ombudsman news

January 2003 issue 24

essential reading for financial firms and consumer advisers

Financial Ombudsman Service

in this issue

about this issue 1

assessing evidence about health in insurance disputes 3

banking – disputed cash payments in 10

availability of flood cover 14

investment case studies 15

ask ombudsman news 20

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about this issue – *January 2003*

Many insurance complaints require us to reach a view about the policyholder's state of health. Disputes involving income protection policies, for example, often centre on whether a policyholder is so incapacitated that they cannot carry out their normal occupation, or on whether the policyholder is 'permanently and totally' disabled. In this edition of ombudsman news we outline how we assess the (frequently conflicting) evidence about health that is presented to us in such disputes. We also provide several related case studies.

Disputes about amounts of cash paid into bank accounts can often cause emotions to run high. Typically, the customer has paid cash in – over the counter or via a deposit point – but then finds that the entire payment has gone missing, or that they have been credited with a smaller amount than they recall paying in. Both customers and firms tend to assume we settle such disputes on the basis of which 'side' we believe. That is not what happens, and in this edition we explain the types of

... we explain the types of evidence we will want to examine.

evidence we will want to examine when dealing with these complaints. Among our case studies on this topic we feature a lady who said she had paid £300 in to her bank account, but was told by the firm that it had no record of ever receiving her payment, and a gentleman who claimed to have paid in £1,000 in cash, but was credited with only £100.

Our usual round-up of recent investment case studies includes several complaints involving maturing pension policies. In one these, the firm told a customer that his wife had reported him dead. In another, the policyholder blamed the firm for 'tipping off' his estranged wife that his policy had matured – thus 'obliging' him to share the money with her.

Finally, as always we welcome your comments and queries. We print the answers to a selection of recent questions in *ask ombudsman news* on the back page of every issue.

... the policyholder blamed the firm for 'tipping off' his estranged wife that his pension policy had matured.

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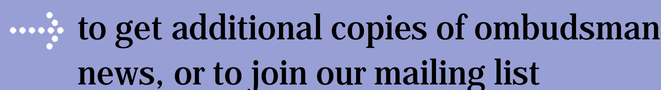

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1 assessing evidence about health in insurance disputes

Many insurance disputes require us to reach a view about the policyholder's state of health.

Dealing with such disputes can be particularly demanding for our casehandlers, both because of the sheer volume of (frequently conflicting) medical evidence and because handling medical records and other personal information requires an especially high degree of care. We must, for instance, be alert to the fact that our investigations may uncover particularly sensitive matters about which the policyholder was previously unaware.

assessing conflicting evidence

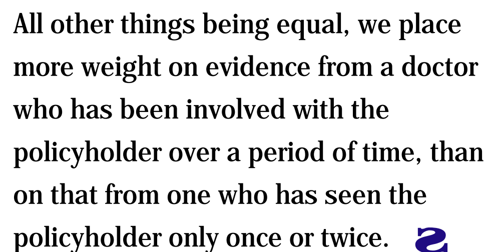
Typically, in such disputes, the policyholder's general practitioner – and perhaps a consultant or other specialist – will have expressed distinct views about the policyholder's circumstances. These views may have been contradicted by medical opinions obtained by the insurer and also by other evidence (such as video surveillance).

It is not part of our role to diagnose the policyholder's condition. We look at all the evidence before reaching an opinion on their probable circumstances – and how these relate to the insurance policy.

Given the range of circumstances we are called on to assess when we examine conflicting evidence, there can be no hard and fast rules about the weight we attach to different factors. However, these are some of the matters we will generally take into account.

- **The doctor's professional qualifications and specialisation.** We usually favour the opinions of a relevant specialist consultant over those of a general practitioner. However, we assess with caution any remarks that specialists, however eminent, make about matters that fall outside their area of specialisation.

- **The degree of knowledge that the doctor providing the evidence has of the policyholder's circumstances.** All other things being equal, we place more weight on evidence from a doctor who has been involved with the policyholder over a period of time, than on that from one who has seen the policyholder only once or twice.



... firms sometimes argue that a doctor has been too ready to 'sign-off' a policyholder as 'unfit' for work.

- **The nature of the doctor's examination.**
  So, for example, we favour reports based directly on a recent physical examination of the policyholder over those based simply on a review of notes that were made after earlier examinations.

- **How close in time the report was to the events at issue.**
  We place most weight on reports made closest in time to the events being considered.

- **The independence of the person reporting or commenting on the issues.**
  Although we take into account reports produced by the firm's staff, and observations made by the policyholder, we normally place more weight on evidence provided by more independent commentators.

- **Any special circumstances surrounding the report.**

reports by general practitioners and consultants

When we consider a doctor's report on a patient's condition, we need to bear in mind that the doctor may have used different criteria or definitions from those used by the firm.

Firms sometimes argue that a doctor has been too ready to 'sign-off' a policyholder as 'unfit' for work. Firms also consider that some doctors – when asked whether a policyholder is capable of continuing to work – place undue weight on whether suitable work is available, or on the policyholder's social and economic circumstances, rather than reporting against the specific requirements of the policy.

