombudsman found that it was reasonable for Seán to have understood that he was to return the vehicle to Ireland, and subsequently bring it to the first company in Northern Ireland. The Ombudsman did not agree with the insurance company's assertions that these were only 'suggestions'. Whilst the Ombudsman accepted that the issue with the repair company was not the fault of the insurance company, he found it had failed to negotiate a resolution or to find an alternative in reasonable time.

The Ombudsman found that the insurance company failed to take into account Seán's age, location and hearing difficulties. The Ombudsman found it unacceptable that Seán was made to feel that he was being avoided when he visited in person.

The Ombudsman substantially upheld the complaint and directed that compensation totalling €7,909.75 be paid to Seán.

Decision Reference: 2018-0100

READ THE FULL DECISION HERE

Rejection of health insurance claim because of pre-existing condition

Ann-Marie and her family held a health insurance policy which they upgraded in September 2014. The upgrade included cover for additional hospitals. However, a two-year waiting period applied for treatment in these hospitals for any ailment, illness or condition that existed prior to the upgrade in cover.

Ann-Marie's daughter underwent surgery in May 2015. Ann-Marie subsequently made a claim under the policy for the medical expenses incurred. The insurance company refused the claim on the grounds that the medical condition pre-existed the cover upgrade and the hospital concerned was therefore not covered due to the two year waiting period.

Ann-Marie had made contact with both the consultant surgeon and the insurance company before the treatment and checked that the procedure was covered. Although the insurance company explained that a pre-existing condition would not be covered, she did not believe her daughter's condition to be pre-existing. She was led to believe in her call by the company's agent that the consultant treating her daughter would have the final decision on whether it was a pre-existing condition. She made the point that she could have chosen to go elsewhere had she known the hospital in question was not covered.

Ann-Marie's belief that the condition was not pre-existing stemmed from letters from the consulting doctor which stated it only became a relevant recurrent condition requiring surgery in December 2014/ January 2015.

The insurance company however, when assessing the claim, stated that its own medical advisers determine when a condition 'commenced' and that their decision is final. Their view was that an incidence of the condition recorded by a GP in May 2013, before it became recurrent and before surgery was recommended, was the commencement of the condition.

The Ombudsman noted that the insurance company's contention that their own advisers are the decision makers was not properly communicated to Ann-Marie. On the contrary, recordings of telephone calls provided evidence that Ann-Marie was told on two separate occasions by the insurance company that her consultant's opinion was the deciding factor. This information was not correct and could have misled her.

Having told Ann-Marie to ask her consultant and informing her that they would accept the consultant's opinion, the Ombudsman also determined it unacceptable that the insurance company did not seek the consultant's report or consider the consultant's opinion, but rather sought GP records and used these as the basis of the decision.

The Ombudsman upheld the complaint and directed the insurance company to admit the claim.

Decision Reference: 2018-0141

READ THE FULL DECISION HERE

Rejection of insurance claim in respect of car seized by the Gardaí

In September 2015, Sandra purchased a car, bearing the registration number 10 XX XXX54, for €8,000 from a seller on an online forum. A couple of weeks later, she added it to her motor insurance policy. However, at the end of October, the car was seized by Gardaí, as they believed it to be an illegal clone. The car has not been returned to Sandra as it is property of a third party, the insurance company which compensated the individual from whom it was originally stolen.

Unknown to Sandra, the vehicle she purchased had been stolen in April 2015. The thieves had altered the vehicle's documents as well as its chassis number and tax disc and sold it to a man who had it for four months. As no Vehicle Registration Certificate (VRC) was issued with the car, this individual's solicitor submitted an affidavit to the Department of Transport who issued him a VRC.

Sandra states that she bought the car in good faith, relying on the VRC issued to her upon purchase.

Sandra argues that she had an insurable interest when she bought the car and that its confiscation was an insurable event. She states that the car is worth between €8,000 and €9,000 and argues that what subsequently transpired was not her fault and therefore seeks that her insurance company replaces the car or provides her with its value.

However, the insurance company disputes this and states that Sandra was never the legal owner and therefore never had an insurable interest in the car. Furthermore, it states that while Sandra insured the vehicle registered 10 XX XXX54, this was not the true registration number and therefore the company's underwriters were denied an opportunity to fully assess the risk.

