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 99

charging differently

The way the ombudsman service is funded was agreed back in 2000 – based on a compromise between the varying approaches used by our predecessor complaints schemes. We get our funding in two ways – through a levy paid by all retail financial businesses – and from case fees paid by businesses when we settle complaints about them (although currently we don't charge businesses for their first three cases each year).

In many ways, this method of raising our funding has served the financial services industry and the ombudsman well. It's simple to explain and relatively low-cost to administer. And it provides a degree of flexibility around volatile case numbers – coping sufficiently as we've grown from handling 25,000 complaints a year to ten times that number.

But there are challenges too. While the current arrangements take a 'one size fits all' approach – applying equally to *all* users from the largest financial group to the sole proprietor – our remit has changed and extended in recent years, and now covers a much wider and more diverse range of businesses.

The way we're currently funded has also made it difficult to manage the financial risks and cost pressures that we face in responding to volatile demand for our service. This has particularly been the case ▸

Financial Ombudsman Service

scan for previous issues

in relation to so-called ‘mass complaints’ like mis-sold payment protection insurance (PPI), which now make up over 50% of our cases (but five years ago accounted for just 2% of our workload).

In addition, case fees *don’t* cover the increasingly important work we do – for example, on our consumer helpline and through our outreach and external liaison activities – to help resolve issues *before* they become formal, ‘chargeable’ complaints.

This is why, over the last few months, we’ve been talking with businesses and their trade associations to develop our thinking on new arrangements for case fees. We believe the new approach we’re suggesting would be fair to all case-fee payers – and could help encourage greater efficiency in complaints handling.

For smaller users, we propose increasing the number of free cases from 3 to 25. This would mean that only 1% of financial businesses would pay *any* case fees at all. For the largest users (the ten or so financial groups that account for over 70% of our caseload), we propose a new group-account arrangement, which would develop over time to measure more accurately the total costs to the ombudsman of the work that each of these groups generates.

This is still only an outline proposal at this stage. Depending on the views of case-fee payers and other stakeholders, we would aim to introduce a new charging structure from April 2013. We will need to consult again on these funding proposals, as further details are finalised. I look forward to hearing from you about what you think.

Natalie Ceeney

chief executive and chief ombudsman

Financial Ombudsman Service

South Quay Plaza
183 Marsh Wall
London E14 9SR

consumer helpline
0800 023 4567
0300 123 9 123
8am to 6pm Monday to Friday
9am to 1pm Saturday

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

switchboard
020 7964 1000

www.financial-ombudsman.org.uk

recent complaints involving debt

Every year during the post-Christmas period we see an increase in the number of debt-related complaints referred to us. So in view of the overall economic difficulties, it is no surprise that we are currently seeing more complaints that involve debt.

The ombudsman service is not able to help with debt problems in general. The service we offer is dispute resolution, not debt or money management. So we are not in a position to provide consumers with debt advice or to act as an intermediary, in helping them to negotiate acceptable repayment arrangements with the business that is pursuing them for a debt.

What we *can* do is to help resolve cases where a dispute has arisen about whether the customer has been treated fairly and reasonably and has received sympathetic and positive treatment in respect of financial hardship. Where it appears to us that a consumer would benefit from specialist debt-counselling, we give them contact details for the main cost-free agencies that could help them.

This set of recent case studies illustrates some of the more common types of complaint referred to us involving debt. These include complaints where consumers:

- say they are being pursued for debts that are not theirs;
- dispute the amount that they owe; *and*
- express concern about the way in which a business has gone about collecting a debt.

99/1
consumer complains of '*harassment*' by debt collector

Mrs C complained to a debt-collecting company that it was causing her '*considerable distress*' by the way in which it was '*harassing*' her with '*threatening letters and phone calls*' about a credit card debt.

The company did not accept that she had grounds for complaint. It said it had not harassed or threatened her in any way and it denied having contacted her '*excessively*'.

It agreed that it had tried to contact her on a number of occasions. However, it said this was because it was having so much difficulty getting any response at all from her. She had failed to answer its letters and had not been prepared to talk on the phone.

Unhappy with this response, Mrs C referred her complaint to us.

complaint not upheld

We asked the company for copies of all the letters it had sent to Mrs C. We also asked for details of the dates, times and duration of all the calls it had made to her, together with recordings of the calls.

We noted that there had been relatively few letters. They were all brief and clear and we thought them polite and helpful in tone.

There had also been relatively few phone calls. These were all of very short duration and had been made during normal working hours. The dates and times of the calls tied-in with the dates and times that Mrs C had given us, when we asked for details of the calls she had received.

The recordings of the calls confirmed what the company had said about Mrs C's failure to engage in any meaningful conversation during these calls. As soon as she had realised who was calling she had simply said she was too busy to talk – and had then hung up.

We did not uphold the complaint. We explained to Mrs C that she was not helping her own situation by ignoring the debt-collecting company – and her debt. We gave her details of a debt advice organisation that could give her free advice and assistance and that could liaise with the debt-collecting company on her behalf, if she wanted it to do that.

