Neutral Citation Number: [2019] EWHC 3036 (Admin)

Case No: CO/1050/2019

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 November 2019

Before :

MRS JUSTICE LANG DBE

- -

Between :

THE QUEEN	**Claimant**
on the application of	
LAURA CRITCHLEY	
- and -	
FINANCIAL OMBUDSMAN SERVICE LIMITED	**Defendant**
(1) BANK OF SCOTLAND PLC (TRADING AS HALIFAX)	**Interested Parties**
(2) THE FINANCIAL CONDUCT AUTHORITY	

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Adam Temple (instructed by **Stephens Wilmot Limited**) for the **Claimant**
James Strachan QC and Benjamin Tankel (instructed by **Financial Ombudsman Service Limited**) for the **Defendant**
Javan Herberg QC (instructed by **Linklaters**) for the **First Interested Party**
The **Second Interested Party** did not appear, but submitted a written representation

Hearing dates: 23 & 24 October 2019

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Approved Judgment

Mrs Justice Lang :

1. The Claimant applies for judicial review of a decision made by an Ombudsman (Mr John Swain), on behalf of the Defendant, dated 14 December 2018, dismissing her complaint against the First Interested Party ("Halifax") that a credit card payment protection insurance ("PPI") policy had been been mis-sold to her.

2. HH Judge Bidder QC, sitting as a Judge of the High Court, granted permission on the papers on all save one ground of challenge, namely, that in making the decision, the Defendant applied an unlawful policy or set of counter-presumptions, evidenced in its Navigator software programme. The Claimant renewed her application for permission on the remaining ground, and I considered it at a 'rolled up' hearing on the same occasion as the substantive hearing.

Facts

3. PPI is a form of insurance cover designed to meet an individual's financial commitments for servicing debt if he or she suffers a loss of income as a result of unemployment, sickness or accident.

4. PPI was sold over a long period, in high volumes. According to the Financial Conduct Authority ("FCA"), between 1990 and 2010, between 52 and 64 million policies were sold to 30 million people.

5. In 2005, the National Association of Citizens Advice Bureaux sent a complaint to the Office of Fair Trading, drawing attention to the excessive profit margins on PPI contracts and widespread rejection of benefits. In October 2006, the Office of Fair Trading produced a report identifying the following concerns:

> "There are indications that consumers receive poor value in the low proportion of premium income paid out in claims (of the order of 20 percent), and we have identified features of the market which adversely affect competition and appear to lead to poor value."

6. The matter was referred to the Competition Commission which published a report into PPI in January 2009. It confirmed the low claims ratio for PPI policies generally, and identified that, within the PPI sector, the value offered by credit card PPI was among the lowest, at 14%, with 86% of the premium going towards commission, expenses and profits. The Competition Commission proposed a package of measures, including a ban on single premium policies, which were particularly financially disadvantageous to consumers, and a ban on the sale of PPI policies contemporaneously with another product.

7. The Financial Services Authority ("FSA") took action against a number of firms for their practices in selling PPI. After consultation it introduced a series of measures, including a specific section in the FSA Handbook (the rule book for authorised firms) addressing the handling of PPI complaints, which I consider in more detail later in my judgment.

8. The Defendant has received more than 2 million PPI complaints. Over 1.7 million have been resolved, and compensation has been awarded in over 1 million complaints. The large volume of complaints has meant that the Defendant has had to treble in size and adapt its processes to handle the increased case load.

9. Complainants have been encouraged and assisted by claims management companies which charge a fee for their services. "We Fight Any Claim" ("WFAC"), has submitted thousands of complaints in relation to PPI policies. It represented the Claimant in her complaint and stands behind her in this claim for judicial review.

10. On 15 April 2002, the Claimant applied successfully for a credit card, and a PPI policy in support of it, from Halifax (which subsequently merged with the Bank of Scotland). Although she thought that she had posted the application, the Ombudsman found, on the evidence from Halifax, that she completed the joint application form in a branch of Halifax, with the benefit of advice from a member of staff. Initially, the credit limit on the credit card was £1,250 and it increased in stages, eventually reaching £1,900.

11. Halifax plc was acting as an insurance intermediary as the PPI policy was underwritten by Halifax Insurance Ireland Limited (an associated company). The policy provided her with life and critical illness cover (payable as a lump sum to meet her outstanding credit card balance, with a maximum of £25,000), and disability and unemployment cover payable as a monthly benefit, at the rate of 10% of the outstanding balance, subject to a maximum of £2,500 per month. Disability and unemployment benefits ceased after 12 consecutive monthly payments or once the balance was paid off, if earlier.

12. The Bank reserved the right to change any term of the policy on 30 days notice.

13. The premium was payable monthly, at a rate of 78p per £100 of credit. It was a general term of the policy that her cover would cease if she did not pay the premiums, and that she was required to continue paying premiums whilst claiming benefits.

14. The terms of the policy restricted, to some extent, her ability to make a claim. In this case, the Claimant's complaint related in particular to the limitations on her disability insurance cover. The term 'disability' was defined, so far as is material, as "a state of incapacity resulting solely from an accidental bodily injury or sickness or disease …. which wholly prevents you from doing your work or other work that your experience or training would allow you to do."

15. Under the heading 'Exclusions', the Policy stated that benefits would not be paid if the disability resulted from, *inter alia*:

    i) "a pre-existing condition, as defined";

    ii) "backache and related conditions unless there is radiological evidence of medical abnormality resulting in disability";

    iii) "any psychotic or psychoneurotic illness, mental or nervous disorder, stress or stress related condition, unless the condition has been diagnosed by a consultant psychiatrist and you are under the continued supervision and receiving treatment from a consultant psychiatrist".

16. The Claimant made use of the card, but she never made a claim on the PPI policy. She cancelled the card and the policy in 2006.

17. At the time of the application, the Claimant was aged 50 (her date of birth is 12 May 1951). She was employed as a supervisor at Wilkinsons (a chain of homeware stores) and had been working there for one year. Her annual income was £12,000. She was entitled to sick pay under the terms of her contract of employment, and in the Defendant's consumer questionnaire she ticked the box which indicated that she was entitled to at least 6 months sick pay, but not more than 12 months. She was also eligible for a redundancy payment, though her evidence as to the amount was inconsistent – either 3 months pay or at least 6 months but less than 12 months. She was entitled to a death in service payment of twice her annual salary. She stated that, in the event that she was unable to work, she would not have been able to afford her card repayments. The Claimant did not have any pre-existing or current health conditions when she made the application.

18. On 14 February 2017, the Claimant made a complaint to Halifax that the PPI policy had been mis-sold to her. She stated in the Defendant's consumer questionnaire that, if she had known of the limitation of the cover, in respect of back pain and mental health, and if she had known of the true cost of the policy, and its poor value, she would not have purchased it. The complaint was made on her behalf by WFAC.

19. Following investigation, Halifax dismissed the complaint in a letter dated 15 March 2017. In summary, the reasons were that the Claimant was eligible for the policy, and it appeared that she had a need for it, as neither her savings nor her employee benefits were sufficient to cover her card payments. Furthermore, she was not significantly affected by any of the policy's exceptions or limitations. Halifax found that she had been adequately advised verbally about the total cost of the PPI policy. She understood it was optional and she explicitly agreed to purchase it. At the relevant time, there was no obligation to disclose the commission payment.

