ombudsman news

essential reading for people interested in financial complaints – and how to prevent or settle them

Financial Ombudsman Service

settling financial disputes, without taking sides

issue 61

open for credit

It has seemed like a long time coming – but at last I can welcome to the Financial Ombudsman Service the 80,000 businesses who hold consumer credit licences. We have long looked forward to this day. Consumers who have complaints about credit transactions that took place from 6 April 2007 will now be able to bring those complaints to us.

Back when I was Insurance Ombudsman, before the Financial Ombudsman Service was set up, my own concern centred on loans and payment protection insurance. Eight years ago to the month – in April 1999 – when addressing a Parliamentary Committee considering the future unified ombudsman scheme I said:

> "If I were part of a one-stop financial services ombudsman scheme, it would be very odd indeed to say to a consumer, *'We can deal with a complaint you have about the insurance that you took out which backs this loan but not about the loan.'* I would not wish to be the ombudsman who had to explain to somebody why we could do one but not the other."

So I feel relieved to be out of this awkward position at last, particularly at a time when concern about payment protection insurance has been growing.

I am grateful for the assistance we have had from consumer-credit trade associations and consumer groups, as well as from journalists – those working on everything from specialist trade magazines through to the regional press. They have all helped in getting the message about the ombudsman service out to communities where, until now, we have had less direct contact. We have done a great deal of work in preparing for this moment, and I very much hope we will be seen to have lived up to expectations.

Walter Merricks chief ombudsman

in this issue

edited and designed by the publications team at the Financial Ombudsman Service

April/May 2007

insurance case studies – non-disclosure, reckless or inadvertent?

Over the years, *ombudsman news* has regularly set out our approach to complaints involving *non-disclosure*. This is the situation where, when applying for (or renewing) insurance, a customer fails to answer a question to the best of their knowledge and belief, and as a result fails to reveal a relevant fact, or misrepresents their situation.

We are continuing to receive a significant number of cases involving non-disclosure, especially in relation to protection insurance. And we regularly receive queries – from both insurers and consumers – on aspects of non-disclosure. So we hope this selection of case studies, focusing on the distinction between *reckless* and *inadvertent* non-disclosure, will prove helpful.

Recklessness, as we use it in this context, derives from the meaning it has in law. It is a familiar and well-used term that arises in civil and criminal cases as well as in legislation. There is no statutory definition but the term has been applied in the courts on a consistent basis for many years. In a 1967 case, Lord Diplock offered the following definition:

'*It must be at least reckless, that is to say, made with actual recognition by the insured himself that a danger exists, and not caring whether or not it is averted.*'

The important point – evident from this and other cases – is that recklessness denotes a degree of *not caring* whether a disclosure is true or false. This contrasts with the situation where a lack of sufficient care and attention has resulted in an incorrect answer being given – regardless of how incorrect that answer may be. In issue 27 of *ombudsman news* (2003) we said '*non-disclosure is clearly reckless if a policyholder appears not to have had any regard for accuracy when completing the proposal form*'. This remains our position.

Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR

switchboard **020 7964 1000**
website **www.financial-ombudsman.org.uk**
consumer enquiries **0845 080 1800**
technical advice desk **020 7964 1400** (this number is for businesses and professional consumer advisers only – consumers should ring us on 0845 080 1800)

ombudsman news is printed on Challenger Offset paper – made from ECF (Elemental Chlorine-Free) wood pulps, acquired from sustainable forest reserves.

For us to conclude that a consumer's non-disclosure or misrepresentation when applying for a policy was reckless rather than inadvertent, we must be satisfied from all the evidence (including that relating to any conversation, marketing documentation, other advice or paperwork available at the time to the consumer), that in answer to a clear question the consumer:

- did not care whether their answer was true or false *and*
- understood, if only in a limited way, that an answer was required, that it was important to the insurer and that there was a consequence to it.

Signing an application form without reading it, and then leaving it with someone else to fill in, would be an example of recklessness. But it would not be reckless to sign an application form without reading it if it had been filled in by an intermediary, when you genuinely believed the intermediary had accurately recorded all of your answers.

... recklessness denotes a degree of *not caring* whether a disclosure is true or false.

case studies
non-disclosure, reckless or inadvertent?

- **61/01**

life and critical illness insurance – back and neck problems – inadvertent non-disclosure

Mr F took out life and critical illness cover in June 2002. Just five months later, in November 2002, he suffered a heart attack and submitted a claim to the insurer.