99/2
consumer complains that debt management company failed to get his debts written-off

Mr B complained about a debt management company that he said had taken his money '*under false pretences*'.

He had contacted the company after seeing it advertise in his daily newspaper. He explained that he owed money on a number of credit cards and store cards and was starting to find it difficult to afford even the minimum repayment requested each month.

Mr B subsequently signed a contract for the company's services, committing him to pay an initial fee and then a monthly administration fee.

A few months later he complained that the company had '*failed to get rid of the debts*'. He said it had led him to believe that it would negotiate with all his creditors and arrange for his debts to be written-off.

The company told him it did not consider he had any grounds for complaint as it had never promised to get any of his debts written-off. It pointed out that it had negotiated successfully on his behalf with more than ten creditors and had agreed reduced repayment arrangements with each of them.

Dissatisfied with this response, Mr B referred his complaint to us.

complaint not upheld

We asked to see the contract that Mr B had signed, together with all the letters and other documents that the debt management company had sent him. We also obtained a recording of Mr B's initial phone call to the company, when it had outlined how it could help him and what it would charge for its services.

We noted that the company had explained very clearly to Mr B – both on the phone and in writing – that it would contact all his creditors and try to agree with each of them a '*managed repayment plan*'. The company had also explained very clearly what it would charge Mr B and how it would pass on his agreed repayment amount each month to each of the creditors.

When explaining on the phone to Mr B how it would negotiate a repayment plan with each of his creditors, the company's representative had said that he '*occasionally*' managed to get a client's debt '*written-off altogether*'. However, the representative had also made it clear that the more usual outcome was that a creditor would agree to accept reduced repayments, over a longer term.

... We explained why we did not think the debt management company had done anything wrong.

We were satisfied, from the evidence, that the company had put a significant amount of effort into negotiating with Mr B's creditors. In each instance it had successfully agreed reduced repayment arrangements.

We explained to Mr B why we did not think the debt management company had done anything wrong and why we could not uphold his complaint. ■

■ **99/3**

consumer complains that debt management company failed to get her debts written-off

Miss J, who worked as a fitness trainer at her local gym, had been finding it difficult to manage all her financial commitments even when she was working full-time. So when her working hours were substantially reduced she soon realised she was in serious financial difficulties.

She later told us that with what seemed to be '*perfect timing*' she received a phone call '*out of the blue*' from a debt management company.

The company representative had explained that he was calling residents in her area to outline the services the company could offer to '*suitable people*'.

Miss J was impressed by what he said the company could do for her and she agreed that he should send her a brochure and application form. She subsequently signed a contract with the company, paying a one-off 'set up' fee and agreeing to an ongoing monthly administration fee.

A few months later, Miss J sent the company a letter of complaint. She said she had only signed-up for its services because it had led her to believe it would get most of her debts written-off. However, it seemed to her that all it had done was to negotiate reduced repayment arrangements with one of her four creditors.

In response, the company sent Miss J a lengthy reply from its solicitor, refuting her complaint and concluding that the company had '*complied with the contract and the law*'.

Miss J then brought her complaint to us. She said she had been unable to understand large sections of the solicitor's letter because it contained so much legal jargon. However, she was unhappy that her concerns appeared to have been dismissed.

complaint upheld

We reviewed all the documents that the company had sent Miss J. The letter from its solicitor argued that the contract she had signed did not contain any '*guarantee*' that her debts would be written-off.

We accepted that – technically – there had been no '*guarantee*'. However, we thought the wording of the company's brochure was unclear about a number of key points. In particular, we thought that any reasonable person reading the brochure would be given the impression that the company would arrange to '*remove*' most of their debts.

We concluded that Miss J would never have signed the contract if she had been given clear information about what the company would actually do for her.

We upheld the complaint. We told the company to refund all the fees it had charged Miss J, together with interest. We also told it to pay her an additional £150, in recognition of the distress and inconvenience it had caused her by its poor handling of her complaint.

99/4
consumer argues with loan provider that her debt is '*unenforceable*'

Mrs A was being pursued by a loan provider for a debt that she did not think she should be required to pay.

After reading on an online forum that debts could be written-off if the loan provider could not supply a '*true copy*' of the original loan agreement, she asked the loan provider to send her a photocopy of the original agreement containing her signature.

The loan provider said it was unable to do this as it no longer had the original agreement. It sent her instead a reconstituted agreement containing all the original terms and conditions. Mrs A responded by saying the loan provider should stop making demands for repayment as the debt was '*now unenforceable in law*'.

The loan provider said that Mrs A was mistaken about this. She therefore referred the dispute to us and asked us to confirm that the debt was '*legally unenforceable*'.

complaint not upheld

We told Mrs A that we did not have the power to declare whether or not credit agreements are legally enforceable, as that is something for a court to decide. However, we said we were able to look into her complaint on the basis of whether the loan provider had treated her in a way that was fair and reasonable.

After obtaining evidence from Mrs A and the loan provider, we established that she had taken out the loan nearly ten years earlier, to pay for some computer equipment. She had been in arrears with her repayments for most of that time. At one stage she had tried to persuade the loan provider to accept a '*partial payment in final settlement of the total amount outstanding*'. And for nearly three years before that she had been paying the loan provider just £1 per month.

