... I'm not seeing much that suggests consumers are more likely to make a speculative claim now than in the past.

Natalie Ceeney, chief executive and chief ombudsman

ombudsman news

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

who's trying it on?

It's not news that we're receiving record levels of complaints. And the media is never short of stories about the widespread lack of trust in financial services – and real-life examples of where financial institutions have got things badly wrong.

But recently, I've noticed a shift in the way this is reported and commented on. Alongside concerns about the banks' sales approach and incentives, I've noticed more talk of "fraudulent claints" – with some reports that people are claiming for policies they never actually had. All this fuels the argument that society's in the grip of "compensation culture" – and that this culture is growing in financial services.

I can't speak for other areas – and I'd imagine that people involved in delivering other services to the public may have a different perspective. But I'm not seeing much that suggests consumers are more likely to make a speculative claim now than in the past.

▶

Financial Ombudsman Service

scan for previous issues

in this issue

We have the legal power to dismiss complaints made by consumers who are being "frivolous and vexatious". We take this power seriously – and we use it. But outside mass disputes – like PPI – we don't find many of these cases.

I'd also expect to see our "uphold rates" affected by such a culture shift. But they're stable – and we actually upheld slightly more complaints last year than we did the year before. It's true that we're busier than ever, but the mounting number of cases reaching us isn't just down to PPI.

We're also seeing more complaints about other things – and we're upholding roughly the same proportion as we always have.

So if the perception of a compensation culture isn't supported by consumer behaviour, where has it come from? I would argue that the answer lies partly with financial businesses themselves. Faced with considerable evidence of bad practice – and hefty costs to put it right – it's tempting to deflect some of the responsibility back onto the consumer. Add to this the ever-present advertising by claims management companies – which bolsters the idea that people will willingly "have a go" – and the picture is complete.

But how has the claims management sector managed to gain such a foothold? Largely because of the mistakes made by financial businesses, and the fact that nobody moved quickly enough to put things right.

Many consumers have been wronged already. Some of these people are now being exploited by companies offering to help them get their money back. To accuse people of "trying it on" feels like another blow.

But as long as we're still getting those text messages telling us to claim money back from the PPI policy we've never even heard of, this idea that we're in the grip of compensation culture is unlikely to go away.

Natalie Ceeney
chief executive and
chief ombudsman

... to accuse people of "trying it on" feels like another blow

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

switchboard 020 7964 1000

consumer helpline
new extended opening hours
Monday to Friday 8am to 8pm *and*
Saturday 9am to 1pm
0800 023 4567 or **0300 123 9 123**

technical advice desk
020 7964 1400
Monday to Friday 9am to 5pm

travel insurance

Travel insurance covers a wider range of risks than any other type of insurance – and the cases we see involve a wide variety of different issues.

We know from our experience that many consumers expect travel insurance to cover *any* and *every* eventuality. But travel insurance policies contain strict limitations and exclusions on the cover they provide – and the amounts an insurer would have to pay if a consumer made a successful claim. Often, consumers only become aware of these restrictions when they need to make a claim. So these restrictions form the basis of many of the complaints we see.

We appreciate that travel insurance claims can be stressful and difficult to sort out. So we make allowances for the difficulties both insurers and customers can have – faced with unfamiliar surroundings, limited information or different time zones.

Our online technical resource contains more information about how we approach cases involving travel insurance. The case studies that follow illustrate some of the more common problems we see – including claims relating to:

- **"pre-existing medical conditions";**
- **lost belongings;**
- **cancelled holidays; *and***
- **"non-disclosure" of information.**

Financial Ombudsman Service

... they had no reason to believe that Mrs T's father was seriously ill

case study 105/1

complaint involving a rejected claim for a holiday cancelled due to a "pre-existing medical condition"

Mr and Mrs T booked a short break to Rome to celebrate their wedding anniversary. They booked their trip online, and took out travel insurance at the same time. A few weeks before they were due to travel, Mrs T's father was diagnosed with lung cancer. They decided to go ahead with the holiday. Sadly, on the day they were due to fly out, Mrs T's father died. They cancelled their trip and made a claim under their travel insurance for the cost of the holiday.

Their claim was rejected on the basis that Mrs T's father had a "pre-existing medical condition".

The insurer said that when they had taken the policy out, they would have been asked whether "anyone upon whom the travel plans depend" had been to a medical consultation or received treatment within the last two years for asthma, bronchitis, or any other lung or respiratory condition.

