ombudsman news

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

in this issue

Financial Ombudsman Service

finding fairness

The majority of us go through challenging or upsetting events at some point in our lives. It's part of being human – as, I think, is the feeling that sometimes life just doesn't seem fair. At the ombudsman, we hear from many people whose lives and livelihoods have taken an unexpected and unwelcome turn – which has resulted in problems with money or financial services.

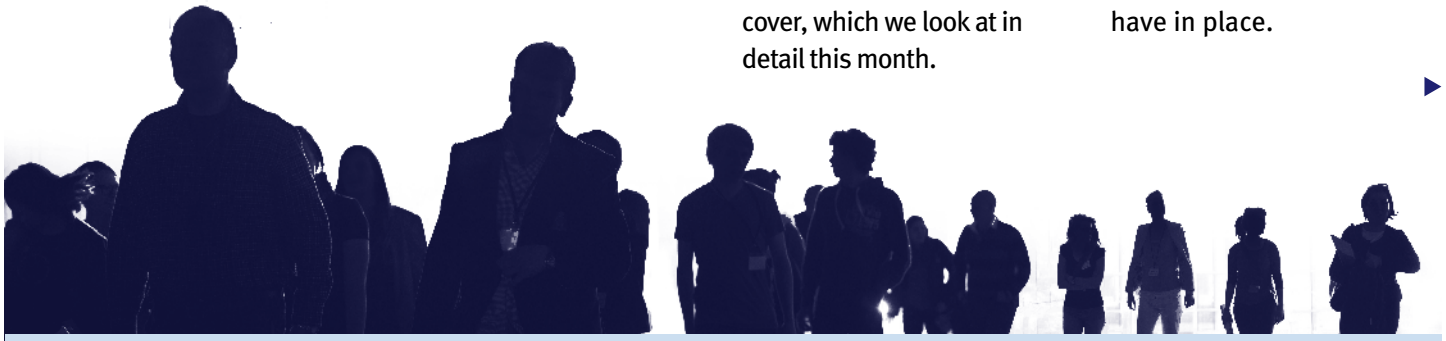
I've introduced *ombudsman news* before by talking about how much people rely on financial businesses throughout life – and all the rites of passage, ups, downs and changes life brings.

And in some cases, it's clear that a business can make a significant difference during a really tough period for their customer. That might mean, for example, a lender showing genuine care and flexibility towards a borrower facing a setback. Or an adviser sensitively guiding someone through the financial consequences of a bereavement.

But when financial worries come on top of existing stress, it's probably inevitable that a business's response won't always be well-received – especially when it's further bad news. I'm thinking in particular about life assurance and critical illness cover, which we look at in detail this month.

If someone's put careful thought – and money – into planning for the worst, it's going to be upsetting if things don't go to plan. If they've died, it's the people close to them who are left to pick up the pieces.

But the solution isn't only ever giving people the answer they're hoping for. That goes for the ombudsman as well as financial providers. In our independent position, we see businesses make mistakes that cause upset – and equally, we see people who simply misunderstand the limits of protection that they, or the people they love, have in place.



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meet us

in November we're in:

- **Bristol**
- **Norwich**

for more events see page 23

scan for previous issues

Caroline Wayman

In most of the complaints we receive about these types of protection, we decide that the business's decision not to pay a claim – while clearly disappointing for their customer – isn't actually unfair.

In a sense, that's encouraging – in that it suggests, in most cases, that businesses are reaching a fair answer first time. On the other hand – whatever our official "uphold" rate – the fact we hear from thousands of people each year about these types of claims suggests things aren't always going as well as they could.

So what needs to happen? From our experience – as we've said before – the value of open, sensitive and regular communication can't be underestimated. Neither can the value of simple human reactions – acknowledging the awful time someone's going through, instead of forgetting it among process, paperwork and jargon.

There's also the question of how the ombudsman can make a difference when it's life – not anything a business has done – that's unfair. Perhaps especially where our involvement doesn't result in a claim being paid, I think we've got a responsibility to listen to why people feel so let down.

If we understand that – while we can't reverse what they've been through – then we can give the independent answer that helps them to take stock and move forward.

And for financial businesses, I hope we can either provide reassurance that they've done their best by their customer – or help them to recognise and learn from what hasn't gone well. Working together, there's a lot we can do to make sure "the worst" isn't any worse than it needs to be.

Caroline

... in most cases, businesses are reaching a fair answer first time

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 4 567

technical advice desk
020 7964 1400
Monday to Friday 8am to 6pm

complaints about life assurance and critical illness cover

When someone makes a claim on life assurance or critical illness cover, they're either bereaved or seriously ill. These experiences are distressing enough in themselves – so it's understandable that problems involving these types of insurance can be extremely upsetting for the people involved.

Critical illness cover can be taken out on its own – or it might be part of other insurance policies such as life or "term" assurance, mortgage endowment policies or "whole-of-life" policies. The complaints we see generally stem either from events around the time a policy was taken out or from how a claim has been dealt with later on. It may be that issues around the sales process come to light only after a claim is made and rejected.

For example, in turning down a claim, an insurer might say their customer didn't tell them important information – either deliberately or through carelessness – with consequences for the claim in hand. This is known as "misrepresentation".

Equally, we hear from people who feel important information – which the insurer has referred to when turning down a claim – wasn't made clear when they took out their policy. Our approach to misrepresentation is published on our website.

Complaints about claims often centre on a disagreement about whether someone's medical condition or disability fits the definition in their policy. We're not the medical experts, so we won't make medical assessments ourselves. But we'll carefully weigh up the medical evidence we have, including the views of any professionals involved.

Where something's gone wrong, putting things right generally involves telling the insurer to pay the claim. In some cases, we'll say a proportionate settlement is fair – for example, if the insurer wasn't given important information from the start, which would have resulted in a lower payment or higher premiums.

