ombudsman **news**

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

made to be broken?

We're probably far enough into the new year that some resolutions are already a distant memory.

Of course, it's nice to have a fresh start. Setting ourselves targets – jogging before work or cutting out unhealthy habits – can motivate us, at least for a while.

But perhaps cold, dark January just isn't the best time to put in place punishing personal standards – or to cut out the comforts that can help cheer up the winter months.

Understanding the standards expected of financial businesses – and the impact on people's lives when they're not met – is central to our work at the ombudsman. In this issue, we look at situations where, because of their customers' particular needs, businesses have additional responsibilities.

As a service that's here to help everyone, we have these responsibilities too.

Problems created by rigidly-applied rules feature frequently in *ombudsman news*. And I think complaints involving equality issues highlight some of the worst things that can happen – from serious upset and inconvenience for consumers, to serious embarrassment and legal consequences for the businesses concerned.

Financial Ombudsman Service

scan for previous issues

in this issue

Caroline Wayman

For several reasons – for example, data protection – rules and procedures are a necessary part of providing financial services. They can also help to ensure that people are treated consistently and fairly. But they're very unlikely to bring about fairness if they can't be adapted to individual circumstances.

In many problems we step into – across the range of issues we cover – we identify a straightforward solution, which should have been clear to the business early on.

Yet because of concerns about "compliance" – or because they didn't know how to handle a sensitive situation – the business couldn't see the wood for the trees.

And instead of really listening to what their customer needed from them – and taking a pragmatic, human approach – they defaulted to "standard procedure".

Perhaps that's the trouble with new year's resolutions. They're made with good intentions – and can give us a useful sense of direction. But by focusing on prescriptive goals and routines, we risk overlooking simpler ways of making things better.

So this year, I think a positive resolution – for financial services, as well as more widely – would be to listen to each other a bit more. Because it's only if we listen – and understand where someone's coming from – that we can also understand how our actions could affect them, and find practical ways to help.

And finally, on the subject of listening, we started consulting publicly on our plans and budget earlier this month. We'd really like to hear what you think – so we can factor as many different views as possible into the work we do this year.

Caroline

... by focusing on prescriptive goals and routines, we risk overlooking simpler ways of making things better

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

follow us online

travel insurance – winter sports

Because of the range of holiday types and destinations, travel insurance policies are also wide-ranging. Winter sports cover is generally offered as an optional extra – recognising the often riskier nature of the activities involved.

But even if someone's paid extra for a specific sort of cover, they're still unlikely to be covered in *every* situation. Like the "standard" sections of an insurance policy, any winter sports "add on" will be subject to limitations and exclusions. And inevitably, this "small print" is at the centre of most of the complaints that reach us.

If their claim is rejected, consumers often tell us that they weren't told about the particular exclusion that the insurer is relying on – for example, liability for damage to hired sports equipment.

In these cases, we'll look into how the policy was sold – and what information was available to the consumer. If we find the information wasn't clear enough, we'll consider whether this had an impact on what the consumer did next.

In other cases, consumers don't necessarily think that their policy was mis-sold – but disagree with the insurer's decision that a certain exclusion should apply. For example, where a claim for medical fees has been made under winter sports cover, an insurer might say that someone should have chosen a public hospital, rather than a private one.

But – like any other type of insurance – a strict application of an exclusion can result in an unfair outcome. So we'll always look at the particular circumstances of what happened – including the urgency of the treatment, and what options were available to the consumer.

If we decide that a claim should be paid – because a policy was mis-sold or because an exclusion was unfairly applied – we'll tell the business responsible to put things right. This generally means paying the claim – adding interest – in line with the other policy terms.

Financial Ombudsman Service

... Mr and Mrs A told us they wouldn't risk skiing without cover

case study
123/1

consumer complains that medical claim has been rejected – because travel insurance doesn't have winter sports cover

Mr and Mrs A's home insurance was up for renewal. They'd heard their bank offered a packaged account that included home insurance, so they had a meeting in their local branch with an adviser.

When the adviser explained more about the home insurance that the account offered, Mr and Mrs A thought that it would cover everything they needed it to. They also thought the travel insurance that came with the account sounded like a good deal, as they took out a policy every year anyway. So they decided to take out the account.

When Mr and Mrs A went skiing later that year, Mr A had an accident – and needed treatment in hospital. But when the couple called the insurer to make a claim for Mr A's medical expenses, it was turned down. The insurer said that winter sports cover was an optional extra – which Mr and Mrs A didn't have.

Mr and Mrs A complained to the bank – saying that they were sure their policy included winter sports. But the bank said that it would have been clear when they took out the bank account that the winter sports cover cost extra. Frustrated, Mr and Mrs A contacted us.

complaint upheld

We needed to decide whether the bank had made sure the insurance was right for Mr and Mrs A. We also needed to know whether the bank had given Mr and Mrs A clear information about the account and its benefits.

We asked the bank for the records they had from the meeting between Mr and Mrs A and the adviser. The bank said that their adviser couldn't remember the details – but the brief customer notes we were sent showed that Mr and Mrs A had said that they went on holiday three times a year. So it was clear that their holiday habits had been discussed.

Mr and Mrs A told us they wouldn't risk skiing without cover. They said that they remembered the adviser telling them winter sports would be covered when they mentioned that they went skiing in France every year. They also showed us that their old travel insurance policy had winter sports cover. So it seemed likely to us that this was a feature they'd have wanted.

The bank said they'd sent Mr and Mrs A a welcome pack which said that the winter sports cover was optional. But they weren't given the pack in the meeting – it was sent a couple of months later. In our view, Mr and Mrs A should have been able to rely on the information they were given in the meeting – without needing to go through detailed documents at a much later date, after they'd already made their decision.

Based on Mr and Mrs A's history of buying insurance, we didn't think they would have gone skiing without it. We thought they would have still taken out the packaged account if they'd known the winter sports cover was extra – as both the home and travel insurance were potentially useful to them. And we thought they would have paid extra for the winter sports cover.

In all the circumstances, we decided that the bank hadn't given Mr and Mrs A clear information about the travel insurance policy included with the packaged bank account.

We told the bank to pay the claim – adding 8% interest, but deducting the cost of the extra winter sports cover that Mr and Mrs A would have bought if the information had been clear.

... the insurer refused to pay out – saying that they hadn't authorised the surgery

case study 123/2

consumer complains that travel insurer won't pay medical claim – as she wasn't covered for travel to the USA

On her second day skiing in the USA, Mrs R fell on the slopes and fractured her ankle. After a discussion with a local doctor, she had surgery at a hospital near to the ski resort.

A week later, when she was back in the UK, Mrs R contacted her travel insurer to claim back her medical costs. But the insurer refused to pay out – saying that they hadn't authorised the surgery.