20. On 13 April 2017, the Claimant complained to the Defendant that the PPI policy had been mis-sold by the Bank.

21. On 8 May 2017, an adjudicator employed by the Defendant assessed her complaint and decided that the PPI policy had not been mis-sold. In reaching her decision, she was guided by Navigator, a software programme which has been designed to assess PPI complaints. It is programmed to ask for information about the claim, and to apply criteria, based upon the relevant Ombudsman jurisprudence, to suggest an outcome. Adjudicators are at liberty to depart from the suggested outcome, though there was evidence before me that they rarely do so.

22. Navigator was praised in the report of Richard Thomas CBE entitled 'The impact of PPI mis-selling on the Financial Ombudsman Service', dated January 2016, at paragraph 1.4, where he said:

> "Of several developments, one stands out – the development of 'Navigator' – a tool which helps to analyse the permutation of circumstances in each case, applies the ombudsman service "jurisprudence" to that permutation, and suggests an appropriate response which the adjudicator can accept, reject or modify.

> Navigator has been absolutely essential enabling the ombudsman service to reconcile the competing demands of volume, quality and consistency."

23. The Claimant did not accept the adjudicator's decision and the complaint was referred to an Ombudsman. On 20 December 2017, the Ombudsman made a provisional decision indicating that he was not minded to uphold the complaint. Both parties made further submissions.

24. On 14 December 2018, the Ombudsman made a final decision not to uphold the complaint. He summarised his conclusions as follows:

> "Mrs C made her decision to take out the policy based on advice and information Halifax gave her about the policy.
>
> Taking into account the law, industry codes of practice and what I consider to have been good practice in 2002 (there were no applicable regulations at the time), Halifax should fairly and reasonably have advised Mrs C with reasonable care and skill. In particular, it should have considered whether the policy was appropriate or "suitable" for her, given her needs and circumstances. It should also fairly and reasonably have provided Mrs C with sufficient clear, fair and not misleading information about the policy it was recommending to enable Mrs C to make an informed decision about whether to follow the recommendation and take out the policy.
>
> Halifax did not act fairly and reasonably in its dealings with Mrs C. It did not advise Mrs C with reasonable care and skill – it did not take sufficient steps to establish whether the policy as suitable for Mrs C (although the policy it recommended was ultimately suitable for her). And it did not provide Mrs C with sufficient information in a clear, fair and not misleading way to enable her to make an informed choice and whether to take out the policy.
>
> Mrs C made her decision to take out the policy based on the recommendation and incomplete information. But if things had happened as they should, on the evidence available in this case, it is more likely than not that Mrs C would still have taken out the policy.
>
> It would not be fair in those circumstances to make an award to compensate Mrs C for the money she spent in connection with the policy."

25. The Ombudsman's decision in the Claimant's case is one of a group of representative decisions identified by the Defendant. The Defendant has identified a further 1,200 similar complaints, in which WFAC is also the representative, and which have not been upheld at the initial stage. The Defendant has asked WFAC to review the similar complaints in the light of the Ombudsmen's decisions on common issues in the

representative cases, and not to refer them for a final Ombudsman's decision in circumstances where those complaints have no realistic prospect of being upheld.

26. The Defendant's decision to identify representative cases, and 1,200 similar claims, and its approach to WFAC, is not the subject matter of this judicial review, which was clearly identified in section 3 of the claim form as the decision made on 14 December 2018 not to uphold the Claimant's complaint. As her case was a representative decision, which was fully considered by an Ombudsman, she was not adversely affected by the procedure which the Defendant has adopted. Therefore I have not considered this issue further in my judgment.

Legal framework

The regulatory regime applicable to the Claimant's PPI policy

27. On 14 January 2005, general insurance, including PPI, became regulated by the FSA. On 1 April 2013, the FSA was replaced by the FCA.

28. In his decision, at paragraph 30, the Ombudsman correctly identified that, since the sale of this policy took place prior to regulation of insurance policies by the FSA, the FSA's and FCA's overarching Principles for Businesses and Insurance conduct rules (ICOB and ICOBS) were not applicable.

29. In paragraph 31 of his decision, the Ombudsman found that, as the policy terminated in 2006, it pre-dated the unfair relationship provisions set out at section 140A of the Consumer Credit Act 1974, as amended. In *Plevin v Paragon Finance* [2014] UKSC 61, the Supreme Court held that a lender's failure to disclose to the consumer the large levels of commission payable out of her single premium PPI policy made her relationship with the lender unfair under section 140A of Consumer Credit Act 1974. It followed that the rules and guidance made by the FCA, concerning complaints about the non-disclosure of commission in the light of the *Plevin* judgment, were not applicable to this complaint.

30. At paragraphs 32 to 41, the Ombudsman set out the regulatory regime which was in existence at the date of this sale, namely, the General Insurance Standards Council's General Insurance Code for private customers ("the GISC Code") and the Association of British Insurers' General Insurance Business Code of Practice for all intermediaries (including Employees of Insurance Companies) other than Registered Insurance Brokers ("the ABI Code").

The Ombudsman Service

31. The Ombudsman Service was established pursuant to Part XVI of the Financial Services and Markets Act 2000 ("FSMA 2000"). Section 225(1) of FSMA 2000 provides:

> "This part provides for a scheme under which certain disputes may be resolved quickly and with minimum formality by an independent person."

32. By section 225(4), paragraphs 13 and 14 of Schedule 17 to FSMA 2000 provide for the making of rules covering the operation and jurisdiction of the Defendant Ombudsman Service. The rules governing the Defendant's jurisdiction are made by the FCA. The rules governing the handling of the complaints are made by the FCA and the Defendant, pursuant to these provisions of Schedule 17.

33. These rules are set out in the FCA Handbook under the section entitled "Dispute Resolution: Complaints" ("DISP"). The rules set out the procedures to be followed and matters to be taken into account by the ombudsmen when determining a complaint.

34. The complaint in this case arose under the Defendant's compulsory jurisdiction, as set out in section 226 of FSMA 2000. Section 228(2) of FSMA 2000 provides that such a complaint:

> "… is to be determined by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case."

35. DISP 3.6.1R of the FCA Handbook reiterates the statutory duty that exists under section 228(2) of FSMA 2000 by requiring ombudsmen to determine complaints by reference to what, in their opinion, is fair and reasonable in all the circumstances of the case.

36. DISP 3.6.4R of the FCA Handbook provides as follows:

> "In considering what is fair and reasonable in all the circumstances of the case, the Ombudsman will take into account:
>
> (1) relevant:
>
> (a) law and regulations;
> (b) regulators' rules, guidance and standards;
> (c) codes of practice; and
>
> (2) (where appropriate) what he considers to have been good industry practice at the relevant time."

37. The test under section 228(2) of FSMA 2000 was considered by Stanley Burnton J. in *R (IFG Financial Services Ltd) v Financial Ombudsman Service* [2005] EWHC 1153 (Admin), at [13]:

> "13. Section 228(2) is at the heart of this case. It is to be noted that it does not require, as it might have done, a complaint to be determined in accordance with the law. The ombudsman is required to determine a complaint by reference to what is, in his opinion, fair and reasonable in all the circumstances of the case. The words "in the opinion of the ombudsman" themselves make it clear that he may be subjective in arriving at his opinion of what is fair and reasonable in all the circumstances of the case. Of course, if his opinion as to what is fair and reasonable in all the circumstances of the case is perverse or irrational, that

> opinion, and any determination made pursuant to it, is liable to be set aside on conventional judicial review grounds."