When Mrs A had first contacted us, she told us there had '*always been considerable doubt*' about whether the debt was hers at all. So we asked her to tell us why she thought the debt might not be hers. We also asked why she had continued making payments for some years – and had made an offer to settle the debt – if she did not believe she owed any money. All she told us in response was that she had not known what else to do.

It was clear from the evidence that Mrs A had taken out the loan and we thought it was fair and reasonable for the loan provider to seek repayment of the debt. We also thought that the loan provider had fully complied with its responsibility to deal with Mrs A's situation sympathetically, in view of her financial difficulties.

We explained this to Mrs A and gave her details of free money advice organisations that she could contact for help in managing her debts. We did not uphold her complaint. ■

99/5

consumer complains that he is being pursued for a debt that is not his

Mr W was in dispute with a debt-collecting company about a credit card debt of £1,500. He insisted that he knew nothing about this debt and he said he thought he had been the victim of fraud.

He told the company that only a few months earlier a different debt-collecting company had contacted him about a debt of a similar size with a different credit card company. In that instance, the debt had been written-off after he had been able to prove that the signature on the application form for the card was not his.

... we said the company had insufficient evidence to show he owed the debt.

He explained that a number of his belongings had been stolen – including documents containing personal information – during a break-in at his previous home, very shortly before he had moved out. He thought that someone must have used those stolen documents to open several accounts in his name.

When the company disregarded this explanation and continued to pursue Mr W vigorously for the debt, he referred his complaint to us.

complaint upheld

We asked the company to send us copies of all the documents it had in connection with this credit card debt. In particular, we wanted to see the original application for the credit card. However, the only documents the company was able to send us were copies of credit card statements, all addressed to Mr W at the house where he used to live.

Mr W produced evidence confirming details of the break-in at that address. And we noted that the credit card statements forwarded to us by the debt-collecting company had all been sent to that same address, some time after he had moved away.

We were satisfied, from what we had seen, that Mr W had been the innocent victim of identity theft and had truly not taken out the credit card.

We upheld the complaint and told the company that, as it had insufficient evidence to show that Mr W owed the debt, it should stop pursuing him for the money. We said it should remove his details from its records and ensure that no adverse information about this debt was registered with any credit reference agency. We also said it should pay Mr W £200, in recognition of the inconvenience it had caused him. ■

99/6

consumer complains that credit card provider failed to set up a repayment plan correctly

Miss G complained that her credit card provider had failed to amend its records correctly after it had agreed a reduced monthly repayment plan with her. As a result, the card provider had contacted her to tell her she was in arrears, even though she had maintained her monthly repayments at the agreed new level. She was also very unhappy to discover that missed payments had been registered on her credit file.

The card provider denied having made any mistake. It told Miss G it had never agreed a repayment plan with her – it had simply said it would accept reduced repayments as a temporary measure, for up to three months. It said it had contacted her about arrears because she had continued paying at the reduced rate beyond the agreed three months.

Unhappy with this response, Miss G referred the dispute to us.

complaint not upheld

We established that Miss G had contacted the card provider shortly after losing her job. She told us she had explained that she was experiencing financial difficulties and could no longer afford the minimum repayment amount required each month.

After discussing the situation with her, the credit card provider had agreed to accept reduced monthly repayments of £20. It told us that it had agreed to this for no more than three months, to help Miss G through what she had said were '*short-term financial difficulties*'.

However, Miss G maintained that it was her '*clear understanding*' that the card provider had agreed to this monthly amount as part of a '*long-term repayment plan*', to last at least until she was able to secure another job.

We listened to a recording of Miss G's initial phone call to the card provider, when she had told it of her financial difficulties. She had said she was '*very hopeful*' of finding another job within the next three months but that she was '*currently*' unable to afford a monthly repayment of more than £20.

The card provider had told her that it would suspend charges on her account for three months and would accept monthly repayments of £20 for that length of time. It had also said that she should get in touch again to discuss her account if she found she needed a longer-term arrangement.

When Miss G had carried on paying just £20 a month for longer than the agreed three months, the card provider had written to her.

... we did not think it unreasonable of the card provider to contact her about the arrears on her account.

It had expressed concern about the arrears on her account and had said she should get in touch to discuss making a formal repayment arrangement if she was still in financial difficulties.

Miss G had contacted the credit provider after receiving this letter – but only to insist that she had already agreed a repayment arrangement and that the credit provider must have made a mistake in its records.

We concluded that the credit card provider had *not* made any formal repayment arrangement with Miss G. It had agreed to accept reduced payments as a temporary measure – for three months. Those repayments were substantially less than her contractual monthly minimum repayment of £120, so we did not think it unreasonable of the card provider to contact her about the arrears on her account.

We did not uphold the complaint. We encouraged Miss G to accept the formal repayment arrangement that the credit card provider proposed after she referred the complaint to us.

Initially, she said she would only accept the repayment arrangement if the card provider removed the adverse information it had put on her credit file. However, we pointed out that the card provider had only started putting information on her credit file *after* it had written to her about its concerns that she was continuing to pay just £20 a month.