Of course, a business isn't responsible for the upsetting events resulting in a claim. But we'll consider whether compensation is due for any unnecessary delays or poor customer service during an already difficult time for their customer.

... he thought he'd taken out a "critical illness" policy – and he'd been left critically ill by his heart attack

case study 129/1

consumer complains that insurer won't pay claim because heart attack doesn't meet policy definition

When Mr B had a heart attack, he gave up work. He'd taken out a critical illness policy with his mortgage – and with no other income to make his mortgage repayments, he contacted his insurer to make a claim.

But after investigating the claim, the insurer wouldn't pay out – saying Mr B's heart attack didn't meet the policy definition.

Unhappy with the insurer's decision, Mr B made a complaint. He said he thought he'd taken out a "critical illness" policy – and he'd been left critically ill by his heart attack.

When the insurer wouldn't change their position, Mr B asked us to look into his complaint.

complaint not upheld

The insurer sent us a copy of the terms of Mr B's policy, which showed it was designed to cover heart attacks "of specified severity". This was defined, along with other factors, as causing cardiac enzymes to rise beyond a certain level.

The insurer's definition was in line with guidelines set by the Association of British Insurers that apply to all critical illness policies.

Looking at the medical evidence the insurer had received from Mr B's consultant, it was clear that Mr B's cardiac enzymes had been significantly lower than the levels set out in the policy.

From their records, it also seemed the insurer had looked at other factors – for example, the results of an echocardiogram test Mr B's consultant had carried out. This also suggested that the heart attack wasn't "severe" as defined by the policy.

Mr B sent us a letter from his GP confirming that he'd had a heart attack. He said his GP had said the insurer's enzyme test was highly sensitive.

When we asked the insurer about the test, they confirmed it was sensitive – because it allowed enzymes to be detected at lower levels. But this didn't change the fact that the level recorded for Mr B was well below the limit set out clearly in the policy.

We were sorry to hear about Mr B's poor health. But in light of everything we'd seen, we didn't tell the insurer to pay the claim.

case study 129/2

consumer complains that insurer should have offered new policy terms after loss of limb wasn't covered

Following an accident at work, Mr L had to have one of his legs amputated. He contacted his insurer to claim on his personal critical illness cover – but was told that his policy only covered the loss of two or more limbs.

Mr L complained. He said he'd looked online and had seen the insurer now offered policies that covered the loss of just one limb. He felt that they should have told him about these newer policies – and that, since they offered that particular cover for newer customers, they should pay his claim anyway.

When the insurer maintained that they wouldn't pay out, Mr L asked us to overturn their decision.

complaint not upheld

We asked the insurer for a copy of Mr L's policy documents. "Loss of limbs" was defined as "The permanent physical severing of two or more limbs from above the wrist or ankle". So we could see that Mr L's claim wasn't covered – and that the policy wording was clear.

Mr L told us the insurer was just trying to get out of paying – and didn't think it was fair they hadn't told him he could have had different cover.

However, we explained that it wouldn't be practical for insurers to tell all their customers each time new products became available. In fact, new cover could turn out to be more expensive. Or it could even mean someone losing valuable cover after being underwritten for the new product, because their health had got worse over time.

While we were sorry to hear about Mr L's accident, we didn't agree the insurer had acted unfairly.

... we could see that Mr L's claim wasn't covered – and that the policy wording was clear

case study 129/3

consumer complains that his retrospective claim for permanent disability has been turned down – even though he's now permanently disabled

Mr R's insurance cover for critical illness had expired more than two years previously. He contacted his insurer to make a retrospective claim for "total permanent disability" – saying he'd been permanently disabled by serious back pain during the time he *was* covered.

The insurer agreed to look into whether Mr R's claim would have been successful. But after reviewing his medical records, they said that his disability hadn't been permanent at that time – and rejected his retrospective claim.

Mr R complained about this decision. He told the insurer that he hadn't worked since the time he was covered, and provided physical assessment reports from the Department for Work and Pensions to show this. But the insurer refused to change their mind, so Mr R contacted us.

complaint not upheld

The insurer sent us the information they'd gathered from Mr R's medical records relating to the time he was covered by their policy. In particular, they pointed out that Mr R's doctor had recommended surgery that apparently had an 80% chance of success.

A letter from Mr R's doctor had encouraged Mr R to stay active, get back to "light duties", and had recommended physiotherapy. There were also notes from a specialist consultant, saying that Mr R's pain seemed to be lessening. From the records, it seemed that the option of surgery had still been available to Mr R at the time his cover expired.

So it seemed it had been possible that Mr R's condition could improve throughout the time he had critical illness cover. And we didn't think a DWP assessment report alone was enough to prove he'd been "permanently" disabled during that period. It showed Mr R had been eligible for certain benefits at a certain time – but health conditions can improve or worsen and benefit payments can change or stop.

We were very sorry to hear that Mr R's health hadn't improved. But we explained that, in light of everything we'd seen, we thought the insurer's answer was fair.

... we didn't think a DWP assessment report alone was enough to prove he'd been "permanently" disabled

... the insurer didn't agree Mr N was covered because he went about his daily life "unaided" by anyone else

case study 129/4

consumer complains that unclear policy wording led to insurer unfairly rejecting claim

After Mr N began to develop pain in his hip and back, his health deteriorated quickly. He made a claim on his life and critical illness policy, which he understood would cover him if he became disabled.

Mr N's insurer arranged for him to see a doctor, and also sent a physiotherapist to review his health. After reviewing both reports, the insurer said he didn't meet the policy's definition of "permanently and totally disabled", so they wouldn't pay the claim.

Mr N insisted his problems were having a serious impact on his daily life – and wouldn't improve in the future. When the insurer wouldn't change their position, he contacted us for help.

complaint upheld

We asked the insurer for a copy of Mr N's policy. This listed seven daily activities, such as washing and household cleaning – and "totally and permanently disabled" was defined as being unable to perform four or more of these tasks unaided.

