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

cutting through the confusion

A friend recently told me about an experience she'd had dealing with her mobile phone service provider. She'd been having a bit of trouble with her phone, and even though it seemed to sort itself out after a couple of days, she rang the company to find out what had happened. She wanted to be able to stop it happening again.

But try as she might, she just couldn't get the person on the helpline to appreciate her problem. She was repeatedly offered £50 compensation – when what she really wanted was an explanation. Ultimately, she went away feeling more bewildered than she had been before she called. And she still had no idea why her phone had been playing up.

For my friend, the consequences weren't serious in the grand scheme of things. It made a good anecdote for a while afterwards. But at the time, it was incredibly frustrating – she felt really fobbed off.

Unfortunately, this kind of thing happens far too commonly within the financial services industry as well.

Financial Ombudsman Service

scan for previous issues

in this issue

Caroline Wayman

Confusion instead of clarity – or "fobbing-off" instead of listening – continues to drive people to us, when things could have been put right so much earlier on.

Mistakes happen, but they need to be learnt from. Earlier in the month, we published information on the number of complaints we'd received, and who they were about. And the data reinforced one thing – some businesses *aren't* learning.

This issue of *ombudsman news* looks at two areas where we see the same types of problems crop up time and again. First we look at travel insurance exclusions – specifically focusing on situations where the policyholder may – or may not – have been drinking alcohol. Then we turn to motor insurance – the second most complained-about insurance product after payment protection insurance (PPI).

In both of these areas, we see too many cases where customers have been treated much like my friend was. As a sector, we need to do something about that.

That means really listening to people – rather than blindly following process. Cutting through the confusion and asking, "how can we sort this out?"

By the time they hang up the phone or reach the end of a letter, people should be feeling they've been heard – and confident everything's in hand.

Caroline

... mistakes happen, but they need to be learnt from

Financial Ombudsman Service
Exchange Tower
London E14 9SR

switchboard 020 7964 1000

consumer helpline
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

follow us online

travel insurance – alcohol exclusions

Last year travel insurance made up only 2% of our overall caseload. But that still means more than 2,000 people felt their claim had been unfairly turned down.

Each year we see the same issues crop up time and again within travel insurance complaints – and we're finding that businesses aren't settling complaints in line with our well-established approach. In fact, last year we upheld 53% of travel insurance cases referred to us – up from 42% in 2011.

We're often asked to step in when an insurer is insisting that someone had been drinking alcohol before having an accident – and is refusing to pay out as a result. The majority of travel insurance policies exclude cover for events that happen after excessive alcohol consumption – but that doesn't mean holidaymakers will only be covered if they don't drink at all.

In some cases, we find that terms describing alcohol consumption aren't clearly defined in the policy – or have been unfairly applied by the insurer to reject a claim. For example, we see cases where insurers accuse their customers of "alcohol abuse" or "alcoholism", even though medical evidence shows they only had one or two drinks.

Similarly we see cases where insurers have jumped to conclusions about what had happened – for example, because of someone's age or the particular resort they were in. But it's our job to look at the evidence. We'll consider any medical reports and accounts of what happened when making our decision.

As with all insurance cases, it is up to an insurer to show that an exclusion applies, not for their customer to show that it doesn't. We expect a high standard of proof from insurers – proof that's consistent with other evidence. We generally put more weight on evidence from blood tests – and less on one-off remarks by a doctor at the time of any accident.

If we decide a claim should have been paid, we'll tell the insurer to meet it, adding interest.

Sometimes, the consequences of an accident are particularly sensitive or distressing – for example, the death of a family member, or an upsetting experience in a foreign hospital.

If an insurer has wrongly turned down a claim, we'll consider whether this caused additional upset for their customer. We'll also take into account whether someone has been pressured for payment of medical expenses that should have been covered.

Equally, we'll explain to the consumer if we think that, on balance, the insurer made the right decision in the circumstances.

Financial Ombudsman Service

case study 120/1

consumer complains that insurer wrongly accused him of "alcohol abuse" when rejecting his claim

Mr J was on holiday in Australia, enjoying a night in a bar in Sydney. Unfortunately, during the night he had an accident – falling down some stairs. He injured himself quite badly – breaking a leg and suffering severe head trauma. He was taken to a hospital and treated for his injuries, including emergency surgery to remove a blood clot that was potentially life-threatening.

When Mr J was able to, he submitted a claim to his travel insurer to reimburse his medical bills. But after a short investigation, the insurer turned down his claim. They said that they had evidence that he'd drunk an excessive amount of alcohol – and blamed his fall on the amount he'd had to drink.

The insurer said that they had a witness account from the bar manager, who said that Mr J had bought numerous shots, glasses of wine and beers.

The insurer also said that the doctor treating Mr J had noted that Mr J "smelled of alcohol" when he'd been admitted into hospital.

The insurance policy excluded cover for claims arising because of, among other things, "*alcohol abuse, alcoholism*". The insurer said that Mr J's actions had constituted "alcohol abuse" – and so the event wasn't covered.

Mr J was very unhappy, so he complained about the insurer's decision. But when they wouldn't change their stance, he decided to turn to us for help.

complaint upheld

The insurer shared their evidence with us – sending us the bar manager's witness account and the doctor's report. When we looked at the manager's statement we noticed that it only said that Mr J had *bought* a number of drinks – there was no mention of how much he'd personally *drunk*.

So we asked Mr J to share his side of the story with us. He told us that he'd been out in a bar with a few friends. He had bought a number of drinks, but he'd only had two pints – most of the drinks he bought had been for his friends.

He told us that during the night he'd had a drink spilt on him, which he said was probably why the doctor smelled alcohol on him.

Mr J had been drinking – he admitted that. What we had to determine was whether the amount he'd had to drink meant that his insurer could fairly reject his claim.