38. This analysis was confirmed by the Court of Appeal in *R (Heather Moor & Edgecomb) v Financial Ombudsman Service* [2008] EWCA Civ 642, per Stanley Burnton LJ, at [41]. As Rix LJ explained, at [80]:

> "80. The effect of these provisions is not to leave the Ombudsman's determination to his entirely subjective views, as though he was operating according to the length of his foot, so to speak. That, it seems to me, is not the effect of the statutory language which defers to the "opinion of the Ombudsman". Rather, that is typical language to emphasise that the decision is for the Ombudsman, not for a judge. However, the Ombudsman remains amenable, through the ordinary process of judicial review, to a challenge on such grounds as perversity or irrationality. That was not in dispute. It was the view of Stanley Burnton J, as he then was, in *R v. FOS Ltd ex parte IFG Financial Services Ltd* [2005] EWHC 1153 (Admin), unreported 19 May 2005, at para 13. That is not the same, however, as saying that the Ombudsman is bound to apply the common law in all its particulars. He is, after all, dealing with complaints, and not legal causes of action, within a particular regulatory setting. Rather, he is obliged ("will") to take relevant law, among other defined matters, into account."

39. Where the Ombudsman departs from the law or relevant rules and guidance from the regulator, which he is required to take into account under DISP 3.6.4R, he must explain why he considered it fair and reasonable to do so: per Rix LJ at [49], in *Heather Moor*.

40. In relation to FCA Handbook rules, there is an important distinction between the construction of those rules (which is a matter for the Court) and the application of those rules to the facts of the case (which is a matter for the decision-maker). In *R v Financial Ombudsman Service ex p Norwich and Peterborough Building Society* [2002] EWHC 2379 (Admin), Ouseley J. confirmed that the task of interpreting the Banking Code was a matter for the Court, applying a "broad, purposive and common sense approach" and "according to its spirit and in a non-technical way" (at [69]-[70]). At [71] he said:

> "71. The Code however is a material consideration for the Ombudsman to take into account. If he misinterprets it, he will have failed to take it into account. It has one meaning. Although people may reasonably differ as to that meaning, it is for the Courts to decide what that one meaning is because it is for the Courts to decide whether a material consideration has been ignored. The Code cannot have as many meanings as reasonable people might attribute to it, all of which have to be considered. The Code is to be applied by banks and other deposit taking institutions; their compliance officers and customers cannot all say that their differing interpretations are right because reasonable. The Code has not simply been produced by or for the Ombudsman's use and application. The fact that it will be

> applied by the Ombudsman in informal adjudications using his expertise does not alter the Court's role in determining the Code's meaning. The BCSB is not the guardian of its meaning; though its views are relevant, it is for the Court to consider and weigh those views as to the Code's interpretation and not simply to review them in effect for rationality."

41. Importantly, in the light of the submissions in this case, Ouseley J. considered that the Ombudsman was entitled to develop criteria as to what constitutes unfairness, and the Courts should be slow to intervene:

> "77. However, those latter authorities, together with *Wakelin v Read* are strong support for Mr Pannick's submissions as to the approach which the Court should adopt to the review of the Ombudsman's decision as to what is unfair. The Ombudsman is entitled, and consistency in decision-making probably obliges him to develop criteria as to what constitutes unfairness. Those criteria are a matter for him. The very concept of "unfairness" is very wide, and permits reasonable people to disagree. But its very width serves as a caution against over-active judicial intervention in the approach adopted by the Ombudsman, in the criteria which he develops or in the application of those criteria or of the concept of unfairness to the circumstances of the case.
>
> 78. It is only if the Ombudsman has committed such errors of reasoning as to deprive his decision of logic that it can be said to be legally irrational. The Court should be very wary of reaching such a conclusion. Its own views as to what would be fair are not to be substituted for the Ombudsman's views when what is at issue is a question of the substantive merits of a decision as to unfairness."

42. DISP 3.5.4R sets out an iterative process for the determination of complaints. For the purposes of DISP 3.5.4R(2) and (3), the assessment of a case worker is a "*provisional assessment*" but an ombudsman may also issue a provisional decision, as happened in this case. DISP 3.5.4R provides as follows:

> "If the Ombudsman decides that an investigation is necessary, he will then:
>
> (1) ensure both parties have been given an opportunity of making representations;
>
> (2) send both parties a provisional assessment, setting out his reasons and a time limit within which either party must respond; and
>
> (3) if either party indicates disagreement with the provisional assessment within that time limit, proceed to determination."

43. By section 228(3) of FSMA 2000, when an ombudsman has determined a complaint he must give a written statement of his determination to both parties. By section 228(4) of FSMA 2000 that statement must, amongst other things, give the ombudsman's reasons for his determination and require the complainant to notify him in writing, before a date specified in the statement, whether he accepts or rejects the determination. By section 228(5) of FSMA 2000 if a complainant accepts the determination within the time specified, it is binding on both parties and final. By section 228(6) of FSMA 2000 if the complainant does not accept the determination within the specified period, he is treated as having rejected it.

44. In *R (Williams) v Financial Ombudsman Service* [2008] EWHC 2142 (Admin), Irwin J. considered the Ombudsman's duty to give adequate reasons at [51]:

> "… The ombudsman has a duty to give clear and comprehensible reasons for his decision. However, he is fully entitled to adopt the findings and conclusions of an adjudicator who has reported on the case, without elaborate adoption of this or that specific sentence, or this or that particular point. These reports are reports, not pleadings. A party to a complaint must know why he has won, or perhaps more importantly why he has lost, in clear and comprehensible terms. That is the requirement, but that is the only requirement and it can be met in a reasonably flexible way. In my judgment, it was fulfilled here. For those reasons, therefore, this court will make no order. The ombudsman's decision was proper and will stand."

45. In *R (Garrison Investment Analysis) v Financial Ombudsman Service* [2006] EWHC 2466 (Admin), Sullivan J. emphasised that the Ombudsman's duty to give reasons had to be considered in the context of the underlying intention of the Ombudsman scheme, stating at [5]:

> "5. Although numerous authorities relating to the giving of reasons were cited in the parties' skeleton arguments, it is unnecessary for present purposes to refer to them in any detail because it is common ground that whether reasons are adequate or not will depend on all the circumstances, and these will include the issues in dispute and the process in which the issues in dispute are being resolved. In this context, it is relevant to note that the underlying intention of the Ombudsman scheme is set out in section 225(1) of the Act, namely, "a scheme under which certain disputes may be resolved quickly and with minimum formality by an independent person." It is axiomatic, therefore, that any Ombudsman's decision letter should be read as a whole and in a common sense, and certainly not in a legalistic, way. Considering other aspects of the procedure, there was no hearing in this case. That is not in the least unusual. Normally disputes are resolved by the Ombudsman after exchanges of correspondence, and a hearing is not ordered unless the Ombudsman considers that one is required in the interests of fairness."

The FCA's guidance to firms handling PPI complaints

46. It was common ground that the Ombudsman was required to take into account the FCA's guidance to firms handling PPI complaints, in DISP Appendix 3 ("DISP App. 3").