Mrs R was confused. She explained that the hospital had told her that they'd contacted the insurer – and as the surgery had gone ahead, she'd assumed it had been authorised. The insurer agreed to review Mrs R's file – but in doing so, they found that her policy didn't cover the USA anyway.

At this point, Mrs R made a complaint. She told the insurer that she had several trips planned for that year – and was sure she'd taken out a policy that covered everything she'd planned to do. She said that if she'd known her operation wasn't covered, she would have returned to the UK to have it – and wouldn't have run up the medical costs.

However, when the insurer wouldn't change their mind, Mrs R asked for our help.

complaint upheld

We asked Mrs R how she'd taken out the policy – so we could better understand why she was saying she thought she was covered for travelling to the USA. She explained that she'd bought the policy on the insurer's website – and thought she'd ticked the right boxes to add "worldwide" and "winter sports" cover.

Mrs R sent us the confirmation email she'd received after buying the policy. In very small print, towards the bottom of the email, it said:

"*Destination: 24/7 Worldwide Exc USA/Can/ Caribbean – AMT* [annual multi-trip]".

We accepted that, on the face of it, the email said that travel to the USA wasn't covered. But we didn't think this information – full of abbreviations and acronyms – was clear enough. In our view, if it had been, Mrs R would have realised that she hadn't bought the cover she wanted. The fact she'd added winter sports cover strongly suggested that she'd intended to take out the right level of cover.

It seemed to us that there had just been a misunderstanding. If Mrs R had been given clearer information in the email – and noticed her mistake – the insurer could have quickly put things right by charging her the extra premium.

However, the insurer was also saying that they hadn't authorised the surgery – and wouldn't have paid for it anyway. So we needed to establish what Mrs R knew about this – and why she'd decided to go ahead.

We asked Mrs R what she remembered about what had happened. She explained that she'd been told by a local doctor that she could return home with a cast and be treated in the UK – or have the fracture "pinned" in the US before she left. She said the hospital had told her they'd contacted the insurer, which she thought meant it had been authorised.

We contacted the hospital and asked for their records of the conversations they'd had with the insurer. They told us that they didn't have recordings of any phone calls – but they sent us call notes made by the doctor who'd seen Mrs R.

The notes indicated that, after the first call to the insurer, the doctor had understood that the surgery had been authorised. They also showed that, in a second conversation, the doctor and the insurer had discussed the fees.

We didn't think the fees would have been discussed if the insurer hadn't said that Mrs R's operation had been authorised. We also didn't think the hospital would have treated Mrs R if they'd had concerns that the insurer wouldn't pay them.

In our view, the evidence strongly suggested that the hospital had believed that the insurer had authorised Mrs R's surgery – and that she had gone ahead on that basis. Mrs R had been given the option of returning home – where she would have been treated for free. We didn't think she would have had the surgery in the USA if she'd known she wasn't covered.

In all the circumstances, we decided the insurer had unfairly rejected Mrs R's claim. We told them to pay it as if she'd bought the right level of cover – adding 8% interest.

... we didn't think she would have had the surgery in the USA if she'd known she wasn't covered

case study 123/3

consumer complains that insurer has rejected claim for private medical fees after breaking leg on skiing holiday

While Mr and Mrs J were skiing in Italy, Mrs J fell and broke her leg – and was admitted to the local state hospital.

The doctor assessing Mrs J told her that she'd need an operation as soon as possible. Because the hospital had a long waiting list, and was running a reduced service over the Easter holidays, he recommended that she be transferred to a private hospital.

While Mrs J was being seen by the doctor, Mr J phoned their travel insurer to tell them what had happened – and to check what treatment would be covered by the policy. The person he spoke to said that they couldn't say – because claims would only be dealt with once the insurer had received the medical records.

... the doctor assessing Mrs J told her that she'd need an operation as soon as possible

Based on the doctor's advice, Mrs J decided to go to a local private hospital for surgery – and Mr J arranged for the hospital to email the doctor's records to the insurer. By the time the insurer emailed back to say they weren't prepared to pay – because they didn't cover private treatment – the surgery was already underway.

Mr J paid Mrs J's medical fees on a credit card. But once they were back in the UK, the couple complained to the insurer. They explained that they would have had the treatment on the Italian state health system. But they'd been told that the treatment was urgent – and they'd been very worried about the consequences of delaying it.

However, the insurer wouldn't change their position – and Mr and Mrs J contacted us.

complaint upheld

The insurer told us that Mr and Mrs J's policy clearly excluded private medical treatment. They said that they expected their customers to take a European Health Insurance Card (EHIC) – allowing them to get lower-cost or free treatment – and to use public hospitals.

We asked the insurer for a copy of the terms and conditions of Mr and Mrs J's policy booklet. The section they were using to turn down the claim was "*Reciprocal Health Care Agreements*", which said:

"*If you are travelling to countries within the European Union (except for the UK), we strongly recommend you take an EHIC card and make sure that any medical treatment is provided at hospitals or by doctors working within the terms of the reciprocal healthcare agreement. If you are admitted to a private clinic you may be transferred to a public hospital as soon as the transfer can be arranged safely.*"

In other circumstances, this wording might have meant that a claim for private medical fees wasn't covered. However, we didn't think Mr and Mrs J's situation was as clear cut as the insurer was saying.

Mr and Mrs J gave us a copy of Mrs J's medical records, which they'd asked the hospital to send them. These confirmed that the doctor had advised Mrs J that she needed treatment urgently. According to the records, she would otherwise be at risk of deep-vein thrombosis and long-term damage to her leg.

The records also confirmed that the doctor had recommended that, because of the Easter holidays, the only way Mrs J could have the surgery within the next week was if she went to a private hospital.

Mr and Mrs J told us that they had EHIC cards. We didn't think there was any reason to doubt – if the situation had been different – that Mrs J would have had treatment on the Italian state system. But given the advice she had received about the risks of delaying the surgery, we could understand why she'd decided to use a private hospital.

The insurer told us that, in their view, if the surgery had really been urgent, the state hospital could have treated Mrs J sooner. But they couldn't provide any medical evidence to show that the surgery *wasn't* urgent. And in our view – in a hospital away from home and under a lot of stress – Mr and Mrs J hadn't been in a position to question the doctor's assessment.

In all the circumstances, we decided that the insurer had unfairly turned down Mr and Mrs J's claim. We told them to pay Mrs J's medical fees – adding 8% interest.

case study 123/4

consumer complains that travel insurance claim has been rejected – because policy excludes use of motorised vehicles

While Mr K was skiing in Canada, he took a few days off to try some other activities. On the second day, he rented a snowmobile – but lost control and collided with a tree. Although Mr K wasn't badly hurt, the snowmobile was damaged – and he had to pay the rental company for the repairs.