We looked at the policy that Mr J had, and in particular the exclusion to do with alcohol. It said "*You are not covered for anything caused as a consequence of: … alcohol abuse, alcoholism*". Neither "alcohol abuse" nor "alcoholism" was defined.

As neither term was defined, we took the common meaning for each of them. Alcoholism is a dependency on alcohol, and alcohol abuse typically means prolonged or regular over-consumption of alcohol. Neither of these definitions seemed to match Mr J's behaviour.

We decided that the insurer didn't have enough evidence to back up their rejection of his claim. So we told them to pay his claim, with interest.

... Mrs D was baffled, and wanted to know how the insurer had reached their decision

case study 120/2

consumer complains that the diagnosing doctor wrongly identified excessive drinking – leading to a rejected claim

Mrs D was on a cruise holiday, when she became unwell. The ship's doctor examined her, taking notes about her circumstances and how she felt. The doctor said that Mrs D should go to a hospital when they next docked.

At the hospital, Mrs D was checked by another doctor. He told her that she was suffering from acute pancreatitis. Mrs D received treatment and was discharged. When she left the hospital, she put in a claim on her travel insurance to cover her medical bills and the cost of getting home.

But when her insurer looked into her claim, they rejected it – saying they wouldn't pay a claim "*arising from the influence or effect of alcohol*."

Mrs D was baffled, and wanted to know how the insurer had reached their decision. They said that they had a report from the doctor at the hospital which said that Mrs D's pancreatitis was caused by her "*extensive history of alcohol use*". The report also said that Mrs D had drunk "*an extraordinary volume of alcohol immediately preceding her illness*".

Mrs D explained that she'd had an injury a few years earlier which had caused pancreatitis – but that had been treated successfully. She said she'd never been a heavy drinker. She also contested the doctor's point about her drinking an "extraordinary volume of alcohol".

But when the insurer wouldn't change their stance, she complained. Both sides reiterated their sides of the story – but neither party would budge.

Mrs D was getting quite frustrated – so brought the matter to us.

complaint upheld

To get some context for Mrs D's pancreatitis we asked her GP for her medical records. When we looked through them, we could only see one reference to alcohol. About ten years earlier there was a note saying "light drinker". Apart from that, there was no mention of alcohol – and importantly no mention of "extensive use" of alcohol.

We also got the medical report from the ship's doctor who had originally helped Mrs D. In it, the doctor noted that Mrs D had last drunk three nights before she felt unwell – and it hadn't been an excessive amount.

Mrs D told us that the hospital's doctor had said that he was teetotal. She said that he'd seemed quite judgemental – and suggested that he might have been prejudiced against her as a result.

Much of the evidence we had seen was contradictory. No blood tests had been carried out, which would have definitively shown how much alcohol Mrs D had in her system when she became ill.

We couldn't say for certain exactly what had happened. But the evidence Mrs D had provided called into question the accuracy of the hospital doctor's report. Given this, we didn't think the insurer had done enough to prove that Mrs D's condition had arisen "*from the influence or effect of alcohol*". So we told the insurer to pay Mrs D's claim, including interest.

We also told them to pay Mrs D £300 for the stress she'd been put through trying to make her claim, while she was receiving demands for payment from the hospital.

... he had gone to hospital after a severe panic attack – and hadn't drunk anything

case study 120/3

consumer complains that alcohol exclusion couldn't apply – as he hadn't been drinking

While he was on holiday in Canada, Mr O became unwell. He went to a local hospital and they assessed him. The doctors diagnosed him as having "*alcohol withdrawal symptoms*" and began treating him.

When he felt well enough, Mr O submitted a claim to his travel insurer so they could reimburse his medical costs.

His insurer looked into the matter and then decided to reject his claim. They said to Mr O that he wasn't covered for anything relating to "*alcohol abuse*" or "*alcoholism*".

Mr O complained. He said that he had gone to hospital after a severe panic attack – and hadn't drunk anything before the incident. He said that the insurer couldn't turn down his claim based on anything to do with alcohol, because he hadn't drunk any.

Mr O and his insurer's conversations were becoming more strained – so Mr O approached us for some help.

complaint not upheld

The insurer sent us a copy of the terms and conditions of Mr O's travel insurance policy. The policy was quite clearly set out. It prominently said that circumstances related to "*alcohol abuse*" or "*alcoholism*" wouldn't be covered.

So we had to decide if Mr O's circumstances were covered by the policy, and whether the insurer was fair in their decision to reject his claim.

We asked the insurer for a copy of the hospital's report from when Mr O was treated. As Mr O had said, he had been admitted following a severe panic attack.

But the doctor had noted that the reason for his panic attack had been "*ethanol withdrawal*" and he was showing "*alcohol withdrawal symptoms*".

In order for someone to display symptoms of ethanol withdrawal, we considered it likely that there had to have been prolonged and heavy use of alcohol. The hospital report also indicated that Mr O had been a heavy drinker in the months leading up to the trip.

So while we could see Mr O's logic that he should be covered because he hadn't drunk anything, we disagreed with his interpretation of the terms and conditions.

We appreciated that this must have been a stressful event for Mr O. But we told him that the insurer hadn't acted unreasonably in declining his claim.

case study 120/4

consumer complains after his insurance claim is declined – saying he'd drunk a normal amount for someone on holiday

Mr K's daughter lived abroad, and as he hadn't seen her in a while he took some time off work and went to visit her.

One night near the end of his holiday, he fell and injured himself quite badly. He went to hospital, where he was examined and treated. Once he was able to, he called his travel insurer to tell them what had happened, and to put in a claim for his medical expenses.

The insurer looked into the matter, but they turned his claim down. They said that they wouldn't pay "*any claim arising directly or indirectly from ... excessive alcohol intake*." They said that they had evidence from the doctor who treated him that Mr K was "*heavily intoxicated*".