47. Under the heading 'Step 1', paragraph 3.1.2 to 3.1.4 provide:

> "3.1.2. At step 1, the aspects of complaint handling dealt with in this appendix are how the *firm* should:
>
> (1) assess a *complaint* in order to establish whether the *firm's* conduct of the sale failed to comply with the *rules*, or was otherwise in breach of the duty of care or any other requirement of the general law (taking into account relevant materials published by the *FCA*, other relevant regulators, the *Financial Ombudsman Service* and *former schemes*). In this appendix this is referred to as a breach or failing by the *firm*;
>
> (2) determine the way the complainant would have acted if a breach of failing by the *firm* had not occurred; and
>
> (3) determine appropriate redress (if any) to offer to a complainant.
>
> 3.1.3 At step 1, where the *firm* determines that there was a breach of failing, the *firm* should consider whether the complainant would have bought the *payment protection contract* in the absence of that breach or failing. This appendix establishes presumptions for the *firm* to apply about how the complainant would have acted if there had instead been no breach or failing by the *firm*. The presumptions are:
>
> (1) for some breaches or failings (see DISP App. 3.6.2.E), the *firm* should presume that the complainant would not have bought the *payment protection contract* they bought;
>
> ….
>
> 3.1.4 There may also be instances where a *firm* concludes after investigation at step 1 that, notwithstanding breaches or failings by the *firm*, the complainant would nevertheless still have proceeded to buy the *payment protection contract* they bought…."

48. Section 3.6 considers the effect of a breach or failing at step 1. It provides as follows:

> "3.6.1 Where the *firm* determines that there was a breach or failing, the *firm* should consider whether the complainant would have bought the *payment protection contract* in the absence of that breach or failing.

3.6.2 In the absence of evidence to the contrary, the *firm* should presume that the complainant would not have bought the *payment protection contract* he bought if the sale was substantially flawed, for example where the *firm*:

(1) pressured the complainant into purchasing the *payment protection contract*; or

(2) did not disclose to the complainant, in good time before the sale was concluded, and in a way that was fair, clear and not misleading, that the policy was optional; or

(3) made the sale without the complainant's explicit agreement to purchase the *policy*; or

(4) did not disclose to the complainant, in good time before the sale was concluded, and in a way that was fair, clear and not misleading, the significant exclusions and limitations, i.e. those that would tend to affect the decisions of *customers* generally to buy the *policy*; or

(5) did not, for an advised sale (including where the *firm* gave advice in a non-advised sales process) take reasonable care to ensure that the *policy* was suitable for the complainant's demands and needs taking into account all relevant factors, including level of cover, cost, and relevant exclusions, excesses, limitations and conditions; or

(6) did not take reasonable steps to ensure the complainant only bought a *policy* for which he was eligible to claim benefits; or

(7) found, while arranging the *policy*, that parts of the cover did not apply but did not disclose this to the *customer*, in good time before the sale was concluded, and in a way that was fair, clear and not misleading; or

(8) did not disclose to the complainant, in good time before the sale was concluded, and in a way that was fair, clear and not misleading, the total (not just monthly) cost of the *policy* separately from any other prices (or the basis for calculating it so that the complainant could verify it); or

…

(10) provided misleading or inaccurate information about the *policy* to the complainant; or

(11) sold the complainant a *policy* where the total cost of the *policy* (including any interest paid on the premium) would

> exceed the benefits payable under the *policy* (other than benefits payable under life cover); or
>
> …
>
> 3.6.3 Relevant evidence might include the complainant's demands, needs and intentions at the time of the sale and any other relevant evidence, including any testimony by the complainant about his reasons at the time of the sale for purchasing the payment protection contract."

49. Halifax submitted, in paragraph 12 of its Detailed Grounds for Contesting the Claim, that the presumption at paragraph 3.6.3 of DISP App. 3 was "no more than a "tie breaker" if the evidence is (highly unusually) precisely equally balanced, or if there is no evidence at all", although Halifax emphasised in its skeleton argument that it was not intending to differ from the applicable FCA Guidance, and accepted that the DISP rules required sufficient evidence in all the circumstances to rebut the presumption..

50. Presumptions may have different weights, depending on their context. In *B v General Medical Council* [2018] EWCA Civ 1497, [2019] 1 W.L.R. 4044 Sales LJ commented on arguments that section 7(4) of the Data Protection Act 1998 created a presumption. Whilst concluding that the section contained no presumption at all, he stated, at [68]:

> "Presumptions come in various different forms and with different effects in the law. Sometimes the only function that a presumption has in a particular context is to operate as a tie-breaker at the end of a process of analysis, if all other competing factors are otherwise precisely in balance. But to say that a presumption applies as a starting point for a particular exercise of analysis (rather than as a final tie-break) suggests that there is some significant hurdle or threshold which one party has to overcome before a decision can be made in his favour."

51. I agree with the Claimant's submission that on an ordinary reading of DISP App. 3, where a firm finds the sale was substantially flawed, it should presume that the complainant would not have bought the payment protection contract in the absence of the flaw. The presumption may be rebutted if there is evidence to the contrary, as illustrated in paragraph 3.6.3. This is an evidential presumption which is capable of being rebutted. It is not merely a tie-breaker.

52. I am fortified in my view that this is the correct interpretation by the opinion of the FSA, expressed in consultation papers when DISP App. 3 was drafted.

53. The FSA consulted on an earlier version of the non-purchase presumption in Consultation Paper 09/23, dated September 2009, recognising in its "approach to redress" that "in many cases it is likely" that the complainant would not have taken any payment protection contract or purchased an alternative one (at paragraphs 2.5.2 & 2.53 of the draft). In its "basic approach", it stated at paragraph 3.2(c) that a firm might conclude that the consumer would have bought the policy in any event "but we expect this will be unusual".

54. Responding to industry objections that the non-purchase presumption was not founded upon evidence and unfairly weighted in favour of the consumer in Consultation Paper 10/06, dated March 2010, the FSA justified the non-purchase presumption, stating that "it is a reasonable and rational presumption that, without those failings, the consumer would not have bought the PPI" (at 42). It went on to say:

> "The proposed guidance indicated that even where there were sales failings, it remains open to the firm to provide evidence for rebutting the presumption and finding that the consumer would in any case have proceeded as they did. We would expect this evidence to be specific to that customer. We have recast the relevant parts of the guidance to make this clearer.
>
> So, when a firm receives a PPI complaint, it should generally seek out relevant information concerning the individual sale and the complainant's circumstances. This evidence is useful in two respects. It should assist a firm in assessing its own behaviour at point of sale, and in judging whether (given any particular sales failings identified) the relevant presumption should apply or whether there is clear and specific evidence which gives good reason to set aside the presumption as to what the complainant would have done in this particular case.
>
> To that extent, and as is often the case with assessing complaints and remedies, the proper emphasis should be on what *a reasonable person* would probably have done in the *particular circumstances*."

55. In August 2010, the FSA issued Policy Statement 10/12, described as feedback on the further consultation in Consultation Paper 10/6. It appended the final version of DISP App. 3. The FSA summarised the responses from the industry which were mainly negative, and concluded as follows:

> "The presumptions represent a way of judging what a customer would generally have done, in our view. …we remain of the view that the presumptions we have set out are reasonable ones fully in the tradition of, and informed by, the kinds of judgments that courts and ombudsmen have long and often been making when assessing claims and complaints and the potential need to put the claimant, as far as practicable, back in the position 'they would have been in' had the breach not occurred.
>
> We …recognise that it would not be possible to establish in every case what a customer would have done in every individual circumstance and that there has to be scope for a firm to depart from the presumptions. So the presumptions are rebuttable – that is, it is open to the firm to evidence that the customer would have bought the policy notwithstanding the breach or failing, in which case no redress will then be required.
>
> …..