However, the insurer refused to meet the claim, on the grounds that Mr F had been reckless in failing to disclose basic information on the application form. It said that after reviewing his medical records, it had discovered that Mr F failed to disclose recurrent problems with his back and neck. He had also failed to disclose that he had made a previous application for similar cover, from a different insurer. That application had never gone ahead but had been deferred, as the insurer had asked for further information which Mr F had never provided.

Mr F complained that the insurer's stance was unreasonable. He said he had simply forgotten that he had made the earlier application. And he had forgotten to mention that he had been referred to an orthopaedic consultant two years earlier for back and neck problems. He pointed out that he *had* mentioned on the form that he suffered from depression. He had also disclosed that his mother had heart problems. And he added that, at the time

he had applied for the policy, he had been going through a particularly traumatic period caring for his wife and son, both of whom had been seriously ill.

complaint upheld

We established that Mr F's back and neck trouble had arisen after his wife had become quadriplegic, following an accident, and he had started having to lift her. And around the same time that Mr F had been referred to an orthopaedic consultant for his neck and back problems, he had been having to accompany his young son (who had a rare disease) on a number of hospital appointments.

Mr F had only the one consultation with the orthopaedic consultant, who had advised him to continue for a time with physiotherapy and medication. We accepted that, in the circumstances, Mr F had simply forgotten to mention the consultation on his application form. And we thought it understandable that Mr F had not thought he had needed to mention these back and neck problems when answering a question on the form about '*back, spine or recurrent joint disorder*'. So we accepted that his failure to disclose this information had been inadvertent.

Mr F did not dispute that he had failed to disclose the earlier insurance application. He said he had simply overlooked this. At the time of this earlier application (1998), he had been fully occupied caring for his wife and family. He had not had time to follow up the insurer's queries and to provide the clarification it needed before it could proceed with his application.

In support of his case, Mr F provided a letter from his cardiologist. This said that if Mr F had been asked to undergo a medical examination when he applied for his current policy in 2002, it was unlikely that this would have led to a diagnosis of coronary heart disease.

We decided that Mr F had not shown a reckless disregard for his answers – his oversights had been inadvertent. In the circumstances, the insurer needed to make a *proportionate* response. In other words, it should rewrite the policy on the terms it would have offered Mr F if it had known the full facts at the outset. In this particular instance, it would have excluded spinal conditions from the disability benefits provided under the policy. It would not have excluded heart attacks or refused to cover Mr F at all.

So we said the insurer should reinstate Mr F's policy – adding the spinal condition exclusion – and deal with the claim. Since no exclusion applied to Mr F's heart attack, the firm had to pay the claim in full (less any premium refund), with interest.

61/02

income protection insurance – non-disclosure after application had been made

In April 2002, Mr J applied for income protection insurance. He answered '*no*' in response to a question on the application form about whether he had received any medical treatment or had any medical consultations in the previous two years. He gave the same answer when the question was put to him during the medical examination that the insurer arranged for him in June 2002.

The application form contained a warning, reminding him he had a duty to inform the insurer immediately if – as a result of anything that happened before the start of the policy – he needed to change any of his answers.

In August 2002 Mr J developed a serious condition which he had not suffered from before. He had a number of consultations about it with his doctor, who prescribed treatment in September 2002 and certified Mr J as unfit to work for the next two months.

The insurer said it sent Mr J a letter in October 2002, confirming its acceptance of his application and asking him if there had been any change in his medical condition since he completed the application form. The policy started a week later.

Just over a year later, Mr J developed leukaemia. The insurer rejected his claim, saying he had been reckless in failing to disclose the medical condition that had arisen in August 2002. The insurer said it would not have been prepared to cover him if it had known about this condition.

Mr J said he never received the insurer's letter in October 2002. And he said that, in any event, the medical condition that had arisen in August 2002 had nothing to do with his claim for leukaemia. Unable to reach agreement with the insurer, Mr J referred his complaint to us.

complaint rejected

We thought it probable that the insurer *had* sent the letter in October 2002, even though Mr J could not recall receiving it. So we considered that by sending this letter, and by including the warning on its application form, the insurer had given Mr J adequate warning of the need to disclose any changes to his health since he had applied for the insurance. However, we noted that the insurer had not sent him a copy of his original application form with this letter, so that he could assess what changes were relevant to the insurer.

We decided that Mr J had not intended to mislead the insurer. We took into account how close – in time – the emergence of the new medical condition in August 2002 and the outcome of the consultations were to:

- the date when he applied for the insurance
- the acceptance letter *and*
- the start date of the policy.