The insurer pointed out that Mrs T's father had been to his doctor with a cough and shortness of breath two months before they had taken out the insurance.

Mr and Mrs T complained to their insurer, saying that when they took out the policy, they had no reason to believe that Mrs T's father was seriously ill – and in fact they couldn't recall him having been to the doctor. When the insurer rejected their complaint, they referred the matter to us.

complaint upheld

As always, we looked at the evidence and listened to both sides of the argument. We decided that even if the couple *had* been aware that Mrs T's father had been to see his doctor with those symptoms, they couldn't be expected to have thought of what had seemed like a single episode of illness in terms of a "lung or respiratory condition" – or to have realised that their insurer would have wanted to know about it.

When we put this to the insurer, they said it was irrelevant whether the couple had been aware of Mrs T's father's illness – because pre-existing conditions were simply not covered by the policy. They said it didn't matter whether a customer was aware of a condition or not.

We pointed out to the insurer that rejecting a claim on this basis could mean that a customer – acting in good faith – could take out a policy and later discover that they had no cover. And we decided that in Mr and Mrs T's case, if the insurer was going to take this approach it would have needed to have done more to explain the implications to them when they took out the policy.

In these circumstances, we upheld the complaint – and told the insurer to put things right by paying the claim.

case study 105/2

consumer complains about claim rejected because trip did not meet conditions for a "journey"

Mr W decided to take his nephew to a theme park. He booked a coach trip, which included an overnight stay. Because Mr W already had an annual travel insurance policy he did not take out any additional cover.

Unfortunately, the day before they were due to travel, Mr W's nephew broke his leg. Mr W had to cancel the trip – and he made a claim under his travel insurance policy.

The insurer turned down Mr W's claim. It said that his trip did not meet the policy's definition of a "journey". Under the terms of his policy, a journey within the UK would only be only covered if he had travelled at least 25 miles away from his home, and had stayed for two or more nights in pre-arranged accommodation.

Mr W was unhappy with this response, so he complained to the insurer. He said it should have drawn his attention to the exclusion when he took the policy out – and that he would not have taken it out in the first place had he known about the exclusion. When his complaint was rejected, he referred the matter to us.

complaint not upheld

We were satisfied that Mr G's policy clearly stated that it only covered UK trips of at least two nights. We did not think this exclusion was unusual, so we would not have expected the insurer to have drawn it specifically to Mr W's attention.

We also asked Mr W why he had taken the policy out in the first place. He told us that he had needed it to cover some trips abroad that he had planned to make during the course of the year. But he was adamant that he would *not* have taken the policy out if he had known about the exclusion relating to UK travel.

Having considered all the arguments, we thought it was likely that even if the insurer *had* drawn this particular exclusion to his attention, he would still have taken the policy out.

We did not uphold the complaint.

... we would not have expected the insurer to draw this exclusion specifically to Mr W's attention

case study
105/3

consumers complain about a rejected claim for a missed flight

Mr and Mrs E booked a summer holiday to Parga in Greece. On their way to the airport, they were stuck in traffic because the police had closed the motorway. Unfortunately, they missed their flight. They phoned their insurer straight away, but could only get through to the medical assistance helpline – who couldn't help them.

Mr and Mrs E tried to find a different way of getting to Parga. They looked at various options but couldn't find any direct flights. And because other flights were last minute, they were expensive. In fact, they cost almost as much as Mr and Mrs E had paid for the holiday in the first place. Concerned about the cost and the inconvenience, they decided to abandon their holiday and go home.

When Mr and Mrs E got home, they made a claim for the cost of the holiday under their travel insurance. Their claim was turned down. The insurer said that although they were covered for a missed departure – and could have claimed up to £500 per person for alternative travel – they were *not* covered if they chose to cancel their holiday.

Mr and Mrs E complained to their insurer, saying they had looked into all the options and hadn't been able to find any appropriate alternative flights. When their complaint was rejected, they asked us to look into it.

complaint upheld

The fact that Mr and Mrs E were covered for missing the flight – because of exceptional and unforeseeable traffic conditions – was not in dispute. And if they had arranged alternative travel, the insurer would have paid their claim. So we needed to look into the options that had been available to them at the time.

We did some research ourselves and found that direct flights to Parga were very limited. We did establish that Mr and Mrs E *could* have booked a flight to a different airport – but that would have been to a different part of Greece and would have meant a difficult and time-consuming onward journey.