> A recording of the sale is not essential to rebut the presumptions. Where it is not available, firms must fairly assess the available evidence to make a decision about what they think would have been likely to have happened, but for the failing, given the circumstances and the evidence about the sale. For example, if the firm failed to disclose the existence of an exclusion relating to pre-existing medical conditions, then it may be reasonable for the firm to rebut the presumption that the customer would not have bought the policy if it can be shown that the customer did not have a pre-existing medical condition….
>
> We have carefully considered, in light of responses, the proposed list of 'substantial flaws' in the proposed Handbook text. We are satisfied that the rebuttable presumptions cover substantial flaws and that our proposals are appropriate because in each case the nature of the failing raises serious doubts over whether the customer would have proceeded with the purchase if there had not been such a failing.
>
> It is true that the presumptions do not make allowance for the materiality of the failings. We consider that the failings amount to substantial flaws irrespective of their materiality to particular consumers, and that it is reasonable and simpler for our guidance not to differentiate the failings in terms of materiality. In practice, firms are likely to be able to factor in considerations of materiality when potentially rebutting the presumptions in the case of a particular complaint. For example, if a firm failed to disclose an exclusion, and if that exclusion did not apply to that customer at the time of the sale …, it may be reasonable for the firm to conclude (assuming there are no other failings) that the exclusion was not material to that customer and that he would have bought the policy anyway, notwithstanding the firm's failure to disclose the exclusion.
>
> We considered the point that presumptions should differentiate between matters of disclosure and matters of suitability, but we see no reason to make this distinction. For example, failing to disclose to a customer a significant exclusion which was relevant for that customer would produce much the same customer outcome as a failure to take into account the exclusion when providing advice to that same customer: in both cases the customer has a policy under which he is excluded from the cover…"

56. In *R (British Bankers Association) v Financial Services Authority* [2011] Bus. LR 1531, the High Court dismissed a challenge to the lawfulness of the FSA's PPI principles and guidance, including aspects of DISP App. 3.

57. In my judgment, these extracts from the FSA's consultation papers and policy statement demonstrate that, in cases where a substantial flaw in the sale had been identified, the FSA intended to introduce an evidential presumption that the customer would not have

purchased the policy, as it believed this to be a reasonable and rational assumption of the customer's likely response in the absence of the flaw. Fairness in the individual case was to be achieved by providing that the presumption could be rebutted by evidence which demonstrated that the customer would probably have purchased the policy in any event. I do not consider that this is properly described as a tie-breaker.

58. I note that the FCA classed the presumption as an "evidential provision" (denoted by the letter 'E') rather than Rules ('R') or Guidance ('G'). As the FCA commented in Policy Statement 10/12 "unlike rules, EP's still leave it open to firms to demonstrate …that any alternative approach by them is fair and we think this much flexibility is appropriate given the varied nature of possible complaints and outcomes".

59. The Claimant also submitted that, where a firm sought to rebut the presumption arising from paragraph 3.6.2, it could only rely on evidence which related to the substantial flaw/s that had been identified. She criticised the holistic approach adopted by the Ombudsman, in which he evaluated the evidence of the policy and the Claimant's individual circumstances as a whole in deciding whether the Claimant would have purchased the policy, absent the substantial flaws. I do not consider that there is any basis for the Claimant's restrictive construction on an ordinary reading of DISP App. 3 paragraphs 3.6.2 and 3.6.3, and the Ombudsman's approach was permissible.

60. It was common ground that DISP App. 3 was guidance addressed to firms, not the Ombudsman Service. The Ombudsman was required to have regard to it in deciding what was fair and reasonable as a material consideration of a class expressly identified in DISP 3 paragraph 3.6.4, namely, regulators' guidance and standards, and good industry practice. In considering whether there was evidence which rebutted the presumption, the provisions on evidence in paragraphs 3.5.8 to 3.5.12 of DISP 3 applied. However, he was entitled to depart from it, if he rationally concluded that there were fair and reasonable grounds for doing so.

61. I agree with the general approach set out in the FCA's response to this claim in a letter dated 14 June 2019 which, after referring to its consultation papers and policy statement, stated:

> "the provisions in DISP App 3 apply to firms not the Defendant or its ombudsmen, which are required to determine disputes referred to the Defendant on the basis of what ombudsmen consider to be fair and reasonable in all the circumstances of the case;
>
> the way in which an ombudsman is required to take into account our rules and guidance is clear from the legislation, rules and previous decided cases;
>
> therefore, it was for the ombudsman, taking into account the use of a 'but for' test, the rebuttable presumptions in DISP App 3 and all other relevant considerations, to decide on the evidence whether or not the complainant would have purchased the PPI policy and therefore whether or not to uphold the complaint. It was open to him to decide that she would have purchased the PPI policy."

62. Mr Sweeney, lead ombudsman and director of casework at the Defendant, drew attention to the FCA's Policy Statement 17/3 issued in March 2017 which reiterated:

> "The PPI market was large, long-established and diverse in its products and their benefits and limitations, costs and value of money, and the channels and ways in which it was sold. Given this diversity, we remain of the view that not all PPI was mis-sold and that, properly sold, PPI could meet some consumers' genuine credit protection needs. Also, as our existing rules and guidance make clear, not all failings in sales processes or practices made sales substantially flawed. Further even in the case of substantially flawed sales, they do not require redress where the consumer would have bought the PPI in any case. Many consumers have successfully claimed on their PPI policies and thus benefited from them."

Grounds of challenge

The Claimant's submissions

63. The Claimant submitted that the Ombudsman misinterpreted DISP App. 3 or failed to apply it correctly. In particular, he failed to apply the presumption in DISP App. 3, and proceeded to decide that the Claimant would have purchased the PPI policy in any event, when there was no evidence to support that conclusion, and it was contradicted by the Claimant's own evidence. The Claimant contended that the evidence relied upon to rebut the presumption in DISP App. 3 had to relate to the substantial flaw which had been identified.

64. In reaching his decision, the Ombudsman followed a policy, or set of counter-presumptions, which are consistently applied by the Defendant in credit card PPI complaints, and evidenced in the Defendant's Navigator software programme used by adjudicators. Even where it finds substantial flaws in the sale, the Defendant rejects complaints on a causation basis, concluding that the complainant would have purchased the policy despite the flaws, unless one or more of the following factors applies:

    i) the complainant was ineligible for the policy;

    ii) the complainant did not genuinely consent to the sale;

    iii) the complainant had a pre-existing condition which would have been excluded under the terms of the policy;

    iv) it fails the Defendant's cost/benefit matrix, which assesses the cost of the policy, the benefits in the event of a claim, and the customer's need for the policy (assessed according to the customer's ability to pay off the borrowing from savings or benefits).

65. By failing to apply the presumption in DISP App. 3, and instead applying the Defendant's policy, or set of counter-presumptions, the Ombudsman failed to decide

the complaint on an individual basis, and failed to have proper regard to all the relevant considerations in the Claimant's case, namely:

i) the Claimant's own evidence that she would not have purchased the policy if she had been made aware of the limitations in cover, its true cost and poor value;

ii) the limitation in the definition of disability;

iii) the limitations in the cover for back pain and mental health problems;

iv) the insurer's right to vary cover or increase premiums;

v) the full cost of the policy;

vi) the poor value of the policy, including the low claims ratio.

His conclusion that she would have purchased the policy in any event was, therefore, irrational.

66. The Claimant submitted that the Ombudsman's conclusion that the policy was suitable for her was flawed because:

i) He failed to consider what Halifax should have done to investigate suitability and what the outcome of that process would have been, including assessing her requirements and objectives;

ii) He failed to take into account relevant considerations, such as the restrictions on cover, the high cost, and poor value;

iii) He took into account her eligibility, which was irrelevant to suitability;

iv) It was irrational in the light of the restrictions on cover, the high cost and the poor value of the policy.