In deciding this case, the Ombudsman highlighted that Sandra's insurance policy deemed that the vehicle was covered 'Provided such vehicle has not been stolen…' Given that both parties agree that the vehicle in question had been stolen, the Ombudsman concluded the above clause governed the policy and therefore the car was not insured.

In addition, the Ombudsman found that it would have been prudent of Sandra to carry out reasonable enquiries prior to purchase, particularly as she was buying it online from a private seller. He concluded that Sandra was effectively seeking to claim for loss arising from the car being returned to its legal owner and that if this constituted an insurable event, it would run contrary to the principles of public policy. Furthermore, the Ombudsman found that it was not reasonable to expect an insurance company to compensate an individual for property seized by the Gardaí and returned to its rightful owner.

The Ombudsman did not uphold the complaint.

Decision Reference: 2018-0160

READ THE FULL DECISION HERE

Mobile phone insurance claim

Leah took out a mobile phone insurance policy in November 2015. After dropping her phone on some stones in September 2016, shattering the screen, she submitted a claim online the next day. Despite the insurer stating that assessments will be processed within 24 hours, it was not until nine days later and after several attempts to speak to someone that she got a response from the insurer, asking for further information. At this point, the insurer also charged her an incorrect amount for her policy excess.

Arranging collection of the broken phone by the insurer's courier caused a further two week delay in the process after the insurer failed to provide a correct address and subsequent bookings were either not made or not carried out. After numerous calls and emails from Leah, the phone was eventually collected.

The phone was not returned for three weeks, despite, again, numerous contacts from Leah to the insurer. It was during this time that Leah made a formal complaint to the insurer, requesting cancellation of her policy, return of premiums paid, return of the incorrect policy excess payment and compensation for call charges and her time in attempting to rectify the situation. At this point, her replacement phone also became faulty.

Between the start of November 2016 and the start of February 2017 Leah engaged in correspondence with four different representatives of the insurer and ultimately its underwriter — after her complaint was escalated. Both entities failed to address aspects of her complaint and once again made an error in respect of the policy excess, refunding the incorrect amount.

A cheque to reimburse the cost of calls to the insurer was provided in February 2017 at the direction of the underwriter, however, the faulty replacement handset was not replaced and there was no policy premium refund. The underwriter states that premiums are non-refundable.

The Ombudsman found errors contained in the responses to Leah's complaint and also that specific elements of it were not addressed. He found that the insurer failed to acknowledge responsibility for errors which led to delays in the processing of the claim in the first instance, or apologise.

The Ombudsman also found that the underwriter failed to address specific central elements of Leah's complaint — notably that she wished to cancel her policy. The Ombudsman was satisfied that in her correspondence in October 2016, Leah gave clear written instructions that she wanted her policy cancelled with immediate effect, yet this did not occur until May the following year when Leah cancelled her direct debit.

The underwriter also failed to address the discrepancy in the amounts refunded in relation to the policy excess, both with Leah, and in preparing its correspondence to the Ombudsman. Thus it did not verify that the actions which it had directed the insurer to carry out to remedy the complaint had been carried out correctly.

Leah's complaint was not assessed thoroughly and appropriately, which itself constitutes poor customer service. A policyholder is entitled to have a complaint investigated thoroughly, with any errors and omissions made, identified, apologised for and appropriately redressed.

The Ombudsman directed that the Provider pay Leah €900 in compensation and to correct all records relating to the termination of the policy, to reflect the fact that she requested a voluntary cancellation of the policy.

Decision Reference: 2018-0208

READ THE FULL DECISION HERE

Communication regarding an income assistance claim

Kathy underwent surgery in July 2016 and was certified unfit for work. Her insurance company declined her claim for income assistance on the basis that the condition was both pre-existing and chronic in nature. Kathy complained that she was wrongly declined her benefit.

Kathy maintained that although the condition was first treated in January 2007 following an accident, she remained treatment- and symptom-free until 2013, thus qualifying her under a policy clause which stated that pre-existing conditions may be covered after two years, as long as, during that period you have remained free of treatment, advice or medication for that condition. She also contended that the condition was not chronic.

