ombudsman news

essential reading for people interested in financial complaints – and how to prevent or settle them

stories behind the numbers

This is the first *ombudsman news* since we published our *annual review* of 2013/2014 – and my head is still packed with facts and figures about our unprecedented year of activity. If you'd like to see for yourself, the information is all available on our website – together with the complaints data we regularly publish about individual financial businesses.

All helpful stuff, statistics. But they don't show the full story. Indeed, what we do at the ombudsman service *can't* be readily represented by a string of numbers.

Mindful of this – and hoping to set the balance right – I recently spent a day working on our consumer helpline.

My day, I was assured by my excellent colleagues, wasn't unusual. People phoned in from across the UK – some worried about a few pounds, some about their livelihoods – but all looking for practical help and assistance.

Many were extremely upset and worried about the difficulties they were facing. Others were angry. Many more seemed resigned in the face of a financial services bureaucracy that they couldn't navigate, however hard they tried. And all wanted the matter sorted out without further delays.

My colleagues answered more than two million of these initial enquiries and complaints last year. 6% of calls to our helpline are about motor insurance – and 23% about payment protection insurance. All this and more is in our *annual review*. But that isn't really the point.

Financial Ombudsman Service

scan for previous issues

in this issue

Tony Boorman

And it certainly isn't the point for each of the consumers and businesses that get in touch with us. Rather, each phone call, each "case", is its own story of specific facts, circumstances and disagreements.

That's where *ombudsman news* steps in: to give readers a feel for the real-world implications of those quotable facts and figures, and the inevitable pie-charts. Because whether it's health insurance or PPI, mortgages or pensions, our job isn't about numbers – it's about individual people, their individual lives, and the very individual consequences of something going wrong.

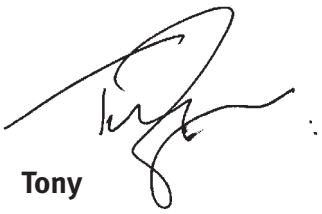
Many consumers tell us they feel they've been treated by their bank or insurer like a number – a seven-digit account or policy reference.

Perhaps that's a consequence of "tick-box" compliance. Or perhaps it's inevitable given the size of the big service providers – and the scale of their operations and procedures.

But in my experience, good case-handling looks beyond the numbers to the story. What happened to that customer, and how did that feel for them?

So I always worry when a financial services executive presents me with spreadsheets and graphs. Useful and necessary, granted – but far from the whole picture.

What's more telling is whether that executive can recount a story about a case they tackled – and what it told them about the service their business provides.



Tony

... our job isn't about numbers – it's about individual people and their individual lives

Financial Ombudsman Service
Exchange Tower
London E14 9SR

switchboard 020 7964 1000

consumer helpline
Monday to Friday 8am to 8pm *and*
Saturday 9am to 1pm
0800 023 4567 or **0300 123 9 123**

technical advice desk
020 7964 1400
Monday to Friday 9am to 5pm

health and medical insurance

Complaints about health and medical insurance can be some of the most sensitive and hardest-fought that we see – as well as some of the most challenging to resolve.

Like any type of insurance, when someone takes out a health and medical insurance policy, they will be hoping they won't have to use it. If they do, however, they expect the policy to pay out – and it's understandable that complaints arise when this doesn't happen. At what is already a difficult time, an insurer's decision to reject a claim can make things even more stressful for a consumer.

We have considerable experience of sorting out complaints about health and medical insurance. But we're not medical experts – and it isn't our role to diagnose the consumers who use our service. We consider carefully all the available medical evidence in each case – whether it is supplied by the consumer's GP, specialists in the relevant field, or by an independent expert instructed by the insurer.

Though every claim – and its wider impact – is individual to the consumer who has brought the complaint, we see similar issues and themes in the cases referred to us.

For example, we are regularly called on to resolve disputes about whether a procedure is covered by a policy – or whether the consumer's condition meets the policy's definition. In these cases, we take into account the advice of the consumer's treating doctor, as well as the evidence provided by the business.

We also see complaints from consumers who have discovered that a new policy – with a new insurer – doesn't provide the same level of cover as their previous policy. In these cases, we look into how the policy was sold to the consumer – and whether and how any differences where highlighted.

We will always look to find a fair and reasonable solution in each individual situation. This may be telling the insurer to meet the claim. In some cases, however, we decide that it is reasonable for the insurer to have rejected a claim – or, where something has gone wrong, that they have already put things right.

The following case studies illustrate the range of complaints we receive.

Financial Ombudsman Service

... the surgeon had said it was very likely that Mrs B would need further surgery

case study 117/1

consumer complains that insurer has rejected private medical insurance claim – on grounds that second operation is a separate procedure

After being diagnosed with breast cancer, Mrs B had a mastectomy in the autumn. Having discussed her options with her surgeon, she underwent breast reconstruction surgery a month later. The reconstruction was authorised and carried out under her private medical insurance.

In January the following year, Mrs B's plastic surgeon wrote to the insurance company, saying he planned to carry out a follow-up reconstructive operation. However, this time the insurer rejected the claim. They said that Mrs B's policy would pay out for "initial reconstructive surgery" only, and any subsequent surgery wasn't covered.

On the advice of her surgeon, Mrs B decided to go ahead with the second operation – and then asked the insurer to reconsider their decision. The insurer refused. Feeling the complaints process might be intimidating, she asked her local branch of a cancer support charity to help her make a complaint. When the complaint was rejected, she asked us to look into it.

complaint upheld

We asked the insurance company for a copy of Mrs B's policy. This confirmed that, as long as it was agreed beforehand, the insurer would pay for "*initial reconstructive surgery*". However, the insurer *wouldn't* pay for "*cosmetic surgery or treatment*", or any procedure relating to "*previous cosmetic or reconstructive treatment*".

We also looked carefully at the correspondence there had been between Mrs B, her plastic surgeon and the insurer. In the letter turning down Mrs B's claim, the insurer had said that their definition of "initial reconstructive surgery" covered "reconstruction of the affected breast."

But they had also said that if the procedures making up the initial surgery "subsequently require revision" then that revision wouldn't be covered by the policy.

We noted, however, that in the letter Mrs B's plastic surgeon sent to the insurer recommending her mastectomy and first reconstruction operation, he had said it was very likely that Mrs B would need further surgery "to complete the procedure". When we asked the surgeon whether it was usual to need further surgery, he explained that it isn't often possible to completely "correct the breast volume" in one operation.

The cancer charity supporting Mrs B referred us to guidance from the National Institute for Health and Care Excellence (NICE). This supported the surgeon's view – confirming that most people need between two and four procedures to achieve a complete reconstruction.

In light of this evidence, we decided it wasn't reasonable to treat Mrs B's second reconstructive operation as separate. In our view, it was part of one reconstructive procedure, and so should be covered under her insurance policy. We told the insurer to meet Mrs B's claim – and to pay her £350 for the upset and inconvenience they had caused.

... the policy also excluded treatment that hadn't been approved by NICE

case study 117/2

consumer complains that insurer has rejected claim made under group policy – on grounds that treatment is "unproven"

Mr S's employer had a group insurance policy for their staff – which had been provided by Insurer A for many years. Following a review of the staff benefits they offered, the employer decided to transfer to Insurer B instead.

