ombudsman news

from the **insurance** division

Financial Ombudsman Service

October 2001

Financial Ombudsman Service

Aimed at financial firms and professional advisers – and at consumer advice agencies – we focus each month on news from one of our three case-handling divisions: banking & loans, investment – and this month – insurance.

## in this issue



Produced by the communications team at the Financial Ombudsman Service



**Walter Merricks** (back), chief ombudsman, with the three principal ombudsmen. From left to right, **David Thomas**, banking and loans, **Jane Whittles**, investment, and **Tony Boorman**, insurance.

# about this issue of *ombudsman news*

by **Tony Boorman**
principal ombudsman
insurance division

This is the last insurance issue of ***ombudsman news*** before N2 (1 December 2001) – the date when the majority of the Financial Services and Markets Act 2000 comes into force. From that date we will follow the new rules of the Financial Ombudsman Service when we deal with cases referred to us.

These new rules form the 'Complaints Sourcebook' which, together with the 'Compensation Sourcebook', makes up Block 4 – 'Redress' of the Financial Services Authority's Handbook of Rules and Guidance.

Perhaps the most significant change for general insurance is the inclusion for the first time within our jurisdiction of complaints from small businesses. A 'small business' means a business with a group annual turnover of less than £1 million at the time it makes the complaint to us. Similar criteria are applied to charities and trustees. In addition to bringing some new policy types into our remit (such as business interruption), the extension of our jurisdiction means we now cover many areas of complaint that we were previously unable to deal with, such as insurance cover for property arranged by a residents' association.

The general approach to resolving disputes under the new Financial Ombudsman Service jurisdiction will remain much as before, with the emphasis on what, in our opinion, is fair and reasonable in all the circumstances of the case. So, comments we have made on case issues in previous editions of ***ombudsman news*** will normally still apply after N2, as will all the topics covered here.

In this edition we consider a variety of household disasters – including floods, dry rot, and damage to items that are part of a suite or matching set. We also:

- discuss the implications of insurers opting to repair or replace goods;
- look at the circumstances where both an intermediary and an insurer are involved in a dispute; and
- give a brief round-up of some of the other cases we have handled in the last three months.

Finally, we would welcome your comments on our latest consultation paper dealing with the complaints from UK customers about banks and insurers based ***outside*** the UK. You'll find more details on the back cover.

**...the general approach to resolving disputes under the new Financial Ombudsman Service jurisdiction will remain much as before.**

# 1 household disasters

Complaints about household contents and buildings insurance account for just over a quarter of our caseload. In this edition of ***ombudsman news*** we look at a few of the more difficult issues that have cropped up in recent months.

## floods

This is the time of year when an insurer's mind turns to floods. We are pleased to note that, to date, we have received very few cases directly relating to last year's widespread flooding. That is a tribute to the industry's efforts and reflects the positive reports in the media and elsewhere about the industry's handling of these flood claims. Of course much of the public discussion following last year's floods has concerned the availability of insurance cover, particularly where there is a history of flooding. Normally however, such matters are outside our jurisdiction and our focus is on those circumstances where a claim arises.

Meanwhile a decision by the Court of Appeal has caused us to reconsider precisely what constitutes a 'flood'. In ***Rohan Investments Ltd v Cunningham***, the court held that a flood could originate from an accumulation of water that was not large, in absolute terms. Whether a particular accumulation of water amounted to a 'flood' would depend, at least in part, on the size of the property affected.

One of the judges – Lord Justice Auld – went further and indicated that a flood could arise from the slow and steady build-up of water and that it was not even necessary for the ingress of water to arise from a natural phenomenon. In his opinion, 'flooding may or may not result from such weather extremes [as storms and tempests]'. He went on to say that 'it is the water that enters and damages the property that is important, not the area or depth of flooding outside that counts'.

### case study – household disasters – floods

n 10/01

**household buildings – flood – rise in water table – whether 'flood'.**

During heavy rainfall in November 2000, Mr B's cellar filled with around four inches of water. He claimed under his household buildings insurance, which included cover for accidental damage. The insurer concluded that the damage was due to a rise in the water table and informed Mr B that this was not covered by the policy.

Mr B argued that the damage was clearly due to a 'flood' and that therefore it was covered under his policy.

**complaint upheld**

Although in the past we had held that such claims were not covered, the 1998 decision by the Court of Appeal referred to above (***Rohan Ltd v Cunningham***) indicated that they might be valid.