... She told the insurer she'd been honest on the claim form about what she'd had to drink

Mr K challenged this. He said that there had been an uneven floor, and he hadn't drunk an unusual amount for someone on holiday.

The insurer wouldn't change their decision – so Mr K complained to us.

complaint not upheld

First we wanted to see what evidence the insurer had used to decline Mr K's claim.

They sent us two things – the results of a blood test and the notes that the doctor had made following Mr K's admission to hospital.

The blood test showed that Mr K's blood alcohol content was particularly high – roughly four times the UK driving limit. The doctor's notes also said that Mr K "*appeared intoxicated*" and had "*impaired mobility*".

Having such a high concentration of alcohol in his blood almost certainly affected how steady his movements were. And taken together with the doctor's statements about Mr K's condition, it didn't seem unreasonable for the insurer to reject Mr K's claim as they had. So we didn't uphold Mr K's complaint.

case study 120/5

consumer complains that insurer has rejected claim on grounds of "excessive" alcohol consumption

Mrs M took a week's holiday in Greece with her sister and some friends. After the group had visited a beachside bar one evening, she returned to her room at their villa. Unfortunately, she hit her head on a bedside table as she was getting into bed, and needed to go to hospital for stitches and overnight observation.

Once she was discharged, Mrs M contacted her travel insurer to claim back her medical expenses. But the insurer wouldn't pay out – saying Mrs M had been over the UK driving limit when the accident happened. In their view, it was clear Mrs M's injury was alcohol-related – and their policies excluded claims "*arising directly or indirectly from excessive alcohol intake*".

Mrs M complained. She told the insurer she'd been honest on the claim form about what she'd had to drink.

But she didn't feel three drinks over the course of an evening was "excessive". In any case, she thought the accident would have happened anyway – she'd just got into bed awkwardly.

When the insurer refused to reconsider, Mrs M referred her complaint to us.

complaint upheld

We explained to the insurer that if they wanted to reject Mrs M's claim, it was for them to show the alcohol exclusion applied – rather than for Mrs M to prove it didn't.

We asked to see the medical evidence that the insurer has used to decide Mrs M had been drinking "excessively". We were sent the results of tests that had been carried out when Mrs M was admitted to hospital – which showed that her blood alcohol level was above the UK driving limit. This broadly corresponded with what Mrs M had herself told the insurer she'd had to drink.

But when we looked at the terms and conditions of Mrs M's policy, we found they didn't actually define what the insurer meant by "excessive" alcohol intake.

And by an everyday definition, we didn't agree that what she'd drunk was necessarily an "excessive" amount for a holidaymaker who wasn't planning on driving – especially over a long evening.

Taking these facts together, we came to the view that the insurer had reached an unfair conclusion. People can be clumsy and have accidents even when they're sober.

From what we'd seen, we decided the insurer had wrongly rejected Mrs M's claim. So we told them to pay her medical expenses, with interest.

case study 120/6

consumer's brother complains that insurer has rejected claim – on grounds that alcohol consumption contributed to his sister's death

Miss H died after falling down the stairs of the French house she'd been renting one autumn. Her brother, Mr H – acting for her estate – claimed on her travel insurance for the payment available if the policyholder died.

After considering the claim, the insurer decided not to pay out. They told Mr H that medical evidence showed Miss H had drunk a significant amount of alcohol before the accident. And their policies excluded claims arising "*directly or indirectly from excessive alcohol intake*".

Mr H complained. He felt the insurer was wrong to link Miss H's death to alcohol – because she could have slipped and fallen anyway. He said he couldn't believe the insurer wouldn't cover anyone who'd been drinking, because it was clear holidaymakers would drink. He argued that if Miss H had known about the exclusion, then she wouldn't have bought that policy in the first place.

But the insurer maintained that they'd made the right decision. Upset and frustrated, Mr H asked us to step in.

complaint not upheld

We agreed with Mr H that many holidaymakers have a drink. But the exclusion in Miss H's policy wasn't unusual – and it was very unlikely she could have found a policy with another insurer that *didn't* exclude alcohol-related claims.

The things we needed to consider were how much Miss H had had to drink – and whether her fall, and her death, were linked to this.

We asked the insurer for the medical evidence they were using to turn down the claim. They sent us Miss H's death certificate, which said that "alcohol intoxication" had been a "contributory cause" of her death.

We also saw a toxicology report carried out as part of the post-mortem. This showed Miss H's blood alcohol concentration had been extremely high – at a level that would have caused severe "ataxia" (problems with balance and coordination) and poor judgement.

We thought these conclusions – reached by independent experts – were very strong evidence that Miss H's alcohol consumption had contributed to her death. In the circumstances, we decided that it was reasonable for the insurer to make that link – and turn down the claim under their alcohol exclusion.

It was clearly a very difficult time for Miss H's family. When we let Mr H know, he was very disappointed – but said he understood our decision.

... the issue was whether Mr S's collapse – and the claim – was caused by his alcohol consumption

case study 120/7

consumer complains that insurer has linked hospital admission to alcohol consumption

One evening, while on holiday with his parents in Croatia, Mr S collapsed and was admitted to hospital. Fortunately, he was discharged after a few hours. But he did run up medical fees – and once he was back in the UK, he contacted his travel insurer to claim them back.

But the insurer refused to pay out. They told Mr S they'd received a report from the Croatian hospital confirming he'd been admitted with "*alcohol intoxication*". This meant Mr S's fees fell under the insurer's exclusion for claims arising "*directly or indirectly from using alcohol*".

Mr S didn't think this was fair. He accepted he'd had a drink that evening, but maintained he hadn't been drunk. He felt the hospital had made assumptions because he was a man in his twenties staying at a resort popular with partygoers. And he was angry the insurer had taken their word for it – rather than looking at the facts.