A year later, Mr S contacted Insurer B to "pre-authorise" surgery to repair damaged cartilage in his left knee. The operation had previously been approved by Insurer A. At first, Insurer B told Mr S that they wouldn't meet the claim because the procedure in question wasn't approved by the National Institute for Health and Care Excellence (NICE), and wasn't proven to be effective.

However, Insurer B then reversed their decision – acknowledging that the claim fell under the "transitional agreement" they had with Mr S's employer for handling claims that had been made shortly before the group policy changed. Mr S went ahead with the operation on his left knee, and the cartilage was repaired successfully.

A few months later, Mr S phoned Insurer B to arrange for the cartilage in his right knee to be repaired in the same way. But this time Insurer B refused to authorise the procedure. They said Insurer A had authorised surgery only to Mr S's left knee – so only the left knee fell under the "transitional agreement". Insurer B pointed out that, as they had previously explained, they wouldn't cover the operation under their *own* policy because it wasn't approved by NICE.

Mr S made a complaint to Insurer B. He argued that, although NICE hadn't approved the procedure, it was approved and widely carried out across the European Union. Insurer B responded to Mr S's complaint – offering him £8,000 towards the cost of the surgery. This was how much the equivalent, NICE-approved procedure would have cost the insurer. However, the surgery Mr S was claiming for cost considerably more. Unhappy with this outcome, he asked us to step in.

complaint upheld

We asked Insurer B for a copy of their policy wording. This explained that they wouldn't cover:

"*experimental, unproven or unregistered treatment that is not considered to be established UK medical practice or for which there is insufficient evidence of safety or effectiveness*".

We noted that the policy also excluded treatment that hadn't been approved by NICE.

The policy also said that if someone decided to have treatment the insurer considered to be "experimental", then the insurer would pay out only the amount they would have paid for "*the nearest equivalent treatment*".

We didn't think the policy wording was unusual or unreasonable. However, we needed to consider carefully whether it had led to a fair outcome in Mr S's case.

We accepted that the procedure Mr S had claimed for wasn't approved by NICE. However, we didn't consider that this meant it was "experimental" or "unproven". In our view, the fact Mr S's left knee had been successfully repaired suggested the treatment was effective – so it was reasonable for him and his consultant to assume it would also be effective on his right knee.

We also looked at the wording of the transitional agreement. This said that if someone asked Insurer B to authorise a treatment that wasn't established practice in the UK – but Insurer A *had* approved that particular treatment – then Insurer B would need to see:

"*proof from your current insurer that this is a benefit covered by the current insurer as stated in the current insurer's plan terms and conditions*".

It seemed to us that Insurer B had applied a very strict interpretation of the transitional agreement. By doing so, they only had to pay for the *exact* treatment that Insurer A had approved – to Mr S's *left* knee. However, there was nothing to suggest Insurer A wouldn't have met the second claim. In fact, given they had authorised the first operation, we considered it very likely that they would have authorised the second.

Mr S also provided a report written by his specialist before his first operation – which recommended that it wouldn't be medically appropriate for both knees to be operated on at the same time. We noted that the transitional agreement failed to mention how long the arrangement would last. Given the two claims had been made in the same policy year, we decided the two operations should be viewed as part of the same course of treatment.

The transitional agreement between Mr S's employer and the two insurers had been put in place to prevent staff from being disadvantaged by the change. But in our view, Mr S had been disadvantaged. We decided, in the particular circumstances of this case, that Insurer B had unfairly rejected Mr S's second claim. We told them to pay the full cost of the procedure Mr S wanted.

case study 117/3

consumer complains that restriction on cover for caesarean sections wasn't made clear in private medical insurance policy

Since Miss R fractured her back, she had been experiencing chronic back pain and limited mobility. She regularly saw a consultant to monitor and manage the pain.

Two years later, when Miss R was several months pregnant, her consultant told her that, because her baby was big, it was very likely that a natural birth would aggravate her injury and worsen the pain. The consultant recommended that Miss R have an elective caesarean section to reduce the risk of damaging her health.

... the consultant recommended that Miss R have an elective caesarean section

... the policy only covered situations where the woman's life was at risk

Miss R had private medical insurance. After receiving the consultant's advice, she sent the insurer a letter from her consultant explaining the situation – and asking the insurer to authorise a caesarean section. But the insurer refused. They told Miss R that, although they accepted that a caesarean was medically necessary in her case, the policy only covered situations where the woman's life was at risk.

Miss R complained to the insurer. She said that, if this restriction existed, it wasn't clear from the policy documents. She pointed out that the policy simply said that the insurer would consider the consultant's report and make a decision.

In their response to the complaint, the insurer said that this particular benefit was "discretionary". However, they said this discretion was used only when the woman's life was at risk. And for this reason, they wouldn't be changing their decision.

Miss R was worried and frustrated – and she referred the complaint to us.

complaint upheld

In her complaint, Miss R had highlighted that she felt the policy wording was ambiguous. We asked the insurer for a copy of the policy document – so we could decide whether or not we agreed with Miss R.

We looked carefully at the policy booklet for mention of pregnancy-related claims – in particular, claims for caesareans. In the "exclusions" section, it was explained that although the insurer didn't cover pregnancy-related claims:

"*We may pay for eligible treatment for delivering a baby by caesarean section. However, we need full clinical details from your consultant before we can give our decision*".

Having read this, we could see what Miss R meant. In our view, the policy document didn't reflect the cover available. It indicated that the insurer would base their decision on the clinical details provided by the consultant – but didn't specify the requirement that a woman's life had to be in danger for a caesarean section claim to be paid.

We pointed this out to the insurance company. They said the requirement formed part of their internal guidelines for exercising their discretion – rather than being a term or condition of the policy – and that was why it wasn't set out in the policy document. The insurer explained that the requirement had been brought in *after* Miss R's cover started. They told us they didn't notify their customers this had happened because they hadn't actually changed any terms and conditions – but only an internal guideline.

We disagreed with the insurer. In our view, they had introduced a strict term into Miss R's policy while it was in place. We thought that the inflexibility of their guidelines meant they couldn't actually apply discretion to each individual customer's claim. The policy terms and conditions said the insurer would consider clinical information provided by the consultant when assessing the claim. And the insurer had already accepted that there was a valid medical reason why Miss R needed to have a caesarean section.

We decided that, in the circumstances, it wasn't fair or reasonable for the insurer to reject Miss R's claim on the grounds that her life wasn't at risk. We told them to re-assess her claim – giving weight to her consultant's opinion in line with the policy's terms and conditions. The insurer told us that they would be reviewing their policy documents – to clarify the cover on offer.

case study 117/4

consumer complains that insurer has rejected critical illness claim on grounds that operation happened after policy had expired

Mr G took out a ten-year critical illness insurance policy in October 2003. This would pay him a lump sum if he was diagnosed with any of a list of serious illnesses specified by the policy. In August 2013, after experiencing chest pains, Mr G found that he needed coronary bypass surgery. He was put on a waiting list – and eventually had the surgery in November 2013.

