This final decision is issued by me, Nimish Patel, an Ombudsman with the Financial Ombudsman Service.

I issued a Provisional Decision on 16 May 2019 ("the Provisional Decision") explaining that I was not minded to uphold the complaint and setting out my reasons for reaching those provisional conclusions. I explained that I would consider the parties' further representations (together with the evidence and arguments submitted before the Provisional Decision) before reaching my final decision.

Neither party made further submissions. This is my final decision on Miss M's complaint.

summary

1. This dispute is about the sale, in 1996, of a payment protection insurance (PPI) policy in connection with a hire purchase (HP) agreement sold by what was then The First Personal Bank plc, and is now Santander Cards UK Limited, who was acting on behalf of Financial Insurance Company Limited ("FICL").

2. I cannot consider this complaint against Santander Cards UK Limited directly. This is because the sale occurred in March 1996, before that firm, or its predecessor-in-title, was regulated by the Financial Services Authority ("FSA") for insurance intermediation activities, or was otherwise covered by our jurisdiction (for example through membership of a former scheme such as the Office of the Banking Ombudsman Scheme). As a result, in the rest of this decision I will refer only to FICL unless it is appropriate to differentiate between FICL and its agent, for example in the application of codes of practice.

3. Miss M complains that FICL did not properly explain the policy's features, exclusions and limitations. She says that, if it had, she would not have taken the policy out.

4. FICL considers that Miss M was provided with full details of the policy and that the policy was not mis-sold.

5. I have carefully considered all of the evidence and arguments submitted by both sides in order to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint.

6. This is not a straightforward complaint, with both parties making credible arguments in support of their positions. But, for the reasons I explain in detail below, I have decided to determine the complaint in favour of FICL, to the extent that I have not made an award in favour of Miss M.

7. This is my final decision. In summary, based on the evidence and arguments submitted during the course of the complaint, my final conclusions are as follows:

   - Miss M made her decision to take out the policy based on the information FICL gave her about the policy.

   - Taking into account the law, industry codes of practice and what I consider to have been good practice in 1996 (the sale took place

before the FSA began to regulate the sale of payment protection contracts like these), FICL should fairly and reasonably have provided Miss M with sufficient clear, fair and not misleading information about the policy it was offering to enable her to make an informed decision about whether to take it out.

- FICL did not act fairly and reasonably in its dealings with Miss M. It did not provide Miss M with sufficient information about the costs, benefits, exclusions and limitations affecting the cover in a clear, fair and not misleading way to enable her to make an informed choice about whether to take out the policy.

- Miss M made her decision to take out the policy based on incomplete information. But if things had happened as they should, on the evidence available in this case, it is more likely than not Miss M would still have taken out the policy.

- It would not be fair in those circumstances to make an award to compensate Miss M for the money she spent in connection with the policy.

8. Under the rules of the Financial Ombudsman Service, I am required to ask Miss M either to accept or reject my decision before XXX.

background to the complaint

a) events leading up to the complaint

9. Miss M applied for the finance on 6 March 1996. The credit agreement (which included the payment protection insurance application) was completed – in the store – requesting both the finance and PPI. The agreement started on the same day.

10. I do not have details of the transactions on Miss M's account, but FICL says the PPI premiums charged to the account amounted to a total of £223.63.

11. FICL also told us that the policy is no longer active and that the HP agreement was closed in August 2005.

b) Miss M's circumstances in 1996

12. When Miss M initially brought her complaint to us, she said:

- she had worked for her employer for 13 years when she applied for the loan and was earning £19,000 a year;

- she was entitled to sick pay and redundancy pay from her employer worth at least six months' pay; and

- she had savings of around £2,000 that were accessible at all times and had been set aside for an emergency.

- she suffered with back pain in around 1990 for which she had received hospital treatment and used medications including ibuprofen and paracetamol. She said the condition had not caused her to take any time off work.

- she bought the policy in connection with a store card she took out while buying clothing.

13. While I note Miss M's representations, the evidence shows she is mistaken both about taking out the policy with a store card and about buying clothing at the time. Rather her HP agreement was for the purchase of computer equipment at Dixons.

c) the policy – what was being sold and what did Miss M buy?

14. FICL has not been able to provide a copy of the policy terms and conditions that would have applied at the time of this sale. However, I do have a copy of a policy document – entitled 'Payment Protection Insurance Certificate of Insurance' dated July 1997. The document post-dates the sale but, in the absence of persuasive evidence to suggest otherwise, I am satisfied I can rely on it as indicative of what Miss M's policy terms and conditions are more likely than not to have said.

15. The terms and conditions were set out in a Certificate of Insurance (although the layout of the document suggests it may have been provided to Miss M in the form of a leaflet). Among other things, the Certificate of Insurance shows that:

- There were eligibility criteria, divided into two sections. The first section included a requirement (in relation to disability and unemployment cover) for the applicant to be aged 18 or over, but under 65, and working – in paid employment for 16 or more hours per week – when the finance started. Had Miss M not met these requirements, she would not have been covered by the PPI element of the policy – but from the information I have, Miss M *did* meet them. Additionally, for life cover the applicant had to be aged 18 or over and less than 70, which Miss M was.

- This section also included criteria for accidental bodily injury and hospitalisation cover, where the applicant had to be aged 65 or over or permanently retired. This was not relevant to Miss M (given that she was aged 48 and was working) at the time of sale.

- The second section of the eligibility criteria said the applicant must not be aware of any sickness, disease, condition or injury in the 12 months before the credit started which may cause them to claim disability benefits (or any time before the start date with regard to life cover). Nor should the applicant be aware of any impending unemployment. If they were, no benefits would be payable for those things. So this section of the eligibility criteria acted as a limitation on the PPI cover.

- The policy provided life cover – it would have paid off Miss M's outstanding balance on her HP agreement in the event of her death up to a maximum of £15,000.

- The policy provided disability cover. Broadly, if Miss M had been unable to carry out the duties of her normal job or a similar job which she was qualified, or may reasonably become qualified, to do when considering her training, education and ability due to sickness, disease or bodily injury, it would have paid a monthly benefit (usually equal to the monthly loan instalment) until the policy ended, the outstanding balance had been paid or a maximum of 12 monthly benefits had been paid, whichever came first.

- The policy provided unemployment benefits. Broadly, if Miss M had become unemployed, the policy would have paid a monthly benefit (usually equal to the monthly loan instalment) until the policy ended, the outstanding balance had been paid or a maximum of 12 monthly benefits had been paid, whichever came first.