When the insurer refused to change their mind, Mr S asked for our help.

complaint upheld

Many people are likely to have a drink on holiday. So we didn't think it would be reasonable for the insurer to automatically reject Mr S's claim just because he'd had a drink. Instead, the issue was whether Mr S's collapse – and the claim – was caused by his alcohol consumption.

We asked the insurer for a copy of the hospital report they'd mentioned. This showed that Mr S's blood alcohol level had been half the UK driving limit when he was admitted. We didn't think this was excessive.

Mr S sent us a letter from his GP confirming that, since returning to the UK, he'd asked for help finding out why he'd collapsed. The GP said that, though the cause wasn't yet obvious, there were a number of possible explanations – from dehydration to an underlying condition.

Based on everything we'd seen, we weren't convinced Mr S's claim was related to whether, or how much, he'd been drinking. And because the insurer hadn't shown the exclusion applied, they needed to meet the claim. We told them to refund Mr S's medical fees, with interest.

dial "o" for ombudsman

It's as old as the ombudsman service itself. And the ombudsman's technical advice desk answers hundreds of questions every week – from businesses, consumer advisers, MPs and researchers.

This month, *ombudsman news* asks **David Bainbridge**, head of outreach, what it's all about.

in a nutshell, David: what's the point of the advice desk?

Because "complaints prevention" is such an important part of our role, we think it warrants its own helpline. We're not just here for businesses, but also for all kinds of people advising consumers – from community advisers to charities, and MPs' caseworkers to Trading Standards.

We're a small team of experts, with experience of handling complaints ourselves. And we've got connections to other subject experts throughout the ombudsman – so whatever the problem, we'll be able to find the answer.

We won't "register" a complaint when someone gets in touch. We'll listen to what's happened – and have an informal chat about how the ombudsman might view the situation, and what the next steps could be.

It's really down to making sure the ombudsman service only "opens a case" where we need to. Sorting things out sooner rather than later saves businesses time and money – and their customers a lot of frustration and uncertainty.

what sorts of things can you help with?

I like to think no question's too big or too small. We hear from very small businesses – sometimes sole practitioners – who've never had a complaint reach us before. If they're worried, we can explain what to expect. Or they might be wondering if we can look at a particular complaint – in which case, we can give a detailed answer about the ins and outs of our jurisdiction.

The larger banks and insurers tend to know how we work. But they still call us – very often, in fact. Usually, it's because they've come across something a bit out of the ordinary in a complaint they're dealing with – like a tricky claim, or a mistake that's had a big or unusual impact on a customer. And they aren't quite sure how to handle it.

David Bainbridge, head of outreach

We also hear from a wide range of people and organisations helping consumers at the front line. We're asked for our view on individual situations – as well as general questions about what we cover, and our approach to certain types of complaint.

Being on the phone is just one part of our job. Out team also coordinates the ombudsman's outreach activities across the UK – talking to people where they live and work. So the advice desk is also your port of call if you'd like to know whether we'll be in your area soon. If you come along to one of our events, there's a good chance you'll meet someone you've spoken to.

you can help with pretty much anything, then?

Well, our ground rule, if you like, is that we won't get into the specifics of a complaint that's already with us – you'll need to talk to the person looking into it.

I should also mention that the advice we give isn't binding. So we ask callers not to quote what we say to third parties – or to anyone at the ombudsman if the complaint goes that far.

if the advice desks says the ombudsman wouldn't agree, does that mean it's not worth taking things further?

On the advice desk, we only ever hear one side of the story, and it's very unlikely we'll get all the facts from one phone call. So we'd never say the ombudsman *definitely* wouldn't agree – either with a business or their customer. That's not what we're here for. If an adjudicator or an ombudsman had heard both sides, the answer may well be different.

But we *are* here to give a healthy dose of pragmatism. We'll be upfront if we think a business has handled something badly – or if we think they've already done enough.

Often, a caller will realise this for themselves as they're talking. Having a conversation – rather than staring at a pile of paper or a screen – really does seem to make the solution more obvious.

is there any advice you'd like to give people *before* they pick up the phone?

The ombudsman sees too many complaints that, with a bit of empathy and common sense, could have been put right so much sooner. I'd say the overriding theme of the conversations we have – and we really can't say it enough – is that rigid procedures and tick boxes hinder rather than help.

Yes, you're going to have to look at the file (we talk to some case handlers who haven't!). But then look beyond the paperwork and the rulebook. Situations are never black and white – and it's very rarely the case that one side's completely right and the other's completely wrong. Ask yourself, what's really fair here? And how can you make that happen? You can have us on speed dial just in case.

the call with the cat

An insurer phoned for help with a household claim. On returning home from their summer holiday, a customer had found that a cat had left unpleasant "presents" all over their bedroom. The bed in particular was so badly damaged that it couldn't be cleaned – so the customer had made a claim for accidental damage.

The insurer explained that they'd rejected the claim because the policy excluded damage caused by pets. The customer had complained – saying they didn't know whose cat was culpable, but they didn't even have one. The caller was now feeling uneasy about turning down the claim – and wanted our view.

We told the caller to think about the purpose of the exclusion in question. We suggested that it was most likely there to stop claims for damage caused by pets that policyholders themselves choose to keep.

It was possible that the situation was a bit less straightforward. For example, if someone had been house-sitting, and there was strong evidence that their pet had caused the damage, we might agree that the claim shouldn't be paid. So the insurer might need to ask a few more questions. But we explained that, based on what we'd heard, we thought they should reconsider their decision.

the call with the "case" that wasn't

An independent financial adviser got in touch after receiving a letter from the ombudsman service – saying that one of their customers had made a complaint. This was the first the IFA had heard of it – and they were very unhappy about being charged a case fee.

