

ombudsman news

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



settling financial disputes,
without taking sides

issue 65

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ombudsman international



Over 1,000 consumers from 88 countries around the world brought complaints to the Financial Ombudsman Service last year – relating to UK-based financial services and products.

I was reminded to check the extent of our international impact after Kitty Ussher MP, the Economic Secretary at the Treasury, recently outlined her policy on opening up the retail financial services market across Europe. She was addressing a London conference attended by 100 financial ombudsmen and regulators from over 30 countries in six continents.

The government's approach, she said, should be focused on EU consumers, and should aim to give them effective consumer protection – and access to comprehensive redress arrangements – if things go wrong.

She wanted to encourage all member states across Europe to ensure that they have dispute-resolution mechanisms in place as an *alternative* to their legal systems – and that these arrangements should be comprehensive, effective, accessible and transparent. That, she said, could really make a difference to consumers' confidence in cross-border financial products and services.

And she acknowledged that in the UK – by underpinning consumers' confidence – the Financial Ombudsman Service makes a really important contribution to the success of the UK's financial services sector. |

- I Many of the ombudsman schemes established both in Europe and elsewhere have designed their schemes on the UK model – and others are in the course of doing this. So as well as serving the redress needs of overseas consumers, the Financial Ombudsman Service is acting as a role model for other countries as they develop their consumer redress systems. And as they develop, we in turn can learn – as we certainly did at the recent conference – from their own experience.

And finally – as I highlighted in the last issue of *ombudsman news*, we have asked Lord Hunt to carry out the second three-yearly independent review of the ombudsman service, focusing on our openness and accessibility to our customers. Lord Hunt is keen to receive feedback and comments from all our users and stakeholders. You can contact him – and find out more – via his review website (www.thehuntreview.org.uk).



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disputes involving pet insurance

Pet insurance is generally designed to help pet owners cover veterinary bills and other related treatment. But it can also cover many other pet-related expenses which may arise – for things such as holiday cancellation, emergency repatriation or quarantine.

The following selection of cases shows how we have dealt with some recent complaints involving pet insurance.

... after a number of visits to the vet, her dog was diagnosed with arthritis.

■ 65/1

pet insurance – incorrect date of diagnosis on claim form results in insurer refusing claim

Mrs F had been worried about her dog, Herbie, for some time. In early July 2005, after a number of visits to the vet, Herbie was diagnosed with arthritis. Mrs F submitted her pet insurance claim immediately, and it was accepted under the terms of the insurer's 'premium policy'. This was the cover Mrs F held at the time, and it provided a maximum benefit of £4,000 (less any excess).

In July 2006 the vet gave Mrs F a continuation claim form to send to the insurer – for Herbie's long-term treatment. This said the condition had first been treated in November 2004.

The insurer refused to pay the claim. It said that in November 2004 Mrs F had only a basic insurance policy in place (with a maximum benefit of just £1,500). The insurer had already paid out more than this, so it said it could not make any further payments for Herbie's arthritis treatment – and that any future arthritis-related claims would be excluded from the policy.

Mrs F was unhappy with this. She said Herbie's condition had not been diagnosed until July 2005. By then, she was covered by the premium policy, so she thought the insurer should continue to cover Herbie's arthritis. |

She backed up her complaint with a detailed letter from the vet, confirming that Herbie had not been diagnosed with arthritis until 22 July 2005.

The insurer still insisted the claim should be dealt with under its basic policy. It said it would not ask for the 'over-payments' it had already made to be returned, but it refused to make any further payments or to meet any further claims for the cost of the arthritis treatment. Mrs F then brought her complaint to us.

complaint upheld

When we investigated the case, we found that the second claim form – sent to the

The evidence suggested that although Herbie was indeed first seen by the vet in November 2004, no diagnosis had been confirmed at that stage. It was not until the return visit in July 2005 that further investigation led to the diagnosis of arthritis.

Having considered all the evidence, including correspondence from the vet, we believed that Herbie had been diagnosed with arthritis in July 2005. We asked the insurer to review Mrs F's claim under the terms of its premium policy and to pay her any amount it owed her under the terms of that policy.



insurer in July 2006 – had been completed by the head veterinary nurse, not by the vet who had actually treated Herbie and who had completed the earlier forms. Mrs F said the nurse had clearly made a mistake when giving the date of diagnosis.

65/2

pet insurer refuses claim on grounds that policyholder 'failed to take reasonable care'

Mrs D was a keen fund-raiser for a local charity, and often took her horse to various outdoor fund-raising events for children to ride. Unfortunately, on the morning of the town's summer fair, Mrs D's horse-box overturned after becoming detached from the vehicle towing it. The horse was seriously injured, and after it had been examined by two vets it had to be put down.

