People are still feeling the pinch – and many more are prepared to take action if they have a problem.

Natalie Ceeney, chief executive and chief ombudsman

ombudsman news

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

feeling wintry

The final issue of the year is always a good opportunity to take stock, and to look ahead to next year. Nobody will be surprised to hear that 2012 has been our busiest year ever. Most people will have seen reports in the media about the dwindling trust between the public and the financial services industry.

Add to this the fact that people are still feeling the pinch – and that many more are prepared to take action if they have a problem – and the upward trend is even less surprising.

And then, of course, there's PPI – which is already the biggest mis-selling scandal in the history of the UK's financial services.

The clean-up operation has scaled up significantly this year to keep pace with demand. We've now received half a million complaints in total about PPI – and so far this year we've handled double the number of cases that we had geared up to receive, following public consultation last year.

▶

Financial Ombudsman Service

scan for previous issues

in this issue

Whatever happens, clearly PPI – on top of a growing caseload in other areas – will present us with some major challenges for some time to come.

Looking ahead, we will need to build on our achievements of the past year. Even though we've had to double in size because of the increased volumes of complaints, we've helped more people than ever, and we've still been able to maintain people's trust and confidence in our services.

This is crucial to us, at a time when trust is eroding in so many institutions. We've also set out plans – broadly welcomed by all sides – to allocate costs in a more transparent and fairer way among the larger businesses, while lifting most smaller businesses out of paying case fees altogether. And we'll be continuing to respond to our customers' changing expectations with some more innovative approaches to casework.

I know that a lot of people will have views on our plans for next year – and on the workload we should be expecting to see coming our way. As usual, we will publish the plans – along with our proposed budget – for consultation in January 2013. I look forward to hearing your thoughts.

Natalie Ceeney
chief executive and chief ombudsman

For a more in-depth look at what's been happening in 2012 and what we can expect next year, *ombudsman news* caught up with Natalie for this issue's *ombudsman focus* – on page 10

... we've helped more people than ever, and still been able to maintain trust and confidence

Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR

switchboard 020 7964 1000

consumer helpline
new extended opening hours
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

regular payments

Standing orders and direct debits are two of the most familiar ways of transferring money or making a payment. In most cases, payments and transfers go through promptly and without any problems.
But sometimes things go wrong. And if a consumer cannot sort a problem out directly with a financial business, we can consider the complaint.

Financial Ombudsman Service

Although standing orders and direct debits might seem similar, they do work differently. We sometimes find that problems are caused by a misunderstanding – on the part of the consumer or the financial business – about how these payment arrangements actually work.

A direct debit is set up by a consumer with the *recipient* of the direct debit payments. The recipient then notifies the consumer's current account provider about the direct debit mandate – and applies for the payments when they are due. The recipient can make changes to the payments that it collects under the arrangement – but consumers who decide to make payments by direct debit are protected by the Direct Debit Guarantee. This requires payment recipients to tell a consumer if there are changes to their direct debit, and banks or building societies to refund the consumer if a payment is made in error.

A standing order is set up by the consumer with their current account provider – and any changes to the standing order are made by the consumer direct with that current account provider. The current account provider sends the regular payments to the recipient named by the consumer – until *either* the consumer tells it to stop *or* the standing order instruction runs out.

Continuous payment authorities are different again. They can only be set up on plastic cards – that is, credit or debit cards. Consumers often use continuous payment authorities to pay ongoing subscription charges – for example, for magazine subscriptions or gym membership. The consumer gives their authority to the supplier that they want to pay – and the supplier then takes the regular payments direct from the consumer's bank. In the cases we see, some consumers have run into problems when they decided to stop the ongoing payments.

Often, they have not been able to make the supplier stop taking the payments – and they can't get their bank to stop things at their end, either. Since November 2009, new rules have meant that consumers have also been able to cancel continuous payment authorities with their own bank.

Our online technical resource contains more information about our approach to cases involving these different payment methods. The case studies that follow illustrate some of the more common problems that we see, including:

- direct debit payments not being paid
- banks failing to cancel a direct debit
- confusion about how banks process direct debits and standing orders – and the implications for consumers

... money to cover a direct debit would need to be in the account the day before the payment was due to come out

- problems cancelling continuous payment authorities

case study 106/1

complaint about unpaid direct debits causing damage to the consumer's reputation

Mr T went into the bank in the afternoon and paid some money into his business account to cover two direct debits that were due to come out of his account that day. However, although Mr T's account was in credit, there was not enough money to cover either of the direct debits – and they were "returned" as unpaid on the same day.