16. There were two underwriters listed in the policy – Financial Assurance Company Limited for the life cover and Financial Insurance Company Limited for the other insurance, both member companies of Consolidated Financial Insurance. The seller was acting as agent for both. However, Miss M's complaint focused on the PPI element of the policy, and FICL provided this element of the cover, so it is the respondent in this complaint.

17. To put the benefits into context, if Miss M had made a successful claim for 12 months, she would have received £773.52 – made up of £64.46 per month.

18. Returning to the policy terms and conditions, there were exclusions – for example, the policy excluded disability claims resulting from pre-existing medical conditions "*which you knew about (or ought reasonably to have known about) in the 12 months before the Start Date* [or] *for which you sought or received advice, treatment or counselling from any Doctor during the 12 months immediately before the Start Date*".

19. The policy also contained limitations on the circumstances in which a successful claim could be made, for example:

    - the policy would have covered Miss M if she was unable to work because of a psychiatric illness or mental or nervous disorder (including stress and stress related conditions), but only if it had been investigated and diagnosed by a relevant consultant.

    - the policy would have covered Miss M if she was unable to work because of backache and related conditions, but only if there was radiological medical evidence of abnormality causing the disability.

d) the complaint and FICL's response

20. Miss M's representative, Claims Advice Bureau (UK) Limited (CAB), made lengthy and substantial representations on her behalf prior to the Provisional Decision.

21. I will not restate them all here. Instead, I will refer to some of the specific representations she has made at relevant times in this decision. But I have read and considered them all carefully. In essence, Miss M said:

- FICL did not give her the information it should have given her about the costs and benefits associated with the policy. She needed to keep her costs to a minimum and the policy was sold to her despite her having other ways of meeting her monthly repayments if she was unable to work.

- It was not enough to present the policy premium as the cost per £100 of the outstanding balance. The true costs were much higher as the premiums were added to the account attracting interest (which compounded over time) and the premiums would continue to be charged during the period of a successful claim, reducing the benefit. This meant the policy was both expensive and represented exceptionally poor value.

- FICL did not tell her about the poor value of the policy, which is illustrated by the low claims ratio, where Miss M says that only 12% of the premium was going towards providing the insurance benefits.

- FICL did not tell her about the limitations affecting the policy – in particular, that the policy would only pay out if she was unable to do her job or alternative work she was capable of doing and that claims arising from back injury and mental health were excluded or limited which significantly reduced the cover provided by the policy and the prospects of making a successful claim. This reduced further the policy's value, particularly as those conditions are the cause of the most common reasons for long term absence.

- These were substantial flaws in the sale process. Had she known the true cost of the policy, the limits on the cover and its poor value, she would not have taken it out.

- In any event, the FCA's guidance at DISP App 3.6.2 E makes it clear that it should be presumed she would not have taken out the policy unless there is evidence to outweigh the presumption. There is no evidence to rebut the presumption.

- FICL should pay compensation to put her in the position she would have been in if she had not taken out the policy.

22. FICL's representations were set out in its response to Miss M's complaint. Again I will not restate them all, but I have read and considered them carefully. In essence, FICL said:

- Miss M applied for her HP agreement in store in March 1996, and the PPI would have been presented as being optional at that point. FICL noted that Miss M signed the section of the credit agreement relating to PPI.

- No advice or recommendations would have been given about the PPI, and it could find no evidence that the sale was not carried out in accordance with the relevant procedures.

- Sufficient information would have been provided at the point of sale for Miss M to make an informed decision, including information about the cost. She would also have been sent the full details of the policy – including eligibility, exclusions and limitations, and levels of cover – after she took it out. It could not see that any of the policy's limitations meant it would have been inappropriate for Miss M at the time of sale.

- Miss M would have been made aware of the PPI premium both at the time of sale and afterwards.

- Overall, it said there was no evidence that the policy was mis-sold.

23. Neither party made any further representations in response to the Provisional Decision.

my findings

24. I have read and considered all the evidence and arguments available to me from the outset, in order to decide what is, in my opinion, fair and reasonable in all the circumstances of the case.

a) jurisdiction

25. As I have explained, this complaint is about finance sold by The First Personal Bank plc – now Santander Cards UK Limited – in 1996. At the time, The First Personal Bank plc was acting as an agent of FICL, which was a member of one of our former schemes at the relevant time – the Insurance Ombudsman Bureau (IOB). FICL has accepted that The First Personal Bank plc was acting on its behalf in the sale of Miss M's policy in 1996. As such, I am considering this complaint about FICL.

b) relevant considerations

26. When considering what is fair and reasonable, I am required to take into account relevant law and regulations, relevant regulators' rules, guidance and standards, relevant codes of practice and, where appropriate, what I consider to have been good industry practice at the time, as set out in DISP 3.6.4 R[1].

27. This sale took place in 1996, before the General Insurance Standards Council (GISC) published its code of practice in June 2000 and before the sale of general insurance products like this became regulated by the FSA in January 2005. So the GISC code, the FSA's (and FCA's) overarching Principles for Businesses, Perimeter Guidance and insurance conduct rules (ICOB and ICOBS) are not applicable to this complaint.

28. FICL was not the lender in this instance. That means the unfair relationship provisions set out at s140A of the Consumer Credit Act, the Supreme Court judgment in *Plevin*[2] about s140A of that Act and the rules and guidance recently made by the FCA about the handling of complaints about the non-disclosure of commission in the light of the *Plevin* judgment, are not applicable either.

[1] The Dispute Resolution Rules can be found in the FCA's Handbook
[2] *Plevin v Paragon Personal Finance Limited [2014] UKSC 61*

29. But there were a number of industry codes in existence at the time, which I am satisfied are applicable to my consideration of what is fair and reasonable in the circumstances of this complaint.

The Association of British Insurers' General Insurance Business Code of Practice for all intermediaries (including Employees of Insurance Companies) other than Registered Insurance Brokers' – 'The ABI Code'

30. First introduced in 1989 and updated in March 1996, the ABI Code set out a framework of general principles within which ABI members and intermediaries were expected to sell general insurance, including payment protection policies like this.

31. The Code said that "*As a condition of membership of the Association of British Insurers (ABI), members undertake to enforce this Code and to use their best endeavours to ensure that all those involved in selling their policies observe its provisions*." FICL was a member of the ABI and the seller – its agent – was acting as an intermediary.

32. Among other things, the Code said that:

- *'It shall be an overriding obligation of an intermediary at all times to conduct business with utmost good faith and integrity.'*
- The intermediary should:
  - *'ensure as far as possible that the policy proposed is suitable to the needs and resources of the prospective policyholder.'*
  - *'explain all the essential provisions of the cover afforded by the policy, or policies, which he is recommending, so as to ensure as far as possible that the prospective policyholder understands what he is buying.'*
  - *'draw attention to any restrictions and exclusions applying to the policy.'*

Guidance on the application of the ABI Code

33. The ABI also issued guidance to member companies on the application of the ABI Code and a note summarising the main points of that guidance.