The insurer reviewed the case but declined the claim, again concluding that the medical condition giving rise to her submission of the claim was pre-existing as defined in her policy terms and conditions.

On both occasions, the insurer employed a third party contractor in Ireland to assess these claims.

The Ombudsman noted that as part of her original claim, Kathy's GP had reported that symptoms had been present "some years - following previous accident" and that she was diagnosed with "well marked OA [osteoarthritis]" on 23 January 2007. Based on this, the Ombudsman was satisfied that it was reasonable for the insurer to conclude that her condition was a chronic, existing condition and that it declined her claim in accordance with the terms and conditions of her income assistance policy.

However, in June 2018, having reviewed the communications issued to Kathy during the assessment and review of her claim, it was noted that the terms and conditions quoted relating to both chronic and pre-existing conditions were not the terms and conditions that applied to Kathy's claim.

Kathy's cover commenced on 1 October 2010. It appears that the contractors quoted a later version of the policy that applied only to agreements that had commenced after 26 November 2012, which included a two-year requalification period when symptom free.

It was the use of this policy wording that led to Kathy appealing the original decision to decline her claim and why she pursued the matter further by way of a complaint to the Ombudsman. It only came to light, late in the day, that the re-qualification period did not in fact apply to her claim.

Administrative errors of this nature are unsatisfactory and can cause considerable confusion, frustration and, indeed, expectation on the basis of an incorrect understanding of the position. A customer ought to be able to rely on the expertise of the insurer.

The Ombudsman accepted that Kathy was not financially disadvantaged by the error because he accepted that the decision to decline her claim was correct in accordance with the correct policy terms and conditions. However he was satisfied that the use by the insurance company of the wrong policy wording constituted particularly poor customer service.

The Ombudsman partially upheld the complaint and directed the Company to pay Kathy €1,200 in compensation.

Decision Reference: 2018-0071

READ THE FULL DECISION HERE

Automatic renewal of travel insurance

In June 2016, Amy took out travel insurance, under the impression that it was a single year policy.

A notice that automatic renewal would occur each year at renewal time unless otherwise notified was not included on the quote page. There was a notice at the bottom of the payments page, but Amy did not see it.

In May 2017, the insurance company emailed Amy with the subject line 'due for renewal'. Within the body of this email, it was explained that there was to be an automatic renewal unless she opted out by calling the insurer. Unware that this was the case and not intending to renew, Amy did not open the email. In June, the insurance company emailed Amy to let her know that her policy had automatically renewed but that there was a 14-day cooling-off period for her to cancel the policy.

A month later, Amy realised that her policy had been renewed and she contacted the insurer to cancel the policy, seeking a refund. This request was denied.

The issue the Financial Services and Pensions Ombudsman had to decide was whether it was reasonable for the insurance provider to automatically renew Amy's travel insurance and subsequently refuse to cancel the policy and refund the premium paid.

The Ombudsman found the location of the automatic renewal notice at the end of the purchasing and payment process unacceptable. He felt this important information should be brought to the attention of consumers before asking for their card payment details. Furthermore, the Ombudsman agreed with Amy's suggestion that the consumer's attention should be directed to this matter by having to select an 'opt in' option.

Additionally, the Ombudsman found it unacceptable that the only way to 'opt out' of automatic renewal was to telephone the insurance company. Given that the original policy was purchased and payment was made online, all correspondence was by email, and that online processes and communications often take place outside of office hours, the Ombudsman found this phone-only method of opting out unacceptable.

While the Ombudsman acknowledged that it would have been helpful if Amy had opened the renewal notice email from the insurer, he agreed with Amy that the subject of the email should have been clearer; for example it could have been 'automatic renewal'.

The Ombudsman found the company's refusal to cancel the policy and provide a refund a month after the renewal 'surprising and most inflexible'. While the company subsequently offered to do so, this was only after Amy had made her complaint to the Financial Services and Pensions Ombudsman and therefore the Ombudsman believed this was no longer a sufficient response.

Considering the entirety of the complaint, the Ombudsman upheld Amy's complaint and directed the insurer to pay Amy €250 in compensation.