Looking at the insurer's records about the claim, we could see the doctor and physiotherapist had disagreed about Mr N's health. We told the insurer to get the view of another doctor and reassess Mr N's claim. But Mr N was still unhappy and contacted us again.

We considered Mr N's complaint about the insurer's second decision. The second doctor said that for four of the activities listed by the policy, Mr N needed some aids to help him – like using a stool when he showered. She also said that Mr N's symptoms were "very unlikely" to improve over time.

These conclusions broadly backed up the first doctor's view of Mr N's situation. But the insurer still didn't agree Mr N was covered – because he went about his daily life "unaided" by anyone else.

However, we pointed out to the insurer that two experts had agreed Mr N couldn't carry out four of the daily tasks "unaided". The policy didn't specify that "unaided" meant without *another person's* help – rather than without the help of practical aids.

Given everything we'd seen, we told the insurer to pay Mr N's claim – backdated to when it was first made and adding interest.

It was also clear that Mr N had been through a considerable amount of worry and stress as a result of the insurer wrongly delaying his claim. To reflect this, we told the insurer to pay him £350 compensation.

... she'd been told that this wasn't cause for concern and that she wouldn't need any treatment for it

case study 129/5

consumer complains that insurer unfairly rejected terminal illness claim because of "non-disclosure"

After Mrs J died from colon cancer, her husband, Mr J, made a claim on her life assurance policy.

However, the insurer turned down the claim. They said that they'd received evidence showing that Mrs J had been having tests on her colon around the time she'd applied for her policy. The insurer said that Mrs J had failed to disclose this important change in her health – and that if she had, they wouldn't have covered her.

Mr J told the insurer that his wife had visited the doctor with symptoms of a colon condition she'd had in the past, which the insurer had known about. He argued that as his wife hadn't known there was anything more serious going on, she couldn't have been expected to tell the insurer about it.

When the insurer wouldn't reconsider their decision, Mr J complained to us.

complaint upheld

The insurer sent us copies of all the letters and documents they'd sent to Mrs J before she renewed her policy. We could see Mrs J had been clearly reminded that she needed to keep the insurer up to date with any changes to her health – and that failing to do this could mean the insurer wouldn't pay a claim.

The insurer also sent us the medical records they'd received from Mrs J's GP and consultant. As the insurer had said, Mrs J had been in contact with her GP and consultant – around the time that she'd taken out her policy – with symptoms relating to her colon.

But we also saw that the symptoms were the same as those Mrs J had experienced a few years before. At that time, according to the records, Mrs J had been diagnosed with "an irregularity of the colon". She'd been told that this wasn't cause for concern and that she wouldn't need any treatment for it – but that she should go back to her GP if the symptoms returned.

Mr J told us that this was why his wife hadn't been worried when she'd noticed the symptoms again. Thinking it was just the same colon irregularity flaring up, she'd visited her GP, who'd arranged for some tests.

We acknowledged that the insurer had told Mrs J about the importance of notifying them of changes to her health. But given she'd had the same symptoms in the past, we could understand why she might not have thought there'd been any change.

In light of this, we didn't think Mrs J had deliberately or carelessly withheld information when taking out her life assurance policy. In the circumstances, we told the insurer to pay the claim, adding 8% interest.

... an experienced specialist had explained to us the reasons why his test results were consistent with a heart attack

case study 129/6

consumer complains that insurer has refused to pay out for a heart attack

Mr D collapsed and fell unconscious while out walking with his wife. He was rushed to hospital and was told by the doctors who treated him that he'd had a heart attack.

When he was well enough, Mr D tried to make a critical illness claim. The insurer accepted that there were signs of damage to Mr D's heart – but believed this had happened unnoticed some time before, during a small "silent" heart attack. They turned down Mr D's claim, saying he hadn't had a heart attack in line with the definition set out in his policy.

Mr D complained, but his insurer refused to change their mind. He then spoke to a heart charity about the dispute – and they put him in touch with us.

complaint upheld

We asked the insurer for a copy of their policy documents. In these, the insurer had defined a heart attack as "*the death of a portion of heart muscle as a result of inadequate blood supply*". And they'd set out the evidence that they'd look for, to confirm a heart attack had happened – "*chest pain, new electrocardiograph (ECG) changes and elevation of cardiac enzymes*".

The insurer told us Mr D hadn't reported any chest pains and that his ECG test results weren't what they would have expected if he'd had a heart attack. They also said his raised cardiac enzyme levels were more likely to be down to his having been resuscitated than his having had a heart attack.

We then spoke to the cardiologist who'd been treating Mr D. She said that, understandably, chest pains aren't usually reported in cases where someone – like Mr D – has fallen unconscious. And Mr D had had a relatively small heart attack, which wouldn't necessarily result in significant ECG test changes.

The cardiologist also explained that resuscitation only causes small enzyme changes – and she believed that the cause was far more likely to be a heart attack. She told us that Mr D's recovery since his fall indicated the damage to his heart had happened then, rather than "silently" beforehand.

We weighed up the medical opinions we'd heard – bearing in mind it's for insurers to prove that policy exclusions apply, rather than for customers to prove that they don't. An experienced specialist – who'd been personally treating Mr D – had explained to us the reasons why his test results were consistent with a heart attack. So on balance, we decided it was most likely this had happened.