Although his critical illness insurance had expired by the time he had the surgery, Mr G understood – from reading the policy booklet he'd been sent – that because the policy was still active when he was put on the waiting list, his claim would be met. However, when he made a claim, the insurance company rejected it. They said that if you were on a waiting list when your policy expired, then the claim would only be paid if you were waiting for an organ transplant.

... he felt that the wording in the policy document was unclear

Mr G complained. He said he felt that the wording in the policy document was unclear – and in the circumstances, the insurer should pay out. When the insurer wouldn't reconsider, Mr G referred the matter to us.

complaint upheld

We asked the insurance company for a copy of the policy documents that Mr G would have been given. Under the heading "*General conditions*", the policy booklet said the policyholder would be covered if, before the policy expiry date, they:

"*suffer from one of the conditions defined under 'Conditions covered', provided they survive until the 14th day from the date of diagnosis, surgery or being added to a waiting list*".

First, we checked that the procedure Mr G had undergone met the policy's definition of "coronary heart bypass surgery". We were satisfied that it had. In fact, Mr G's condition was more severe than the policy required – he had had three arteries corrected, whereas the policy only specified *one*.

Under the heading "*Conditions covered*", the policy listed "*Major organ transplant – including being added to a waiting list for a major organ transplant*".

The insurer told us that, from this wording, it should have been clear to Mr G that his claim wouldn't be met. They acknowledged that Mr G had been put on the waiting list for his operation while his policy was in place. However, they argued that because Mr G didn't undergo his surgery until the cover had ended – and it wasn't organ transplant surgery – they had acted reasonably in rejecting his claim.

We disagreed. We felt the general condition contradicted the wording under "*Conditions covered*". In our view, the policy wording was ambiguous – and we could see why Mr G had thought his claim would be met. We explained to the insurer that our approach is to interpret any ambiguity in a contract in favour of the party who didn't write it – the consumer. This is in line with well-established legal principles.

We noted also that Mr G had been on put on a waiting list for the surgery six weeks before the policy expired. But in his local area, the waiting time for coronary bypass surgery was more than six weeks – and his policy had expired by the time he reached the top of the list. If the waiting time had been shorter, Mr G's claim would have been paid. We didn't think it was fair that he should be penalised because of the hospital waiting times in the area where he lived.

In the circumstances, we decided the insurer had unfairly rejected Mr G's claim. We told them to offer him what he was entitled to under the policy – adding 8% interest from the date of the claim to the date of the settlement. The insurer volunteered to pay Mr G £300 for the upset they'd caused by rejecting his claim in the first place.

... the broker acknowledged Mr K had accurately answered the question he'd been asked

case study
117/5

consumer complains that private medical insurance doesn't cover pre-existing condition – and that it has been mis-sold

Mr K had a private medical insurance policy with Insurer C, which he took out through an insurance broker. During the application process, Mr K had told the broker that he had a heart condition and diabetes – and wanted the policy to cover both these pre-existing conditions. Three months into the policy, he made a successful claim for treatment relating to his diabetes.

However, because Mr K had made a claim, Insurer C quoted a significantly higher premium when his policy came up for renewal. So the broker who had arranged the original policy offered to search for alternatives. They went through a series of health-related questions with Mr K – and this time, based on his answers, recommended a lower-cost policy provided by Insurer D. Mr K went with the broker's recommendation and his application was accepted by Insurer D.

A few months later, Mr K phoned Insurer D with a question about his cover. During the conversation, he was very surprised to be told that his policy didn't cover his heart condition or his diabetes. Mr K contacted the broker straight away. He said he wouldn't have taken out a policy that didn't cover his pre-existing conditions – and felt that the replacement policy had been mis-sold.

The broker said they would look into Mr K's complaint – and a week later, they got back in touch. They said they had discovered that during the application process, their representative should have asked Mr K, "*Have you ever had any cancer, heart or psychiatric conditions?*" However, they had actually asked him: "*Have you had any cancer, heart or psychiatric conditions in the past 5 years?*" Mr K had answered "no" – because his heart condition hadn't been treated in the past five years.

The broker acknowledged Mr K had accurately answered the question he'd been asked. And they accepted that this had led to an unsuitable recommendation. The broker explained that a policy that covered Mr K's pre-existing conditions would be more expensive. But they offered to put in place a suitable policy from that point forwards – and meet the extra expense for the first year.

Mr K didn't agree to this – and asked the broker to refund all the money he'd paid towards the unsuitable policy with Insurer D. When they refused, he referred the matter to us.

complaint not upheld

Mr K told us his priority when looking for insurance was that his diabetes and heart condition would be covered. We saw that the prospect of not having the right cover had caused him a lot of stress. In our view, his not taking out cover – even though it would be more expensive – was never an option for him.

We explained to Mr K that our role is to put someone in the position they would be in if the business hadn't made a mistake. The broker's mistake hadn't left him out-of-pocket. In our view, the broker had suggested a fair way putting things right – ensuring Mr K had the cover he wanted, and paying the difference in recognition of their error.

We noted that the broker had also offered Mr K £100 to compensate for the upset the situation had caused him. We told Mr K we thought this was reasonable.

case study 117/6

consumer's husband complains that insurer has rejected critical illness claim – because the consumer didn't live long enough after diagnosis

Mrs L had a major stroke and was admitted to hospital. Sadly, she didn't regain consciousness – and, following discussions with her family, her life support was withdrawn. She died two weeks after the stroke.

Mrs L had taken out critical illness insurance some years previously. Mrs L's husband made a claim on his late wife's behalf under the policy. The insurance company sent the claim form back to Mr L – saying it needed to be signed by Mrs L's GP and the solicitor dealing with her estate. Mr L visited the GP and the solicitor to get the form signed, and sent the paperwork back again.

But the insurer then rejected the claim. They explained that critical illness insurance was different to life cover – which would have paid out when Mrs L died. They pointed Mr L to the policy's terms and conditions – which said that the policyholder had to survive for 28 days or more after falling ill to be eligible for the benefit.

Mr L complained to the insurer. He said that the decision to withdraw Mrs L's life support was the hardest he'd ever made. He explained that the family had agreed to go ahead quickly because they'd been told Mrs L's organs could be used in an urgent transplant operation. However, the insurer wouldn't reconsider – and Mr L asked us to step in.

complaint upheld

We asked to see the policy terms and conditions – so we could consider the condition the insurance company had mentioned. The document confirmed that:

"*The insured person must survive for at least 28 days after the date of diagnosis, otherwise benefit will not be paid*".

... the insurer explained that critical illness insurance was different to life cover

... we noted that "treatment for obesity" was clearly listed in the "exclusions" section

We thought the condition was worded clearly. But we needed to decide whether it had been applied fairly in Mrs L's case. There was no evidence to suggest that Mrs L wouldn't have lived longer – for 28 days – if her life support hadn't been withdrawn. We thought her family had taken that decision because it was possible someone else's life could be saved.

In this situation, we didn't think it was reasonable for the insurer to enforce the 28-day condition.