A few days later – once he was back in the UK – Mr K phoned his travel insurer to explain what had happened. But the person on the insurer's helpline said that while Mr K's policy covered some "personal liabilities", it excluded claims arising from the use of "motorised vehicles". So they wouldn't refund the money he'd paid out for the repairs to the snowmobile.

Unhappy with this response, Mr K complained to his bank – who he'd bought the policy from. He said that he'd paid extra for winter sports cover – and expected to be covered for all winter sports.

The bank told Mr K that as none of their staff had spoken to him about the policy, they didn't feel they'd done anything wrong – but that he could complain to the insurance company if he wasn't happy with their decision. When he contacted the insurer again, they said that the policy documents clearly set out what they weren't prepared to cover – and so they weren't willing to change their mind.

Frustrated – and still unsure which business was responsible – Mr K contacted us.

complaint not upheld

We asked Mr K how he'd bought the insurance. He said he'd picked up an application form in a branch of his bank on his way out. He said he didn't really have a problem with anything the bank had done – but he was angry that no one had let him know about the exclusion.

To see whether Mr K had been given clear information about what the policy covered, we asked the travel insurer to send us a copy of policy documents that he'd been sent.

From the paperwork, we saw snowmobiling was listed under the winter sports that the policy covered. But next to the word "snowmobiling", there was an asterisk. And directly underneath the list of sports – on the same page – was a note saying that the policy's "personal liability" cover excluded claims arising from the use of "*any form of motorised vehicle*". In our view, this exclusion was clearly set out. We thought that Mr K must have just overlooked it.

We explained to Mr K that his policy would have covered his medical fees if he'd been hurt in the accident. But we took the view that the policy wording was clear that the cost of the damage to the snowmobile – his "personal liability" – wasn't covered.

We also explained that, based on the cases we see, we didn't think this sort of exclusion was unusual in travel insurance policies. So in our view, the insurer could rely on the exclusion to turn down the claim – even though it hadn't been specifically highlighted.

Mr K said, on reflection, he was glad he hadn't needed to make a medical claim. He was disappointed – but said he'd double-check his insurance next time he was planning a trip.

... it excluded claims arising from the use of "motorised vehicles"

... we decided that it was more likely than not that Mr E hadn't been told about the policy limit

case study 123/5

consumer complains that travel insurer has rejected claim for cancelled course fees and flights

As part of his gap year, Mr E booked a three-month winter sports trip. A few weeks in – while he was snowboarding in New Zealand – he badly injured his ankle and was advised to rest it for several weeks.

Mr E's schedule was tight – and he was due to start a skiing course in Canada the following week. Realising that his ankle wouldn't be healed in time, he called his travel insurer to see if he'd be covered for the cost of cancelling the course. He also wanted to cancel his flight to Canada, and from Canada back to the UK.

Following the phone call, Mr E contacted the course provider in Canada to cancel his place, booked new air tickets and returned to the UK.

When Mr E later made a claim, the insurer offered him £2,000. Disappointed, Mr E explained to the insurer that the cost of the course alone was £6,000 – aside from the cost of the flights. But the insurer explained that the policy limit was £2,000 – and was clearly set out in the policy booklet Mr E had been sent.

Mr E made a complaint. He said that he'd been told when he phoned the insurer from New Zealand that all his costs would be met. He said that if he'd been told about the limit, he wouldn't have cancelled his plans – and would instead have arranged for his brother to take his place on the snowboarding course, and to use the homeward flight from Canada.

However, the insurer refused to increase their offer – and Mr E asked us to step in.

complaint upheld

We asked the insurer for the recording of the call Mr E had made to them from New Zealand. But they told us that the call hadn't been recorded because of a "technical error". We explained that, without any clear evidence about what Mr E was told, we'd make our decision based on what we thought was most likely to have happened.

We asked the insurer for their records of Mr E's complaint – and looked carefully at what Mr E had said about what he'd been told by the insurer. In our view, the accounts he'd given of the conversations he'd had were detailed and consistent. They were also consistent with the account he'd given us.

Mr E told us that his brother was also on a gap year, and could have easily flown out to Canada to take his place on the course. We contacted the ski school to find out whether they'd have accepted Mr E's brother instead of Mr E – and they confirmed that they would have. We also confirmed with the airline that Mr E's ticket was transferrable – or could have been used later in the year.

Taking all these facts together, we decided that it was more likely than not that Mr E hadn't been told about the policy limit. We thought that if he had been told – given there were other options available – he wouldn't have cancelled either the course or the flights, running up costs over £2,000.

We accepted that, because of the short timeframe, Mr E's brother wouldn't have got to Canada before the course began. We estimated he would have missed the first half of it – so we thought it was fair to tell the insurer to pay half the course fees.

We also told the insurer to cover the full costs of the cancelled flights, which Mr E could have used or transferred if he'd known about the policy limit. We said 8% interest should be added to the money Mr E was owed.

case study 123/6

consumer complains that insurer has rejected claim for UK medical costs – after skiing accident abroad

Miss L was skiing with her sister in Canada when she fell and badly hurt her back. She was taken by snow cat back to the resort, where she was seen by a doctor. On the doctor's advice, she received treatment at a Canadian hospital.

When Miss L was back in the UK, she saw a consultant at her local private hospital – who recommended a course of treatment. Miss L had travel insurance with winter sports cover – and phoned the insurer to explain what had happened. Following this conversation, she arranged further consultant's appointments, scans and physiotherapy relating to her back injury.

When Miss L claimed for her medical costs, the insurer agreed to pay for the treatment she'd had in Canada – as well as what she'd had back home. But although the insurer said they'd pay for her physiotherapy in the UK, they refused to pay the consultant's and scan fees – saying that their policies didn't include "specialist treatment" in the UK.

Miss L thought this was unfair – and made a complaint. She said that she remembered listing the treatment she wanted to have when she phoned the insurer. And she remembered the person she spoke to telling her that her claim would be paid.

However, the insurer wouldn't change their position – and Miss L asked us to step in.

complaint upheld

We asked the insurer for a copy of the terms and conditions of Miss L's policy. Under the heading "*What you are not covered for*", the policy listed "*treatments you receive within Great Britain except for claims payable under Section 14*". Section 14 was "*physiotherapy*".

... she was taken by snow cat back to the resort, where she was seen by a doctor

... it was reasonable that Miss L had relied on what the insurer had told her

Based on this, it looked like part of Miss L's claim was excluded. But we needed to establish what she'd been told about her claim – and whether the insurer could have warned her earlier on that they wouldn't pay for specialist treatment once she was home.

We asked for the insurer's records of all the contact they'd had with Miss L. We saw that the day after her accident, Miss L had sent the insurer an email – explaining that: "*I may need to have a scan and see a specialist – depending on how I recover over the next week*".

It wasn't clear from this email that this specialist treatment would happen once Miss L was back home. So we didn't think the insurer hadn't done anything wrong by not mentioning the policy's exclusions at that stage.