34. The 'Guidance Notes for Intermediaries' issued in December 1994 included:

> *When selling insurance intermediaries must:*
>
> *...2.5 Explain the essential provisions of the insurance cover, draw attention to any restrictions and exclusions under it, as well as the consequences of non-disclosure…*
>
> *…2.13 If an independent intermediary, disclose commission on request…*

35. The ‘Resume for Intermediaries’, published in July 1999 and relating to the ABI Code, explained how insurers should interpret some of the key requirements of the code including:

> *2.2.1 “Best endeavours”*
>
> *This aspect is relevant to ABI members who are responsible for enforcing the Code rather than intermediaries. The phrase is linked to the member “undertaking to enforce the Code” and use of the phrase “best endeavours” means that every practical effort should be made within reasonable bounds as well as in accordance with the general framework of guidance and individual insurers’ operational methods. The procedural guidance in paragraph 3 provides a more structured framework whereby this obligation on ABI members can be met more definitely.*
>
> *2.2.2 “Explain all the essential provisions”*
>
> *It is necessary for the intermediary (insurer, if dealing direct) to provide an overview of the policy. The detail will vary depending on the particular class of insurance. However, the proposer should have a reasonable understanding of what he is buying, whether this is explained orally or whether he is given a summary and his attention drawn to the main points. In this respect, it is important to recognise the responsibility under the ABI Statement of General Insurance Practice that insurers will work towards clearer policy wordings.*
>
> *The intermediary is not expected to go through all the provisions and exclusions in detail. The important feature is to identify the level of cover being provided (for example, in the case of household contents whether it is “indemnity” or “new for old”), that the type of policy being sold suits the circumstances of the proposer and the level of protection they are seeking as far as possible. It is not good enough simply to offer, for example, an indemnity basis of cover without explaining the limitations and, indeed, that other options are available, unless, of course, the proposer wittingly asks for that type of cover.*
>
> *2.2.3 “Draw attention to any restrictions and exclusions”*
>
> *The same general principles outlined above apply equally here. Certain exclusions, conditions, restrictions etc under a particular policy will be common to all policyholders, for example, a condition about fraud. In those circumstances, it would not be necessary to identify these other than by reference to general exclusions applying to all policyholders of a particular type of insurance, either orally or in policyholder documentation.*
>
> *However, some will be more relevant and, indeed, significant to certain but not other policyholders. An example would be where benefit to self-employed people is either excluded or severely restricted for redundancy cover under a creditor insurance policy. Clearly, self-employed people should be made aware of this so they can decide whether the other benefits under the policy and the premium to be paid justifies taking out such a policy.*

3.1 Detailed procedural guidance to assist insurers and intermediaries alike to more properly observe the provisions of the Code have been prepared. As a reasonable minimum to comply with the overall obligations under the Code, members have agreed:

- *to follow, rigorously, revised appointment criteria for the appointment of new agents;*
- *to remind intermediaries on a regular basis (annually as a minimum) about their duty to display a declaration of status, both in offices and documentation. The examples of their sales documentation and other literature should also be provided (again annually as a minimum) for verification purposes;*
- *to supply all intermediaries with the ABI produced guidance notes designed to give a brief overview of the ABI Code. The notes are intended to help intermediaries to comply with their obligations to insurers under the Code and to explain how they should go about the selling process.*
- *an individual member of the insurance staff should be appointed to oversee the procedural aspects, possibly doubling as the ABI Code contact;*
- *for creditor, travel and extended warranty / mechanical breakdown insurance, where particular difficulties have arisen, extra care should be taken to ensure that the relevant sales forces are conversant in the requirements of the Code and obliged to follow more specific procedures for dealing with agents selling these mass-marketed products.*

36. The Resume for Intermediaries also highlighted the importance of the ABI Code. It noted:

"The Code is mandatory for business sold by ABI members in the UK. The DTI are responsible for ensuring that companies which are not members of ABI comply with the Code and, in addition, bringing the Code to the attention of foreign insurance companies covering UK risks on a services basis as part of the UK's general good rules."

The ABI Statement of Practice for Payment Protection Insurance

37. The ABI also published a statement in December 1996 about PPI. Among other things, it said:

Providers will give sufficient detail of the essential provisions of the cover afforded by the policy so as to ensure, as far as is possible, that the prospective insured person understands what he/she is buying.

In particular:

- *the suitability of a contract will be explained to those who are self-employed, those on contract or part time work, and those with pre-existing medical conditions;*
- *details of the main features of the cover as well as important and relevant restrictions will be made available and highlighted at the time the insurance is taken out with full details being sent afterwards;*
- *all written material will be clear and not misleading;*
- *full details of the cover will be provided as soon as possible after completion of the contract.*

Finance & Leasing Association (FLA) Code of Practice

38. This Code was introduced in 1992, and set out standards of good practice for the finance and leasing industry. Section 4 of the Code covered Credit Protection Insurance, the provisions being as follows:

4.1 Members shall ensure that customers are made aware, where appropriate, of the availability of credit protection insurance.

4.2 Details of the major items of cover and exclusions under credit protection insurance policies arranged by the member, including eligibility criteria, shall be set out both clearly and prominently in appropriate literature. Customers shall be given this information, together with the cost of the cover, prior to making a decision to apply for insurance or at the time that an application for insurance is being made.

4.3 Customers shall be supplied with full details of the credit protection insurance policy terms as soon as possible after the making of the agreement (but not more than 21 days after the making of the agreement or before any instalment becomes due under it, whichever is later).

39. As I have explained, FICL was a member of the ABI, so it was subject to the ABI Code and its associated requirements as set out above. The seller – but not FICL – was a member of the FLA and subscribed to the FLA Code, so I consider it reasonable to assume that the seller (as a member of the FLA) should have complied with its Code when selling PPI, and this extends to when it was acting as an agent of FICL.

40. So I am satisfied it is right that I should take these Codes into account when deciding what is, in my opinion, fair and reasonable in the circumstances of Miss M's case.

The law

41. I have also taken account of the law, including: the law relating to negligence and contract (including the express and implied duty on professional advisers to give advice with reasonable skill, care and diligence); the law relating to the duty of utmost good faith; the law relating to misrepresentation and the law relating to causation and remoteness.