We also noted that Mr L had been asked to submit the claim form *twice* – only for the claim to be turned down. In rejecting the claim only after Mr L had gone to the trouble of getting the additional signatures, we felt the insurer had made an upsetting situation all the more stressful.

We appreciated that Mrs L's policy wasn't life cover – and that in different circumstances the condition would apply. However, given what had happened in this particular case, we thought the insurer's decision was unreasonable. We told the insurer to meet the claim – adding 8% interest from the date of Mrs L's stroke to the date of the settlement. This would be payable to Mrs L's estate.

case study 117/7

consumer complains that private medical insurance claim has been rejected – because insurer says there was no "acute flare up" of a "chronic" condition

Mr N was morbidly obese and also had type 2 diabetes. Over the years, his diabetes had become increasingly difficult to control. Mr N discussed his options with his GP, who said that, as Mr N was already taking the maximum dosage of tablets to control his blood sugars, he would have to start taking insulin. To avoid this, however, the GP recommended that Mr N try gastric bypass surgery.

Mr N decided to follow his GP's advice. He had private medical insurance, and wrote to his insurer – with a supporting letter from the GP – asking them to authorise a gastric bypass operation. But the insurer refused. They said that Mr N's policy excluded treatment for obesity. And it also excluded treatment for "chronic conditions" like diabetes – unless there had been an "acute flare up" of the condition.

In the insurer's view, Mr N's diabetes hadn't "flared up" – but had been worsening for some time. So they weren't willing to pay for any treatment relating to it.

Despite the insurer's response, Mr N went ahead with the operation. Shortly afterwards, he asked the insurer to reconsider their position – and to refund his medical costs. The insurer wouldn't agree to this, and Mr N made a complaint. When the insurer stood by their decision, we were asked to step in.

complaint not upheld

We asked to see the policy terms and conditions – so we could consider the exclusions the insurer was relying on to reject the claim. We noted that "*treatment for obesity*" was clearly listed in the "exclusions" section.

... it appeared his condition had grown worse over time

However, Mr N provided a letter from the consultant surgeon who had carried out his operation. This explained that, although weight loss can alleviate type 2 diabetes, weight loss wasn't the main reason that gastric bypass surgery had been recommended to Mr N. According to the surgeon, gastric bypass surgery has a hormonal response that affects the body's sensitivity to insulin. So the "*primary reason*" for the surgery was the effect on Mr N's diabetes – and any effect on his weight was "*a secondary gain*".

In light of this expert view, we thought it very likely that the surgery hadn't been directly intended as a treatment for Mr N's obesity – but rather for his diabetes. So the insurer hadn't been right to rely on the policy's obesity exclusion.

However, this didn't necessarily mean that Mr N's claim should be paid. For this to happen, we would need to be satisfied he had experienced an "acute flare up" of his diabetes. Looking at the policy, we found an "acute flare up" was defined as:

"*a sudden and unexpected deterioration of a chronic condition that is likely to respond quickly to treatment*".

We noted that in his letter to the insurer supporting the claim, Mr N's GP had explained that once tablets are no longer effective, and a patient is facing the need to start insulin treatment, the only alternative is gastric bypass surgery. The letter from the consultant surgeon also said that because taking insulin can cause further weight gain, the prospect of insulin treatment strengthens the case for having gastric bypass surgery.

Mr N told us that since his operation, he no longer needed to take tablets – and hadn't had to start taking insulin. He thought that the fact his diabetes had "responded quickly to treatment" showed that it had been "acute" before he had the operation.

We acknowledged that Mr N's condition had reached a very serious point – and that the surgery had improved his situation. However, type 2 diabetes is a progressive condition – and there was nothing to suggest that the way Mr N's condition had progressed had been either "sudden" or "unexpected". It appeared his condition had grown worse over time – and his GP had recommended the usual strategies for managing it.

We decided that – based on all the available evidence – Mr N's chronic condition hadn't gone through an "acute flare up". So while the policy's obesity exclusion didn't apply in Mr N's case, the exclusion relating to chronic conditions *did* – and the insurer had been reasonable to reject the claim on this basis. We didn't uphold the complaint.

... they had to prove that the policyholder was no longer "incapacitated"

case study 117/8

consumer complains that insurer has stopped paying income protection benefit – on grounds that consumer is no longer incapacitated

Mrs B was a self-employed IT consultant. However, she found herself becoming increasingly exhausted – and eventually felt she could no longer work. Shortly afterwards, she was diagnosed with chronic fatigue syndrome.

Mrs B made a claim on her income protection policy, which she had taken out when she started working for herself. The insurer agreed that her condition prevented her from working and began paying her a monthly benefit.

A year later, however, the insurer told Mrs B that they would be stopping the payments. They said they had made this decision because she had been observed carrying out various activities – including attending a home and garden exhibition.

The insurer felt the footage they had taken conflicted with what Mrs B had told them about the level of activity she was capable of. In their view, she had exaggerated her incapacity – and she was in fact able to work.

Mrs B disagreed with the insurer and made a complaint – asking them to restart the payments. When they refused, she referred the matter to us.

complaint upheld

First, we considered the policy's definition of "incapacity" – to check what Mrs B was covered for. This said:

"*Incapacity means that because of sickness or accident, you are unable to carry out any of the duties of the occupation stated in the schedule*".

In the schedule, Mrs B's occupation was listed as "IT consultant". So we needed to decide whether the insurer's evidence showed she was able to do this particular job.

We asked the insurer to provide us with the footage they had used as grounds to stop Mrs B's payments. They told us they had carried out surveillance over a period of four days – and had found "considerable discrepancies" between what Mrs B said she could do and what she had been seen doing. However, the footage we were sent lasted only 20 minutes – and showed Mrs B walking around the home and garden exhibition. Other activities she had apparently been seen carrying out – including driving to the chemist and the supermarket – were listed in an accompanying report.

We got in touch with the specialist who had diagnosed Mrs B and was helping to manage her condition – to ask for his view on her ability to work. The specialist told us that he believed Mrs B remained "*significantly incapacitated*". He felt in particular that the "brain fog" she experienced – which he said was a common symptom of chronic fatigue syndrome – meant it wouldn't be possible for her to perform an intellectually demanding role like an IT consultant.

Having watched the insurer's footage, the specialist told us he didn't think it showed Mrs B doing anything intellectually demanding – or that contradicted the diagnosis he'd given.

He also said he was aware that Mrs B had experienced significant "payback" – particularly bad fatigue – for days after attending the exhibition.

We reminded the insurer that if they wanted to stop paying a claim they had already accepted, they had to prove that the policyholder was no longer "incapacitated" in line with the policy. And we didn't think the insurer had proved that Mrs B was capable of working as an IT consultant. In our view, the opinion of a chronic fatigue specialist carried significantly more weight than the short surveillance footage the insurer had provided.

In light of all the evidence, we decided the insurer had wrongly stopped Mrs B's benefit – and we upheld her complaint. We told the insurer to restart Mrs B's payments – backdated from the time they had been stopped and adding 8% interest. By this time, Mrs B hadn't received any payments for a year. We also told the insurer to pay her £200 to compensate for the upset and inconvenience their actions had caused.

there's more to PPI than meets the eye

Sharing our insight with our customers – highlighting and making sense of the issues we're seeing – is a fundamental and ongoing part of our work. And as we explained in our *annual review*, payment protection insurance (PPI) is one area in which we've noticed a development over the past year – with complaints becoming increasingly entrenched.