Mrs D later submitted a claim for the veterinary fees she had incurred – and for the value of her horse. Initially, the insurer made an offer which would only cover the veterinary fees. However, when it received its loss adjuster's report, the insurer discovered that the horse had injured his leg in a similar accident two years earlier.

The insurer then withdrew the offer (which had not yet been formally accepted). It said it doubted Ms D's trailer had been roadworthy and it believed she was in breach of the policy condition '*to take reasonable precautions to prevent accidents, illness, loss or damage*'. It also stated that she should have disclosed the first accident at the time she renewed her policy.

Mrs D was unhappy that the insurer had withdrawn its offer. She thought it should meet her claim for both the veterinary fees *and* the value of her horse, so she brought her complaint to us.

complaint upheld

We had to consider whether Mrs D had breached the policy condition that required her to take '*reasonable care*'. In order to reject the claim on these grounds, the insurer had to demonstrate that Mrs D had been '*reckless*'. It had to show that she had realised there was a risk involved in transporting her horse but had either taken no steps to avert it, or taken steps she knew were inadequate.

We found no evidence that she had been aware of the problem – that the tow-bar was corroded. Showing the trailer to be unroadworthy would not be sufficient to demonstrate Mrs D's recklessness. The terms of the insurance policy did not require her to keep the vehicle in good condition. And in any event, she had borrowed the vehicle – it was not hers. We accepted that Mrs D had not appreciated the trailer was in a poor state of repair.

We noted that when Mrs D renewed the policy, the insurer had asked her to disclose '*any material fact*'. Mrs D told us that the injury to the horse had been so minor that it had never occurred to her to disclose it. In our view, her failure to disclose the earlier injury had been inadvertent, rather than reckless.

We told the insurer it should meet Mrs D's claim for both the veterinary fees and the value of her horse.

■ 65/3

pet insurer refuses to meet hydrotherapy claim because treatment not carried out by a vet or registered member of a relevant association

Mr and Mrs J's dog, Ruby, was very fit and active until November 2003, when she suffered a prolapsed disc. Her veterinary surgeon recommended a course of hydrotherapy. This would help Ruby to regain the use of her hind legs as well as assisting with her rehabilitation in general.

Mr J told us that he had checked the proposed treatment with the insurer and was told it would be covered.

Ruby responded very well to the hydrotherapy. However, when Mr and Mrs J submitted the claim, the insurer refused to meet it. |

... the insurer did not routinely approve all hydrotherapy claims.

It said that – unless the treatment was carried out by a vet or a member of the Canine Hydrotherapy Association (HCA) or other relevant association – the policy specifically excluded *'the cost of hiring a swimming pool, hydrotherapy pool or any other pool or hydrotherapy equipment'*. The insurer said that although it had previously paid similar claims, it would not do so in this case as neither the hydrotherapist nor the veterinary nurse were members of the HCA.

complaint upheld

We understood why the insurer did not routinely approve all hydrotherapy claims. However, we noted that Ruby's treatment had been recommended by a qualified veterinary surgeon. The clinical evidence made it clear that the hydrotherapy had contributed to her recovery and that she had derived significant benefit from it. We also noted that the therapy had been administered by an experienced veterinary nurse – the only qualified hydrotherapist within some hours travelling time from Mr and Mrs J's home.

It was true that the veterinary nurse was not a member of the HCA. However, we were satisfied that she was sufficiently well qualified and experienced to provide an appropriate level of treatment.

... against the advice of their vet – they decided to keep the kitten.



We believed that the fair and reasonable outcome in this case was for the insurer to act as if the treatment had been carried out by a member of the HCA. So we instructed the insurer to meet Mr and Mrs J's claim.

■ 65/4 pet insurance – claim rejected because it related to a pre-existing condition

After visiting a friend whose cat had recently had kittens, Mr and Mrs W became besotted with the runt of the litter. They were offered the kitten and – against the advice of their vet – decided to keep her. Mr and Mrs W named the kitten 'Pepper' and insured her straight away.

Pepper had suffered from serious health problems since her birth and eventually had to be put down. When Mr and Mrs W later came to claim £2,000 for the cost of her treatment, their insurer refused to pay. It said that the policy they had taken out excluded any pre-existing conditions.

Mr and Mrs W argued that Pepper's initial problems had been fully dealt with while she still lived with their friend. They indicated that they had phoned the insurer before taking Pepper to an animal hospital after she had become seriously ill. And they suggested that the insurer had said it would meet all veterinary and hospital charges.

The couple said these were expenses which they would not otherwise have incurred, as they would have had the kitten put down immediately rather than getting her treated at the hospital.

The insurer did not accept that it had agreed to cover all the costs. However, it said that as there might have been some misunderstanding about this, it would pay 50% of the veterinary costs as a goodwill gesture.

complaint not upheld

The vet's notes showed clearly that Mr and Mrs W had been aware, when they were offered the kitten, that she had serious unresolved health problems.