**...the decision has caused us to reconsider precisely what constitutes a 'flood'.**

We considered that, as a result of this decision, the complaint should succeed. This was partly because the wider interpretation of 'flood' was closer to the ordinary expectations of householders. The decision in this court case was contrary to a previous Court of Appeal ruling (***Young v Sun Alliance***) in 1977, but we considered Mr B was entitled to the benefit of the more favourable case.

## a lot of rot

Do exclusions for wet rot and dry rot in household policies apply even when the rot is the direct result of an insured event (such as escape of water from a bath)? Much depends on how the exclusion is worded.

Although, increasingly, insurers include a general provision that excludes dry/wet rot however it has arisen, a few of these insurers do not apply the exclusion where the rot was caused directly by an insured event. From the policyholder's perspective, this is clearly a better position for insurers to adopt and we may need to consider whether it should be taken to represent good insurance practice generally. It certainly reflects a general theme of providing cover for the unexpected. For the time being, however, if the exclusion is worded and positioned in a way that makes reasonably clear the insurer's intention to exclude damage by rot – however it arises – we consider the insurer is entitled to disclaim liability for rot, even if it was caused by an escape of water or other insured event.

Of course, separate considerations apply where the rot developed as a result of an incomplete or inadequate repair of water damage caused by an insured event, where the repair was carried out on behalf of the insurer. In such cases, the insurer would be responsible for the consequences of inadequate repair, regardless of the exclusion.

### case study – household disasters – rot

n 10/02

**household buildings – exclusion for dry rot – rot discovered in course of subsidence repairs – whether exclusion applied.**

Mr N's household buildings insurer agreed to repair his property when it was affected by subsidence. The property was underpinned and superstructure repairs were undertaken. However, the repairer then found rising damp and stopped work until it had been rectified. While installing a damp-proof course, workmen found widespread woodworm and dry rot.

Mr N accepted that his policy did not cover the cost of eradicating either woodworm or dry rot and he arranged for the additional work to be carried out. However, his contractor discovered that the bearer wall supporting the

infected timbers along the flank side of the house had collapsed in several places.

The insurer accepted this was further subsidence damage and it paid for rebuilding the wall. But it refused to meet the cost of removing and replacing the timbers and joists, maintaining that it was not liable, even though this work was required in order to carry out the subsidence repairs. This was because the timbers and joists were affected by dry rot, which was excluded from cover.

Mr N argued that the insurer should at least pay the proportion of the costs which related to the damaged part of the wall.

**complaint upheld in part**

The insurer was responsible for repairing property damaged as a result of an insured peril. Had the insurer noticed the damage to the bearer wall at a different time, it would have had to remove and replace the floor in order to complete the repairs. We concluded that the fact the damage was only noticed in the course of other repairs did not affect the insurer's liability.

However, that liability was limited to the section of the floor affected by the insured damage. The insurer accepted our view that it was liable for the cost of removing and refitting the timbers adjacent to the damaged part of the bearer wall.

Mr N argued that the insurer should reimburse the full cost of removing the floor. We did not agree. It was clear that the timbers were rotten and could not be replaced. The cost of putting in new boards and joists was not covered by the policy and the insurer was not liable. Moreover, the replacement wood meant that Mr N was in a better position after the repairs than before.

## a bit of damage in time...

Occasionally we see cases where, although policyholders have acted sensibly to protect their property, their preventative action has caused some damage. Insurance is obviously not there to cover deliberate damage by policyholders and policyholders must take reasonable precautions to safeguard their property. However, it seems strange that there are circumstances where policyholders may sometimes be better off allowing serious damage to take place, rather than taking steps to prevent it and ending up with an unrecoverable loss.

The following case is an example of just these circumstances. We concluded that the policyholder had acted reasonably and that, in all probability, his actions saved the insurer from a far larger claim. It was therefore reasonable to require the insurer to meet the costs of the damage.

## case studies – household disasters – preventative action

n 10/03

**household buildings – deliberate damage – damage caused deliberately to limit greater loss – whether policyholder covered for deliberate damage.**

When a blocked pipe caused water to flow back up into Mr J's kitchen, he quickly called out a plumber. The plumber broke the pipe and diverted the water before it caused any damage. However, when Mr J put in a claim for reimbursement of the plumber's charges (£70.50), the insurer rejected the claim on the grounds that the policy did not include any cover for accidental damage. Damage due to escape of water ***was*** covered under the policy, but Mr J had not claimed for any damage to his property other than the broken pipe. He argued that it was only the plumber's prompt action that prevented damage from occurring.