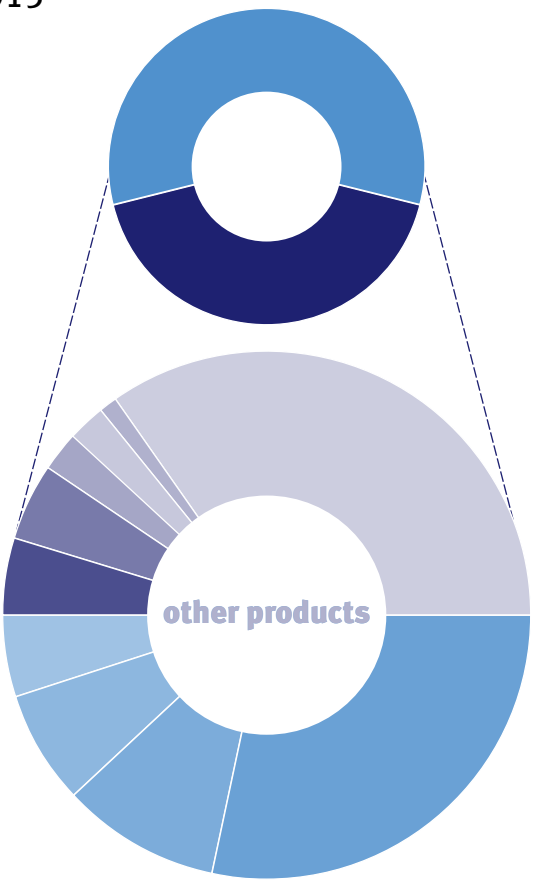
We also pointed out to the insurer that even if Mr D had had a smaller or "silent" heart attack, their policy didn't say these types of heart attack were excluded.

To put right their error, we told the insurer to pay Mr D's claim, adding 8% interest.

the financial products that consumers complained about most to the ombudsman service in July, August and September 2015

- payment protection insurance (PPI) 58%
- complaints about other products 42%

- packaged bank accounts 12%
- current accounts 4%
- house mortgages 3%
- car and motorcycle insurance 2%
- credit card accounts 2%
- overdrafts and loans 2%
- buildings insurance 1%
- hire purchase 1%
- payday loans 0.5%
- complaints about other products 14.5%



	so far this year April – September 2015			
	enquiries received	new cases	ombudsman	% of cases upheld
payment protection insurance	124,590	98,460	5,591	73%
packaged bank accounts	29,030	22,264	1,433	11%
current accounts	14,153	6,934	1,218	34%
car and motorcycle insurance	13,604	4,095	669	33%
house mortgages	8,316	5,948	1,337	31%
credit card accounts	7,047	3,955	844	31%
overdrafts and loans	5,288	3,270	790	34%
buildings insurance	3,720	2,143	526	37%
hire purchase	3,329	1,384	296	40%
payday loans	2,486	930	264	69%
personal pensions	2,338	751	149	26%
mortgage endowments	2,101	1,075	214	20%
credit broking	1,599	377	159	66%
travel insurance	2,183	1,158	400	49%
“point of sale” loans	1,922	1,053	229	43%
debt collecting	1,481	419	66	38%

ombudsman focus: **second quarter statistics**

a snapshot of our complaint figures for the second quarter of the 2015/2016 financial year

Every quarter, we publish updates in *ombudsman news* about the financial products and services people have contacted us about.

Over the years, we've introduced more information – including the number of enquiries we receive, the number of complaints passed to an ombudsman for a final decision and what proportion we resolved in favour of consumers.

In this issue we focus on data from the second quarter of the financial year 2015/2016 – showing the new complaints we received during July, August and September of this year.

During those three months:

- We handled 141,622 enquiries from consumers, taking on 85,896 new cases – with 9,715 complaints passed to an ombudsman as the final stage of our complaints handling process.
- PPI remained the most complained about financial product, with 49,672 new cases in the second quarter. Packaged bank accounts were the second most complained about product, with 10,163 new cases – slightly down from the previous quarter.
- The proportion of complaints we upheld in favour of consumers was 51% - ranging from 3% (for complaints about SERPs) to 72% (for complaints about PPI).

… in Q2 July – September 2015				… in Q1 April – June 2015				in the whole of 2014/2015 April 2014 – March 2015			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
61,315	49,672	2,437	72%	62,105	49,377	3,152	74%	274,517	204,943	23,771	62%
15,078	10,163	832	11%	13,768	12,119	606	10%	32,018	21,348	562	33%
6,993	3,355	648	32%	6,944	3,667	570	36%	31,483	13,455	1,780	37%
7,113	2,081	309	34%	6,263	2,037	358	32%	25,140	7,361	1,512	35%
3,881	2,609	626	30%	4,136	3,338	710	32%	19,970	12,286	3,012	33%
3,327	1,894	442	31%	3,425	2,017	401	32%	15,770	8,115	1,342	33%
2,457	1,520	418	33%	2,614	1,696	373	35%	11,971	6,255	1,346	38%
1,844	1,017	291	39%	1,800	1,142	235	34%	9,087	4,510	925	37%
1,748	761	168	43%	1,570	660	129	37%	4,949	1,784	377	40%
1,185	499	113	70%	1,278	452	152	68%	5,111	1,157	222	64%
1,105	458	74	27%	1,206	294	74	23%	3,067	1,161	334	27%
966	459	111	20%	1,082	608	104	20%	5,353	2,573	438	24%
551	127	81	63%	1,005	235	78	69%	19,266	1,213	326	64%
1,138	552	187	48%	996	614	213	49%	4,371	2,307	426	46%
914	499	115	42%	938	567	114	43%	3,841	1,582	345	39%
700	218	32	39%	824	278	35	36%	3,434	843	100	33%

	so far this year April – September 2015			
	enquiries received	new cases	ombudsman	% of cases upheld
inter-bank transfers	1,779	955	139	36%
deposit and savings accounts	1,542	966	235	35%
term assurance	1,546	1,162	295	27%
home emergency cover	1,253	880	202	46%
contents insurance	1,259	746	164	33%
derivatives	722	173	58	31%
whole-of-life policies	1,244	806	214	20%
warranties	1,163	478	70	29%
electronic money	1,146	320	52	29%
catalogue shopping	1,027	445	73	50%
debit and cash cards	967	491	102	37%
pet and livestock insurance	975	529	126	21%
secured loans	873	604	107	28%
investment ISAs	853	728	136	36%
portfolio management	820	636	279	46%
cash ISA – individual savings account	741	466	76	40%
self-invested personal pensions (SIPPs)	868	545	207	49%
commercial vehicle insurance	838	306	58	34%
share dealings	755	416	106	39%
mobile phone insurance	752	272	32	49%
card protection insurance	772	371	23	57%
income protection	701	503	130	30%
roadside assistance	663	393	52	42%
private medical and dental insurance	596	430	113	35%
critical illness insurance	560	392	116	20%
specialist insurance	588	280	29	62%
annuities	554	458	110	19%
legal expenses insurance	515	350	145	28%
credit reference agency	511	158	26	40%
debt adjusting	467	264	96	59%
merchant acquiring	437	224	48	29%
direct debits and standing orders	507	267	38	34%
cheques and drafts	444	260	55	44%
commercial property insurance	449	354	99	37%
store cards	430	254	45	47%
guaranteed bonds	299	297	101	20%