There was no doubt that the exclusion for pre-existing medical conditions applied.

The evidence did not support Mr and Mrs W's claim that the insurer had said it would cover all the fees. They had made

only a very brief call to the insurer before taking the kitten into hospital. This call was not long enough for them to have raised any significant issues. They had a more detailed conversation with the insurer four days after the kitten went into hospital – by which point most of the costs had already been incurred.

Mr and Mrs W were told by the insurer that the claim would be covered if it was an *'ongoing problem which had previously been met'*. We thought it possible that the couple had simply misunderstood the position. In the circumstances, we considered the insurer's offer to pay 50% of the charges was both fair and reasonable, and we advised Mr and Mrs W to accept it.

■ 65/5

pet insurance – claim rejected because policy limited cover for treatment of any one condition to a 12-month period

Mrs G's three-year old beagle, Jasper, was diagnosed with a condition where his rear kneecaps were constantly dislocating or slipping out of position. This was very painful and Jasper suffered to the extent that he had difficulty walking. Surgery was needed and Jasper's rear right leg was operated on in December 2001.

The vet recommended that Jasper's rear left leg should also be operated on, ideally in the first few weeks of February 2002. But Mrs G did not arrange any further treatment until September 2005. When she then submitted a claim

for the cost of the final operation, the insurer rejected it. It pointed out that Jasper’s treatment had begun in 2001 – when his condition was first identified. The policy terms clearly stated that any condition would only be covered for 12 months after the initial treatment began. Unhappy about the insurer’s decision, Mrs G brought her complaint to us.

complaint upheld

The insurer told us that, at the time of the initial claim, it would have made it clear that there was a 12-month limitation on the treatment of any one condition. Unfortunately, the insurer was unable to produce any evidence to support this.

Mrs G insisted that the limitation had not been brought to her attention. She said if she had been told she needed to have all Jasper’s treatment carried out within 12 months, she would have done this. The only reason she had waited so long was that Jasper was still very young and the leg did not appear to require immediate treatment.

We decided that the policy limitation was a significant term that the insurer should have brought to Mrs G’s attention. However, we could not be sure that this had happened.

Mrs G’s decision to postpone the treatment had not prejudiced the insurer. Mrs G had renewed her policy each year, and was not attempting to claim for more than she would have originally been entitled to. So we instructed the insurer to reimburse Mrs G for the cost of Jasper’s surgery – although we did agree to it applying a limit to the claim, based on what the treatment would have cost in 2002.



■ 65/6

pet insurance – administrative error prevents policyholder renewing policy before it lapses

Mr T’s pet insurance policy gave comprehensive cover for his expensive pair of breeding cockatiels, Rosie and Jim. The insurer who arranged the policy did not itself offer this sort of specialist cover and instead acted as an intermediary for the actual underwriter.

Towards the end of 2005, the underwriter notified the intermediary of its intention to terminate the pet insurance scheme. The intermediary arranged, at short notice, to contact all policyholders and advise them of the situation.

Cover had already been arranged with a second underwriter, and the intermediary told existing customers that while most of them would be covered by the new policy, some would not be eligible. These customers would continue to be covered under the existing arrangements with the original underwriter.

... there was a 12-month limitation on the treatment of any one condition.

At the time Mr T's policy was due for renewal – in December 2005 – one of his cockatiels, Jim, was undergoing long-term treatment for a skin condition. Because of that ongoing claim, Rosie and Jim were not eligible for cover under the new scheme and would continue to be covered by the original policy. Unfortunately, an administrative error meant that the renewal letter that contained this information was not sent to Mr T. By the time the error came to light, Mr T's renewal date had passed and the policy had lapsed.



Following negotiations with the underwriter, the original insurer offered to accept liability for the continuation of Jim's treatment. This would apply from the date Mr T's policy lapsed until the treatment was completed, or the policy limit for that claim was reached.

The insurer also offered Mr T £100 for the distress and inconvenience he had been caused. Mr T was unhappy with the situation. He wanted to receive indefinite cover for Jim's treatment on the same terms he had enjoyed previously.

complaint not upheld

When we considered the case, it was evident that even if Mr T's policy had not lapsed, he would only – at best – have been able to secure the continued benefit of cover for a further twelve months – and up to any applicable policy limit. We noted that Jim had been in the middle of treatment for his skin condition when the policy was nearing the end of its annual contract. This meant that if the policy had been renewed on the same terms, cover for his treatment would have continued either until its completion or until the relevant policy limit had been reached.