But we also listened to the phone call between Miss L and the insurer – which happened around a month after her accident. In this call, Miss L explained that she was now back home – and went on to ask whether she'd be covered for various specific treatments.

At one point, she asked:

"*But what about the specialist appointment?*"

The insurer asked if the appointments were related to Miss L's skiing injury. When she said yes, she was told:

"*As long as you have the paperwork, that's something we can definitely look at for you ... and we'll have the claim to you shortly.*"

Miss L had clearly been concerned to know exactly what was and wasn't covered. And she'd mentioned the particular treatment she had planned. We thought the insurer should have told her during the call that some of these costs wouldn't be covered. In our view, it was reasonable that Miss L had relied on what the insurer had told her.

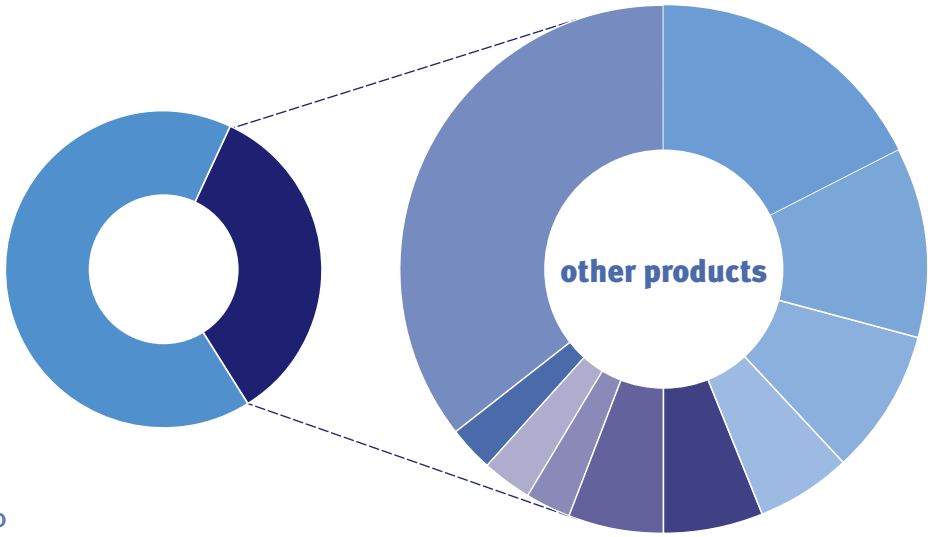
We thought it was unlikely that Miss L would have gone ahead with the private specialist treatment if she'd known she'd have to pay for it. In the circumstances, we decided that the insurer should pay Miss L's claim, adding interest.

However, we saw that Miss L had already run up the cost of a consultant's appointment before phoning the insurer to check whether she was covered. We thought she could have contacted the insurer before this appointment. So we only asked the insurer to cover the cost the treatment that Miss L had received *after* the phone call.

the financial products that consumers complained about most to the ombudsman service in October, November and December 2014

- payment protection insurance (PPI) 66%
- complaints about other products 34%

- packaged bank accounts 6%
- current accounts 4%
- house mortgages 3%
- credit card accounts 2%
- car and motorcycle insurance 2%
- overdrafts and loans 2%
- buildings insurance 1%
- mortgage endowments 1%
- term assurance 1%
- complaints about other products 12%



enquiries: these are problems where consumers have asked us for help, reassurance and explanations.
cases: these are complaints that need more detailed further work by our adjudicators.
ombudsman: these are cases where either the business or consumer has appealed to the ombudsman for a final decision.

	so far this year April – December 2014			
	enquiries received	new cases	ombudsman	% of cases upheld
payment protection insurance (PPI)	209,702	161,266	16,602	59%
current accounts	22,739	9,615	1,269	36%
car and motorcycle insurance	18,226	5,306	1,163	34%
packaged bank accounts	16,705	11,444	244	42%
credit broking	16,358	816	163	64%
house mortgages	14,305	8,873	2,209	33%
credit card accounts	11,276	5,884	951	32%
overdrafts and loans	8,298	4,369	955	38%
buildings insurance	6,698	3,339	703	37%
mortgage endowments	3,915	1,886	358	24%
hire purchase	3,454	1,271	291	39%

ombudsman focus: **third quarter statistics**

A snapshot of the work we have done during the *third quarter* of the 2014/2015 financial year.

We regularly publish updates in *ombudsman news* about the financial products people have complained about – and what proportion of those products we have upheld in favour of consumers.

In this issue of *ombudsman news* we focus on data for the third quarter of the financial year 2014/2015 – showing how many enquiries and new complaints we received, the numbers of complaints passed to an ombudsman for a final decision and what proportion we resolved in favour of consumers.

During October, November and December 2014:

- **Consumers referred a total of 74,357 new complaints about financial businesses – of which 48,516 were complaints about payment protection insurance (PPI).**
- **The ombudsman received around 4,000 new PPI complaints each week. Bank accounts and mortgages were the next most complained about financial products.**
- **During the quarter the proportion of complaints we upheld in favour of consumers ranged between 85% (for card protection insurance complaints) and 3% (for complaints about state earnings-related pensions (SERPs)). The PPI uphold rate for the year to date is 59%.**

in the third quarter October – December 2014				in the whole of 2013/14			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
61,611	48,516	4,903	64%	533,908	399,939	14,904	65%
6,620	2,891	411	36%	33,411	13,676	2,255	33%
5,356	1,532	332	35%	27,425	7,190	1,136	38%
6,895	4,186	134	39%	7,403	5,668	94	77%
4,839	303	51	65%	6,376	649	256	56%
3,791	2,529	792	33%	22,125	12,598	2,795	29%
3,009	1,630	323	31%	20,446	10,120	1,622	30%
2,442	1,315	318	37%	13,381	6,306	1,661	35%
1,844	855	256	36%	10,340	4,095	901	44%
993	480	102	24%	7,531	3,573	861	28%
1,090	444	88	41%	4,260	1,511	368	42%

	so far this year April – December 2014			
	enquiries received	new cases	ombudsman	% of cases upheld
payday loans	3,333	635	151	66%
travel insurance	3,139	1,598	304	45%
"point of sale" loans	2,729	1,076	252	38%
deposit and savings accounts	2,580	1,411	268	38%
term assurance	2,531	2,006	375	21%
debt collecting	2,508	639	71	32%
personal pensions	2,288	888	261	27%
contents insurance	2,287	1,034	206	34%
card protection insurance	2,224	1,094	27	87%
whole-of-life policies	1,963	1,168	253	24%
inter-bank transfers	1,839	889	125	46%
debit and cash cards	1,744	738	119	42%
catalogue shopping	1,616	644	65	57%
warranties	1,615	536	60	40%
electronic money	1,549	364	42	43%
secured loans	1,354	768	161	36%
home emergency cover	1,337	830	158	39%
income protection	1,218	817	185	36%
portfolio management	1,212	862	407	50%
commercial vehicle insurance	1,164	353	86	37%
mobile phone insurance	1,131	386	37	50%
pet and livestock insurance	1,123	529	85	29%
debt adjusting	1,117	364	82	65%
investment ISAs	1,091	692	171	43%
cash ISA – individual savings account	998	564	60	46%
self-invested personal pensions (SIPPs)	968	634	403	57%
roadside assistance	957	510	74	38%
critical illness insurance	947	590	115	23%
share dealings	900	466	143	35%
direct debits and standing orders	882	387	62	44%
store cards	810	313	47	33%