We told Miss G that the information on her file was a fair and accurate reflection of her account status. There were therefore no grounds for asking the card provider to amend or remove it. ■

... he explained that his business had been badly affected by the downturn in the economy.

99/7

consumer acting as guarantor for a loan complains of unfair treatment by loan provider

A self-employed landscape gardener, Mr M, complained to a loan provider that its persistent letters and phone calls were causing him '*considerable distress*'.

The loan provider got in touch with him several years after he had agreed to act as guarantor for a loan taken out by his daughter. She had fallen seriously behind with her repayments after losing her job and the loan provider wrote to Mr M, telling him he was responsible for ensuring all future repayments were made in full.

Mr M wrote back to say that he would do what he could. However, as his own financial position had '*worsened very considerably*' over the past year, he could not afford to pay as large an amount as the loan provider was demanding.

The loan provider never responded to this letter. But just over a week after Mr M had sent it, he began receiving standard letters from the loan provider – demanding payment. He ignored the first of these, assuming it was computer-generated and had been sent in error.

When he received another demand for payment a few weeks later he wrote to the loan provider again. This time he enclosed detailed statements of his income and expenditure. He asked if he could make payments at a reduced rate and explained that his business had been badly affected by the downturn in the economy, as well as by his inability to work at all for several months because of ill-health.

The loan provider failed to reply to this letter so Mr M made a number of attempts to make contact by phone in order to discuss his situation. He said that each time he rang he was simply told that someone would call him back the same day. However, this never happened.

Soon after this he began getting several phone calls a day from the

loan provider, sometimes late at night. The staff who called him appeared to have no knowledge of his earlier correspondence – and no interest in discussing his circumstances. They simply demanded payment, in a way he said he found '*intimidating and upsetting*'.

He then sent a letter of complaint to the loan provider's head office. The reply, sent some weeks later, failed to address any of the points he had made but asserted that the loan provider acted '*at all times in accordance with the law*'.

Mr M then referred his complaint to us.

complaint upheld

We were satisfied from the evidence that Mr M was experiencing genuine financial difficulties and could not afford the full amount that the loan provider was seeking each month. He had, however, agreed to make regular payments and had asked the loan provider to discuss with him the minimum amount it would accept.

The loan provider could not give us any explanation when we asked it why it had never responded to this request. After looking at the loan provider's letters to Mr M, and at its own internal notes on the case, we concluded that it had deliberately ignored his letters and phone calls and had pursued him for payment in an unreasonable manner.

We upheld the complaint. We reminded the loan provider that it was required to treat consumers positively and sympathetically if they were in genuine financial difficulties. We said it could not ignore this obligation simply because Mr M was a guarantor for the loan, rather than the person who had originally taken it out.

We told the loan provider to reach agreement with Mr M on an affordable repayment plan that took proper account of his financial circumstances.

We said the loan provider should also remove all the '*late payment*' and other administration charges that it had applied to the account since it had first contacted Mr M about the debt. And we said it should also pay him £300 to reflect the distress and inconvenience it had caused him. ■

... he could not afford to pay as large an amount as the loan provider was demanding.

ombudsman focus:
third quarter statistics

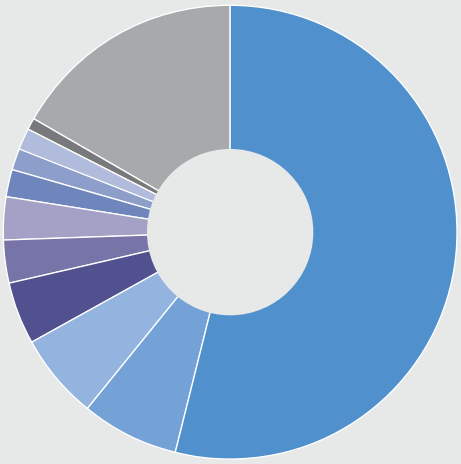
a snapshot of our complaint figures for the *third quarter* of the 2011/2012 financial year

In issue 97 of *ombudsman news* we published data for the *second quarter* of the 2011/2012 financial year – showing how many new complaints we received, and what proportion we resolved in favour of consumers, during July, August and September of this year.

The focus in this current issue of *ombudsman news* is our complaints workload in the *third quarter* of 2011/2012 (covering October, November and December 2011).

what consumers complained about to the ombudsman service in October, November and December 2011

payment protection insurance (PPI)
credit card accounts
current accounts
house mortgages
car and motorcycle insurance
overdrafts and loans
buildings insurance
deposit and savings accounts
mortgage endowments
travel insurance
'point of sale' loans
whole-of-life policies
contents insurance
personal pensions
hire purchase
term assurance
portfolio management



