Neutral Citation: [2015] IEHC 217

**THE HIGH COURT**

**[2013 No. 280 MCA]**

**IN THE MATTER OF AN APPEAL PURSUANT TO PART VII(B) OF THE CENTRAL BANK ACT, 1942, AND CHAPTER 6 AND SECTION 57CL THEREOF (AS AMENDED AND INSERTED BY THE CENTRAL BANK AND FINANCIAL SERVICES AUTHORITY OF IRELAND ACT, 2004)**

**BETWEEN**

**PHILOMENA GEOGHEGAN**

**APPELLANT**

**AND**

**THE FINANCIAL SERVICES OMBUDSMAN**

**RESPONDENT**

**AND**

**SEAMUS WHELAN, SALES REP FOR PROGRESSIVE LIFE ASSURANCE (IRISH LIFE), PROGRESSIVE LIFE ASSURANCE (IRISH LIFE) AND PERMANENT TSB**

**NOTICE PARTIES**

**JUDGMENT of Kearns P. delivered on 27th day of March, 2015**

The appellant appeals against the finding of the Financial Services Ombudsman ('the Ombudsman') dated the 30th July, 2013 wherein it was held that the appellant's complaint against the notice parties was not substantiated pursuant to section 57CI(2) of the Central Bank and Financial Services Authority of Ireland Act 2004.

**BACKGROUND**

In or about May 1998 the appellant and her husband applied for a mortgage to build a family home at Ring, Tyrrellspass, Co. Westmeath. As part of this process the appellant and her husband were required to take out a life assurance policy and met with Mr. Seamus Whelan, sales representative of Irish Progressive Life Assurance (subsequently 'Irish Life'), for this purpose. A policy agreement was signed on the 26th May, 1998. The appellant is described in the documentation as a housewife while her husband is described as a building supervisor.

The following year the appellant and her husband decided to enhance their cover to include critical illness benefit and once again met with Mr. Whelan for the purposes of having this cover added to their existing policy. The proposal document was signed on the 21st June, 1999 and completed on the 28th June, 1999 and the monthly premium payable increased accordingly. Thereafter, the policy holders received annual 'indexation notices' from Irish Life which provided details of the sum assured and the amount of critical illness cover. In 2006, the critical illness cover began to be described on these notices as 'Accelerated Specified Illness Cover'.

Unfortunately, the appellant's husband became unwell towards the end of 2008 and was unable to continue working. He was subsequently diagnosed as suffering from cardiomyopathy and on the 20th March, 2009 a claim was made under the critical illness policy. Irish Life subsequently received medical reports from doctors responsible for Mr. Geoghegan's care. By letter dated the 27th May, 2009 Irish Life informed the claimants that "*on assessment of these reports, we are not in a position to admit a Specified Illness Cover claim*." The letter further explained the insurer's reasoning as follows:–

> "*We assessed your claim under the Heart Attack definition which is as follows:*
>
> *'Heart Attack:*
>
> *Shall mean the death of a portion of heart muscle as a result of a myocardial infarction arising from inadequate blood supply to the relevant area, the diagnosis being evidenced by all of the following:*
>
> *1. A history of typical chest pain*
>
> *2. New electrocardiographic changes; and*
>
> *3. Significantly elevated levels of cardiac enzymes'*
>
> *While you did have an episode of breathlessness and palpitations based in the medical evidence we received you were diagnosed with Atrial Fibrillation. This does not fulfil the criteria for a heart attack as out lined in the above definition."*

Ultimately, a final response letter issued from the insurer and the appellant submitted a complaint form to the Ombudsman on the 13th November, 2012. The complaint form set out the background to the claim and indicated that the monthly premium payable was €325.26. The claim form expressed the belief of Mr. and Mrs. Geoghegan that they were covered for all manner of serious illness under the policy rather than being limited to certain specified illnesses. At the time of making the complaint the Geoghegans had paid in excess of €40,000 to Irish Life for "*what turns out to be coverage on illness we don't have*."

In a subsequent letter to the Ombudsman dated the 6th December, 2012, Ms. Geoghegan states that at the time of signing the proposal forms it was not her understanding that only specified illnesses were covered. On the 13th December, 2012 the Ombudsman indicated that a full investigation would take place but, because of the requirements of section 57BX of the 2004 Act, the Ombudsman was not in a position to examine any aspect of the complaint which had occurred more than six years previously. This precluded the Ombudsman from investigating the circumstances of the sale of the policy or the nature of the information provided to Mr. and Mrs. Geoghegan in relation to the policy at that time.

The Ombudsman subsequently carried out an investigation into the appellant's complaint and required the insurer to provide various documents including the terms and conditions of the policy, the original application form, the policy schedule, and copies of correspondence in relation to the policy.

