DRN-3537106

The complaint

Mr and Mrs R complained that Sense Network Limited ('Sense') incorrectly told Mrs R she couldn't claim on a serious illness policy, and then mis-sold a protection policy to them.

What happened

The background to this complaint is well known to both parties. So, I'll only provide an overview of key events here. Mr R was a joint policy holder on the relevant policies but, for ease, I've largely referred to actions and comments as those of Mrs R.

Mrs R had been a client of Sense since around 2008. In January 2010, Mr and Mrs R were buying a new home and approached their Sense Independent Financial Adviser (IFA) about taking out a mortgage and protection policies. It's the protection policies that are the subject of this decision. The policy taken out at that time was a joint decreasing term life and serious illness plan for a term of 25 years. The sum assured matched the mortgage amount of just under £190,000. I'll refer to the underwriter of this plan as "Company A".

In May 2011, Mr and Mrs R then took out two single, level term life assurance policies, with the assistance of the same Sense adviser, as Mrs R had recently given birth. The sum assured for each of the policies was £200,000 and the term was 20 years. I'll refer to the underwriter of these plans as "Company B".

Mrs R was unfortunately diagnosed with skin cancer in October 2011. She underwent treatment, was given a very positive prognosis and no further treatment was required.

In January 2012 Mrs R arranged to meet with the Sense adviser and an additional joint life, serious illness and income protection policy was taken out at that time with Company A. Looking only at the life and critical illness part of the policy, this provided decreasing term life cover of £365,000 and around £160,000 of serious illness cover. The policy term was 23 years.

The policy taken out in January 2010 was cancelled by Company A in May 2012, as Mrs R had cancelled the direct debit several months earlier and premiums were not paid.

Mrs R submitted a claim to Company A in late 2020 in relation to her 2011 cancer diagnosis, under the policy that was in place in October 2011. Company A accepted the claim in January 2021 and paid a settlement of £46,651.81. Company A said Mrs R should have notified it of her claim within six months of her diagnosis and, as this didn't happen, no interest would be paid. Company A also said Mrs R's diagnosis wasn't disclosed to it when she later applied for two other policies in 2012. It said its underwriters confirmed that had it been aware of her diagnosis of melanoma, it wouldn't have offered these policies. As a result, it refunded the premiums on both, totalling around £2,500.

Mrs R complained to Sense. She said she told the Sense adviser back in 2012 about her cancer diagnosis, and rather than make a claim for her, the adviser sold her a new policy and told her she was covered from that point on. Mrs R asked Sense to pay interest on the

late claim settlement, as well as £750 compensation for the distress and inconvenience she experienced.

Sense responded and said as it wasn't there during the meeting between its adviser and Mrs R, it relied on documentation prepared at the time. Sense said this showed Mrs R had a shortfall in cover and the meeting in 2012 took place to arrange appropriate cover.

Sense said its adviser had asked for the medical information required on the application form and the responses noted were clearly from Mrs R. It said it might have been the case that Mrs R was advised by her doctor that the lesion was benign, and this was what she told its adviser. Sense said it would normally provide clients with details of information supplied and policy documentation, so they could review it and report any inaccuracies to the Sense adviser.

Sense said Mrs R could have made a claim either directly or indirectly with the insurer. It said had its adviser been made aware of an illness that might be covered by an existing policy, he would have assisted her and contacted the insurer. Sense also thought the complaint had been brought out of time by Mrs R, and so wasn't one this Service could consider.

Mrs R remained unhappy and so complained to this Service. Our Investigator said Mrs R's complaint had been brought to this Service in time and partially upheld it. He thought a conversation about Mrs R's health took place in 2012 because some information was disclosed on the 2012 application. But he felt the documents relied on didn't say anything about Mrs R disclosing the extent of her condition. He said advisers don't assess claims, this is a task for the underwriter. So he didn't think there was enough information to fairly say that Sense was aware of the extent of Mrs R's diagnosis and had advised her not to submit a claim.

But our Investigator thought the 2012 policy was mis-sold. He said the income and expenditure prepared at the time didn't properly reflect whether this new policy was affordable. And there was no reason for this policy to replace the policy taken out in 2010, as the earlier policy offered broader serious illness cover, which the fact find said Mrs R wanted. Our Investigator said the 2012 policy premiums had already been refunded by Company A, but Sense should pay interest of 8% per year from the point the policy started to when it was refunded, and the interest calculations could be made on a month by month basis. He also suggested £250 for distress and inconvenience caused.