Although, in the light of the warning letter, he should have understood the need to disclose his new condition, we recognised that a duty to disclose information after an application has been accepted is a particularly onerous requirement that few consumers anticipate.

In this case we considered that, despite the insurer's warnings, Mr J had not fully understood the need to inform the insurer of any changes to his health. So his non-disclosure had been inadvertent rather than the result of a reckless disregard for the truth of his answers.

... we decided he had not intended to mislead the insurer.

The usual remedy for inadvertent non-disclosure is to allow the insurer to rewrite the policy on the terms it would have imposed, had it known the full facts. In this case we were persuaded by the insurer's evidence that it would not have offered Mr J any cover at all, had it known about his new medical condition. So we concluded that it was fair for the insurer to:

- refuse to consider the claim
- cancel the policy from the outset *and*
- refund the premiums that Mr J had paid.

61/03

life and critical illness insurance – asthma – inadvertent non-disclosure

Mrs B applied for life and critical illness cover in March 2000 during a face-to-face meeting with a representative of the insurer, who completed the application for her.

Several years later, after Mrs B developed breast cancer, the insurer declined her claim on the grounds of reckless non-disclosure. And it *avoided* the policy (in other words, treated it as if it had never existed).

The insurer said this was an instance of reckless non-disclosure because Mrs B had failed to mention that she suffered from asthma, even though several of the questions on the application form should have prompted her to disclose this. It said that if it had it known about her asthma, it would have increased the premium.

Mrs B challenged the insurer's decision. She said she had informed the representative about her asthma at the time she applied for the policy. He had said the insurer was not interested in such '*run of the mill*' matters. He had told her there was no need to mention the condition because it was fully controlled by an inhaler and she had never had to use a nebuliser or go into hospital because of it. The insurer disputed this – and said it had a statement from the representative confirming that he would never have suggested that an applicant omitted details of any health matter, however trivial.

complaint upheld

We found that Mrs B *had* disclosed her asthma on a separate application she'd made to the insurer a few months later, through a different representative. It was clear from her medical records that Mrs B's asthma was well-controlled, and she had never needed to use a nebuliser or go into hospital because of it.

We also noticed that the application form, which the insurer's representative had completed for Mrs B, contained several mistakes. These included the fact that he had ticked the box indicating that Mrs B was a non-smoker but had also stated that she smoked an average of five cigarettes a day.

Mrs B had disclosed her asthma in a subsequent application to the same insurer, so we accepted that she had not intended to keep quiet about the condition. And in view of the mildness of her asthma, it was plausible to believe that the representative might have told her there was no need to mention it.

We could not be certain what had happened during the meeting between Mrs B and the insurer's representative. It was clear that the representative had guided her through

... if the insurer had known the facts, it would not have offered him any cover.

the application. The mistakes on the form suggested that he might not have captured accurately all the information that she gave him. However, he insisted that he had followed the correct procedure. We thought it likely that there had been a misunderstanding about what information needed to be disclosed on the form.

Mrs B had signed the declaration stating that the information on the form was true, to the best of her knowledge and belief. We were persuaded by the evidence that she had assumed the representative had recorded her answers correctly, so she had not thought she had any reason not to sign it. In any event, she had not been given a copy of the answers to check before signing.

In the circumstances, we were unable to conclude that Mrs B had been reckless in her approach to the application. There was nothing to suggest that she had not cared whether her answers were true or false. So we concluded that any non-disclosure was likely to have been inadvertent.

We required the insurer to meet the claim on a *proportionate* basis. In this case, that meant the insurer should calculate the premium that Mrs B would have been charged, if her asthma had been disclosed on her application form. It should then pay a proportion of her claim, equivalent to the proportion of this premium that she had actually been charged. It should also pay her interest on this amount.

■ 61/04

life and critical illness insurance – smoking – monitoring of blood pressure – no non-disclosure

When Mr L applied for life assurance in July 2005 he stated that he had not smoked within the previous 12 months. Asked about any medical consultations, he said he had sought advice about a hernia that had subsequently required surgery. He also disclosed that there was a history of hypertension in his family.

Five months later he submitted a claim for oesophageal cancer. The insurer rejected the claim, on the grounds of reckless non-disclosure, and it *avoided* the policy. It said that when looking into his claim it discovered that he had previously been a heavy smoker. It accepted that he had now stopped smoking. However, there was a record of his regularly having smoked one cigar a day at the start of the 12-month period in question. The insurer said Mr L should also have disclosed that his blood pressure had been monitored in the period between 8 June and 18 July 2005.