67. The Ombudsman erred in failing to conclude that, independently of DISP App. 3, there had been a breach of the duty of utmost good faith by reason of Halifax's failure to disclose the policy limitations and exclusions to the Claimant, as well as the poor value of the policy.

68. Finally, the Claimant submitted that the Ombudsman failed to give adequate reasons for his conclusions.

Submissions by the Defendant and Halifax

69. In response, the Defendant and Halifax submitted that the Ombudsman correctly interpreted and applied DISP App. 3, but in any event, he was entitled to depart from it if he thought it fair and reasonable to do so. The Claimant's contention that the evidence to rebut the presumption was limited to the substantial flaw identified was not to be found in the wording of DISP App. 3.

70. There was no evidence to support the Claimant's contention that the Ombudsman was applying an alternative policy or a set of counter-presumptions when making his decision. In particular, he did not use the Navigator software programme or the cost/benefit matrix.

71. In concluding that the policy was suitable for the Claimant, and that the Claimant would have purchased the policy in any event, the Ombudsman took into account all relevant considerations, and reached a rational conclusion. He was entitled to give little weight to the Claimant's own statement that she would not have purchased the policy. His reasons were adequate and intelligible.

72. The Ombudsman's rejection of the Claimant's submission based upon the common law principle of utmost good faith was lawful, and adequately reasoned.

Conclusions

73. The Claimant accepted that the Ombudsman correctly identified the regulatory regime governing the Claimant's policy, as summarised in paragraphs 27 to 30 of my judgment above.

DISP App. 3

74. On my reading of the Ombudsman's decision, there was nothing to suggest that the Ombudsman misinterpreted DISP App. 3. The Claimant did not identify any specific error of interpretation other than her general submission that the Ombudsman did not correctly apply the terms of DISP App. 3. The Ombudsman referred to it fully in his decision (paragraphs 44 to 47) and I have no doubt that, as an experienced Ombudsman, who had dealt with many previous PPI complaints, he was well aware of its provisions.

75. The Ombudsman considered that his approach and his findings were consistent with the guidance in DISP App. 3, which he expressly applied (paragraphs 130 to 133, 137).

76. The Ombudsman found that there were significant failings in the sale of the policy by Halifax to the Claimant, and that, in consequence, the sale was "substantially flawed" within the meaning of paragraph 3.6.2 of DISP App. 3. However, he went on to find that there was evidence to rebut the presumption that she would not have bought the policy if these failings had not occurred, having regard to her "demands, needs and intentions at the time of sale, including any testimony by the complainant about his reasons at the time of sale for purchasing the payment protection contract" (paragraph 3.6.3).

Suitability

77. On the question of suitability, the Ombudsman found that Halifax recommended the policy to her, but it did not act with reasonable care and skill in establishing whether the policy was suitable for her. There was no evidence to show that Halifax took steps to establish whether the Claimant would have been caught by the significant exclusions and limitations in the policy, which might have meant it did not fully meet her needs.

For example, there was nothing to suggest that Halifax considered whether she had any pre-existing medical conditions (paragraphs 66, 67).

78. However, the Ombudsman concluded that the policy was suitable for her, for the reasons set out in paragraph 68:

> "68. Whilst I am not persuaded Halifax did all it should have done to determine whether the policy was suitable for Mrs C, I am satisfied it is more likely than not that the policy was ultimately suitable for her given what I consider were Mrs C's needs and circumstances at the time. In reaching that conclusion I have taken into consideration:
>
> – Mrs C met the eligibility criteria for the policy.
>
> – Mrs C had a need for the policy. Even allowing for her sickness and redundancy entitlements from her employer, it seems likely to me that Mrs C's finances would have been put under strain if she was not working. The policy would have helped Mrs C manage the consequences were she to be unable to work.
>
> – The policy was on balance affordable for Mrs C. The premium varied based on the statement balance applicable each month. Halifax's records indicate that the credit limit under the card started at £1,250, eventually reaching £1,900. Even if Mrs C's statement balance was around her credit limit each month, a premium cost of 78p per £100 of that balance would seem to have been affordable for her, based on her recorded salary, and as I haven't seen anything about her wider financial circumstances at the time to suggest differently.
>
> – The exclusions and limitations did not make the policy unsuitable for Mrs C. There was nothing about Mrs C's employment or occupation which would have made it - difficult for her to claim. Mrs C did not have any pre-existing medical condition, and was not suffering from any mental health or back problems.
>
> – Whilst the policy would only pay benefits for a maximum of 12 months for each disability or unemployment claim, in my view it still provided useful cover given Mrs C's circumstances, and the potential consequences if Mrs C were to be unable to meet the credit card repayments."

79. In my judgment, the Claimant was wrong to submit that eligibility was not relevant to the question of suitability. Plainly, if an individual was not eligible to claim under the terms of the policy, then the policy was unsuitable for him or her.

80. The Claimant contended that the Ombudsman erred in failing to ask himself what Halifax should have done to investigate suitability and what the outcome of that process would have been, relying on the case of *Saville v Central Capital Ltd* [2014] EWCA Civ 337, per Floyd LJ at [61]. I do not accept this submission. The Ombudsman considered what Halifax should have done to assess suitability, and concluded that it failed in its duties at the point of sale. At paragraph 135, the Ombudsman considered the *Saville* case, as it was referred to in the Claimant's representations. He correctly distinguished it on the facts. He went on to say, that even if Halifax had asked the questions which the Claimant contended it should have asked, the likely outcome was that the Claimant would have taken out the policy, given the benefits it still provided and her overall circumstances.

81. The Claimant also contended that the Ombudsman failed to take into account the limitations on cover, the high cost and poor value of the policy, and the benefits, and that his conclusion that the policy was suitable was irrational. The Claimant submitted that the policy was an expensive product, and the limitations on making a successful claim (a claims ratio of 14%) meant that it was poor value and therefore obviously not suitable.

82. On a fair reading of the decision as a whole, I consider that the Ombudsman had these considerations well in mind, but he took a different view to the Claimant and WFAC. He did not consider that it was poor value. At paragraph 18, he set out a table showing the benefits which the Claimant would receive in the event of a claim, concluding that "the policy would more than cover the contractual monthly minimum payment and would clear the outstanding balance in full" over the 12 month period of payments. As the Claimant had a modest income of £12,000 p.a. and no savings, it would have been a strain to meet repayments on the card if she was unable to work, taking into account her limited employment benefits. Despite the statistically low level of successful claims, there was nothing to suggest that the limitations on pre-existing medical conditions and on claims concerning back pain or mental health claims made the policy unsuitable for this particular individual. In my judgment, the Ombudsman was entitled to reach this rational conclusion, in the exercise of his judgment. He gave detailed reasons for his decision, which met the required standard.

Non-disclosure

1. Limitations

83. The Ombudsman considered, even if the Claimant was given the policy booklet at the meeting, she would not have had an opportunity to study it before she entered into the policy. She would have based her decision upon what she was told by the Halifax sales representative.

84. In respect of the exclusions and limitations in the policy, the Ombudsman found that the policy terms on back conditions and mental health claims were a significant limitation, which the Halifax representative should have brought to her attention. The Ombudsman accepted that these were common conditions which frequently result in absence from work. The evidential requirements in the policy for these conditions were more onerous than those which applied to any other disability for which a claim was made.

85. Although the policy described them as 'exclusions', he considered that they were 'limitations' because back conditions and mental health claims were not entirely excluded. In my view, the Claimant's concern about the nomenclature was misplaced; I do not consider that it affected the Ombudsman's approach.