Mr T complained to his bank. He said that he had gone into the bank specifically to pay in money to cover the payments – and that his reputation with two of his suppliers had been damaged. He pointed out that his statement showed the money going into his account on the same day as the direct debits were due to be come out.

The bank explained to Mr T that to make sure the money was available to cover the payments, he would have needed to pay it into his account by the end of the working day *before* the direct debts were due to go out. The bank rejected Mr T's complaint, and he asked us to investigate.

complaint not upheld

We reviewed the terms and conditions of Mr T's business bank account. We found they explained clearly that money to cover a direct debit would need to be in the account *the day before* the payment was due to come out. We also noted that Mr T had found himself in a similar situation before – and that the bank had explained the terms and conditions to him then.

We noted that the bank had processed the direct debits early in the morning – and well before Mr T had paid in the money he had intended to cover them. We explained to Mr T that banks usually do process payments early – which is why the money would have needed to be in his account the previous day.

In these circumstances, we did not uphold the complaint.

case study 106/2

complaint about a bank allowing direct debits without holding any "signed authority"

Mr M had been paying his monthly mobile phone bill by direct debit. Shortly after he cancelled his contract – and paid the outstanding balance on his account – he noticed that his mobile phone provider had taken some money from his bank account by direct debit. He contacted them to ask why they had taken the payment – and reminded them that he didn't owe them any money. The mobile phone provider acknowledged its mistake and refunded the money to his account.

Although his money had been refunded, Mr M was annoyed about what had happened. So he wrote to his bank to ask why the direct debit had gone through without his permission. The bank wrote back to Mr M. It explained that when he had taken out the contract with the mobile phone provider, a direct debit had been set up under the Automated Direct Debit Instruction Service – usually shortened to AUDDIS. This scheme allows direct debits to be set up electronically – without the provider of goods or services needing to send paper instructions to the bank. But Mr M was unhappy with this explanation, and decided to refer his complaint to us.

complaint not upheld

When we looked into Mr M's case, we concluded that the bank had set up the direct debit correctly. It had used the information supplied by the mobile phone provider through "AUDDIS". We explained this to Mr M.

We also explained to Mr M that under the Direct Debit Guarantee, a bank must refund any payments taken in error. But in this case, Mr M's mobile phone provider had already put things right – so we did not ask his bank to do anything else.

... he wrote to his bank to ask why the direct debit had gone through without his permission

case study 106/3

complaint about a bank failing to cancel a direct debit

Mr E had a number of direct debits set up on his bank account. He was looking to reduce his outgoings, so he printed off a list of his regular payments to look for things he could manage without. He decided that going to the gym twice a week was a luxury he could no longer afford. So he wrote to the gym to cancel his membership – and asked his bank to cancel the direct debit.

However, the bank did *not* cancel the direct debit to the gym and the payments continued for a few months – until Mr E noticed that they were still coming out of his account. When he complained to his bank, it apologised for the mistake and offered him £50 for the inconvenience it had caused.

Mr E was not satisfied with this response – and asked the bank to refund the payments it had made to his gym in error. The bank refused, saying that Mr E should have noticed that the payments were still being made – and that he had "continued to benefit" from his gym membership.

Mr E was still unhappy, so he decided to refer the matter to us.

complaint upheld

We weighed up both sides of the argument. We did not think it was reasonable for the bank to say that Mr E had "benefited" from his continued gym membership – not least because he had cancelled it, so would have had no reason to have gone to the gym. And we did not agree with the bank that Mr E should have noticed that the payments had continued to be made.

We also reminded the bank of its responsibilities under the Direct Debit Guarantee scheme – which covers exactly this sort of situation. We told the bank to refund to Mr E the payments it had made since he had cancelled the direct debit. We also told the bank to pay him £150 for the inconvenience it had caused him.