Conversely, we find that some doctors make over-ambitious estimates of what the policyholder can reasonably be expected to achieve. This may result from a misunderstanding about what the person's occupation entails, or perhaps from comparison with an apparently similar patient who may have been more than normally well-motivated, or have had very different circumstances to contend with.

Sometimes we find perfectly logical reasons for the apparently conflicting assessments presented to us. For example, a general practitioner's view of a relatively unusual medical condition, based on symptoms present in the early stages of the illness may – understandably – differ from the view of a consultant. The consultant has a specialist knowledge of the condition and generally sees the patient when the condition is more advanced and the symptoms may be more distinct.

Some firms use reports from occupational physicians as evidence in connection with a claim. In our view, while these reports may be helpful in forming an overall picture, they are unlikely to overturn assessments made by consultants in the relevant specialisation.

… the doctor may have used different criteria or definitions from those used by the firm.

use of 'capacity evaluation' or similar tests

Just as firms sometimes have concerns about the medical evidence that policyholders present in support of a claim, so policyholders may sometimes have severe reservations about evidence used by firms. This is particularly the case with evidence based on the results of 'capacity evaluation' or similar tests. These tests try to measure – on a consistent basis – the policyholder's ability to carry out various activities. They are most appropriate for assessing a limited range of conditions, such as back pain and muscular complaints, and they can help add to the range of medical evidence available. However, the tests are not decisive and they can often produce findings that are inconsistent with other test results.

Firms sometimes conclude that policyholders must have been exaggerating the effect of their physical symptoms if they appear not to have exerted maximum effort during a test. Substantial exaggeration is, of course, likely to raise questions about the validity of the claim. But there may be a perfectly innocent explanation for a policyholder's appearing to 'hold back' when undertaking test activities. Someone already in considerable pain, for example, may understandably be wary of any movement that might make matters worse.

We are unlikely to support firms that, having agreed to pay benefits to a policyholder, subsequently use the results of a capacity evaluation test, on their own, to justify stopping payment of those benefits.

… sometimes we find perfectly logical reasons for the apparently conflicting assessments.

use of video evidence

Firms often ask us to take into account evidence obtained by surveillance – usually by video. Inconsistencies between what a video shows a policyholder doing – and what the policyholder has told their doctor and the firm that they can manage – will not necessarily lead to the failure of the complaint. However, serious inconsistencies are likely to weaken the policyholder's case and to reduce the weight we would normally place on the relevant medical reports.

Someone who claims to be too ill to continue in work, for example, but who is then filmed carrying out a similar occupation, is unlikely to succeed with their claim.

More often, however, video evidence is ambivalent. First, it may show activity over a limited period, so it does not prove that the person can perform the activity consistently over the longer term. Second, videos seldom show activity that is of direct relevance to the dispute. So it should not automatically be assumed that the ability to perform one sort of activity indicates the ability to carry out another.

What, for example, does a trip to the supermarket demonstrate, in relation to the ability to carry out a full-time occupation? The definition of 'disability' in most policies does not require a person to be housebound. So video evidence of someone shopping, hanging out washing on the line, or making

… video surveillance seldom shows activity that is of direct relevance to the dispute.

a trip to the pub with friends is unlikely to be proof that the person fails to comply with the policy definition of 'disability'.

In assessing video evidence of a policyholder's capabilities, we exercise caution before reaching any conclusions that conflict with the medical evidence. Normally, we favour medical evidence over video evidence unless an independent medical assessment suggests that the activity shown in the video is inconsistent with previous medical reports. So where appropriate, for example, we may ask the doctor who carried out the independent medical examination, to comment on the apparent inconsistency.

additional medical reports commissioned by the ombudsman service

We expect firms to have investigated cases thoroughly before they are referred to us, and to have obtained any necessary reports. However, we may occasionally conclude that further medical reports would help us settle the dispute.

In such instances, we will appoint a relevant medical expert to review the medical evidence and/or to examine the policyholder. Where this happens, the doctor will report direct to us and it will be for us – not the firm or the policyholder – to decide which doctor to appoint and what the terms of reference will be.

case studies – assessing evidence about health in insurance disputes

■ 24/01

income protection – disability – policyholder disabled from original occupation but not disabled from 'any' occupation – policyholder's condition deteriorating – whether firm entitled to terminate benefits

Mr B, an electrician, took out an income protection policy. This would provide him with benefit for up to 24 months if he were unable to carry out his normal occupation due to disability caused by accident or sickness. The benefit would, however, stop after 24 months unless he was medically unable to perform 'any' occupation for which he was suited.

In May 1997, Mr B was injured in a road traffic accident. As a result, he suffered severe back, neck and arm pain and saw a consultant orthopaedic surgeon, who identified a degenerative condition. Mr B made a successful claim under the policy and his benefits continued after the initial 24-month period.

However, in January 2001, the firm arranged for Mr B to be examined by a consultant neurosurgeon, who concluded that Mr B might be able to undertake a 'desk job'. In November of that year, the firm appointed an investigator to carry out some video surveillance of Mr B. This showed him bending, lifting, crouching and driving without any apparent restriction. In December 2001, on the strength of this video, the firm terminated his benefits.

... we may conclude that further medical reports would help us settle the dispute.