The original insurer would not have been obliged to continue to provide the same level of cover at the next policy renewal. Equally, no other pet insurer would have been under any obligation to offer the same terms as those held under the original policy. In the circumstances, we told Mr T that we were not able to require the intermediary – or either of the insurers – to provide indefinite cover for the treatment of Jim's skin condition.



om•buds•man

noun (pl. -men)

[Swedish, from *ombud* commissioner, agent, repr]

An official appointed to investigate individuals' complaints against maladministration, esp. that of public authorities; esp a British official of this kind (officially called the Parliamentary Commissioner for Administration), first appointed 1967.

the ombudsmen of the Financial Ombudsman Service

this month's ombudsman focus answers some of the questions we're most frequently asked about our ombudsmen



who exactly is 'the ombudsman'?

We actually have not just one ombudsman but a panel of them. This is headed up by our chief ombudsman, Walter Merricks, together with the two principal ombudsmen – decisions director, Tony Boorman, and corporate director, David Thomas. Alongside them are our four lead ombudsmen and 24 ombudsmen.

how does someone get to be an ombudsman?

Appointments to the statutory panel of ombudsmen are made under paragraphs 4 and 5 of schedule 17 of the *Financial Services and Markets Act 2000*. These appointments are made by our board of non-executive directors, who are themselves appointed as public-interest members on terms that secure their independence from those whose disputes we settle.

The board is required by law to appoint ombudsmen who have appropriate qualifications and experience – and they appoint ombudsmen on terms that ensure their independence.

and what sort of experience do ombudsmen need?

Our ombudsmen come from a wide range of backgrounds, as can be seen from their biographical details on our website (in the section 'about us'). Some have worked previously as solicitors or barristers – in private practice, a corporate environment or for a government department or agency.

Our panel also includes several former bank or building society managers and senior executives from other areas of financial services – as well as accountants and actuaries, and former regulators and compliance consultants.

The diversity of experience our ombudsman panel can draw on is well-illustrated by the types of organisations where individual ombudsmen worked before joining us.

In addition to some of the UK's major financial and accountancy firms, this includes the Audit Commission, the Serious Fraud Office, the Office of Fair Trading, the Department of Business, Enterprise and Regulatory Reform, the Association of Certified Chartered Accountants, Lloyd's of London, the Law Society, the Insolvency Service, the Office for the Supervision of Solicitors, the Police Complaints Authority, Ofgem (the energy regulator) and Ofcom.

A number of panel members also gained valuable experience in one or other of our predecessor complaints-handling organisations – such as the Office of the Banking Ombudsman, the Insurance

Ombudsman Bureau, the Office of the Building Societies Ombudsman and the Personal Investment Authority Ombudsman Bureau.

what's the role of ombudsmen in complaints-handling?

Our process for handling disputes between consumers and financial services companies is designed to ensure that as many as possible of the cases referred to us can be dealt with at an early stage.

The vast majority of these disputes are resolved informally by our adjudicators. But in around one in ten cases it is not possible to reach an agreement between the customer and the financial services business. So here we appoint one of our ombudsmen to review the case and make a final decision.

When an ombudsman becomes directly involved in a dispute at this stage, they will carry out their own independent review of the complaint before issuing a final decision. This is the last 'appeal' stage of a procedure that will have involved a number of reviews – at increasing levels of formality.

It is the end of our process and neither the business nor the consumer can appeal against an

ombudsman's decision by going to another ombudsman. Even the chief ombudsman cannot alter an ombudsman's decision once it has been made.

As long as the consumer accepts an ombudsman's final decision – within the timescale set down by the ombudsman dealing with the case – then that decision is binding on both the consumer and the business.

If the ombudsman concludes that the business was in the wrong, then it is required by law to do what the ombudsman has decided is necessary to put things right for the consumer. In the unlikely event that a business fails to comply with the decision, the consumer can go to court to get the decision enforced.

where does the ombudsman get the power to make these decisions?

These powers are set out in the *Financial Services and Markets Act 2000* and they include the power to instruct a business to do what is necessary to put things right for the consumer, where the business was in the wrong.

Depending on the individual case, this could involve anything from telling the business to amend incorrect

information on a customer's credit-reference file through to paying a customer compensation. The ombudsman has the power to require the business to pay up to £100,000 (plus interest) and the ombudsman can recommend that larger sums are paid. But in most cases where an ombudsman tells a business to pay compensation to its customer, the amount involved is much less than this.

do different ombudsmen have different roles?

All our ombudsmen – whatever their official job titles – are members of the statutory ombudsman panel and have the same powers in handling individual cases. In practice most of our ombudsmen specialise in deciding cases in a particular area of casework. The ombudsmen working in each casework area meet weekly to discuss issues that are specific to that sector. And the entire panel meets regularly to enable the ombudsmen to discuss issues arising in complaints – so as to share knowledge and help ensure consistency of approach.

