DRN-4727468

The complaint

Mr T complains about the way that Inter Partner Assistance SA (IPA) handled a medical expenses claim he made on a travel insurance policy.

What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Mr T has travel insurance as a benefit of a charge card.

In September 2023, Mr T was abroad in a country I'll call J. Unfortunately, he suffered an injury and needed to seek medical attention. He tried to contact IPA's emergency medical assistance team using the details given in the policy terms but was directed to call a number shown on the back of his card.

Following multiple dropped calls to the assistance team, when Mr T did get through, he wasn't directed to a particular hospital. So after the hotel directed Mr T to a medical centre which didn't offer the facilities he needed, he ultimately found and was admitted to a hospital and diagnosed with a fractured ankle.

IPA appointed a local agent to liaise with the hospital. But there was a delay in being able to obtain a medical report from the hospital, given the request fell over a weekend. Mr T asked for his hotel booking to be extended. However, it seems IPA told him there was no room at the hotel and so he needed to make arrangements himself.

A few days later, IPA agreed to cover Mr T's claim and it agreed to pay for his repatriation to the UK, although it had initially wrongly assumed that Mr T was arranging his own return. But there was an issue with IPA's email system sending email information to Mr T and so he wasn't receiving emails or updates. Ultimately, he was only told about the repatriation arrangement a few hours prior to his departure after he chased up the information by phone. And while Mr T needed a taxi to transport him from his hotel to the airport, it seems this couldn't be organised by IPA. So Mr T had to arrange his own taxi.

While Mr T's return journey went smoothly, there was a delay in letting him know how to go about claiming his out of pocket expenses and how to make a curtailment claim. These were significant and included a large phone bill due to the volume of calls Mr T had needed to make to chase up the progress of his claim.

Mr T was unhappy with the way IPA had handled his claim and he complained. He was dissatisfied with the number of issues he'd experienced and also because he felt IPA's claims information was misleading.

IPA accepted that it had made a number of errors in the way it had handled Mr T's claim. It accepted that he'd had difficulty getting through to the assistance team and that the contact details and some of the claims information was misleading. It considered that the assistance team should have helped Mr T to find a hospital at the outset rather than leaving him to

arrange this. It also acknowledged that it could and should have looked into the issue with Mr T's email much sooner, as this could have been resolved far more promptly. It said that had the issue been resolved, Mr T would have been kept far better informed about the status of his claim. It accepted too that it ought to have ensured Mr T was provided with transport from his hotel to the airport. And it considered that Mr T should have been contacted by the medical assistance team, following his return, to check how things were and to explain the process for claiming out of pocket expenses.

So to recognise the impact of its errors on Mr T, it offered to pay him £650 compensation.

Mr T didn't think IPA's offer was sufficient to reflect the impact of its claims handling on him and so he asked us to look into his complaint.

Our investigator felt IPA should increase its offer of compensation to a total amount of £850. In addition to the mistakes IPA had identified, he also thought it should have logged a claim for Mr T a day sooner than it had, which he thought would have reduced the delay in obtaining a medical report. He thought IPA ought to have let Mr T know there was cover available for a friend or relative to travel to join him in J. And he didn't think IPA had been as proactive as it should have been in keeping Mr T updated.

Mr T didn't think the investigator's proposed award was enough to put things right. And IPA didn't respond to our investigator's assessment. So the complaint's been passed to me to decide.

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.

Having done so, I agree with our investigator that the fair outcome to this complaint is for IPA to pay Mr T total compensation of £850 (inclusive of the £650 it's already offered) and I'll explain why.

First, I'd like to reassure Mr T and IPA that while I've summarised the background to this complaint and their submissions to us, I've carefully considered all that's been said and sent. In this decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

I must also make our role clear. We're not the industry regulator and so we can't tell financial businesses how they should operate or to change their processes and procedures. Our role is to investigate individual complaints brought by consumers and decide whether, in the specific circumstances of a complaint, we consider a financial business has made an error which has caused a consumer to lose out. And, if we think it has, we will decide how we think a financial business should put things right – which may include an award for a consumer's trouble and upset. However, our awards aren't intended to fine or punish the businesses we cover.

The relevant regulator's rules say that insurers must handle claims promptly and fairly and that they must provide policyholders with reasonable guidance to help them make a claim. I've taken those rules into account, amongst other regulatory principles and relevant considerations, to decide whether I think IPA treated Mr T fairly.