In response to this, Mr B produced further medical evidence in support of his claim for 'total disability'. Although, as the video showed and his doctor's report confirmed, he was able to carry out some activities, he said this was only possible at the risk of his health, and that undertaking a job would aggravate his condition.

complaint rejected

We accepted that Mr B's condition had continued to deteriorate and that he was now incapable of any work. What we had to decide was whether he had met the policy definition of 'total disability' in December 2001, when the firm had stopped paying his benefit.

The medical evidence that Mr B provided at that time suggested that there were some jobs involving only 'light' duties that Mr B *could* undertake. In order to continue receiving benefits after the first 24 months, Mr B needed to meet the policy definition of 'disabled' – '*unable to perform any occupation*'. Since he did not satisfy these criteria, we concluded that the firm had been right to withdraw his benefits.

Although we did not uphold the complaint, the firm agreed to refund the premiums Mr B had paid after December 2001.

■ 24/02

income protection – disability – policyholder disabled from original occupation but able to undertake part-time work – whether entitled to any benefit – method of calculation of benefit

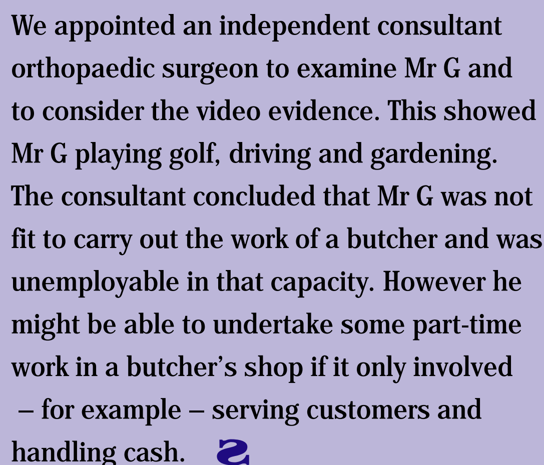
Mr G, a self-employed butcher, developed disabling back pain and claimed under his income protection insurance policy. In December 1990, the firm accepted his claim and started paying him benefits.

By 1996, Mr G was still unable to work. The firm offered to make final settlement of the claim by paying him a lump sum of £167,376. Mr G did not accept the offer and he continued to receive monthly payments.

In 1999, the firm required Mr G to attend a 'functional capacity' examination by a physiotherapist. She concluded that Mr G had not been exerting himself in the tests to his full ability, and that it was impossible to determine whether he was physically capable of returning to his former occupation. The firm had also obtained video evidence. On the basis of this and the test results, it stopped paying Mr G's benefits.

complaint upheld in part

We appointed an independent consultant orthopaedic surgeon to examine Mr G and to consider the video evidence. This showed Mr G playing golf, driving and gardening. The consultant concluded that Mr G was not fit to carry out the work of a butcher and was unemployable in that capacity. However he might be able to undertake some part-time work in a butcher's shop if it only involved – for example – serving customers and handling cash.



... we had to decide whether he had met the policy definition of 'total disability'.

The policy definition of 'disability' was very strict. Taken literally, it might mean that a policyholder's ability to carry out a minor administrative element of an otherwise physically demanding job would justify a firm's rejection of a claim. However, it is accepted market practice to treat someone as 'disabled' if they are unable to perform the 'material and substantial' duties of their ordinary occupation.

As a butcher, Mr G's main duties involved heavy physical work, with much bending and carrying. He spent most of the day on his feet. As well as preparing food, he had to lift heavy carcasses and to spend a considerable time standing behind the counter, serving customers.

When he first applied for the policy, Mr G had described his normal day's work as being split equally between 'jointing' and 'selling/serving' and the firm had insured him on this basis. The type of part-time work that the consultant had suggested he might be able to do was markedly different from this. Any difficulty Mr G might encounter in finding such work was not relevant to an assessment of his disability.

We accepted that Mr G was capable of performing some part-time work, but only in a limited and lower-skilled role. The duties involved would be materially different from his original occupation and less remunerative.

The policy did not deal clearly with this type of situation, but it did provide for the payment of a reduced benefit.
We concluded that the firm should reinstate Mr G's claim and pay him benefits calculated at 66% of the full rate. It should also make him backdated payments at this reduced rate, plus interest, from the time when it had stopped his benefits.

■ 24/03
critical illness – definition – angioplasty – whether claim invalid unless meeting strict definition of condition

Mr T took out life assurance to cover his £150,000 mortgage. The policy benefit was payable if he died or was diagnosed with a 'critical illness'. Some weeks after he took out the policy, he was diagnosed with atherosclerosis. He was advised to have balloon angioplasty to correct the narrowing of his arteries.

After Mr T submitted a claim for the policy benefit, the firm wrote to his consultant asking whether the blockage was '*at least 70% in two or more coronary arteries*'. This was the policy definition of 'angioplasty'. The consultant confirmed

that one artery was 95-99% blocked and another was 50% blocked. He said that this was a particularly serious and life-threatening condition and would have been fatal if left untreated.

Mr T was dismayed when the firm then wrote to him saying it would not pay the claim because it did not meet the terms of the policy.

complaint upheld

Insurers are, of course, entitled to decide what conditions they wish to cover. But they are obliged to make the terms of their policies clear to customers. Mr T had taken out a policy to cover him for critical illness. By any ordinary definition, he had experienced a critical illness that required urgent treatment. If his doctor had not performed balloon angioplasty, Mr T would have required bypass surgery, which would also have entitled him to claim under this policy.