One possible cause we've identified for this is the confusion that exists around how different types of PPI policy – and PPI complaint – differ from each other. So we asked **Richard Thompson**, lead ombudsman in PPI, to explain why there's more to PPI than meets the eye.

looking at the annual review, most PPI complaints were about mis-sold policies. And most were upheld. So aren't all PPI cases very similar?

Well, yes and no. It's true that we often see similar issues being raised when people tell us their PPI was mis-sold. But there are also many differences. Businesses and their sales processes, the type of policy involved, and the consumers who were sold them all combine to make very individual situations that we have to unpick.

And although our experience of thousands of PPI complaints has allowed us to set out some key principles for sorting them out, considering the individual facts and individual circumstances remains the heart of our approach. This is just as important for PPI as for any other area of our work.

but someone following the news over recent years could have a very different impression about PPI...

It's fair to say that some media coverage – and the inevitable text messages and daytime TV adverts – could lead people to assume that all PPI is the same, and that all PPI was completely useless and sold under dubious circumstances.

But our experience is very different. As we pointed out in our *annual review*, published last month, the proportion of complaints where we agree a policy was mis-sold ranges from 2% to 97% – depending on the type of policy and the business involved. Yes, 99% of the PPI cases we see are about the sale of policies. But each customer, and what happened to them, is unique – and we must reflect that in our how we resolve each complaint.

Unfortunately, this "common wisdom" about PPI can lead to confusion – and frustration – when we don't ultimately uphold a complaint that someone thought they were sure to "win".

from your experience, what are people particularly confused about?

There are three areas in particular where we're seeing some confusion. There are complaints about mortgage PPI (MPPI) and where the PPI was sold by a smaller business. And also complaints where the business has offered to pay compensation – but where the consumer is unhappy or unsure about the amount.

so taking MPPI first – is it really that different from PPI on a loan?

If you put a PPI policy and an MPPI policy side by side, you'd find a lot of similarities. But our approach looks beyond the small print. We look at the wider sales practices, the accompanying documentation, and what actually happened at the point of sale. Only then can we decide whether or not a business let their customer down.

... 99% of the PPI cases we see are about the sale of policies. But each customer, and what happened to them, is unique

Richard Thompson
lead ombudsman, PPI

Taking out a mortgage is probably the largest long-term financial commitment that many people take on in their lives. When you look at it like that, it's understandable why some homeowners might be attracted to the idea of protecting themselves against missing repayments if they became ill or lost their job. Perhaps more so for a mortgage than for many of the other credit products PPI might be sold with – say credit cards or smaller loans.

Many of the PPI complaints we see turn on whether the seller explained clearly how the policies worked. And when it comes to MPPI, we generally find that sellers provided better information and quality of advice than sellers of other forms of PPI.

is it just the quality of the advice that sets MPPI apart then?

Another difference is the cost. We often find MPPI policies offered better value – and were more flexible – than other types of PPI. But the affordability of the policy is just one aspect we look at when we're considering a PPI complaint.

does that mean you're unlikely to uphold a complaint about MPPI?

It's true that the overall uphold rate for MPPI is lower than for other forms of PPI. But just because we find MPPI policies *generally* represent better value for money – and are *generally* better-explained to customers – doesn't mean that things don't go wrong.

Where we do uphold an MPPI complaint, it's often because there were restrictions relating to self-employment or pre-existing medical conditions that limited the level of cover. And these restrictions weren't explained properly to consumers who *were* self-employed, or who *had* pre-existing medical conditions. This is an issue we see in complaints about other types of PPI.

We also see cases where consumers weren't told that the policy was optional – thinking instead that it was part and parcel of the mortgage. It's in circumstances like these that we tend to agree MPPI has been mis-sold.

what about PPI sold by smaller businesses?

Cases where PPI was sold by a smaller businesses can look quite different to those cases involving a large bank or insurer.

Take car finance, for example. Most PPI policies provide cover in the event of accident, sickness or unemployment. However, many PPI policies we've seen sold by car dealerships weren't "standard" PPI. Often, they had cover added, like life or critical illness insurance – or had cover removed, like protection for unemployment. This meant that these polices potentially offered a greater level of flexibility – to both consumers and sellers.

▶

is it just car finance policies that differ?

Though we do see quite a lot of PPI complaints involving car finance, we also see cases where PPI was sold alongside retail credit – for example, with a sofa or a TV. A main difference between these policies and "standard" PPI is the relative cost – and the benefits they could potentially provide.

Policies sold with retail credit are generally more expensive than other types of PPI – but that often reflects the higher level of benefits they offer if someone falls ill or loses their job. It's important we look carefully at the relative costs and benefits of a policy when we're considering whether it's likely a consumer would have taken it out.

what about complaints about compensation – is there more than one way to put things right?

Well, it's not always straightforward. For example, the consumer's wider financial situation can have a big impact on how compensation, or "redress", is paid. We see disputes involving a business's "right of set-off" – that is, whether they can use the compensation to reduce another debt the consumer has with them – and also about whether account fees and charges have been refunded.

and what about "comparative redress"?

Comparative redress is effectively paying someone the difference between the cost of the PPI premiums they actually paid, and the amount the business thinks they *should* have paid for a more suitable, but less expensive policy. It's sometimes also called "alternative redress".

So, for example, someone might have taken out a loan that had a "single premium" PPI policy sold with it – that is, where they paid the full cost of the policy upfront and then paid interest on it over the term of the loan. That can be a very expensive form of PPI.

When the business looks into a complaint about the sale of a single-premium PPI policy, they might accept that it was mis-sold. But the business might also conclude that the consumer still would have wanted cover for their loan. And that if the single-premium policy had been properly explained, the consumer would probably still have taken out PPI – but a policy with cheaper monthly payments instead. In these circumstances, the business might offer the consumer the difference in cost between the two policies.

do you get a lot of complaints about comparative redress?

Proportionally, the number of cases is quite small. But we know a lot of people are confused by comparative redress – and are asking us whether it's fair or not. So we expect that we'll start to see more complaints reaching us.

… and *is* it fair?

Businesses are entitled to offer comparative redress under the PPI complaint-handling rules set out by the regulator, the Financial Conduct Authority (FCA) – but only in specific circumstances. If someone thinks the business has got it wrong or they've been treated unfairly, they can talk to us and we'll look into what's happened – to make sure the outcome is fair on both sides.

… we know a lot of people are confused by comparative redress – and are asking us whether it's fair or not

what about the "right of set-off"?

The "right of set-off" means that if someone makes a successful PPI complaint, any compensation they're entitled to could be used to reduce another debt they have with the same business. Assessing whether or not this is fair can be complicated – though we do agree it's fair in certain circumstances.

there's been a lot of talk in the media about compensation for fees and charges – what's that all about?

The issue of fees and charges mostly crops up in complaints about PPI sold alongside credit card accounts. In these cases, our job is to decide whether, when calculating compensation, the business has taken into consideration any fees and charges the consumer incurred. And then whether those charges would have applied if the account hadn't had PPI.