54%	payment protection insurance (PPI)
7%	credit card accounts
6%	current accounts
4.5%	mortgages
3%	car and motorcycle insurance
3%	overdrafts and loans
2%	buildings insurance
1.5%	deposit and savings accounts
1.5%	mortgage endowments
1%	travel insurance
16.5%	complaints about other products

the financial products that consumers complained about most to the ombudsman service in October, November and December 2011

number of new cases					% resolved in favour of consumer				
Q3 (Oct to Dec) 2011/12	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10	**Q3 (Oct to Dec) 2011/12**	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10
30,301	19,259	56,025	104,597	49,196	**68%**	92%	55%	66%	89%
4,032	5,751	5,500	17,356	18,301	**51%**	55%	60%	61%	68%
3,421	4,197	3,201	19,373	24,515	**35%**	32%	26%	27%	20%
2,383	2,796	2,044	7,060	7,452	**24%**	33%	36%	36%	37%
1,814	2,116	1,741	5,784	5,451	**49%**	46%	47%	45%	38%
1,566	1,718	1,402	5,805	6,255	**36%**	38%	39%	43%	48%
1,100	1,505	1,225	3,469	3,437	**51%**	51%	44%	42%	43%
912	1,233	880	4,326	4,508	**46%**	40%	40%	42%	52%
888	895	603	3,048	5,400	**29%**	28%	26%	31%	38%
550	728	582	2,503	1,956	**44%**	50%	50%	42%	44%
537	619	568	2,765	1,735	**47%**	52%	36%	36%	52%
519	596	393	1,444	1,690	**27%**	32%	29%	33%	28%
494	642	461	1,697	1,863	**53%**	55%	47%	41%	38%
450	506	347	1,126	1,359	**35%**	37%	39%	36%	29%
402	459	394	1,395	1,430	**39%**	48%	46%	43%	48%
352	344	194	926	912	**27%**	25%	26%	27%	24%
321	371	254	1,148	1,040	**59%**	61%	68%	67%	48%

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what consumers complained about to the ombudsman service in October, November and December 2011

home emergency cover
warranties
specialist insurance
income protection
endowment savings plans
investment ISAs
debit and cash cards
unit-linked investment bonds
catalogue shopping
critical illness insurance
debt collecting
inter-bank transfers
legal expenses insurance
'with-profits' bonds
cheques and drafts
mobile phone insurance
share dealings
credit broking
self-invested personal pensions (SIPPs)
pet and livestock insurance
annuities
direct debits and standing orders
private medical and dental insurance
(non-regulated) guaranteed bonds
electronic money

ombudsman focus:

third quarter statistics

number of new cases					% resolved in favour of consumer				
Q3 (Oct to Dec) 2011/12	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10	**Q3 (Oct to Dec) 2011/12**	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10
296	415	388	*	*	**72%**	66%	59%	*	*
239	240	205	895	863	**66%**	63%	66%	61%	53%
228	259	253	1,791	1,070	**51%**	53%	54%	51%	50%
227	211	179	702	740	**33%**	45%	41%	42%	39%
201	250	207	924	1,512	**34%**	38%	35%	33%	25%
200	304	156	824	1,301	**50%**	57%	54%	48%	42%
195	208	196	878	964	**44%**	36%	35%	41%	43%
194	200	178	849	2,453	**59%**	67%	70%	72%	57%
182	197	133	582	755	**64%**	61%	60%	66%	79%
182	215	162	528	598	**27%**	33%	36%	31%	31%
181	206	151	512	697	**35%**	36%	31%	42%	42%
176	216	132	529	606	**42%**	44%	40%	43%	43%
172	232	177	619	597	**27%**	17%	23%	21%	25%
171	186	165	683	1,056	**29%**	23%	31%	37%	28%
149	200	173	691	773	**43%**	49%	48%	47%	49%
145	177	119	*	*	**72%**	52%	58%	*	*
142	166	135	979	1,105	**51%**	50%	51%	62%	52%
133	165	194	697	341	**63%**	70%	74%	63%	62%
127	125	108	417	410	**62%**	54%	52%	46%	53%
126	158	121	438	462	**46%**	36%	37%	31%	24%
123	137	103	423	501	**32%**	41%	42%	37%	33%
122	174	138	571	737	**44%**	39%	44%	45%	48%
122	150	95	506	652	**41%**	53%	49%	50%	35%
119	103	120	430	421	**46%**	47%	41%	40%	50%
108	109	94	369	453	**28%**	30%	33%	36%	49%

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

continued

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what consumers complained about to the ombudsman service in October, November and December 2011

store cards
roadside assistance
debt adjusting
commercial vehicle insurance
commercial property insurance
payday loans
guaranteed bonds
personal accident insurance
guaranteed asset protection ('gap' insurance)
hiring/leasing/renting
occupational pension transfers and opt-outs
state earnings-related pension (SERPs)
merchant acquiring
business protection insurance
OEIC – Open Ended Investment Companies
building warranties
money remittance
'structured capital-at-risk' products
unit trusts
total
other products and services

ombudsman focus:

third quarter statistics

number of new cases					% resolved in favour of consumer				
Q3 (Oct to Dec) 2011/12	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10	**Q3 (Oct to Dec) 2011/12**	Q2 (Jul to Sep) 2011/12	Q1 (Apr to Jun) 2011/12	full year 2010/11	full year 2009/10
106	138	107	480	574	**56%**	76%	74%	70%	74%
105	95	85	300	226	**44%**	58%	52%	40%	35%
101	125	102	302	231	**59%**	69%	57%	54%	65%
83	111	82	317	290	**33%**	41%	37%	36%	35%
81	82	65	429	487	**34%**	28%	31%	31%	22%
75	**	**	59	33	**73%**	**	**	64%	58%
72	118	74	408	595	**26%**	36%	43%	40%	37%
70	72	62	304	274	**42%**	41%	56%	49%	26%
61	70	44	182	224	**47%**	57%	35%	46%	53%
61	60	**	221	283	**30%**	62%	**	43%	37%
61	79	57	281	368	**29%**	40%	47%	49%	48%
59	81	71	196	560	**3%**	1%	3%	7%	2%
49	66	**	110	95	**17%**	17%	**	15%	18%
45	49	**	204	222	**29%**	31%	**	22%	25%
37	**	**	140	329	**61%**	**	**	76%	56%
33	40	**	121	161	**42%**	31%	**	39%	40%
****	44	**	68	19	****	50%	**	47%	50%
****	46	34	550	273	****	96%	96%	52%	49%
****	**	32	125	192	****	**	51%	65%	44%
55,401	50,014	80,711	204,257	160,641	**52%**	80%	49%	51%	50%
506	631	590	1,864	2,371	**47%**	45%	43%	34%	42%
55,907	**50,645**	**81,301**	**206,121**	**163,012**	**52%**	**80%**	**49%**	**51%**	**50%**

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

complaints involving personal accident insurance

Every year we deal with a relatively small but steady number of complaints involving personal accident insurance. Policies of this type generally offer a defined level of benefit where a policyholder dies – or suffers serious injury – as a result of an accident.

This set of case studies illustrates some of the themes that tend to arise most frequently in the complaints referred to us. They include disputes about:

- whether or not the policy covers a specific injury, or the circumstances in which it was sustained;
- whether an accident was the sole cause of an injury or whether a pre-existing condition contributed to the problem; *and*
- the level of benefit payable under a policy, if a claim is met.

99/8

personal accident insurer refuses to pay claim for hearing loss

A former soldier, Mr K, complained that his personal accident insurer refused to pay his claim for loss of hearing in both ears.

Mr K said his hearing loss had come about after he was caught up in an intensive bombing campaign during his last two weeks of military service in the Middle East. He sent the insurer a statement from his doctor, confirming that the cause of his disability was '*exposure to loud noise while on active service*'.

The insurer told Mr K it was unable to pay his claim, as the policy only covered injuries that were caused by '*a sudden act and not by any gradual cause*'.

Mr K thought the insurer had '*interpreted the situation incorrectly*'. He said the explosions that had led to his hearing loss were not '*a gradual cause but a short series of sudden acts with a cumulative effect*'.

When the insurer refused to reconsider his claim, Mr K referred his complaint to us.

complaint upheld

The policy was not designed to provide benefit for injuries that arose as a result of a gradually-occurring degenerative process or disease.

But it was clear from the medical evidence that Mr K's hearing loss had not been caused by either of these things.

Mr K had been unable to pinpoint any one specific incident (or '*sudden act*') as the cause of his hearing loss.

However, the evidence showed it had come about as the direct result of a short series of '*sudden acts*' – a short but defined period of explosions during his last two weeks of active duty. We did not think these circumstances could properly be considered a '*gradual cause*' of the type the policy excluded.

We said the insurer should pay the claim and that it should also pay Mr K £350 for the distress and inconvenience it had caused him by significant delays in its handling of the claim.

99/9

consumer queries the level of benefit payable under his personal injury policy after he gives up his job because of a disability

Mr J injured his left knee very seriously while playing cricket with his village team. He made a claim on his personal accident policy and sent the insurer a medical report from the surgeon who had operated on his knee.

This report stated that Mr J was likely to have mobility problems for the rest of his life. The report also noted that the knee injury had '*resulted in Mr J having to give up work, being now unable to continue with his occupation*'.

Before his accident, Mr J had worked full-time as an estate agent. He told the insurer that the injury meant he was '*unable to continue in work*' as he could '*no longer get out and about, inspecting properties and showing prospective buyers around*'.

The insurer told Mr J it would pay him £10,000. This was the maximum amount payable under the section of the policy that covered '*permanent total disability, which prevents you from carrying out your usual occupation, and which will probably continue for the rest of your life*'.

Mr J complained to the insurer that it had failed to assess his claim correctly. He had expected to receive the substantially larger sum that was payable for policyholders no longer able to work '*in any occupation whatsoever*'. However, the insurer told him his circumstances did not meet the strict criteria set out in the policy for that level of benefit. Mr J then referred his complaint to us.

complaint not upheld

After examining the terms and conditions of the policy, together with the medical evidence that Mr J had submitted, we concluded that the insurer *had* assessed the claim correctly.

The highest level of benefit was only paid in very specific circumstances, which were set out clearly in the policy. In order to qualify, Mr J would have had to provide evidence that he was unable to work in any occupation whatsoever, for the rest of his life, and that this situation had come about entirely as a result of his injury.

