DRN-5374027

The complaint

Mrs H is unhappy, in summary, as she doesn't think Aviva Limited ('Aviva') has correctly administered her reviewable Whole of Life policy held with it. And she feels this was mis-sold.

What happened

While I've taken all the submissions and available information into account, and I note Mrs H has made detailed points in support of her complaint, I've outlined what I think are the key events and points involved in the complaint below.

In mid-1988 Mrs H and her late husband, Mr H, received advice to each take out a Hamilton Life reviewable whole of life policy – The Universal Plan – where their premiums were paid by a single direct debit. And Aviva is now responsible for this complaint, so I will refer to it throughout. Mrs H's policy commenced for a £30 monthly premium and a sum assured of £80,000, being the same premium amount but a lower sum assured than that which Mr H took out. Mrs H's sum assured was guaranteed for ten years until the first review, after which reviews would take place every ten years until Mrs H turned 60 and then every five thereafter.

In 1995, Mrs H contacted Aviva concerned that she and Mr H hadn't been set up as each other's policy beneficiary in the way she'd asked for. And she pointed out, in summary, that she felt that the adviser hadn't answered her questions convincingly at the time, was hurried and felt more concerned with selling the policy. And, in response, I understand the beneficiary matter was addressed by Aviva.

Mrs H's 1998 and 2008 reviews were missed by Aviva. Aviva has since said that in 2015/2026 it carried out a product governance exercise where it reviewed its mortality rates and retrospectively updated this with charges recalculated. And that Mrs H's missed reviews were also rerun and it was found these would have passed with no changes being required to her policy.

Aviva wrote to Mrs H in late 2015 – seemingly as a result of the above governance exercise – and said that it had identified some irregularities with the policy value. It apologised for this and said it added extra units to Mrs H's policy in mid-2015 to ensure the value is correct and that she hadn't lost out because of its mistake.

Mrs H's 2016 annual statement was two pages long, the cover letter said it contained information to keep track of her investment and the main information was that the total policy value was just under £7,000, when previously statements had largely only included the unit price and number of units held. And Mrs H's 2018 annual statement contained similar information to that in 2016, but it now said the policy value was just over £8,650.

Mrs H's 2018 review letter set out that Aviva reviews her policy every five years to ensure the current benefits could be maintained. And that the existing premium and sum assured would remain guaranteed until the next review, in 2023. It enclosed an illustration to show what the value of the policy might be at the next review date and how long the fund value

might last for. It explained that if those values were lower than her current cash in value of just over £8,600, then this means the cost of providing the benefits will be higher than the premium being paid. So that difference will be met by her fund. And it said in bold writing that at future reviews before the fund value is used up she might be asked to increase her premium to maintain the sum assured, or that would need to be reduced. The enclosed illustration set out that, while the information wasn't guaranteed, after five years Mrs H's policy value might be between £8,100 and £11,000. And that it could be between 15 to 22 years before her fund value was used up.

Mrs H's 2019 and 2021 annual statements – which were correctly addressed – both contained the same type of information. These said, for example, that it takes the cost of providing the benefits from the fund value, these are based on age and will generally increase each year as the insured gets older.

The 2019 annual statement said Mrs H's fund value was just under £8,900. It said that the total invested in the policy in the last 15 months was just over £562, which included Mrs H's total premiums of £450. And it set this against total policy costs of just over £560, which included a cost of cover totalling just over £478.

And the 2021 annual statement said Mrs H's fund value was just under £8,700. It said that the total invested in the policy in the last ten months was just over £372, which included Mrs H's total premiums of £300. And it said this against total policy costs of just over £402, which included a cost of cover totalling just over £352.

The 2023 review letter provided similar general information to the 2018 review letter. But this said the current cash in value was now just over £9,400. And the enclosed illustration set out that, while the information wasn't guaranteed, after five years Mrs H's policy value might be between £7,500 and £10,500. And that it could be between 11 to 15 years before her fund value was used up.

After Mrs H's husband sadly passed away, she complained to Aviva and our Service about several concerns about both policies. Mrs H's complaint was comprised of detailed points, which are summarised below – as I've said, I don't intend to detail or address every point here, I've set out what I think are the key points which I think relate back to the sale and administration of her policy. To be clear, I'm only considering Mrs H's complaint about her policy here. And, as an Ombudsman has already decided that we can consider Mrs H's sale complaint, I'll only address the merits of her complaint.

