the Q&A page

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

Q. What can my business do if we don't agree with an adjudicator's view on a complaint that's been made about us?

A. Please engage early on – and as fully as possible – with the adjudicator working on your case. Don't hold back your facts and arguments for later. Your adjudicator will have seen many cases before that are similar to yours – and will have a pretty good idea of how the ombudsman would be likely to view your particular case.

If you don't agree with the adjudicator's initial informal view, explain your concerns to them – setting out your reasons and any new facts and arguments. If you still disagree after the adjudicator has responded to your concerns, then you can 'appeal' by asking for a review and a final decision by an ombudsman. This only happens in around one in ten cases.

A final decision by the ombudsman is binding on you, if the consumer accepts it. It's the end of our process – so you should make sure you've presented all your arguments and facts to us well before this stage.

Don't wait for the ombudsman's decision and *only then* send us a lengthy detailed submission, arguing why we are wrong. You need to have raised all your points before then, and we will give you plenty of opportunity to do this.

Because we are a public body – providing a service to the public – we can be 'judicially reviewed' by the courts. A judicial review will generally focus on the *way* in which an ombudsman has arrived at a decision, not on the individual facts and merits of the dispute itself. Simply disagreeing with the ombudsman is not generally considered grounds for judicial review. So you would probably want to have obtained your own legal advice before deciding to begin judicial review proceedings.

Q. What's your approach when a consumer claims for distress and inconvenience?

A. We consider this separately from any redress we may award to put the consumer in the financial position they would now be in, if the business hadn't got things wrong.

We do not believe consumers should automatically be compensated for having to make a complaint. If a business has handled a consumer's complaint fairly and promptly – explaining clearly why it did not consider the complaint justified – then we may decide the consumer has not suffered any significant inconvenience in pursuing the matter.

But where we think the consumer faced obstacles and difficulties that we would not expect, as part of the normal process of pursuing a complaint, we might tell the business to pay the consumer a specified sum, as compensation for particular distress or inconvenience.

The amount involved is usually modest – up to £300. Exceptionally, we may award more than £1,000 if we believe the business has handled the complaint particularly poorly, causing the consumer clear hardship and aggravation.

For more information about our approach, see the technical note, *compensation for distress, inconvenience or other non-financial loss* in the online technical resource section of our website.

designed, edited and produced by the communications team, Financial Ombudsman Service ref: 619

Ombudsman news

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

Natalie Ceeney, chief executive and chief ombudsman

issue 87

'A window on the real world'

As I noted in last month's issue, I'm still spending a fair amount of time getting to know a wide range of our stakeholders. I've been particularly struck by how often *Ombudsman news* crops up in these conversations – and it's been encouraging to receive so much positive feedback.

The case studies are particularly popular with all our readers. The chief executive of one large financial services business said '*they are a window on the real world*' helping him '*better understand the customer's viewpoint*.' The head of another business said the cases '*serve as a reality check – a valuable prompt to take a close look at the grass roots*'. By doing that he can ensure the examples of poor service outlined in some of the cases are not also happening in his own business.

Promoting 'complaints-prevention' – by feeding back information about the complaints we see – has always been an important feature of the ombudsman's work. We do this through *Ombudsman news*, but also at regular meetings with businesses, where we talk through the trends emerging in our casework. We take part, too, in a wide range of seminars, conferences and other events – and of course we make a wealth of information available on our website.

Financial Ombudsman Service

Some businesses still have a fairly narrow view of complaints-handling, with the focus firmly on rules, compliance and procedures. But – increasingly – smarter businesses are taking a broader and more customer-focused approach. Good complaints-handling is a powerful way of generating customer loyalty. Research shows that if a business handles a customer's complaint really well, that customer will think more highly of the business than customers who have never had a complaint.

And the most successful businesses are those that *also* view complaints as a valuable source of customer insight. By seeing what can be learnt from the complaints they receive, businesses quickly discover what aspects of their operations may need improving. Putting things right then results in a better service all round – for *all* their customers.

We are keen to increase the amount of information we provide about the numbers and types of complaints we see – to help businesses consider what lessons can be drawn from the data. The *ombudsman focus* feature in issue 86 was well received by many readers. It presented selected data from our *annual review*, cut in a slightly different way to show – at a glance – some of the casework figures we are most-frequently asked about during the year.

We are aware that many people would welcome seeing our complaint data more frequently, so on page 8 of this issue you'll find our complaint figures for the first quarter of the current financial year. From now on, we will publish these figures every quarter, making it easier for everyone to see the numbers and trends as they emerge – rather than having to wait till after the end of each financial year to see them in our *annual review*. As ever, there's a difficult balance between overwhelming people with information and satisfying those who want a huge amount of detail. We hope we're managing to get it about right. As always, I'd welcome your views on this, as well as on any other aspect of our work.