... we did not agree with the bank that Mr E should have noticed that the payments had continued to be made

... she said the bank should not have made the payment later than the date she had asked it to

case study
106/4

complaint about a bank processing a standing order in error – which led to recipient receiving money twice

Mrs N decided to switch her current account to a different bank. She used her new bank's account switching service to transfer her direct debits and standing orders across to her new account. These included a standing order to pay rent to her landlord each month. The first payment was due to go out on the first day of the following month.

On the day the payment was due to go out, there wasn't enough money in Mrs N's account to cover it. Mrs N decided to pay her landlord in cash for that month's rent. However, a few days later, she paid more money into her account – and her bank processed the rent standing order.

When she realised what had happened, Mrs N complained to her bank. She said that it should not have made the payment later than the date she had asked it to – and that she was now out of pocket. The bank rejected her complaint. It pointed out that her standing order instruction had always said that if there was not enough money in her account to make a payment, the bank would make the payment as soon as enough money became available. Mrs N was not satisfied with this response – and referred the matter to us.

complaint not upheld

When we looked at Mrs N's standing order instruction, we saw that it *did* explain clearly what would happen if there was not enough money in her account on the day the standing order payment was due. So we were satisfied that the bank had not made a mistake when it paid the standing order – and that it could not reasonably have realised that Mrs N had decided to make a one-off payment for that month.

So although Mrs N's landlord had been paid twice that month, we did not think it was reasonable to hold the bank responsible for it. We suggested to Mrs N that she speak to her landlord directly about getting the overpayment refunded.

case study
106/5

complaint from consumers with power of attorney about bank making payments under a continuous payment authority

Mr C and Ms A's father was becoming less confident in managing his finances. So he decided to ask his son and daughter, Mr C and Ms A, to look after his financial affairs – and made a power of attorney. Mr C and Ms A wrote to their father's bank to tell it that they would be managing their father's finances – and instructed it to cancel all the direct debits set up on his account.

A year later, Mr C and Ms A were surprised to find that some regular payments had been made from their father's account. Ms A phoned the bank to ask what had happened, and was told that the payments were to do with a satellite television subscription.

Mr C and Ms A complained to the bank. They explained that they had asked for all their father's direct debits to be cancelled – and that it had not happened. The bank responded to their letter. It said that the payments in question were not direct debits, but a "continuous payment authority" – and that it had been obliged to make the payments. It suggested that Mr C and Ms A contact the satellite television provider to get a refund.

Mr C and Ms A were unhappy with the bank's response – and they asked us to look into the situation.

We explained to Mr C and Ms A that a "continuous payment authority" (often called a CPA) is not the same thing as a direct debit. A continuous payment authority is a payment arrangement that a consumer sets up on their plastic card. This type of payment arrangement is often used to enable regular monthly payments – for example, to pay for a gym membership or internet subscription.

But it can *also* be used to enable a supplier to take variable payments at any time during the month. The consumer gives their authority to the supplier that they want to pay – and the supplier then takes the payments direct from the consumer's bank.

We discussed Mr C and Ms A's situation with their bank. We pointed out that when Mr C and Ms A had taken on their father's financial affairs, they had written to the bank to explain the situation. Although they had not specifically mentioned the satellite TV payment, we felt the bank should have known enough about their circumstances to have clarified with them whether they had wanted to cancel *all* the payments coming out of their father's account – or just the direct debits. After we spoke to the bank, it got in touch with Mr C and Ms A and offered to put things right.

... the bank said it had been obliged to make the payments

... he felt the bank should have written to the department store to explain the situation

case study 106/6

complaint about a bank not paying a direct debit

Mr N took out a store card with a department store. Rather than worry about remembering to pay off the balance each month, he set up a direct debit to pay off the monthly balance in full. Two months later, the store wrote to Mr N to tell him that the direct debit had not been paid. So Mr N got in touch with his bank to find out what was happening.

Mr N's bank looked into it, and wrote to him explaining that the store's instruction for the direct debit had included the wrong bank account number for him. This meant the bank had not been able to take the payment from Mr N's account. Mr N did not feel that this was good enough. He felt the bank should have written to the department store to explain the situation. When the bank rejected his complaint, Mr N decided to refer the matter to us.

complaint not upheld

When we investigated what had happened, we found that the store *had* submitted the wrong account number to the bank. So the bank had been rejecting the payment because it could not find the account it was supposed to come out of.