In early 2023, Aviva sent Mrs H its final response letter not upholding her complaint, although it offered her £150 in compensation for the service it had provided.

In respect of the sale of Mrs H's policy and its reviewability she has said, in summary, that this was sold as guaranteed throughout rather than reviewable. She said this is supported by the documents. And that something having gone wrong at the sale is supported by her 1995 complaint. Mrs H said Aviva has distorted the policy terms and interpreted the documents over the years in a way that supports its position, also taking a long time to review the Product Particulars she provided it with. Mrs H also said the premium was inappropriately apportioned at the time by the adviser – hers should have been lower and more paid towards Mr H's policy, given she was a non-smoker with a lower sum assured.

In respect of the policy administration Mrs H said, in summary, that reviews – being those due in 1998 and 2008 – were missed for nearly thirty years, despite being required by policy terms and so the reviewability shouldn't be invoked. Mrs H said the exercise Aviva carried out, and wrote to her about, in 2015 was only designed to help the policy get to the 2018 review to protect Aviva. And, while this led to an increase in units held, if the reviews had

been received then she would have been able to consider her options, such as going elsewhere. So this has directly contributed to why she still has the policy.

Mrs H also said that after Mr H passed away Aviva's system cancelled the single direct debit which funded both their policy premiums. This meant that, overall, two of Mrs H's premiums weren't collected in late 2020 and she thinks this has resulted in hers being underfunded. She'd like evidence this has been put right. And thinks this indicates there might have been a wider problem where Aviva failed to appropriately allocate premiums to her policy throughout on the basis the system couldn't distinguish between the two.

One of our Investigators looked into Mrs H's complaint. In respect of the policy sale they said, in summary, that they weren't persuaded this was unsuitable for Mrs H's needs bearing in mind her circumstances at the time, nor that Mrs H wasn't told of the policy's reviewable nature. And they weren't persuaded Mrs H's premium was unsuitable or inappropriate. Our Investigator also said that, even if Aviva hadn't missed the reviews, and had also provided Mrs H with the information it should have at the tipping point, on balance they weren't persuaded she would have done anything differently. They also said that, while finding out reviews were missed caused Mrs H some annoyance, this hasn't negatively impacted the policy itself. And Aviva has put right the governance and cancelled direct debit issues in the way we'd expect. So our Investigator said they weren't asking Aviva to do anything further.

In response, Mrs H seemed to accept Aviva has put right the impact of the governance and cancelled direct debit issues on her policy. But Mrs H didn't agree with the overall complaint outcome, for largely the same reasons as those already summarised above. And she also pointed to some example case studies on our website, which she feels resemble the circumstances of her complaint.

Our Investigator explained their position remained unchanged, when bearing in mind the individual circumstances of Mrs H's complaint. And because no agreement could be reached the case has been passed to me for a 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.

Having done so, while I understand Mrs H will be disappointed and I recognise her strength of feeling, I'm not asking Aviva to do anything further for the reasons set out below, which are largely the same as those given by our Investigator.

In deciding this complaint I've taken into account the law, any relevant regulatory rules including the principles and good industry practice at the time.

While I've carefully considered the entirety of the submissions the parties have provided, my decision focuses on what I consider to be the central issues. The purpose of my decision isn't to comment on every point or question made, rather it's to set out my decision and reasons for reaching it.

And in reaching my conclusions, I've also considered, amongst other things:

- The FCA's Principles for Businesses, in particular Principle 6 and Principle 7 (PRIN).
- The FCA's Conduct of Business Sourcebook (COBS), in particular COBS 2.1.1R(1) and COBS 4.2.1R(1).

- The FCA's Final guidance on the "*Fair treatment of long-standing customers in the life insurance sector"* (FG16/8).

The sale

Policy reviewability

It doesn't seem to be in dispute that Mrs H needed and wanted the cover at the time. And Mrs H's complaint isn't that this was unsuitable for her needs in the circumstances. So I haven't considered that in any detail here, other than to briefly say for completeness that I think it's clear that at the time there was a want and need for the policy to provide sufficient cover for Mrs H's family – her husband and young children – if she were to pass away. So I don't think the recommendation was unsuitable in the circumstances.