However, at such short notice – and faced with the prospect of a long and complicated journey – we could understand why they had decided to abandon their holiday. We could also see why they had been concerned about the cost – especially when they hadn't been able to get hold of anyone at the insurer who could help them.

In these circumstances, we concluded that it was fair and reasonable for the insurer to pay the claim. We told it to pay the couple the cost of the holiday, less the policy excess. We pointed out that this figure was probably lower than the amount it would have needed to pay if Mr and Mrs E had managed to organise alternative travel to Parga – and had claimed for those costs.

... they hadn't been able to get hold of anyone at the insurer who could help them

... they said that they had not deliberately given misleading information

case study 105/4

consumer complains about medical expenses claim rejected because of a "pre-existing medical condition"

When Mr and Mrs P booked a holiday to Thailand, they took out an annual travel insurance policy. Two days into their holiday, Mrs P developed a cough and was having trouble breathing. She was taken into hospital and diagnosed with a chest infection. Mr P contacted their insurer to ask for help.

The insurer contacted Mrs P's GP in the UK to discuss her condition. Five days later, someone from the insurer phoned Mr P to let him know that it wouldn't provide cover – because Mrs P had a "pre-existing medical condition".

When they returned to the UK, Mr and Mrs P complained to the insurer. They said that they had not deliberately given misleading information. They also complained about how long it had taken the insurer to make a decision about the claim – which they said had forced them to build up additional medical expenses.

When the insurer rejected their complaint, they referred the matter to us.

complaint not upheld

When we reviewed Mr and Mrs P's policy documents, we found it was set out very clearly that they would not be covered if, during the previous five years, either of them had "suffered from or received medical advice, treatment, or medication" for a number of conditions – including breathing conditions.

We also looked at the medical notes supplied by Mrs P's GP. The notes showed that she had been diagnosed with "chronic obstructive pulmonary disease" a few weeks before their insurance policy had been taken out.

In these circumstances, while we accepted that Mr and Mrs P had not set out to mislead the insurer, we did not think its decision had been unreasonable – because the claim had clearly been excluded by the policy.

We then looked at how long it had taken the insurer to make its decision. Although the insurer had taken five days to get back to Mr P with its decision, we established that it had waited three days to receive the information it needed from Mrs P's doctor. So we did not think the insurer had caused an unreasonable delay.

We did not uphold the complaint.

case study 105/5

complaint about a medical expenses claim rejected because repatriation "had not been necessary"

Mr and Mrs F went on holiday to Tuscany. While they were away Mrs F experienced an upset stomach and abdominal pain. Mr F, a surgical consultant, decided that his wife needed to be brought back to the UK as quickly as possible for treatment.

He and his wife had travel insurance as part of their joint bank account. So he contacted their insurer's medical helpline to ask them to help. Instead of making arrangements to repatriate Mrs F, the insurer suggested that Mr F take her to a local medical centre so that she could be examined. The insurer told Mr F that he needed medical advice on whether repatriation was necessary – and whether his wife was fit to fly.

Instead, Mr F paid £5,000 for a private aircraft and they flew back to the UK. When they got back, Mrs F was treated for mild gastritis.

Mr and Mrs F submitted a claim under their travel insurance for the costs of the flight home – which their insurer turned down. It said that Mr F had not followed the advice he had been given by their medical helpline.

Unhappy with this, Mr and Mrs F made a complaint. They said the wording of their policy had not given a clear explanation of the service offered by the medical helpline – and that Mr F had not felt able to trust the advice he had been given because staff were not medically qualified.

When the insurer rejected their complaint, Mr and Mrs F referred the matter to us.

complaint not upheld

We listened to both sides of the argument and looked at the evidence. When we reviewed Mr and Mrs F's policy document, we were satisfied that it *had* explained the service offered by the medical helpline.

The document said that where necessary, an experienced member of staff on the helpline would coordinate an appropriate response – including dealing with appropriate hospitals. They would also consult medical advisers on treatment and any possibility of repatriation.

The document also made it clear that only reasonable travel costs would be paid, and that a repatriation claim would only be paid if it was "confirmed to be medically necessary" by a medical practitioner. Although Mr F was a medical practitioner, he had not been able to explain why repatriation had been medically necessary – especially when adequate medical facilities had been available in the local area.

