DRN-4626719

The complaint

Mr S complains that Royal & Sun Alliance Insurance Limited ("RSA") has unfairly handled a theft claim under his home insurance policy leading to his insurance being voided.

Any reference to Mr S or RSA includes respective agents and representatives.

What happened

The background of this complaint is well known to both parties, so I've summarised events.

On 20 June 2023 Mr S took out a home insurance policy with RSA. Mr S's previous insurer had cancelled his policy a day before the RSA cover was taken.

On 29 August 2023 Mr S made a claim under his RSA home insurance policy. He said he'd lost his bag while shopping, which included money, a smart watch and a laptop.

RSA considered the claim but declined it. It also voided Mr S's policy, saying he had failed to take reasonable care and misrepresented his insurance history at the policy's inception – related to previous claims and a cancellation.

Mr S complained, saying that RSA's actions failed to take into account his mental health at the time he took out the policy. He said RSA also refused to consider medical evidence regarding this. Mr S also raised other concerns about service provided by RSA, including:

- RSA involving its underwriter related to the decision on his policy and claim.
- Various communication issues and delays, including accessibility to a video interview system, complaint handling and an agent assuring him his claim would be upheld as she'd "*get this sorted out*".
- He said RSA failed to send him policy documentation.

On 10 October 2023 RSA answered Mr S's complaint within a final response. It stood by its position on its handling and delays. It said it would not offer policies to people who had made more than two claims within three years, nor anyone who has had a policy cancelled. As Mr S had five claims within three years, and his last policy was cancelled in June 2023 it wouldn't have offered him a policy. It said it had given clear instructions on how to use the video call and stood by its decision to retain premiums.

RSA also said one of its agents had been forced to communicate by email only as their phone was not functional for a short time – which it said was an accident. It also stood by its decision to deliver its outcome on the policy and claim in writing. And said its agent's comments in relation to getting the matter "*sorted out*" was not a guarantee the claim would be upheld.

RSA awarded £100 in total for a lack of call back from a manager, and a mistake within the first claims call where an agent failed to apply a police reference number correctly as well as failed to conduct further checks into Mr S's claims history. RSA also addressed further

concerns about complaint handling, and receipt of policy documents which it didn't uphold.

The case came to this Service and one of our Investigators looked into what happened.:

- She was satisfied Mr S had made a misrepresentation as he'd answered clear questions related to his claim's history and insurance cancellation incorrectly. And RSA had demonstrated it wouldn't have offered cover to Mr S if it had known the facts in question.

  She said Mr S's medical evidence supported Mr S's ability to answer questions could be impacted by a lack of medication – but this was from August 2023 – several months after the sale in June 2023. And given Mr S had called to take out the insurance a day after his previous policy was cancelled, it seemed the cancellation was in his mind and the trigger to him taking out the RSA policy. So, she was satisfied Mr S hadn't taken reasonable care and had made a reckless misrepresentation.
- The Investigator also considered the handling and communication issues raised.
  - She was satisfied RSA's decision to involve its underwriter in making a claims decision was fair.
  - RSA's handling of the claim had not been without issue, and she highlighted that RSA should've called Mr S to deliver the outcome in his circumstances. And that RSA's actions related to Mr S's medical evidence was dismissive and made him feel not listened to.
  - She disagreed RSA's agent had promised Mr S that his claim would be upheld.
  - She said RSA was allowed eight weeks to investigate a complaint – which it had acted within.
  - She said evidence supported RSA had sent Mr S policy documents.
  - RSA had reasonably explained how to use its video system.

So, she directed RSA to pay an additional £100 on top of the £100 it had already paid.

Mr S disagreed. He raised several concerns, including:

- Reiterating his medical evidence and circumstances impacting his ability to answer questions accurately.
- He reiterated the assurance and expectation that RSA's agent had given him by saying "*I'll get this sorted out*." He was frustrated we did not have a copy of this call. And he reiterated issues related to customer service and claims handling.

The Investigator looked again but didn't change her mind. Amongst going over her assessment, she said the content of the call related to the agent giving assurances in question wasn't in dispute – in so much as both parties agreed exactly what was said, so she hadn't thought this was necessary to obtain. She also said she felt RSA's refusal to discuss the matter with Mr S past 13 October 2023 was fair as it had completed its findings and given referral rights to this Service.

So, the matter has been passed to me for an Ombudsman's 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.

Mr S's submissions to this Service are extensive, with many different complaint points being raised. Within this decision I won't be responding in similar detail. This is not intended as a discourtesy, but a reflection of the informal nature of this Service.

My role is to focus on what I consider the crux of the complaint to be which means I will only comment on those things I consider relevant to the decision I need to make. That may also mean I don't comment on everything Mr S has said, and in places I may group matters together, but I can confirm I have read and considered everything said by both parties.