**complaint upheld**

We agreed with Mr J that the plumber's actions were a direct and necessary consequence of the escape of water and were consistent with his duty under the policy to take all reasonable steps to prevent loss. The insurer did not dispute that the plumber's action had prevented considerable damage to the cupboards and floors. This damage would have been covered under the policy and could well have exceeded the cost of fracturing and repairing the pipe.

In such cases we would not consider it reasonable to require an insurer to reimburse the cost of deliberately-caused damage unless the claimant satisfied us that:

- he had acted reasonably and in order to prevent damage which was covered under the insurance policy; and
- the damage he was acting to prevent would cost significantly more than the damage deliberately caused.

Mr J satisfied both elements of this test and we therefore required the insurer to reimburse him for the plumber's bill.

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n 10/04

**household buildings – subsidence – preventative work – whether insurer liable for cost.**

In 1997, Mr and Mrs L noticed cracking in their garage. The loss adjusters appointed by their insurer concluded that it was caused by conifer trees owned by Mr and Mrs L's neighbour – Mr G. Mr G's insurer also appointed loss adjusters. They did not think the conifers were to blame, but they recommended the removal of several other trees.

Mr and Mrs L's loss adjusters monitored the property for the next twelve months and were satisfied that it had stabilised. The couple's insurer offered to carry out repairs but, after consulting a solicitor, Mr and Mrs L rejected the offer.

Both insurers agreed that three of the conifers would be removed, the remainder kept at their existing height, and that a new fence should be constructed. Mr and Mrs L said that Mr G's insurer should pay for the work. They argued that Mr G was benefiting whereas they had been unfairly obliged to pay the £1,000 policy excess towards the cost of the work. They sought compensation for their insurer's delay of three and a half years in progressing matters and said that this, in addition to their being subjected to Mr G's 'foul and abusive' language, had made them ill.

**complaint rejected**

Mr and Mrs L's insurer was not obliged to force Mr G to remove all his trees, as the couple required, nor did it have any duty to fund the legal proceedings they wished to undertake. Mr and Mrs L were unable – or unwilling – to take legal action at their own expense and had not chosen to include legal expenses cover in their insurance.

We considered that the insurer had dealt with the claim properly and was justified in deciding not to have repairs carried out until the property had stabilised.

## matching sets

For many years, we have awarded compensation to customers who have referred complaints to us about 'loss of match' where, for example, one part of a three-piece suite has been damaged and it has not been possible to obtain an exact replacement for the damaged item. Our typical award is 50% of the cost of replacing the undamaged items. We have applied this approach to buildings insurance as well as to contents insurance.

However this approach is not always appropriate. For example, bathroom tiles give rise to similar disputes, but we are not usually sympathetic to demands for compensation when only a few of them need to be replaced. In these cases, we will assess the claim to see what effect the loss of match has on the remaining items. If there is no substantial loss, then we are unlikely to consider that any additional compensation should be paid. Conversely, where matching is intrinsic to the value of the objects, we will make an award for full replacement.

## case studies – household disasters – matching sets

n

**household contents – exclusion for undamaged items – matching sets – clothing – business suit – whether separate 'items'.**

Mr C bought a suit in the summer sales, which was a real bargain. Three weeks later, he accidentally leant on a bleached surface and the trousers were discoloured. He claimed under his household contents insurance and the insurer agreed to pay for a new pair of trousers. As they were not sold separately, it offered him £206, which was 40% of the cost of the suit, less the policy excess of £50.

Mr C complained that he could not replace the trousers on their own and said he was entitled to the cost of a new suit (£515). The insurer increased its offer to include a contribution of 50% of the cost of a replacement jacket, but it refused to pay the full cost of a new suit. It said the policy stated:

> 'We will treat an individual item of a matching set of articles or suite of furniture or sanitary fittings or other bathroom fittings as a single item.'
>
> 'We will pay for damaged items but not for the other pieces of the set or suite which is not damaged.'

Dissatisfied with the insurer's response, Mr C brought his complaint to us.

