Ombudsman news

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

chief ombudsman, **Walter Merricks**

issue 77

‘*consumer responsibilities*’

Some parts of the financial services industry have been talking about what they call ‘*consumer responsibilities*’ – and pressing the Financial Services Authority (FSA) to say more about this. There are certainly many things that prudent consumers should do, in their own interests, and greater publicity for these things can only be welcome. But the law actually imposes few obligations on consumers – and the FSA itself has no power to impose obligations on them.

A topic often raised with me is whether consumers have a responsibility only to complain if their experiences absolutely justify their doing so. But the unfettered right of consumers to complain – and the obligation on financial businesses to examine and respond to consumer complaints – is very clear. Now is perhaps not the best time for anyone to be suggesting that the right of individuals to raise a complaint should be restricted – as the ombudsman service has just recorded the highest-ever proportion of disputes upheld in favour of consumers.

Financial Ombudsman Service

But should claims-management companies, who can be assumed to be knowledgeable, be more careful and selective – and bear some responsibility if the complaints they sponsor are unjustified? Lord Hunt, in his review of our service, definitely thought so. The scatter-gun approach used by a few claims-management companies – firing off unspecific complaints about any and every product a consumer may have, without identifying what they are or what their client is concerned about – is understandably criticised.

But the principle of '*consumer responsibility*' – whatever it may mean – should not allow a firm that behaves badly to shift the blame onto its victims by blaming them for being too gullible.

For nearly ten years the ombudsman service has been successfully holding the balance by applying well-established tests of fairness and reasonableness in the individual circumstances of particular disputes. I am confident it will continue to do so for the next ten years – and more.

Walter Merricks, chief ombudsman

Financial Ombudsman Service

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switchboard
020 7964 1000

consumer helpline
0845 080 1800 *or* **0300 123 9 123**
open 8am to 6pm Monday to Friday

technical advice desk
020 7964 1400
open 10am to 4pm Monday to Friday

www.financial-ombudsman.org.uk

Financial complaints involving the use of the internet

77/1

consumer complains of financial loss after cashier in bank branch gave him inaccurate information about his online account

Mr T, who had a current account and an internet savings account with bank A, decided to close down his internet account. He would then put his savings in a new account with a different bank – bank B.

He planned to send his savings to bank B in the form of a cheque, so he first needed to transfer the money from his internet account to his current account. He was unsure how long this would take, so he called in at a local branch of bank A and spoke to one of the cashiers. She told him the transfer would be '*instantaneous*' as it was an internal transaction.

So Mr T then posted a cheque to bank B by second-class post, reckoning that it would take at least two days to arrive.

In view of what the cashier had told him, he thought he was allowing ample time for the money to reach his current account before bank B got the cheque.

Early the next morning, he logged-on to his internet account. He entered all the information needed to close the account and transfer his savings to his current account. After he had pressed the button to confirm he wished to proceed, an on-screen message told him the transfer might take '*up to 48 hours*'.

Mr T then cancelled his cheque. He was alarmed by the possibility that it might arrive at bank B before the funds reached his current account. Four days later, once he was sure his savings had been transferred, Mr T sent bank B another cheque.

He then wrote to bank A. He said its cashier had misled him about the length of time it would take to transfer the money from his internet account. He wanted compensation for the

interest he said he had lost, as a result of the delay. He also wanted bank A to refund the fee it had charged for cancelling his cheque.

Bank A acknowledged that Mr T had been misinformed when he visited the branch. However, it pointed out that branch staff did not normally get involved in queries relating to internet accounts. It added that Mr T had not been financially disadvantaged, as he had continued to receive interest on his money within the internet savings account until his savings were transferred.

Unhappy with this response, Mr T referred his complaint to us.

... the terms and conditions clearly stated that the account could only be managed online.

complaint upheld in part

We saw no evidence that Mr T had lost out, as far as interest payments were concerned. The rate offered on his new account was almost identical to the one he had received from his internet account, and bank A had continued to pay interest until his money reached bank B.