86. The Ombudsman also found that the terms of the policy differed from what the Claimant might have expected because the definition of disability in the policy meant that she could only claim for disability benefits if she was unable to do either her own job or other work that her experience and training would allow her to do (paragraph 113).

87. The Ombudsman further found that Halifax did not act reasonably and fairly in drawing to her attention the term in the policy which permitted the insurer to unilaterally vary the premium and the cover (paragraph 117).

2. Cost

88. In relation to cost, the Ombudsman found that the Claimant was given an approximation of the policy's cost, in that she was told that the cost was calculated at 78p per £100 of the card balance (paragraph 70). However, that information was insufficient in that it was not explained to the Claimant that:

i) the cost of the premium at 78p per £100 did not necessarily convey the true monthly cost, because this would vary depending on the size of the outstanding balance (paragraph 76);

ii) premiums would continue to be incurred during a successful claim (paragraph 76); and

iii) the premiums themselves would attract interest if the outstanding balance each month was not repaid (paragraph 76).

89. The Ombudsman found that Halifax was not required to disclose more detailed information about the value of the policy and the low average claims ratio of 14%. To avoid repetition, I consider this topic below, under the heading 'The duty of utmost good faith'.

Would the Claimant have purchased the policy without the substantial flaws identified?

90. At paragraph 96, the Ombudsman went on to consider whether, "if Halifax had explained things properly", the Claimant would have acted differently or whether she would have taken out the policy in any event. The Ombudsman gave careful consideration to the likely response of the Claimant, evaluating the available evidence, and exercising his judgment.

91. Although the Claimant clearly stated in her complaint that she would not have wanted the policy if she had been fully informed of its terms, the Ombudsman gave little weight to this evidence. He found that the Claimant's recollections of the sale were, owing to the significant passage of time, likely to be limited. In my view, he was justified in reaching this conclusion. He had already found that she had forgotten that she went

into the Branch and had a meeting with a Halifax representative when she was given advice on the PPI policy. Her recollection was that she had applied by post and did not receive any advice when she applied. Plainly she had little recollection of the sale. The Ombudsman also formed the view that the statements in her complaint asserting that she would not have wanted to take out the policy if its terms had been properly explained to her, had been included on the advice of WFAC as the relevant paragraphs resembled quite closely the consumer representations made in other complaints where WFAC were the representatives. In my view, he was entitled to take this view. The weight to be given to the evidence was quintessentially a judgment for the decision-maker, and not susceptible to legal challenge in the absence of a public law error.

92. In my judgment, the Claimant's contention that he did not evaluate the costs versus the benefits of the policy was incorrect. The Ombudsman directed himself on the issue of cost and benefit in the following terms:

> "98. Deciding whether to follow advice to take out insurance requires the consumer to weigh up a number of factors before deciding whether to proceed. PPI policies typically provide cover in a variety of situations, some of which may be of greater interest or relevance to the consumer than others.
>
> 99. Effectively the consumer has to weigh up in their own minds the cost of the policy against the benefits offered in return and the potential consequences they will suffer if they don't have insurance should the risks come to fruition …"

93. The Ombudsman carefully evaluated the cost of the policy against its benefits, taking into account the following factors:

i) She was eligible for the benefits and the Ombudsman had earlier found that the policy was suitable for her, for the reasons set out at paragraph 68;

ii) She had some interest in taking out a PPI contract at the time, when it was suggested to her (paragraph 100);

iii) In her personal circumstances (a low income and no savings), she would have seen the payments under the policy as a benefit if she was unable to work as they would clear the entire balance on the credit card for an affordable premium (as demonstrated by the table in paragraph 18) during what would likely to be a difficult period, even though she may have been able to manage for a time with just her employment benefits (paragraphs 106, 128);

iv) Although Halifax did not disclose the full cost to her and there was lack of clarity on the amount of the benefits payable, the ultimate position was not dissimilar to what she would reasonably have thought to be the case and which she appeared to find acceptable (paragraphs 108 to 111);

v) Even if the Claimant had been made aware of the unilateral variation clause in the contract, it would not have been likely to make a difference to her decision to buy the policy, as she was entitled to 30 days notice of any proposed variation

and she would have been able to cancel the contract if she wished to do so, and seek cover from another provider (paragraphs 118, 119);

vi) The definition of "disability" meant that she could only claim if she could not do either her own job or other work that her experience or training would allow her to do. This may have given her pause for thought, but in all probability the chances that she would have been capable of other work if she was unable to continue working as a store supervisor were limited, and so this term did not make the policy unsuitable for her, and it was possible that she would not have been overly concerned by it (paragraph 113);

vii) The limitations on cover for back pain and mental health, because of onerous evidential requirements, might well have given the Claimant pause for thought (paragraph 125), but in her particular circumstances (as set out earlier in the decision) there were still good reasons to take out the policy, notwithstanding these limitations (paragraphs 126, 127).

94. The Ombudsman concluded that if the Claimant had weighed up the costs versus the benefits, with all the information with which she should have been provided, she would have been more likely than not to have treated the benefits as outweighing the cost:

> "128. Having considered all of the evidence and arguments in this case, in my view, it is more likely than not that Mrs C would still have taken out the policy. The policy was suitable for her, was sufficiently close to what she likely thought she was getting, and could still have provided a useful benefit in a difficult time, notwithstanding her employment benefits. It would have helped minimise her outgoings, and it is possible that in the absence of any savings Mrs C may have wanted to avoid using her sick pay or redundancy pay for the card repayments, so as to be able to manage her other everyday expenses. It is likely she would also have thought about whether the cost to benefit proposition still worked for her, and I consider it more likely than not that she would have taken out the policy in any event."

95. In my judgment, the Ombudsman took into account all considerations which were relevant to the Claimant's purchase of the policy in 2002, applying the regulatory regime in existence as at that time. As I have indicated above in paragraph 59 of my judgment, under DISP App. 3 he was entitled to take a holistic approach, in which he evaluated the evidence of the policy and the Claimant's individual circumstances as a whole, in deciding whether the Claimant would have purchased the policy, absent the substantial flaws. In the course of that exercise, the decision shows that he clearly had regard to the materiality of the flaws identified. In my judgment, his conclusion cannot be characterised as irrational and his reasons met the required standard.

96. The Ombudsman considered that his approach was consistent with DISP App. 3 and the relevant presumption, stating:

> "132. I have thought about what outcome applying the FCA's guidance to this complaint might lead to. In the language of DISP App 3, I have found it would be reasonable to conclude

> that there were substantial flaws in the sales process. In those circumstances, DISP App 3 says it should be presumed Mrs C would not have bought the payment protection insurance she bought unless, in the particular circumstances of the complaint, there is evidence to rebut the presumption.
>
> 133. I am satisfied, applying DISP App 3, it is reasonable to conclude the presumption is rebutted in the particular facts and circumstances of this complaint. Based on the evidence pertaining to Mrs C's circumstances I have considered above, I consider it reasonable to conclude the position Mrs C found herself in as a result of the sale was the same position she would have been in had the 'breach' or 'significant failings' not occurred."

97. However, the Ombudsman went on to say, at paragraphs 137 - 138:

> "137. Even if I am ultimately departing from the guidance for firms set out at DISP App 3 (which I don't consider I am), I am doing so because I do not consider, in this case, that it would represent fair compensation to put Mrs C in the position she would have been in if she had not bought the policy.
>
> 138. That is because, whilst I accept it is possible that Mrs C would not have taken out the policy, I am satisfied that of the two possibilities, it is more likely than not that she would still have taken out the policy if her needs had been assessed correctly and she had been given clear, fair and not misleading information about the policy she was buying."