Mr L said he had only smoked cigars very occasionally since giving up heavy smoking in 1994. And he insisted that he had accurately stated on the application form that he had not smoked at all in the previous 12 months. He did not deny that his blood pressure had been monitored for a few weeks. But he said this had only been done in advance of – and in connection with – the hernia operation.

complaint upheld

On his application form, Mr L had provided clear details of his impending hernia surgery and also the family history of

hypertension. He had obviously given some attention to the application form and taken it seriously in this respect. The insurer had not sought any additional information about these matters, either on the form or subsequently.

The blood pressure monitoring had clearly been simply a preparatory step before the surgery for his hernia. It had been considered a necessary precaution because of the family history of hypertension. Mr L had disclosed both the surgery and the history of hypertension, so we did not consider that he had also been obliged to disclose the blood pressure monitoring. There was no separate question that would have required specific disclosure of it, and in any event the results of the monitoring had not merited any medical follow-up.

Mr L submitted evidence from his GP, who said he could not recall his conversation with Mr L and accepted that he might have misunderstood Mr L's history. The GP also said that the computer system on which he entered details of patients' tobacco consumption was unable to record a minimum consumption of *less* than one cigar or cigarette per day. We were satisfied, on a balance of probabilities, that Mr L had told the truth when he stated that he had not smoked in the 12 months before July 2005. So we concluded there had not been any non-disclosure in relation to his smoking. We required the insurer to meet Mr L's claim in full.

61/05

life assurance – alcoholic counselling – reckless non-disclosure

Mrs M took out two life assurance policies in November 2002. One was in her sole name and the other was a joint policy with her husband. Both application forms contained the questions:

'Do you consume alcoholic drinks?'

'Are you currently receiving any medical treatment or attention?'

'Have you ever sought or been given medical advice to reduce the level of your drinking?'

Mrs M answered '*No*' to each question.

Several years later Mrs M died. The insurer would not meet Mr M's claim because it said Mrs M had failed to disclose that, since 2000, she had been receiving treatment from a consultant psychiatrist in relation to 'cessation of drinking'. She had also failed to disclose that she had been attending Alcoholics Anonymous meetings. The insurer regarded Mrs M's non-disclosure as deliberate or reckless, and it *avoided* both policies.

Mrs M's representatives argued that she had stopped drinking in 2002. The consultant psychiatrist stated that he had been monitoring Mrs M's abstinence and not giving '*medical advice*' about reducing her drinking. He also said that he had advised Mrs M that her alcohol dependency should not be considered as an illness. However, the insurer contended that Mrs M should have realised that her history of drink problems was relevant to the insurance.

complaint rejected

We decided that Mrs M had been entitled to answer '*No*' to the question, '*Do you consume alcoholic drinks?*' She was not consuming alcohol at that time. On the question '*Are you currently receiving any medical treatment or attention?*' we were satisfied that she *had* been receiving medical treatment or attention from her consultant psychiatrist in relation to drinking. However, we recognised that her

consultant's approach was to minimise any suggestions that his role was medical, and we accepted that her incorrect answer to the question had probably been made innocently or inadvertently.

We accepted that Mrs M had stopped drinking before 2002, but it was clear that she had continued to seek regular advice to support her decision to eliminate alcohol. So we thought her answer to the question, '*Have you ever sought or been given medical advice to reduce the level of your drinking*' was incorrect. We did not agree with her representatives that advice on maintaining her abstinence was not advice '*to reduce the level of her drinking*'. We concluded that there was no evidence that Mrs M had deliberately given the wrong answer to this question. But neither was it likely that her answer had been innocent or inadvertent.

In our view, she could not have stopped to properly consider the question or her answer. Had she done so, we thought it unlikely that she would have given the answer that she did; the question would have raised issues that were fresh in her mind, and that we believed she knew were important to the insurer. We therefore regarded Mrs M's answer as reckless non-disclosure.

We accepted that the insurer would not have issued either policy if it had been aware of the true facts. Its decision to decline the claim and *avoid* both policies had therefore been justified.

... we decided that the insurer's decision had been justified.