The terms and conditions of the internet account clearly stated that the account could only be managed online, and that any queries should be made by telephone or by email, not at a bank branch.

We accepted bank A's point that it was not usual for branch staff to be asked questions relating to the bank's internet accounts. However, we did not think that excused the fact that the cashier had misinformed Mr T. She could simply have given him details of the internet account's phone and email helpline, rather than attempting to answer his query herself.

We said bank A should pay Mr T £50. This covered the amount he had been charged for stopping the cheque, together with a token amount in recognition of the inconvenience it had caused him by its poor handling of his initial enquiry. ■

... both the online process and the wording of the instructions were clear and straightforward

77/2

consumer provides inaccurate details of his income when applying online for a mortgage

After completing an online mortgage application, Mr B was told he had the lender's '*agreement in principle*' for a mortgage of £324,000. Based on this provisional agreement, and as part of the mortgage application process, Mr B authorised a payment to the lender for a booking fee and a valuation fee.

Before it could proceed further with the application, the lender needed to see proof of Mr B's income. After checking through the documents Mr B sent to confirm his income, the lender said it could not lend him more than £260,000. It said his income was '*not sufficient to support a larger amount*'.

Mr B complained that the lender had '*broken the agreement*' and he asked it to return the fees he had already paid. However, the lender refused to do this. It said it had given its '*agreement in principle*' in good faith, based on the information he provided in his online application. It added that it had already spent some time processing his application and had made arrangements for the valuation, even though this had not gone ahead.

Unable to get any further with his complaint, Mr B came to us.

complaint not upheld

The lender sent us a copy of Mr B's online mortgage application form. He had indicated that he received a monthly bonus of £7,000. However, this was not reflected in the documents he later sent the lender. We noted that the £7,000 was not, in fact, related to Mr B's main employment. It was the annual net profit of a separate business that he ran.

We then checked the online application process itself. We looked to see if there was anything about its wording or design that might have misled or confused Mr B – resulting in his entering incorrect information on the form. However, both the online process and the wording of the instructions were clear and straightforward.

We concluded that Mr B had made an unfortunate error when he completed the mortgage application online. That error led directly to the lender's saying it would be prepared to lend him £324,000 – subject to the usual verification of income and a valuation of the property in question.

We said that the fair and reasonable outcome in this particular case was for the lender to refund the valuation fee – as no valuation had taken place. However, we agreed with the lender that it should not refund the booking fee. ■

... he had made an unfortunate error when he completed the mortgage application online.

■ 77/3
consumer denies withholding significant information when applying online for motor insurance

Ms L was due to renew her motor insurance policy but was not particularly happy with the quote she received from her existing insurer. She applied online to a different insurer and was able to obtain a more competitively-priced policy.

A few months later she was involved in a road traffic accident. However, when she put in a claim under her new policy, the insurer refused to pay out. It had discovered that when she applied for her policy, she had said she had no penalty points on her driving licence. In fact she had nine points. The insurer said she had '*intentionally withheld*' this information, so it would '*avoid*' the policy. This meant it would treat the policy as if it had never existed. It would return the premiums she had paid but it would not pay the claim.

Ms L denied that she had intentionally withheld any information. However, the insurer refused to reconsider its decision, so she brought her complaint to us.

... she applied online and was able to obtain a more competitively-priced policy.

complaint not upheld

The insurer sent us details of the forms Ms L had completed online. We looked in particular at the section relating to penalty points. Ms L had told us that this section was set out in a very misleading way. And she said '*the computer must have automatically reverted to a default position that showed a different answer to the one I gave*'.

We found nothing misleading about the way the page was structured, and the wording and layout were perfectly clear. Ms L had been asked to select one of several options to indicate how many points, if any, she had on her licence. There was no '*default position*' that could have led to her inadvertently sending an incorrect answer.