The four lead ombudsmen – Jane Hingston, Peter Hinchliffe, Caroline Mitchell and Caroline Wayman – are specifically responsible for the four main |

areas of our casework – banking & credit, insurance, investment & pensions, and mortgage endowments respectively. They lead the ombudsman teams working in these casework areas and keep in touch with our stakeholders in their sector.

The two principal ombudsmen have very specific roles. Decisions director, Tony Boorman, supports the chief ombudsman by managing the teams of ombudsmen, co-ordinating their work and ensuring the consistency of approach and decisions across all areas of our casework.

Corporate director, David Thomas, supports the chief ombudsman in the area of corporate policy. This includes strategic planning; legislation and rules; relations with government, regulators and the European Commission; our process for considering wider implications issues; and coordinating the work of our policy, legal and service review teams.

The chief ombudsman, Walter Merricks is – in effect – the chief executive of the Financial

Ombudsman Service. He leads the senior executive team and is accountable to the board for the performance of the organisation as a whole. So he rarely gets involved in individual cases – and then only if they are cases of particular significance and wider implications. But he is, of course, involved in managing the impact of different areas of complaint, and of major financial issues affecting consumers.

how do ombudsmen and adjudicators work together?

In addition to extensive experience in all aspects of dispute-resolution, each of our ombudsmen has specialist subject knowledge, ranging – ombudsman to ombudsman – from medical insurance to consumer credit.

The ombudsmen hold regular meetings with adjudicators, to keep everyone up-to-date with legal and regulatory developments and to help ensure a consistent approach to the handling of individual cases. This also gives the ombudsmen the opportunity to learn about any emerging trends in the types of complaint that are just

starting to reach us – but that have not yet escalated to a stage requiring an ombudsman’s direct involvement.

can I get to meet the ombudsmen personally?

We resolve most disputes between consumers and businesses without the need for face-to-face meetings. But ombudsmen devote a significant amount of time to meeting stakeholders in the financial services and consumer-advice sectors – including speaking at seminars and taking part in media interviews.

and finally – no ombudswomen then?

The gender-neutral word ‘ombuds’ is widely used in some parts of the world, including America and Australia. However, the word ‘ombudsman’ – which is Swedish – is not itself gender-specific. We don’t differentiate between ombudsmen and ombudswomen. But in case you were wondering, 10 of the 31 members of our panel of ombudsmen are women. ❖

case studies illustrating the diversity of disputes handled by the ombudsman service

The ombudsman service is able to look at complaints about a very wide range of financial matters, ranging from banking, insurance, mortgages and pensions to credit and store cards, hire purchase and pawnbroking.

This selection of recent case studies illustrates the breadth and diversity of the disputes we handle and includes:

- a claim made under a marine insurance policy after an explosion on a boat
- a dispute about interest payments on a mortgage taken out with a credit union
- a complaint about advice to invest in a film partnership
- a claim made by a builder, under his contractors' all-risks commercial insurance policy, for serious fire damage; *and*
- a customer's problems in getting an electronic payment company to refund her money after the concert tickets she bought over the internet failed to arrive.

■ 65/7

marine insurance – whether explosion and resulting damage caused by policyholder's *'recklessness'* while installing gas heater in cabin of his boat

Mr A was devastated when he had a phone call to say his boat had been badly damaged by an explosion in the cabin. Since buying the boat a year earlier he had put a great deal of money and effort into renovating it and had spent almost every weekend – and most of his annual leave – on the boat.

After inspecting the damage, Mr A put in a claim under his marine insurance policy. However, the insurer refused to pay out. It said that, in installing a gas heater in the cabin, Mr A had *'knowingly taken insufficient measures to avert the risk of a faulty and dangerous installation'*. The insurer said that this constituted *'recklessness'* and was therefore a breach of a policy condition.

The insurer based its view on a report prepared by the marine surveyor it had appointed to inspect the damage. The surveyor concluded that the cause of the explosion was the gas heater Mr A had installed in the cabin.

Mr A disputed the surveyor's conclusions. He was not convinced that the heater *had* caused the explosion and he put forward several alternative theories.

He strenuously denied that he had acted recklessly in installing the heater, and said that he had considerable experience in installing such appliances correctly and had taken appropriate care. |

When the insurer insisted that the circumstances of the case meant that it was not obliged to meet Mr A's claim, he brought his complaint to us.

complaint upheld

To decide whether the insurance company was entitled to refuse Mr A's claim, we needed to consider whether Mr A had been reckless when he installed the gas appliance. In other words, we had to try and establish whether he failed to take adequate measures to avert the risk of a faulty and dangerous installation.

In reaching its conclusions on the case, the insurer had relied heavily on the advice of the marine surveyor. So we reviewed the surveyor's report and his subsequent correspondence with the insurer.