We explained this to Mr J and told him we thought the insurer had assessed his claim in a way that was fair and reasonable. We did not uphold the complaint. ■

99/10
personal accident insurer turns down claim for permanent disability because of underlying medical condition

Mr T had an accidental injuries policy that offered cover to policyholders if they suffered an injury that resulted in permanent disability. He complained to his insurer after it turned down his claim for the loss of use of an ankle joint.

The insurer accepted that Mr T had injured his right ankle after a serious fall – and that he had ultimately lost the use of this ankle joint.

... his circumstances did not meet the strict criteria set out in the policy for that higher level of benefit

However, it told him his claim had not met the policy conditions because his disability had not '*occurred solely and independently of any other cause*'.

The medical evidence had shown that, at the time of his fall, Mr T was suffering from '*asymptomatic arthritis*' in the ankle that was subsequently injured.

Mr T thought the insurer's decision was unfair. He pointed out that the arthritis was '*asymptomatic*' (in other words, displaying no symptoms). He said he had been totally unaware that he had arthritis until *after* the accident, when he had undergone a number of medical tests. And he said he did not see how the arthritis could have affected the outcome of his fall to the extent that he was not entitled to any benefit at all under the policy.

To support his complaint, Mr T arranged an independent medical examination. The resulting report concluded that his accident had been '*90% responsible*' for his disability.

Mr T sent the report to the insurer but it remained unwilling to reconsider his claim. He therefore referred his complaint to us.

complaint upheld in part

The medical evidence confirmed that Mr T had lost the use of his ankle joint and that – at the time of his accident – the arthritis had been present but he would not have had any reason to be aware of this.

The medical opinion was that, if it had not been for the accident, Mr T's underlying condition would probably have remained asymptomatic and he would never have needed an operation to replace his ankle joint.

In cases like this, where an accident has caused a disabling injury *over and above* any degree of disability caused by an underlying condition, it has long been our practice to require the insurer to settle the claim on a proportionate basis.

We upheld the complaint.
The independent medical report had said the accident was 90% responsible for Mr T's disability, so we told the insurer to pay the claim on a proportionate basis of 90%. We said it should also pay interest on this amount.

99/11
insurer refuses to pay personal accident claim because of an underlying medical condition

Mr D made a claim under his personal accident policy for '*total and permanent loss of use*' of his left leg. He said his disability had come about as a result of a fall, when he had slipped on some water on his bathroom floor.

After examining the medical evidence, including a statement from Mr D's GP that '*functional loss of use of the left foot is effectively 100%*', the insurer offered to pay Mr D for '*total and permanent loss of use of one foot*'.

Mr D thought he should have been offered the significantly larger sum that was payable for the loss of an entire leg. He therefore rejected the insurer's offer and complained that it had failed to assess his claim correctly.

The insurer then paid for an independent medical report.
The specialist who examined Mr D and produced this report concluded that Mr D's fall had not caused any '*significant new injury*' to his left foot.

The specialist noted that this foot had been badly injured some years earlier and that Mr D's use of the foot had continued to be limited ever since, even though he had undergone a considerable amount of treatment.

The specialist conceded that Mr D's fall might have '*aggravated the existing problem*'. However, he said that if this had happened, '*any effects attributable solely to the fall*' would only have lasted a few weeks.

The insurer then told Mr D it was rejecting his claim altogether, on the grounds that there was a '*pre-accident history of injury*' to his left foot.
Unhappy with this, Mr D brought his complaint to us.

complaint not upheld
After looking carefully at all the evidence we concluded that the accident had not caused the problem for which Mr D was claiming on his policy.

... the insurer said her disability was not covered because it had not been caused by an '*accident*'

There was clear, independent medical evidence showing that Mr D had a significant history of treatment to his left foot – and that this treatment pre-dated both the events relating to his claim *and* the start date of his policy.

We did not uphold the complaint. We told Mr D that, in the circumstances, the insurer had been right to reject the claim entirely, as it did not meet the terms and conditions of the policy. ■

■ **99/12**

complaint about a rejected claim following complications during pregnancy

Mrs E referred her complaint to us after her insurer turned down the claim for permanent disability that she had made under her personal accident policy.

She had become permanently disabled after suffering a stroke during childbirth. The insurer told her that her disability was not covered because it had not been caused by an '*accident*'. The policy defined '*accident*' as '*a sudden and unforeseen event*'.

The insurer said that her stroke was the result of a rare complication of pregnancy – and pregnancy was not '*a sudden and unforeseen event*'.

complaint upheld

After looking at all the evidence we concluded that the insurer had not acted reasonably in refusing to pay the claim.

We pointed out to the insurer that although childbirth itself is not a '*sudden and unforeseen event*', the stroke that had led to Mrs E's disability resulted from a rare and totally unexpected complication of childbirth.

The cause of Mrs E's disability did, therefore, meet the policy definition of '*accident*' as a '*sudden and unforeseen event*'. And as the policy did not exclude complications of childbirth, we said the insurer should pay the claim. ■

... we concluded that he had suffered an '*accidental bodily injury*', as defined by the policy.