**complaint upheld**

We did not accept that the insurer should regard the suit as 'a matching set of articles'. The jacket and trousers could only be purchased together, so we did not agree that – individually – they were 'single items'. On the contrary, the two pieces were together a 'single item' and we considered that settlement should be reached on that basis. The clause the insurer had relied on was not appropriate in these circumstances and we required the insurer to pay the balance of the claim, plus interest.

n 10/06

**Fraud – household contents – damage to one part of three-piece suite – whether claim that all of suite damaged was 'fraud'.**

Mrs M telephoned her insurer to notify it of damage to an armchair, which was part of a three-piece suite. She said that dye from her husband's trousers had stained the fabric. The insurer agreed to clean the chair, but Mrs M insisted that the whole suite would have to be cleaned, otherwise the chair would no longer match the other items in the suite.

**...the jacket and trousers could only be purchased together, so we did not agree that – individually – they were 'single items'.**

After the insurer explained that it had no liability for the undamaged furniture, Mrs M said that all three pieces of furniture had been stained in the same way. The investigator appointed by the insurer to assess the damage reported that only one chair was stained.

The insurer then told Mrs M that it was cancelling her policy because she had 'used fraud to gain a benefit'. Mrs M explained that she had no intention of defrauding the insurer and had only said the other furniture was damaged because she was dissatisfied with the insurer's decision not to pay for the whole suite. The insurer sent her a tape recording of the telephone conversation in which she said all three items were stained, but she maintained she had only been joking.

**complaint rejected**

The insurer's tape made it clear that Mrs M had stated there was damage to all three pieces of furniture. She did not seem to be joking. Moreover, she had allowed the insurer to arrange for an investigator to visit her rather than simply arranging for the chair to be cleaned. This indicated that she was pursuing her claim that all three parts of the suite were stained and should be cleaned.

Mrs M had attempted to gain an advantage by deception and the policy terms clearly entitled the insurer to cancel the policy. We were satisfied that the insurer had treated her fairly and in accordance with the policy terms.

n 10/07

**Household buildings – replacement – loss of match – tiles – whether policyholder entitled to compensation for loss of match in replacement of damaged tiles.**

Fourteen tiles in Mr and Mrs J's bathroom were damaged. The insurer agreed to replace these tiles but refused their request to re-tile the entire room. It explained that the policy specifically excluded 'the cost of replacing any undamaged item or part of any item solely because it forms part of a set, suite, or one of a number of items of similar nature, colour or design'.

After the couple expressed their dissatisfaction, the insurer made an additional payment representing 50% of the cost of re-tiling the remainder of the room.

**...the dog rushed into the sitting room and knocked into the table, tipping the tin of paint over the sofa.**

**complaint rejected**

The insurer had drafted its policy carefully. There was no reason why the policy should be disregarded or distorted simply because Mr and Mrs J had not appreciated that the wording might not allow them to claim for re-tiling the whole room. On the other hand, strict application of the terms would leave many householders – if not most – with a finish they would regard as unacceptable. The insurer's payment of 50% of the cost of total re-tiling was in line with our usual approach and we were satisfied it was reasonable in the circumstances of this case.

## case studies – household disasters – accidental damage

n

**household contents – accidental damage – lack of reasonable care – burden of proof.**

While Mr M was touching up the paintwork on his sitting room wall, there was a knock at the front door. He put the tin of paint on a table and went to the door. As he opened it, a gust of wind blew through the house and the kitchen door swung open, letting his dog loose. The dog rushed into the sitting room and knocked into the table, tipping the tin of paint over the sofa – part of a three-piece suite.

Mr M claimed under the accidental damage section of his household insurance. The insurer rejected his claim, on the ground that he had not complied with the policy condition to take reasonable steps to prevent damage. It considered he was negligent because he had not covered the sofa before starting to paint.

However, after Mr M explained that he had not been redecorating – only touching up some marks on the wall, the insurer made an offer of £600 towards the cost of replacing the three-piece suite. Mr M refused this offer and referred the complaint to us.

**complaint upheld**

To prove the alleged lack of reasonable care, the insurer had to show that Mr M had been reckless. That meant proving that he had recognised there was a risk of damage but had failed to take reasonable precautions to prevent it.

There was no indication that Mr M had been reckless and we considered the insurer should meet the cost of replacing the damaged sofa. If the sofa could no longer be replaced, then the insurer should also pay 50% towards the cost of replacing the other matching parts of the suite.

# 2 repair, replace or cash?

Most household policies now provide 'new-for-old' cover but leave it to the insurer (not the policyholder) to decide whether the claim should be settled by repair, replacement, reinstatement or cash settlement. We take the view that the insurer must exercise this power reasonably, in the circumstances of the individual case. This has a number of implications for both parties.