Mrs R didn't agree with what our Investigator said so this came to me for a decision.

I issued a provisional decision on 28 April 2022. I said I intended to uphold Mrs R's complaint as I thought it was more likely than not that the actions of the Sense adviser caused Mrs R to be in the position where a claim was not submitted to Company A in 2012, when it could have been. I said I intended to ask Sense to pay interest on the settlement amount from Company A at 8% per annum simple from 14 March 2012 to the date Company A settled the claim in 2021.

I said I also intended to uphold Mrs R's mis-sale complaint, although I didn't intend to ask Sense to take any further action as Company A had already refunded the premiums on the mis-sold policies. I said Sense should pay Mrs R £250 for the distress and inconvenience caused.

Both parties were given the opportunity to respond. Mrs R responded and agreed with the outcome. Sense also responded and didn't have any further comments to make.

I am now in a position to issue a final decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Sense says Mrs R's complaint has been brought outside the relevant time limits. But I'm satisfied this Service can consider Mrs R's complaint. I'll explain why.

Our Service can consider a wide variety of complaints about financial services, but we aren't free to look into every complaint that's referred to us. The rules that set out what complaints we can consider are the Dispute Resolution (DISP) rules set out in the Financial Conduct Authority handbook.

One of these rules (DISP 2.8.2 R) says we cannot consider a complaint, unless the business consents, if it was referred to us more than:

(a) six years after the event complained of; or (if later)
(b) three years from the date on which the complainant became aware (or ought reasonably to have become aware) that he had cause for complaint;

unless:
(3) in the view of the Ombudsman, the failure to comply with the time limits in DISP 2.8.2 R was as a result of exceptional circumstances

Looking first of all at DISP 2.8.2 (a), I'm satisfied that Mrs R's complaint about Sense incorrectly advising her about a claim back in 2012 was made more than six years after that particular event, since Mrs R didn't complain to Sense until 2021.

I've then looked at DISP 2.8.2 (b), namely, when Mrs R became aware (or ought reasonably to have become aware) that she had cause for complaint. I don't think Mrs R would reasonably have been aware that she had cause for complaint back in 2012. Her testimony is that she was told she couldn't claim for the particular condition she suffered from and she accepted this. It wasn't until she had a financial review in 2020 and subsequently submitted and had a claim paid by Company A that she became aware that she had cause to complain about the Sense adviser's actions back in 2012. This complaint was therefore made within the three year time limit. So I'm satisfied that Mrs R's complaint has been brought to this Service within the time limits and is one we can consider.

So I've considered Mrs R's complaint. Firstly, I want to assure Mrs R that I have taken all of the information provided into consideration, even if not every point made by Mrs R is mentioned in this decision. I'll only address the comments and evidence I see to be relevant in reaching a fair and reasonable outcome here.

Mrs R complains she told the Sense adviser about her cancer diagnosis and he didn't make a claim on her behalf. The difficulty I have in looking at this complaint about what was or wasn't said in the meeting Mrs R had with the adviser is that I wasn't there, and so can't know what was said. So I have to rely on evidence brought to me by both parties.

Mrs R has provided her testimony of what was said in that meeting. No testimony has been provided by Sense, but it has provided a great deal of documentation.

I've looked carefully at all of the documents relating to the 2012 meeting, including the "Your Information" document. This is a key document that I would usually rely heavily on. However

there are problems with the accuracy of the information in this document and I've think it's fair to say there are too many inaccuracies for me to be able to reasonably rely on it as being representative of why the meeting happened, what Mrs R's needs were at that time, what was discussed and why specific recommendations were made.

For clarity, some of the inaccuracies I am referring to are:

- A reference to Mrs R's residential mortgage being protected by life cover only. This is not the case. The mortgage was protected by both life and serious illness cover that had been arranged by the same Sense adviser in 2010.
- In a similar vein, a question in the form asking if Mrs R's mortgage would be cleared if she was to die or suffer from a critical illness has been incorrectly answered "no".
- A reference to the life and serious illness policy taken out in 2010 already being cancelled, when this was not the case. It's my understanding the Sense adviser didn't cancel this policy when the new one was taken out – as I would have expected. Instead he asked Mrs R to cancel her direct debit and so the policy was eventually cancelled by Company A around four months later.
- A second reference to the policy with Company A that says *"during an attempt to make monthly savings in 2011, they cancelled the protection plans in force".* As I said, this is incorrect.
- A sparse and inadequate income and expenditure that, for example, didn't account for food and clothing expenses.
- A reference to three mortgaged properties, including two buy to let properties. From what I can see, this is incorrect. Mrs R says there was only one mortgaged buy to let property. Having looked at both earlier and later documents provided by Sense, I can see evidence of only one mortgaged buy to let property. In addition, I can see that the Sense adviser assisted Mrs R in insuring her properties in 2012, and only two properties, Mrs R's home and one buy to let property, were insured.
- A reference to each mortgaged property having a 23 year mortgage term. Based on all of the evidence provided, it seems this is incorrect and the buy to let mortgage had a shorter mortgage term, as it had been owned for longer.
- The outstanding mortgage balance on the residential property is listed as £160,000, while the application form for a new mortgage over two years later, when Mrs R was moving home, lists the outstanding mortgage as around £169,000
- From what I can see, the outstanding mortgage balance listed on the buy to let property – £75,000 – is incorrect and was higher than is suggested in earlier and later documents. It's my understanding that the outstanding amount was £58,000 and wouldn't change as it's an interest only mortgage.
- A reference to the meeting being set up as Mrs R wanted to arrange cover for her residential and buy to let mortgage. As outlined above, Mrs R already had adequate cover.

These aren't minor or inconsequential inaccuracies. These are key pieces of information that would have been relied on by the Sense adviser to justify selling an additional protection policy to Mrs R. So given the significant inaccuracies in this particular document, I don't think it would be fair for me to rely on it in the way I usually would.

I've also looked carefully at what Mrs R has said, and I am more persuaded by her testimony. Specifically:

- Mrs R was diagnosed with cancer in October 2011 and by January 2012 was coming to the end of her cancer treatment. She said it was at this point that she contacted the Sense adviser to discuss her diagnosis with a view to making a claim. This seems plausible. From what I've seen, Mrs R is someone who has taken steps to ensure she has adequate cover for, for instance, her mortgage and to provide for her children in the event of her passing away. So it makes sense that she would want to

check if she was covered under her serious illness policy following her cancer diagnosis. By 2012 Mrs R had built up a relationship with the Sense adviser and so, again, it makes sense that she would contact him, rather than the insurer, about possibly making a claim.

- When Mrs R contacted this Service she said she was told by the Sense adviser that her condition wasn't serious enough for her to make a claim. And it's certainly the case that some critical or serious illness policies will not pay claims for conditions such as Mrs R's. If Mrs R had taken out a policy with a different insurer, then it might have been the case that her condition was not severe enough for her to meet the policy definition. However, her particular policy provided cover for less severe forms of cancer. It's possible the Sense adviser didn't consider the terms of the particular policy she bought. I think that what Mrs R said about being told by the Sense adviser that her condition wasn't serious enough for a claim to be submitted is plausible.
- It's clear Mrs R did disclose some information to the adviser about her condition, as the application form mentions a benign mole that had been removed. I think it's unlikely that Mrs R failed to disclose the extent of her condition to the adviser, as there's no reason for her to do this. She already had adequate cover in place, so it seems unlikely she downplayed her condition in order to take out another policy. I think it's more likely than not that her reason for disclosing her condition would have been to see if she could claim under the cover she already had in place. If she was disclosing her condition to see if a claim could be made, then it's more likely than not that she disclosed the full extent of her condition.

What I need to do here is make a decision about what is more likely than not to have happened, on the balance of probabilities, in relation to whether Mrs R told the Sense adviser about her recent diagnosis and whether she was told a claim wouldn't be successful.

Having carefully considered all of the evidence, I'm persuaded that it's more likely than not that Mrs R contacted the Sense adviser following her treatment for cancer to check whether she would be able to make a claim; that the adviser didn't properly consider the terms of her particular policy – where, unlike some other policies, she would have received a settlement for a less severe condition – and Mrs R relied on what he said. Mrs R had relied on him for a number of years to provide her with a mortgage, protection policies and home insurance policies and is likely to have trusted his judgement, given that he was the professional and the more knowledgeable of the two in this situation. At that stage, Mrs R was told that her cancer had been successfully removed and so I can see how she's likely to have agreed that her condition was not so serious that it might have met the requirements for a serious illness claim. This might explain why she didn't go directly to the insurer herself, which of course she could have done. But the issue here is that the adviser should not have told her she couldn't make a claim. It's not his role to do this.