When considering what's fair and reasonable in the circumstances I need to take into account relevant law and regulations, regulators' rules, guidance and standards, codes of practice and, where appropriate, what I consider to have been good industry practice at the time.

Before I begin, I want to highlight Mr S has detailed his medical history and circumstances around this to this Service. The nature of these events is known to both parties. So, out of respect for Mr S, I won't repeat the details here, suffice to say I'm sorry to hear of what has happened and that he has my sympathies.

Given the number of complaint points in hand, I've grouped these together for brevity. I'll address these in turn.

Misrepresentation

The relevant law in this case is The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). This requires consumers to take reasonable care not to make a misrepresentation when taking out a consumer insurance contract (a policy). The standard of care is that of a reasonable consumer.

And if a consumer fails to do this, the insurer has certain remedies provided the misrepresentation is - what CIDRA describes as – a qualifying misrepresentation. For it to be a qualifying misrepresentation the insurer must show it would have offered the policy on different terms or not at all if the consumer hadn't made the misrepresentation.

CIDRA sets out a number of considerations for deciding whether the consumer failed to take reasonable care. And the remedy available to the insurer under CIDRA depends on whether the qualifying misrepresentation was deliberate or reckless, or careless.

RSA has said Mr S failed to take reasonable care to not make a misrepresentation when he took out the insurance policy – failing to accurately say how many claims he'd made during a three-year period, as well as failing to highlight he'd had an insurance policy cancelled.

I've looked at the sales process Mr S would've seen when taking out the insurance online. In regard to the policy history he would've seen the question:

> *"Have you or anyone living at the property made any home insurance claims or suffered any losses in the last 5 years?"*

This gave the options of yes or no. There was also a separate question that asked how many years no-claims bonus did the applicant have – with options of 0-9+ as options.

There was a separate section related to cancellation. This stated:

> "*Have you or anyone living in the property ever been refused insurance, had insurance cancelled/voided by a provider or had special terms imposed?*"

This gave the options of yes and no.

I'm satisfied these questions were clear, fair, and not misleading.

It's also not in dispute that Mr S did answer these incorrectly. In doing so he stated he'd made two previous contents claims, when actually he'd made five. And he'd said he'd not had a policy cancelled, when his previous policy had ended the day before or around that time.

On this basis, on its face, I'm satisfied that reasonable care was not taken when answering the two questions.

Mr S has provided various medical evidence in this case. I've reviewed the notes from a doctor that states that a lack of medication and frame of mind in August 2023 would explain his reason for not accurately representing his claims history. Mr S has also provided a letter from another medical expert. Their comments state that given the circumstances of Mr S' trauma and his mental health, it was understandable why he had not made accurate decisions regarding his insurance.

I want to be clear here that the test for whether or not the consumer took reasonable care is set out in CIDRA. The standard of care required is that of a "*reasonable consumer*". This means I need to consider what a reasonable consumer would have done in the circumstances – as opposed to looking into the exact reasons why Mr S made the misrepresentation.

While I acknowledge Mr S's circumstances at the time, as I've outlined, I have to consider the standard of care required by a reasonable consumer. And here, I'm satisfied the questions were clear, fair and not misleading, so while I acknowledge the medical practitioner's comments – these haven't changed my mind.

For completeness though, even if I could consider Mr S's particular circumstances I would still reach the same outcome. This is because Mr S's previous policy was cancelled the day before his RSA policy was taken out. So even if I agreed it was beyond his control to answer questions accurately about his claims history as his doctor has suggested, I would need to consider whether this impacted his ability to answer the question related to cancellation. And it appears to me his reason for contacting RSA to take a policy was prompted by the cancellation of his previous policy shortly before. So it seems it was present in Mr S's mind at the time of the sale – and the circumstances around it wouldn't have persuaded me that he had taken reasonable care in answering the question.

I want to reiterate here though, the test I have to apply is that of the reasonable consumer which is what I've done in this case.

I then have to consider whether these misrepresentations were qualifying. That is to say, if RSA was aware of these facts would it have still offered the policy, or offered it on different terms, or not at all.

RSA has shown this Service underwriting guidance that supports that it would not have provided cover for an applicant with as many claims as Mr S had made. And it's shown its underwriting guidance that supports it wouldn't have offered Mr S cover if an applicant had a policy cancelled as his previous policy had been.

So, I'm satisfied the misrepresentations in this case were qualifying ones.

RSA has determined Mr S's misrepresentation was either deliberate or reckless based on the circumstances.

A qualifying misrepresentation will be deliberate or reckless if the consumer:

- knew the information they provided was untrue or misleading or did not care whether it was untrue or misleading; *and*
- knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer

As there are two misrepresentations in this case, I will first focus on the one related to the previous cancellation. RSA's decision is that Mr S either knew his answer related to having a policy cancelled was either untrue, misleading or he didn't care whether it was untrue or misleading.