Assessing the extent to which an artery is blocked is not an exact science. Firms should exercise caution in assessing cases on such a formulaic basis and should normally take account, instead, of the overall seriousness of the condition claimed for. Moreover, the firm's decision to pay benefit only to patients whose arteries were blocked by more than a specific percentage constituted an 'onerous' policy condition, so the firm should have made this very clear in its literature.

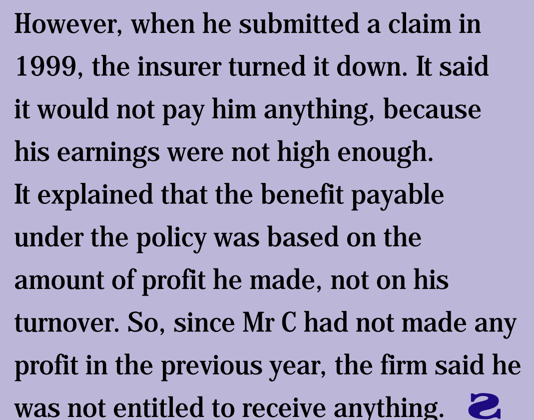
We concluded that Mr T's condition was so serious that it was not appropriate for the firm to rely on a strict, formulaic interpretation of the policy. We required it to pay the maximum we can award, £100,000 plus interest, but we recommended that the firm should also pay the balance of the claim.

■ 24/04

income protection – 'income' – self-employed policyholder – benefit assessed on earnings – policyholder not informed of restriction – whether assessment of benefit a significant restriction – whether insurer liable to assess benefit on turnover not earnings

Mr C, a self-employed catering machine repairer, took out an insurance policy in 1993 through his bank. This would pay him a monthly income if he became too ill to work. The policy said it would provide a weekly income benefit of £90 if he suffered a disability that lasted more than 13 weeks.

However, when he submitted a claim in 1999, the insurer turned it down. It said it would not pay him anything, because his earnings were not high enough. It explained that the benefit payable under the policy was based on the amount of profit he made, not on his turnover. So, since Mr C had not made any profit in the previous year, the firm said he was not entitled to receive anything.



... the firm should have made this very clear in its literature.

… if the policy had been explained properly, he would never have bought it.

Mr C was very surprised to hear this. He said that the bank had not properly explained how the policy worked and that the examples it had shown him to illustrate the potential benefits of the policy had been misleading. The bank denied that its salesman had made any error in recommending the policy. And in response to Mr C's complaint that the bank had not told him that payment of benefit depended on his earnings, it said it was not part of the salesman's responsibility to go into such matters.

complaint upheld in part

The bank had plainly failed to ensure that the policy it sold to Mr C was suitable for his circumstances. It had also failed to draw his attention to the way in which benefits would be calculated. If the policy had been explained properly, he would never have bought it, since he could not have made a successful claim unless his earnings increased significantly. He could not have obtained a policy that calculated benefits on the basis of turnover, so we did not consider the insurer was liable to meet the claim.

However, since he would not have bought the policy if the bank had explained it properly to him, we decided that the bank had to:

- reimburse Mr C the full cost of all the premiums he had paid, plus interest; *and*
- pay him £250 compensation for distress and inconvenience.

2 banking – disputed cash payments in

A number of the complaints we receive concern disputes about cash paid into bank accounts – whether over the counter or through a deposit point. Sometimes the entire payment appears to have gone missing; sometimes the firm has credited the customer's account with a smaller amount than the customer recalls paying in.

Such disputes can cause emotions to run high. Often, both firms and customers feel that their integrity is in question and they assume we will attempt to settle matters simply by deciding which party we 'believe'. But that is not what happens.

We collect all the available evidence and information so that we have as full a picture as possible of the circumstances surrounding the disputed payment. More often than not, a complaint of this type is decided on the balance of probabilities – in other words, on what, in the light of the evidence, we think is most likely to have happened. If we do not uphold the complaint, it is generally because the firm's recollection of events is more probable than the customer's, or because the customer's recollection is at odds with the documentary evidence.

The evidence we examine when we look into such disputes can include:

- any receipt issued for the payment;
- the firm's video footage (though this is often inconclusive);
- any documentary evidence from the customer of where the cash came from;
- the firm's cash reconciliation records;
- the firm's deposit point records.

We obtain a detailed statement of the customer's version of events and normally ask for corroborating statements from any third parties or witnesses involved. We may also ask for details of any accounts the customer holds with other firms, so that we can make enquiries there.

Similarly, we obtain a statement from the employee or employees involved. If there is any suspicion of fraud, we will find out whether any previous, similar complaints have been brought against that employee or branch. If they have, we will examine the firm's internal investigation papers.

Where a significant period of time has elapsed between the disputed cash payment and the customer's complaint about it, then the complaint will clearly be much more difficult to investigate. Recollections become less clear over time and documentary evidence may have been lost or destroyed as part of routine clearing of files.