... in Q2 July – September 2015				... in Q1 April – June 2015				in the whole of 2014/2015 April 2014 – March 2015			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
858	475	77	34%	820	470	60	38%	2,844	1,323	179	45%
736	433	128	34%	742	506	106	36%	3,582	1,971	400	39%
710	524	154	26%	717	603	138	28%	3,592	2,644	483	21%
515	367	129	43%	700	506	74	50%	2,397	1,298	218	43%
581	359	87	34%	629	379	77	32%	3,134	1,436	273	34%
95	59	38	25%	604	120	20	38%	361	197	60	31%
618	401	125	21%	603	412	9	18%	2,674	1,587	331	23%
570	252	35	29%	574	222	35	29%	2,341	777	89	39%
587	172	29	27%	524	146	24	31%	2,173	491	61	42%
502	225	35	47%	485	217	38	53%	2,314	882	107	55%
476	238	50	34%	461	244	52	41%	2,432	1,043	160	43%
497	267	73	18%	456	265	53	23%	1,645	790	153	28%
410	290	50	31%	442	311	56	24%	1,931	1,070	222	36%
385	327	86	37%	438	409	51	35%	1,619	1,006	216	42%
397	290	133	44%	416	368	147	48%	1,763	1,236	494	51%
312	234	45	41%	403	228	31	40%	1,290	746	88	45%
426	281	120	47%	390	261	89	51%	1,467	951	497	60%
421	139	23	34%	380	156	35	34%	1,653	514	122	36%
367	217	46	44%	361	197	59	34%	1,366	689	172	36%
378	125	14	51%	359	148	18	46%	1,575	536	45	51%
362	173	15	47%	358	211	7	68%	2,886	1,401	33	85%
330	256	74	34%	346	250	56	26%	1,676	1,146	239	35%
337	191	23	39%	301	195	29	44%	1,389	733	107	37%
288	213	73	31%	285	212	40	39%	1,194	786	201	36%
283	198	66	16%	277	205	51	24%	1,268	791	169	24%
318	139	15	52%	269	141	13	69%	1,009	350	51	53%
250	207	61	18%	265	245	49	20%	1,149	776	148	20%
243	160	97	30%	260	187	48	26%	1,131	672	354	34%
277	83	13	35%	221	72	13	48%	792	189	38	36%
230	131	51	58%	214	125	45	61%	1,441	508	112	62%
204	103	29	26%	213	115	19	29%	908	367	84	23%
285	133	20	32%	212	132	18	37%	1,210	541	86	41%
218	128	24	41%	208	138	31	46%	1,055	563	100	51%
202	164	46	37%	208	180	53	37%	1,079	645	181	38%
216	124	22	39%	191	127	23	52%	1,140	450	63	37%
117	97	67	22%	158	195	34	19%	870	555	55	13%

	so far this year April – September 2015			
	enquiries received	new cases	ombudsman	% of cases upheld
personal accident insurance	384	297	49	31%
unit-linked investment bonds	328	312	115	38%
occupational pension transfers and opt**outs	326	230	79	32%
hiring/leasing/renting	527	243	53	39%
state earnings-related pension (SERPs)	194	159	10	3%
business protection insurance	250	149	38	28%
“with-profits” bonds	196	110	33	19%
endowment savings plans	265	202	54	26%
interest rate hedge	254	241	48	48%
guaranteed asset protection (“gap” insurance)	207	107	13	19%
building warranties	188	144	95	27%
debt counselling	196	123	24	36%
conditional sale	222	220	89	42%
home credit	148	102	31	43%
income drawdowns	112	72	35	39%
(non-regulated) guaranteed bonds	70	34	10	29%
caravan insurance	120	49	18	37%
children’s savings plans	–	–	–	–
film partnerships	–	–	–	–
foreign currency	119	48	6	33%
FSAVC – free standing additional voluntary contributions	133	74	28	48%
investment trusts	–	–	–	–
money remittance	–	–	–	–
OEICs (open-ended investment companies)	109	91	16	42%
pensions mortgages	–	–	–	–
PEP – personal equity plans	49	47	6	42%
premium bonds	91	36	5	34%
safe custody	50	40	10	46%
savings certificates/bonds	78	53	6	40%
SCARPs – structured capital at risk products	–	–	–	–
spread betting	200	98	13	5%
unit trusts	101	69	21	44%
sub total	257,720	174,745	19,047	51%
other products and services	24,737	474	255	30%
total	**282,457**	**175,219**	**19,302**	**51%**