We explained to Mr N how the automated direct debit process works – and why his bank would not have been able to identify the account the direct debit was actually intended for.

We were satisfied that the bank had returned the direct debit request to the store – and had added the explanation "no account". We thought this should have alerted the store card issuer to a problem with the account number – and that they should have dealt with the problem from there. We suggested to Mr N that he take our letter to the department store to see what solutions they could come up with.

ombudsman focus: **so that was 2012**

For many people, 2012 will forever be associated with the Queen's Diamond Jubilee and the London Olympics. But what has it meant for the ombudsman? *ombudsman news* caught up with Natalie Ceeney to find out

how would you sum up the year so far, Natalie?

I mentioned in my introduction to this issue that we've never been busier – and that nobody's very surprised to hear it. But what might come as a surprise is exactly how much busier we've been – and the fact that this isn't just down to PPI. The truth is, we've seen more complaints about everything. Between June and September this year, complaints about banking and credit were up some 15% on last year. And cases involving general insurance (that is, not PPI) were up by around 10%.

In a difficult economic climate, with more people than ever feeling the pinch, it's not surprising that complaints have increased – and that people are more prepared to pursue them.

We're certainly seeing more cases from people who are struggling financially.

Add to this the fact that people are increasingly feeling more empowered to find out information for themselves – and that trust in financial services providers is generally considered to have slumped – and I think it's inevitable that more people than ever are referring problems to us that they can't sort out themselves with their bank, insurer or financial business.

Obviously it's been disappointing that more complaints haven't been resolved without our having to get involved. But that's the reality. And unfortunately, it looks likely that this will continue into next year.

so what's happening? Who's complaining about what, and why?

The work we do can give us – and the financial services industry more widely – some valuable insight into what's happening out there. We've had some new issues coming up this year. The RBS Group's IT problem over the summer was something that no one was expecting. And we're seeing more cases involving interest rate hedging products, financial hardship, payday loans, mobile phone insurance and packaged bank accounts.

We also look for trends in consumer behaviour to help us improve our services. I want to be clear that, despite growing media concern about "fraudulent behaviour" we haven't seen an increase in people bringing complaints to us inappropriately. In our general casework – that is, not PPI complaints, we're finding in favour of the consumer in roughly the same proportion of cases that we always have. But I can't talk about trends without talking about PPI ...

of course – so tell me more about what's happening in PPI

Complaints about mis-sold PPI have dominated our workload this year. We've now received over 500,000 complaints about PPI – and are still getting over 1000 new PPI complaints referred to us each day. This has given us some major challenges.

We've had to find a way to deal with unprecedented numbers of enquiries without compromising on our standards. It's widely known that we've had to pretty much double the number of our case handlers. But if you consider the scale of the problem – with about 35 million PPI policies estimated to have been sold and, so far just under 5 million or so complaints – you won't be surprised to hear that we expect the clean-up operation will take time, and will need a lot of resource allocated to it.

It has to be done properly, and it will take time. We're currently working on our plans for increasing our capacity yet again to deal with the current high volumes of cases. We'll be putting these plans out for public consultation in January, as part of our annual budget discussions.

what does all this mean for financial businesses?

Of the 100,000 or so financial businesses that we cover, in fact 95% never have any contact with us at all. So this means very little for them. Of the businesses that do have complaints referred to us about them, three quarters have fewer than three cases a year. One of our major concerns is to allocate costs fairly and transparently – making sure that they're borne by those businesses involved in the most complaints.

does that mean that smaller businesses won't be affected?

At the moment, we don't charge businesses case fees for the first three cases. And we're just finalising proposals that we'll consult on in January to increase this to 25 free cases from April 2013. This would lift most businesses out of paying any case fees at all – which feels like the right direction to be heading in.

and how about consumers?

In general casework – not PPI – it's inevitable that the higher number of complaints we've received has put pressure on us. But despite the increased volume of cases, we're still resolving most complaints in under six months – and we're working on a number of initiatives to reduce waiting times further. For people who refer PPI cases to us, I'm afraid the wait is likely to be much longer, just because of the scale of the clean-up operation we've got on. But we will always be honest with people about what they can expect – and keep them informed about how their case is progressing.