Natalie Ceeney
chief executive and chief ombudsman

Financial Ombudsman Service

South Quay Plaza
183 Marsh Wall
London E14 9SR

switchboard
020 7964 1000

consumer helpline
08000 234 567
0300 123 9 123
open 8am to 6pm Monday to Friday

technical advice desk
020 7964 1400
open 10am to 4pm Monday to Friday

www.financial-ombudsman.org.uk

Banking complaints about misapplied credit

We receive a number of complaints each year concerning 'misapplied credit', where a bank has incorrectly credited a customer's account with money that was meant for someone else. When the bank subsequently attempts to reclaim the money, the customer may object – arguing that since the error was not theirs, they should not be required to pay anything back.

In the board game *Monopoly*© it is good news if you get a card telling you that the bank has made an error in your favour – as you get to keep the money. But in real life, things are different. When dealing with complaints about misapplied credit, we generally take the view that consumers are required to return any money paid to them by mistake.

In certain circumstances, however, we may sometimes think it fair for the consumer to keep some or all of the money. This will usually be where the consumer reasonably believed that the money was theirs to spend – and spent it in a way they would not otherwise (or usually) have done.

Here are a few of the cases we have dealt with recently.

87/1

consumer unwilling to repay money credited to her bank account in error

After Mrs M visited the local branch of her bank and paid in a cheque for £100, the bank incorrectly credited her account with £1,000.

A week later, unaware of this mistake, she called in at the branch to withdraw a small amount of money from the cash machine. The balance displayed on-screen was considerably higher than she had expected, so she thought she should check it. She queued up to speak to a cashier, who confirmed that the on-screen balance was correct.

Mrs M had retired a few months earlier. She was aware that a former colleague had received a sizeable tax rebate when he retired. So she concluded, from the large balance on her account, that she too had been sent a rebate.

It was nearly four months before the bank discovered its error. Mrs M said she was then '*very distressed to receive a demand, out of the blue, for £900*'. She explained to the bank that she was unable to repay the money as she had already spent it – taking her niece with her on a holiday to Italy.

The bank told her it would set up a repayment plan so she could pay the money back in monthly instalments. Mrs M thought it unfair that she should have to repay the money at all. The bank disagreed, so Mrs M came to us.

complaint upheld

We examined all the available evidence. We were satisfied that Mrs M had been under the impression that a tax rebate might be paid in to her account, at around the time when the bank error occurred. She had not known how much she might receive. And it was only when she queried her tax position, several months after she became aware of the bank's error, that she found she had never been due for a rebate after all.

We noted that Mrs B had taken the precaution of checking with a cashier at her bank branch, as soon as she noticed that the balance on her current account was unusually high. She had relied on what the cashier told her and we thought it reasonable for her to have believed that the money was hers.

Mrs M had acted in good faith when spending the money on a holiday. The trip was not one she could normally have afforded and as it had no resale value, there was no way in which the bank could recover any of the money she spent on it.

... we said the bank was acting reasonably in expecting him to pay the money back.

We told the bank that, in the circumstances of this particular case, it was not entitled to recover the £900 that it had credited to Mrs M's account in error. ■

■ **87/2**

bank mistakenly duplicates the transfer of funds into consumer's current account

When £1,000 was transferred into Mr A's current account, the bank accidentally duplicated the transfer, crediting him with £2,000.

Two weeks later, the bank discovered the error and asked Mr A to repay £1,000. Mr A said he could not do this as he had already spent the money.

The bank then told him it was prepared to accept ten monthly payments of £100. Mr A argued that he had a right to keep the money, as he said the bank '*should not have made such a mistake*'. The bank insisted that Mr A was obliged to repay the money, so he eventually referred his complaint to us.

complaint not upheld

Mr A sent us documents confirming that he had been expecting a transfer of £1,000. There was nothing to suggest he expected more than this amount – or more than one transfer. And a statement of his account, sent to him a few days after the transfer, showed clearly that two £1,000 credits had been made on the same day with the same reference details.

So we were satisfied that Mr A should have been aware that an error of some kind had occurred – and that the 'extra' £1,000 was not his to spend or keep. The bank confirmed that it was still willing to accept the money in ten interest-free monthly instalments, rather than as a one-off payment.

We told Mr A that, in the circumstances, the bank was acting reasonably in expecting him to pay the money back. We did not uphold the complaint. ■

87/3

bank miscalculates interest payable when closing customer's account

Mrs V's bank sent her a cheque for £103,954 after she closed her savings account.

A few days later, the bank wrote and asked her to return £1,454. This was the difference between the amount it said it *should* have sent her (£102,500) and the amount it had sent her in error, after miscalculating the interest due on her savings.

Mrs V thought the bank was acting unreasonably and she refused to pay back the money. She said she had received the cheque in good faith. She had been very disappointed to learn that the interest on her savings was smaller than had first appeared – and she did not think she '*should be penalised for the bank's failure to work out the interest correctly*'.

... she thought the bank was acting unreasonably.