Sector:

Investment

READ THE FULL DECISION HERE

Decision Reference: 2018-0021

Fees, charges and communications relating to an investment

A group of investors entered into an investment agreement with a fund management company, through an independent intermediary and on three occasions, commencing in 1996, money totalling €270,000 was invested into various funds. In December 2013, the intermediary provided the group with a valuation of €250,000 for their investment; however, when the investors eventually received a valuation directly from the fund manager, they discovered that the total value of the investments was less than €2,000.

While the intermediary is under investigation by the Central Bank and is reported to have had its licence removed, the investors believe that the fund management company, against which they made the complaint to the Financial Services and Pensions Ombudsman did not do what it was authorised to do in terms of the payment of fees to the intermediary and the provision of fund updates to the investors.

On the first issue, while the agreement between the fund manager and the investors specified the maximum commissions payable to the intermediary at between 0.5% and 1% per annum, the investors argued that the fund manager began approving commissions at double or quadruple the agreed rate around January 2010. The investors believe that the fund management company was negligent for paying the rates requested by the intermediary rather than by the fund manager itself and that this led to the overcharging of the investors.

Secondly, the investors point out that the fund management company's agreement specified that balances should be sent to their home address. The investors stated that the company began sending the statements to only the intermediary and not their home addresses solely upon the request of the intermediary. According to the investors, this led to a situation where they received false valuations for over 14 years and were denied the opportunity to take rational action on foot of losses.

The fund management company argued that the investors' true grievance lay with the intermediary and that the claim was an attempt to recover their trading losses. The fund manager argued that it had been entitled to rely on its initial due diligence and that it was reasonable for it to trust the authority given to the intermediary by the investors.

On the matter of communication, the fund management company stated that it had always acted transparently and co-operatively with the investors.

The Ombudsman found that greater and better oversight was required by the fund management company regarding the instructions it was receiving from the intermediary regarding fee changes and the changes of address for communication purposes. Both types of instructions should have been given by the investors in writing and signed by them and no evidence of this had been submitted.

Furthermore, the Ombudsman found that oversight requirements, as per the company's own agreement with the investors, could have avoided or alleviated the alleged acts or omissions by the intermediary that are claimed by the complainants.

However, he also pointed out that the investors themselves had a general oversight obligation to make sure they were receiving information from the fund manager, and when such information had stopped coming through, to question the matter.

The Ombudsman partially upheld the complaint and directed the fund management company to pay the complainants €15,000 in compensation.

Decision Reference: 2018-0073

READ THE FULL DECISION HERE

Processing instructions on encashment of an investment

Harold and Sally each held 50% beneficial ownership of an investment bond of a certain company, which was owned by and in the name of a pension trustees firm. The bond was written on a Joint Life First Death basis. In two payments in 2013 and 2014, GBP £245,265 was invested into the bond. The sum assured was 101% of the bond value on the date of notification of death. The bond was fully surrendered on 14 December 2015 in the amount of GBP £272,489.33.

It was November 2015 when Harold and Sally decided to surrender the bond and the trustees firm contacted the investment company on 27 November 2015 to instruct this request. The couple argued that the surrender should have taken no more than 5 working days from the receipt of all the paperwork and that the fact that their funds didn't arrive until 16 December 2015 resulted in financial loss due to exchange rate movements during the surrender process. Therefore, they sought compensation of €6,290, the difference they believed to exist between the GBP-Euro exchange rate on 11 December 2015 and 16 December 2015. They also sought an apology.

In response, the company stated that the trustees had emailed it on 27 November 2015 to instruct a full surrender of the bond. Attached to this email, with the originals to follow by post, were a series of documents. According to the company, its service level agreement for reviewing documents is 5 working days. Having reviewed the documentation, the company emailed the trustees on 3 December advising that a bank statement for the couple's bank account and the original policy documents were both missing.

The company stated that it received the required documentation on 14 December, processed the surrender immediately for disinvestment overnight and that payment was made before noon on 15 December. Therefore, the company stated it was satisfied there were no servicing issues and that the bond was released immediately after it received the last outstanding document.

In examining this complaint, the Ombudsman considered a large volume of correspondence between the parties. He found there were 'crossed wires' in some of this correspondence which was caused by the involvement of three separate parties – the company, the trustees and the couple's financial adviser.