61/06

life assurance – incorrect height and weight given – deliberate non-disclosure

When Mr K took out life assurance, he stated that he was 6 feet tall and weighed 16 stone. Following his death from a blood clot at the age of 37, just five months after taking out the policy, the insurer discovered that Mr K's actual height was 5'9" and his weight was over 21 stone. Mr K had also failed to inform the insurer about his kidney stone and gout. The insurer said that if it had known the full facts, it would have loaded the premium by 275%. It considered that his answers amounted to either reckless or deliberate non-disclosure and it *avoided* the policy.

complaint rejected

We had no reason to suppose that Mr K had not understood the form he was completing. We noted that, in response to clear questions about his health, he had failed to provide relevant information. As far as the information about his height and weight was concerned, the evidence suggested that he was aware that he was obese. We established that his weight had been recorded as 25 stone in May 1999, 24 stone in September 1999 and 21.2 stone at the post-mortem, less than five months after he had stated on the form that his weight was 16 stone.

We were satisfied, on a balance of probabilities, that at the time Mr K signed the application form he could not have believed his weight was only 16 stone. Nor could he have believed he was 6 feet tall. The disparity between his actual weight and height and the information he gave on the form was so great that it was difficult to accept that he had been unaware of it. We decided that the insurer was entitled to *avoid* the policy on the grounds that Mr K's non-disclosure had been deliberate.

complaints-handling by FSA-regulated firms: a more principles-based and outcome-focused approach

The Financial Services Authority (FSA) is developing its approach to regulation, to become more *principles-based* and *outcome-focused*.

Stuart King (head of retail intelligence at the FSA) and **David Thomas** (corporate director at the Financial Ombudsman Service) explain what this means for FSA-regulated firms and the way they handle complaints.This follows on from their explanation of the *wider-implications* process in *ombudsman news* issue 57 (October/November 2006).

the FSA is talking about 'more principles-based' regulation and being more 'outcome-focused'. What does this mean?

The FSA wants its regulatory work, and the senior management of firms, to focus more on the outcomes for consumers and others rather than on the particular ways in which firms do things – so a focus on substance, not process.

By reducing the number of prescriptive rules, the FSA will give firms more flexibility to treat their customers fairly. And focusing on outcomes will enable firms to move away from a literal and 'box-ticking' approach. Overall, the FSA will aim to produce a more effective regulatory regime.

is this a break with the past?

It's a significant shift in emphasis but principles-based regulation is not new. The FSA's regulatory approach is founded on 11 high-level principles, which describe the outcomes firms should aim to achieve and the ways in which the FSA expects firms to behave. The FSA has been moving in the direction of a more principles-based approach to regulation for some time. This is an enhancement of the FSA's long-established *risk-based* approach, where FSA resources are focused on the areas of greater risk.

Having an effective ombudsman service in place to deal with the problems that individual consumers experience is essential in enabling the FSA to focus its resources in this way. This is because consumers can have confidence that each complaint will be dealt with promptly and fairly by the ombudsman.

does this mean that eventually there will not be any detailed rules?

The FSA's approach will continue to combine the existing high-level principles with some detailed rules but the balance is changing. Greater detail will always be required in certain circumstances, particularly with more complex products. But, where possible, these too will focus on outcomes.

how will firms cope with the change?

Senior management of firms will need to take greater responsibility for aligning their business objectives with the FSA's regulatory goals. This approach needs to be embedded throughout a business, so must be led from the top.

To enable firms to rise to this challenge, the FSA has developed a range of material which will supplement the principles and help senior management think for themselves how to meet the high-level requirements. Other FSA material is being added over time, including examples of good and poor practice.

The FSA is also envisaging greater use of industry codes and guidance to help firms consider how to meet its minimum standards.

how does the FSA consider this will affect consumers?

The FSA wants to have a stronger focus on the outcomes that really matter for consumers, investors and markets. The move to a more principles-based approach is not about any lowering of standards – but about delivering these outcomes more effectively. Customers should get better treatment through the management of firms taking responsibility for running their businesses in accordance with the principles, rather than through

firms or, indeed regulators, mechanistically following detailed rules alone.

will the rules on how firms handle complaints be changed?

The FSA recently finished consulting on proposed changes to DISP 1 (the rules and guidance on how firms deal with complaints). The changes reflect the move to fewer, more outcome-focused rules, which remove some rigid processes while focusing more clearly on firms' central obligation to treat complainants fairly and deal with them promptly.

In particular, the FSA aims to clarify and emphasise the main goals of prompt, effective and fair complaint resolution, while reducing 'box ticking' and debates about insignificant process issues. The changes should provide a regime that can be swiftly grasped by firms' senior management, so they understand their own responsibilities in this area.

what does this mean for the way firms handle complaints from their customers?

