DRN-4820765

The complaint

Mrs C complains that Essential Finance Group Management Limited mis-sold her a life and critical illness policy. Mrs C says Essential should have disclosed that she was awaiting a colonoscopy, when it applied for the policy on her behalf.

What happened

The history of this complaint is well-known to the parties, so I won't repeat all the details here. In summary, in November 2022, Mrs C took out cover through Essential. She wanted a life and critical illness policy to protect her mortgage.

The sales process started in August 2022. During the initial sales call, Mrs C disclosed that she'd been referred for a colonoscopy, after experiencing '*bleeding PR'*. Mrs C described the incident as *'just a routine thing, I think, nothing urgent'* and said her GP thought it might be linked to her periods.

It seems the sales agent misunderstood the nature of the disclosure, failing to make the link between the symptom described and the referral for a colonoscopy. In a call to the insurer in September 2022, Essential sought the insurer's view about a disclosure of blood in urine. The insurer gave an indication that if there'd been no recurrence of symptoms, after six months a policy would be accepted on standard terms.

In November 2022, Essential spoke to Mrs C again about setting up her policy. Mrs C said she'd spoken to the waiting list co-ordinator regarding her outstanding '*scan'*, but that it wouldn't be until May 2023. She asked if that would be a problem and whether the fact she was still waiting for the investigation mattered. Essential referred to its conversation with the insurer, saying it should be ok to proceed as it'd been more than six months since she'd had symptoms.

The policy commenced and Mrs C received a copy of her application form the insurer. She was asked to confirm everything was accurate via a 'checking your details' request. Mrs C did this online the same day. No corrections were made.

Very unfortunately, in May 2023, Mrs C had a recurrence of symptoms. Following expedited tests, she received a diagnosis of bowel cancer in August 2023. But when she sought to claim on her policy, the insurer declined to pay out, saying it hadn't been made aware of the referral and outstanding colonoscopy. It said that had it known, it would not have offered cover. So it cancelled Mrs C's policy and refunded her the premiums paid.

Mrs C complained, saying she'd made a full disclosure to Essential and holding Essential responsible for the non-disclosure. She thought Essential should honour the claim and pay her the sum she'd expected to receive from the policy.

Essential partially upheld Mrs C's complaint. It said that Mrs C had played down her situation and used medical terminology – *bleeding PR* – which its agent had not realised meant bleeding from the rectum. It noted that Mrs C was medically qualified. It also said its advisor had stressed to Mrs C the importance of giving full and accurate information and that she'd had the opportunity to correct any wrong or missing information when she received the checking your details request and her full application form. Essential said that with full disclosure, Mrs C would not have been able to take out the policy, or any critical illness cover with any insurer.

However, Essential acknowledged that a better understanding and further clarity could've been sought during the sales calls. It accepted the service provided by the agent fell below expected standards. In acknowledgement of the distress and inconvenience caused, it offered £300 compensation for poor service.

Mrs C remained unhappy and came to the Financial Ombudsman Service. An investigator looked into things but didn't uphold the complaint. She thought Essential's offer of £300 was fair.

Mrs C disagreed so the complaint has come to me for 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.

Having done so, I'm not going to ask Essential to compensate Mrs C beyond the £300 offer already made. I recognise my decision will be very disappointing for Mrs C and I'm sorry about that. A summary of my reasons is given below, focusing on the key points and evidence I consider material to my decision.

I think Essential should've picked up on the disclosure of a referral for a colonoscopy and been clearer in its questioning, to establish exactly what Mrs C's health situation was. This fundamental lack of clarity about the disclosure led to the insurer being asked irrelevant questions about blood in the urine, rather than rectal bleeding. I think it also influenced the subsequent conversation between Essential and Mrs C in November 2022, when there was a further missed opportunity for clarification. To my mind, Essential's agent and Mrs C were not approaching the conversation about her symptoms from the same perspective. Mrs C had disclosed the outstanding colonoscopy as a result of rectal bleeding. But Essential had a different understanding of her situation which didn't demonstrate awareness of the significance of the disclosure.

I do think Mrs C presented the outstanding investigation in terms that may've contributed to the misunderstanding. She initially described it as *'just a routine thing, I think, nothing urgent'*. And when asked later on in the original call about the symptoms, Mrs C said, *'not to be too blunt, but I was bleeding PR, but only on one occasion, so, you know, it hasn't happened since, so I just wanted to get it checked out, so I think, like I say, it's obviously not urgent, 'cause I haven't heard anything*.' I'm mindful that the insurer's claim decline letter – sent to us by Mrs C – makes reference to her medical history, which indicates her symptoms were not a one-off, but of a more longstanding nature.

It's also clear from the calls that Mrs C was concerned the outstanding investigation would impact on her ability to get cover. When Essential called her again in November 2022, she

said she'd contacted the waiting list co-ordinator and been told it would be a year – so she'd be waiting until May 2023. She questioned whether the fact she was still awaiting investigation would matter in terms of the policy. Conversation took place about an insurer's attitude to investigations and there was mention by the agent of providers allowing certain things to go '*under the radar'*. But again, approaching the conversation from different understandings, clarity about Mrs C's actual situation was missed.

Finally, I note Mrs C did confirm to the insurer that all of the details on her application form were accurate. The application form asks a question about outstanding investigations to which the answer was recorded as 'no'. Mrs C argues that she thought this was correct, having disclosed to Essential. I think it was open to her to clarify at this point.

With a referral to hospital and colonoscopy outstanding, I'm satisfied the policy shouldn't have been sold to Mrs C. But that isn't enough for me to say Essential should pay Mrs C the value of her claim. When we find a business has done something wrong, we can tell them what to do to put things right. That means putting Mrs C back in the position she would have been if nothing had gone wrong. In this case, information wasn't disclosed when it should have been. So I have to think about what would've happened if full disclosure had been made.

Mrs C's insurer said in its claim decline letter that, with full disclosure, it would not have offered cover. And Mrs C has referred to her husband speaking to another insurer about her circumstances and being told the same thing. Equally, Essential said Mrs C wouldn't have been able to obtain cover and I'm not aware of any insurer that would offer cover with a referral for a colonoscopy outstanding. So, the fact is, had all gone right and full disclosure been made, Mrs C would not have been offered a policy.

So regardless of Essential's role in misunderstanding the nature of the disclosure and failing to pass on accurate information to the insurer, I'm afraid the reason why Mrs C didn't have the protection she wanted is because of her health circumstances at the time of application. It wouldn't be fair for me to tell Essential to pay Mrs C the value of a claim on a policy she would never have had, had Essential understood the medical details she provided and passed them on accurately to the insurer.

Essential has made an offer of £300 to Mrs C in acknowledgement that there were service failings which have caused Mrs C distress and inconvenience. I'm aware Mrs C considers this amount insulting and, against an anticipated six-figure pay out, I can understand why she feels this way. I acknowledge a modest payment for distress and inconvenience won't resolve this complaint to Mrs C's satisfaction. But overall, I don't think Essential's offer is unreasonable.

Putting things right

Essential should now pay Mrs C £300 compensation for distress and inconvenience.

My final decision

My final decision is that Essential Finance Group Management Limited should settle this complaint as outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs C to accept or reject my decision before 2 August 2024.

Jo Chilvers
Ombudsman