It was clear that the insurer's medical helpline had not thought it necessary – or appropriate – to repatriate Mrs F immediately – not least because she may not have been fit to fly. We did not think this had been unreasonable in the circumstances.

We appreciated that Mrs F's condition would have been very worrying for her husband. However, we did not think that arranging private repatriation had been reasonable or proportionate. So we did not uphold the complaint.

... a repatriation claim would only be paid if it was "confirmed to be medically necessary"

... we decided that they had reported the loss to a "relevant authority"

case study 105/6

complaint about a rejected claim for lost luggage

Mr and Mrs M booked a cruise from Miami to the Bahamas. To join the ship, they needed to fly to Philadelphia and get a connecting flight to Miami. Unfortunately, the flight to Miami was cancelled because of bad weather – and they were asked to board a flight to Tampa instead.

When they arrived in Tampa, they waited at baggage reclaim for Mr M's suitcase. When it didn't appear, they spoke to a member of staff at the airline – and were told that the suitcase had gone missing. They boarded the cruise ship, and explained the situation immediately to a member of staff. The ship's staff helped them make some more enquiries about the missing suitcase, but it was never found.

Mr M submitted a claim to his travel insurer. The insurer turned down his claim, saying he should have reported the matter to the police. Unhappy with this response, Mr M made a complaint. When this was rejected, he referred the matter to us.

complaint upheld

We looked at Mr and Mrs M's policy document. We found that to make a successful claim, they would have needed to report a missing item "to the police, or another relevant authority". Although they had not reported the missing luggage to the police, they *had* reported it to the airline and the cruise company – and been given a reference number by both. So we decided that they *had* reported the loss to a "relevant authority" – and satisfied the conditions set out in their policy. We told the insurer to put things right and deal with their claim in line with the policy conditions.

case study 105/7

complaint about a medical expenses claim rejected for "non-disclosure"

Mr and Mrs D booked a holiday to Australia. They decided to take out some travel insurance – and spoke to the insurer's medical helpline to answer some questions about their health. During the conversation, Mr D told the adviser that he suffered from diabetes. The adviser said that he could still be covered, but would need to pay an additional premium.

Unfortunately, while they were away, Mr D became ill and was taken to hospital. He was told that he had had a heart attack. Mrs D contacted their insurer, and was told that it would make some enquiries with Mr D's GP in the UK before confirming whether it would accept the claim.

The GP told the insurer that Mr D had been taking regular medication for high blood pressure and high cholesterol. The insurer then turned down Mr D's claim. It said if it had known he had been taking medication for these conditions, it would not have sold him the policy.

Mr D disagreed with the insurer's decision. He pointed out that his policy specifically said that high blood pressure and high cholesterol would be covered as long as they were well controlled. He argued that his were. When the insurer rejected his complaint, he referred the matter to us.

complaint not upheld

We listened to both sides of the argument. We noted that Mr D *had* told the insurer about his diabetes. But when we asked him why he hadn't told the insurer about his high blood pressure and high cholesterol, he couldn't give us a reasonable explanation.

We also looked at transcripts of the conversation between Mr D and the adviser on the insurer's medical helpline. When Mr D was asked whether he had "ever been advised to take medication for high blood pressure" he said "no".

In light of the evidence, we decided that the insurer had acted reasonably in rejecting Mr D's claim, and we did not uphold the complaint.

case study
105/8

complaint about the automatic renewal of a travel insurance policy

Mr O knew he would be going abroad a few times in one year, so he took out an annual travel insurance policy. During the year, his insurer sent him the occasional email about his policy and other travel-related updates. Just before Mr O's policy was due to expire, his insurer renewed it automatically – and he was charged £60 for the premium. Mr O complained to the insurer, saying that he had not intended to renew the policy and that he had not been made aware that it would happen automatically.

The insurer responded, telling Mr O that the automatic renewal had been explained in the paperwork he had been given when he had taken out the policy. The insurer also said it had written to Mr O before the policy was due to expire to let him know that it would be renewed – unless he got in touch with them within 14 days to ask them not to renew it.

Mr O told the insurer that he had not received a letter from them – and that the first he'd heard of it was when he checked his bank statement. He also asked why they hadn't got in touch with him by email – just as they had been doing all year. When the insurer stuck to its original position, Mr O asked us to look into the matter.

complaint upheld

Weighing up the facts, we had no reason to doubt that the insurer had sent Mr O a letter. But we also accepted his argument that he had never received it.