The FSA expects firms to treat their customers fairly. This is one of the FSA's principles and it requires senior management to ensure the firm both thinks and works in ways that support fair treatment of all its customers. This should improve the way businesses treat their customers and reduce causes of complaint.

But when customers do have cause for complaint, the FSA expects firms to take their complaints seriously, and deal with them fairly and promptly. It also involves firms identifying the underlying causes of complaints and learning any lessons for the future.

does this change in the FSA's approach mean that ombudsman decisions will in future 'make rules'?

No. The ombudsman service is part of the statutory mechanism for maintaining consumer confidence in financial services. The ombudsman is operationally independent of the FSA and has no power to make rules for FSA-regulated firms. Its role is to act as an informal alternative to the civil courts in resolving individual disputes.

Like the FSA, the ombudsman service is concerned with firms providing fair outcomes rather than with the processes firms use. Parliament has decided that ombudsman decisions should be based on what the ombudsman considers fair and reasonable in the specific circumstances of the individual case. When considering cases, the ombudsman takes into account the law, regulatory rules, codes and good practice at the time of the relevant events.

will it change the ombudsman's approach?

No. Ombudsman decisions generally turn on disputes of fact (where the customer and the firm cannot agree what happened) or on legal principles and contract interpretation (as elaborated by courts) – rather than on the detail of FSA rules. Firms sometimes forget that they are subject to the same laws as any other business, and that the FSA rulebook is not a complete description of their legal responsibilities.

So the criteria on which the ombudsman decides complaints will not change. But in the process of simplifying its *Handbook*, the FSA is taking into account lessons learned from the ombudsman's experience.

will the rules on how the ombudsman handles complaints be affected?

The FSA and the ombudsman service are currently working on simplifying DISP 2 to 4 – which set out the scope of the ombudsman service and the procedures it follows.

The aim is to explain these more clearly and succinctly. A consultation paper will follow later this year.

but what about cases with wider implications?

Very occasionally, ombudsman decisions (like court decisions) may have wider-implications for other cases – perhaps because they affect a wide range of consumers or of firms. For these, the FSA and the ombudsman service have developed the *wider implications* process referred to in issue 57 of *ombudsman news* (Oct/Nov 2006) – and detailed at www.ombudsmanandfsa.info

and the end result?

The transition to a more principles-based regulatory environment is not about reducing the standards of complaint handling by firms, or the way that unresolved complaints are viewed and determined by the ombudsman service. But as firms adopt the principles – particularly *treating customer fairly* – into their culture, their customers should benefit from the greater flexibility this approach offers.❖

mortgage endowment complaints – *capping* where the policy remains linked to a mortgage

In November 2005 we published a technical note on *mortgage endowment redress in more complicated cases* (available in the publications section of our website, www.financial-ombudsman.org.uk). Among other things, that note sets out our general approach to mortgage endowment complaints – where the business believes the calculation of loss should be restricted (or 'capped') to a date in the past when, in its view, the consumer was aware of a problem with their policy, so could have done something about it.

The note explains that our approach is likely to depend on whether or not the policy remains linked to the consumer's mortgage. This article sets out in more detail the thinking behind our approach to cases where the policy *does* remain linked to the mortgage.

our normal approach

In 'standard' mortgage endowment mis-selling complaints, where the policy remains linked to a mortgage, we will usually tell the business to pay compensation to put the consumer in the position they would have been in, if they had taken a repayment mortgage at the outset.

We ask the business to pay compensation calculated up to the date the complaint is resolved (or the date of our final decision), in accordance with the approach set out in the FSA's guidance, *Handling Mortgage Endowment Complaints*.

We are normally unlikely to accept the argument, put forward by some businesses, that the loss calculation should be restricted (or 'capped') to a date in the past. The date proposed is usually that of the 'red' or 'amber' re-projection letter (letters warning of a high risk – or a risk – that the policy will fail to reach the target amount).

The FSA provided some guidance on this issue in its December 2004 letter to Chief Executives of some regulated firms. Among other things, it said that reducing a complainant's recoverable loss is only likely to be fair where:

- *'The options available to address the shortfall are clearly communicated and are a fair representation of **all** the options available to that complainant.*
- *The consequences of not taking action are clearly communicated,* ie *that any future compensation may be reduced due to the complainant's inaction.*
- *The business can demonstrate that it is in all the circumstances reasonable to expect the complainant to have taken action which would prevent further losses accruing.'*

when might we accept capping arguments?