**THE OMBUDSMAN'S DECISION**

The Ombudsman issued its decision on the 30th July, 2013. It was reiterated that the Ombudsman was precluded from considering the circumstances of the sale of the policy and any other aspects of the complaint which occurred more than six years previously. Therefore, the Ombudsman stated that "*the issue for consideration is whether the Provider has assessed the Complainant's claim*

*correctly and in accordance with the terms and conditions of the critical illness cover offered by his policy*."

The Ombudsman stated that section 38 of the policy terms and conditions relates to critical illness and states as follows:

> *"A Critical Illness shall be deemed to be contracted by a Life Assured when the said Life Assured is diagnosed as having incurred or undergone Aorta Graft Surgery, Benign Brain Tumour, Blindness, Cancer, Coronary Artery Surgery, Heart Attack, Heart Valve Surgery, Major Organ Transplantation, Motor Neurone Disease, Multiple Sclerosis, Paralysis, Renal Failure or Stroke…"*

The terms and conditions document also provides a definition of each of these conditions. The Ombudsman found that, for the purposes of the appellant's complaint, the relevant definition was 'Heart Attack' as set out in section 38(vi) and which was referred to in the letter from the insurer refusing the appellant's claim. In light of this definition, and having regard to the medical evidence, the Ombudsman concluded:–

> *"While I empathise with the Complainant and his wife in this instance, I find that the medical evidence submitted supports the Provider's decision to decline the claim in dispute and I make no finding against the Provider in this regard…*
>
> *…The complaint is not substantiated pursuant to Section 57CI(2) of the Central Bank and Financial Services Authority of Ireland Act 2004."*

**SUBMISSIONS**

Mrs. Geoghegan, representing herself at the outset of these proceedings, submitted that it was her understanding that the life assurance policy and the critical illness policy were separate policies as she had signed separate proposal forms. It was submitted that the appellant and her husband always understood that all major illness would be covered by the critical illness policy and that, owing to the high monthly premium, they would not have taken out the cover had they known it covered only specified illnesses.

In October 2014 Mr. Gerry O'Donnell solicitor came on record for the appellant and sought to introduce fresh documentation which was not before the Ombudsman. The respondent adopted a neutral position in relation to the admission of these documents. It is submitted by Mr. O'Donnell that the documents show that in 2006 the critical illness cover changed and began to be described as 'accelerated specific illness cover'. It is further submitted that additional documentation shows that the notice party has upheld claims in respect of cardiomyopathy from claimants whose policies were commenced at the same time as that of the appellant and her husband.

Counsel for the respondent submits that the applicable test for an appeal against a decision of the Financial Services Ombudsman is set out in *Ulster Bank v. Financial Services Ombudsman & Ors.* [2006] IEHC 323 wherein Finnegan P. stated:–

> *"To succeed on this appeal the Plaintiff must establish as a matter of probability that, taking the adjudicative process as a whole, the decision reached was vitiated by a serious and significant error or a series of such errors. In applying the test the Court will have regard to the degree of expertise and specialist knowledge of the Defendant. The deferential standard is that applied by Keane C.J. in Orange v. The Director of Telecommunications Regulation & Anor and not that in The State (Keegan) v. Stardust Compensation Tribunal."*

This test was followed by MacMenamin J. in *Molloy v. Financial Services Ombudsman* (Unreported, High Court, 15th April, 2011) and *Ryan v. Financial Services Ombudsman and Irish Life & Permanent Plc.* (Unreported, High Court, 23rd September, 2011).

It is submitted that statutory appeals such as this bear many of the same features of judicial review and that, in particular, there can be an error within jurisdiction in so far as the error falls short of being a serious and significant error. In this regard, counsel refers the Court to the decision of MacMenamin J. in *Hayes v. Financial Services Ombudsman & Ors*. (Unreported, High Court, 3rd November, 2008) wherein it was stated that:–

> *"…while a statutory appeal (such as this) is not a judicial review, and where the decision maker is acting within his own area of professional expertise, the test set out by Finnegan P. suggests that it bears many of the features of a judicial review. In particular, it is clear that there may be a permissible error if it is within jurisdiction, albeit only insofar as that error falls short of being one which is serious and significant."*

MacMenamin J. went on to refer to the approach of Finnegan P. in *Ulster Bank* as "*a well established and accepted test*".