We were concerned by some of the surveyor's findings. For example, he had noted that the heater was not of a type intended for use '*in a marine situation*'. However, our investigations showed that this was not the case.

We also noted that in response to a written query by the insurer, the surveyor had said that he did not feel Mr A had been '*reckless*' when installing the heater, merely that he had '*probably been unaware of the perils involved*.'

In the light of the available evidence, we concluded that Mr A *had* understood the risks and had taken appropriate steps to ensure the heater was installed safely.

He had not, therefore, acted '*recklessly*'. We told the insurer it should deal with the claim, in accordance with the terms of the policy.

■ 65/8

consumer charged additional interest by credit union because of delays in applying monthly mortgage repayments to her mortgage account

Ms T took out a mortgage loan from her local credit union. She arranged for her employer to send the credit union an amount of money each month, direct from her salary, to cover her monthly mortgage repayment.

For some while everything appeared to be running smoothly, but then Ms T discovered that the credit union had been charging additional interest. This appeared to be because her monthly mortgage repayments had frequently not been credited to her account until two or three days after the date they were due.

Ms T complained to the credit union, saying that since the payments were made automatically from her salary, the delays must be down to the credit union's slowness in applying the payments to her account. She said it was unfair that she was being penalised for this and she asked for a refund of the extra interest she had been charged. She calculated that the amount she was owed was over £2,000.

The credit union denied that it had been responsible for the problem, but it

offered Ms T a goodwill payment of £25. Extremely unhappy with this response, Ms T then brought her complaint to us.

complaint not upheld

Our investigation showed that the problem had come about because of inefficiencies on the part of Ms T's employer, when transferring money direct from Ms T's salary to the credit union. So the delays were the fault of Ms T's employer, not the credit union.

When calculating the amount of additional interest she had been charged, Ms T had assumed the interest would have been based on the whole of the mortgage debt each month. In fact, it had been based just on the amount of the delayed mortgage repayment.

We were therefore able to reassure her that the actual amount of additional interest she had paid in total was very small. It was certainly less than the £25 that the credit union had offered as a goodwill gesture – and that it confirmed it was still prepared to pay her.

- 65/9 couple inappropriately advised to invest in a film partnership when seeking to reduce their tax liability

Mr and Mrs E had their own limited company, which was their main business. As its profits were below the relevant limit, the company qualified for small companies' tax relief – so less tax was payable.

They consulted Mr J, a financial adviser, about how best to invest some of their spare capital, while also reducing their tax liability as far as possible. Acting on the advice they were given, the couple became investors in a film partnership. Such investments qualify for special tax treatment.

Not long afterwards, Mr and Mrs E were surprised to discover that their tax position had worsened. For tax purposes, the film partnership was treated as an *associate* of the limited company. This meant the small companies' tax relief they received in respect of their limited company had been halved, and the amount of tax payable increased.

Mr J rejected the couple's complaint about the advice he had given them. He said this had been correct at the time they had consulted him. It was only at a later date that the interpretation of the relevant tax legislation had changed – as a result of the final appeal hearing in the court case of *R v Inland Revenue Commissioners ex parte Newfields Developments Ltd* in 2001.

Mr and Mrs E remained unhappy with the situation and they brought their complaint to us.

complaint upheld

When we looked into the case it became clear that the adviser had not understood the special rules that apply to film partnerships. He had not looked properly into Mr and Mrs E's financial and tax position before advising them, and should have realised the tax implications of their main business being a limited company.

The tax legislation under which Mr and Mrs E were caught out had already been in existence for some years when Mr J advised them. It was true that the final appeal in the *Newfields Developments* case had come *after* the couple had sought advice. However, the first decision in the case (which was upheld in the final appeal) had been issued almost a year before Mr and Mrs E had sought advice from Mr J.

We decided that Mr J should have been aware of the implications of the first court decision and should have informed Mr and Mrs E of the risk that it would be upheld on appeal. If he had done this, Mr and Mrs E would never have invested in the film partnership – they wanted to reduce their tax not increase it.

So we ordered Mr J to compensate Mr and Mrs E for the extra tax payable as a result of his poor advice.

.....

- **65/10**
consumer credit – hire purchase company breaches consumer confidentiality when dealing with a customer’s arrears

Miss C lived at home with her elderly parents. They disapproved very strongly of any form of credit, so she thought it best not to reveal that she had taken out a hire purchase agreement in order to buy them a new 45-inch television. This was a replacement for their existing television – a much smaller and very out-of-date model that no longer worked properly and was beyond repair.

Her parents were delighted with the new television, particularly as Miss C had led them to believe she had been able to pay for it outright, after receiving a large and unexpected bonus from her employer. But despite her best intentions, Miss C found it quite a struggle to keep up with the weekly repayments and it wasn’t long before she had built up quite substantial arrears.