Occasionally, in cases where the policy remains linked to the mortgage, we will agree that the business should calculate the consumer's recoverable losses to an earlier date (often six months *after* the consumer received a 'red' letter, by which time they ought reasonably to have realised they had cause for complaint).

This might happen in cases where:

- the consumer is particularly financially sophisticated (for example, because they work in a relevant part of the industry) *or*
- the consumer sought and received professional advice about the options and action they might take to prevent further losses from arising, but then failed to take reasonable steps.

However, as we illustrate in the second of our case studies (61/08), we do not always accept capping arguments simply because the consumer has discussed matters with an adviser.

case studies:
mortgage endowment complaints – *capping* where the policy remains linked to a mortgage

- **61/07**

a fairly typical mortgage endowment case where the business has sought to *cap* the consumer's loss

In February 2004, shortly after they received a second 'red' re-projection letter, Mr and Mrs G complained about the sale of their unit-linked endowment policy. The business upheld their complaint but restricted the loss calculation to 12 March 2001, six months after the date when it had sent Mr and Mrs G their first 'red' letter.

The business said:

- When Mr and Mrs G received the 'red' letter in September 2000, they ought reasonably to have realised that they had cause for complaint about the advice they received at the time of the sale.
- It could not be held responsible for any losses Mr and Mrs G incurred after they had become aware of the position, because there had been a '*break in the chain of causation*' when the couple received the letter.
- Once Mr and Mrs G became aware that the policy had been mis-sold – and they had chosen to retain it when they were free to dispose of it – they could not expect to receive any further compensation.
- Even if it remained responsible for the losses Mr and Mrs G incurred after they had become aware of the position, Mr and Mrs G had a duty to 'mitigate' their loss by, for example, increasing their premiums within a reasonable period of time (six months).

- However, Mr and Mrs G had not taken any action, so it did not consider it was responsible for any losses incurred because of the couple's failure to do anything.

We agreed with the business that Mr and Mrs G ought reasonably to have realised they had cause for complaint when they received the first 'red' letter. But we did *not* think it fair to conclude that the business could not be held responsible for any losses Mr and Mrs G incurred after becoming aware that they had cause for complaint. This was because:

- the policy remained linked to their mortgage (and Mr and Mrs G intended to use the policy to repay their mortgage) *and*
- the letter Mr and Mrs G had received was not about surrendering the policy, but about addressing the likelihood of it resulting in a shortfall when it matured *and*
- the business had not warned Mr and Mrs G that compensation might be reduced if they did not surrender the policy.

We did not think it was reasonable in those circumstances:

- to expect Mr and Mrs G to have surrendered their policy after they received the first 'red 'letter *or*
- for the business to treat the couple as if they should have done this.

If Mr and Mrs G had stopped using the policy in connection with their mortgage *before* they received the 'red' letter, it is likely that we would have taken a different view. In those circumstances, the couple would have had a more straightforward choice – whether (knowing the risks) they should keep the policy as a means of saving, or whether they should dispose of it.

We also considered the comments made by the business about 'mitigation' of loss. At the time Mr and Mrs G received the first 'red' letter, their loss was the difference in monetary terms between their position with their endowment mortgage and the position they would have been in, if they had taken out a repayment mortgage at the outset. Their loss was *not* the projected shortfall, although it was that shortfall, highlighted in the 'red' letters, that had prompted their complaint.

By capping the loss calculation to 12 March 2001, the business was effectively saying that at that date:

- there was a course of action Mr and Mrs G could have taken that would have prevented their position (compared with the repayment position) from deteriorating further *and*
- the couple ought reasonably to have identified and taken that course of action to avoid further losses.

We agreed that Mr and Mrs G could, in theory, have avoided (most) further losses from arising by surrendering the policy, using the surrender proceeds to reduce their mortgage, and then converting the balance to a repayment basis. However, we did not think it unreasonable that Mr and Mrs G had not identified and taken that action.

Although the 'red' letter had urged the couple to take action to address the shortfall, the options highlighted in the letter were not designed to avoid the loss for which they were now seeking compensation. If Mr and Mrs G had increased their premiums they might have made matters worse – they could have lost some of that money as well, while increasing their costs.

Mr and Mrs G were not financially sophisticated and we were not persuaded that, as a result of reading the 'red' letter, they ought to have realised what steps would prevent their position from getting worse (as compared with the position they would have been in if they had a repayment mortgage).