... we've had to find a way to deal with unprecedented numbers of enquiries without compromising on our standards

what were your main achievements this year?

What I'm most pleased about is that we've helped more people than ever – and crucially, that we've retained their confidence in our services. Over three quarters of people who have used us would recommend us to a friend or a member of their family. When trust is such a big issue in our sector, I find this very reassuring.

The fact we've managed to do this at the same time that we've had to double the size of our organisation – and test out some innovative work to meet our customers' changing expectations – makes me even more proud.

It was an incredible summer. How did you find it?

It was amazing. People might not realise that we're based only a quarter of a mile away from the Olympic Stadium – so it really felt as though we were in the heart of the action. On a more mundane level, like everyone else based around here, we'd made plans for all kinds of disruption – and we were determined that our customers wouldn't be affected. We thought it all through – from people's journeys to work to rescheduling deliveries of loo roll.

But actually, everything turned out fine. We soaked up the atmosphere and just got on with it. In fact, our productivity rose slightly over the summer. Maybe we were basking in the reflected glory of Team GB.

looking ahead to next year, what would need to happen to start re-building trust between consumers and the financial services industry?

Here at the ombudsman service, we deal with many cases should already have been sorted out by financial businesses. It's therefore disappointing that we've had to expand so significantly – and our growth is itself an illustration of some of the problems in the industry.

But I do keep returning to the issue of trust. I'm convinced that something can be done about the problems we're seeing. And there are things that businesses can do, and equally, things that consumers can do.

I'd like to see businesses making sure they deliver what they promise to their customers. I'd like to see them learning lessons from the complaints they receive – and offering consumers a fair deal in the first place. And I'd like to see businesses thinking differently about people who complain. These people are not problems – and dealing with their concerns fairly and properly can help improve things for the future.

Consumers can play their part too. I would encourage people to seek out all the information and advice they can – and not to bury their head in the sand if they think they have a problem. Most things can be sorted out by talking openly to their bank or insurer or financial business early on.

As well as resolving individual disputes, our role in this is to share the insight we gather from our work to help prevent problems in the future. And in the meantime, we'll be working as hard as we can to deal with the cases that come our way as effectively as we can.

So far, the Mayan prophecy about the world ending in 2012 hasn't come to pass. Will you be on edge as the year draws to a close?

No – I'm too busy gearing up for 2013. I'm pretty confident there'll be one. In fact, I'm so confident that plans for next year are already well underway. In the first few weeks of the New Year we'll be consulting on plans, budgets, trends and workloads for 2013-14. I'm looking forward to hearing people's views on our plans and proposals.

pet insurance

Pet insurance is designed to help consumers pay for unexpected vet's bills and related treatment. Pet insurance policies are very popular. But like most insurance policies, they do not cover *every* eventuality. The policies often include restrictions that may not always be obvious to consumers.
The problems we see usually arise when an insurer refuses to pay a claim. This may happen because the insurer says that:

- **the pet already suffered from the condition when the policy was taken out**
- **the pet first showed signs of the condition shortly after the policy was taken out, and the policy did not cover conditions arising so soon**
- **the consumer was claiming for treatment that took place more than 12 months after the condition became apparent, and the cover only lasted for 12 months after the first sign of the condition**
- **the consumer failed to disclose important information about the pet's medical history when they took the policy out.**

Cases involving pet insurance are dealt with by a specialist team of experienced people. When we consider these cases, we look at the policy wording and any other relevant documents. We also take into account any medical evidence provided by vets – for example, clinical notes and written submissions.

In June 2012, we published a final decision on our website about a case involving an insurer's decision to withdraw from the pet insurance market. Their decision to withdraw had meant that a consumer – who had believed that her pet would be covered for life – would need to look elsewhere for her insurance. If she had chosen to take out a new policy independently, her pet's "pre-existing medical condition" may not have been covered – and she would have been left to foot the bill for her any treatment for her pet's condition in the future.

Essentially, we told the insurer that its description of the policy as "life-long" was misleading – and that if it had communicated earlier and more clearly with its customer, she would have been able to make alternative arrangements for her pet. As it was, we were pleased the insurer responded to our findings by offering their customer a new policy – that would give the same cover for her pet's condition as her original policy.