The IFA hadn't had a complaint reach us before – so the experience was completely new.

We explained that if a consumer wants us to, we can write to a business to explain why they're not happy. But this doesn't mean we've taken on the case. We reassured the IFA that we wouldn't take things further until he'd had the chance to look into his customer's concerns – and then only if the customer wasn't happy. And we explained that, whatever happened, we don't charge a fee for the first 25 cases involving a business in any one year.

The IFA was relieved to hear this – and went on to talk the complaint through with us to make sure he was on the right lines. We also let him know when our small business roadshow would be nearby, so he could meet the ombudsman face to face.

the call with the bills

We took a call from a small community charity in the North West. Someone had come into their office with a bag of unopened letters – most of which were from businesses chasing repayments. The charity had worked out that the client had more than £15,000 of debt, including council tax, utility bills, home finance and payday loans.

The caller explained that the client had lost their job and just couldn't afford the repayments. They'd stopped opening the letters as they couldn't cope with the stress. The charity had identified which debts were priorities – but didn't know how to sort out the rest.

We explained that we expect lenders to treat customers in financial difficulties in a positive and sympathetic way. A good starting point would be to work out what the client could afford to repay each month – and make an offer to each of the lenders.

We told the caller that if she didn't feel a lender had acted fairly, then she could ask the ombudsman service to step in. We talked about the sorts of complaints we cover, and gave contact details for organisations that could help with anything else – for example, problems with utility companies.

get in touch

You can reach the advice desk on **020 7964 1400** between 9am and 5pm, Monday to Friday. It's usually quicker to get an answer over the phone, but you can also email **technical.advice@financial-ombudsman.org.uk**.

We're a small, busy team. And we want to focus on giving support to businesses and people who are helping consumers.

If your customer or client wants to get in touch with the ombudsman service, let them know about our consumer helpline – **0800 023 4 567** or **0300 123 9 123**.

motor insurance – theft claims

Aside from PPI, we see more complaints about car and motorcycle insurance than any other type of insurance. And cases involving theft or attempted theft make up a large part of these.

According to police figures, car thefts in the UK have fallen considerably – from 378,000 in 1997 to 90,000 in 2013. But over the past few years, the number of contested claims reaching us has been relatively steady. During that time, we've decided in around four in every ten cases that a claim has been wrongly rejected.

If someone tells us their theft claim has been unfairly turned down, we'll look at the exclusion the insurer is relying on – and whether the insurer has shown it applies. We'll also consider whether the exclusion was drawn to the consumer's attention.

Nearly all motor insurance policies exclude cover for theft if the keys were left in or on the vehicle, or if the vehicle was left unlocked and unattended. But in the cases we see, what "unattended" means is often called into question.

When we're making our decision, we'll take into account the Court of Appeal's judgment in *Hayward v Norwich Union*. So we might decide that a car was "attended" even if the driver wasn't in it – as long as they were close enough that their presence would be likely to deter a thief.

And we might say it isn't reasonable to apply an exclusion in exceptional circumstances – for example, an emergency – where leaving their car unattended isn't the driver's most pressing concern.

An insurer might tell us that their customer has been "reckless" – that is, they knew there was a risk their vehicle could be stolen, but they didn't take sufficient steps to protect it. But this can be difficult to show. And in many cases, while we might agree someone's been careless, we don't agree they were "reckless". In these cases, we tell the insurer to pay the claim.

Financial Ombudsman Service

... the person she'd spoken to at the insurance company hadn't mentioned the exclusion at all

case study 120/8

consumer complains when insurer rejects claim because keys were left in car

Miss V worked as a care assistant. Unfortunately, while she was helping a client one evening, her car was stolen from where she'd parked it outside the client's house.

Miss V made a claim on her car insurance. But the insurer wouldn't pay out – saying their insurance policies excluded theft claims where the keys had been left in the car. It appeared that the thief had smashed the car window – and driven away using a key which they'd found on a bigger bunch that Miss V had left in the car.

Miss V complained about the insurer's decision. She accepted that she'd left a car key inside the car. But she explained that she'd locked the car, and the bunch of keys wasn't on show – it had been covered by some aprons underneath the passenger seat.

She said that, in any case, this was the first she'd heard about the exclusion in question – and she thought she should have been told about it earlier.

However, the insurer told Miss V she had been "reckless" – and wouldn't change their mind. Frustrated, she asked us to step in.

complaint upheld

We needed to establish whether the "keys in car" exclusion had been drawn to Miss V's attention – and whether she had been "reckless".

First, we asked Miss V to explain how the policy was sold to her. She told us that she'd taken it out over the phone – and that the person she'd spoken to hadn't said anything about the exclusion. She said that because there was a charge to send the policy documents by post, she'd agreed they could be emailed to her instead.

We asked the insurer to provide a recording of the call, and a copy of any emails that had been sent to Miss V. We found that, as Miss V had remembered, the person she'd spoken to at the insurance company hadn't mentioned the exclusion at all. Neither had the documents that she'd been sent by email.

The insurer told us that the exclusion was set out in the full policy document, which was available to customers on their website. However, this document hadn't been sent to Miss V – and in any case, it was more than twenty pages long. In our view, such an important exclusion should have been made much clearer.

Because Miss V used her own car to visit her clients, she had insured it for business as well as personal use. Looking at the emails between the insurer and Miss V, we saw that the insurer had originally missed off the business cover – and she'd contacted them to make sure it was added.

This indicated that Miss V had read the information she was sent about the cover. We thought that if she'd received clear information about the exclusion, she would have taken note of it – and would have thought twice about leaving her bunch of keys in the car.

To agree that Miss V had been "reckless", we needed to decide whether she'd recognised the risk posed by leaving the keys behind – but had gone ahead anyway, without taking reasonable steps to protect her car.