In order to provide the insurer with the information that she had no points on her licence, she had first had to select the '*zero*' option, and then to click on '*yes*' when prompted to confirm that this was her answer.

We therefore thought it more likely than not that Ms L had intentionally misled the insurer about her penalty points. We said the insurer was entitled to reject the claim and to '*avoid*' the policy. ■

77/4

consumer complains that problems with his online share-dealing account caused him to place duplicate order by mistake

Mr A was an experienced investor who regularly bought and sold shares through firm C's online dealing service. He told us he had been interested for some while in making a sizeable investment in the shares of a particular bank. He had been watching the share price closely before deciding the time was right to make his purchase. ▸

... there was a problem with the website and he was unable to log-on to his share-dealing account.

However, after deciding to invest just under £24,000 in the bank's shares, he was frustrated to find there was a problem with firm C's website and he was unable to log-on to his share-dealing account. He therefore rang firm C's phone dealing service and placed an order for the shares.

Later that afternoon, Mr A successfully logged-on to his online account with firm C. However, when he looked at the list of recent transactions he was unable to find any reference to his phone order. Assuming that there had been some error and that firm C had failed to process the order – Mr A then put through an order online for the bank shares.

In due course, Mr A discovered that his phone order had, after all, gone through – as had his later online order. He contacted firm C and asked it to cancel the second order, as he did not have sufficient funds to cover it. Firm C refused to cancel the deal, but it allowed him fourteen days to raise the necessary funds. He settled the account 10 days later.

Mr A then complained to firm C about its refusal to cancel one of the deals. He said it was only because its online system had let him down that he had inadvertently placed a duplicate order. He could not afford to retain both lots of shares and wanted firm C to compensate him if he was forced to sell the '*unwanted*' shares at a loss.

Firm C denied that it was responsible in any way for Mr A placing the second order and it said it was not liable for any losses he might incur. Mr A then referred his complaint to us.

complaint not upheld

In the terms and conditions of its online dealing service, firm C stated that it could not be held responsible for any problems resulting from the service being temporarily unavailable. It also said that there might be a delay before 'executed trades' were listed online in the customer's account. Customers were advised to phone the firm's helpdesk if they had any queries about recent transactions.

... he said the firm's online system had let him down.

Mr A said that before placing his order online he had tried to call the helpline. However, he had been annoyed to find that the line was busy. He said he did not want to '*waste any more time waiting to get through on the phone*'. He was anxious to ensure he got his shares before there was any adverse price movement, so he had gone ahead with the online purchase.

We did not uphold Mr A's complaint. We said it had been his decision to place the second order without first checking whether his phone order had gone through. The firm could not be held responsible for his decision or for any losses he sustained as a result. ■

Frequently-asked questions about the ombudsman service

Continuing our occasional series, we feature the answers to some more of the questions we are most-frequently asked by businesses about the way we work. You will find the answers to more questions in our guides for businesses (see page 12) and on our website, in the special resource (www.financial-ombudsman.org.uk/faq/businesses).

What must my business do when it receives a complaint from a consumer?

The ombudsman service will get involved in looking at a consumer's complaint against your business *only* if you have already had the opportunity to deal with the complaint – and the consumer remains unhappy with your response.

Your business must have in place – and operate – an in-house complaints-handling procedure that complies with the complaints-handling rules. Among other things, these rules require you to:

- send the consumer a prompt written acknowledgment (if you have not been able to resolve the complaint on the spot, or by the end of the next working day);
- ensure you keep the consumer reasonably informed about the progress of their complaint; *and*
- send the consumer a 'final response' within eight weeks from the date your business received the complaint (as long as you have not already resolved the complaint by sending a response which the consumer has accepted in writing).

The time limits for dealing with a complaint apply from the date a complaint is received *anywhere* within your business. And a consumer (or someone acting on their behalf) is entitled to inform you of their complaint in a number of ways – for example, by email, phone or in person.