In reaching his decision, he was satisfied that the surrender of the bond was not delayed as a result of any administrative error on the company's part. Rather, it was clear that on the 4 December, the trustees confirmed that they had not yet sent an original bank statement to the company. Therefore, even if that document had arrived by post on the next working day, the company service level agreement deemed that the company had acted within the necessary timeframe of 5 working days to review the document and a further 5 working days for the surrender to be actioned. Furthermore, on the 13 December, the trustees acknowledged that while the bank statement had been sent, 'it may not have reached (the company) yet'. Therefore, the Ombudsman found that on this date, the trustees accepted that there may still have been an outstanding document.

In addition, the Ombudsman noted that the policy was surrendered overnight on 14 December, with the monies transferred on 15 December and that the issue of exchange rates fell outside the control of the company.

The Ombudsman did not uphold the complaint.

Value of the preserved benefit of a pension scheme

James became a member of a pension scheme in 1998. In 2013, his employer was advised that an additional lump sum payment of €800,000 would be required for the scheme, of which James was the only member, in order to meet the statutory funding standard. Following a consultative process, an agreement was reached with James to cap his benefits at their value as of 20 March 2014. The trustees were advised and the rules of the scheme were changed in accordance with the law. The value of James' benefit was calculated at €2,776,548.

James left employment at the end of 2014 and, as per the agreement, no further benefits were accrued following the March date.

Sadly, in 2016, James passed away. As he passed away before reaching retirement age, the preserved benefit of the scheme became payable to his personal representative. Following the statutory re-evaluation, the trustees of the scheme again calculated the preserved benefit of the scheme to stand at €2,776,548.

However, his wife Siobhán, who made the complaint to the Financial Services and Pensions Ombudsman believed that the benefit should in fact amount to €3,758,000. She argued that in the scheme, the term 'Member' did not extend beyond her husband and that while the scheme caps the 'Member's entitlements' on 20 March 2014, it did not extend the cap to the entitlements of other beneficiaries of the scheme. Siobhán noted that she never gave her consent to the capping of her benefits under the scheme.

The Ombudsman noted that, as the amendment did not reduce the member's benefit, it had not actually been necessary for the trustees to attain James' consent; but that they had done so anyway.

Fundamental to Siobhán's complaint, the Ombudsman found that the letter of notification from 1998 clearly stated that if death occurred before the preserved benefit became payable, the benefit payable is the member's benefit and not the entitlement of some other beneficiary under the scheme.

The Ombudsman accepted that there was a provision in the trust deed to change the rules in the way the trustees did and that the change made was carried out in accordance with those provisions.

The Ombudsman found that the amount payable to James' personal representative was €2,776,548 so he did not uphold the complaint.

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Refusal to grant an injury warrant under the Local Government Superannuation Scheme

Dennis is a former Local Authority employee who retired in 2011 on the grounds of ill-health and is in receipt of the full ill health retirement benefit.

The statutory basis for retirement benefits for local authority employees is the Local Government Superannuation Scheme (LGSS). A clause of the LGSS provides for the award of an allowance in the case of injury sustained in the course of work. Dennis alleged that it was injury (stress) sustained in the course of his work that led to his retirement and that he should therefore, also be entitled to an injury warrant. However, his former employer disagreed.

Dennis stated that in November 2001, he interviewed for a senior position but that the interview board failed to recommend him for promotion. He submitted several allegations of discrimination taking place in the time that followed, such as a junior staff member being promoted ahead of him and being assigned menial posts not in keeping with his qualifications, role and experience.

Dennis was diagnosed with post-traumatic stress disorder, which eventually led to his application for ill health early retirement. He claimed that medical professionals believed that if he had been given a more meaningful role, he may have had a more favourable outcome with regard to physical and mental stress and personal injury.

In response, Dennis' former employer stated that no single incident can clearly be identified as the cause of the condition which was said to be a qualifying injury in Dennis' case, nor was there any record of any incident involving Dennis in discharge of his duties which may have caused the injury.

