

The complaint

Trustees Ms D and Mr G complain, on behalf of the trust 'S', that Prudential Assurance Company Limited ('Prudential') avoided a whole of life assurance policy for the late Mr S and declined a claim because of this. The trustees also complain about the way the matter was handled.

The trustees have been represented by Mrs S, the late Mr S's wife, who raised the claim.

Another business handled the claim on behalf of Prudential, but for ease in my decision I will refer only to Prudential.

What happened

In April 2012 Mr S applied for a whole of life plan with Prudential. He did so via an independent financial advisor (IFA). The policy he applied for initially had a sum assured of £550,000. This was accepted and cover started around a week later. The policy was then placed in trust with Ms D and Mr G as trustees.

Sadly, in November 2018 Mr S passed away. So, Mrs S submitted a claim on behalf of the trust.

To help its assessment of the claim Prudential requested information from Mr S's GP. Based on the evidence gathered, Prudential said there were aspects of Mr S's medical history which it felt he ought to have told it about when he applied for the policy. In particular:

- Long-standing, treated anxiety and depression (documented from as early as 2001).
- Acute Psychotic Disorder (09/06/2011 – 22/06/2011), with active monitoring by Community mental health team since then.
- Excessive alcohol consumption (documented from as early as 29/08/2007).

After reviewing things, Prudential decided Mr S had deliberately misrepresented his circumstances by failing to share this history in the application form in response to the questions he was asked. In June 2019, it wrote to Mrs S to confirm it had avoided the policy (treated it as if it had never existed) and declined the claim because of this. It refunded the premiums that had been paid. It noted it would never have offered Mr S cover had it had the above information. In the letter Prudential sent it didn't explain to Mrs S why it had declined the claim but gave this information to Mr S's GP. And advised Mrs S to make an appointment with the GP to discuss this information.

Once Mrs S had this information, she felt what Prudential had done was unfair and complained, asking it to review its decision. In particular, she noted:

- Mr S disclosed he'd suffered from anxiety for three years. Mr S had also completed an additional form with his IFA, in which he'd noted he had been suffering from anxiety/depression. Mrs S enclosed a copy of this form for Prudential's reference.

- Mrs S recalled the week mentioned by Prudential in relation to the Acute Psychotic Disorder and noted they'd visited Accident and Emergency (A&E) due to Mr S's heightened anxiety. Mrs S said the incident was confirmed as anxiety and depression and Mr S's medication was increased, but he wasn't admitted to hospital, nor did he have 'active' monitoring by the community mental health team.
- Mr S's medical records from 2007 state he was drinking 2-3 rums every night. Mrs S said Mr S did drink this much on occasion, but he later reduced his drinking. She noted this would still only equate to 3 units a day, about 21 units per week.

Mrs S also complained about the handling of the matter. She noted Prudential had sent a letter addressed to Mr S when the policy was avoided, which was distressing. Mrs S also said it was upsetting having to wait for a GP appointment to understand why the policy had been avoided and the claim declined.

Mrs S also disagreed that Prudential would have declined to offer cover. She said an underwriter who worked for the same business as the administering company had recently advised it would have added a 55% rating (charged higher premiums for the same cover). She noted Mr S would have willingly paid a higher premium, as the policy was being paid for by a family trust.

Prudential looked into the complaint. It apologised for the fact it had suggested Mr S didn't disclose his anxiety and depression. It agreed that the additional form included this information and was provided to Prudential at that time. It accepted that in this Mr S disclosed that he had ongoing anxiety and depression since 2003 and that he'd had blood tests and medication for this. He detailed that he'd seen a specialist and, in connection with this, provided his GP's details.

Prudential also acknowledged that Mrs S had been caused upset by having to wait for a GP appointment to understand the why it had avoided the policy and declined the claim. It apologised for the letter it sent addressed to Mr S. It offered £500 compensation to Mrs S for this and for the time taken to respond to the complaint.

In relation to the avoidance of the policy and claim, Prudential said:

- That the medical notes show Mr S was diagnosed by a consultant psychiatrist with Acute Psychotic disorder. It noted Mr S was prescribed anti-psychotic medication and had experienced visual and auditory hallucinations. It said this was not long before he applied for the policy and so it felt he'd have known about this diagnosis.
- The medical notes show Mr S was advised about safe alcohol limits in 2007 and in June 2011. The medical notes show he was drinking a bottle of rum every two days and two cans a night and trying to cut down. It was also recorded that he'd abused alcohol over recent years.