99/13

dispute over whether consumer's injury happened '*accidentally*' as required by policy terms

Mr A had insurance cover under his employer's group policy for, among other things, '*accidental bodily injury*'. He put in a claim under this section of the policy for paraplegia (paralysis of the lower part of the body).

He said the accident giving rise to his disability had occurred while he was playing football with his local amateur team. He had been perfectly fit and well at the start of the match. However, during the match he had suddenly become aware of acute pain between his shoulder blades. He had subsequently been admitted to hospital and was eventually diagnosed with paraplegia.

The insurer turned down Mr A's claim. It said the medical report provided by Mr A's doctor stated that there was no evidence that the disability had been caused by any '*accidental bodily injury either during the football match or otherwise*'.

The medical report said that the paralysis had resulted from a '*previously existing but undetected congenital abnormality*' (in other words, something that had been present when he was born).

Mr A complained that the insurer had treated him unfairly. He said he did not see how it could be considered anything but an accident that he had '*started a game of football in perfect health and become paralysed for life by the end of it*'.

In response, the insurer told him that the policy defined '*accidental bodily injury*' as an '*injury to the body caused by a sudden act and not by any gradual cause or degenerative process*'.

The insurer said that the '*intentional movements*' he would have made while playing football could not reasonably be said to '*constitute or cause accidental bodily injuries as defined in the policy*'.

Mr A then referred his complaint to us.

complaint upheld

The terms and conditions of many personal accident policies state that, for benefit to be paid, the accidental bodily injury needs to have come about as a result of something that was not only a '*sudden, unexpected and chance event*', but that was also '*external, violent and visible*'.

However, Mr A's policy required only that the accidental bodily injury was caused by a '*sudden event*'.

There had been no '*accident*' in the ordinary, everyday sense (he had not tripped, slipped *etc*). But there was no dispute about the fact that – before the football game – Mr A had been fit and well. He had not been in any pain or discomfort and had been quite unaware of the congenital abnormality that was subsequently discovered.

The paralysis had come about after a '*sudden event*' during the game. So we concluded that Mr A *had* suffered an '*accidental bodily injury*', as defined by the policy, and he therefore had a valid claim for paraplegia benefit under the policy. We upheld the complaint and told the insurer to pay the claim.

At the time we were considering this case, we were unable to *require* businesses to pay any amounts over £100,000 (this has now increased to £150,000 for complaints received since 1 January 2012).

The total sum payable in this claim was more than the £100,000 maximum compensation that applied at that time. However, the insurer confirmed that it would pay Mr A the full amount to which he was entitled. It said the dispute had never been about *how much* it should pay, only about whether it was liable to pay the claim at all. ■■■

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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. You mentioned in the last *ombudsman news* that you'd dealt with your 300,000th payment protection insurance (PPI) case. What are you doing to manage this workload effectively?

A. The challenges of our PPI workload are unprecedented. The number of new complaints about mis-sold PPI that we are assuming we will receive in 2012/2013 – 165,000 – will account for around 60% of our new cases next year. But we *could* receive a significantly higher or lower number than this – and there is considerable uncertainty about the volume of these cases in future years.

Initial feedback from stakeholders suggests that most believe we will continue to receive substantial volumes of PPI complaints for another two or three years. This seems a sensible basis on which to plan, given the size of the PPI market (with up to 6.5 million policies bought annually), the number of PPI complaints (1 million) made direct to banks and other financial businesses last year alone, and the potential extent of detriment to consumers.

Having to gear up to manage a workload on this scale means that the costs we incur in handling PPI cases will be significantly higher than the cost of handling other cases. We do not think it would be fair for these higher – PPI-related – costs to be met by businesses *not* involved in mass PPI claims. This is why we are proposing a supplementary case fee of £350 (in addition to the standard case fee of £500) for each PPI mis-selling case that is referred to us. But the fee will be chargeable *only* when businesses have *more than* 25 of these cases a year, reflecting where the costs are actually incurred in sorting out PPI mis-selling.

We are currently consulting on these proposals – and on how we plan to manage and fund the record complaints workload we expect next year. The document setting out our proposed plans and budget is on our website – and we look forward to hearing your views and feedback.

Q. In your interview with Sir Christopher Kelly (issue 98 – November/December 2011) you said he was stepping down as chairman of the ombudsman service. Has his successor been named yet?

A. Yes, Sir Nicholas Montagu KCB has been appointed as the chairman of our non-executive board of directors, to succeed Sir Christopher Kelly KCB – when he steps down as chairman in January 2012, after seven years.

Sir Nicholas is the former chairman of the Board of Inland Revenue, with over twenty years as a senior civil servant working on issues ranging from pensions to public service reform.

The appointment was made by the Financial Services Authority (FSA) under the *Financial Services and Markets Act 2000* – with the approval of HM Treasury – and it followed a recruitment exercise earlier in the year, including advertising in the press.

Our board has strategic responsibility for running the ombudsman service – ensuring the organisation is properly resourced and able to carry out its work effectively, impartially and independently.

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