She was out at work when a representative of the hire purchase company rang her on her home phone number to discuss the arrears. He was far from discreet and the message he left with Miss C’s mother, who had answered the phone, made it very clear that Miss C had bought the television on hire purchase and had been having difficulties affording the repayments.

A few days later, the same representative visited Miss C’s home to serve notice that the hire purchase agreement would be terminated. Miss C claimed that the representative had been extremely rude and aggressive during the visit, and a few days later she made a formal complaint.

She said the company had behaved in a very unprofessional manner and she objected – in particular – to its failure to respect the confidentiality of its financial relationship with her. Miss C would have liked to keep the television and to work out a way of bringing her repayments up to date. However, once her parents had become aware of the hire purchase arrangement, she felt she had no alternative but to give up the television altogether – which was a huge disappointment to the whole family.

complaint upheld

Miss C referred the matter to us when the hire purchase company failed to respond to her complaint. We were satisfied that the company had breached its duty of confidentiality to Miss C when it disclosed information about her hire purchase agreement – and the arrears – to her mother. And the company admitted that it had failed to serve the termination notice in a professional manner.

These actions had caused Miss C significant embarrassment and distress. Our normal approach in such situations is to assess a suitable amount to be paid as compensation. However, Miss C said she was not bothered about that. All she really wanted was a television set.

After we discussed the situation with the hire purchase company, it offered to compensate Miss C by giving her a smaller, second-hand television set, which she was happy to accept.

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- 65/11 stockbroker persuades client to invest in penny shares, despite client’s confusion about the level of risk involved

Mr G decided to buy some penny shares after a stockbroker had contacted him, recommending the shares.

The stockbroker explained to Mr G that as he was a new client he would need to complete various forms and open an account before the sale could go ahead. Mr G duly completed, signed and returned the forms.

One of the forms asked about any investment restrictions, related to the client’s attitude to risk. In response to this question, Mr G said he did not want to invest in anything that involved ‘*above normal risk*’.

This restriction, rightly, caused the stockbroker concern. Apart from the difficulty of knowing what Mr G meant by ‘*above normal risk*’, the stockbroker had already recommended what he considered to be high-risk shares to Mr G.

So he phoned Mr G to try and clarify the position. After some discussion, Mr G agreed that the stockbroker should go ahead and buy the shares for him.

Some months later, after the shares had fallen considerably in value, Mr G complained to the stockbroker, saying he had been at fault in selling him the penny shares. Mr G said he had not wanted to take so great a risk with his investment. When the stockbroker rejected the complaint, Mr G came to us.

complaint upheld

As part of our investigation into the complaint, we asked the stockbroker to let us have a tape recording of the telephone conversation with Mr G, after Mr G had returned the forms.

In the course of that conversation, Mr G had said that he did not want ‘*anything speculative*’. The stockbroker had said ‘*Well this particular form of investment is speculative – you do understand that don’t you?*’ Mr G had said he didn’t understand that to be the case. |

There then followed a brief conversation in which the stockbroker tried to explain that the shares were higher-risk than the blue chip shares that Mr G had mentioned buying in the past. It was not clear, however, that Mr G had understood this. In the end Mr G told the stockbroker to go ahead and buy the penny shares.

When making his complaint to us, Mr G said that he felt he was out of his depth. We agreed. It was clear to us that the stockbroker was more interested in selling the shares to Mr G than in ensuring they were suitable for him.

Having established that Mr G did not want anything that was ‘speculative’ and ‘above normal risk’ – and that he did not really understand the concept of risk – the stockbroker should not then have continued with the sale. Nor should he have sold Mr G similarly risky shares a couple of months after selling him the penny shares. We said the stockbroker should refund all the money Mr G had invested, together with interest.

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- 65/12 contractors’ all-risks commercial insurance policy – liabilities to third parties – claim for serious fire damage during renovation work – whether claim can be dismissed on grounds of contractor’s carelessness and breach of policy condition

Mr K bought a large house that needed major restoration. It was while this work was taking place that there was a serious fire, thought to have been caused by a

blowtorch used by one of the builders. The estimate for repairing the damage looked like totalling at least £750,000 and the building contractor, Mr B, put in a claim under his contractors’ all-risks commercial insurance policy for liabilities to third parties.

He was extremely surprised when the insurer rejected the claim. It said he had breached a specific policy condition regarding the preparations necessary during the use of heat in building works. The insurer said that it could also dismiss the claim on the grounds of the builder’s carelessness.