Although Mr O's policy documents *did* make it clear that the policy would be renewed automatically, we wouldn't usually expect a consumer to remember this a year later. So the dispute turned on the way the insurer had alerted Mr O to the renewal.

The insurer said it had written to him. But we took into account the fact that it had sent Mr O emails throughout the year – and so we could understand why he had assumed he would get an email about the renewal. And we also noted that the "cooling off" provisions in the policy – which explained his right to cancel – said that the insurer would communicate with the customer by email.

Taking all this into account, we concluded that the insurer had not taken reasonable steps to alert Mr O to the fact that his policy would be renewed automatically. We accepted that Mr O had not wanted to renew his policy – and told the insurer to refund him the £60 renewal premium plus interest.

... the first he'd heard of it was when he checked his bank statement

... what was not in dispute was the fact that the briefcase was clearly valuable

case study 105/9

complaint about a rejected claim for a missing bag

Mr R and a colleague were in India on a business trip. They travelled from Mumbai to Delhi by train. The train was very crowded and Mr R left his briefcase in the luggage compartment. When they arrived in Delhi, Mr R realised that his briefcase had gone missing. He was particularly upset because the briefcase had been a present from his wife. It was an expensive designer brand – and it had also contained his laptop. He reported the incident to railway staff and to the police.

Mr R made a claim under his travel insurance policy. His insurer turned down the claim on the basis that he had failed to comply with the conditions of the policy – which stated that he "must take all reasonable precautions to safeguard belongings from loss, damage or theft". It also excluded "loss, theft of or damage to valuables left unattended at any time".

Mr R complained to the insurer. He said that when he had referred to the luggage compartment, he had actually meant the space under his seat. He also told the insurer that he had only left his seat a couple of times to use the toilet – and that his colleague had been looking after the briefcase while he was away from his seat. He argued that he had therefore taken reasonable precautions to safeguard his briefcase, and that he had not left it unattended.

When the insurer refused to change its mind, Mr R referred the matter to us.

complaint not upheld

When we looked into the detail of the case, we could find no clear evidence to show where Mr R had left his briefcase – or where his colleague had been sitting when the briefcase went missing.

However, what was not in dispute was the fact that the briefcase was clearly valuable. We thought this would have made it particularly attractive to a thief. So bearing in mind how valuable the briefcase and its contents were – and how crowded the train had been – we were surprised that Mr R hadn't taken more care to make sure this particular item was safe.

Taking all the circumstances of the case into account, we concluded that the insurer had acted reasonably in turning down Mr R's claim.

... they would have expected their luggage to be in safe hands

case study
105/10

complaint about rejected claim for lost baggage

Mr and Mrs A were staying in a hotel in Austria. On the last morning of their holiday, they were due to travel by coach to the airport. They checked out of their room and left their luggage with the hotel porter to be loaded onto the coach while they had breakfast.

When they came back to the reception area, their luggage was missing. The hotel couldn't explain exactly what had happened, but they thought the porter must have put the luggage on the wrong coach. Unfortunately, they never managed to track it down.

When they got home, Mr and Mrs A submitted a claim for their lost luggage. Their insurer rejected the claim. It said that their policy terms excluded "any personal belongings or baggage you lose or are stolen while they are not in your control or while they are in control of any person other than an airline or carrier".

Mr and Mrs A complained, saying that they would expect a hotel porter to be considered a "carrier". But when the insurer disagreed, they referred the matter to us.

complaint upheld

Having looked carefully at the circumstances, we took the view that Mr and Mrs A had acted reasonably when they had left their suitcases with the porter. After all, it was his job to handle luggage and they would have expected it to be in safe hands. We also thought they could reasonably expect their insurance to cover such an ordinary scenario – especially as their policy had not defined what it had meant by a "carrier".

We concluded that had Mr and Mrs A been aware they would not be covered in these circumstances, it is likely they would have acted differently – and would probably have kept their luggage with them. So we told the insurer to pay the claim, plus interest.

... our approach to this kind of case is well established

case study 105/11

complaint about a rejected claim for a holiday cancelled because of ill-health

Mrs B was in good health – although she occasionally suffered from sinus pain and migraines. However, while she was shopping in the supermarket, she felt dizzy and passed out for a few minutes.

Although this had never happened before – and she felt fine afterwards – she made an appointment with her GP just to get herself checked over. When she saw the doctor a few days later, Mrs B explained that she had felt fine before and since her dizzy spell.