So businesses must make sure all relevant staff can recognise a complaint and know how their complaints process works. Businesses must also ensure that their complaints process is accessible for consumers with different needs – for example, because of a disability.

Full details of the time limits and other requirements are set out in the 'DISP' section of the *FSA handbook* (available online at http://fsahandbook.info/FSA/html/handbook/DISP).

If a complaint about my business is referred to the ombudsman service, will you need written statements from my employees?

If a dispute between your business and the consumer involves different recollections of a key event, we may need to ask for a written statement from a current or former employee of your business.

If we ask for a written statement from an employee, setting out how they recall a particular event, the statement should be in their own words – and signed by them. They should distinguish clearly between what they *actually remember* doing and what they think they *would have done* in that type of situation.

We expect you to make reasonable efforts to obtain written statements from any employee who may have information relevant to the complaint – even if they are no longer working for you.

Will it matter if my business can't let you have a copy of every item of correspondence we sent to the consumer?

We usually ask to see copies of any letters and other documents that are relevant to the complaint. We appreciate that some of your correspondence may have taken the form of standard letters, generated automatically by computer. Where it is not possible to let us have a copy of an actual letter, we may accept a copy of the standard letter that was in use at the time – together with the computer record showing that the standard letter was definitely generated. Simply telling us the standard letter *would have been* generated may not be enough.

What about confidentiality?

We will have regard for your rights of privacy. We do not automatically copy to both sides all the information we have on a case. But, in general, you should assume that we may disclose to the consumer any information you send us about the complaint. We will certainly need to summarise information that is central to our decision, as well as disclosing other information where we think it appropriate.

If you believe that some information should be confidential between you and the ombudsman service, you should mark that information clearly – and tell us why you do not think we should pass it to the consumer. We will consider your request – but we may not agree to it unless there is a strong case for confidentiality, such as security reasons. Our statutory right to demand information overrides your duty of confidentiality to any third party.

Finding out more about the ombudsman service

You can download our recently-revised guides for businesses from the publications page of our website – or you can obtain copies, free of charge, by contacting our publications team (*phone* 020 7964 0092 or *email* publications@financial-ombudsman.org.uk).

The ombudsman and smaller businesses is a brief guide aimed at those businesses we cover that don't usually have much contact with us, as they don't generally receive complaints.

The ombudsman and larger businesses is a detailed guide aimed at people working in areas such as compliance units and customer service departments of larger financial services groups, who deal regularly with complaints and the ombudsman service.

A selection of cases involving private medical insurance

In issue 51 of *ombudsman news* (January/February 2006) we reported on an informal seminar we hosted on complaints about private medical insurance. The seminar involved our insurance ombudsmen and an audience made up of representatives from around 30 insurance companies and intermediary firms, as well as officials from the Association of British Insurers (ABI) and the Association of Medical Insurance Intermediaries. Discussions at the seminar covered a range of issues including:

- the main causes of private medical insurance complaints referred to the ombudsman;
- how adjudicators and ombudsmen decide whether an insurer should pay for medical treatment;
- how the ombudsman assesses the medical evidence in disputes over medical claims; *and*
- the ombudsman's position regarding exclusions for unproven and/or experimental treatment.

Since the seminar, the number of complaints we have received about private medical insurance has remained at a low level – under 1% of the total number of complaints received. Last year (the financial year 2008/09), out of the total of 127,471 new cases we received overall, 514 involved disputes over private medical insurance. The selection of case studies below covers the types of issue we see in these cases – and illustrates the themes and general approach we outlined at the seminar.

77/5
private medical insurer refuses to pay claim for treatment undertaken while policyholder was abroad

While she was working temporarily in Portugal, Mrs J was referred to a medical consultant as she had been suffering from a persistent sore throat. Concerned that she might have a form of cancer, the consultant recommended that she should undergo a biopsy '*as soon as possible*'.