… in Q2 July – September 2015				… in Q1 April – June 2015				in the whole of 2014/2015 April 2014 – March 2015			
enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld	enquiries received	new cases	ombudsman	% of case upheld
204	144	25	34%	154	148	25	28%	681	422	96	31%
148	133	70	37%	154	161	45	39%	739	560	261	47%
166	99	46	24%	141	128	34	43%	661	457	186	49%
272	122	35	41%	138	138	18	35%	921	333	72	35%
59	53	7	5%	134	106	3	2%	525	436	17	2%
123	71	18	29%	121	74	20	26%	540	253	59	35%
93	49	24	17%	116	79	9	23%	454	260	54	32%
122	104	29	29%	109	87	25	22%	707	509	119	19%
131	119	16	49%	104	122	32	47%	498	287	100	65%
103	54	3	26%	98	55	10	11%	423	206	35	26%
97	75	79	20%	82	64	16	49%	422	299	130	58%
120	67	11	43%	77	60	12	34%	621	140	27	46%
90	109	42	38%	70	75	45	46%	385	290	90	41%
59	36	17	48%	67	50	13	38%	287	136	35	36%
–	–	–	–	43	42	16	47%	184	180	92	42%
–	–	–	–	–	–	–	–	272	149	28	33%
–	–	–	–	–	–	–	–	280	98	26	39%
–	–	–	–	–	–	–	–	72	50	3	34%
–	–	–	–	–	–	–	–	216	174	195	6%
–	–	–	–	–	–	–	–	166	74	14	30%
57	39	14	41%	–	–	–	–	191	142	59	48%
–	–	–	–	–	–	–	–	154	71	22	30%
–	–	–	–	–	–	–	–	262	109	9	52%
49	45	12	43%	–	–	–	–	154	118	83	48%
–	–	–	–	–	–	–	–	125	94	35	46%
–	–	–	–	–	–	–	–	96	63	14	22%
–	–	–	–	–	–	–	–	187	72	15	29%
–	–	–	–	–	–	–	–	119	81	28	48%
–	–	–	–	–	–	–	–	157	51	11	33%
–	–	–	–	–	–	–	–	59	37	31	33%
79	49	6	4%	–	–	–	–	196	98	45	19%
–	–	–	–	–	–	–	–	174	93	30	49%
126,288	85,427	9,511	51%	126,052	89,388	9,328	51%	542,626	328895	45,230	55%
15,334	469	204	35%	14,783	547	259	32%	60,769	614	151	38%
141,622	**85,896**	**9,715**	**51%**	**140,835**	**89,935**	**9,587**	**50%**	**603,395**	**329509**	**45,381**	**55%**

complaints involving credit and hire purchase

People might not automatically associate things like cars, furniture and solar panels with the financial ombudsman. But they can all be bought using credit. And – in certain circumstances – the financial business that provided the credit can be held liable if something goes wrong.

For the most part, this extra protection comes from the *Consumer Credit Act* – section 75 in particular. If hire purchase is involved, the *Supply of Goods (Implied Terms) Act 1973* will apply.

The limits that apply under these rules can be complicated – and may be at the root of the dispute that we're called in to sort out. Credit providers as well as their customers can both be confused, and we often need to explain how things stand as part of deciding a way forward.

In most cases involving section 75, we'll need to establish whether there's been a breach of contract on the part of the supplier of goods or services – or whether they were misrepresented to the person buying them. This can involve, for example, finding out what someone was *told* about the thing they were buying – compared with what they actually *received*.

Most complaints we see about hire purchase involve finance agreements for vehicles. We'll need to decide whether the vehicle matches what the customer was told they were getting – and whether the quality is satisfactory.

If we find that a credit provider has wrongly refused to deal with a claim made under these rules, we'll generally tell them to cancel the agreement and give a refund. Depending on the circumstances, we may suggest another practical solution that both sides agree is fair.

As our case studies show, given the wide range of everyday goods and services that can be bought on credit, problems with credit agreements can have a range of consequences for people's lives. In putting things right, we'll consider the trouble or extra costs someone's experienced as a result of the credit provider's mistake – for example, being left without a car to get around.

This month the new *Consumer Rights Act* comes into force – which may be relevant to some complaints that we see in the future. The Act changes some key rules around buying goods and services and makes existing law in this area easier to understand.

Financial Ombudsman Service

... after the finance provider took the car a few days later, Ms E complained – saying she'd changed her mind

case study 129/7

consumer complains that finance provider took car without her consent

When her hours were cut, Ms E began to have financial difficulties – and missed a payment on her car hire purchase agreement.

She contacted the finance provider, explaining she wanted to end the agreement under a "voluntary termination". After a discussion about Ms E's account history – including some unpaid arrears – it was agreed she would instead "voluntarily surrender" the car, allowing the finance provider to sell it at auction.

After the finance provider took the car a few days later, Ms E complained – saying she'd changed her mind. She said the finance provider hadn't had her written consent to take the car – and believed she was now entitled to all her money back.

The finance provider maintained they'd had Ms E's consent – and had followed the instructions she'd given. Ms E disagreed and contacted us.

complaint not upheld

We looked at the terms of Ms E's finance agreement. These said that if a vehicle was taken back without a court order or the customer's consent, the customer had the right to get back any money paid under the agreement.

The finance provider hadn't had a court order in Ms E's case, so we needed evidence about whether she'd given her consent.

The finance provider sent recordings of the conversations they'd had with Ms E over the phone. In our view, when Ms E first called the finance provider, they'd clearly explained her options – and she'd clearly agreed to surrender her car.

It appeared that Ms E had later phoned the finance provider asking for more time to think. But she'd called them back the same day to say she wanted to go ahead, telling the finance provider where her car was parked.

From the finance provider's records, we could also see they'd asked Ms E to send them her written consent to take the car. She'd rung back twice to check they'd got it. And when she was told they hadn't, she'd said she'd send another letter.

We appreciated that Ms E might have had second thoughts – and was disappointed about losing her car. But from what we'd seen, it was clear she'd wanted the voluntary surrender to go ahead before it actually happened.

We explained to Ms E that we didn't think the finance provider had acted unfairly – or that she was entitled to her money back.

case study 129/8

consumer complains that he was mis-sold a loan for an energy-saving heat pump and solar panels

Mr K and his wife, both retired, were worried about their energy bills. After receiving a marketing call about a "government scheme", they arranged for a home improvements company to replace their boiler with a heat pump and install solar panels.