That case was covered extensively in the media. So we have chosen the case studies that follow to illustrate some different issues, including:

- **"pre-existing medical conditions"**
- **a "pre-disposition" to a medical condition**
- **a rejected claim for the loss of a horse – where the decision to put the horse down was not in line with British Equine Veterinary Association (BEVA) guidelines**

Our *online technical resource*, available on our website, contains more information about our approach to cases involving pet insurance.

Financial Ombudsman Service

... we doubted whether she would have taken out a policy that would not cover Bella's condition

case study 106/7

complaint about a "pre-existing medical condition"

Mrs R's dog, Bella, had a recurring hip problem. Mrs R had an insurance policy in place for Bella, and had made a successful claim for the cost of some treatment. But she was unhappy with the way she had been treated by her insurer, and decided to switch to another provider. So she phoned a different insurer, spoke to an adviser and took out a policy. She then cancelled her original policy.

About a year later, Bella needed more treatment for her hip problem – and Mrs R put in a claim to cover the cost of the vet's fees.

But the insurer turned down her claim on the grounds that Bella's treatment had been for a "pre-existing medical condition", which the policy did not cover.

Mrs R was unhappy with this and complained to the insurer. She said that she had asked specifically whether Bella's hip problem would be covered – and had been told that it would. She added that she would definitely *not* have taken the policy out if she had been told that the condition would not be covered.

In its response, the insurer accepted that Mrs R had told them about Bella's hip problem. But it did not agree that it had said it would cover the condition. The insurer also said that Mrs R should have read the policy terms carefully. Mrs R was not sure what else she could do, so she decided to refer the matter to us.

complaint upheld

The insurer could not give us a recording of the phone conversation that had taken place between Mrs R and the adviser. But it did give us a note that the adviser had taken during the call. Although the note was not particularly detailed, it did indicate that the representative had "advised the consumer of the terms and conditions".

However, when we looked into Mrs R's circumstances, we doubted the fact that she would have taken out a policy that would *not* cover Bella's condition. After all, she had known that Bella's condition would have been likely to continue, and that she might have needed to claim under her new policy.

We thought it was likely that *if* Mrs R had been given the full picture by the insurer, she would have kept her existing policy – and continued to be covered by it, rather than take out a new one and risk *not* being covered.

In these circumstances, we told the insurer to pay the claim.

case study 106/8

complaint about a claim rejected because of a "pre-existing medical condition"

For two years, Mr V had held an insurance policy for his cat, Florence. When Florence had to have a tumour removed, Mr V made a claim under the policy to cover the vet's bill.

Mr V's insurer turned down the claim. It said that Florence's treatment had related to a "pre-existing medical condition". It also said that when Mr V had taken the policy out, he should have mentioned that Florence had already seen the vet about two lumps – and that had he done so, it would have applied an additional exclusion to the policy that related specifically to tumours, cysts and abscesses.

Mr V thought this was unfair, and contacted the insurer to complain. He said that when he had taken the policy out, the vet had not diagnosed the cause of the Florence's lumps – and had simply advised him to monitor her. Mr V also said that the lumps had not grown or changed by the time he took out the policy – so he had not thought he had needed to disclose them. Mr V also argued that he had given the insurer the contact details for Florence's vet – and that the insurer could have investigated the situation before it had set up the policy.

complaint not upheld

In effect, Mr V's insurer was *retrospectively* applying the exclusion for tumours, cysts and abscesses. So we needed to decide whether this was fair and reasonable in the circumstances. When we listened to the phone conversation during which Mr V had taken out the policy, we found that the insurer had asked him whether Florence had "*shown any signs of an illness or injury or been unwell, either now or in the past?*" Mr V had answered "*No*."

We also looked at Mr V's policy documents. They defined a "pre-existing medical condition" as "*an injury or illness that is caused by, relates to, or results from, an injury, illness or clinical signs your pet had before the section was added to your insurance*". We thought that this explanation was clear – and that Mr V should have realised that Florence's condition would not be covered by the policy.

In these circumstances, we did not uphold the complaint.