This procedure was carried out ten days later, in Portugal, and Mrs J put in a claim to her medical insurer. However, the insurer refused to pay out. It said she was only covered for medical treatment outside the UK if it was required as a result of a '*medical emergency*'. The insurer did not consider this case to have been a medical emergency.

Mrs J thought this was unfair. She complained to the insurer, saying it had failed to take into account the consultant's '*expert opinion that immediate action was required*'.

In response, the insurer pointed to the fact that the biopsy had not taken place until ten days after she had seen the consultant. The insurer added that, in its view, it would not have been particularly difficult for Mrs J to have returned home, so that the biopsy could be carried out in the UK. Flights could be arranged at short notice and at a relatively low cost.

Mrs J then referred her complaint to us.

complaint upheld in part

We noted that the policy terms and conditions clearly excluded medical treatment that was undertaken outside the UK, except in an emergency. The exact meaning of '*emergency*' was not defined, but (as is normal in such circumstances) could be taken to have its ordinary, everyday meaning.

We noted the Portuguese consultant's opinion that Mrs J needed a biopsy in order to establish whether or not she had cancer. There was clearly some urgency about carrying out the procedure. However, we noted that the consultant had said that action was required '*as soon as possible*', not immediately.

The biopsy had taken place ten days after Mrs J had first consulted him. Given the timescale involved, we concluded on balance that the situation had not been a '*medical emergency*'.

However, we noted that if Mrs J had returned to the UK to have the biopsy, the insurer would have been obliged to pay for it, under the terms of the policy.

We said that the fair and reasonable outcome in this case was for the insurer to pay Mrs J the amount she would have been charged for the biopsy in the UK. This was, in fact, considerably less than the amount she had actually paid. ■

77/6
private medical insurer refuses to pay the full cost of a consultation with a specialist who is not on its approved list

Mrs C, who was in her 60s, was experiencing increasing problems with mobility. She had private medical insurance and her GP decided to refer her to Mr Q, a consultant at the local hospital.

Before confirming the date of her appointment, Mrs C contacted her insurer to get authorisation. She was taken aback when the insurer said it would not pay for her to see Mr Q. The insurer explained that although her policy covered the costs of a consultation with a specialist, that specialist would have to be chosen from those on its approved list.

The insurer sent her its list of approved consultants and suggested she should ask her GP to refer her to one of them. However, Mrs C discovered that none of these consultants were based in her home town – or even within what she felt was reasonable travelling distance. She therefore contacted the insurer again.

Mrs C explained that visiting any of the consultants on its list would entail a lengthy journey for her. She said she would find this difficult – not only because of her mobility problems but also because she suffered from incontinence.

The insurer told Mrs C that it appreciated the particular problems she faced. However, it said that Mr Q's fees were higher than those of the consultants on its list.

The insurer offered to pay her an additional amount, in recognition of any distress or inconvenience caused by its handling of the matter. However, it insisted that it was unable to meet the cost of a consultation with Mr Q. Mrs C then referred her complaint to us.

complaint upheld

We noted that over that past year or so, the insurer had been gradually reducing its list of approved consultants. In our view, this left Mrs C in a position where she was unable to receive the full benefit of her policy. Her medical condition was covered, but none of the consultants on the insurer's list were within reasonable travelling distance for her.

... the insurer said she would have to see one of its approved specialists.

Our enquiries suggested that Mr Q's fees were not particularly high, when compared to the fees charged by other consultants in the area. So we said that in these particular circumstances, the insurer should pay her the amount it would cost to see one of its approved consultants. She could then use that sum to see Mr Q at her local hospital.

77/7

private medical insurer refuses to authorise the ongoing use of a drug it considers to be '*experimental*'

After being diagnosed with cancer in 2004, Mr J successfully underwent a course of chemotherapy. Within a year he was in remission and able to return full-time to his job as a draftsman for a large construction firm.

Unfortunately, in April 2008 he suffered a relapse. His specialist recommended a further course of chemotherapy, using a different drug, and Mr J's private medical insurer agreed to meet the cost of this treatment.