It said the correct answers to the relevant questions would have meant it obtained a GP report. And it thought the risk Mr S's overall medical history presented would have made him uninsurable at that time. It said it wouldn't have offered a policy and so it didn't agree to change its decision to avoid the policy and decline the claim.

Mrs S remained unhappy with Prudential's response and so brought the complaint to our Service on behalf of the trust. Mrs S questioned why Prudential didn't write to Mr S's GP back when the policy was taken out. And she said that Prudential's premium refund didn't in any way reflect the financial impact that the decision to decline the claim had had on her family.

Mrs S also told us the IFA didn't make Mr S aware of the importance of documenting each of the illnesses he'd suffered from, such that he felt that disclosing anxiety/depression was sufficient. Mrs S said Mr S didn't know of the specific medical term or diagnosis of 'Acute Psychotic disorder'. Mrs S didn't think anyone could be expected to detail this, when they'd already detailed anxiety/depression, which she said was how the illness was understood by Mr S.

Mrs S also acknowledged there were occasional periods when Mr S would drink to excess, usually brought on by his mental health issues or during holidays/celebrations. But she didn't think these could be counted as 'regular' which is what the question asked.

Our Investigator looked into things and thought Mr S had made a careless, rather than deliberate, misrepresentation. But they were ultimately of the opinion that Prudential was entitled to avoid the policy and decline the claim. They also thought the compensation offered by Prudential in relation to its handling of the matter was reasonable. The trustees didn't agree, so the matter was passed to me to decide.

After reviewing the complaint, I intended to reach the same outcome as the Investigator but for slightly different reasons. So, I issued a provisional decision so that the trustees and Prudential had the opportunity to comment before a final decision was given.

Following receipt of my provisional decision, neither Prudential nor the trustees raised any further comments in relation to the merits of this complaint.

So, I'm now in a position to issue my final decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

I'd like to start by saying I'm very sorry for Mrs S's loss. I'm conscious that to have the policy avoided and the claim declined, whilst also dealing with the bereavement must have been incredibly difficult for her and her family.

I also want to highlight that this policy was held in trust. Therefore, it is ultimately the trustees of that trust that are bringing this complaint to our Service, not Mrs S as an individual. And this has implications for the kinds of awards I can make. For example, I cannot award for the upset or distress Mrs S has experienced.

This is relevant to the concerns that have been raised about Prudential's handling of the matter. Mrs S is unhappy as she had to contact Mr S's GP to get further information and Prudential sent a letter addressed to the late Mr S. Prudential has agreed it made mistakes here, so what I need to consider in this decision is their impact – but I can only consider their impact on the trustees of the trust. Whilst I don't doubt Mrs S found all of this very distressing, I cannot award for the upset caused to her, as she is not one of the trustees. And this means she is not an eligible complainant. And I haven't seen any evidence to persuade me the trustees were inconvenienced by these mistakes over and above what I'd usually expect where a policy is avoided and a claim declined. For these reasons, I won't be asking Prudential to do anything further in relation to this part of the complaint.

I'm aware that concerns have also been raised over the way this policy was sold to Mr S, in particular, the guidance Mr S was given when answering application questions. The IFA, through whom Mr S purchased the policy, was independent of Prudential. So, Prudential

isn't responsible for their actions. This complaint is about Prudential, so in this decision I won't be commenting on the concerns S has about the IFA.

I'd also like to be clear that my decision won't address every point or comment made by either the trust's representatives or by Prudential. I mean no discourtesy by this, and I'd like to reassure all parties that I have considered all the comments and evidence they've provided to our Service. But my decision will only address what I see to be relevant in reaching a fair and reasonable outcome to this complaint.

Misrepresentation

I've taken into account the relevant legislation at the time this policy was taken out which is The Marine Insurance Act 1906. I'll refer to this as 'the Act'. I've also considered the industry guidance that was in place at the time Prudential made its decision. This is called, *"Misrepresentation and Treating Customers Fairly – ABI Code of Practice Managing Claims For Individual and Group Life, Critical Illness and Income Protection Insurance Products April 2013"*. I will refer to this as 'the code'.