The bank insisted that it was entitled to have the money back, so Mrs V brought her complaint to us.

complaint upheld in part

We accepted Mrs V's point that the bank should have ensured its calculations were correct before it sent her the cheque. We also accepted that she had been very disappointed when she found she had earned less interest on her savings than she had first thought.

However, the error had not caused her any actual loss. The bank had discovered it quickly and had contacted her before she had done anything with the money. When it re-calculated the interest it did so correctly, in line with its published rates and with the terms and conditions Mrs V was given when she opened the account.

So we said that the bank was entitled to recover from Mrs V the amount it had paid her in error. However, in recognition of the disappointment and inconvenience the bank had caused her, we said it should allow her to retain £50.

... The bank discovered its error quickly and contacted her before she had spent the money.

87/4

online banking – bill payment is credited to someone other than the intended recipient

Mr D used his bank's online facilities to transfer £75 to a colleague, who had taken part in a sponsored bike-ride. He was unaware, at the time, that although he entered most of the details correctly, he made an error when entering the *number* of the account into which the money was to be paid.

Several weeks later he contacted his bank, after discovering that his colleague had not received the money. The bank traced the payment and found it had been credited to a third party – whose account number matched the one Mr D had entered in error.

Mr D accepted that he had made an error with the account number. However, the details of the *name* on the account had been correct. He therefore could not understand why the bank had not spotted the mismatch and queried it, before paying the money into the 'wrong' account.

Mr D wanted the bank to reimburse him for the lost payment. The bank refused, on the grounds that he, not the bank, had made the mistake. Mr D challenged this. He said that if the bank always sent payments to the account number entered online – even where this did not match the other details provided – then there should be a warning about this on the website.

The bank rejected Mr D's complaint. It said it had not been under any obligation to check the payment details he had entered online. Unhappy with this response, Mr D brought his complaint to us.

complaint upheld

We examined the bank's process for the online payment of bills. Banking industry guidance states that consumers should be specifically warned if payments will be processed and credited using just the account *number*. There was no such warning on the bank's website. We therefore told the bank to reimburse Mr D for the £75 payment. ■

ombudsman focus: quarterly account

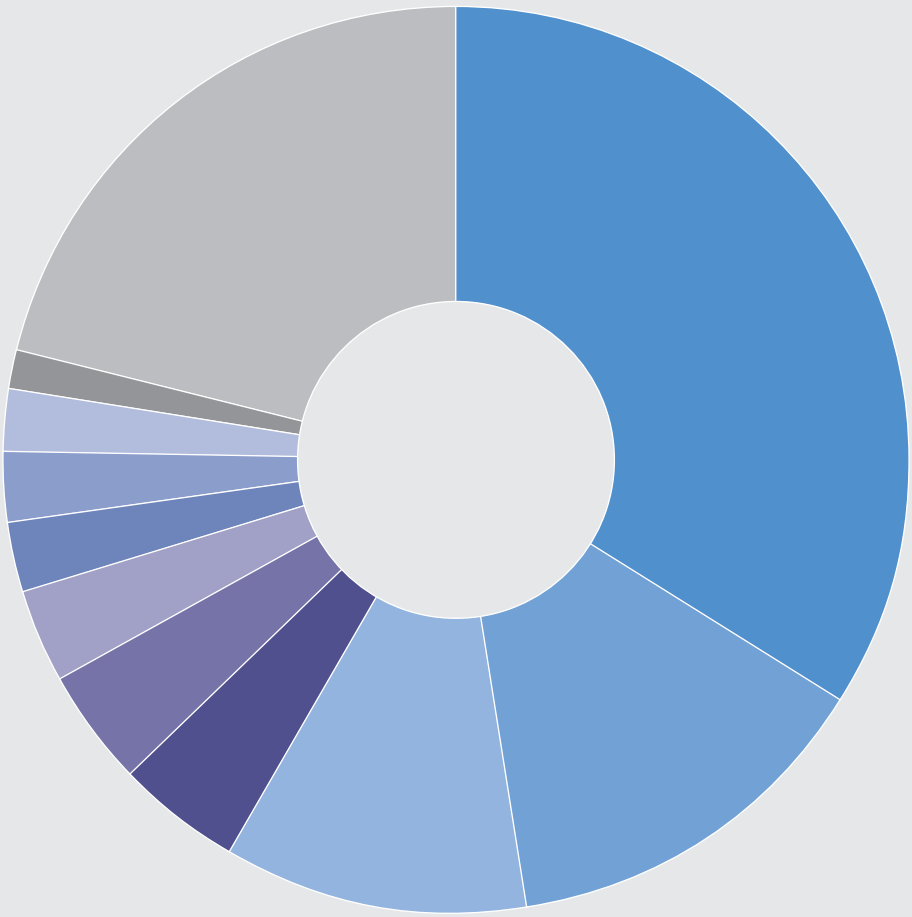
a snapshot of our complaint figures for the first quarter of the 2010/2011 financial year

We mentioned in the last issue of *Ombudsman news* (issue 86) that one of the most visited sections of the online version of our *annual review* is the double-page chart, listing the number of new complaints referred to the ombudsman service. The chart shows the number of cases for each specific financial product and service during the year.