Any firm that receives a complaint of this type must take care not to destroy any associated documentation. It should also make sure that any staff members involved write down their recollections of events as quickly as possible.

... both firms and customers may feel that their integrity is in question.

banking case studies – disputed cash payments in

■ 24/5

discrepancies between branch cash records and customer's deposit via self-service deposit facility

Ms J said that she paid £300 into her bank account, via the firm's self-service deposit facility, in order to meet forthcoming bills. However, the firm told her it had no record of receiving the payment.

complaint upheld

We looked at all the available evidence. Although there had been no similar complaints about that branch, there were some discrepancies in the branch cash records that the firm could not explain. Ms J appeared to be an honest and reliable witness and it was clear from her bank statements that she regularly paid in a similar amount to cover certain bills.

We concluded, on the balance of probabilities, that Ms J's recollection was likely to be correct. We therefore required the firm to make good the deposit and to pay Ms J £50 to compensate her for the inconvenience she had suffered.

■ 24/6

over-the-counter deposit – authenticity of receipt disputed

Mrs A said that she paid in £1,600 over the counter at a branch of the firm, to be credited to her credit card account. The firm said it had no record of receiving the money

... there were some discrepancies in the branch cash records that the firm could not explain.

and it disputed the authenticity of the 'receipt' she produced, which was ragged and partly illegible.

Mrs A explained the state of the receipt by saying that she had left it in the pocket of her jeans when they went in the wash.

complaint rejected

We found no evidence of any discrepancy in the branch's records of cash payments. However, those parts of Mrs A's receipt that were still legible revealed an amount that was different from the one she claimed to have paid in, together with part of an account number that was not hers. On the balance of probabilities, we thought the firm's version of events was more likely to be correct. We therefore rejected her complaint.

■ 24/7

amount of deposit disputed – 'lost' cash – deposit slip altered by firm

Mr K said that he had visited his branch to make a payment into his savings account – comprising a £1,000 cheque and £500 in cash. He said he paid the money over the counter and was given a stamped deposit slip for £1,500.

When he received his bank statement a month later, Mr K found that the firm had credited him with only £1,000. He raised this with the firm and was told this was the total amount he had paid in. Insisting that he had paid in more than this, he made a formal complaint. However, the bank maintained he must have been mistaken, so he came to us.

complaint upheld

When the firm had processed Mr K's payment, it had found no cash, only the cheque for £1,000. All the cash tills had balanced, so it concluded that the deposit slip must have been incorrect. It had therefore altered its copy of the deposit slip. The firm claimed that, following its standard practice in such situations, it would have sent Mr K a computer-generated letter telling him what it had done.

As the cashier who had stamped Mr K's deposit slip was no longer with the firm, we were unable to obtain a statement from him, but we noted that the slip had not been completed in full. It detailed the total amount paid in, but not how the payment was made up.

Although the firm said it would automatically have contacted Mr K to tell him it had adjusted its record of the amount paid in, there was no evidence it had done this. And we thought that Mr K would have complained right away had he received such a letter.

Since it seemed likely that Mr K's version of events was correct, we required the firm to credit him with £500 and to pay him £75 compensation for inconvenience.

... the firm disputed the authenticity of the 'receipt', which was ragged and partly illegible.

■ 24/8

lost receipt – customer's claim that cash withdrawals made up of notes not in circulation

Mr D, who lived in Scotland, claimed that he had deposited £1,000 in cash into his account with firm A. So he was most concerned when his bank statement showed that he had deposited just £100.

He said that the £1,000 came originally from his account with firm B. He claimed to have taken the money out over a period of weeks, withdrawing £200 a time from the cash machine. He then paid all the cash, which was entirely in £20 notes, into his account with firm A.

complaint rejected

When the dispute came to us, Mr D told us he was unable to produce the receipt that firm A had given him when he paid in the money. He said he had not checked it at the time and he had since lost it. However, he said he recalled that some of the £20 notes were not Scottish ones, but old Bank of England notes. These notes had been taken out of circulation shortly before Mr D had made the payment into his account, but Mr D said that firm A had agreed to take them.

We found no discrepancies in firm A's cash records. And although it kept records of any withdrawn notes it accepted, it had no record of the old Bank of England notes Mr D said he had paid in.

When we questioned firm B, it insisted that Mr D could not have obtained the old Bank of England notes from its Scottish cash machines. It said these were filled only with the Scottish notes it issued itself. It also pointed out that it was very unlikely for a cash-machine withdrawal for £200 to consist entirely of £20 notes; such withdrawals almost always included two £10 notes. The machine might occasionally have run out of £10 notes, but this was unlikely to have happened five times.

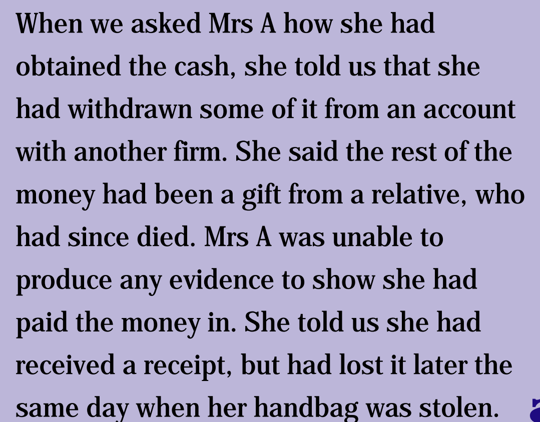
In the circumstances, it appeared unlikely that Mr D's recollection was correct and we rejected his complaint.