in the third quarter October – December 2014				in the whole of 2013/14			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
1,229	245	40	69%	5,378	794	128	63%
925	499	94	43%	4,574	2,247	563	53%
830	323	86	36%	3,658	1,418	295	38%
717	429	88	37%	4,714	2,515	737	41%
601	543	129	24%	4,836	3,426	767	19%
795	268	29	34%	3,088	557	68	39%
624	248	88	33%	3,432	1,320	471	31%
690	312	72	33%	3,968	1,771	392	39%
507	265	14	85%	2,180	1,118	38	77%
550	357	81	25%	3,135	1,808	453	21%
626	299	43	47%	2,113	952	199	36%
488	203	43	44%	2,719	1,177	221	41%
463	173	27	59%	2,411	792	114	56%
511	170	18	34%	2,368	754	93	48%
486	106	16	40%	1,899	435	43	32%
361	212	49	31%	1,874	1,053	248	32%
408	182	57	42%	2,637	1,387	163	49%
334	237	66	34%	2,175	1,421	385	30%
369	266	138	51%	1,653	1,166	457	61%
333	88	30	42%	1,799	561	112	41%
352	127	6	50%	1,681	551	92	69%
359	155	12	26%	1,537	720	123	31%
282	106	17	66%	1,458	530	185	74%
331	250	53	41%	1,385	929	243	43%
236	160	22	48%	1,448	842	94	45%
247	157	154	59%	1,480	969	255	63%
310	198	15	31%	1,288	668	97	43%
278	210	35	20%	1,470	906	301	26%
246	123	36	46%	1,449	694	203	36%
279	108	18	39%	1,285	534	104	41%
250	90	11	38%	1,105	466	79	45%

**This table shows all financial products and services where we received (and settled) at least 30 cases. This is consistent with the approach we take on publishing complaints data relating to named individual businesses. Where financial products are shown with a double asterisk, we received fewer than 30 cases during the relevant period.

	so far this year April – December 2014			
	enquiries received	new cases	ombudsman	% of cases upheld
private medical and dental insurance	808	541	153	36%
legal expenses insurance	784	489	291	33%
cheques and drafts	777	419	74	50%
annuities	767	553	109	21%
specialist insurance	751	319	32	51%
commercial property insurance	735	477	141	37%
hiring/leasing/renting	621	223	47	33%
merchant acquiring	621	256	61	20%
credit reference agency	559	127	20	33%
endowment savings plans	512	387	93	18%
guaranteed bonds	454	287	37	15%
personal accident insurance	442	301	81	30%
occupational pension transfers and opt outs	411	306	146	51%
business protection insurance	402	180	44	35%
“with-profits” bonds	358	195	41	32%
state earnings-related pension (SERPs)	352	303	15	2%
interest rate hedge	320	185	69	69%
building warranties	318	241	104	61%
guaranteed asset protection (“gap” insurance)	310	164	28	23%
conditional sale	237	186	62	43%
(non-regulated) guaranteed bonds	227	121	25	33%
caravan insurance	219	77	18	35%
money remittance	206	103	8	50%
home credit	188	96	18	33%
derivatives	149	131	45	24%
free standing additional voluntary contributions (FSAVC)	142	110	43	44%
film partnerships	134	107	161	7%
income drawdowns	130	141	67	41%
investment trusts	123	61	15	27%
open-ended investment companies (OEICs)	118	91	71	46%

in the third quarter October – December 2014				in the whole of 2013/14			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
231	146	38	34%	1,629	988	294	40%
219	128	172	33%	1,218	691	229	42%
199	129	19	57%	1,242	569	131	45%
174	150	40	25%	912	601	157	32%
237	91	7	48%	1,456	406	55	59%
190	121	45	32%	1,173	740	215	43%
195	71	12	38%	907	291	51	35%
182	81	21	21%	912	352	72	19%
174	57	10	26%	629	131	26	39%
113	102	31	17%	962	655	179	19%
197	129	14	18%	579	419	82	22%
102	77	22	33%	760	477	136	31%
89	101	40	53%	627	428	162	44%
119	65	13	35%	597	274	57	38%
126	80	8	28%	493	304	86	30%
84	78	5	3%	621	527	33	2%
111	82	9	51%	297	135	121	80%
102	87	16	34%	516	384	87	64%
73	39	11	21%	540	247	28	25%
49	34	21	46%	317	225	69	44%
77	40	4	31%	270	122	30	34%
57	**	5	**	256	81	18	34%
61	**	3	**	308	117	15	46%
56	**	3	**	270	138	29	33%
47	**	15	**	134	81	33	25%
29	**	10	**	303	172	38	38%
51	39	44	3%	224	201	34	18%
21	**	13	**	224	169	103	49%
45	**	4	**	–	**	–	**
25	**	13	**	256	219	72	32%

	so far this year April – December 2014			
	enquiries received	new cases	ombudsman	% of cases upheld
premium bonds	114	46	11	31%
spread betting	113	61	34	19%
unit trusts	108	52	28	49%
foreign currency	108	46	8	38%
pensions mortgages	96	69	31	41%
safe custody	85	64	24	51%
savings certificates/bonds	81	35	8	37%
personal equity plans (PEP)	75	46	10	14%
structured capital at risk products (SCARPs)	55	40	21	26%
children's savings plans	53	37	1	37%
sub total	396,849	246,002	32,287	53%
other products and services	58,209	402	115	40%
total	**455,058**	**246,404**	**32,402**	**53%**

in the third quarter October – December 2014				in the whole of 2013/14			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
25	**	3	**	124	55	13	36%
27	**	10	**	183	126	71	49%
36	**	7	**	139	109	40	34%
37	**	2	**	191	94	20	31%
26	**	13	**	155	95	29	54%
21	**	4	**	165	105	36	57%
21	**	1	**	–	**	–	**
20	**	3	**	–	**	–	**
19	**	3	**	–	**	–	**
11	**	**	**	–	**	–	**
117,468	73,856	10,047	57%	783,792	511,420	38,083	58%
22,544	501	76	41%	78,474	747	314	24%
140,012	**74,357**	**10,123**	**57%**	**863,266**	**512,167**	**38,397**	**58%**

making reasonable adjustments – and meeting particular needs

Every year we hear from large numbers of people who feel they've been treated unfairly by a business that hasn't adapted its services to meet their individual needs.