IPA accepts that it made clear and significant errors in its handling of this claim. Mr T has provided phone bill evidence which shows the volume of the calls he made and IPA appears to acknowledge that he had real difficulty in being able to get through to the emergency

assistance line. It agrees too that the policy terms shouldn't include a number for emergency assistance which simply directs policyholders to call elsewhere. The information provided also indicated that Mr T could effectively expect an English-speaking doctor to assist him – which would have been helpful to him. However, this wasn't a service IPA actually offered. It says it's passed on feedback on this point. And even when Mr T did get through to the relevant team, it's clear that he wasn't helped with finding an appropriate medical centre – even though this was a service IPA was in a position to provide. As such then, I think Mr T was faced with unreasonable barriers to making a claim and in seeking necessary treatment for an acute and painful injury. I don't doubt that this caused Mr T unnecessary additional trouble and upset when he was already in a worrying situation.

Like the investigator, I think IPA should have registered the claim on the day Mr T first called – which was a weekday. Instead, it didn't log a claim until the following day – a weekend day. Whilst I can't say with certainty that the treating hospital would have been in a position to provide a medical report ahead of the start of the weekend, it's certainly possible that it could have done so. This would have accordingly reduced the time it took for IPA to confirm cover.

Mr T faced clear difficulties during the life of the claim, too. IPA doesn't dispute Mr T's account that he received differing levels of customer service dependent on which office he spoke with. IPA largely communicated with Mr T by email, even though it appears to have been aware early on that he wasn't receiving its emails. IPA agreed that its staff could have investigated the cause of this issue some time earlier. The IT team identified the issue fairly swiftly once it was raised and so a fix could have been implemented far sooner to ensure Mr T received IPA's updates. I think this is likely to have lessened Mr T's upset and frustration while he was abroad had he been able to access IPA's claim updates. And it's clear too that IPA initially wrongly believed that Mr T would be arranging his own repatriation – which I appreciate would have caused him further upset and worry.

It's unfortunate too that Mr T effectively had to organise his own extended accommodation as a result of the communication blocks here. While IPA may have looked into extending his booking, ultimately, Mr T had to arrange and pay for things himself. And I agree with our investigator that, at times, IPA wasn't as proactive in trying to get in touch with Mr T as it ought to have been. This led to Mr T unnecessarily needing to chase updates, by phone, at significant time and expense to him. And I think many of Mr T's concerns could have been alleviated had he been kept updated and reassured that cover was in place and arrangements for his repatriation would be made. I'd add too that as the investigator said, the policy did provide cover for a friend or relative to visit Mr T in hospital. I think this should have been explained to Mr T – even though I can't say, on balance, that he'd have made such arrangements.

Even when IPA did make repatriation arrangements, these weren't communicated to Mr T in a way he could access. This meant he only learned about the travel plans a few short hours before he was due to fly home. This was compounded by IPA's failure to arrange a taxi for him to take him to the airport. Given the nature of Mr T's injury, he clearly required transport and again, I think it caused Mr T unnecessary worry and frustration when he had to make these arrangements himself. And IPA acknowledges that following Mr T's return to the UK, it ought to have followed-up with him to check how his repatriation went and to explain the claims process to him. So I don't think IPA gave Mr T clear guidance about how to make a claim.

Overall, I think there were significant errors made by IPA during the life of this claim. And given Mr T was abroad, with a painful injury and unable to receive updates from IPA except at considerable effort and cost on his part, I think this likely did cause him a substantial amount of additional, avoidable, material distress and inconvenience. I think IPA likely too

made Mr T's situation harder than it needed to be, rather than providing Mr T with the medical assistance he was entitled to under the terms of the policy. In my view then, a total, substantial compensation award of £850 (inclusive of the £650 compensation IPA has already offered) is fair, reasonable and proportionate to reflect the likely impact I think IPA's claim handling failings had on him. I'm also satisfied that this award is in line with our published approach to awards for distress and inconvenience, which our investigator has already shared with Mr T.

In all the circumstances, I find that a total of £850 is fair and reasonable to reflect the mistakes IPA made in the handling of Mr T's claim. And so I now direct it to pay Mr T £850 (less any compensation it may already have paid).

My final decision

For the reasons I've given above, my final decision is that I uphold this complaint.

I direct Inter Partner Assistance SA to pay Mr T total compensation of £850 (inclusive of the £650 compensation it's already offered) If IPA has already paid Mr T £650 compensation, it can deduct this amount from the total award.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr T to accept or reject my decision before 31 May 2024.

Lisa Barham
Ombudsman