It also maintained that it was satisfied that its procedures and processes regarding appointments were fair, impartial and transparent and that Dennis could have pursued the matter with the Workplace Relations Commission if he wished.

In his analysis of this complaint, the Ombudsman firstly pointed out that Dennis' allegations of discrimination cannot be determined by the FSPO.

The Ombudsman outlined that the granting (or not) of the injury warrant is a discretionary decision that he cannot change. Rather, the scope of his power is to ensure that the pension scheme authorities have followed the proper procedure in arriving at their decision and if they have not, the Ombudsman can refer the matter back to the scheme authorities with a direction that the proper procedure is to be followed.

The LGSS does not specify a procedure that must be followed in assessing applications for the injury warrant and, in this case, the employer has not adopted any formal procedure for the assessment of such applications. Detailing the sequence of events that led to the denial of Dennis' request for the warrant and his subsequent appeal of this decision, the Ombudsman was satisfied that nothing in the procedure followed by Dennis' employer contravened the provisions of the LGSS.

The Ombudsman did not uphold the complaint.

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Pension plan investment performance

Andrew was a deferred member of a contributory pension plan. A portion of his benefit derived from contributions he made to an additional voluntary contribution (AVC) fund, which was invested with an asset management organisation. However, Andrew claimed that after this organisation was acquired by an investment management company, he was informed that his fund had been converted from an aggressive fund, invested in equities, to a passive fund, invested in cash and bonds. According to Andrew, this led to a serious decrease in the plan's investment performance.

In response to Andrew's complaint to the Ombudsman, the trustees stated that the fund was not passively managed as Andrew had claimed but was actively managed. In addition, they stated that the fund invested in a wide range of asset classes, including equities, corporate bonds and cash and that the allocation between each asset class was at the discretion of the manager. In addition, the trustees argued that they had no reason to believe that a specific communication regarding the changes to the fund had been necessary.

In examining the evidence presented, the Ombudsman noted that almost two years after the asset management organisation took over the fund and after informing the trustees of their intentions, the fund managers changed the method of benchmarking their performance from relative to absolute return, broadened the range of asset classes in which the fund was invested, and renamed the fund. Further changes to these elements were subsequently made, but the Ombudsman noted that the risk profile remained similar. The Ombudsman also found that the fund remained actively managed at all times.

The Ombudsman noted that the Disclosure of Information Regulations do not place an obligation on trustees and plan administrators to inform members when fund managers change the way the fund is being managed. However, the Ombudsman found that while there was no obligation, on the basis of good practice, the trustees could have informed the members of the changes that had taken place. The Ombudsman suggested that this complaint could have been avoided if the trustees had informed the members.

However, the Ombudsman noted that Andrew himself was responsible for monitoring the performance of his own AVCs and that if he had done so regularly, he would have been aware of the fund's poor performance. Furthermore, Andrew voiced many allegations concerning the accuracy of performance statistics provided by the fund's record keepers, however, the Ombudsman found that the two values needed to accurately monitor performance were kept up-to-date and were available to Andrew at all times.

During the course of the Ombudsman's investigations, Andrew informed the Office that he was experiencing difficulties in obtaining information about his pension investments and had been notified of the trustees' intention to wind up the defined benefit pension plan and transfer his entitlement into the defined contribution plan. The trustees responded that Andrew's AVCs were invested in a dynamic diversified fund. The trustees stated that there was no transfer of any of his investment and that the numerous name changes were the only further alterations made. It argued that changes to the fund did not require a specific communication and that members had access to regularly updated fund factsheets.

The Ombudsman emphasised that to award financial redress in the case of a pension complaint, he needed to be able to point to some plan rule, trust deed clause, regulation, piece of legislation or obligation with which the plan administrators or trustees had failed to comply, and which had caused financial loss to the complainant. While he believed it would have been appropriate for the trustees to inform the members of the changes made by the fund managers, there was no maladministration at the root of Andrew's financial loss. Therefore, the Ombudsman did not uphold the complaint.

Unlike the case studies published in other sections of this Digest, the full text of this decision is not available as the Financial Services and Pensions Ombudsman Act 2017 does not provide the power to publish the full text decision in relation to complaints against pension providers.