Where a customer's request relates to one or more so called "protected characteristics", businesses have a duty under law to make reasonable adjustments to remove barriers to using their services. These "protected characteristics" – which include race, disability and sexual orientation – are set out in the Equality Act 2010, which brought together previously separate legislation relating to different types of discrimination.

But consumers rarely articulate their complaint as "discrimination" – or invoke the Equality Act. More often than not, they're simply frustrated at being unable to access the services they want or need to – and feel that the business's processes are unnecessarily inflexible and impersonal.

As financial services are delivered across a growing number of channels – and services are increasingly "personalised" – it can be particularly upsetting to be faced with systems and procedures that apparently can't be tailored.

The Equality Act places an additional, legal onus on businesses to meet their customers' needs. But businesses are required to treat all their customers fairly – regardless of whether they have a "protected characteristic". In our view, responding to customers' reasonable requests – and delivering services in ways that are accessible to everyone – is just a question of good customer service.

In many cases we're asked to step into, the business is aware of its legal obligations – but has overlooked a simple, pragmatic solution. All too often, the practical steps we suggest could have been put in place much sooner – avoiding unnecessary delays, frustration and inconvenience for the consumer.

These case studies highlight the range of complaints we receive – and the ways we help move things forward.

Financial Ombudsman Service

... without online banking to transfer money, she also couldn't top up her bank account

case study
123/7

consumer complains that bank has failed to make reasonable adjustments – so she can't access online banking

Following an illness, Ms S lost her hearing and had problems with mobility. She went about her day-to-day activities with the help of a support worker – but was finding it increasingly difficult to leave the house herself. To help her manage her finances without visiting her nearest bank branch, she decided to start using online banking.

Ms S followed the steps on the bank's website to set up her account. But at the final stage, the bank said she'd need to authorise the process by phone. She used the bank's webchat option to ask if she could authorise her account by text or email instead – explaining that she was deaf, so she couldn't use the phone. But the webchat adviser said that she couldn't, as it wasn't "*in line with the bank's security procedures*".

That week, Ms S's card was swallowed by a faulty cash machine in the small corner shop near to her house. The same afternoon, she sent the bank a letter to tell them what had happened. But she didn't get a new card until nearly three weeks later.

Although Ms S was able to pay for her shopping without a card – as she kept money at home for her support workers to use – she grew increasingly worried as her cash ran out. And without online banking to transfer money, she also couldn't top up her bank account. Because of this, several of her direct debits bounced and the bank applied charges to her account.

Ms S didn't think it was her fault that she couldn't access her account. She sent the bank an email, complaining that the charges were unfair – and that she was being treated unfairly because of her disability.

When the bank responded a week later, they apologised for the inconvenience they'd caused Ms S – and said they'd remove all the bank charges. They also set out some other ways that Ms S could authorise online banking.

But Ms S didn't think any of the options would work for her. She replied to the bank, explaining that she didn't have a landline to use TextTalk – and she didn't use British Sign Language. And although the bank had suggested giving Ms S's support worker access to her account, she said that she wasn't comfortable doing that – as she saw several different support workers.

When the bank wrote back asking Ms S to phone the complaint handler – which she'd already explained she couldn't do – she asked us to step in, saying she felt like she was going round in circles.

complaint upheld

We asked to see the bank's records of their contact with Ms S. These confirmed that she'd told them she couldn't use the phone – and that this had been clearly flagged on their system.

We asked the bank about their online banking facility – and whether there was any way someone could set it up without using the phone. They told us that if someone didn't answer the authorisation call, then an activation code would be sent through the post automatically.

It seemed to us that the bank had failed to tell Ms S that there was a more straightforward way she could authorise her online banking – which didn't even involve them making any adjustments. We pointed out to the bank that if they'd told Ms S about this, the problem probably wouldn't have arisen in the first place.

Looking at the bank's response to Ms S's complaint, it was clear that they knew about their responsibility to make reasonable adjustments. And they'd accepted that they'd taken too long to send her a new card.

But although they'd refunded the charges, the bank hadn't recognised the unnecessary worry, inconvenience and stress Ms S had experienced while she waited for the new card. They also hadn't acknowledged the frustration they'd caused by suggesting she should phone them – when she'd repeatedly explained to them why she couldn't.

She'd also had the worry of not knowing when she'd be able to top up her bank account – and how long she'd have to make her cash last.

In our view, the bank hadn't fully appreciated the significant impact of their actions on Ms S. In all the circumstances, we told them to pay her £500 – to recognise the unnecessary upset and inconvenience they'd caused her.

... the adviser said they didn't know how to move things forward – and neither did Mr O

case study 123/8

consumer complains that bank won't provide internet banking login details in a suitable format

Mr O was registered as partially sighted – and managed his finances online using screen-reading software. After he upgraded his computer's operating system, he found that the login details he'd asked his bank's website to "remember" had been deleted – so he couldn't access his account.

When Mr O phoned the bank's helpline, he was told he'd be sent a new access code by post. Mr O explained that any correspondence the bank sent would need to be in a large, dark font – otherwise he wouldn't be able to read it. The helpline adviser confirmed that the bank could do this, and that Mr O should receive the code within five working days.

When the post arrived two days later, Mr O found that the bank hadn't adjusted their letter at all. When he phoned the bank's helpline again, they apologised and said they'd issue another code the same day.

The second time round, the bank had adjusted the font of the covering letter. But the access code itself was printed on a plastic panel – and was too small and light for Mr O to read.

Growing increasingly frustrated, Mr O rang the helpline again to complain. The adviser told him that the code had to be printed in exactly that way on the plastic panel. They offered to text an access code to Mr O – but he explained that text messages were also too small for him to read.

The adviser then suggested that Mr O ask someone to read the code to him. Mr O said he was surprised to be told that – because as he understood it, he would then be liable for any fraud on his account.

The adviser said they didn't know how to move things forward – and neither did Mr O. He told the bank that he felt they were discriminating against their blind and partially-sighted customers. He then contacted us – asking if we could make the bank change their system.

complaint resolved

When we contacted the bank about Mr O's situation, they told us that they knew they'd given him very poor customer service. They said that he'd always had the option to manage his account by phone – but they accepted that he should have the choice to use online banking, as he'd been doing for some years.

We reminded the bank that – aside from offering a choice – they had an obligation to make reasonable adjustments to meet their customers' particular needs.

During our involvement, the bank said they could send Mr O the access code on a CD. They offered him £250 to cover the cost of the unnecessary phone calls, and to compensate him for the frustration and inconvenience he'd experienced. The bank also said that – following a review of their processes – they were planning to offer audio format to all their blind and partially-sighted customers.