If we decide fees or charges were incurred only because PPI was added to the account – and wouldn't have been charged if there had been no PPI in place – we generally tell the business to refund those charges as part of the overall redress package, paying interest where that's appropriate.

are you having to spend a lot of time addressing all this confusion?

As far as we can, we're trying to help businesses and claims management companies understand where we're coming from. And not just once we've formally stepped in to a complaint. Ideally, we don't want things to reach that point.

For the bigger firms that sold PPI – as well as the large claims management companies – that means having conversations as early and as often as possible. We share information about trends in the complaints we're receiving – including misunderstandings we've spotted that we think need clearing up.

It's about cooperating, and making sure our respective processes are running smoothly. When you consider the number of people involved in PPI complaints against larger businesses – and in those being handled by claims managers – it's clear why this is so important.

And we're here to support smaller businesses, too. As well as our online technical resource, our technical advice desk can answer any questions about our approach – or give guidance on tricky complaints that we're not yet involved in. It's available to consumer advisers and claims managers, too. We've also been explaining our approach face-to-face at practical workshops aimed specifically at smaller businesses who sold PPI.

So yes – we have been spending time working through issues. But if it means a customer gets an answer sooner, then it's time well spent – after all, that's beneficial for everyone involved. ✪

... that means having conversations as early and as often as possible

credit files and credit reference agencies

Although awareness of credit files has grown over the past few years – largely in the context of debt and financial difficulties – they remain something many people don't really think about. And yet credit ratings can have a huge impact on people's lives – affecting activities ranging from mortgage and loan applications, to taking out mobile phone contracts and credit cards.

Credit reports mostly operate in the background – away from people's day-to-day attention. So it's understandable that many consumers don't know how their credit report works or what's kept on it – and people often don't realise there's a problem until it's too late. It's only when trying to apply for some form of credit that they discover their credit rating is a stumbling block.

So the correct and responsible handling of credit files is very important – as incorrectly-recorded information or delays updating a file can have considerable knock-on effects.

We inevitably see complaints about the administration of credit files. For example, we see cases where a consumer has cancelled a subscription – sometimes after a free trial – only to find their request hasn't been processed, and they've ended up with a mark on their credit file.

However, in the case studies that follow we share some of the common, but less well-explored areas of confusion we see in complaints involving credit files. These range from problems with joint-accounts and payment plans – to consumers finding they can't get credit because of the information held about them.

Another area we look at is poor communication – or the absence of communication – between credit reference agencies and other financial businesses. This can sometimes lead to consumers being disadvantaged. And as the case studies show, the language of credit files and credit reference agencies is very important too – as many people struggle to understand the reasons behind what's happened with their credit files.

Financial Ombudsman Service

... Mr S wasn't sure what "delinquent" meant

case study 117/9

consumer complains that his credit report showed missed payments – when he had agreed a reduced payment plan with his bank

When Mr S found he was struggling to make the repayments on his loan, he phoned his bank and agreed a reduced repayment plan. Mr S made his monthly payments in line with this plan – without missing a payment.

A couple of years later, when Mr S's finances improved, he paid off his debts and applied for a mortgage. However, the mortgage provider told him he wasn't eligible for the best interest rate because his credit rating wasn't good enough.

Mr S went online and checked his credit report. He found that it showed missed payments – and his account was shown as "delinquent".

Mr S wasn't sure what "delinquent" meant in this context – and he was sure he hadn't missed any payments on his loan. So he phoned his bank to find out what was going on.

The bank told him that the information they had recorded on his credit report was accurate. But Mr S didn't agree, and complained. He pointed out that he had never missed a payment on his loan – and in fact, that he had agreed a reduced payment plan with the bank precisely because he wanted to avoid missing a payment. Mr S said he accepted that the reduced payment plan should appear on his credit report – but said the account shouldn't show as "delinquent".

The bank replied, saying that the information on Mr S's credit report was accurate – and that they hadn't done anything wrong. Unhappy with this response, Mr S got in touch with us.

complaint not upheld

When we spoke to the bank, they agreed that Mr S hadn't missed any payments on his reduced payment plan. So we needed to consider whether what the bank had reported to the credit reference agencies was accurate.

We asked Mr S to send us a copy of his full credit report. And we asked the bank to explain exactly what it had reported to the credit reference agencies.

The bank also sent us a copy of some guidance it had received from one of the credit reference agencies on how to report information. The guidance said that, even when a customer has agreed a reduced repayment plan, any arrears that accrue on the account must still be reported.

The bank's records showed that although Mr S hadn't missed a payment, arrears were building up on his account because he was making less than the full payment each month. The bank reported these arrears to the credit reference agencies and, when they added up to more than one full monthly payment, it showed as a "missed payment" on Mr S's credit file.

So we found that the bank *had* sent accurate information to the credit reference agencies – because they were reporting the arrears that were building up on Mr S's account. The credit reference agency that Mr S had requested his credit report from recorded arrears as "missed payments".

We also established that the credit reference agency recorded an account as "delinquent" when it had more than three months' worth of arrears on it. We could understand that this had been confusing for Mr S – but it wasn't anything to do with the way the bank had reported information about his account.

We rang Mr S to explain what had happened. He said he understood, and was happy to leave the complaint there. But he said he still thought the way his account had been described on his credit report was very confusing.

... the bank had told her that she wouldn't be affected by her husband's IVA

case study 117/10

consumer complains that bank recorded default on joint loan on her credit file – because her husband entered into an IVA

Mr and Mrs R had a joint loan. After they separated, both their names stayed on the loan – but Mr R stopped paying his contribution, and Mrs R made the full loan repayments herself.

Six months later, Mr R was struggling financially and entered into an Individual Voluntary Arrangement (IVA). Mrs R called her bank to find out whether her husband's IVA would affect her. The bank reassured Mrs R that as long as she continued to make the full loan repayments, her husband's IVA would not have any effect on her credit file. However, the bank went on to record a default on Mrs R's credit file in relation to the loan account.

When Mrs R found out what had happened, she complained to the bank. She pointed out that the bank had told her that she wouldn't be affected by her husband's IVA – and that nothing would show up on her credit file.

The bank accepted that they'd made a mistake when they told Mrs R that her credit file wouldn't be affected – and they offered her some compensation to make up for their mistake. But they said they'd acted correctly when they recorded the default on her credit file – and refused to remove the default on her account.

Mrs R complained again – saying that she thought the bank wasn't treating her fairly. When the bank turned down her complaint, she asked us to step in.

complaint upheld

We needed to establish whether the bank had acted fairly and reasonably when it recorded a default on Mrs R's credit file. The bank told us that they couldn't report different information for the individual holders of a joint account – and so it was their policy to record a default on the credit files of *both* account holders when one of them entered into an IVA. Because of this, the bank said that Mrs R's credit report *had* to show a default if her husband's credit file showed one.

We noted that Mrs R had made all the monthly payments on her loan. So we took the view that it wasn't fair for Mrs R to have a default recorded against her just because the bank had limited ways of recording information with the credit reference agencies.