The approach taken by former schemes

42. Under the Transitional Provisions[3] which continue to apply to complaints like this about acts or omissions before 1 December 2001, I am also required to take into account what determination the relevant former scheme – in this case the IOB (which FICL subscribed to) – might have been expected to reach in relation to an equivalent complaint.

43. In that respect I note that, under the IOB's terms of reference, the Ombudsman's duties were, among other things:

(i) To have regard to and act in conformity with

(a) the terms of any contract;

(b) any applicable rule of law, judicial authority or statutory provision; and

(c) the general principles of good insurance, investment or marketing practice, the ABI's Statement and Codes of Insurance Practice, and the LAUTRO and IMRO rules; but with (c) prevailing over (b) in favour of the complainant.

(ii) To have regard to (without being bound by) any previous decision of any Ombudsman.

(iii) To have regard to (without being bound by) any guidance of a general nature given by Council.

(iv) In the light of (i) (ii) and (iii), to assess what solution would be fair and reasonable in all the circumstances.

The FCA's guidance for firms Handling PPI complaints – DISP App 3

44. I am also mindful of the evidential provisions and guidance set out at DISP App 3, first issued by the FSA in 2010, which sets out how firms should handle complaints relating to the sale of payment protection contracts like Miss M's.

45. The sale took place before insurance mediation became a regulated activity in January 2005, so FICL was required to take into account the evidential provisions in DISP App 3 as if they were guidance when considering Miss M's complaint.

46. I note DISP App 3 includes guidance for firms about assessing a complaint in order to establish whether the firm's conduct of the sale fell short of the regulatory and legal standards expected at the time of sale – referred to as 'breaches or failings'. It did not impose new, retrospective, expectations about selling standards.

47. DISP App 3 also contains guidance for firms about determining the way the complainant would have acted if a breach or failing by the firm had not occurred. In relation to that it says:

[3] The Financial Services and Markets Act 2000 (Transitional Provisions) (Ombudsman Scheme and Complaints Scheme) Order 2001 (SI 2001/2326)

DISP App 3.1.3 G

Where the firm determines that there was a breach or failing, the firm should consider whether the complainant would have bought the payment protection contract in the absence of that breach or failing. This appendix establishes presumptions for the firm to apply about how the complainant would have acted if there had instead been no breach or failing by the firm. The presumptions are:

(1) for some breaches or failings (see DISP App 3.6.2 E), the firm should presume that the complainant would not have bought the payment protection contract he bought; and

(2) for certain of those breaches or failings (see DISP App 3.7.7 E), where the complainant bought a single premium payment protection contract, the firm may presume that the complainant would have bought a regular premium payment protection contract instead of the payment protection contract he bought.

DISP 3.1.4 G

There may also be instances where a firm concludes after investigation that, notwithstanding breaches or failings by the firm, the complainant would nevertheless still have proceeded to buy the payment protection contract he bought.

DISP App 3.6.1 E

Where the firm determines that there was a breach or failing, the firm should consider whether the complainant would have bought the payment protection contract in the absence of that breach or failing.

DISP App 3.6.2 E

In the absence of evidence to the contrary, the firm should presume that the complainant would not have bought the payment protection contract he bought if the sale was substantially flawed, for example where the firm:

(3) did not disclose to the complainant, in good time before the sale was concluded, and in a way that was fair, clear and not misleading, the significant exclusions and limitations, i.e. those that would tend to affect the decisions of customers generally to buy the policy;

(8) did not disclose to the complainant, in good time before the sale was concluded and in a way that was fair, clear and not misleading, the total (not just monthly) cost of the policy separately from any other process (or the basis for calculating it so that the complainant could verify it);

(10) provided misleading or inaccurate information about the policy to the complainant;

DISP App 3.6.3 E

Relevant evidence might include the complainant's demands, needs and intentions at the time of the sale and any other relevant evidence, including any testimony by the complainant about his reasons at the time of the sale for purchasing the payment protection contract.

Overall

48. Taking the relevant considerations into account, it seems to me that the overarching questions I need to consider in deciding what is, in my opinion, fair and reasonable in all the circumstances of this complaint, are:

- If FICL gave advice, whether it advised Miss M with reasonable care and skill – in particular, whether the policy was appropriate or 'suitable' for her, given her needs and circumstances.
- Whether FICL gave Miss M sufficient, appropriate and timely information to enable him to make an informed choice about whether to take out the policy, including drawing to her attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.
- If, having considered these questions, I determine the complaint in favour of Miss M, I must then go on to consider whether and to what extent she suffered loss or damage and what I consider would amount to fair compensation for that loss or damage.

49. Miss M says FICL ought fairly and reasonably to have gone further than I have suggested when providing information. I shall address Miss M's representations about this later on.

c) the sale – what actually happened?

50. The evidence in this case is quite limited. When Miss M sent us her PPI questionnaire (PPIQ) in March 2018 she said the policy was sold in a meeting. She did not say whether she was advised to take out the PPI.

51. FICL said that:

- Miss M took out the HP agreement and associated PPI in a store.
- The credit agreement had a section headed 'Payment Protection Insurance Application' – in which she had to sign (separately from her signature for the credit) to say that she wanted the policy.
- Sufficient information would have been provided at the time of sale for Miss M to make an informed decision, including information about the cost.
- It would have sent documentation confirming the sale of the policy, and providing full details of the insurance (including details of the cooling off period and cancellation terms), after Miss M took out the HP agreement and policy.

52. FICL has provided copies of Miss M's signed credit agreement and a Certificate of Insurance which post-dates the sale. In the section of the credit agreement headed 'Payment Protection Insurance Application' it says:

> *"An optional Payment Protection Insurance plan (details with your copy of the agreement) is available in connection with this Account and will be provided (subject to eligibility) if you sign the box opposite. If you require Payment Protection Insurance the monthly premium, currently an amount equivalent to 11.0% of your monthly loan repayment should be remitted with your loan repayment each month.*
>
> *Current Monthly Payment Protection Premium 6.39*
> *Monthly Payment inclusive of Loan Repayment and Insurance Premium 64.46*
> *The premium is variable as is the method of calculation*
> *I require Payment Protection Insurance*

53. Below this text was a box marked '*Signature'*. Miss M's signature appears in the box.

54. Having considered both parties' representations, and keeping in mind the limitations in the evidence they have been able to provide (which is not surprising given the sale took place more than 20 years ago, and the account was closed over 10 years ago), I find:

- Miss M took out the HP agreement and policy while in a store, with the account being opened there and then.

- It is more likely than not that the HP agreement was part of a pack, given out at the time of sale, which included a customer copy containing more information about the policy – as the wording in the HP agreement suggests was the case. But in the absence of a copy of that document, or a sample copy, I cannot say how much information was included or how it was set out.