Mr O accepted the bank's offer – and said he was pleased that his complaint would make a difference to other customers.

... he couldn't speak on the phone as his stroke had affected his speech

case study
123/9

consumer complains that mortgage company won't discuss arrears in writing – and is insisting on phone contact

A few years into his mortgage, Mr G had a stroke and was registered as disabled. As he could no longer work, his income fell considerably – and he missed several months' repayments. But once he began to receive welfare payments, he arranged with the mortgage company to pay an extra £50 a month to make up the money he hadn't paid.

Every six months, the mortgage company reviewed the arrangement – and asked Mr G to let them know if he wanted to extend it. So every six months, Mr G wrote back to the mortgage company to say that he did.

The arrangement had been in place for a couple of years when Mr G received a different letter from the mortgage company. This said that he needed to phone them about his arrears – and that they were applying a £30 charge.

Mr G was confused by this – but wrote back to remind the mortgage company about his arrangement. He also explained that he couldn't speak on the phone as his stroke had affected his speech – so he needed to deal with things in writing.

But a couple of weeks later, Mr G received the same automated letter – again telling him that he needed to call the mortgage company. He sent a letter back – asking the company to write to him.

When the mortgage company still didn't respond, Mr G made a complaint. This time, the mortgage company replied. They said that if Mr G wanted to continue with his repayment arrangement, they would need to have a "discussion" about his income and expenditure. The letter then gave the number of the team he'd need to call.

Frustrated – and worried about the charges being applied to his account – Mr G contacted us. He said that he felt discriminated against – and didn't see why a "discussion" couldn't happen by post.

complaint upheld

We asked the mortgage company why they thought they needed to talk to Mr G on the phone. They told us that they felt the discussion would be more "interactive" that way – and that the process would take too long by post.

We accepted that, a certain way into the arrangement, the mortgage company might need confirmation that Mr G's circumstances hadn't changed. But we explained that even if it was their standard procedure, it wasn't possible – let alone reasonable – to expect him to have to phone them.

We pointed out that in failing to adapt their process for Mr G, the mortgage company was in breach of equality legislation – which obliged them to make reasonable adjustments to remove barriers to using their services.

We told the mortgage company to communicate with Mr G in writing from now on. Unless something went wrong with the post, we didn't see that a written "discussion" need take a long time. It would certainly take less time than escalating a complaint to us.

We noted that Mr G was still making the payments under his original agreement with the mortgage company. In our view, if the mortgage company had agreed to write to him from the start, they could have confirmed that the arrangement still stood – or agreed a new one – much sooner.

In the circumstances, we thought the charges were unfair – and we told the mortgage company to refund them. We also told them to pay Mr G £300 to compensate for the worry and frustration their actions had caused.

... in the circumstances, we thought the charges were unfair

case study 123/10

consumer complains that lender is chasing debt – despite knowing about financial difficulties and mental ill health

Mr M was in the army – but when he developed post-traumatic stress disorder, he was unable to work. Without a regular income, he started to fall behind on the repayments of a loan he'd taken out.

Worried about the interest and charges being added to the loan, Mr M decided to contact the lender to talk about the problems he was having. When he mentioned that he had post-traumatic stress, they asked him to fill out a form to provide evidence of his mental health condition, along with an income and expenditure form.

The lender told Mr M that their debt collection department would now hand over his account to a "specialist team". They said that once he'd returned the paperwork, that team would be in touch to discuss a repayment plan.

... some of the questions were triggering his post-traumatic stress

When Mr M came to fill in the form, he found that some of the questions were triggering his post-traumatic stress. Not sure what to do, he asked his local community advice centre for help. The adviser there wrote to the lender on Mr M's behalf – explaining the problem and asking if there was another way of getting the information they needed.

But the next time Mr M heard from the lender, it was from their debt collection department, who were chasing the debt. Mr M was worried and confused – as he'd been expecting to hear from the "specialist" team to arrange a repayment plan. Over the next few weeks, the lender's debt collection department continued to phone Mr M about the debt – and to apply interest and charges to the loan account.

With the help of his local advice centre, Mr M made a complaint. He explained that the situation was making his mental health much worse – and that although he was getting support, he was finding things increasingly difficult. He asked the lender if they could contact him by email from now on, because speaking on the phone made him extremely stressed.

Mr M also asked if he could have a single point of contact at the lender – so he didn't have to explain things time and time again, which he was finding very traumatic. But when the lender replied after a couple of days, they said that as different staff worked at different times, this wouldn't be possible.

When he got another phone call about the debt, Mr M emailed us – saying he felt the lender wasn't interested in helping him, and he didn't know what to do.

complaint upheld

We asked the lender for the history of the contact they'd had with Mr M. Looking at this, it was clear that Mr M had been open about his mental health – even though it had been very difficult for him to talk about it.

We were concerned about the aggressive tone of many of the lender's letters and phone calls. We reminded the lender of their responsibility to treat their customers in financial difficulties sympathetically and positively – whether or not they're experiencing mental ill health.

We also thought that the lender should have addressed Mr M's concerns about the form they'd asked him to complete – rather than just passing his account back to their debt collection department.

Turning to Mr M's request to be contacted by email, we pointed out to the lender that equality legislation requires businesses to make reasonable adjustments to help customers with specific needs. And in line with industry guidance, they needed to consider their customers' reasonable requests about how to be contacted. In our view, even if Mr M hadn't been experiencing mental ill health, there wasn't anything unreasonable about his request to be contacted by email.

In the circumstances, we decided the lender had treated Mr M unfairly. We told them to make sure that they only contacted him by email from now on.

We acknowledged that it might not always be possible for Mr M to speak to the same person. But we told the lender to give him a main point of contact, and to put a clear note on his account so other members of staff would be aware of his circumstances – without him having to explain every time he spoke to someone new.

It was clear that the lender's poor treatment of Mr M had caused him very significant distress – making his mental health deteriorate badly. The advice centre told us that he'd gone missing for two days – and that when he was found, he'd said he couldn't deal with the lenders' repeated phone calls.

So as well as telling the lender to refund the interest and charges they'd applied after finding out about Mr M's difficulties, we also told them to pay him £2,500. We explained to the lender that this was a substantial amount – because we could see that their actions and attitude had had a very significant and very serious impact on Mr M.

We confirmed with the lender that the person who would be Mr M's main point of contact would now get in touch with him to arrange a repayment plan – based on the information he could give them.

... we could understand why Ms B had remained so frustrated and upset

case study 123/11

consumer complains that bank blocked credit card – after mistaking gender reassignment for fraud

Ms B had recently moved to a new flat. When she was going over her latest credit card statement online, she noticed the card was still registered to her old address.

Realising that it had slipped her mind in the move, she phoned the credit card provider – her bank – to give them her new address. The person she spoke to said her details could easily be changed over the phone. They then asked Ms B several questions to confirm her identity.