This often gives rise to further queries to our technical advice desk – with regular requests throughout the year from different stakeholders for updated figures relating to one or other specific financial product.

We have therefore decided to start using *Ombudsman news* to publish snapshots of our workload on a *quarterly* basis. This should make it easier for everyone to see the numbers and trends as they emerge throughout the year – rather than only seeing the figures *annually*, after the financial year has ended.

the financial products that consumers complained about most to the ombudsman service in April, May and June 2010



payment protection insurance (PPI)	34%	deposit and savings accounts	2.5%
current accounts	13.5%	buildings insurance	2.5%
credit card accounts	11%	mortgage endowments	2%
house mortgages	4.5%	'point of sale' loans	1.5%
overdrafts and loans	4%	complaints about other products	21%
car and motorcycle insurance	3.5%		

what consumers complained about to the ombudsman service in April, May and June 2010

	number of new cases		% resolved in favour of consumer	
	first three months of 2010/2011 (April, May, June)	full financial year 2009/2010	**first three months of 2010/2011 (April, May, June)**	full financial year 2009/2010
payment protection insurance (PPI)	**13,520**	49,196	**81%**	89%
current accounts	**5,420**	24,515	**26%**	20%
credit card accounts	**4,296**	18,301	**62%**	68%
house mortgages	**1,721**	7,452	**33%**	37%
overdrafts and loans	**1,564**	6,255	**43%**	48%
car and motorcycle insurance	**1,436**	5,451	**46%**	38%
deposit and savings accounts	**1,009**	4,508	**40%**	52%
buildings insurance	**955**	3,437	**43%**	43%
mortgage endowments	**944**	5,400	**30%**	38%
'point of sale' loans	**622**	1,735	**46%**	52%
travel insurance	**553**	1,956	**55%**	44%
share dealing	**485**	1,105	**65%**	52%
contents insurance	**444**	1,863	**37%**	38%
whole-of-life policies	**409**	1,690	**35%**	28%
hire purchase	**399**	1,430	**44%**	48%
specialist insurance	**397**	1,070	**46%**	50%
personal pensions	**357**	1,359	**30%**	29%
portfolio management	**246**	1,040	**46%**	48%
'with-profits' bonds	**233**	1,056	**35%**	28%
endowment savings plans	**229**	1,512	**31%**	25%
debit and cash cards	**220**	964	**41%**	43%
warranties	**219**	863	**53%**	53%
unit-linked investment bonds	**204**	2,453	**62%**	57%
term assurance	**200**	912	**32%**	24%
catalogue shopping	**196**	755	**71%**	79%
income protection	**188**	740	**40%**	39%
investment ISAs	**185**	1,301	**46%**	42%
cheques and drafts	**148**	773	**43%**	49%
legal expenses insurance	**142**	597	**21%**	25%
direct debits and standing orders	**140**	737	**38%**	48%
private medical and dental insurance	**140**	652	**49%**	35%
critical illness insurance	**138**	598	**35%**	31%
debt collecting	**136**	697	**37%**	42%

	number of new cases		% resolved in favour of consumer	
	first three months of 2010/2011 (April, May, June)	full financial year 2009/2010	**first three months of 2010/2011 (April, May, June)**	full financial year year 2009/2010
interbank transfers	**124**	606	**46%**	43%
self-invested personal pensions (SIPPs)	**112**	410	**47%**	53%
electronic money	**111**	453	**40%**	49%
guaranteed bonds	**104**	595	**48%**	37%
store cards	**100**	574	**58%**	74%
credit broking	**99**	341	**57%**	62%
pet and livestock insurance	**99**	462	**44%**	24%
annuities	**95**	501	**29%**	33%
(non-regulated) guaranteed bonds	**82**	421	**44%**	50%
personal accident insurance	**80**	274	**48%**	26%
hiring, leasing and renting	**69**	283	**41%**	37%
commercial property insurance	**68**	487	**34%**	22%
spread betting	**62**	191	**17%**	19%
debt adjusting	**60**	231	**55%**	65%
state earnings-related pension (SERPs)	**60**	560	**7%**	2%
roadside assistance	**59**	226	**45%**	35%
debt counselling	**56**	163	**57%**	63%
occupational pension transfers and opt-outs	**55**	368	**48%**	48%
business protection insurance	**53**	222	**23%**	26%
commercial vehicle insurance	**52**	290	**35%**	35%
guaranteed asset protection ('gap' insurance)	**48**	224	**49%**	53%
unit trusts	**36**	192	**57%**	44%
open ended investment companies ('oeics')	**34**	329	**67%**	56%
total	**39,213**	160,776	**52%**	50%
other products and services	**363**	2,236	**43%**	42%
	39,576	**163,012**	**52%**	**50%**

The table above shows all products and services where we received (and settled) at least 30 cases during the quarter. We have included this information to be consistent with our policy on publishing complaints data relating to named individual businesses. The policy was agreed after public consultation and the complaints data is available on our website.