In these circumstances, we told the bank to make sure they found a way of removing the default from Mrs R's credit file – and to pay her additional compensation for the trouble they had put her to.

... the person on the bank's helpline told Mr A not to worry

case study
117/11

consumer complains that bank failed to send his credit card statements – and registered information on his credit report when he missed his payments

In December Mr A received a letter from his bank saying that he had missed two monthly payments on his credit card – and that his account had gone into arrears. Mr A phoned the bank and explained that he hadn't received a statement for the last two months – so he hadn't known how much to pay.

The person on the bank's helpline told Mr A not to worry. They said he could make a payment straight away to clear the arrears, and that there would be no problem with his credit report. Mr A made a payment over the phone and brought the account back up to date.

But when Mr A tried to set up a new phone contract a few weeks later, he was told he'd failed the credit check. He looked at his credit report online – and was surprised and confused to see that the bank had recorded two "missed payment" markers on his credit file.

Mr A was unhappy with what the bank had done – and he made a complaint. He said he'd been told that there wouldn't be a problem with his credit file – and that it was unfair that the bank was blaming him when it was their fault he hadn't received his monthly statements. He pointed out that he had always paid his bill on time and had never missed any other payments. And he said he was concerned that he would struggle to get a mortgage or other credit in the future.

The bank responded to Mr A, saying they couldn't find any reason why he hadn't received his statements. They also said that the missed payment markers were "*a true and accurate reflection of the running of the account*". They accepted that they had got it wrong when they'd told Mr A that there wouldn't be any information recorded on his credit file about the missed payments – and they offered to pay him £200 compensation.

But Mr A still wasn't happy with this – and got in touch with us.

complaint resolved

The bank accepted that their adviser had incorrectly told Mr A that his credit report wouldn't be affected. But they felt the compensation they'd already offered him was reasonable.

We asked the bank for evidence that they had issued the statements – and sent them to the correct address. Looking at the records they sent us, we didn't see anything to suggest that the bank hadn't sent the statements.

However, we didn't find any reason to doubt Mr A when he said he hadn't actually received the statements. And looking at the history of Mr A's credit card account, we saw that he had never missed a payment before. So we decided it was possible there had been a problem with the post.

We took the view that if Mr A had received the statements, he would probably have made the payments. We also noted that he used his credit card regularly – and would have had a balance to pay off most months. Given this, we couldn't quite understand why Mr A was saying that the only reason he hadn't made the payments was because he hadn't received a statement.

We explained to Mr A that we didn't doubt that his statements hadn't arrived. But that we felt he still would have been aware of the need to make the payments. We were satisfied that the bank had passed on accurate information to the credit reference agencies. And because the bank hadn't made an error, we didn't ask them to remove the information relating to the missed payments.

However, as part of our investigation, we discussed with the bank the fact that the information on his credit file could affect Mr A's ability to get credit in the future. In the circumstances, they said they would remove the information as a gesture of goodwill.

case study 117/12

consumer complains bank has registered default on credit card account – when a reduced payment plan was in place

Over the summer, Miss L was having difficulties managing her credit card account. She frequently went over her credit limit and had missed a few payments – putting her account into arrears. By the autumn, she had brought her account up to date – but had recently gone over her credit limit again.

Recognising she was having some difficulty with her finances, Miss L contacted her bank to see whether they would accept a lower minimum payment for her credit card account. The bank agreed to Miss L's offer. Very shortly afterwards, however, the bank sent Miss L a default notice.

Unfortunately, Miss L had missed the first payment under the new arrangement. But she quickly caught up – and by early the next year her financial situation had improved enough for her to be able to clear the outstanding balance on the card. Once she had done this, she complained to the bank that the default notice had been unfair.

The bank told Miss L that they hadn't made an error. They said they had registered a payment plan – and when Miss L hadn't kept to it, the correct process to follow was to issue a default notice. Miss L didn't accept this explanation and brought the complaint to us.

complaint upheld

The bank told us that they considered the default was an accurate reflection of the way the account was run – so they wouldn't arrange to remove it.

We considered whether the bank had followed the Information Commissioner's Office (ICO) guidance about registering a default. We noted that if a creditor classes a consumer's offer as a "token" payment which they don't think is acceptable, they can apply a default immediately.

... it seemed the bank had acted as if Miss L had been making "token" payments

However, it was clear that the bank had accepted the amount Miss L had offered – and that an agreed temporary arrangement was in place. In these circumstances, the guidance said that a default could be issued if the account was three months or more in arrears.

The bank had issued the default immediately after Miss L missed her first payment under the arrangement she'd agreed with them. We noted that at this time, Miss L wasn't three months in arrears. Looking at the ICO's guidance, it seemed the bank had acted as if Miss L had been making "token" payments.

In our view, however, the amount Miss L had offered was too high to be considered a "token" payment. In any case, the bank had accepted Miss L's offer – and so they shouldn't have issued the default notice unless Miss L had been three months or more in arrears.

We considered whether the bank's relationship with Miss L had broken down. But we explained to the bank that we didn't think that it had. Miss L had kept the bank up to date with her situation and had offered a repayment plan – which we thought showed she wanted to cooperate and pay back what she owed. Likewise, the bank had shown it was willing to cooperate with Miss L by agreeing to the plan.

In the circumstances, we told the bank to remove the default from Miss L's account – making sure her credit file reflected what had actually happened, while still recording the fact a repayment plan had been put in place. We also recommended that the bank compensate Miss L for the upset their error had caused her, which they agreed to do.

case study
117/13

consumer complains that bank has recorded paid-off debt as "partially settled" – rather than "settled"

In early February, Mr C lost his job. He started to search for work – but it was taking longer to find something than he had hoped. He found himself falling deeper into arrears and missing payments on his credit card.

Worried about the consequences of missing payments, Mr C contacted his bank to see if he could pay a smaller sum each month towards his credit card balance. The bank seemed to appreciate Mr C's situation – and agreed, in the circumstances, to allow Mr C to make lower payments.

... we had to decide when the default should have been registered

Unfortunately, Mr C soon realised he wouldn't even be able to pay the reduced amount every month. So he contacted the bank again. This time, they agreed to give him three months to try and sort out his finances – and avoid his account defaulting. But Mr C was still unable to find a job – and so couldn't meet the payments he'd agreed to. After the three months passed, the bank suspended interest on the credit card account.

After six months, Mr C found a new job. Because there hadn't been any interest accruing on his debt, he was able to reduce the debt quite quickly. Then, following discussions with Mr C, the bank decided to accept 80% of the remaining debt in full and final settlement – and Mr C paid this amount.

However, the bank put a default marker on Mr C's credit file showing the debt as only "partially settled". Mr C thought this was unfair. He complained to the bank, saying that as the bank had agreed to accept less than the full amount, the marker should say "settled" instead. He also said the default should have been applied earlier – when the debt was greatest – so that it would "drop off" his credit file sooner.

However, the bank disagreed – and Mr C contacted us for help.

complaint partially upheld

First, we considered whether the credit marker should say "partially settled" or just "settled". We explained to Mr C that although his bank had agreed to accept less than the full debt to resolve the matter, this still meant they hadn't recouped all of the money they were owed. So we thought it was fair that a "partially settled" marker had been added to his credit file.