■ 24/9

dispute concerning transaction made four years earlier – firm had no record of customer's account – customer unable to produce relevant documentation

Mrs A's dispute concerned the £10,000 in cash that she claimed to have paid in over the counter four years earlier. The firm told her that it had no record of this transaction and no account in her name.

complaint rejected



When we asked Mrs A how she had obtained the cash, she told us that she had withdrawn some of it from an account with another firm. She said the rest of the money had been a gift from a relative, who had since died. Mrs A was unable to produce any evidence to show she had paid the money in. She told us she had received a receipt, but had lost it later the same day when her handbag was stolen.

When we asked Mrs A why she had waited four years before bringing her complaint to us, she said she had reported the incident to the police at the time but they had decided not to pursue it. She was able to produce documents showing that she had withdrawn £1,000 in cash from an account with another firm. However, she had withdrawn the money a year before she made the alleged deposit. She was unable to produce any documents relating to the rest of the money.

Having looked at all the evidence and information available, we concluded that we were unable to uphold her complaint.

... the machine might occasionally have run out of £10 notes, but this was unlikely to have happened five times.

3 availability of flood cover

This winter has again seen many homes across the United Kingdom suffering severe flood damage. In general, our experience has been that firms respond well to these difficult claims. But perhaps of more concern to many policyholders is whether they will be covered for any future flood damage when they renew their insurance.

The Association of British Insurers (ABI) has recently issued its '*Statement of Principles on the Provision of Flooding Insurance'.* This explains the circumstances in which firms that are members of the ABI will make flood cover available, and what will happen in relation to the properties that are most at risk. It describes situations where *'existing flood defences provide less protection than the Department for Environment, Food & Rural Affairs' indicative minimum standard of 1 in 75 years for urban areas'*.

In such cases, the ABI says, *'Where improvements in flood defences sufficient to meet these standards are scheduled for completion within the next 5 years, insurers will maintain flood cover for domestic properties and small businesses which they already insure. The premiums charged and other policy terms – such as excesses – will reflect the risk.'*

The ABI recognises that disputes may arise about how the statement applies to individual cases, and we have been considering the approach we should take to any of these disputes that come to us.

4 investment case studies

We do not usually deal with complaints that concern a firm's decisions about whether or not to offer cover. For example, we would not normally investigate a complaint about a firm's refusal to offer car insurance to a young driver. Such matters concern the firm's commercial judgement and, under our rules, we can dismiss complaints without considering their merits if they centre on a firm's legitimate use of its commercial judgement.

Compliance with the ABI statement would seem to represent good industry practice and, in any disputed decision to decline to renew flood cover, we would need to be satisfied that an insurer had fully complied with the statement. So firms should note that we *will* look into complaints referred to us about the availability of flood cover. A firm that fails to comply with the commitments in the ABI statement is unlikely to be making an appropriate use of its commercial judgement.

In looking at such disputes, our role will be to see whether, in its handling of the matter, the firm has complied with the ABI statement and other relevant industry requirements. It is not our role to require a firm to make flood cover (or any other cover) available where – for legitimate commercial reasons – it has decided that it does not wish to do this.

These case studies illustrate some of the complaints we have dealt with recently about a wide range of investment matters.

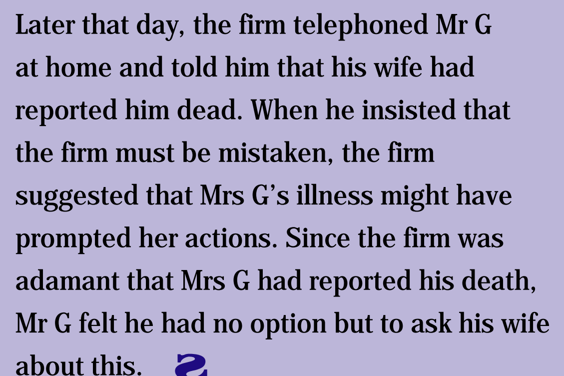
■ 24/10

pension policy – firm makes false allegations – ombudsman requires firm to apologise in person

Ten years after Mr G had set up a personal pension plan, the firm contacted his employer, RD Ltd, who contributed to the plan. The firm asked RD Ltd why it was still making contributions for Mr G, as his wife had contacted the firm several months earlier to report his death.

When RD Ltd confirmed that Mr G was still very much alive, the firm concluded that his wife must have said that he was dead so that she could get access to his pension. The firm asked to speak to Mr G on the telephone, but was told he had left early to visit his wife, who suffered from multiple sclerosis and had recently been admitted to hospital.

Later that day, the firm telephoned Mr G at home and told him that his wife had reported him dead. When he insisted that the firm must be mistaken, the firm suggested that Mrs G's illness might have prompted her actions. Since the firm was adamant that Mrs G had reported his death, Mr G felt he had no option but to ask his wife about this.



... we said that a senior member of the firm's staff should apologise in person.