For a small number of products listed in this table, the figure shown for complaints received in the financial year 2009/2010 differs slightly from the number published in the *annual review*. This is because certain related products are grouped together differently in the *annual review*, for ease of presentation.

Insurance complaints connected with travel or holidays

This selection of recent travel and holiday-related case studies illustrates some of the circumstances that can give rise to insurance complaints.

87/5
insurer rejects claim for cost of curtailing holiday as a result of injury

During the first part of her holiday, aboard a cruise ship, Miss H tripped and badly injured her ankle. She had been due to leave the ship the following day, when it reached Cyprus, as she had booked to stay at a hotel there for a week before flying home to the UK.

Because of her injury, Miss H felt there was no possibility of continuing her holiday. She was only able to get around by using a wheelchair and she needed assistance to get in or out of the wheelchair. She therefore rang her insurer's helpline and asked for assistance in getting back home.

The insurer told her it would reimburse the cost of any necessary medical treatment she received while abroad. It said it could not do more than that, as it did not consider there was any '*medical necessity*' for her to curtail her holiday. Dismayed by this news, Miss H made her own arrangements to return home.

She later put in a claim for the expenses she said she had incurred as a result of her injuries. These included:

- the cost of cancelling her week's holiday at the hotel in Cyprus

... she said the insurer handled her claim badly.

- the cost of her journey back to the UK, including the flight and taxi fares
- compensation for the time she had taken off work in order to have physiotherapy; *and*
- the cost of taxi fares to and from her physiotherapy appointments.

Miss H said the insurer had underestimated the effect of her injury and she asked for compensation for the distress and inconvenience she had been caused. She said the insurer had let her down badly by its '*failure to provide appropriate assistance*' when she rang its helpline. When the insurer refused to meet her claim or to compensate her, Miss H complained to us.

complaint upheld in part

Medical evidence provided by the ship's doctor confirmed that Miss H had suffered a '*left ankle ligament rupture*.' The doctor had recommended '*complete immobilisation of the ankle for 10-14 days*'. And he had thought it necessary '*by medical reason*' for her to disembark and return home, cancelling her hotel stay in Cyprus.

Miss H had been travelling on her own and the hotel had confirmed that it was unable to provide the additional assistance she would have needed for a week's stay, bearing in mind that she was effectively wheelchair-bound.

We concluded that there *had* been a medical necessity for Miss H to curtail her holiday – and that the insurer was liable for the costs she had incurred in cancelling her hotel booking and travelling back home. We said the insurer should pay these costs in full, together with interest.

However, we explained to Miss H that her travel policy did not cover her for the time she had needed to take off work, or for any of the other costs she had claimed in connection with the treatment she received once she was back home in the UK.

We agreed with Miss H that the insurer should have given her the assistance she was entitled to, under the policy, when she asked for help in getting back to the UK. So we said it should pay ▸

her £250 in recognition of the distress and inconvenience that its poor service had caused her.

87/6

travel insurer turns down claim for additional travel costs incurred because of a rail strike

Industrial action by French rail workers disrupted Mr C's journey to Italy. He had planned to travel by train from London to Paris, where he would stay overnight before continuing on by rail the next day, making one further change of train before he reached Milan.

Everything ran smoothly until Mr C got to Paris. It then became clear that the industrial action would seriously delay his train from Paris. This would prevent him from making the connection with the Milan train, on which he had booked a seat. He therefore decided to travel direct from Paris to Milan by air.

After he returned home to the UK, Mr C put in a claim to his travel insurer for the cost of this flight. The insurer rejected his claim, saying that, under the terms of his policy, it was only able to pay '*additional costs incurred in reaching a destination*' if a policyholder arrived '*at the final point of international departure too late to board for travel on the outward journey from the UK*.'

The insurer said it considered Mr C's '*final point of international departure*' for his journey from the UK to have been when he boarded the Eurostar train in London. It said there was '*no cover for the other legs of the journey*.'

Mr C thought this unreasonable and he complained to the insurer. He pointed out that although he had planned and booked the journey as three separate stages, these stages were all part of one outward journey. He said he believed that his policy provided cover for the circumstances in which he had felt obliged to buy the air ticket. He also noted that the policy wording regarding the '*final point of international departure from the UK*' appeared to him to be ambiguous.

When the insurer refused to reconsider his claim, Mr C came to us.

complaint upheld

It was clear from the evidence provided by Mr C that although his journey was broken into three stages, invol ving three different trains and an overnight stay in Paris, it was planned as a continuous journey from London to Milan.

We noted that the policy covered delay in boarding '*the ship, aircraft or train ... as a direct result of ... failure of scheduled public transport*'. We then looked at what the policy said about additional costs when the policyholder arrived

'*at the final point of international departure too late to board for travel on the outward journey from the UK*.'