I want to be clear that I have taken Mr S's medical evidence into account when looking at RSA's decision regarding this. And my thinking is along the same lines as I've described above related to the reasonable care question.

In the circumstances of Mr S seemingly being prompted to take the RSA cover after his previous policy was cancelled, it strikes me RSA's conclusion was fair and that he'd have either known his answer was untrue, or misleading, or he didn't care whether it was true or misleading. I say this as I'm satisfied its most likely Mr S was taking out the cover with RSA because he was aware his previous insurer had recently cancelled his policy.

RSA's decision also means it believes Mr S either knew the cancellation was relevant to RSA or did not care. I think the clear question RSA asked around the previous cancellations support RSA's position that Mr S would've known or didn't care whether it was relevant to RSA.

As I'm satisfied Mr S's misrepresentation related to the cancellation should be treated as either a deliberate or reckless one, I've looked at the actions RSA can take in accordance with CIDRA. CIDRA allows it to void the policy from inception and retain premiums. This is in line with the actions RSA has taken so I'm satisfied its actions were fair and reasonable in the circumstances.

As I'm satisfied at least one of the two misrepresentations was deliberate or reckless, I see no reason to explore the additional reason related to claims history as this will not change the overall outcome or steps that RSA is allowed to take.

Handling, customer service, and other issues

Mr S has raised a range of issues related to handling, customer service, and other points throughout the life of this complaint. I'll address these in turn.

- Mr S was unhappy with RSA's decision to involve its underwriter in making a claims decision. This is RSA's commercial decision to determine how its claims handling process works, and I see no issue with it doing so. So, in principle, this isn't a point I would uphold. Furthermore, in light of my findings regarding the misrepresentation I'm satisfied its decision making was fair and reasonable.
- Having reviewed the history of the claim, largely I think it proceeded in a timely manner taking into account the circumstances and evidence to consider, the matter

was answered within around six weeks of the claim being made. I also accept that Mr S would've preferred for a particular agent he'd been discussing matters to continue calling him but this stopped in late September 2023. RSA says this was due to a phone becoming unusable. This appears to me to be an unfortunate accident and I can see Mr S was updated regularly on what was happening. I have seen Mr S has also objected to RSA refusing to discuss the matter with him since it came to this Service. In the circumstances I don't think RSA's actions are unreasonable as its already outlined its position and to go over matters while this Service investigates is unlikely to be productive.

- Our Investigator has previously explored some of the customer service issues which occurred during the life of the claim. This included, amongst other things, missed call-backs and a mistake from RSA's agent during the first notification of loss call which caused a minor delay. It accepted these errors and awarded £100 compensation. I've considered these and also RSA's decision to not call Mr S directly to discuss the outcome of its decision making. And RSA's approach to consideration of Mr S's medical evidence. In the circumstances I'm in agreement RSA could've handled some of these matters better than it did given Mr S's particular needs and sensitivities around the matters that he was sharing. Taking into account the life of the claim and actions taken, I'm in agreement an additional £100 compensation is fair and reasonable in the circumstances to account for any claims handling issues across this time.
- Mr S has explained at length the importance he placed on one of RSA's agents' words related to getting the matter "*sorted out*". There's no dispute over exactly what was said, but simply a back-and-forth discussion regarding interpretations of this phrase with Mr S strongly believing this meant his claim would be upheld. I accept Mr S may have interpreted the agent's comments in this way, but I don't think their language was unclear, misleading, nor was their intent to misguide him. So, this isn't something I'm going to look to make any award for or direct RSA to do anything differently.
- Mr S raised concerns about RSA's complaint handling. This isn't a regulated activity in its own right, but I can see RSA responded to a complaint raised by Mr S within the eight weeks it is allowed so there's little I can add to this.
- Mr S has said he wasn't sent copies of policy documents. As our Investigator previously outlined, RSA has provided evidence showing these were sent to Mr S's home. I can't see that he ever contacted RSA to say these weren't received at the time. So, I'm satisfied in the circumstances RSA most likely met its obligations in this regard.
- Mr S raised concerns about RSA's online video system. I've seen the details he's provided and seemingly the system required Mr S to copy and paste a link into an alternative browser. Even if I accepted this could've been clearer on RSA's part – although I think the steps appear clear – this isn't something I would've looked to make a further award for in light of the limited impact.

My final decision

For all of the above reasons I'm upholding this complaint. Royal & Sun Alliance Insurance Limited must pay Mr S £100 compensation to take into account the distress and inconvenience it has caused him throughout its handling of this matter.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr S to accept or reject my decision before 9 May 2024.

Jack Baldry
Ombudsman