Her doctor looked at her symptoms and medical history – and concluded that the incident had probably been related to a migraine. However, to be on the safe side, he referred Mrs B to the hospital for a brain scan – to rule out the possibility of a more serious issue, like a minor stroke.

In his referral letter to the hospital, the doctor stressed he did not think Mrs B had suffered a stroke. But he wanted her to have the scan to "rule this out once and for all".

Mrs B was given an appointment for the first week in January. Just before Christmas, she decided to book a week's holiday in mid-January – and took out a travel insurance policy at the same time.

The result of the scan confirmed that Mrs B had in fact suffered a minor stroke. She was told that she shouldn't fly for at least six months – so she cancelled her holiday and put in a claim under her travel insurance.

The insurer rejected Mrs B's claim. It said that the policy contained an exclusion that meant cover would not be offered for:

"*... any condition of which the policyholder was aware at commencement of the policy or for which he/she received advice, treatment or counselling from any registered medical practitioner during the 12 months preceding the commencement date, whether diagnosed or not.*"

complaint upheld

We listened to both sides of the argument. Although the insurer insisted it had acted correctly in turning down Mrs B's claim, we disagreed. We pointed out that when Mrs B had taken the policy out, both she and her GP had thought that the fainting incident had been a one-off – and had been caused by a migraine, not a stroke. After all, the GP's letter to the hospital had mentioned the need to "rule out the possibility" of something more serious than a migraine.

Our approach to this kind of case is well established – so we were disappointed that this case had to be referred to us to resolve.

We told the insurer to pay the claim – along with interest from the date Mrs B had cancelled the holiday. We also said the insurer should compensate Mrs B for the distress and inconvenience it had caused her.

ombudsman focus: **second quarter statistics**

a snapshot of our complaint figures for the *second quarter* of the **2012/2013** financial year

Since September 2009 we have been publishing complaints data on our website every six months about named individual businesses. The data shows the number of new complaints – and the proportion of complaints we upheld in favour of consumers – for businesses that have 30 or more new cases (and 30 or more resolved cases) in each six-month period.

We published our latest set of complaints data in September – covering the period from 1 January to 30 June 2012. During this six-month period:

- **we received a total of 135,170 new complaints – a 27% increase on the previous period;**
- **91% of the total number of cases came from 169 financial businesses (out of more than 100,000 businesses covered by the ombudsman);**
- **complaints about payment protection insurance (PPI) made up 63% of the total complaints – with 85,562 new PPI complaints (compared to 49,419 in the previous six months);**
- **five banking groups accounted for 71% of all new PPI cases; and**
- **the uphold rate for PPI complaints ranged from 5% to 98% – with the ombudsman upholding 71% on average.**

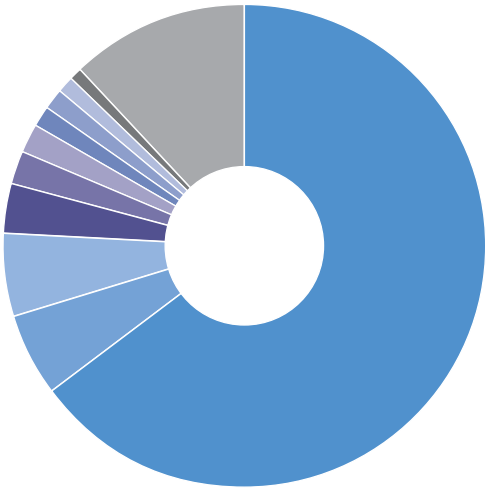
We also publish updates in *ombudsman news* on a *quarterly* basis – showing what kind of financial products people have complained about and what proportion of complaints about different products we have upheld in favour of consumers.