Where insurers opt for repair, we consider they have a duty to explain the implications of any choices made by either party. If the repairer is chosen by the insurer – or its agents (such as loss adjusters) – then it is normally the insurer who will be liable to make good any deficiencies in the repair.

Where a policyholder insists on a particular repairer carrying out the work, then it is the policyholder who will generally be responsible for the quality of the work. This does not mean that every repairer who has provided a claimant with an estimate will be regarded as the claimant's ***chosen*** contractor. We have considered complaints where the insurer told the policyholder to obtain estimates and the policyholder sought the loss adjuster's assistance in doing so. In these circumstances, we have concluded that the insurer, rather than the policyholder, was liable for the repairer's shortcomings.

Even if the policyholder chose the repairer entirely independently, the insurer will be responsible for rectifying deficiencies in the work if it or its agents 'controlled' the repairer, for example by requiring the repairer to cut his costs or to use certain materials or parts. In those circumstances, the repairer can no longer be regarded as the policyholder's agent.

Opting for 'replacement' is only a reasonable option on the insurer's part if the object claimed for can be replaced. If the object is antique jewellery, for example, then it is not open to the insurer to insist the claimant buys a modern replacement from a chain shop. Similar issues arise whenever the replacement options are limited. It may, for example, be unreasonable to limit a policyholder's choice of replacement to a particular retailer.

Policyholders should be allowed to choose where they purchase a replacement and they are entitled to a cash settlement if they cannot find an acceptable alternative. In such circumstances, we would not regard it as reasonable for the insurer to make a deduction from the cash settlement to represent any discount it would have got if the policyholder had bought a replacement from one of the insurer's nominated suppliers. Nor would it necessarily be appropriate for the insurer to offer vouchers to the policyholder. If the option of replacement is not available, then the only way in which the insurer can indemnify a claimant is by a cash settlement.

In some cases, policyholders may not wish to purchase a replacement for the damaged or stolen goods. This may be, for example, because their circumstances have changed, or the object had sentimental value. Where this is the case, we will normally ask the insurer to agree a cash settlement.

**...he complained about the insurer's failure to get the work done properly in the first place.**

## case study – repair

n 10/09

**household buildings – repairs – failure to repair properly – policyholder suffering distress and inconvenience – appropriate compensation.**

After Dr I's flat was seriously damaged by fire in October 1997, the insurer appointed loss adjusters and builders to handle his claim. Extensive work was necessary, but the flat was expected to be ready for Dr I to move back into by May 1998.

In the event, the work was not carried out to an acceptable standard and a second firm of builders had to be brought in to put matters right.

For the first few months, Dr I lived in rented accommodation but he then moved in with his father. Repairs were finally completed in December 1999. Dr I complained about the insurer's failure to get the work done properly in the first place, and he sought compensation in excess of £309,000. This included £216,000 for 20 months of distress and aggravation; reimbursement of various costs including telephone bills, legal expenses, and mortgage charges; payments for his time spent supervising and reporting on the work; and finally a payment in recognition of his inability to sell the flat while the work was in progress.

**complaint upheld in part**

The insurer acknowledged that it failed to ensure the original repair work was up to standard, but we were satisfied that it took appropriate steps to remedy the situation. What we had to decide was how much compensation the insurer should pay to reflect the added inconvenience to Dr I, and any expenses he incurred, over and above what he would have had to endure anyway as a result of the fire.

We took the view that whatever had happened, he would still have had to pay his mortgage and other property-related costs. We were not persuaded that he would have sold the flat, had it not been for the problems encountered; nor were we satisfied that he needed to involve solicitors to progress the remedial work. In our opinion, the insurer had already paid Dr I at least £4,000 compensation for alternative accommodation costs while he was living with his father. Taking this into account, we awarded Dr I a total of £3,750 compensation. This comprised £1,000 for the time he spent in overseeing and reporting on the work, £750 for distress and general inconvenience, and £2,000 for loss of use and enjoyment of his flat for the period between the expected and actual completion dates.

# 3 why we publish case studies

Many firms tell us they find the case studies in ***ombudsman news*** a very helpful way of keeping their staff up to date with ombudsman decisions. Of course, not all the cases will be directly relevant to every firm's business – and some may appear to turn on a unique set of events. But the cases can all be useful in illustrating our general approach and giving examples of both good and bad complaints-handling practice among firms. The lessons to be learnt can help firms settle any disputes quickly and satisfactorily themselves, without the need for our involvement.