There was no definition of '*international departure*' and we agreed with Mr C that the term could be interpreted in more than one way. We also agreed with him that the words '*from the UK*' could be taken simply to distinguish the outward journey from the return journey – and to show that the policy covered the journey to reach the main destination, rather than any travel or shorter trips taken during the holiday itself.

In line with well-established legal principles, our approach in cases involving policy terms that we consider ambiguous is to interpret the wording in the way that is most favourable to the consumer. So we said the insurer should pay Mr C's claim for the cost of his flight to Milan. We said the insurer should also add interest to this amount, backdated to when Mr C made the claim.

87/7
policyholder unable to claim cost of cancelling holiday because of pre-existing medical condition

Mr and Mrs N cancelled their holiday because Mrs N was taken ill shortly before the start of their trip. The couple had bought a travel policy from their travel agent, at the time they booked the holiday. They therefore put in a claim for the cancellation costs.

In answer to the insurer's questions about their reason for cancellation, they described the symptoms of Mrs N's illness. The nature of these symptoms suggested to the insurer that Mrs N had the digestive disorder, diverticulitis.

When asked to confirm details of Mrs N's medical history, her GP confirmed that she had been diagnosed with diverticulitis some five years earlier. Her most recent consultation with her GP about the condition was six months before the couple booked their holiday and bought the policy.

The insurer turned down the claim, on the grounds that the policy excluded claims '*arising or resulting from a medical condition or related illness that the policyholder should reasonably have known about before the purchase of the policy*.'

Mr and Mrs N complained that the insurer was being unreasonable. They said Mrs N had been in good health at the time they took out the policy and they had not been aware that she had been diagnosed with diverticulitis.

complaint not upheld

It was clear from the medical evidence that Mrs N had been diagnosed with diverticulitis in 2004. She had visited her local hospital on a number of occasions since then to undergo tests or to see a consultant in connection with the condition. So it seemed unlikely that the couple could have been unaware of the diagnosis.

Even if they had not been familiar with the medical terminology relating to the condition, they would have known that Mrs N suffered from symptoms that were serious enough at times to require hospital treatment.

The couple accepted that when they had bought the policy the travel agent asked both of them some questions about their health.

We were unable to establish whether or not he had also explained the significance of the policy exclusion for pre-existing medical conditions. However, we noted that a clearly-worded statement about this exclusion was placed prominently on the front page of the couple's policy document. We did not uphold their complaint. ■

87/8

insurer rejects claim for medical expenses incurred abroad

Mr D was taken ill while on holiday and spent several days in hospital with pleurisy before he returned to the UK. Once he had recovered he put in a claim to his travel insurer. This was turned down on the grounds that Mr D's illness related to pre-existing respiratory conditions.

The insurer said its enquiries suggested that Mr D had been diagnosed with '*asthma and bronchial hyperactivity*' and that he had experienced '*previous episodes of pneumonia, bronchitis and pleurisy*'.

Mr D accepted that he had suffered from breathing problems in the past, including separate episodes of pneumonia, bronchitis and pleurisy. However, he said these episodes did not relate to a pre-existing condition that he ought to have declared. They had come about – like the illness he had while on holiday – because of '*one-off infections*'.

He added that during his admission to hospital he had been '*greatly troubled by a number of repeated and unnecessary*' phone calls from the assistance company that was acting for the insurer. He said he had been suffering from extreme breathing difficulties at the time and the calls

had created '*additional stress at an already difficult and worrying time*.'

The insurer refused to reconsider the claim. It said it had based its decision on the view of its chief medical officer. She considered that Mr D's medical history put him at '*an increased risk of contracting a respiratory illness and would affect its subsequent severity and recovery*.' In response to Mr D's complaint about the phone calls, the insurer said that '*very few calls*' had been made – and these were from the nurses at its assistance company, who were concerned about Mr D's well-being.

Unable to resolve matters with his insurer, Mr D came to us.

complaint upheld

The medical evidence confirmed that Mr D had suffered from breathing difficulties in the past. His GP had told the insurer that there could *possibly* be a connection between the illness Mr D experienced while on holiday and the respiratory conditions he had experienced in the past. However, the GP had said that he could only have determined this with any certainty if he had been able to examine Mr D at the time of his latest illness.

The GP said that '*asthma*' had been recorded for data purposes on Mr D's medical records but Mr D had never actually been given this diagnosis.

We noted that there was no medical evidence to confirm that Mr D's illness during his holiday was linked to his previous respiratory problems. And, significantly, we noted that the insurer's own records acknowledged that '*pleurisy did not arise directly or indirectly from asthma*'. So the insurer's decision to reject the claim appeared to be inconsistent with its own policy terms.

We then looked at the insurer's records of the phone calls made to Mr D during his admission to hospital. We noted some inconsistencies between these records and what the insurer had told Mr D when he complained about the calls. Overall, we thought it likely that a number of calls had been made within a relatively short period of time. The primary purpose of the calls appeared to be to gather administrative details about Mr D's likely stay in hospital. It seemed to us that these calls would have been far better directed to staff at the hospital rather than to Mr D himself – particularly at such a difficult time.