She strenuously denied having any contact with the firm at all. The situation understandably caused the couple considerable distress, especially given Mrs G's fragile state of health. After Mr G complained to the firm, it eventually agreed that it must have been mistaken, and it sent his wife some flowers. Dissatisfied with the firm's handling of the matter, Mr G brought his complaint to us.

complaint upheld

The firm should have checked its facts very thoroughly before it contacted Mr G. And the poor state of Mrs G's health magnified the couple's justified distress at the way the firm had treated them.

Initially, the firm maintained that there was no question of it paying any compensation. It said that the couple had not suffered any financial loss and the firm had no legal liability. Eventually, it offered Mr G £200. He refused to accept this, saying it was an inadequate amount. We agreed. We ordered the firm to pay him £400 and we said that a senior member of the firm's staff should arrange to visit the couple to hand over the cheque and apologise in person.

■ 24/11

equity ISA – firm's actions prevent customer investing for that tax-year, but he suffered no loss

In March 2002, Mr K arranged to invest £7,000 into an equity ISA (Individual Savings Account) for the 2001/02 tax year.

He completed his application and sent in his cheque in good time for the firm to complete the transaction before 5 April.

Mr K then went abroad on business. While he was away he realised he had forgotten to transfer funds into his current account to cover the cheque he had sent the firm. He rang the firm and discovered that the cheque had been returned unpaid. He claimed that during his telephone conversation with the firm, it had agreed to re-present the cheque. By the time it did this, there would be sufficient funds in his account.

When Mr K returned to the UK, after the end of the tax-year, he found that the cheque had been returned to him – the firm had not re-presented it. He complained to the firm, demanding compensation since it had lost him the opportunity to invest for the tax-year. The firm declined any responsibility so he brought his complaint to us.

complaint settled

We established that Mr K used his full ISA allowance each year and that he had sufficient funds to have done so in 2001/02. The firm's actions had prevented him from using his full ISA-entitlement for that tax-year.

However, when we looked into what would have happened to Mr K's investment if the firm *had* re-presented his cheque before the end of the tax-year, we found that, because of poor stock market performance, the value would have fallen by approximately £400.

So although Mr K had lost his ISA allowance for 2001/02, he had not made a financial loss. Indeed, he had been able to earn interest on the money he would otherwise have put into his ISA. Any loss in tax benefits would be outweighed by the advantage he had already

received. Although inadvertently, he had benefited from the firm's failure to re-present his cheque so we did not require the firm to pay him redress.

■ 24/12

unit-linked endowment policy – mis-sold as savings vehicle

Miss C's complaint concerned the firm's mis-selling of a unit-linked endowment policy, together with life assurance, when, as an 18-year-old student, she had sought advice on a means of saving for the future.

She said she not wanted to take any risks with her financial affairs and that, since she had been single at the time with no dependents, there had been no need for any life cover.

The firm rejected her complaint. It said that the adviser had discussed various different options with Miss C at the time of the sale, and that he had not thought life cover was right for her circumstances. However, he had arranged the life cover for her because she said her parents had told her they thought it was essential.

complaint upheld

We upheld Miss C's complaint on several grounds.

There was no evidence that the adviser had properly determined Miss C's attitude to investment risk. The products he had sold were inappropriate for her circumstances at the time, and there was no evidence that he had discussed any alternatives with her. In the 'fact find' he had incorrectly described the endowment policy as carrying a low risk.

He had also noted that the aim of the investment was '*for future efficient repayment of mortgage and loans*'. This had not been Miss C's intention at the time of the sale.

We therefore ordered the firm to refund, with interest, the premiums she had paid for both policies.

■ 24/13

share capital restructuring – shareholder's loss of expectation

Mr T held shares in XY Ltd. He had read in the press that it intended to return unneeded capital to shareholders by restructuring its share capital. It would do this by replacing each existing holding of 21 old 'ordinary' shares with 17 new ordinary shares, and 21 'B' shares.

XY Ltd was offering special purchase arrangements for shareholders who sold these 'B' shares as soon as they received them. The terms of the 'B' shares were intended to discourage shareholders from keeping them, with the aim of:

- reducing the number of ordinary shares in issue;
- providing shareholders with a proportion of the original shareholding's value as capital payment, by purchasing and cancelling the 'B' shares; and
- making a corresponding reduction in XY Ltd's capital reserves.

Mr T contacted his stockbroker ('the firm') for more information. The conversation he had with the firm led him to believe that the ordinary shares would have approximately the

... the only loss he had suffered was one of expectation.

same value as his existing shares and that the 'B' shares would be a bonus. So when he subsequently received 809 ordinary shares and 1000 'B' shares, he decided to sell the 'B' shares immediately. He received £800 for them.

However, he then realised that the ordinary shares he received were worth £700 less than the firm had led him to expect. He complained to the firm, asking it to send him £700 to bring the value of these shares up to the amount he had thought they would be worth.

The firm would not do this. However, it offered to repurchase the 'B' shares for him from XY Ltd, if he returned the £800 he had received for them. This would put him back in the position he would have been in before he sold the 'B' shares. At this point, Mr T brought his complaint to us.

complaint rejected

We decided that the only loss Mr T had suffered was one of expectation, because he had thought that the ordinary shares would be worth more than they were.