It appears, from a letter we were sent recently, that customers' advisers sometimes pay more attention to ***ombudsman news*** case studies than the staff of insurers' claims departments do. An insurance broker wrote:

'... I recently obtained payment [for a client] of £27,000 under a personal accident policy. The man had held for some years a ... personal accident policy that contained a £27,000 lump sum benefit for loss of sight in an eye. A splinter shot into his eye and after two years a claim was made for the capital sum...

'[The insurer] requested an examination by their specialist and this was held 30 months after the accident. Despite repeated requests by the man's solicitor [the insurer] refused to pay, contending that sight had **not** been lost as 3% remained.

'Unwilling to bear Court Costs of further action by the solicitor, the man sought my aid ... The same week you published an identical case [***January 2001 – case 01/18 – where we concluded that an insurer should meet a claim for loss of sight from a lady who was left with only an estimated 2-3% vision after an accident***]. The insurer duly paid but omitted to add £1,500 by way of an index-linked increase in the amount. When I drew this to their attention the further £1,500 was duly paid.'

**...many firms find the case studies a very helpful way of keeping their staff up to date with ombudsman decisions.**

# 4 insurers, intermediaries and the ombudsman service

The GISC (General Insurance Standards Council) code for private customers is starting to have a significant role in our casework. This new Code builds on the position established under the ABI (Association of British Insurers) Code of Practice. Our initial assessment is that – so long as the GISC code is widely adopted and complied with by intermediaries and insurers – it should enhance the protection available to customers. As a matter of good industry practice, we would expect all firms that are covered by the Financial Ombudsman Service to observe the Code and to take reasonable steps to ensure that other firms involved in selling their policies do so as well.

Customers often contact us with complaints that turn out to be about an intermediary or other company that is not covered by our jurisdiction. At present, few intermediaries are covered by the Ombudsman Service and matters are made more confusing for customers by the recent growth in insurance products branded with the names of intermediaries or other firms, where the name of the actual insurer is all but invisible to the policyholder.

In many of the cases referred to us, further enquiry shows that the complaint is actually about payment of a claim by the insurer, and hence something with which we can deal. We have been looking at other circumstances where we believe it appropriate for us to investigate complaints about intermediaries or other companies that we do not cover. In essence, this will be when the company complained about acts with the authority of the insurer, or as its agent.

During many transactions, an intermediary will be acting both for the insurer and for the customer (albeit at different stages of what customers may consider a seamless single process). The position is complicated further by the fact that the precise position will depend on any agreements made between the insurer and intermediary to allow the intermediary to act on the insurer's behalf. These agreements are not usually evident to the customer or indeed always immediately apparent to us when we first look at a case.

Normally, an intermediary will be acting for its customer when it is seeking out the best quote to meet the customer's requirements. However, if it has an arrangement to generally recommend a particular insurer, then the advice it gives may be a matter for us to consider in relation to that insurer.

Similarly, an intermediary is usually acting for its customer when it receives customer policy documentation from the insurer and forwards it to the customer. But intermediaries often write motor cover notes on behalf of the insurer and some may have wider authority to prepare and issue policy documents. In these cases, we may be able to consider any resulting complaints.

## ...at present, few intermediaries are covered by the Ombudsman Service

Sometimes, the insurer may delegate authority to the intermediary to accept proposals and even to decide some terms. The intermediary may also have a role on behalf of the insurer in the claims process. In these cases the actions the intermediary takes on behalf of the insurer fall within our jurisdiction.

These are not the only examples where we are able to settle disputes which, initially, may appear to be directed against intermediaries not covered by the Financial Ombudsman Service. It is by no means straightforward to identify which cases we can deal with. We are therefore working closely with the GISC and its disputes resolution service to ensure cases are handled by which ever of us is best placed to deal with the matter. In the longer term, the objective must remain to bring complaints about intermediaries into the jurisdiction of the Financial Ombudsman Service.

# 5 case round-up

The following cases show some of the range of issues we have considered in the last three months.

n 10/10

**Fraud – motor – policyholder submitting false receipt in proof of purchase – whether insurer entitled to reject damage claim.**

Miss F submitted a claim after her car was damaged by thieves. The insurer's engineer decided the car was beyond economical repair and the insurer would not settle the claim without proof of the amount Miss F had paid for the car. In fact, Miss F's boyfriend had given the car to her, but she produced a receipt showing she had paid £3,800.