There wasn't any dispute that Miss V had locked the car. And she hadn't left the keys in the ignition or on a seat where they would have been visible. They had been covered by aprons, which themselves wouldn't have attracted prospective thieves.

While we accepted Miss V might have been careless, we didn't think that she had been "reckless". In the circumstances, we told the insurer to meet Miss V's claim.

case study 120/9

consumers complain that insurer has rejected theft claim because car was left unattended on driveway

Mr and Mrs G kept their two cars parked on their driveway. One January morning, as they were de-icing their cars with the keys in the ignition and the engines running, thieves drove away with both cars.

Mr and Mrs G immediately reported the theft to the police – and then claimed on their car insurance. But the insurer said they wouldn't pay out for theft if a car had been left unattended with the keys inside.

Mr and Mrs G complained. They said they hadn't left their cars unattended – as Mrs G had been in the porch at the time. And they didn't think the insurer had told them about the "keys in car" exclusion anyway.

However, the insurer pointed to Mrs G's police statement, where she'd said she was in the kitchen and Mr G was upstairs when the cars were stolen. The insurer also said that the exclusion was clearly mentioned in the paperwork that Mr and Mrs G would have received during the sales process.

Feeling they'd reached a deadlock – and fed up with relying on colleagues for lifts to work – Mr and Mrs G referred the complaint to us.

complaint not upheld

It wasn't clear what had happened on the morning the cars were stolen. So we needed to decide what was most likely to have happened.

We confirmed that Mrs G had told the police that both she and her husband had been inside the house when the cars were stolen. We appreciated that she'd been very shaken up when she made the police statement – and she was now remembering things differently. But it seemed to us that the version of events she'd given immediately after the theft would have probably been the more accurate.

We were also sent photos of the driveway – and noted that the porch was very close to where the cars had been parked. So we thought that if Mrs G had been in the porch, prospective thieves would have been put off.

In light of this, we decided that Mr and Mrs G had most likely been inside the house – and had left their cars unattended with the keys in the ignition.

But we still had to consider whether Mr and Mrs G had been made aware of the "keys in cars" exclusion. We asked the insurer for a copy of the information that Mr and Mrs G were sent when they took out the policy. In our view, the exclusion was prominent in the policy booklet. And it was clearly set out in the short key facts document that Mr and Mrs G had been given.

We were very sorry to hear what had happened to Mr and Mrs G. But we explained that, based on what we'd seen, we thought the insurer had acted fairly. We didn't uphold their complaint.

... we appreciated that she'd been very shaken up when she made the police statement

... when Mr B came back to pick up his car on Sunday, it was gone

case study 120/10

consumer complains that insurer has rejected theft claim because car keys were left in coat pocket

Mr B went out one Friday evening to celebrate a friend's birthday. He parked outside his friend's house – where he'd arranged to meet up with a larger group – and had a few drinks in the garden before they all set off on foot to the local pub.

Unfortunately, when Mr B came back to pick up his car on Sunday, it was gone. He phoned the police to report the car as stolen, and later made a claim on his car insurance. He explained to the insurer that he'd locked his car– but now realised that he'd put the keys in the pocket of his jacket, which he'd left over the back of a chair in his friend's garden.

The insurer wasn't impressed with Mr B's explanation. They said it was a condition of his cover that he should "take all reasonable steps" to protect his car from loss or damage. In the insurer's view, Mr B hadn't done this – and his actions had been "reckless".

Although Mr B asked the insurer to reconsider, they refused to pay out. So he asked us to step in.

complaint upheld

We acknowledged that the insurer felt Mr B had put his car at risk by leaving the keys behind in his jacket. But for us to decide he'd been "reckless" – and that the claim shouldn't be paid – they would need to show he'd been aware of the risk.

We asked the insurer for recordings of the calls between Mr B and their claims handlers, and for a copy of his claim form. We also asked Mr B some questions over the phone about what had happened.

From the accounts Mr B had given, it appeared he hadn't thought to check at any point over the weekend that his car was safe – and he'd only turned up to collect it on Sunday. He hadn't asked anyone to keep an eye on his jacket. Nor had he tried to put it somewhere less visible. If he'd done any of these things, that might have suggested he knew there was a risk that the keys might be taken. Given Mr B had left the jacket in the garden of a friend, we could understand that he hadn't been particularly worried.

We agreed that leaving car keys in an unattended jacket wasn't a very sensible thing to do – and would increase the risk of the car being stolen. But putting together all the information we had, we didn't think Mr B had recognised that risk.

In light of this, we didn't agree Mr B had been "reckless" – and we told the insurer to meet his claim.

... Mrs L didn't book the car in to have the locks reprogrammed straight away

case study
120/11

consumer complains that insurer has rejected claim because locks weren't changed when keys were stolen

Mrs L's car was stolen from outside her house, but it was found the next day and returned to her. The driver's window had been smashed, and she had it repaired at her local garage.

It was a couple of days after the car had been repaired – when her daughter, back from university, asked to borrow it – that Mrs L realised the spare keys were missing. But she didn't book the car in to have the locks reprogrammed straight away. Instead, she decided to park the car in different places a short way from her house until the locks were sorted out.

After a week, Mrs L's car was stolen again – and this time it wasn't found. When she made a claim on her car insurance, the insurer wouldn't pay out. They said with the keys missing, the car was clearly at risk of being stolen – and Mrs L hadn't taken "*reasonable steps*" to protect it.

Although Mrs L asked the insurer to reconsider, they wouldn't change their mind – so she contacted us.

complaint not upheld

It was clear from the way Mrs L had parked in different places that she'd realised her car was at risk of being stolen. We needed to decide whether, knowing about the risk, she'd gone far enough to protect her car.