We upheld the complaint. We said the insurer should deal with the claim for medical expenses, adding interest to the settlement. We said it should also pay Mr D £250 to reflect the distress and inconvenience caused by its inappropriate phone calls and its poor handling of the claim. ■

87/9
travel insurer refuses to pay claim for theft of a camera

Mr M's travel insurer turned down his claim for the theft of a camera that he said he bought while on holiday in Spain. The insurer said he had failed to provide sufficient evidence of his loss.

Mr M put in his claim when he returned home after his holiday. He said the camera had been taken from his locked suitcase at some time during his return journey, after the case had been checked-in at the airport.

The insurer rejected the claim on the basis that the policy did not cover '*valuables*', such as cameras, if they were left in checked-in luggage rather than being kept with hand luggage.

Mr M complained about this to his insurer. He said that when he had put in his claim he had assumed that the camera had been taken from his case during the return journey. However, on reflection he now thought the camera had been stolen from his hotel room in Spain.

He said that after buying the camera at the start of his holiday he had locked it in his suitcase. The case was kept in his hotel room – and he had never left the room unlocked. He said he had packed in a hurry at the end of his trip and had only realised that the camera was missing when he unpacked, two days after returning home. He had then looked carefully at the lock and seen that it must have been forced open and stuck back together again. He had not noticed this before leaving the hotel, so had assumed that the theft took place *after* he had checked-in his case at the airport.

The insurer said it was unwilling to reconsider the claim unless Mr M could provide more convincing evidence that the camera had indeed been lost or stolen, and that this had happened while he was taking reasonable care of it.

The insurer again drew Mr M's attention to the fact that his policy did not cover the loss or theft of valuables which had been '*left unattended*'. It also noted that Mr M had failed to report the loss to either the hotel or the airline.

Mr M then referred his complaint to us.

complaint not upheld

Mr M told us he had never been sent any policy documents, so had not known he needed to provide confirmation that he had reported the loss. He had also been unaware that the policy stated that he should not leave the camera '*unattended*'.

... he had failed to report the loss to either the hotel or the airline.

We noted that the policy provided only limited cover for items defined as '*valuables*' (which included cameras). And we took the view that most people would not need to have seen the detailed terms of an insurance policy to realise that items such as cameras should not be left unattended, as they could easily be stolen.

We concluded from the degree of uncertainty and inconsistency in Mr M's claim that the insurer had acted reasonably in not paying the claim. We did not uphold the complaint.

87/10

travel insurer disputes validity of claim for damage to clothing and theft of possessions

When Miss J returned from holiday she put in a claim to her travel insurer. She said a number of her possessions had been stolen or damaged during her flight out to Turkey. The total value of her claim was £1,600.

The stolen items included jewellery, a camera, a kettle and an iron. And she said that some of the clothes in her case had been damaged when the contents of a bottle of perfume and a jar of coffee leaked over them. She said she had packed the perfume and the coffee very carefully in her case, to prevent any leaks or breakage. However the glass bottle and jar had both been smashed – probably at the same time that the case itself was badly damaged.

The insurer rejected the claim. It said Miss J had not been able to provide any receipts to prove her ownership of the lost or damaged items. She had not notified either the airline or the police and she had failed to complete the airline's '*property irregularity report*', as the insurance policy required her to do.

The insurer also noted that the policy excluded claims for '*loss or damage of valuables left in luggage while in transit*' and for '*perishable goods and bottles or any damage caused by their contents*'.

After complaining unsuccessfully to the insurer, Miss J came to us.

complaint not upheld

Miss J told us she had been unable to obtain and complete a '*property irregularity report*'. Her outward flight had been diverted and had landed very late at night at a military airport rather than at its intended destination.

She said it was obvious as soon as she collected her suitcase after the flight that it had been badly damaged. However, she had not been aware, until she finally arrived at the hotel, that some of the contents had been stolen or damaged.

Miss J sent us, '*as proof*', some photographs of the damaged suitcase. We pointed out that the photographs proved that the case was damaged – but not that any of the contents had been lost or damaged. And we noted that she had already received compensation from the tour operator for the damage to her suitcase.

We did not think it reasonable for the insurer to have insisted on seeing a receipt or other proof of ownership for every item that Miss J reported lost or damaged. But we noted that she was unable to explain why, given the significant damage to her suitcase, she had not checked the contents while she was still at the airport.

She admitted that she had been waiting over three hours for the coach that was taking her on to her hotel. It seemed to us that this was ample time in which she could have looked through the contents of her case and made some kind of official report of any theft or damage she discovered.

We also noted that Miss J was unable to provide any satisfactory answer to our questions about whether she had taken the affected items of clothing to a professional dry cleaner, to see if the stains could be removed.