The investigator appointed by the insurer discovered that it was the boyfriend who had purchased the car and that he had only paid £2,700. The insurer advised Miss F that it would not make any payment because she had presented false evidence in support of her claim. It explained that the policy terms justified its rejecting a claim entirely if a claimant submitted any forged or false document. Miss F argued that her boyfriend had given her the receipt and that she had no reason to believe it was not genuine.

**complaint upheld**

The insurer's liability under the policy terms was limited to settling the claim by paying the car's market value. The insurer's aim in asking to see the receipt was not to establish

the car's value but to obtain proof that Miss F had owned the car and to confirm its make, model and age. There was independent proof both of the car's existence and of Miss F's ownership of it. Clearly, we would not support any customer who produced fictitious evidence to gain more than their just entitlement, but that was not the situation here. The insurer's liability would have been the same even if Miss F had told the truth and said the car was a present from her boyfriend.

In the circumstances, we were satisfied that Miss F had suffered a genuine loss and that she had not attempted to claim more than her proper entitlement under the policy terms. We concluded that the insurer should pay Miss F the car's market value, plus interest.

n 10/11

**Personal accident – quadriplegia – policyholder disabled in four limbs – policy definition of 'quadriplegia' more restrictive – whether policyholder entitled to benefit.**

An extremely serious accident left Mr F with a major permanent disability. He was covered under a personal accident policy and the insurer made a payment of £125,000, the policy benefit for paraplegia – paralysis of the lower part of the body.

Mr F claimed he was entitled to a total payment of £250,000 on the ground that he was disabled in all four limbs. The insurer rejected his claim. It stated that Mr F did not fit its policy definition of 'quadriplegia' – 'permanent and total paralysis of the two upper limbs and two lower limbs'. The insurer relied on a medical report it had obtained. This stated that Mr F retained 'gross motor function in terms of shoulders and arms' and could 'form a primitive handgrip', even though he had lost the majority of his hand function and his 'pincer grip' was dramatically reduced.

**complaint upheld**

When Mr F took out the policy in March 1996, it did not include cover for either paraplegia or quadriplegia. These benefits were added in June 1998, but this 're-launch' of the policy had not included the definition on which the insurer relied. In the circumstances, we considered the claim should be assessed in the light of the ordinary meaning of the word 'quadriplegia'. Mr F's own medical advisers were satisfied that – in general medical terms – he ***was*** 'quadriplegic'. We therefore considered it unreasonable for the insurer to use a narrower definition. After our involvement, the insurer agreed to pay Mr F the balance of £125,000.

n 10/12

**extended warranty – theft – exclusion for claims without proof of 'forced and violent entry or exit' – whether proof of theft sufficient.**

Among other items stolen in a burglary, Mr O lost his 'surround sound' television speakers. Mr O had extended warranty insurance for the speakers, but this only included cover for theft so long as the product had 'been stolen by forced and

violent entry or exit'. The insurer repudiated the claim because Mr O could not provide evidence of 'forced and violent entry or exit'.

After the burglar had been caught and convicted, Mr O asked the insurer to reconsider his claim. He asserted that the burglar had gained entry to his flat by damaging the front door, its frame and lock. The insurer checked with the police, but rejected the claim again on finding none of this damage was mentioned in the crime report.

**complaint rejected**

There was a clear distinction between 'forced' and 'violent' entry. Unless the burglar had entered through an open door or window, his entry was doubtless 'forced'. However, 'violent' required proof of some physical damage to the property. Mr O could produce no evidence of this,so the insurer was justified in rejecting the claim.

n 10/13

**personal accident – loss of fingers – assessment of compensation.**

Mr J made a claim under his personal accident policy after cutting three of his fingers with a knife. He was dissatisfied with the insurer's offer of £4,221.30, based on loss of function of the affected fingers, and instead sought the full permanent total disablement benefit of £105,000. He maintained that his injuries meant he could no longer use his left hand well enough to continue his job as a sheet metal worker. He also sought compensation totalling £125,000. This comprised: £25,000 for time off work and loss of potential earnings, £20,000 a year for having to seek employment with lower earning potential and £80,000 for loss of the projected value of his company pension scheme.