Instead, I think the key sale issues are that Mrs H feels the policy wasn't clearly explained as she wasn't made aware that it's reviewable – she has pointed to her 1995 letter as evidence of the adviser's hurried manner, for example – and that the premium amount was unsuitably apportioned. And, to be clear, while I might reference the wider circumstances surrounding the sale where I think appropriate here, I've only considered Mrs H's complaint about the sale of her policy – our Service has already given a separate decision in respect of her late husband's sale complaint.

I recognise the Product Particulars say Mrs H had undertaken to pay premiums of £30 per month throughout life. And that, upon death, Aviva guaranteed to pay the greater of the sum assured – set out as £80,000 – or the policy value. So I can appreciate why this document, when taken by itself and looking back at it and the sale many years later, might have caused Mrs H to think the policy isn't reviewable or that she wasn't told that it is at the time. But I've had to consider all the available information to decide this and what I think is likely to have happened at the time of sale.

I can see Mrs H was given a copy of both her Policy Schedule and Universal Plan policy document at the time. In the way I'd expect, the Policy Schedule sets out the premium as £30 payable at commencement date and monthly thereafter and the sum assured as £80,000 and I can't see that any guarantee was given about these amounts or what these might be in future. And section 14 of the policy document under a 'Policy Reviews' heading set out that:

> '*The Life Company will review the policy every 10 years and every 5 years after age 60 and will advise the insured of* [her] *options for varying the levels of premium and sum insured for the period to the next review date*.'

While I've considered Mrs H's comments, I think this clearly explains the policy will be reviewed and in what timescales. And that it also indicates – and it could be reasonably understood from this – that the sum assured and/premiums may need to change and that this will need to be in one of the ways set out by Aviva at those times.

The Universal Plan policy brochure likely provided at the time of sale also clearly explained in an understandable way, in summary, that since the level of the death benefit depended on the performance of the unit investments, Aviva would review the policy at specified intervals and advise of the options to vary the premiums and sum assured at each review date. It explained that if performance is lower than the assumptions the cover was based on then an increase in premiums to maintain the sum assured will be necessary at reviews. And that it should be remembered that the policy will lapse if the units held become unable to support the policy benefits.

While the notes made about the recommendation on forms available from the time are brief, this doesn't mean there wasn't a discussion about the reviewability of the plan. I think it's likely there was given that's the nature of the plan. And, having looked at all the available information from the time, for the above reasons I think it's more likely than not that it was explained to Mrs H that the plan is reviewable.

In addition, it seems Mrs H's plan was taken out on a standard basis where more of her premium would be invested. Such that, although it would normally provide less cover for the same amount of premium at the outset, it's more likely to pass reviews without changes, last longer (in the way I note that Mrs H's policy has to date) and hopefully be maintained throughout life with no premium increase. So, respectfully, while I appreciate Mrs H thinks her plan is one that should stay the same throughout rather than being reviewable, I think it's more likely she was told what I've explained above, in respect of her particular plan being on more of a standard basis which, while reviewable, will hopefully be maintained throughout life.

So, in summary, I think Aviva is entitled to review the policy and its benefits. And that the reviewable nature of the policy, including how it might impact the premium and sum assured, was set out clearly enough at the time of sale and that the relevant material information was likely explained to Mrs H by the adviser. On balance, I've not seen enough to persuade me that this wasn't the case.

Premium apportionment

Mrs H has also said the premiums were inappropriately proportioned at the time – that as her sum assured was lower than Mr H's this means her premium should have been less than half of the total amount they were paying. Respectfully though, I think Mrs H is largely concerned about the impact of this on Mr H's plan which isn't something I'm considering here.

And, based on the available information, I'm not persuaded Mrs H's premium was inappropriate or unsuitable at the time of sale. When considering suitability we'd expect the adviser to look at what sum assured was suitable in the circumstances for Mrs H and whether the respective premium for that was affordable, for example. The premium was agreed to at the time and I've seen nothing to suggest the chosen amounts were unsuitable or unaffordable for Mrs H. And there is some evidence in the form of notes which show the adviser considered affordability and any existing cover, for example, in the way I'd expect.