Mr T had never been entitled to receive the £700 he asked the firm to pay him. His only options had been to sell the 'B' shares, or to keep them to sell at a later date.

We explained this to Mr T and, on our recommendation, he accepted the £50 that the firm offered him as a goodwill gesture.

■ 24/14

unit trust – customer dissatisfied with firm's information about fund's prospects

For several years, Mr M had held a unit trust investment with the firm. He had not obtained advice before putting his money in the unit trust since he considered himself sufficiently knowledgeable to be able to arrange his own investments.

In March 2000 he became concerned about his investment's performance. He emailed the firm for further information about the fund, so that he could assess its future prospects. In response, the firm directed him to the page on its website that dealt with queries of this kind.

The firm did not hear from Mr M again until March 2002, by which time the value of his investment had fallen further. He complained that when he had contacted the firm two years earlier, the information on its website had not been detailed enough for his needs. He argued that if the firm had given him more detailed information when he had asked for it, he would have sold his investment right away. So he considered the firm liable for the difference between what he would have got for his investment if he had cashed it in during March 2000, and its current value.

Dissatisfied with the firm's response, Mr M brought his complaint to us.

complaint rejected

The relevant pages of the company's website were no longer available but we obtained copies of the firm's annual fund reports. These reports provided exactly the kind of detailed information that Mr M had said that he needed. Like all the firm's unitholders, he had received regular copies of these reports. They were also available on the website.

In our view, the firm had taken reasonable steps to provide Mr M with information about the fund. It was not responsible for any losses he had suffered by retaining his investment. We also noted that Mr M should have gone back to the firm at the time if he was dissatisfied with the amount of information the firm had provided in March 2000, in response to his query.

■ 24/15

Maturing pension policy – firm blamed for revealing details to policyholder's separated wife

Shortly after Mr W's pension policy matured, his wife, from whom he had been separated for some time, contacted him about it. Reluctantly, but voluntarily, he gave her 50% of the maturity value.

Mr W had not told his wife about the policy and he was convinced that she had been told about it by the firm, or by someone related to one of the firm's employees. He complained to the firm that he would have been able to keep all the proceeds for himself, had it not been for its 'intervention'. When the firm rejected his complaint, he came to us.

complaint rejected

There was no evidence that any of the firm's employees or their relatives had revealed details of the policy to Mrs W. And although Mr W put forward a variety of alternative ways in which his wife might have learnt about the policy, we found nothing to back any of his theories.

We established that the policy was solely in Mr W's name and had not been assigned to anyone else. If he had chosen, voluntarily, to give his wife half of the proceeds, then this was entirely a matter between him and his wife.

Neither the firm nor anyone else could be said to have caused him financial loss. We therefore rejected the complaint.

help and advice for firms and consumer advisers

our technical advice desk can

- provide general guidance on how the ombudsman is likely to view specific issues
- explain how the ombudsman service works
- answer technical queries
- explain how the ombudsman rules affect your firm.

phone 020 7964 1400
email technical.advice@financial-ombudsman.org.uk

our external liaison team can

- visit you to discuss issues relating to the ombudsman service
- arrange for your staff to visit us
- organise or speak at seminars, workshops and conferences.

phone 020 7964 0132
email liaison.team@financial-ombudsman.org.uk

ask ombudsman news

your questions answered

timeliness targets

Q How long does the ombudsman service take to consider and resolve complaints?

A This largely depends on whether the customer and the firm both agree – at an early stage – to any recommendation or informal settlement that we may suggest – or whether either party requests the next, more formal stage of the process. The more formal stage includes detailed investigations and a full appeals process. It could involve seeking views and information from a range of experts and other people outside the ombudsman service. Obviously, this will take time, not least because some of those we need to contact may not respond to our enquiries as quickly as we would like.

In the *plan & budget* we published recently, we reported that our new targets are to close 45% of cases within three months and 80% of cases within six months. We aim to have closed 90% of cases within 9 months.

On average, we resolve around 45% of complaints at the early stage. 40% go on to the stage that requires an investigation and a formal report setting out our recommendations. Only about 15% of complaints require an individual final decision by an ombudsman. However ombudsmen are also involved indirectly at *all* stages, to make sure that their approach to different types of complaint is followed consistently at all times.

Between a third and a half of the cases where ombudsmen make formal final decisions are decided wholly or partly in the consumer's favour.

too ill to work – can firm refuse policy pay-out?

Q Can a firm refuse to pay benefits under an income protection policy simply because the policyholder's doctors can't diagnose precisely what is wrong? The doctors that my client consulted have all concluded that he is too ill to continue with his former occupation. However, the firm won't pay up. I can find nothing in the policy that says a clear diagnosis must have been reached before the claim is valid.

A In some circumstances, the fact that no agreed physical causes can be found for a patient's symptoms might cast doubt on the genuineness of their condition.

But the lack of a clear diagnosis does not, in itself, demonstrate that the firm should reject the claim. Indeed, even if the doctors treating the patient are at a loss to explain his condition, providing they agree that it prevents him from continuing with his former occupation, then the lack of a diagnosis should not affect the claim's validity.

(*for more on insurance disputes involving health, see page 3 of this issue.*)