- It is more likely than not that FICL *did* send the policy document to Miss M after she took out the HP agreement, even if Miss M does not remember receiving it – but that would not have played a part in her decision to apply for the policy, so it is of little consequence to the sale (other than to clarify what Miss M bought).

- It is more likely than not that policy terms and conditions similar to those set out in the Certificate of Insurance that FICL supplied, and as I have found, this was more likely than not to have been sent out after the sale.

d) did things happen as they should in 1996?

55. Both parties agree that the information FICL gave Miss M about the policy was set out in a store. And I have not seen anything in the evidence I have that contradicts FICL's testimony so as to suggest that advice was given. Rather, it seems more likely, given the circumstances of the sale – as I will set out below – that FICL gave Miss M the HP agreement and potentially other information containing information about the policy while in store.

56. So the question I need to consider is whether FICL provided Miss M with sufficient information in an appropriate way to enable her to make a properly informed decision about whether to take out the policy.

57. For the reasons I shall explain, I do not think it did. Exactly how, and the extent to which, FICL fell short of what was reasonably expected of it, and its relevance to Miss M is, in my view, important to my consideration of the question which ultimately lies at the heart of this complaint: would Miss M have acted differently if FICL had explained things properly?

58. Having considered all of the information, including Miss M's representations about what happened, I am satisfied it is more likely then not that Miss M agreed to the policy, knowing that she did not have to take it out.

59. In reaching that conclusion, I note the HP agreement shows Miss M signed separately for the policy.

60. I have set out above the wording in the policy section of the credit agreement. This does not say the insurance is compulsory and, by having to sign to take out the insurance, I am not persuaded Miss M would have been given the impression that she did not have a choice about whether to take it out or not.

61. I have also considered whether the sales assistant gave Miss M sufficient information about the cover provided by the policy to enable her to make an informed decision about whether to take out the policy.

62. Miss M has not provided much detail about the sequence of events – which is unsurprising given the length of time since she took out the HP agreement and policy.

63. Because of the limited evidence, I cannot know what happened in the store when Miss M took out the finance and policy. FICL says only that it gave Miss M sufficient information at the time of the sale, and has provided a copy of the signed credit agreement and policy application form. Given the sale was carried out in a non-financial business, I consider it more likely than not that any reference to the policy would have been fleeting – nothing which might reasonably be described as a detailed discussion or conversation about it.

64. I think it is likely that, when Miss M went into the store, she was given the HP agreement and possibly more material about both it and the policy so as to encourage her to take them.

65. However, the evidence from the time of the sale does not tell us whether Miss M was given any verbal information about the monthly premium – even in passing – or information about the monthly benefit or about the exclusions and limitations, before she agreed to take out the policy. The limited evidence there is suggests that FICL

relied on the policy information set out in the customer copy of the HP agreement to provide that information, albeit which I can see did clearly include the monthly premium. I am satisfied that this reflected the true cost of the policy as, for example, unlike PPI attached to credit cards the premiums were not added to the account and so did not attract interest.

66. The HP agreement did refer to the further details of the policy being provided to Miss M with her copy of the agreement. I have found that Miss M would more likely than not have been given that document. But, as I have explained, I do not have a copy of it, so I cannot say how the policy information would have been presented, or how much of the document would have been taken up with the terms and conditions relating to the credit agreement. Neither can I know what opportunity Miss M may have had to read such a document at the time of the sale.

67. While I am satisfied FICL also sent the Certificate of Insurance setting out full policy conditions to Miss M after the event, I do not consider that means FICL gave Miss M the information she fairly and reasonably needed to make an informed decision about whether to take out the policy before she did so. I am mindful that:

- Miss M did not base her decision to take out the policy on the Certificate of Insurance.

- There is not enough evidence to show Miss M was told in store that she should hold off making a final decision about taking out the policy until she had received and considered the Certificate of Insurance.

- It was for FICL – and indeed its agent – to provide Miss M with the most important information she required to make her decision before she took out the policy (see the 1996 ABI Statement of Practice for PPI and the FLA Code), with full conditions afterwards.

68. I think it is more likely than not that FICL gave Miss M some information about the premium, cover provided, and things like the significant restrictions on disability cover because that was the kind of information it was required to draw to the customer's attention by the ABI Code, which it had undertaken to comply with.

69. But I am not persuaded FICL did enough to present all of that information in a way that was fair and reasonable to Miss M. I am not persuaded that FICL drew the important information about the policy terms to Miss M's attention, especially in the context of a sale in a store while she was purchasing goods. And although I cannot say what took place in the store at the point of sale, I consider it unlikely that Miss M was given much information about the policy verbally – as I have said above, I consider it likely that any mention of the policy was fleeting.

70. Overall, having considered the parties' representations about what happened, I am not persuaded FICL did enough to present information about the policy in a way that was fair and reasonable to Miss M. I am not persuaded that Miss M was given all of the information she needed about the policy at the point of sale to make an informed decision about whether to take it out.

71. However, as I have said, I am satisfied that FICL sent the full policy conditions to Miss M after the event. I have also kept in mind that Miss M was charged premiums totalling just over £223 while the HP agreement was running. As I have said, I think

the monthly premium was clearly set out in the HP agreement, and I have no evidence to suggest that Miss M queried the premiums after the sale, or attempted to cancel the policy if she was unhappy with it.

72. I have considered how my findings interact with the FCA's list of significant failings in its guidance for firms handling PPI complaints set out at DISP App 3.

73. It seems to me that it would be reasonable to conclude that there were significant failings in this case. For example, I am not satisfied FICL disclosed to Miss M before the sale was concluded, and in a way that was clear, fair and not misleading, the significant limitations and exclusions that would tend to affect the decision of customers generally to take out the policy [DISP App 3.6.2 E (4)].

74. Despite that, I am satisfied that FICL disclosed the cost information envisaged at DISP App 3.6.2 E (8). FICL disclosed the monthly premium – a very important piece of information – on the HP agreement.

75. I have considered carefully Miss M's arguments that FICL should have done more than I have found it should have done and provided additional information. I have given particular thought to Miss M's view that the common law duty of utmost meant that:

- FICL should have explained the low claims ratio (and what she considers to be the inherent poor value) and the fact that little of the premium went to FICL as the insurer.
- FICL should have told her not just about the limitations and exclusions, but also about the significance of them.

But having done so, I am not persuaded by Miss M's views in that regard.