Mr B complained to the insurer that the specific policy condition it said he had breached had not been part of his insurance contract, so he could not be bound by it. The insurer disagreed. After a lengthy dispute about which of several slightly different versions of the policy condition applied in this case, and about the precise legal interpretation of these different versions, Mr B referred the complaint to us.

complaint upheld

We concluded that the policy condition could properly be considered a part of Mr B’s insurance contract. The differences in the wording of the various versions of the policy condition were immaterial as far as this specific dispute was concerned. That was because none of the versions explained exactly what policyholders were expected to do – over and above taking standard fire-prevention precautions – in order to comply with the policy condition. We were satisfied from the evidence that Mr B *had* ensured his

staff had taken all standard precautions. There was nothing to substantiate the insurer's view that it could also reject the claim on the grounds of the contractor's carelessness. So we said the insurer should deal with the claim. It agreed to our recommendation that that it should pay the full amount due, even if this came to more than £100,000 – the maximum award we have the power to insist on in any individual case.

■ 65/13

electronic payment company declines to deal with customer's complaint about non-delivery of tickets bought over the internet

In early February Miss A bought a pair of concert tickets over the internet, making an electronic payment. The concert – featuring her favourite singer – was scheduled for the first week of August and there was a message on the concert website saying that tickets would not be sent out until four weeks before the event.

However, Miss A failed to notice this. So when the tickets had still not arrived by the beginning of March, she assumed that they had gone astray. She therefore sent a formal claim to the electronic payment company.

The company explained that the tickets had not yet been sent out – but that she would get them in the first week of July. So Miss A agreed to withdraw her claim. However, by the beginning of August the tickets had still not arrived. Miss A contacted the electronic payment

company again – saying she needed to re-open the claim for the missing tickets. However, she was told she could not do that. Citing the terms of its user agreement, the company's representative told her that it was not possible to re-open a claim that had previously been resolved. Unable to get any further, Miss A referred the matter to us.

complaint upheld

The electronic payment company's user agreement did indeed state that once a claim has been raised and closed it cannot be re-opened. And the company insisted on sticking to this policy in all circumstances.

In our view, Miss A was fairly relying on the electronic payment company's advertised 'buyer protection policy' to ensure that her money would be refunded if the tickets failed to arrive. The policy restriction – that a closed claim could not be re-opened – was not featured particularly prominently in the information that users were given. And we were unable to conclude that, in this particular case, it had been clearly brought to Miss A's attention.

We also thought that, if Miss A had known of the restriction, she would not have agreed to 'close' the complaint after she had first contacted the company about the missing tickets. In the light of this, we upheld the complaint and told the business that it should refund in full the amount Miss A had paid for the tickets.

payment protection disputes

a money adviser at a free debt-advice service emails ...

Q With payment protection insurance under scrutiny from the media, regulators and consumer groups, is the ombudsman seeing more complaints about this type of insurance?

A Yes. Last year saw a 39% increase in the number of disputes referred to us about payment protection insurance (sometimes called 'loan protection' or 'PPI'). And it looks as though this year the number of disputes we deal with involving these policies could double – to over 4,000 cases.

Broadly, we see three types of complaint involving loan protection insurance. The first is where a claim on a payment protection policy is turned down. In other words, the consumer has bought a policy and made a claim on it – but the insurer says it is entitled to reject the claim under the terms of the policy.

The second type of complaint we see involves payment protection policies that may have been 'mis-sold'. This might be the case if, for example, a consumer did not realise they were taking out a policy that they did not actually want; or if the policy was not properly described to the consumer.

The third type of problem involves disputes about refunds of premiums – where the consumer has paid for a payment protection policy with an up-front single premium (which is frequently added to the loan). If the consumer pays off the loan early, only a small refund may be available – and this can give rise to complaints. |

Our factsheet on payment protection insurance gives more information about the issues which crop up most frequently in the disputes we see involving this type of insurance. It is part of our series of consumer factsheets, available from the publications page of our website (www.financial-ombudsman.org.uk).

missing the post

an independent financial adviser emails ...

Q Luckily – during the recent postal strike – my firm didn't need to send any of our clients a final response letter to a complaint. I guess we could have made sure we met the 8-week deadline for sending out the letter by emailing it to the client. But we'd not have been able to send your consumer leaflet that needs to accompany the letter.

In case the postal strikes return in the coming months, I'd appreciate knowing whether the Financial Ombudsman Service would allow us to email an electronic version of the leaflet to customers, followed up by a hard copy when the post resumes.

A In exceptional circumstances, where the postal service is seriously disrupted and you need to send a customer a final response letter by email, you might like to consider emailing your client a link to the following page of our website (www.financial-ombudsman.org.uk/publications/consumer-leaflet.htm).

In order to meet the regulatory requirements you would, of course, need to follow this up by sending the customer a hard copy version of our consumer leaflet, *your complaint and the ombudsman*, as soon as the postal service resumed.

ombudsman news gives general information on the position at the date of publication. It is not a definitive statement of the law, our approach or our procedure. The illustrative case studies are based broadly on real-life cases, but are not precedents. Individual cases are decided on their own facts.