What this means is that I'm satisfied it was more likely than not that it was the actions of the Sense adviser that caused Mrs R to be in the position where a claim was not submitted to Company A back in 2012, when it could have been. Mrs R didn't receive a claim settlement until 2021, when a different adviser reviewed her finances and suggested a claim might have been successful, and so was deprived of the settlement amount for some years.

In order to put things right I think Sense should pay interest on the settlement amount at 8% per annum simple. I've considered when the interest should be paid from. The meeting with the Sense adviser was 18 January 2012 and I think it would be reasonable to assume a claim made at that point would have taken around 8 weeks to assess. So I think it's fair for interest to be paid from 14 March 2012 to the date Company A settled the claim in 2021.

I've also looked at whether the Sense adviser mis-sold the protection policy bought by Mrs R following the meeting in January 2012. I've already outlined the areas in the "Your

Information" document that are inaccurate. Some of these are relevant here, so I'll repeat them for clarity.

Mrs R already had adequate life and serious illness cover with Company A for her mortgage, and she and Mr R had separate life cover of £200,000 each with Company B. A reference was made in the paperwork to all of the above policies being cancelled before the meeting was held, when this was not the case. Although I note there's also a reference to the individual life policies still being in place. Nonetheless, from what I can see, there was no shortfall in cover here, as suggested in the paperwork.

The income and expenditure drawn up was incomplete. It didn't include expenditure such as food or clothing. This means the budget calculations that came from the income and expenditure plan aren't likely to be accurate. So given that the budget calculations are flawed and that there was no shortfall in cover, I'm satisfied that the policy sold to Mrs R following the January 2012 meeting was one she didn't need and so was mis-sold.

I know that Sense has said the new policies provided comparable cover, but I don't agree that this is the case. From what I can see, the monthly premium for the policy taken out in 2010 with Company A was £95.79 and the combined premium for the two life policies with Company B was £22.54. So the cost of the various protection policies that were in place when the meeting was held in January 2012 was £118.33. However, the monthly premium for the policy recommended by the Sense adviser in 2012 was £121.93. So there's no cost saving to Mrs R here. There's also a decrease in cover as the 2012 policy doesn't provide full serious illness cover for her mortgage – a lower, incorrect mortgage balance is listed. In addition, the cover provided in 2012 is on a decreasing term basis, while the two £200,000 life policies through Company B were level term.

The issue here is that even if the policy sold in 2012 was comparable, this is not enough. It's got to be the case that if an IFA is selling a policy designed to cover roughly the same commitments, then there's got to be a benefit to the consumer. Otherwise the only benefit is to the IFA through additional commission payments from the insurer. And I've not seen that there was a benefit to Mrs R. So, as I said, I am satisfied the policy sold to Mrs R in 2012 was mis-sold.

When a policy is mis-sold, I might tell the business in question to put things right by refunding the premiums paid to the consumer. However, in this case, Company A has already refunded the premiums. I can see that our Investigator suggested Sense should pay interest on the premiums paid, but I think that if the 2012 policy hadn't been sold to Mrs R then she would most likely have kept her other policy in place, at least until 2014 when the policy bought in 2012 was cancelled. So I don't think there's any need to pay interest when I think Mrs R would have continued to pay premiums on the policy taken out in 2010.

I've considered whether a payment for distress and inconvenience is fair here. It's certainly the case that errors have been made, but this Service doesn't punish businesses for errors made. Instead we look at whether errors caused any distress or inconvenience to the consumer. I've no doubt that Mrs R must have been very pleased to hear in 2021 that her claim was successful. Equally I'm sure it would have caused her some distress to know that this claim could have been paid some years ago. So I think it's fair to award compensation for distress and inconvenience, and I'm satisfied the amount of £250 suggested by our Investigator is fair.

Mrs R also complained that Sense incorrectly recorded the details of her cancer diagnosis on the application form for the policy taken out in 2012. I agree that it's likely Mrs R disclosed the full details of her medical condition to the Sense adviser, and that this was then likely recorded incorrectly by him. Company A said they wouldn't have provided her with the policy

if they had known about her cancer diagnosis and so have refunded all premiums. So there's no loss to Mrs R as a result of that error and I'm not asking Sense to take any further action here.

My final decision

I require Sense Network Limited to pay interest at 8% per annum simple on the settlement amount paid to Mrs R by Company A in 2021, calculated from 14 March 2012 to the date the settlement amount was paid by Company A to Mrs R.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr R and Mrs R to accept or reject my decision before 8 July 2022.

Martina Ryan
Ombudsman