... the insurer said he should have mentioned that Florence had already seen the vet about two lumps

case study 106/9

claim is rejected because of a "pre-existing medical condition" – which had been diagnosed but not treated

Mr L's dog, Ivy, was diagnosed with a dislocated knee cap in 2007. She needed some treatment, and Mr L claimed under the insurance policy he had in place for Ivy. His insurer rejected his claim on the grounds that it related to a "pre-existing medical condition" – because Ivy's condition had been diagnosed in 2004. Mr L complained, saying that Ivy had never been treated for anything like this before. When the insurer stuck to its original position, Mr L asked us to investigate.

complaint not upheld

When we reviewed the evidence, we found the vet's notes showed that Ivy had been diagnosed with the same condition in 2004. However, it had not been treated. When we asked the vet why, she told us that she had not expected the condition to present Ivy with any problems in the future.

We explained to Mr L that even though Ivy had not been *treated* for this condition in 2004, "pre-existing medical conditions" do not just relate to treatment. Mr L's policy document had defined a pre-existing medical condition as "*any condition or symptoms or signs of injury, illness or disease, occurring or existing in any form prior to the start of this insurance*". So we were satisfied that the insurer had not acted wrongly in turning down Mr L's claim – and we did not uphold the complaint.

... even though Ivy had not been treated in 2004, "pre-existing medical conditions" do not just relate to treatment

... he argued that he had acted in the best interests of his horse

case study 106/10

claim for loss of a horse – rejected because it was not carried out in line with "BEVA" guidelines

Mr C owned a horse, Amber. Unfortunately, Amber was suffering from a degenerative joint disease in one of her legs, and she went lame. Mr C phoned his insurer to ask whether his policy would cover him for the loss of the horse. An adviser went through Mr C's policy with him. She explained that if he made a successful claim, the policy would pay a lump sum benefit on his horse's death. The adviser also went through the relevant criteria relating to euthanasia. After the conversation, she sent Mr C a letter and a claim form.

Amber's pain increased, and eventually, Mr C decided that she was suffering too much. He contacted his vet, who came out and put the horse down at Mr C's request. Mr C made a claim under his insurance policy for the loss of the horse. His claim was turned down. The insurer said that the euthanasia had not met the conditions set out in guidelines given by the British Equine Veterinary Association (BEVA). The insurer also pointed out to Mr C that the policy said that for a euthanasia claim to be valid, the insurer would need to give written consent before the horse was put down.

Mr C complained to the insurer, saying that the BEVA guidelines were not mentioned in his policy terms and conditions. He pointed out that his policy *did* allow him to make a valid claim without written permission if the horse was slaughtered on humane grounds. He argued that he had acted in the best interests of his horse – which was in pain – and he said that he *had* been given written consent from the insurer when they had written to him enclosing the claim form. When the insurer rejected Mr C's complaint, he referred the matter to us.

complaint not upheld

We explained to Mr C that the British Equine Veterinary Association published its guidelines to help with insurance claims. The guidelines say that it is up to the attending vet to decide whether to advise the owner if the horse should be put down – regardless of whether or not the horse is insured. They also say that for a horse to be put down, it must be shown that "no other options of treatment are available to that horse, at that time."

... the insurer had not given written consent before the horse was put down

When we reviewed Mr C's policy documents, we found that they did not mention the BEVA guidelines explicitly. However, we decided that this was not crucial to the case. The policy *did* make it clear that the destruction of a horse must be "immediately necessary" and that it would only be covered if "no other treatment was available". We would usually use the BEVA guidelines as an indication of how this should work in practice. To establish whether this had been the case, we looked at the evidence supplied by Mr C's vet – as well as the insurer's vet. They agreed that Amber's condition was possibly treatable – and that she could have been given anti-inflammatories and retired to a paddock. So she did not fit the guidelines or the policy terms for a claim.

We also needed to establish whether the insurer had given written consent for the horse to be put down. We noted that the insurer's letter to Mr C – which he had argued had given written consent for Amber to be put down – had said that the insurer would "need to receive a fully completed claim form, before we can consider the validity of your claim." So we concluded that the insurer had *not* given written consent before the horse was put down.

In these circumstances, although we sympathised with Mr C for the loss of his horse, we took the view that the decision to put Amber down had not met the conditions set out in his policy. We did not uphold the case.