By August of that year, Mr J was again in remission. However, his consultant recommended that '*in order to achieve complete remission... to remove residual disease...*' he should continue receiving infusions of the same drug, at three-monthly intervals, for an initial period of 12 months.

Before undertaking this treatment, Mr J contacted his insurer. It had not crossed his mind that there would be any difficulty in obtaining the insurer's authorisation. However, the insurer said it was unable to pay for the proposed treatment. It told him it did not think the use of this particular drug would have any impact on his underlying condition, which had now become '*chronic*'.

It also said that it considered the use of the drug in question for treatment after remission was '*experimental*'. And it reminded him that it had written to all its policyholders in May 2005, saying it was withdrawing funding for '*experimental*' treatment.

Mr J told the insurer he thought its attitude was '*unreasonable*'. He pointed out that his consultant had told him the proposed treatment was '*effective, recognised and authorised for use*' in treating his particular condition. However, the insurer still insisted that it was unable to fund the treatment. Mr J then brought his complaint to us.

complaint upheld

We noted that the policy explicitly covered treatment, '*intended to stabilise and bring under control a chronic condition*'. However, there was also an exclusion that clearly stated the insurer would not pay for '*the use of a drug or treatment which has not been established as being effective or which is experimental*'.

The insurer was committed to reimburse the cost of medical treatment covered by the policy and it was for the policyholder's consultant, not the insurer, to decide the appropriate treatment. What we needed to do was to determine whether the insurer had applied the policy exclusion fairly and reasonably, in all the circumstances of this particular case.

We noted that the drug in question was one that the insurer mentioned in its letter to policyholders of May 2005, when it said it was withdrawing funding for treatment using certain types of drug. However, the insurer had authorised and paid for Mr J's treatment using that same drug in April 2008.

We looked at medical evidence, provided by both the insurer and by Mr J's consultant, concerning the use of the drug in question. We found the drug was widely considered to be a well-established and effective treatment for patients in a similar situation to Mr J. The evidence suggested that the chance of complete remission after treatment was up to 10%, while there was a 60% chance of partial remission.

We took the view that, on the balance of the evidence, the insurer should authorise the use of the drug in this case. The evidence on its use and potential effectiveness indicated that it was no longer experimental – and that it could improve, or at least stabilise, Mr J's condition.

We told the insurer that it should pay for the proposed course of treatment, if Mr J decided to proceed with it. We also said the insurer could exclude the cost of any treatment, medical attention or surgery that might arise in any future claims from Mr J, if they came about as a consequence of his undergoing treatment with this drug. ■

77/8
private medical insurer refuses to authorise payment for surgical procedure it says is '*unproven*'

After being referred to a consultant surgeon, Mr E was told he needed prostate surgery. He rang his insurer to obtain authorisation and was told the procedure was covered by his policy. A few days later, Mr E received a letter confirming the insurer's authorisation.

The exact procedure that Mr E's surgeon planned to carry out was to be undertaken as a robot-assisted operation. The surgeon was aware that some insurers had declined to cover this particular procedure in the past. So even though he knew Mr E had already obtained authorisation, the surgeon told him he would contact the insurer. He wanted to be certain it was fully aware of what was proposed.

Mr E then decided he ought to phone the insurer again himself, just to check the position. Initially, he was told that the exact procedure he was having was covered by his policy. Later the same day, however, the insurer rang Mr E to say it would not be able to pay the full cost of the procedure.

The insurer told Mr E that the proposed treatment was considered to be '*experimental or unproven*', so it was not covered by the policy. The insurer was prepared to pay an amount '*equivalent to the cost of the procedure based on conventional treatment*'. But it pointed out that there would probably still be a shortfall, which would be Mr E's responsibility.

Very unhappy with this outcome, Mr E complained to the insurer that it had '*reneged*' on its agreement. He disagreed with the insurer's view that the robot-assisted procedure was '*experimental*', and he said he understood the procedure was widely used in many NHS hospitals.