A few weeks later Mr K contacted the company to say that the heat pump wasn't working properly. While trying to resolve the problem, Mr K complained that he hadn't known he, not the government, was paying for the improvements – through a loan – and asked for his money back.

The home improvement company referred Mr K's complaint to the loan provider. When the loan provider refused to refund him, he contacted us.

complaint resolved

We asked Mr K to tell us more about how the energy-saving measures had been sold to him. He explained that after the phone call, two salesmen had visited his home. Mr K said the salesmen had spent several hours at his home – presenting graphs they said were from a government website, showing that the couple could save thousands of pounds.

Mr K remembered being asked to sign some forms. He said the salesmen had told him that the costs listed on the form simply showed how much the government would have to pay for the installation.

Mr K said he'd been told he'd save around £25,000 over the next 20 years. On the other hand, it seemed the finance agreement was for £40,000 over ten years. This clearly didn't make financial sense – and we didn't think Mr K would have gone ahead if the full costs had been explained to him.

There was nothing to contradict Mr K's version of events – and in the circumstances, we decided that Mr K hadn't known what he was signing up for.

Mr K told us that, while he was very unhappy with the heat pump, he'd like to keep the solar panels. The finance provider agreed to take out the heat pump and reinstall the boiler. And following a discussion with us and Mr K, they arranged a new interest-free loan for the solar panels only – which significantly reduced the monthly cost.

... Mr K said he'd been told he'd save around £25,000 over the next 20 years

... the engineer had estimated how long the faults had been present – which was far longer than Miss G had owned the van

case study
129/9

consumer complains about van bought on hire purchase

Miss G bought a van on hire purchase, but soon after discovered several problems with it. When the problems continued despite attempts to put them right, she said that she wanted to return the van and cancel the finance agreement.

An independent inspection of the van – arranged by the finance provider – concluded that the van's faults were down to wear and tear, and poor maintenance. Based on this, the finance provider refused to cancel the agreement – saying the inspection didn't prove that the damage arose before Miss G bought the van.

The van then failed its MOT and a second independent inspection was carried out. This time the engineer concluded that the van was "*of unsatisfactory quality at the time of purchase*".

When the finance provider still wouldn't change their decision, Miss G got in touch with us.

complaint upheld

To decide if the finance provider had acted fairly, we needed to establish the condition of the van when it was sold to Miss G. This meant looking closely at the two independent reports – and deciding which was more reliable.

The first report confirmed that there were several separate faults with the van – and concluded that these were down to wear and tear, and poor maintenance. However, it didn't mention when the faults might have arisen – or how long the poor maintenance had been ongoing.

On the other hand, it seemed the second report was far more specific. The engineer had estimated how long the faults had been present – which was far longer than Miss G had owned the van.

The second engineer had also pointed out that the van hadn't been serviced in the four years before Miss G bought it. In our view, this backed up the conclusion that it had been poorly maintained before Miss G bought it.

On balance, we decided that the findings of the second, more detailed report were more reliable – and that it was likely the van hadn't been of satisfactory quality when Miss G bought it.

To put things right, we told the finance provider to let Miss G return the van and cancel the hire purchase agreement. We also told them to refund Miss G's initial deposit for the van and all the monthly payments she'd made since the failed MOT – adding 8% interest.

case study
129/10

consumer complains that finance provider won't accept new sofa is faulty

Mrs O bought a new sofa on a "buy now, pay later" credit agreement with a catalogue company.

The day after it was delivered she phoned the company to say one of the seat covers had a fault. She was told the company would look into it.

A couple of weeks later – having heard nothing since – Mrs O called the company again to say that one of the arms of the sofa had completely lost its shape. She said the sofa was faulty and that she wanted to return it.

The catalogue company then sent one of their technicians to look at the sofa. The technician reported that there were no manufacturing faults. He believed that the sofa arm had its lost shape because Mrs O's son had been lying across the sofa and resting his head on the arm.

Based on the technician's findings, the catalogue company told Mrs O that she wouldn't be able to return the sofa – and would have to pay £45 for the technician's report.

Mrs O complained – but when the catalogue company refused to reconsider, she contacted us.

complaint upheld

We asked the company for a copy of the report. It didn't seem their technician's report had suggested any alternative reason for the wear to the sofa. The only explanation he'd put forward was that someone, Mrs O's son, had been lying on it.

But in our view, lying across a sofa was a perfectly normal thing to do – and a sofa should be fit for this type of general use. In any case, considering Mrs O's sofa had been less than a month old when the technician carried out his report, we didn't think it was reasonable for it to have already been showing signs of wear.

From the catalogue company's records, we could see that they'd recorded Mrs O's initial concerns about the seat cover. No one seemed to have followed this up. But we thought it suggested there had been manufacturing problems with the sofa from the start. Mrs O sent us photos showing the sofa had disintegrated further in the meantime, meaning it was unusable.

Overall, we thought it was likely that the sofa had been faulty when Mrs O bought it.

We told the catalogue company to cancel Mrs O's credit agreement, to ensure it didn't show on her credit records, and to pay £150 to reflect the inconvenience their poor service had caused.

In the circumstances, we also told the company to repay the £45 technician's charge.

... in our view, lying across a sofa was a perfectly normal thing to do

... when his car was delivered he found that there wasn't enough headroom inside for him to drive comfortably

case study 129/11

consumer complains that he wasn't told important information about the sunroof when he bought a new car

Mr A bought a new car on finance from a local dealership. He'd sat in the test model in the showroom – but when his car was delivered he found that there wasn't enough headroom inside for him to drive comfortably.

Mr A took the car back to the dealership, who adjusted his seating position. When the problem persisted, the dealership then said that the sunroof might be the cause of Mr A's problem. According to the dealership's technician, this had reduced the headroom in the car by nearly two inches in this model – but this was perfectly normal.