Mrs L told us that she'd phoned round several local garages about getting her car's locks reprogrammed – but hadn't been able to book it in immediately. However, when we asked the insurer for records of the contact they'd had with Mrs L, we found she'd told their claim investigator that she hadn't had time to phone any garages.

It wasn't clear what had actually happened. But in our view, even if Mrs L *had* phoned the garages, she could have taken the next available appointment – rather than not making any arrangement at all.

Mrs L said she'd phoned the insurer when she realised the keys were missing. She felt they should have been more helpful and given her some practical advice about how to keep her car safe.

But according to the insurer's records, Mrs L hadn't phoned the insurer until her car was stolen for the second time. And even if she *had* phoned when she said, we didn't think the insurer would have told her anything that she didn't already know – that the locks would need to be reprogrammed, and that the car should be kept secure in the meantime.

We asked Mrs L what steps she'd taken to protect her car while she was waiting for the locks to be sorted out. She said she'd phoned the council to ask whether they had a lock-up to rent, but none were available – so she'd decided just to keep moving the car around.

Given Mrs L's car had already been stolen once – probably with the same missing keys – we thought she could have done more. For example, she hadn't used a crook lock, or made enquiries about renting a garage once she knew the council couldn't help.

We were sorry that Mrs L was having to deal with the situation. But we agreed with the insurer that she hadn't done enough to keep her car safe – so we didn't uphold her complaint.

... it was extremely difficult for cars like Miss A's to be stolen without a programmed key

case study 120/12

consumer complains that insurer has rejected claim – saying car couldn't have been stolen without key

One evening, Miss A's car went missing from where she'd parked it outside a friend's flat. It was found a week later a few miles away – with a damaged front door and bonnet.

Miss A had already told the police her car had been stolen. And after she'd picked up the car from the garage that had been holding it, she phoned her car insurer to make a claim.

The insurer said they'd need to look into what had happened before agreeing to pay out. Over the next few weeks, they asked Miss A questions over the phone and carried out their own investigation.

Eventually, they wrote to Miss A to say they weren't willing to meet the claim. They said they'd received evidence from a third party that her car had crashed into another vehicle – and that the third party's account of the collision was consistent with the damage to Miss A's car. The third party had taken a photo of a male driver running away after the crash.

According to the insurer, it would have been almost impossible for someone to drive Miss A's car away without one of the two keys it had been sold with. And because the two sets of keys had always been in Miss A's possession, they weren't convinced things had happened exactly as she'd said.

Miss A complained – saying she'd heard that cars could now be stolen without any keys. But the insurer said that only high-value vehicles were being targeted in this way – so it was highly unlikely in Miss A's case.

Upset at the suggestion she'd somehow been involved, Miss A asked us to step in.

complaint upheld

We asked the insurer for the evidence they'd used to make their decision. The paperwork they sent us included photos of the damage to the car and a report by an "independent security analyst".

We read the report very carefully. It explained that the immobilisation technology involved meant it was extremely difficult for cars like Miss A's to be stolen without a programmed key. It would be a very complicated and noisy process – which a thief wouldn't even try, because passers-by would be sure to notice.

But we weren't convinced by the analyst's view. We explained to the insurer that we have regular conversations with security specialists – so we can make sure we're reaching fair, informed decisions in cases like Miss A's.

We know that it's not only high-value cars that are being stolen without their programmed keys – and that the process can be relatively quick. Looking at the photos of the damage, we saw the driver's window had been smashed. We didn't see why someone with a key would have broken into the car in this way.

... the police hadn't raised any concerns about Miss A's version of events

We pointed out to the insurer that if they were implying Miss A hadn't told the truth – and that the driver had been using one of her two programmed keys – then they needed to prove it.

But nothing we'd seen had done so – or made us doubt what Miss A had said. We noted that the police hadn't raised any concerns about Miss A's version of events. And neither had the claims handler who'd interviewed Miss A over the phone.

In the circumstances, we told the insurer to meet Miss A's claim. We also told them to pay her £500 to reflect the inconvenience of the long delay in paying her claim, and the upset and embarrassment they'd caused by suggesting she'd been involved in the incident.

case study
120/13

consumer complains after business rejected claim on grounds that his key must have been used in theft

Mr N hired a motorhome for two weeks' holiday abroad with his family. He left a key to his house with his neighbour so she could feed his cat. But when he got back, Mr N discovered that his car had been stolen from his driveway. He immediately phoned the police and his insurer to try to sort things out.

After about a week, the police tracked down his car. It had been burnt out, left about ten miles from Mr N's house.

The insurer sent someone to inspect the car, and asked Mr N a few questions. They wanted to know how many keys the car had come with. Mr N said there had been two, and sent them to the insurer as proof.

The insurer's representative said that the car hadn't sustained any "theft-related" damage. They said that it was likely that a key had been used to take the car.

But Mr N said there were no signs that his house had been broken into, and both keys had been in the house while he was on holiday. He said the only person with access to his house was his neighbour – a family friend in her eighties. The insurer agreed that they didn't think Mr N's neighbour was likely to be involved.

The insurer was adamant that a key must have been used in the theft – so rejected Mr N's claim. They said that it would have been very difficult not to damage the car if a key hadn't been used. And they said that a thief was unlikely to go to such lengths only to burn out the car.

Mr N complained. He said that he needed the claim to be paid as he was having to take public transport to get around, and was having to allow far more time for journeys than usual. But the insurer stuck to their decision – so Mr N approached us to see if we could help.

... The insurer was adamant that a key must have been used in the theft

complaint upheld

When we checked with the police, they said that there was nothing suspicious about Mr N's circumstances or testimony. They also confirmed that Mr N's house hadn't been broken into.