Letter from a complainant

Some complaints are resolved by mediation at an early stage. However, sometimes even where mediation has not been successful in the early stages of a dispute and the investigation process is at an advanced stage, the parties will wish to return to mediation. This is because matters in contention become clearer through the investigation process and the exchange of evidence. This is what happened in the case of the complainant who wrote the letter below in December 2018. It has been reproduced with the permission of the complainant, to show the value to our customers of both our mediation and investigation services.

Dear Director A,

I hope that you are well.

I am writing to thank you, most sincerely, for all of your work in relation to my complaint which was concluded through mediated settlement by your colleague [Director B]. I am really happy with the agreed resolution but I am compelled to write to you personally to express my heartfelt gratitude to you and your Department for everything that you did in investigating my case. The outcome that I received could not have happened without the professional investigation of this matter by your Department. Of this, I am in no doubt and I will be eternally grateful for every piece of work that you and your team put into this matter.

I particularly want to commend the work of [Investigation Officer] on this case which was outstanding. I have written directly to [Investigation Officer] to tell her this but it is important that I tell you, as Director of Investigations, Adjudication and Legal Services, that I hold [Investigation Officer] in the highest of esteem for her impartial dedication, professionalism and courtesy to me.

Thank you for your intervention in this matter at the time immediately prior to my contemplation to go to Adjudication. Your unbiased and clear assessment of my options helped me at a time when my judgment was clouded by anger at the Bank.

I very much appreciated this intervention which brought about a resolution to the dispute.

I had many reasons for putting up such a fight in this case. My loan was sold by the Bank to a Fund who were threatening to foreclose on me and this event would have caused the eviction of my tenant (who is a very vulnerable person) from this property and would have impacted on my mother's home which I co-own. There is no property to rent in [provincial town] at the moment so I would not have been able to re-house my tenant and the implications for my mother, at her age, are beyond what I could ever contemplate. So this dispute was never, ever, about money or property but in fact it was about people, and homes, and lives. Because of the work that you do in your Department, I have secured a positive outcome for not just me but for my tenant and my Mam. As a person with no legal training or qualifications, and no legal counsel, your service enabled me, an ordinary person, to take on the might of the [bank] and achieve justice. In my opinion, this makes your work most meaningful.

Nollaig shona, agus guím 2019 síochánta agus rathúil ort.

The complainant's name and address and other identifying features have been redacted to protect her privacy.

3 STEPS TO MAKING A COMPLAINT TO THE FSPO

1

Contact your provider

You should make your complaint with whoever provided the service or product to you, this could be your bank, insurance company, credit union, money lender etc.

You should speak or write to either the person you usually deal with, or ask for the complaints manager to make a complaint.

What information should you give them?

- ☑ **Make it very clear that you are making a complaint.**
- ☑ **Explain your complaint.**
- ☑ **Suggest how they should put it right.**

Provide detailed information, including:

- **Relevant dates, places and times**
- **Details of any phone conversations and meetings** (e.g. who was involved, when they took place and what was said)
- **Copies of relevant documents**, such as contracts, statements, emails, letters, invoices and receipts.

BEFORE MAKING A COMPLAINT TO THE FSPO, YOU MUST GIVE YOUR PROVIDER A CHANCE TO SORT OUT THE PROBLEM.

2

Be patient and persistent

The provider should deal with your complaint through its complaint handling process. The provider may take up to 40 working days to deal with your complaint.

When you complain to the provider be persistent. If nothing happens, call the provider to check on the progress of your complaint.

The provider should fully investigate your complaint.

Resolved

In the majority of cases the provider will resolve your complaint.

Not yet resolved

If they don't resolve it, they will issue a final response letter to you.

A final response

should set out what the provider has done to investigate your complaint through its complaint handling process. It should advise you to contact the FSPO as your next step, if you remain unhappy.

3

Contact the FSPO

If you remain unhappy after receiving your final response letter, you may contact the FSPO. To progress your complaint, we will need:

A **A completed complaint form**

&

B **A copy of your final response letter.**

If you are having difficulty getting the final response and 40 working days has passed or if your provider is not engaging with you please let us know and we will follow up on the complaint for you.

An tOmbudsman Seirbhísí
Airgeadais agus Pinsean

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