In this issue of *ombudsman news* we focus on data for the *second* quarter of the financial year 2012/2013 – showing how many new complaints we received, and what proportion we resolved in favour of consumers, during July, August and September of this year. This follows the similar set of data we published in June 2012 (in issue 103 of *ombudsman news*) covering the first quarter of the financial year 2012/2013.

payment protection insurance (PPI)
current accounts
credit card accounts
house mortgages
overdrafts and loans
car and motorcycle insurance
deposit and savings accounts
buildings insurance
mortgage endowments
travel insurance
term assurance
whole-of-life policies
personal pensions
“point of sale” loans
contents insurance
investment ISAs

Financial Ombudsman Service

the financial products that consumers complained about most to the ombudsman service in July, August and September 2012



- payment protection insurance (PPI) 65%
- current accounts 5.5%
- credit card accounts 5.4%
- mortgages 3.3%
- overdrafts and loans 2.3%
- car and motorcycle insurance 2%
- deposit and savings accounts 1.4%
- buildings insurance 1.3%
- mortgage endowments 1.2%
- travel insurance 0.7%
- complaints about other products 11.9%

number of new cases			
Q2 (Jul to Sep) 2012/13	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11
66,882	32,445	157,716	104,597
5,658	3,543	14,057	19,373
5,634	3,716	18,977	17,356
3,463	2,234	9,530	7,060
2,379	1,744	6,239	5,805
2,051	1,715	7,264	5,784
1,451	825	3,734	4,326
1,360	1,060	4,556	3,469
1,202	907	3,267	3,048
707	472	2,400	2,503
697	464	1,432	926
657	530	1,828	1,444
620	405	1,496	1,126
520	444	2,247	2,765
494	445	2,089	1,697
481	305	904	824

% resolved in favour of consumer			
Q2 (Jul to Sep) 2012/13	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11
68%	69%	82%	66%
32%	33%	31%	27%
44%	49%	54%	61%
27%	26%	28%	36%
37%	36%	38%	43%
48%	54%	49%	45%
40%	42%	44%	42%
49%	47%	50%	42%
21%	25%	28%	31%
45%	52%	52%	42%
11%	12%	23%	27%
23%	26%	32%	33%
36%	32%	35%	36%
40%	42%	45%	36%
43%	43%	52%	41%
25%	40%	51%	48%

* Complaints involving home emergency cover and mobile phone insurance were previously categorised under "specialist insurance" – and were not shown separately in previous years.

** This table shows all financial products and services where we received (and settled) at least 30 cases. This is consistent with the approach we take on publishing complaints data relating to named individual businesses. Where financial products are shown with a double asterisk, we received (and settled) fewer than 30 cases during the relevant period.

portfolio management
hire purchase
home emergency cover
debit and cash cards
critical illness insurance
income protection
debt collecting
endowment savings plans
inter-bank transfers
warranties
unit-linked investment bonds
catalogue shopping
legal expenses insurance
private medical and dental insurance
direct debits and standing orders
pet and livestock insurance
"with-profits" bonds
specialist insurance
mobile phone insurance
self-invested personal pensions (SIPPs)
annuities
cheques and drafts
store cards
guaranteed bonds
secured loans
share dealings
credit broking
payday loans
debt adjusting
commercial vehicle insurance

number of new cases				% resolved in favour of consumer			
Q2 (Jul to Sep) 2012/13	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11	**Q2 (Jul to Sep) 2012/13**	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11
460	300	1,152	1,148	**49%**	59%	63%	67%
442	383	1,545	1,395	**41%**	39%	43%	43%
364	290	1,473	*	**59%**	66%	69%	*
355	201	836	878	**48%**	37%	40%	41%
348	234	817	528	**26%**	20%	31%	31%
336	291	950	702	**25%**	31%	41%	42%
305	233	576	512	**48%**	40%	38%	42%
274	183	875	924	**21%**	24%	33%	33%
273	158	688	529	**39%**	44%	42%	43%
256	176	881	895	**63%**	56%	63%	61%
254	166	856	849	**40%**	40%	64%	72%
224	160	695	582	**58%**	55%	60%	66%
221	178	779	619	**34%**	26%	26%	21%
214	158	513	506	**34%**	34%	46%	50%
208	100	538	571	**47%**	44%	47%	45%
207	221	554	438	**58%**	53%	40%	31%
202	146	542	683	**20%**	21%	27%	37%
197	197	791	1,791	**59%**	58%	53%	51%
193	134	599	*	**72%**	61%	63%	*
179	128	499	417	**62%**	46%	61%	46%
178	113	511	423	**25%**	25%	35%	37%
178	131	670	691	**42%**	50%	47%	47%
161	137	476	480	**59%**	64%	67%	70%
160	81	352	408	**25%**	35%	35%	40%
151	**	**	**	**16%**	**	**	**
146	139	549	979	**36%**	49%	50%	62%
145	112	627	697	**67%**	57%	68%	63%
145	126	296	59	**74%**	77%	81%	64%
141	106	462	302	**66%**	71%	63%	54%
139	121	436	317	**45%**	46%	38%	36%