Next, we turned to the timing of the mark on Mr C's credit file. We were mindful that defaults stay on a credit file for six years – and can have a big impact on someone's chances of securing credit. When we looked into the sequence of events, we took the view that a default shouldn't have been added while Mr C was making the minimum payments he was contractually obliged to make.

So we had to decide when the default *should* have been registered. Looking at the account, we decided that the default should have been marked on Mr C's credit file when he failed to meet the terms of his repayment plan – at the point that the bank stopped applying interest to his debt. This was three months after he'd informed the bank of his situation and he'd been given time to sort out his finances.

We told the bank to back-date the marker on Mr C's credit file – to reflect more accurately exactly when he had defaulted on his payments. This meant that the default would "drop off" at the earlier time, and not disadvantage Mr C for longer than was fair. The bank agreed – and volunteered to pay Mr C £100 for the frustration and worry they had caused him.

... the broker said the lender had found there was some negative information on Mr J's credit file

case study 117/14

consumer complains mortgage offer has been withdrawn – because someone else's information has been wrongly recorded on his credit file

Mr J had been looking to move house, and approached a broker to help him find a mortgage. The broker arranged a "mortgage offer in principle" – and shortly afterwards, Mr J bought a house at an auction. However, when Mr J got in touch with his broker to let them know, he was told that particular mortgage offer was no longer available. The broker said this was because the lender had found there was some negative information on Mr J's credit file. The broker had managed to find another lender willing to lend to Mr J – but at a higher interest rate.

Mr J wasn't aware of any reason why any negative information would have been recorded on his credit file. But because he needed to pay for the house quickly, he didn't feel he could pursue the matter straight away – so he accepted the new offer.

Mr J then paid to look at his credit file to see what the problem could be. He was very surprised to find several defaults had been recorded – relating to various credit accounts and mortgages that he'd never taken out. He queried the information with the credit reference agency, who agreed to look into what had happened.

It turned out the credit reference agency had made a mistake. The information related to a *different* Mr J – but had been incorrectly recorded on Mr J's file. The credit reference agency apologised, and offered Mr J £1,500 to compensate for the trouble their error had caused.

However, Mr J didn't feel this was enough to make up for the inconvenience and stress of having to arrange a new mortgage in a rush. He made a complaint – but when the credit reference agency maintained they'd offered enough, the complaint was referred to us.

complaint not upheld

We asked to see details of both the original mortgage and the second one that the broker had found – and carefully compared them. We noted that both mortgages had been offered at a three-year "fixed" interest rate. The effect of the second mortgage's higher interest rate was that Mr J would pay just over £100 extra over the three years. We also noted that the second mortgage required Mr J to pay an arrangement fee – around £800 – whereas the first didn't.

Even if we applied interest at our usual rate of 8% to the payments Mr J had already made, the compensation offered by the credit reference agency was far more than the total of the fees Mr J had already paid together with the extra payments he would make over the next three years. Excluding the fees and extra payments, we felt the remainder of the compensation on offer was adequate.

We appreciated that losing a mortgage offer – and finding another at such short notice – had been very stressful for Mr J. But we explained to him that we thought the credit reference agency's offer was fair. We didn't uphold the complaint.

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Q? &A

featuring questions raised recently with our free, expert helpline for businesses and advice workers

I hear you're in the process of moving offices. What does that mean for old stocks of your consumer leaflet – and other documents – where your old address is mentioned?

Our main office at South Quay, East London – where we've been based for 15 years – is soon to be demolished to make way for a 73-storey tower dubbed "the Toothpick". We've had to find ourselves a new home – and we're now well underway with bringing our staff together under one roof just across the road. So this month, our registered address changed to:

Financial Ombudsman Service
Exchange Tower
London E14 9SR

But we're not expecting businesses to change everything in one go. We know these things can take time – we're going through exactly the same thing ourselves. So this is more about a gentle transition. Post addressed to our old building at South Quay Plaza will continue to be forwarded to our new building for the foreseeable future. And our phone numbers and email addresses won't be changing.

We know that a number of organisations have already chosen to update "easier" bits and pieces – and will update the rest when they carry out their regular internal review of their publications. This is also a good opportunity to make sure you're not calling us the "FOS" – as we know many customers find financial acronyms unwelcoming and confusing.

We've already updated our consumer leaflet, *your complaint and the ombudsman*, with our new address – as well as making it more visible and accessible. But there's no need for you for you to throw away older versions. With our long-term postal redirection in place, you have the breathing space to update your documents over a sensible period of time, and to use up your old stocks too.

But if you *would* like to start using our new consumer leaflet, you can order them online at:

www.financial-ombudsman.org.uk/publications/leaflet_ordering.htm

On a final note: as some of you will be aware – having first thought we'd be changing postcodes – we heard from Royal Mail very late in the day that we can keep our existing postcode, E14 9SR. This postcode is now permanently "attached" to the ombudsman – like a "PO-box". But please don't worry if you'd already made changes to show the *geographical* postcode for our new location at Exchange Tower (E14 9GE). *Both* postcodes will get mail to the right place. Going forward, though, it's probably best that you use E14 9SR.

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Q? &A

featuring questions raised recently with our free, expert helpline for businesses and advice workers

I heard you've changed your approach to compensation for distress and inconvenience. What does that mean for how my business handles complaints?

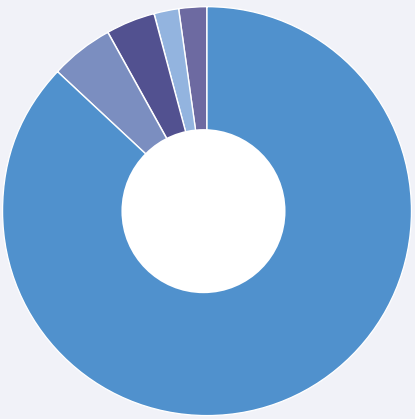
We've always said that addressing "non-financial loss" – the wider effect of a problem on that individual consumer – is as important a part of complaint-handling as making sure the consumer isn't out-of-pocket. Acknowledging and making up for the trouble and upset your customer has gone through because of your error can go a long way to restoring their trust in your business.

The way we consider this kind of non-financial impact hasn't changed – and neither have the rules, set by the regulator, that allow us to make awards for it. But we've reviewed the guidance we give on our approach – to make sure it reflects what fairness means today, in light of changing customer expectations and changing business practices. We regularly review all of our guidance – and rely on honest conversations with businesses and our other stakeholders to establish what's working and where more support is needed.

Distress and inconvenience have only ever been two of the types of non-financial loss we consider. Our updated guidance takes a practical look, with examples, at how to assess the bigger picture. That means making sure not to focus narrowly on "D and I" only – which we know can lead to an unsatisfactory outcome for both sides. Instead, it means thinking about that individual customer – in their individual circumstances – and addressing the very individual consequences the problem had for them.

complaints about payment protection insurance (PPI)

- **87%** banks
- **5%** insurance intermediaries
- **4%** building societies
- **2%** general insurers
- **2%** other



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