So we asked the insurer for the information from their investigation. They said that the theft report they'd commissioned said that the car couldn't have been stolen without a key. When we asked what else they'd assessed to reject the claim, the insurer repeated that they thought it was unlikely that the car would have been stolen just to burn it out.

As far as we could see, there was no evidence to suggest that a key *had* been used. And when we consulted motor security experts, they said that Mr N's car had a "two-star" security rating. Even cars with a five-star rating can be stolen quickly without using a key – so we thought it was likely that Mr N's car could have been taken without one too.

There are many devices that can be used to take a car without using a key. So we thought that the insurer was rejecting Mr N's claim based largely on guesswork.

Taking all these facts together, we decided that Mr N's car was likely to have been stolen without a key. And so we took the view that it wasn't fair for the insurer to turn down his claim.

We told the insurer to pay Mr N the value of the car, plus interest. We also told them to pay him £400 for being unable to use his car for a considerable time, and to compensate him for the inconvenience he'd been caused.

... the key Mr Z had sent to the insurer was made three years after the van itself

case study 120/14

consumer complains about rejected claim after his van is stolen

Mr Z had a van which he kept on his driveway. One morning, when he was leaving the house to go to work, he was shocked to find that his van had been stolen overnight. He immediately phoned the police and his insurer to report the theft.

The police investigated the theft, but couldn't track down the stolen van. Meanwhile the insurer had already started their own investigation. As part of it, they asked Mr Z to provide "any and all keys" that he had for the van.

Mr Z sent one key to the insurer – saying that it was the only one he'd ever had for the van. As the key was electric, the insurer asked a specialist to confirm that it was genuine.

When the specialist reported back, they said there were a couple of things that they felt were suspicious. Apparently, the key Mr Z had sent to the insurer was made three years after the van itself. The specialist also said that the key's blade didn't match the locks that Mr Z's type of van would have – and the electronic chip within the key was missing.

The third party said that the key supplied wouldn't even have been able to open the van's doors – let alone start the engine.

The insurer passed on these findings to Mr Z, saying that they didn't think he'd supplied them with the right key. They said that they also had proof that the van had been supplied with two keys when Mr Z had bought it. This led them to believe that two keys for the van were unaccounted for. So they turned down the claim.

Mr Z complained. He said that this was the original key he was given with the van. He suggested that perhaps the chip had "fallen out" – or that the key had been tampered with by the third party.

The insurer disagreed with Mr Z – repeating the findings of the report they had. They said that the van was most likely taken with an original key.

As the insurer and Mr Z couldn't agree, Mr Z decided to see if we could help.

complaint not upheld

We asked the insurer to share with us the report that they'd commissioned. And when they did, we could see why they had cause for suspicion.

The report set out clearly the differences between the key that Mr Z's van would have been supplied with, and the key that he'd sent the insurer. Significantly, it showed that in order for the chip to be tampered with or removed, the blade of the key would have to be taken off. So it seemed very unlikely that the chip would have just "fallen out" as Mr Z suggested.

The chip "talks" to the engine of a vehicle, disabling the immobiliser. So without the correct chip, Mr Z's van wouldn't start. This suggested that Mr Z hadn't provided the right key.

The insurer also showed us evidence from the van's manufacturer that their vans always had two keys supplied. We could see nothing out of the ordinary with this.

In the circumstances, we told Mr Z that we thought the insurer's decision was reasonable. We didn't uphold his complaint.

... it seemed very unlikely that the chip would have just "fallen out" as Mr Z suggested

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Q? &A

Featuring questions raised recently with our free, expert advice desk for businesses and consumer advisers

Our customer's mother died while he was visiting her overseas. He's now staying longer to help sort things out, and he's claimed the cost of his flights under "cancellation and curtailment". We've extended our sympathies – but when it came down to it, we didn't pay the claim. He's now made a complaint. Did we make the right call?

You told us that when your customer called to take out the policy, he asked if he'd be covered for a missed departure. You're concerned this suggests he knew his mother was unwell before he left.

But it's important to establish how much he really knew about his mother's health. You might need to ask – sensitively – for medical evidence.

We'd only agree it's reasonable for you to turn down the claim if you can show he knew before he travelled that his mother had a medical condition.

It's also important to think about the *intention* of the clause you've mentioned. Usually, "cancellation or curtailment" is there to cover the costs of someone having to cut their trip short if their relative falls ill or dies.

It seems you'd pay the claim if he was on holiday and his mother fell ill back in the UK. This situation is the opposite, but the costs are essentially the same. Thinking about what's fair, it's likely we'd say this claim should be covered.

Of course, if the complaint reached us, we'd need more information before making a decision. But let's hope you can get things sorted before then. There's more about our approach to travel insurance on our website.

I'm an insurance broker. I've recently heard from a client who had a car accident driving a friend to the airport. He's made a claim, but the insurer won't pay out. It turns out the friend had given my client £20 to cover petrol costs – but the insurance policy excludes damage caused while the car's being used as a hire vehicle. I've seen the policy and the term is there in black and white – I just don't think it's fair. Do you?

People take out insurance to give them peace of mind – knowing that they're covered if something unfortunate happens. Equally, insurers put terms in their policies to exclude situations they don't want to cover – which is generally considered to be a commercial decision.

Unfortunately, as you've highlighted, those black and white words can cause problems.

In your client's case, the insurer has applied the policy terms very strictly – saying that by accepting money for petrol, he is effectively acting as a driver for hire.

But we're here to look at what's fair. And we'd say the insurer needs to look at the intention of the clause in question before using it to turn down a claim. This one's probably there to stop claims from people who've been using their vehicles as an unlicensed taxi.

This doesn't seem to be what's happened here. From what you've said, your client was doing his friend a favour and accepted the £20 to cover his costs, rather than make a profit. So we'd suggest the insurer reconsider their decision.

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