Review outcomes depend on several factors such as actual and estimated investment performance and policy costs. And the latter is impacted by risk factors including, for example, age, gender and smoker status and whether assumptions are borne out. While the way Aviva charges for cover isn't something the Service is directly able to look into or question, I can see, for example, that Mrs H was a non-smoker with a lower sum assured. Amongst other things, this will have contributed towards her review outcomes. And while Mrs H could potentially have paid less, that could have led to her plan failing reviews instead.

So, in summary, having taken into account all the available information and comments, I'm not asking Aviva to do anything in respect of the sale of Mrs H's plan as I'm not persuaded it did anything wrong.

Another main complaint point of Mrs H's concerns the reviews though, including reviews being missed. Aviva had certain requirements relating to its ongoing administration of the plan. So I've considered below whether or not Aviva treated Mrs H fairly by providing enough information when it should have to enable her to make an informed decision about the plan.

The policy administration

What is the fair and reasonable outcome in the circumstances of this complaint?

The key feature of this type of policy is that part of the premiums paid throughout the years was to be invested to pay for the increasing costs of life cover later in life. This is because, like any other policyholder, there's an increased likelihood of increasing life cover costs as they get older, as the very nature of this type of policy means as someone gets older, the risk to the insurer increases due to the risk of a claim and so do mortality costs. So, the effect of these increasing costs on the value of the policy are simply an inevitable consequence of the policy becoming more expensive as the policyholder gets older. As I've said, this is very typical for these types of policies. And it is also what allows these policies to be more affordable at the outset.

In the early years, when life cover costs are low, part of the premiums are invested to build up a fund that can be used to help pay for the increasing life cover costs in later years. At this stage, the premiums can meet the costs of the cover on their own. However, if the premiums remain at the same level, there inevitably comes a point where the life cover costs will exceed the monthly premium and units in the investment fund need to be sold to meet the shortfall, reducing the investment fund value over time – unless the fund's growth outpaces the rise in cover costs.

Eventually, regular increases in the cost of life cover will outpace the growth in the fund, so that as units in the fund continue to be sold, it will reach a point when the firm concludes that the premiums being paid and the fund value are no longer enough to pay for the costs of cover. To maintain the policy with its existing life cover, the premiums (if they are still at or around the level they were when the policy began) will need to increase often suddenly and substantially and will continue to increase each year as the consumers get older and the life cover costs increase accordingly, unless the sum assured has been reduced.

At this point, there can be several poor outcomes for the consumer. It's possible that the investment fund will be almost completely depleted, leaving little surrender value. Any increase in premiums is likely to be very expensive and potentially unaffordable at a time when the consumer may be retired or close to retirement and have limited means to meet significant increases in costs. Alternatively, if the level of life cover has reduced substantially, the policy may no longer meet the consumer's objectives or ceases to be a cost-effective proposition.

The impact of the sudden and significant changes to the premium or level of life cover that occur at that point, can be mitigated by adjusting the terms of the cover earlier in the life of the policy. If, for instance, a consumer elects to increase premiums some years *before* this point, then this will have a smoothing effect over time, so that the policy is less likely to fail a review and the sudden and dramatic premium increases down the track can be avoided.

This gives the consumer the chance to set premiums at a more affordable and sustainable level for a longer period – even for the rest of their lifetime. The new premiums will be higher than they were at the outset, but not as high as they would otherwise need to become.

Alternatively, at that earlier point, a consumer who is faced with significant increases in premiums or decreases in the level of life cover down the track might decide the policy itself is no longer cost effective, or that it is failing to meet its objectives, and elect to surrender the policy. In other cases, a consumer might decide that it is worth maintaining the policy on its existing terms right up to the point that the policy fails a review.

The opportunity for a consumer to make these decisions is a key event in the life of the policy. Given the impact of increasing life cover costs on the investment fund, and in time on the premiums (or sum assured), consumers have important decisions to make about whether to retain the policy, increase the premiums and / or decrease the sum assured during the life of the policy. Those decisions become more difficult the longer the consumer pays into the policy and the options available for mitigating poor outcomes start to diminish. So it is in the consumer's interest to make key decisions at an early stage in the policy's life cycle, and to do so in an informed way, firms need to provide consumers with clear, fair and not misleading information.

Increasing life cover charges and what should Aviva have told Mrs H?