Overall, we did not think that Miss J had adequately demonstrated that she had sustained any loss that was covered by the terms of her travel insurance policy. We did not uphold her complaint. ■

87/11

insurer turns down claim for lost/damaged property because policyholder failed to obtain '*property irregularity report*'

Mr A put in an insurance claim for property that he said had been stolen or damaged while he was travelling with his wife and two small children to visit his parents in South Africa.

When they reached the airport in Johannesburg he noticed that one of their suitcases had been damaged. He said he had not managed – at that stage – to check the contents of the damaged case or to look in detail at the rest of their belongings.

The family had only a brief amount of time in which to collect their luggage before transferring to an internal flight for the last part of their journey. And he said that he and his wife had been distracted by the need to attend to one of their children, who was unwell. However, Mr A *did* report the damaged case to airport staff, who advised him to inform his insurer and the police.

When they finally reached their destination, Mr A discovered that his son's pushchair had been irreparably damaged in transit. He also found that a number of items were missing from the damaged suitcase, including a video camera. He reported all of this to the local police and received written confirmation from them.

The insurer rejected Mr A's claim. It said its policy only covered loss or damage that occurred during a journey if the policyholder reported it to the carrier as soon as it was discovered – and obtained a '*property irregularity report*'. The insurer also noted that its policy did not cover valuables that had not been kept in hand luggage.

Mr A thought the insurer had treated him unfairly. He said he had packed the video camera in a suitcase because he and his wife would not have been able to carry it. They were '*already well-laden*', carrying their children and everything the children needed during the journey.

He pointed out that the circumstances of his journey made it impossible for him to establish the full extent of his losses – and to obtain a '*property irregularity report*' – while he was still at Johannesburg airport.

However, he had informed staff at the airport as soon as he realised his case was damaged. He had followed their advice in contacting the police and he thought the police report was acceptable evidence.

When the insurer refused to reconsider its decision, Mr A came to us.

... he said he would prefer to get his vehicle assessed and repaired in the UK.

complaint upheld in part

We accepted that in failing to obtain a '*property irregularity report*', Mr A had not strictly complied with the terms of the policy. However, he had followed the advice of the airline staff in reporting the loss and damage to the local police. He had also ensured he received written confirmation of this.

We thought this was reasonable, bearing in mind he was travelling with two small children and had only been at the airport for a short time while awaiting a connecting, internal flight.

The insurer argued that the police report did not provide full details of all the missing or damaged items. But we pointed out that a report from the airline would not have provided any independent verification of Mr A's account of events. Mr A's failure to obtain that document had not, therefore, prejudiced the insurer's position. Moreover, the insurer's own '*Key Facts*' document about the policy stated that claims for theft or damage should be reported '*to the transport carrier or the local police*.'

So we said the insurer should accept the police report as evidence that an '*insured event*' had taken place.

We accepted Mr A's explanation of why he had not kept his video camera with his hand luggage. However, the policy clearly stated that valuables were not covered if they were '*outside of the insured person's control in transit*.' So we said the insurer should exclude the cost of the video camera but meet all the rest of Mr A's claim, together with interest. ■

■ **87/12**

insurer refuses to meet the cost of returning broken-down vehicle to the UK for repair

Mr K was on holiday in France in his motorhome when it developed a fault. He had 'European roadside assistance' cover, so he phoned his insurer, who arranged for an agent to inspect the vehicle and tow it to a local garage for repair.

After carrying out some minor work, which failed to solve the problem, the garage told Mr K that his vehicle's engine would need to be replaced, at an estimated cost of 6,000 euros.

Mr K contacted his insurer and said he was not certain that the engine *did* need replacing. He said he would prefer to get his vehicle assessed and repaired in the UK.

The insurer told him it was unable to pay the costs of doing this. It said it could only pay for the vehicle to be brought back to the UK for repair if the French garage could not complete the necessary work before Mr K's planned return date to the UK. However, the garage had confirmed that the repairs *could* be completed within this time.

Unhappy with the situation, Mr K made his own arrangements to get his motorhome back to the UK, at a cost of £1,136. The problem was then found to have been caused by a blocked air filter, costing £46.40 to replace.

Mr K contacted his insurer to explain what had happened. He said his '*lack of faith*' in the French garage had been justified by events. And he pointed out that by bringing his vehicle back and getting it inspected by his own garage, he had saved '*a sizeable amount of money for a repair that was not necessary*'. He put in a claim for the costs he had incurred in getting his motorhome back to the UK.

The insurer refused to reimburse Mr K. It also told him it was not responsible for the advice provided by the garage in France. Mr K then complained to us.

complaint upheld

We noted that Mr K's policy covered him for travel expenses that would allow him *either* to continue a planned journey *or* to return home, if his vehicle broke down and repairs could not be completed within 12 hours.

We thought, on balance, that the repairs proposed by the garage in France would probably have taken more than 12 hours to complete. So we considered that Mr K had a valid claim under this part of the policy. We told the insurer to pay the claim, together with interest. ■■■