76. Under the law which existed at the time, both parties to an insurance contract owed a duty of utmost good faith to the other. By way of summary only, both parties had duties to disclose material facts and to refrain from making material misrepresentations to the other.

77. Usually, the focus of any dispute tends to be on the extent of the obligations the duty of utmost good faith places on the person seeking insurance to disclose to the insurer the information it needs to determine and calculate the risk it will be taking if it agrees to provide the insurance.

78. But an insurer also has a duty to disclose:

...all facts known to him which are material either to the nature of the risk sought to be covered or the recoverability of a claim under the policy which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer.[4]

79. MacGillivray on Insurance Law[5] explains that the duty does not extend to giving the insured the benefit of the insurer's market experience, such as for instance, that the

[4] *Banque Keyser Ullmann SA v Skandia (U.K.) Insurance Co. Ltd [1990] 1Q.B. 665, 772*
[5] MacGillivray on Insurance Law 14th edition 17-094

same risk could be covered for a lower premium either by another insurer or, presumably, by the same insurer under a different type of insurance contract; and the insurer is not required to perform the role of the insured's broker in this regard.

80. I cannot be certain, but I think it is unlikely a court would conclude an insurer should have disclosed the claims ratio and 'value' information, or contextualised the information about the limitations on disability cover in the way Miss M says FICL should have done by virtue of the duty of utmost good faith. In any event, I do not think it would be fair or reasonable in the circumstances of this case to impose such requirements on FICL.

81. FICL was the insurer in this transaction – and as I have explained, the sale was carried out by its agent. The agent is an intermediary for the purposes of the ABI Code, and that Code also referred to an overriding duty on the intermediary to act with utmost good faith and integrity.

82. The Guidance Notes for Intermediaries and the Resume for Intermediaries about the application of the ABI Code, which I have referred to in this decision, do not refer to that duty or elaborate on what it was intended to mean. But I think it is unlikely that it was intended to place a greater or substantially different, obligation on the intermediary to that owed by the insurer.

83. I consider it more likely than not that the reference to an overriding duty on the intermediary was a reminder of the importance of disclosing material information to both the insurer and the insured (depending on whom the intermediary was acting for), reflecting the legal duty those parties were under. And it seems likely the provisions of the ABI Code were in effect intended to be practical examples of how the intermediary might meet the overarching principles of utmost good faith and integrity as well as expected standards of good practice.

84. I also note there was no expectation at the time under the provisions of the ABI Code that insurers or intermediaries should proactively disclose commission – for example, the guidance to the ABI Code published in December 1994 said only that independent intermediaries should disclose commission on request.

85. Nor do I consider it can reasonably be inferred from the ABI Statement of Practice for Payment Protection Insurance (which gave further information about the expectations in PPI sales) that insurers or intermediaries were expected to disclose the kind of information Miss M says FICL should have done.

86. So it seems very unlikely that it was ever the intention of the ABI Code that intermediaries should provide the kind of additional information Miss M suggests it should. In any event, I am not of the view that it would be fair and reasonable in the circumstances of the case to impose a greater or substantially different, obligation on the intermediary to that owed by the insurer.

87. Looking at the FLA Code, there is no reference to commission, and it requires that details of the cover and the exclusions are set out '*both clearly and prominently in appropriate literature*'. So this did not impose higher standards on the agent than the ABI Code did (through FICL).

88. Overall, taking into account the law, industry codes and standards of good practice applicable to this complaint, I am not persuaded that FICL – directly or through its

agent – ought fairly and reasonably to have provided the additional information Miss M says it should have done.

89. But for the reasons and in the ways I have set out, I find the information FICL gave Miss M was insufficient and presented the policy in an unbalanced way. I do not have enough evidence to say that Miss M's attention was drawn – in a clear and fair manner – to the important information about the policy. So the information Miss M based her decision on was – most likely – ultimately misleading. I am not persuaded that was fair and reasonable in all the circumstances.

e) what effect did FICL's shortcomings have on Miss M? to what extent did Miss M suffer loss or damage as a result?

90. I have found FICL did not do all it should fairly and reasonably have done when it sold this policy to Miss M, so I have considered whether it would be fair and reasonable to conclude Miss M suffered loss and damage as a result.

91. It seems to me that, whether or not Miss M has suffered loss or damage in this case depends on whether, if FICL had explained things properly, Miss M would have acted differently, or whether she would have taken out the policy in any event.

92. Miss M says she would not have taken out the policy and I should, in any event, presume that she would not have taken it out given the substantial failings in the sales process I have identified (unless FICL can produce evidence to show she would have taken out the policy, which Miss M says it cannot because the failings were so fundamental).

93. I have carefully considered the representations of both sides and the evidence relating to them.

94. Taking out insurance like this, based only on information, requires the consumer to weigh up a number of factors before deciding whether to proceed. Policies such as these typically provide cover in a variety of situations, some of which may be of greater interest or relevance to the consumer than others.

95. Effectively the consumer has to weigh up in their own mind the cost of the policy against the benefits offered in return and the potential consequences they will suffer if they do not have insurance should the risks come to fruition. That is why it was for FICL (through its agent) to provide the information about the policy's features, so the consumer could make that assessment.

96. The evidence in this case suggests that Miss M clearly had some interest in taking out payment protection insurance. In saying that, I do not mean she actively sought insurance or that it was her intention to take out insurance before she applied for the HP agreement – I have seen nothing to suggest she did.

97. Rather, I mean when Miss M was given information in the store that there was a product she could buy that would both protect her HP payments in the event that she was unable to work because of disability or unemployment and which would pay off her outstanding balance if she died, that resonated with her in some way and she concluded that she wanted that product.

98. The issue here is that the decision Miss M made was based on incomplete information, meaning what she thought she was getting is not exactly what she got. And she would have had different things to weigh up when deciding to take out the policy if FICL had provided the information in an appropriate way.

99. I consider that, in deciding what is fair and reasonable in this case and whether Miss M suffered loss or damage as a result, the evidence about the extent to which the product differed from what Miss M might reasonably have expected from what she was told, is relevant to the consideration of what would have happened had everything happened as it should have.

100. In considering the above, I have also borne in mind that in this case, the evidence about Miss M's circumstances at the time of sale shows that the policy was not fundamentally wrong or unsuitable for her. She was eligible for its benefits and it provided cover that could have proved useful to her should the insured risks have come to fruition – even allowing for the limitations on the disability cover it provided.

101. Miss M's own evidence or 'testimony' is that if she had been unable to work through accident or sickness her employer would only have paid her for a limited time. If she was made redundant, she says she would have received a payment equal to at least six months' pay. And she says she had savings of around £2,000.