Having answered all the questions correctly, Ms B was surprised to be told that her address couldn't be changed at that time. When Ms B asked why, the person on the bank's helpline said that they needed to clear something up with their manager – and that Ms B shouldn't worry for the time being.

A few days later, Ms B tried to use her card to pay the deposit for her new kitchen – but it was declined.

When she phoned the bank to tell them what had happened, she was told the card had been stopped – and she'd need to go in to her local branch to verify her identity.

Ms B did as the bank had told her. But she had to phone back again the following week – after her card was declined yet again when she was out shopping. This time, Ms B was told that her account had been passed to the fraud team – and that to sort things out, she'd have to go into the branch again and get them to call the fraud team on her behalf.

When Ms B visited the branch, a member of staff took her into a room and phoned the fraud team. It turned out that the card had been blocked because concerns had been raised about the pitch of Ms B's voice. When she'd phoned up to change her address, the person on the helpline had reported that a man had been trying to use the card. So the bank had treated any subsequent transactions as fraud.

Ms B told the member of staff that she wanted to make a complaint. She said that she'd had gender reassignment surgery three years previously – and had already given the bank her statutory declaration and medical records. She said the bank had confirmed at the time that they'd made a note on their system to show that she was no longer Mr B, but Ms B.

The member of staff apologised – and the next day, a letter arrived confirming that Ms B's address had been updated and her card had been unblocked. But upset and embarrassed by what had happened, she asked us to step in.

complaint upheld

When we asked to see the bank's customer notes on Ms B, we found that it was clearly recorded that she'd undergone gender reassignment.

It seemed the problem had arisen because the person on the bank's helpline hadn't checked the notes. If they had, we didn't think they would have concluded that someone was trying to fraudulently use Ms B's account.

We pointed out to the bank that because of their oversight, Ms B had had the inconvenience of finding another way to pay the deposit for her kitchen – and of making two separate visits to the branch.

And to unblock her account, she'd had no alternative but to disclose sensitive personal information to someone she didn't know. Ms B told us that she'd found this particularly distressing. She said she was angry at having to explain herself – when she knew the bank already had the information on file.

Looking at everything that had happened, we could understand why Ms B had remained so frustrated and upset – even though, on the face of it, the bank had sorted out the original problem. The bank admitted that they hadn't considered what Ms B had been through because of their mistake.

In the circumstances, we told the bank to pay Ms B £500 – to recognise the considerable frustration and embarrassment they'd caused.

... Mrs H hadn't understood what she needed to do

case study 123/12

consumer complains insurer failed to communicate with her in Polish and unfairly rejected claim after rain damage

Mrs H lived in a small flat in a sheltered housing complex. During some very bad weather, her roof was damaged – and water got in to her flat through the ceiling.

As soon as the housing association had fixed the roof, Mrs H contacted her home insurer to claim for replacing her living room carpet and several items – which had been ruined by the leak.

Mrs H was 80 and was losing her hearing – so rather than call the insurer, she wrote them a letter.

She'd made a claim before when she'd been burgled – and had already let them know why she couldn't use the phone. The insurer had also previously written to her in her native Polish – as she'd explained during the previous claim that as she was getting older, she was having trouble remembering her English.

The insurer sent a loss adjuster to Mrs H's flat to have a look at the damage. As the loss adjuster left, he gave Mrs H some paperwork she'd need to fill out to get the claim paid.

Because the loss adjuster had spoken English – and Mrs H wasn't familiar with the insurance language he'd used – she didn't understand what he wanted her to do. When the insurer hadn't heard from Mrs H for a week, they wrote again to say that they couldn't calculate the loss without more evidence about the costs involved.

But the insurer wrote their letter in English – and Mrs H still didn't understand what she was supposed to do. Very anxious about whether more people would be visiting her flat, she contacted the warden of her sheltered housing – who phoned us on her behalf.

complaint resolved

The insurer told us that the loss adjuster had estimated the repairs would cost about £1,000. But as Mrs H "hadn't cooperated" with them, they weren't prepared to pay the claim.

But in our view – looking at what had happened – it should have been clear to the insurer that Mrs H hadn't understood what she needed to do. As the insurer had known that Mrs H spoke very little English, they could have arranged for a Polish speaker to accompany the loss adjuster – or at least had the paperwork he left her with translated.

We thought if the insurer had taken these steps, Mrs H would have been able to provide the evidence to back up her claim. We didn't agree that she "hadn't cooperated". The insurer's actions simply meant that she couldn't cooperate.

When we pointed all this out to the insurer, they apologised to Mrs H – and said they'd translate all the documents and pay the claim as soon as possible. The insurer also asked Mrs H how they could make up for the confusion and worry they'd caused by not considering her needs – and she asked them to make a donation to her local church fund.

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Q? &A

I've seen your online video about a Viking. What's that got to do with financial services?

According to our research, one in five people can name us – unprompted – as the people they can come to if they've got a problem with a financial business. And around half say they recognise our name when they're told it.

That means there are people who've heard the word "ombudsman" – but aren't sure what it means.

And there are some people who haven't heard it at all. It's important we try to change this – so that everyone knows that, if something goes wrong, there's an independent, unbiased organisation that can help. Not just for problems with money, but with other products and services too.

One way we raise awareness of ombudsmen is using Hakon, our Viking, to explain the meaning of the old Norse word *ombudsman* – and how we and other "alternative dispute resolution" providers can help people sort out complaints and concerns. More than 150,000 people have watched the video so far.

Will you publish a decision even if someone asks you not to?

We've always shared our approach to complaints – through *ombudsman news*, our outreach work, and our online technical resource. But from April 2013, we've been required by law to publish all our final decisions. Since then, we've published more than 50,000 ombudsmen decisions on our website.

We let people know when they first complain to us that if their complaint is escalated all the way to an ombudsman, the decision will be published. The only time we may decide *not* to publish a particular decision is if it could be easily identified – or if for some reason it would be inappropriate to do so.

We're very rarely asked not to publish a decision – but we'll always look into any concerns a business or consumer might have.

I haven't received quite as many calls about PPI recently. Does that mean it's all over?

We're definitely seeing fewer complaints about PPI. We're now receiving around 4,000 each week – compared with a peak of 12,000.

By March next year, we think we'll have around 180,000 PPI cases outstanding. Despite the strong headway we continue to make into resolving these cases, that's still a lot of complaints.

So the fallout from PPI mis-selling is far from over – and we expect to be sorting it out for a few years yet.

We know many things have an impact on the number and type of complaints that reach us – from claims manager activity and media coverage, to changes in the rules and how businesses handle complaints in-house.

So we have to factor in a lot of uncertainty when we're forecasting what we'll be seeing in the future.

We've recently set out our plans for the year ahead in our plans and budget consultation – which you can find on our website, along with details of how to give your views.

Financial Ombudsman Service