Nor did we think it unreasonable that they had not taken any action until they complained, after receiving the second letter. The 'red' letter had not explained the consequences of not taking action (that is, that any future compensation might be reduced). And even if Mr and Mrs G had taken the action suggested in the 'red' letter, their loss might still have increased while the policy remained in force.

We told the business to carry out a full loss calculation to the date of our decision.

61/08

a mortgage endowment case illustrating that we do not always accept arguments for 'capping' simply because the customers had discussed their situation with an adviser

In June 2000, after receiving an 'amber' re-projection letter about their endowment policy, Mr and Mrs T contacted the business and arranged to meet one of its advisers, to discuss their options. However, they took no action after this meeting – either to address the shortfall or to complain about the sale of the policy.

Nearly three years later, in April 2003, Mr and Mrs T received a 'red' re-projection letter. They then complained to the business. Although the business accepted their complaint about the sale of the policy, it said it was not responsible for the losses the couple had incurred *after* 1 August 2000. This was the date of their meeting with the adviser.

The business told us that during that meeting the adviser had explained the risks relating to the mortgage. And to back up its case, the business provided a copy of the 'fact find' and report that the adviser had prepared at the August 2000 meeting. These documents indicated that the adviser had discussed with the couple the options for addressing the shortfall, set out in the 'amber' letter. This included the option to '*wait and see*'.

There was no evidence to suggest the adviser had discussed the steps the couple might take to prevent their position from getting any worse. The adviser had not, for example, discussed surrendering their policy and converting their mortgage to a repayment basis – a step which would have prevented the losses that arose later.

The adviser had recorded that Mr and Mrs T could not afford either to put any money aside or to make a lump sum reduction or other arrangement to address the shortfall. As they had a second policy, they had decided to wait and see for the time being, and to review their position when that second policy matured in 2003.

We concluded that although they had met an adviser, Mr and Mrs T were not aware of the type of action they could take to help avoid future losses. The adviser had not explained this to them.

In the circumstances, we did not think it was reasonable for the business to cap the compensation calculation and we told it to carry out a full loss calculation to the date of decision.

ask ombudsman news

consumer credit query

a motor retailer writes...

Q My business has a consumer-credit licence and I'm aware there have been changes that affect the way we now have to handle any complaints about the loans and finance we arrange. However, I'm not as clear as I probably should be about what this means in practical terms. Can you please let me know how I can find out more about this?

A These changes have come about as a result of new legislation – the *Consumer Credit Act 2006*. From 6 April 2007 all businesses that hold a standard consumer credit licence (issued by the Office of Fair Trading) must, by law, comply with new complaints-handling requirements.

So businesses such as yours must ensure you follow proper procedures when dealing with complaints about your consumer credit activities. And your customers have the right to refer unresolved disputes about these activities to the Financial Ombudsman Service.

Our comprehensive website offers a wealth of information, including a special section about consumer credit complaints (www.financial-ombudsman.org.uk/faq/consumer_credit.html). This gives the answers to a number of the more commonly-asked questions that consumer-credit businesses ask about the Financial Ombudsman Service. It covers a range of topics including:

- the procedures that consumer-credit businesses must follow when dealing with customers' complaints
- the way in which the ombudsman service operates
- the services and help that the ombudsman service offers to the businesses it covers *and*
- where you can get more detailed information.

All businesses covered by the ombudsman are also welcome to contact our technical advice desk for informal help or guidance. The technical advice desk can help by:

- providing general guidance on how the ombudsman might view casework issues
- helping you find the information you need about the ombudsman service
- explaining how the ombudsman service works
- helping with technical queries.

You can contact our technical advice desk on 020 7964 1400 – or email technical.advice@financial-ombudsman.org.uk

ombudsman consumer leaflet

a furniture retailer emails...

Q Can you please tell me how I can get copies of the consumer leaflet, which I understand I need to send my customers if they have a complaint involving the consumer credit side of my business?

A Copies of our consumer leaflet, *your complaint and the ombudsman*, are available in packs of 25 at £5 per pack – including postage and packing. To order copies, please send us a cheque together with a completed order form (available on the publications page of our website).

We recently revised this leaflet to reflect the fact that – since 6 April 2007 – we cover businesses that have a consumer credit licence. Financial firms whose activities we *already* covered before 6 April 2007 may use up their existing supplies before ordering copies of the new version. For more information about ordering supplies of our leaflet, visit the publications page of our website (www.financial-ombudsman.org.uk).