Similarly, in relation to the nature of an appeal from a decision of the Ombudsman, Hedigan J. stated in *Governey v. Financial Services Ombudsman* [2013] IEHC 403 that:–

> *"The appeal is thus not a de novo one. Whilst it is not a judicial review, it does bear many of its characteristics and on a scale between de novo and judicial review is far closer to judicial review. A notable characteristic that this type of appeal has in common with judicial review is the deference that this Court must accord to the FSO as a specialist expert Tribunal working within its own area of professional expertise. Thus, there may be a permissible error if it is within jurisdiction insofar as it falls short of being one which is serious and significant. In determining factual matters, I can only quash the FSO's decision if I am persuaded that he could not have reasonably come to his decision based on the facts he had before him."*

Counsel for the Ombudsman submits that the finding arrived at was one which was open to the Ombudsman to make on the basis of the material before him. Counsel submits that the courts have tended not to second-guess decisions made by the Ombudsman on the merits. In this regard, counsel refers once again to the decision in *Governey*. Hedigan J. stated that:–

> *"The Court must not consider complaints about process or merits in isolation but must consider the adjudicative process as a whole. The Court must decide whether there has been a serious and significant error or series of such errors which vitiate the decision. The Court must adopt a deferential stance to the office of the FSO bearing in mind that it is exercising its expert and specialist knowledge in the financial services industry. It is the assessor of evidence and the determiner of facts. This Court can only intervene if it comes to the conclusion that on findings of fact he had no relevant evidence before him upon which he could reasonably conclude as he did. This Court does not sit as a court of appeal on the facts. It may not assess the evidence and interpose its own judgment for that of the expert body charged*

*by the Oireachtas with doing so. This Court has neither the jurisdiction nor the competence to do so."*

It is further submitted that, as stated by Feeney J. in *Twomey v. Financial Services Ombudsman* (Unreported, High Court, 26th July, 2013), the Ombudsman's role in the statutory scheme is not to step into the shoes of the insurer but rather, it must assess the manner in which the insurance company has conducted itself.

Counsel for the respondent submits that when one considers the process as a whole there is no sufficient basis made out for the Court to intervene in respect of the decision made and the appellant has failed to establish that there was a serious or significant error on the part of the Ombudsman.

**DISCUSSION**

This case arises from a particularly unfortunate set of circumstances. The appellant and her husband have paid considerable monthly premia to the insurer since 1998 in respect of a unit linked life assurance policy, to which critical illness cover was added in 1999. The appellant, representing herself at the outset of these proceedings, told the Court that she and her husband are not seeking a substantial monetary sum under the policy, but rather, are merely seeking to be treated in a fair and pragmatic manner by the insurer in circumstances where the appellant's husband was forced to retire due to serious illness in 2008 and where in excess of €40,000 in premia has been paid to date.

While the Court has a great deal of sympathy for the appellant and her husband, the Court's role is limited to considering whether or not the Financial Service Ombudsman erred in its decision. It is clear from the long line of case law outlined above that the relevant test is that set out by Finnegan P. in *Ulster Bank v. Financial Services Ombudsman*; namely, was the decision reached by the Ombudsman vitiated by a serious and significant error or series of errors. Having carefully considered all of the materials which were before the Ombudsman and having regard to the deferential stance required to be adopted by the Court, I am satisfied that the Ombudsman did not err in its decision on the basis of the information which was before it. In relation to the alleged mis-selling of the policy, this is a matter which the Ombudsman was precluded from considering by virtue of s. 57BX of the 2004 Act.

It is clear from the annual indexation notices sent to Mr. and Mrs. Geoghegan that the name of the illness cover changed without warning in 2006 from 'critical illness cover' to 'accelerated specified illness cover'. It is noteworthy that, according to Mr. Peter Farrell, team manager in the notice party's protection claims department, this change occurred in order to "*clarify that the cover at issue was limited to illnesses specified in the policy rather than covering all illnesses*." While the Court could reasonably draw an inference from this averment that there was some confusion amongst policy holders in relation to the nature of the policy which would, at the very least, warrant a pragmatic and equitable response from the insurer in relation to the appellant's claim, this does not alter the reality that the appellant and her husband signed a proposal document at the time of taking out the cover which expressly stated which illnesses the policy was limited to. Furthermore, it is evident from the documentation available that the critical illness cover was to be added to the existing life assurance policy rather than constituting a distinct policy under separate terms.

The appellant's solicitor also presented the Court with a number of documents which indicate that the insurer has upheld claims from other policy holders who suffer from cardiomyopathy. These policies were apparently commenced around the same time as the appellants. While this understandably compounds the appellant's sense of unfairness and frustration at the insurer's unwillingness to engage with her claim in an empathetic manner, it is clear from the case law outlined above that this Court can not compel the notice party to deviate from the obstinate stance it has adopted.

The Court does consider it appropriate to note, however, that while financial service providers and institutions have obvious commercial responsibilities and various duties and obligations, in certain special circumstances, where a patent unfairness arises, they should not be precluded from acting with an appropriate deal of empathy towards consumers.

**DECISION**

For the reasons outlined above the appeal is dismissed.