Looking at the available evidence, also including historical cost of cover information provided by Aviva – which it has reasonably confirmed to us is based on the adjusted holding after the 2015 governance exercise and 2021 premium collection adjustments, reflecting the values as these should have otherwise been if there hadn't been any errors – I can see that by policy year ending 2007, the monthly cost of Mrs H's policy had become around £358, nearly as much as her total annual premiums of £360. And by 2008 these costs had risen to over £400 and become higher than the same total annual premiums.

So, based on the available evidence, I think 2008 was therefore a key point in the product's life cycle and for Mrs H's interests and information needs. By that point the policy was costing more than the premiums paid. Although I note that from 2009 the policy costs significantly dropped and became less than Mrs H's annual premiums again, that is until 2019 when these became higher than the premiums again.

Taking into account the regulatory obligations I have set out above (PRIN) and what I consider to be standards of good industry practice at the time (including the regulator's views as expressed in FG16/8), and in any event what I consider to have been fair and reasonable in the circumstances, I'm satisfied that Aviva should have taken steps to ensure it communicated information to enable Mrs H to evaluate the impact of the increasing life cover costs on the policy and the options available to her in a clear, fair and not misleading way. This needed to include the risks, costs and benefits associated with those options, as well as giving her clear timelines for the making of decisions where applicable.

And, in my view, this is something that Aviva needed to do given I think it's likely the tipping point occurred around 2008. By giving Mrs H clear information about how much the policy was costing and allowing her to compare those costs with the premiums she was paying, Aviva would've been acting consistently with the guidance at FG 16/8 that firms provide *"regular communications"* with customers – and to ensure that, in their communications, that *"firms [include] sufficient and clearly explained details regarding the performance of the product, its value and the impact of fees and charges"*. Such communications also needed to specifically set out the *"value of any premiums paid in over that period", and "charges incurred over the period in monetary figures",* including *"major components and the charge to the customer for benefits such as life cover and guarantees".*

What information did Aviva give Mrs H

Around the time the tipping point had been reached in 2008 or within a reasonable timescale afterwards, Aviva had an opportunity to provide Mrs H with clear information to enable her to consider her options and make a timely decision. Particularly given that, with each year that passed, life cover costs could continue to increase, making any potential mitigating steps more costly than these otherwise would be over time.

I think Aviva should've provided the information I previously outlined in a clear and accurate format, along with clear information about the options available to Mrs H, together with the costs and benefits as well as time frames for reply. And not in a passive way that required the consumer to draw important inferences for themselves. Even if precise numerical information about the costs of those options could not be given, then at the very least I would expect to see reasonable approximations or illustrative examples so that they could reasonably appreciate the importance of considering their options at that point.

It seems that as well as the 1998 review being missed, the 2008 review was also missed. So Mrs H wasn't provided with any information around the time of the 'tipping point' in 2008 when Aviva should have given her sufficient and clearly explained details for her to appreciate how much the policy has been actually costing, that the gap between the premium and the charges had closed, or was closing, and how to make the policy sustainable for life, for example.

From around 2018/2019 onwards, Mrs H was provided with more of the type of information I'd reasonably expect to see in the review letters and statements. But, while the review letters did set out what might happen in the future in respect of Mrs H's policy value and when this might be used up for changes to be needed, these didn't contain detail the costs of cover versus premiums, for example. And while the statements contained information which showed the policy costs were exceeding the premiums, these didn't contain any projections or provide any information about the possible future impact of this or how to make the policy sustainable for life, for example.

So, having taken everything into account, as well as reviews being missed, I'm satisfied Mrs H wasn't provided with enough information about the policy when she should have been and relating to the cost of providing cover, for example. This means I think there was an imbalance of knowledge between Aviva and Mrs H, which meant she couldn't make a fully informed decision about what steps she wanted or needed to take following the tipping point being reached.

What, if anything, would Mrs H have done differently?

Mrs H has said that Aviva shouldn't invoke the reviewability of the plan given the significant length of time reviews were missed for. But I can't fairly say that Aviva shouldn't carry out reviews given that, as set out above, it is entitled to do so as per the policy terms. Instead, where something has gone wrong then I'll consider what, if anything, I think is likely to have otherwise happened. To be more specific, would Mrs H likely be in a different position now if Aviva had done what it should have.

Had Mrs H been given clear, fair and not misleading information when she should have been, the options open to her would have been to surrender the policy for the cash in value, increase the premiums to maintain the sum assured, reduce the sum assured or take no action.