Under the Act, the onus is on the person taking out the policy to disclose material facts to the insurer. A material fact is something that a reasonable writer would want to know about. And, if they fail to do this and this induced the insurer to enter into the policy, then it will be entitled to avoid it (treat it as if it never existed).

However, we have a long-established approach to decide what's fair and reasonable, which is different to the Act and is largely set out in the code.

The code says misrepresentation is the omission of material information that the insurer has asked for and that would have resulted in a different underwriting outcome had it been disclosed. The code requires that a reasonable person would have considered the information relevant to the insurer. It classifies misrepresentations and sets out different remedies available to the insurer dependent on the classification.

Deliberate misrepresentation is defined by the code as occurring where in the circumstances, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer. The code says such categorisation should be reserved for only the most serious cases of misrepresentation. An insurer is then allowed to avoid the policy and decline the claim.

The code says careless misrepresentation results from insufficient care and includes anything from an understandable oversight or an inadvertent mistake to serious negligence. An insurer is then allowed to apply a proportionate remedy as outlined in the code. This can involve declining avoiding the policy and declining the claim if the policy would never have been offered by the insurer had it been given the information it ought to have had.

The code says innocent misrepresentation happens when the customer has acted honestly and reasonably in all the circumstances. And an insurer should then pay the claim in full.

The code also says consideration should also be given to how clear and concise and relevant the questions asked were and to whether the customer had the opportunity to check their answers and whether the warnings given were adequately prominent.

Given the concerns raised about the guidance given to Mr S by the IFA, I can understand why the trustees think this is relevant when assessing whether Mr S took care not to make a misrepresentation. But the code states:

'If the intermediary was clearly acting on behalf of the customer...the intermediary (as opposed to the insurer) should be accountable for any misrepresentation resulting directly from the intermediary's action or omission.'

As outlined above, the IFA was acting on Mr S's behalf and not on Prudential's. So, I think Prudential can fairly rely on the information given to it by Mr S's agent, providing it highlighted the importance of providing accurate information.

I'm satisfied that in the declaration of health form Prudential warned that not including relevant information could result in the non-payment of the claim. And whilst Mr S chose to have the paperwork relating to his policy sent to his IFA directly, Prudential still sent copy of the confirmation schedule directly to Mr S. This schedule included a list of the questions asked and the answers submitted by his IFA. The letter stated that his answers were the basis of the agreement between Prudential and Mr S and it advised he should carefully check his answers and get in touch if they were incorrect. So, Mr S was given direct access to his application, the questions asked and his answers by Prudential. And I think Prudential made it clear that Mr S needed to ensure the answers were correct.

I'm aware the representatives of the trust feel Prudential ought to have contacted Mr S's GP following his application. But I wouldn't necessarily expect an insurer to request medical evidence at the start of a policy. It is not practical for an insurer to do this for every application and so it is accepted industry practice that insurers can rely on the information given to them by the consumer. Insurers would only request further medical evidence where they feel it necessary to assess an application or if they were carrying out randomly selected checks. I appreciate this was a large sum assured with high premiums, but this doesn't change the fact that Prudential was under no obligation to double check Mr S's answers. I'm also satisfied Prudential made it clear within the application form that its standard process is to request a random sample of medical records and it did not suggest it would be definitely be checking Mr S's medical records.

Keeping all of this in mind, I've then considered the evidence surrounding to the two key areas where Prudential thinks there has been misrepresentation.

Alcohol use

In the application Mr S was asked:

- *'Do you or have you in the past 5 years ever regularly consumed more than 30 units of alcohol per week. 1 unit = 25ml of spirits or a small (125ml) glass of wine or ½ pint of beer, lager or cider'*

Mr S answered no.

The policy was completed April 2012, which means Prudential asked about Mr S's drinking between April 2007 and April 2012.

There are several entries within the medical records of relevance here:

- In Aug 2007 Mrs S's GP notes show a consultation about his depression and anxiety. In this it is noted that Mr S is *'at times excess drinking-2-3 rums every night-advised re [disputed] safe limit 28 u per week-cut down alcohol-have 2 alcohol free days each week'*.¹

¹ To be clear, the reference to *'disputed'* here is within the GP record.