commercial property insurance
state earnings-related pension (SERPs)
personal accident insurance
electronic money
(non-regulated) guaranteed bonds
roadside assistance
guaranteed asset protection (“gap” insurance)
hiring/leasing/renting
occupational pension transfers and opt-outs
business protection insurance
merchant acquiring
unit trusts
OEIC – open-ended investment companies
spread betting
debt counselling
building warranties
money remittance
“structured capital-at-risk” products
total
other products and services

number of new cases				% resolved in favour of consumer			
Q2 (Jul to Sep) 2012/13	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11	**Q2 (Jul to Sep) 2012/13**	Q1 (Apr to Jun) 2012/13	full year 2011/12	full year 2010/11
131	98	629	429	**35%**	33%	34%	31%
131	88	294	196	**2%**	4%	2%	7%
121	87	322	304	**37%**	45%	47%	49%
107	83	403	369	**26%**	27%	33%	36%
101	80	484	430	**42%**	40%	46%	40%
101	62	364	300	**45%**	47%	49%	40%
83	60	213	182	**17%**	27%	44%	46%
83	66	240	221	**38%**	23%	46%	43%
83	60	331	281	**42%**	53%	43%	49%
71	**	160	204	**48%**	**	27%	22%
51	35	206	110	**25%**	24%	21%	15%
42	**	138	125	**41%**	**	52%	65%
35	**	141	140	**54%**	**	47%	76%
34	**	165	219	**68%**	**	23%	21%
30	**	124	155	**63%**	**	57%	53%
**	**	129	121	**	**	38%	39%
**	**	114	68	**	**	44%	47%
**	**	139	550	**	**	90%	52%
102,516	57,076	262,581	204,257	**48%**	50%	64%	51%
681	714	1,794	1,864	**37%**	37%	45%	34%
103,197	**57,790**	**264,375**	**206,121**	**48%**	**50%**	**64%**	**51%**

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Q? &A

featuring questions that businesses and advice workers have raised recently with the ombudsman's technical advice desk – our free, expert service for professional complaints-handlers

question

What is the difference between a "final response" and a "final decision"? And is an "adjudication" something different? I'm confused!

answer

Jargon is confusing. That's why we really don't like using it. But we do have some standard processes for dealing with cases – and we need to describe the different stages somehow. It might be useful to have a look at the *complaints handling rules* on our website – where some of the terms you mention are explained. In the meantime, this is what those terms mean.

A "final response" is the answer that a business gives to a consumer when it has investigated a complaint. It usually comes in the form of a letter. Once the business has given its answer – or if it takes more than eight weeks to give an answer – the consumer can bring the complaint to us.

Most complaints that are referred to us are resolved informally by our adjudicators and case assessors. But if necessary, an ombudsman will issue a "final decision" to resolve the dispute formally and bring the process to an end.

An "adjudication" or "assessment" are ways we can set out our view on a case more informally than with an ombudsman's decision.

We might use this where, for example, we think that the business needs to do something to put things right, but we don't fully agree with what the consumer wants. This is sometimes the most practical way to resolve a dispute to the satisfaction of both the consumer and the business. You can read more about our process in our *quick guides for businesses* – available in the publications section of our website.

question

We are an insurance company and one of our customers has made a claim for storm damage to a roof. We sent an appointed loss adjuster out to survey the damage – and their report says that the roof was old and in quite bad condition. Will the ombudsman agree with our decision to turn down the claim because our policy excludes wear and tear?

answer

We would first need to look at what the consumer was told when they took the policy out. We would look at their policy documents. If the exclusion clause is unclear or hard to find, then we may decide that it isn't fair to apply it – even if the roof is in bad repair. If the exclusion is prominent and easy to read, we would move on to consider the circumstances and the evidence available to us.

This might involve analysing the loss adjuster's report, looking at any accompanying photographs and speaking to the consumer and the loss adjuster to hear their accounts of the site visit.

Ultimately, we would need to identify the main cause of the damage. If the roof was in such a bad condition that the damage was likely to happen in the very near future, regardless of the storm, then it might be fair to apply the exclusion.

However, if the extreme weather was the main reason that the roof was damaged, then we would be likely to recommend that the claim is paid.

For more details on our approach to storm damage complaints, have a look at our technical note on storm damage in the publications section of our website.

Financial Ombudsman Service