I've taken into account that Mrs H has said, amongst other things, that by 2018 her options were more limited due to age. But that if she'd been provided with the information she should have then she would have known the policy was reviewable, explored options outside of life cover and surrendered the policy given her circumstances were considerably different by then. Mrs H also said she only really looked into the policy after Mr H passed away in 2020, so she wasn't aware she might need to surrender this in 2018. And that her complaint was with our Service since July 2021, so it didn't feel appropriate to do so.

But, on balance and for the reasons set out below, having considered all the submissions and information to decide what, if anything, I think would have likely happened if Aviva had

provided Mrs H all the information it should have, I don't think it's likely that anything would have been done differently in the circumstances.

In respect of the missed reviews, at the point the 1998 review should have been carried out, Mrs H still had a child in school and another in college living at home. The premiums were still meeting the policy costs. And Aviva has said that both the 1998 and 2008 reviews of Mrs H's policy would have passed with no changes required. So, I don't think Mrs H is likely to have surrendered the policy. And Mrs H's actions since then don't persuade me that she's likely to have done so if she'd been provided with more information in 2008 around the time of the tipping point about, for example, the policy costs versus premiums either, for the following reasons.

Mrs H was given some information in Aviva's 2018 and 2023 letters to know that if the cost of providing the benefits is higher than the premium being paid then that difference will be met by her fund. And if that's the case then at future reviews before the fund value is used up then she might be asked to increase her premium to maintain the sum assured, or that would need to be reduced. So these set out what might happen in the future. And Mrs H was made aware in her 2019 and 2021 annual statements that the costs of cover were exceeding her premiums. And, while Mrs H has said her options were more limited in respect of going elsewhere by this time, as far as we were last aware as of early 2025, she'd still chosen to keep the policy knowing the above information rather than cashing it in for the surrender value, which was around £9,000 in 2019 and had continued to increase into 2023.

I also think it's clear from Mrs H's submissions that having and maintaining the policy for the same premium of £30 per month has been important to her. And particularly given Mrs H has recognised to us that, despite her unhappiness with Aviva, part of the reason she hadn't surrendered the policy – as of early 2025 at least – was because her sum assured had been maintained. So I think it's clear there has been a continued desire and need for it.

So, even if Aviva had provided Mrs H with the information it should have in the way I've set out above, I'm not persuaded she would likely have taken a different course of action. This means I'm not asking Aviva to do anything.

Other concerns

It isn't in dispute that Aviva got things wrong when it, for example, failed to collect Mrs H's portion of the direct debit for her policy when it should have. While Mrs H was concerned about whether Aviva had put right the impact of this, as well as the earlier 2015 governance issue, on her policy she has since accepted these issues are resolved. So I don't intend to consider these in any detail, other than to say for completeness that Aviva has confirmed it has put the policy back in the position it would have otherwise been in if not for these errors in the way we'd expect it to, having taken into account what the investment value would have otherwise been.

I'm not persuaded that the direct debit issue was indicative of a possible historical problem with the allocation of Mrs H's premiums to her policy in the way she has said it is – I've seen nothing to suggest that was the case. And, so, I'm not asking Aviva to do anything further here.

I recognise, for example, that Mrs H and Aviva shared a few letters back and forth concerning the cancelled direct debit during an already difficult time for her. And reviews were missed for a significant time, causing Mrs H frustration when she found this out. In resolution of her complaint though Mrs H said she wants a meaningful apology from Aviva, as well as its reassurance these things won't happen again, rather than what she has said is the empty gesture of compensation it has offered. But I can see that Aviva has apologised

and put its errors right. Our role isn't to punish nor regulate the business – that's the role of the regulator, the Financial Conduct Authority. And, respectfully, I think one of Mrs H's main concerns – aside from her mis-sale complaint which I haven't upheld – is the level of sum assured now payable on the late Mr H's policy which, as I've said, isn't something I've considered here.

So, I'm not asking Aviva to do anything more than pay Mrs H the £150 in compensation that it has already offered, if it hasn't already done that. I think that's a fair and reasonable amount in the particular circumstances of this complaint.

My final decision

For the reasons given, Aviva Life & Pensions UK Limited should pay Mrs H £150 in compensation, if it hasn't already. I'm not asking it to do anything more than that.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H to accept or reject my decision before 22 December 2025.

Holly Jackson
Ombudsman