- A letter from the CMHT following a review on 10 June 2011 connected with Mr S's hallucinations said *'was drinking heavily rum and spirits plus 2-3 beers per night but this has reduced recently.'*
- Another letter from the CMHT on 13 June 2011 states under the section *'drug and alcohol history'* *'1 bottle of rum every two days but is trying to cut down and 2 cans a night. Reported 4 Magners last night.'*
- On the discharge document completed by the CMHT on 22 June 2011 it also states *'He has abused alcohol over recent years. He's cut down and currently drinking approx. 2 pints of cider each evening.'*
- And in August 2011 there is also a GP note which states Mr S *'stopped drinking alcohol again last few days.'*

The entries show Mr S's drinking was at times greater than 30 units a week. But Mrs S has said that whilst there were occasions where Mr S would drink to excess, this wasn't 'regular'.

The question doesn't define the term regular. But I'm not persuaded that this makes the question unclear. I think a reasonable person would be able to understand that what Prudential was asking about here is excessive drinking beyond 'occasional' - so excessive drinking beyond the occasional holiday or celebratory occasions Mrs S mentioned.

I think the medical entries indicate that regular excessive drinking was something Mr S was struggling with in the years prior to his application. There is reference to the him having *'abused'* alcohol, which isn't a term typically used by medical professionals where someone has drunk excessively on occasion. The evidence also shows Mr S was actively seeking to try to reduce his drinking which indicates he considered it, at times, problematic. And the records suggest his drinking reached high levels – for example *'1 bottle of rum every two days'*.

I appreciate there may have been points where Mr S was drinking less than the 30 units a week. The medical snapshot of Mr S's drinking does support Mrs S's account that it varied. But the question doesn't ask if he was constantly drinking excessively, it asks *'Do you or have you in the past 5 years ever regularly consumed more than 30 units of alcohol per week.'* And I think the medical records show there were points where Mr S was regularly consuming over this.

So, I think Prudential can fairly say that a reasonable person, in Mr S's circumstances, ought to have known that this information was relevant and should have answered this question 'yes'.

Acute Psychotic disorder

The questions Prudential has said are relevant here are:

- *'Have you ever had any of the following: Mental illness that has required hospital treatment or referral to a psychiatrist or other specialist?'*

Mr S answered no.

- *'In the last 5 years have you had any of the following: Any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorders?'*

Mr S answered yes.

- *'In the last 6 months have you taken or been prescribed drugs, medicines, tablets or any other form of treatment? (over the counter medication and oral contraception can be disregarded).'*

Mr S answered yes.

There were then further forms available which could be completed and submitted with the application form where a positive answer was given. One of these was completed. In this form Mr S was asked *'What is the medical condition?'* and he declared anxiety/depression which he said begun in June 2003 and remained ongoing. He described symptoms of feeling anxious, irregular sleep, not wanting to go out and constant fatigue. He said he'd seen a specialist for this and when asked for their details, gave contact information for his GP. When asked what specialist investigations there'd been, he declared blood tests and prescribed medication.

Having looked at the medical evidence, I again think it's fair for Prudential to say Mr S didn't declare material information that reasonable person would have considered relevant to the insurer – I'll explain why.

The medical records show that in June 2011 Mr S told his GP he was experiencing visual and auditory hallucinations. The notes also suggest he attended A&E and required sedatives on one occasion that month. The GP referred Mr S for assessment by the community mental health team (CMHT) and he was prescribed a number of medications by the team in question, one of which was an anti-psychotic drug. By mid-June 2011 Mr S was seen by a consultant psychiatrist from the CMHT at his home address. Throughout June 2011 he saw the CMHT on multiple occasions. He was discharged at the end of the month and told to continue medication. He was ultimately diagnosed with Acute Psychotic disorder as well as a long-standing history of mixed anxiety and depression. In August 2011 Mr S experienced hallucinations again after he'd stopped his medication – he told the GP he thought this was a sleeping tablet – and he was advised to resume this.

Looking at the first question listed above, I think it is clear and specific. And I'm satisfied Mr S should have answered the question 'yes'. And that's because Mr S was referred to and saw a psychiatrist for a mental illness, I would also argue that the CMHT are a team of specialists to which Mr S was referred.