Mr A contacted the finance provider, saying he was unhappy that he hadn't been told about this when he was deciding whether to buy the car. He was concerned that he'd never be able to drive his car comfortably.

The finance provider told Mr A that it was his responsibility to check that the car was suitable for him. They wouldn't allow him to reject the car completely – but instead offered to part exchange it for another without a sunroof.

But Mr A wanted a car with a sunroof – so when the finance provider refused to change their mind, he contacted us.

complaint upheld

Mr A sent us a video of himself sitting in the driver's seat of his car – showing that he wasn't able to drive without leaning forward or to the side. We checked a number of independent websites and confirmed that installing a sunroof in the model Mr A had chosen would reduce the headroom by nearly two inches.

We asked to see the sales brochure that Mr A had been given. However, the space reduction wasn't mentioned.

Mr A was around average height. This suggested the reduction in headroom could affect a significant number of people – so we thought it was important information that needed to be brought to customers' attention.

In our view, we didn't think it was reasonable to expect Mr A to know the impact of installing a sunroof in different models of cars.

We also noted that a *newer* sales brochure that Mr A sent us *did* mention the reduced headroom. So it seemed the car manufacturer now thought this was information customers needed to be given.

We decided that if Mr A had been told about the reduction in headroom, he wouldn't have bought the car with the sunroof. So we told the finance provider to cancel the agreement, refund the deposit Mr A had paid, adding interest – then to let him reject the car, writing off any remaining debt.

To reflect the discomfort Mr A had experienced whilst driving the car, we suggested the finance provider refund 30% of the any payments he'd made over that period. We also told them to pay £150 for the poor service Mr A had received.

... a couple of years later, the alarm company went out of business and so could no longer carry out the monitoring and maintenance

case study 129/12

consumer complains that finance provider won't refund part of her home alarm contract – after supplier goes out of business

Mrs M took out a point-of-sale loan to buy a home alarm, and at the same time paid for monitoring and maintenance services for 10 years. But a couple of years later, the alarm company went out of business and so could no longer carry out the monitoring and maintenance.

By this time, Mrs M had already paid back the loan. She got in touch with the finance provider to ask for a refund for the ongoing services that she now wouldn't receive.

But the finance provider refused. They said that the contract Mrs M had with the company was for the alarm only – and didn't include the cost of monitoring and maintenance. They said this service was a free add-on.

Mrs M complained, saying the monitoring and maintenance were part of the alarm package.

When the finance provider wouldn't reconsider, she contacted us.

complaint upheld

Mrs M sent us the information she'd been given before buying the alarm. This clearly mentioned "24 hour monitoring day in, day out" and "10 years' free monitoring and maintenance".

We asked the finance provider for a copy of the finance agreement. The agreement said that the loan was for the "alarm system and installation only" – but then went on to refer to a "total package price".

The money Mrs M had borrowed was also listed on the agreement as a "monitoring and maintenance set-up fee".

In our view, both the agreement and the other information Mrs M had been given suggested that the 10 years' monitoring and maintenance was part of the package she was paying for.

Mrs M told us she'd bought another alarm with monitoring and maintenance as soon as the alarm company had stopped trading. Given this, we thought that the monitoring and maintenance was a key factor in her decision to buy the original alarm.

In light of what we'd seen, we decided there had been a breach of contract. To put things right, we told the finance provider to give Mrs M a partial refund – taking into account the cost of the monitoring and maintenance services that she'd received before the alarm company went bust – adding 8% interest.

upcoming events ...

smaller business:		
meet the ombudsman roadshow	Oxford	17 November
	Bristol	18 November
consumer adviser:		
working together with the ombudsman	Lincoln	4 November
	Cambridge	10 November
	Norwich	11 November
industry event:		
'closer to home' conference for building societies	London	18 November

For more information – and to book – go to *news and outreach* on our website.

want to tell us what you think about ombudsman news?

We want *ombudsman news* to help people sort out problems quickly and fairly – and to keep up to date with our work.

So this month, we'll be asking people for their views in a short survey. Watch out for your chance to have a say by email.

If you don't receive your copy of *ombudsman news* by email, and you'd like to have a say, you can sign up by sending us a quick email at ombudsman.news@financial-ombudsman.org.uk

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Q? &A

I'm a bit confused about which of your phone numbers to use. What's the difference – and which will be cheapest?

We've had three different numbers since we were set up – as numbers that are low-cost or free from *all* types of phone have only gradually become available over the years.

We haven't promoted our original 0845 number since we've been able to offer a cheaper 0800 number, which is free from landlines.

Until recently our 0300 number was the cheaper option from mobiles – free for people with a package of phone minutes and charged at local rates on pay-as-you-go.

But since July this year, 0800 numbers have been free from mobiles as well as landlines.

So that's likely to be the cheapest option for most people from now on – and one we'll encourage people to use. If someone tells us they're worried about the cost of calling us, we'll always offer to call them instead.

Meanwhile, some people continue to prefer to call us from a payphone – 2,567 did so last year.

I heard that you've started asking businesses for information within three days. Is that right?

A few months ago – in *ombudsman news* 125 – we explained the challenge of meeting people's changing expectations of the services they use. Both for us and for the businesses we cover, that's partly about speed. At a time when technology means people can manage their money in seconds, it's hard to justify taking months to resolve problems.

So if you're someone we talk to on a regular basis, you might have noticed we're asking for some things in a shorter time-frame than before.

But it won't be three days "across the board". In fact, we think rigid processes are in completely the opposite direction to the one we need to be heading in.

Instead, we think about the nature of the information – and the nature of the problem – when deciding what's a reasonable timeframe. It doesn't make sense to set a three week deadline for information in writing if a short phone call could move things forward the same day.

We appreciate there will be times when it isn't easy to find what we've asked for – for example, where there are other parties you need to contact. But generally, you'll of course have the information from your own investigation of the complaint. If you let us know about any difficulty as soon as you can, we can agree a realistic date.

Financial Ombudsman Service