... the vets agreed that Amber's condition was possibly treatable

case study 106/11

claim is rejected because of "pre-disposition" to a medical condition

In 2010, Miss R's dog, Haversham, had surgery to remove two mammary lumps and a growth in her urinary tract. Earlier in the year, Miss R had taken out an insurance policy for Haversham – and she made a claim under the policy to cover some of the vet's fees. The insurer turned down the claim. It said that Haversham had a "predisposition" to this condition.
The insurer also pointed out that when Haversham had been examined by the vet in 2006, the vet had found a nodule in her right mammary gland. Although the vet had decided not to treat the condition, Miss R's insurer said that she should have told it about her dog's history when she took out the policy.

Miss R complained to the insurer. She said that it had not asked her any questions about her dog's medical history when she took out the policy.
And she said that even if the insurer *had* asked her about it, she would not have mentioned anything because back in 2006, the vet had assured her that the nodule was not serious. She added that when she took out the policy, she had no reason to believe that Haversham would be likely to experience this sort of problem. When the insurer refused to reconsider, Miss R referred the matter to us.

complaint upheld

We looked at the evidence given to us by both parties. This included the paperwork that Miss R had filled in when she had taken out the policy. We found that although Miss R had ticked a box on the application form to confirm she had understood that Haversham would not be covered for "pre-existing medical conditions", she had *not* been asked explicitly about Haversham's medical history.

We also reviewed a statement supplied by Miss R's vet. The vet said that the nodule he had found in 2006 was of "such insignificance" that unless Miss R had been asked for Haversham's full medical history when she took out the policy, he would not have expected her to mention it. He also said that the mammary lumps and the tumour in the dog's urinary tract were "completely unrelated" to the condition he had identified in 2006.

In these circumstances, we did not think that Miss R could reasonably be expected to have offered her insurer details about Haversham's medical history. We upheld the complaint – and told the insurer to pay the claim.

FSC www.fsc.org MIX Paper from responsible sources FSC® C001785

Printed on Challenger Offset paper made from ECF (Elemental Chlorine-Free) wood pulps, acquired from sustainable forest reserves.

100% of the inks used in *Ombudsman News* are vegetable-oil based, 95% of press chemicals are recycled for further use, and on average 99% of waste associated with this publication is recycled.

Q? &A

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

question

I'm a solicitor and my client has been paying for PPI on his personal loan for four years. We strongly feel that the policy was mis-sold. My client already had payment protection cover through his employer – and he has no recollection of agreeing to additional PPI. The bank has rejected the complaint and has produced a copy of the loan agreement. In the small print there is a box ticked supposedly showing that my client consented to the sale of PPI. Is that "case closed"?

answer

Not necessarily. When we look at complaints we weigh up the evidence from both parties. The business has produced a document which, it says, proves that your client agreed to the sale of PPI – and we would take this into account.
But we also listen to the other side of the story.

For example, if you showed us evidence of the cover that your client already had through his employer, this could support his argument that he wouldn't have taken out PPI because he had no need for it.
We would also ask the business for any other relevant information it might have – for example, notes that were made at the time the policy was sold.

Now that he has had the bank's response, if your client does want to refer the complaint to us, you can download a complaint form from our website or call us on 0300 123 9123.
You might also want to have a look at the online technical resource on our website, which contains a lot more information about how we approach PPI cases.

question

I work for the Citizen's Advice service and I am trying to help a customer who sent some money to the wrong person by mistake. She set up a standing order but got the last digit of the account number wrong. Her bank has said that it can't help. And the bank she sent the money to says it can't talk to her because she isn't a customer and because of data protection issues. Is there anything else she can do?

answer

If the banks had both acted quickly as soon as the customer told them about the mistake, then it might be that neither business has done anything wrong – even if the money has gone. But they should both be talking to your customer and giving her as much information as they can to help her find out what has happened.

Standing orders are covered by the Payment Services Regulations – a set of rules that apply to almost every bank. These came into force on 1 November 2009. The regulations allow both the sender and the receiver of money in a transaction to bring a complaint about either the sending or receiving bank. So your customer could complain to both banks that were involved.

The bank that received the money doesn't need to disclose any protected information about its customer or the receiving account, but it should still do everything it reasonably can to help.

If your customer can't sort this out with the banks, she might want to consider bringing a complaint against them. You can find more information about how we look at cases involving payments made to the wrong person in our online technical resource on our website.

ref: 730

Financial Ombudsman Service