**complaint upheld in part**

We did not consider Mr J was entitled to permanent total disablement benefit. This benefit was only payable to those whose injuries prevented them 'from engaging in any occupation for which he/she is fitted by reason of education, training or experience for the remainder of their life' and the medical evidence available did not justify this conclusion. Indeed, Mr J had retrained to work as a clerk. The policy did not provide cover for the other consequential losses for which he sought compensation.

The policy ***did*** provide for 10% of the sum assured to be paid for the loss of use of any finger and we were satisfied the insurer was correct in approaching Mr J's claim on that basis. However, following a reassessment of the medical evidence, we decided the insurer should increase its offer to £5,171.09.

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**household contents – non-disclosure – convictions – whether insurer entitled to avoid policy.**

In 1999, Mr N – a gardener – took out household insurance through his bank. He signed a form stating that he had no criminal convictions. However, when he made a theft claim the following year, the

insurer learnt that he had been sentenced to four years' imprisonment in 1985 for theft from commercial premises. As this conviction was still not 'spent' in 1999, the insurer treated the policy as if it had never been issued.

Mr N argued that his previous insurance company had been aware of his conviction and had covered him regardless, telling him the conviction was 'spent'. He also asserted that his bank manager knew of his conviction. However the bank manager was certainly aware that policy applications from anyone with a conviction were unacceptable and there was no record of his having any conversation with Mr N about this.

**complaint rejected**

Mr N did not provide us with any details of his criminal record, though it seemed surprising that he received such a long sentence for a relatively minor offence. We invited him to clarify this but he failed to respond. We were therefore satisfied that there was no ground for requiring the insurer to alter its decision. Mr N had not provided a correct answer to a clear question and we were unable to accept his contention that the insurer had been made aware of the true facts.

n 10/15

**Household buildings – escape of water – exclusion if property unoccupied – whether insurer would have covered unoccupied property.**

Mr D was trustee of a trust whose property included a house that he insured under a standard buildings policy. After the house became vacant on 25 October 1999, he left the central heating on and inspected the property once a week, but did not tell the insurer that the house was unoccupied. During December 1999, he was ill for a fortnight and unable to visit the house as regularly as before. When he next inspected the house, at the end of December, he discovered that a pipe had burst, causing extensive water damage.

The insurer rejected Mr D's claim, stating that the policy did not cover damage caused by escape of water if the property was unoccupied for more than 30 days.

**complaint upheld in part**

It was clear that the house had been unoccupied for more than 30 days when the damage occurred. And we were satisfied that the insurer had taken all reasonable steps to draw Mr D's attention to the exclusion.

However, when we asked the insurer what steps it would have required Mr D to take if he had told it the house was unoccupied, it said it would have required him to keep the central heating on and to inspect the property at weekly intervals. As Mr D had – in fact – complied with these requirements, until he became ill, we considered the insurer should deal with his claim. But because Mr D's illness had prevented him from inspecting the house every week, and this gap in inspections had increased the amount of damage, we decided the insurer should pay 80% of the claim, less the excess.

# out and about

Explaining our role and how we operate is an important part of our work. In recent months we have organised a number of presentations for Citizens Advice Bureaux, Trading Standards departments and local advice agencies. We have also provided training on the new complaints-handling rules and related ombudsman issues for a wide range of financial firms – from large corporations to small firms of stockbrokers and independent financial advisers.

If you would like us to arrange a workshop, training day or other event for your firm or organisation, just contact

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

Financial Ombudsman Service

# ombudsman consultation paper: **complaints from UK consumers about insurers and banks based outside the UK**

**Please respond by 15 December 2001**

We invite your comments on our current consultation paper – dealing with complaints from UK customers about banks and insurers based *outside* the UK.

As our new rules currently stand, complaints relating to firms based outside the UK are not covered by the ombudsman. Those firms include a number of general insurance subsidiaries of major UK firms, which sell travel and loan protection policies into the UK from their bases in Ireland.

We believe it would benefit firms such as these – and their customers – if we allowed them to join our 'voluntary jurisdiction', subject to some conditions. We have therefore proposed changes to the rules. These changes would affect certain banks and general insurance companies based outside the UK but within the European Economic Area.

You can view the consultation paper on our website at www.financial-ombudsman.org.uk/news/index.html

## services for professional complaints-handlers and consumer advisers

### our technical advice desk

provides general guidance on how the ombudsman is likely to view specific issues
explains how the ombudsman service works
answers technical queries
explains how the new ombudsman rules will affect your firm

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

### our external liaison team can

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

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