In its response, the insurer said it accepted it '*could have been more clear about exactly what costs were covered*'. It said it would therefore increase the sum it had already agreed to pay towards the cost of his surgery. However, it still insisted that it was unable to cover the full cost of a robot-assisted procedure.

Mr E thought it unacceptable that he would still have to pay a certain amount towards a procedure that – in his view – should be fully covered by his policy. He therefore brought his complaint to us.

... we needed to determine whether the robot-assisted procedure was '*experimental and/or unproven*'.

complaint not upheld

To decide the complaint, we needed to determine whether the robot-assisted procedure was '*experimental and/or unproven*', and whether the insurer had acted fairly and reasonably by offering to pay no more than the cost of an equivalent conventional procedure.

We noted that the policy wording clearly set out that it would not pay for '*treatment which has not been established as being effective or which is experimental*.'

In assessing the claim, the insurer had referred to guidance issued by NICE (The National Institute for Health and Clinical Excellence). This suggested it was not yet clear whether a robot-assisted procedure offered any advantage over a conventional procedure.

NICE is an independent organisation providing national guidance on areas such as public health, treatment regimes, procedures within the NHS, and clinical practice.

Given the status of NICE, we thought it reasonable for the insurer to take its findings into account.

The insurer had offered to pay Mr E an amount equivalent to the cost of undergoing a conventional procedure, together with an additional sum in recognition of the confusion it had caused by its poor handling of the claim. We told him we thought this was fair and reasonable, in all the circumstances of the case. ■■■

the Q&A page

featuring questions that businesses and advice workers have raised recently with the ombudsman's technical advice desk – our free, expert service for professional complaints-handlers

Q. When and how does the ombudsman add interest if it awards compensation to a consumer?

A. In complaints where a consumer has been wrongly deprived of a sum of money in the past – for example, where an insurance claim was wrongly rejected – we usually require the financial business to add interest from the date the consumer *should have had* the money until the date the money is actually paid.

In some cases, there will be an identifiable cost that the consumer incurred as a result of having to borrow money in the meantime. In other cases, there will be an identifiable loss of income on other funds that the consumer had to use instead.

But in most cases, the effect on the consumer's finances could only be discovered by making speculative assumptions. So unless it is apparent what the consumer's borrowing cost (or investment loss) actually was, we are likely to award interest at 8% a year simple.

The law requires the financial business to deduct lower-rate tax from this, and some consumers may also have to pay higher-rate tax – even if they had to pay non-tax-deductible interest on borrowing in the meantime.

The current low rates paid on deposit accounts are not an appropriate yardstick. The rates of interest consumers have to pay in order to borrow are much higher. And we are usually awarding compensation for past periods, when deposit rates were higher.

Q. At the beginning of the year, *ombudsman news* mentioned a new definition for the type of business that can bring a complaint to the ombudsman. Has this happened yet?

A. Currently complaints can be made by, or on behalf of, customers (or potential customers) who are:

- private individuals
- small businesses with an annual turnover under £1 million (some other limits may also apply)
- charities with a yearly income under £1 million
- trusts with net assets under £1 million.

From 1 November 2009 these definitions will change, reflecting European Union law. The new definitions will be:

- private individuals *and*
- 'micro-enterprises'.

'Micro-enterprises' will be able to bring complaints to the ombudsman as long as they have an annual turnover of under 2 million euros (approx £1.7 million) and fewer than ten employees.

The proportion of complaints referred to us by smaller businesses increased slightly last year – from 2% to 3% of all cases. However, we know that sole traders, in particular, don't always register their complaint with us as a *business* complaint, because they often see the issues as personal rather than commercial. The small rise in complaints brought by businesses may reflect our outreach work in this area, which has included liaising with smaller-business trade associations and networks, taking part in events such as *Business Start-Up* shows, and arranging targeted coverage in specialist business-to-business publications.

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