102. I think it is reasonable to conclude that, from Miss M's perspective, she saw some benefit in having insurance in her circumstances. If the risk the policy was concerned about came to fruition, the policy would help her manage the consequences – it would help reduce her outgoings during what would likely be a difficult period, despite her other means.

103. While Miss M was interested in the policy, was eligible, had good reason for wanting cover and was informed what the cost and benefits were, the policy did not work entirely as she might have thought.

104. I consider it unlikely that the limitations and exclusions were explained to Miss M. But I do think that, even if they had been explained to her adequately, it is unlikely to have dissuaded her from taking out the policy, for the reasons I have set out below.

105. I am not persuaded FICL clearly explained the pre-existing medical exclusions to Miss M or the limitations regarding claims for backache and related conditions and for psychiatric illness or mental or nervous disorders. But I do not think it is more likely than not that these would have dissuaded Miss M from taking out the policy. Although Miss M had suffered with back pain, that was several years before the time of sale. By her own account, the condition was treated when it arose and had not caused her to take any time off work. So I do not think Miss M would have considered it likely that the problem would recur or that she would have needed to claim on the policy for it. And she had not previously suffered psychiatric or mental illness. Nor have I seen evidence to show it is more likely than not that she would have thought she would in her circumstances.

106. The terms of the policy also differed from what Miss M might have expected because she would only be entitled to disability benefits if she was unable to do her normal job or a similar job which, in the insurer's reasonable opinion, her training, education and ability qualified her to do. I accept this may have given Miss M pause for thought but,

on the other hand, and taking into account the employment information provided to us, it is possible she may have considered it unlikely that, if she was unable (through disability) to carry on her own job, she would have been able to do similar work that she may reasonably be qualified to do.

107. Miss M has provided information about what she would have done with more information, which I have considered carefully. She says:

It was during a meeting that I was sold the PPI policy in March, 1996. I was sold the PPI at store. During the conversation we discussed the credit limit. When the policy was sold I had a salary of £19,000. As I was entitled to full sick pay from my employer I did not require a PPI policy. Furthermore I would have received a payment if I were made redundant. I would have received at least 6 months full pay from my employer in the event of redundancy. I had enough savings to cover monthly payments should I have not been able to work due to sickness or unemployment. When the policy was taken out I had £2,000 in savings. My savings were held with in Abbey National bank account. These savings are accessible at all times. The savings were for an emergency and easily accessible.

Santander Store Cards did not explain the terms and conditions of the policy.

In particular they did not tell me how much the PPI really costs. They didn't explain the effects of compound interest being charged at store card interest rates which I now understand means the balance would at least triple over a 10 year period or that premiums would continue during a claim. I was never given any indication of this true cost or how expensive it really would be.

The point being that PPI was usually presented as being cheap but I now understand that it was very expensive. I would not have bought the policy if I had understood this. The exclusions and limitations were also not explained – the reasons it would not have paid out. Claims Advice Bureau say Santander Store Cards had a duty to explain these exclusions and limitations in a way that an ordinary person like me would have understood. I can definitely say that Santander Store Cards did not do this. Claims Advice Bureau have further explained that a high proportion of reasons anyone is likely to miss work were excluded – in particular bad backs and mental conditions such as stress, depression and anxiety. These statistically are among the most likely reasons for anyone being off work and I can say that these exclusions were not disclosed to me.

If Santander Store Cards had said that they were excluding the most common reasons people miss work I can say that would not have wanted this PPI for that reason alone.

The policy was mean to protect me from sickness. It is now obvious that it was never going to do what it was supposed to be for. It was supposed to protect payments if you couldn't work but would not have done that in a majority of cases.

Let me be clear – I would not have wanted this policy had I been told this. In fact, I have suffered from back problems myself and although I have not yet lost time at work because of them, this shows how people are likely to be affected by them. On top of this, I also now understand 'pre-existing conditions' were not covered. This sounds like a piece of jargon to me, but Claims Advice Bureau have explained what it meant. I have had the following health problems:

Condition: back pain, Date: circa 1990, Treatment: hospital, Meds (inc. non-prescription): ibuprofen & paracetamol,

So it turns out that bad backs might have been excluded TWICE because they were 'pre-existing' and possibly excluded anyway. If the exclusion for pre-existing conditions had been explained to me, it is clear I would not have wanted this policy.

In addition to the above, there are more reasons as well why I now understand this PPI should not have been sold to me, and why if it had been explained properly, I would not have wanted it.

In my job as a accounts department, I had sickness cover – see above. I also had redundancy and would have got at least 6 months or more, but less than 12 months redundancy pay if I had been made redundant.

So the PPI was expensive and really unlikely to pay out and on top of that I was covered anyway.

On top of this I now understand that on average, firms kept 88% of each premium payment as profit and expenses. The policy was utterly appalling value for money. I am not in a position to waste money or make insurance businesses richer at my expense. Everybody knows that companies are entitled to make a fair profit, but not an unfair one – I would not have wanted to be taken advantage of. I don't think anybody would. As well as everything else, I was financially stretched. I have often had to run an overdraft. Claims Advice Bureau say that for me, even more than anybody else, it was wrong for me to spend money on this PPI which was both really expensive, and unlikely to pay out.

I don't think this PPI should have been sold to me and I would not have wanted it if it had been properly explained. Claims Advice Bureau say that Santander Store Cards were supposed to treat me fairly and not take advantage of me, but it cannot be right to sell a product like this without explaining the exclusions, and that they were keeping so much money for something with so little value to me. I feel badly let down by Santander Store Cards. PPI was just included as part of my package with my store card. I had no interest in PPI and would not have had it if Santander Store Cards had not included it with the package.

108. Miss M is effectively saying that, as a result of what her representative CAB has told her, both about what it considers should have happened and what she should have decided at the time, she would not have taken out the policy.

109. In light of the findings I have already made, I do not think Miss M's representations demonstrate what she claims, because much of the information she says would have affected her decision would not have been known to her at the time of sale, even if everything had happened as it should. For example:

- There was no legal, code, or good practice requirement on FICL (or its agent) to disclose all of the information she says it should have disclosed.

- I am satisfied the requirement on FICL in 1996 was to draw her attention to the limitations, not to give the limitations the context Miss M says FICL should have given them.

110. I am also mindful that: Miss M's recollections of the sale are, owing to the significant passage of time, likely to be limited; her representations about what she would have done are made in support of a claim for compensation; and the paragraphs I have quoted resemble quite closely the consumer representations made in other cases where CAB represents the consumer.

111. But I do accept the limitations on the policy might well have given Miss M pause for thought – as Miss M says, these are common conditions.