In reaching this view, I've thought carefully about the comments Mrs S has made to our Service. In particular, she said that Acute Psychotic disorder is a medical term they weren't aware of and Mr S understood his symptoms to be part of his anxiety and depression. And having considered the relevant medical evidence, I haven't seen anything that categorically shows this specific term was used by medical professionals when discussing Mr S's symptoms with him and his family. The disorder itself is mentioned in the psychiatrist report and in the discharge notes from the CMHT at that time. But these are the only two places it appears. What is listed in the original referral and assessment by the CMHT is known depression with increased features of psychosis. I've also seen no evidence Mr S saw the community mental health team again following his discharge in late June 2011 such that I think this diagnosis would have been discussed further. The GP notes from during or after this assessment don't mention this condition.

However, what the medical evidence does show was that Mr S experienced visual and auditory hallucinations in June and August 2011 and was prescribed anti-psychotic medication to manage this. This then led to a specialist referral to, appointments with and treatment by the CMHT. As well as an assessment by a consultant psychiatrist. All of which I think would have been significant and therefore memorable.

So, even if I were to accept that Mr S likely thought the mental illness he saw the CMHT and the consultant psychiatrist for was anxiety and depression, I think he still should have answered 'yes' to the first question.

Where I think material information has been omitted, I need to consider what would have happened had the correct answer been given.

For the purposes of this application, generic additional forms were available that asked further questions about positive answers. It is not entirely clear from the application form whether more than one form needed to be completed where the same condition leads to more than one positive answer. However, I note that Mr S answered the second two questions outlined above 'yes' and submitted only one further form in connection with both disclosures. Mr S's application was accepted on this basis and so I'm satisfied that at that time, Prudential was willing to accept one form per declared condition rather than per answer.

In the further form submitted, Mr S declared his anxiety and depression. He did not declare Acute Psychotic disorder. But if I were to accept Mrs S's account of how Mr S understood his illness, he may not have known to declare this separately.

That being said, having reviewed the form Mr S did complete, I'm still satisfied Prudential can fairly conclude Mr S ought to have added more information. Key for me here is the fact Mr S was again asked if he saw a specialist for his condition. It then asked for the specialists' name, address and the last date he saw them and whether he was still attending. But Mr S gave only his GP details. This question is specific and clear. It is correct that Mr S did see his GP about this issue. But he also saw the CHMT on multiple occasions throughout June 2011, less than a year before his application. This included seeing a consultant psychiatrist. As outlined above, I think this would have been memorable given its significance and how recent it was. So, I still think Prudential can fairly say Mr S omitted material information that he ought to have known was relevant.

What would have happened?

Prudential has said that a declaration of the referral to the CMHT and the psychiatrist in 2011 would have prompted a request for a full GP report. And it ultimately wouldn't have offered Mr S the policy.

The trust's representatives have disagreed. Mrs S's account is that an underwriter said they would likely have charged more but would still have offered Mr S policy. Mrs S noted Mr S would have been willing to pay a higher premium as the policy was being paid for by a trust.

I have seen no evidence to show that an underwriter said this to Mrs S, nor what information they were given at the point they said this. But even if she was told this, I have personally reviewed the underwriting evidence provided by Prudential in connection with this complaint. And having done so, I'm satisfied that this information would have changed the underwriting outcome, so I do think these omissions were material misrepresentations.

Specifically, I think the underwriters would have reviewed Mr S's particular circumstances and would not have offered cover.

Due to the fact underwriting information is commercially sensitive, I'm not in a position to share this evidence with S or its representatives. But I'd like to reassure them that I've carefully considered this when reaching this decision.

Prudential classified this as a deliberate misrepresentation. Our Investigator felt careless was a more appropriate classification. However, I don't feel it is necessary for me to reach a finding on this point as the action that Prudential has taken would be appropriate for either categorisation.

I say this noting that I don't feel it can be argued that the categorisation of innocent misrepresentation applies here. And that's because I think the evidence suggests Mr S ought to have known he needed to declare the information on his application set out above.

Given Prudential would never have offered Mr S cover, I'm of the opinion that its avoidance of the policy and refusal of the claim with a full refund of the premiums paid, is fair and reasonable.

My final decision

For the reasons outlined above, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms D and Mr G as trustees of the S Trust to accept or reject my decision before 12 May 2022.

Jade Cunningham
Ombudsman