112. While it is likely Miss M would have expected to provide some medical evidence to support a claim arising from a back condition or mental health condition (as the policy required for other conditions), the steps required for these conditions were more onerous than she might reasonably have expected (which is ultimately why FICL needed to draw them to her attention).

113. I accept Miss M may well have concluded that the policy was not as good as she thought and she might have decided not to proceed. This limitation on cover, when coupled with the other shortcomings in this sale, might have dissuaded many consumers in different circumstances from Miss M from taking out the policy.

114. But Miss M, in her circumstances, still had some good reasons to take out the policy, notwithstanding the limitations of the policy.

115. I consider it fair and reasonable to think Miss M would have weighed up the various other considerations, in particular her limited other means of meeting her payments, particularly in the event she was off work due to disability. It is likely she would also have thought about whether the cost to benefit proposition still worked for her.

116. Having considered all of the evidence and arguments in this case I consider it more likely than not that that Miss M would still have taken out the policy. The policy was sufficiently close to what she thought she was getting and Miss M had limited other means of meeting her HP payments if she was unable to work. And in those circumstances I consider it more likely than not that she would have taken out the policy in any event.

117. I have also considered Miss M's representations about causation and DISP App 3. That guidance is for firms, but it is a relevant consideration I take it into account along with many other things when I decide what is in my opinion fair and reasonable.

118. I am mindful of the purpose of the guidance. I do not think it was ever intended to be at odds with the approach I have taken. The FSA explained its thinking in the policy statement[6] at the time:

"…we have taken as a starting point the typical approach in law (which we understand also to be the FOS's general approach) that the customer should be put in the

[6] Financial Services Authority Policy Statement 10/12 The assessment and redress of Payment Protection Insurance complaints – Feedback on the further consultation in CP 10/6 and final Handbook text – page 43 - 45

position they would have been in if there had been no failure to comply with its obligations on the part of the firm. Typically that involves considering what the customer would have done 'but for' the firm's breach or failing. Firms have also been making such 'but for' judgements for many years, it being the basic tenet of complaint handling. Complaints about PPI are not new or unusual in this respect. We are satisfied that the 'but for' test is a reasonable one in the circumstances.

The presumptions represent a way of judging what a customer would generally have done, in our view. Having given due consideration to responses concerning presumptions we remain of the view that the presumptions we have set out are reasonable ones fully in the tradition of, and informed by, the kinds of judgements that courts and ombudsmen have long and often been making when assessing claims and complaints and the potential need to put the claimant, as far as practicable, back in the position 'they would have been in' had the breach not occurred.

We also recognise that it would not be possible to establish in every case what a customer would have done in every individual circumstance and that there has to be scope for a firm to depart from the presumptions. So, the presumptions are rebuttable – that is, it is open to the firm to evidence that the customer would have bought the policy notwithstanding the breach or failing, in which case no redress will then be required."

119. It also said:

"A recording of the sale is not essential to rebut the presumptions. Where it is not available, firms must fairly assess the available evidence to make a decision about what they think would have been likely to have happened, but for the failing, given the circumstances and the evidence about the sale. For example, if the firm failed to disclose the existence of an exclusion relating to pre-existing medical conditions, then it may be reasonable for the firm to rebut the presumption that the customer would not have bought the policy if it can be shown that the customer did not have a pre-existing medical condition. It is unlikely that a recording of the sale would elicit this information. The PPIQ, if properly completed, will however provide this information.

We have carefully considered, in light of responses, the proposed list of 'substantial flaws' in the proposed Handbook text. We are satisfied that the rebuttable presumptions cover substantial flaws and that our proposals are appropriate because in each case the nature of the failing raises serious doubts over whether the customer would have proceeded with the purchase if there had not been such a failing.

It is true that the presumptions do not make allowance for the materiality of the failings. We consider that the failings amount to substantial flaws irrespective of their materiality to particular consumers, and that it is reasonable and simpler for our guidance not to differentiate the failings in terms of materiality. In practice, firms are likely to be able to factor in considerations of materiality when potentially rebutting the presumptions in the case of a particular complaint. For example if a firm failed to disclose an exclusion, and if that exclusion did not apply to that customer at the time of the sale (something which can be evidenced relatively straightforwardly with reference to the policy), it may be reasonable for the firm to conclude (assuming there are no other failings) that the exclusion was not

material to that customer and that he would have bought the policy anyway, notwithstanding the firm's failure to disclose the exclusion…"

120. I have thought about what outcome applying the FCA's guidance to this complaint might lead to. In the language of DISP App 3, I have found it would be reasonable to conclude there were substantial flaws in the sales process. In those circumstances, DISP App 3 says it should be presumed Miss M would not have bought the payment protection insurance she bought unless, in the particular circumstances of the complaint, there is evidence to rebut the presumption.

121. I am satisfied, applying DISP App 3, it is reasonable to conclude the presumption is rebutted in the particular facts and circumstances of this complaint. Based on the evidence pertaining to Miss M's circumstances I have considered above I consider it reasonable to conclude the position Miss M found herself in as a result of the sale was the same position she would have been in had the 'breach' or 'significant failings' not occurred.

122. But even if I am ultimately departing from the guidance for firms set out at DISP App 3 (which I do not consider I am), I am doing so because I do not consider, in this case, that it would represent fair compensation to put Miss M in the position she would have been in if she had not bought the policy.

123. That is because, while I accept it is possible that Miss M would not have taken out the policy I am satisfied that, of the two possibilities, it is more likely than not that she would still have taken out the policy if she had been given clear, fair and not misleading information about the policy she was buying.

124. I am satisfied it would not be fair and reasonable in those circumstances to conclude FICL should pay Miss M redress, as that would put her in a better position than she would have been in if everything had happened as it should have done.

125. It follows from my findings that on the balance of probabilities it is more likely than not that Miss M would have taken out the policy if things had happened as they should, that I am not persuaded she has suffered loss or damage as a consequence of the way this policy was sold.

126. I have thought about whether it would be appropriate to make an award of some kind because of the flaws I have identified in the sale process even though I have found Miss M would still have taken out the policy. I have not seen anything in the evidence relating to this case which leads me to conclude that Miss M suffered material distress or inconvenience, or any other form of non-pecuniary financial loss, because of the way the policy was sold. In those circumstances, I do not consider it would be fair to make an award.

my final decision

127. Overall, having considered all the evidence and arguments to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint and for the reasons I have set out in detail above, my final decision is that I do not make an award or direction in favour of Miss M.

128. I now ask Miss M to either accept or reject my decision before 24 July 2019.

Nimish Patel
ombudsman