98. I accept the Defendant's submission that this conclusion that was open to the Ombudsman on the proper application of his statutory duty under section 228(2) of FSMA 2000. He was required to determine the complaint based on what was, in his opinion, fair and reasonable in all the circumstances of the case. In my judgment, he discharged that duty lawfully. Therefore, even if his decision was construed as contrary to the presumption in the guidance in DISP App. 3, it would not be unlawful in any event.

99. The Claimant's contention that he was applying a policy or set of counter-presumptions which unlawfully limited the factors taken into account, and failed to take account of the Claimant's individual circumstances, is demonstrably not correct. There is no reference to any such policy or counter-presumptions in the decision; the Ombudsman undertook a thorough, individualised consideration of the Claimant's position. I accept the Ombudsman's evidence that he did not use the Navigator tool when making his decision, nor did he rely on the Navigator summary generated by the adjudicator in the Claimant's case. The cost/benefit matrix produced in evidence appears to be part of the input into the Navigator programme. I am satisfied that the Ombudsman did not use this matrix in making his decision. Whilst I appreciate the concerns that WFAC may have about the risks of using a software programme in the determination of claims, this case was not the appropriate vehicle for a challenge to the manner in which Navigator has been programmed, and used, by adjudicators.

100. The Claimant criticised the Ombudsman for not adopting the approach taken by Ombudsman Futer's decision (ref. DRN0991762) in which, after considering the costs of the policy and the complainant's circumstances, he concluded that the complainant would not have purchased the policy if he had fully understood the cost, and so the presumption in DISP App. 3 had not been rebutted. I did not find this decision of any assistance since it was based upon Ombudsman Futer's assessment of evidence which was specific to the particular complaint before him. The facts were significantly different to the facts in this case as it concerned the sale of a single premium PPI policy (in connection with a personal loan).

101. I observe that the evidence that different Ombudsmen are reaching different conclusions on PPI complaints tends to confirm that they are considering each case individually, and not applying an unlawful policy or set of counter-presumptions. It is a feature of any independent judicial system, including this Court, that different judges may lawfully reach different conclusions, even in similar cases. For example, in *R (Doling) v Financial Ombudsman Service* CO/2274/2019, in which the claimant is supported by WFAC, and represented by Mr Temple, and relies on similar arguments to this claim, Sir Duncan Ouseley, sitting as a Judge of the High Court, observed that he would not have granted permission to apply for judicial review were it not for the fact that HH Judge Bidder QC had already granted permission on similar arguments in this case.

The duty of utmost good faith

102. The Claimant submitted that Halifax was in breach of the duty of utmost good faith because (1) the exclusions/limitations in the policy were not drawn to her attention; and (2) very low claims ratios should have been disclosed as a matter of reasonableness or commercial standards of decency. According to the Claimant, the Ombudsman erred in rejecting this submission.

103. The Ombudsman addressed the Claimant's submission at paragraphs 77 to 92 of his decision, which reads as follows:

> "77. I have considered carefully Mrs C's arguments that Halifax should have done more than I have found it should have done and provided additional information. I have given particular thought to Mrs C's view that the common law duty of utmost good faith meant that:
>
> – Halifax should have explained the low claims ratio (and what she considers to be the inherent poor value) and the fact much of the premium went to Halifax rather than the insurer.
>
> – Halifax should have told her not just about the limitations and exclusions, but also about the significance of them.
>
> 78. Halifax did have to consider the features of the policy and weigh up the significance of the exclusions and limitations to ensure the policy it was recommending was suitable for Mrs C's needs, and it also had to explain the features of the cover.

But I am not persuaded by Mrs C's views about what the duty of utmost good faith required.

79. Under the law which existed at the time, both parties to an insurance contract owed a duty of utmost good faith to the other. By way of summary only, both parties had duties to disclose material facts and to refrain from making material misrepresentations to the other.

80. Usually, the focus of any dispute tends to be on the extent of the obligations the duty of utmost good faith places on the person seeking insurance to disclose to the insurer the information it needs to determine and calculate the risk it will be taking if it agrees to provide the insurance.

81. But an insurer also has a duty to disclose:

… all facts known to him which are material either to the nature of the risk sought to be covered or the recoverability of a claim under the policy which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer. [*Banque Keyser Ullman SA v Skandia (U.K.) Insurance Ltd* [1990] 1Q.B. 665, 772]

82. MacGillivray on Insurance Law [MacGillivary on Insurance Law 13th edition 17-094] explains that the duty does not extend to giving the insured the benefit of the insurer's market experience, such as for instance, that the same risk could be covered for a lower premium either by another insurer or, presumably, by the same insurer under a different type of insurance contract; and the insurer is not required to perform the role of the insured's broker in this regard.

83. I cannot be certain, but I think it is unlikely a court would conclude an insurer should have disclosed the claims ratio and 'value' information, or contextualised the information about the limitations on disability cover in the way Mrs C says Halifax should have done by virtue of the duty of utmost good faith. In any event, I do not think it would be fair or reasonable in the circumstances of this case to impose such requirements on Halifax.

84. In its response to the provisional decision, WFAC referred to a decision of the Federal Court of Australia (*AMP Financial Planning PTY Limited v CGU Insurance Limited [2005] FCAFC 185)* and quoted selectively from it. It also made some additional representations about the duty of utmost good faith. I have considered this point, along with its other representations in this respect, but they have not changed my view about Mrs C's complaint.

85. Halifax was not the insurer in this transaction. Regardless, the ABI Code also referred to an overriding duty on the intermediary to act with utmost good faith and integrity.

86. The guidance Notes for Intermediaries and the Resume for Intermediaries about the application of the ABI Code which I have referred to in this decision do not refer to that duty or elaborate on what it was intended to mean. But I think it is unlikely that it was intended to place a greater or substantially different, obligation on the intermediary to that owed by the insurer.

87. I consider it more likely than not that the reference to an overriding duty on the intermediary was a reminder of the importance of disclosing material information to both the insurer and the insured (depending on whom the intermediary was acting for), reflecting the legal duty those parties were under. And it seems likely the provisions of the ABI Code were in effect intended to be practical examples of how the intermediary might meet the overarching principles of utmost good faith and integrity as well as expected standards of good practice.

88. I also note Mrs C's representations that the unemployment terms dramatically reduced the scope of cover, in that voluntary redundancy is not covered, and that someone being made redundant and signing a compromise agreement would render their redundancy voluntary. In my view, the suggestion that this 'dramatically' reduces the scope of cover is a generalisation. Whether or not a redundancy is voluntary (and indeed whether or not a compromise agreement is entered into by the parties) will depend on the individual circumstances, and our expectation would be that an insurer would take reasonable steps to establish the consumer's circumstances before paying or declining a claim.

89. I also note there was no expectation at the time under the provisions of the ABI Code or the GISC Code that insurers or intermediaries should proactively disclose commission. For example, the guidance to the ABI Code published in December 1994 said only that independent intermediaries should disclose commission on request and the GISC Code said that members would disclose information about commission and other amounts received on request.

90. Nor do I consider it can reasonably be inferred from the ABI Statement of Practice for Payment Protection Insurance (which gave further information about the expectations in PPI sales) that insurers or intermediaries were expected to disclose the kind of information Mrs C says Halifax should have done.

> 91. So it seems very unlikely that it was ever the intention of the ABI Code that intermediaries should provide the kind of additional information Mrs C suggests it should. ln any event, I am not of the view that it would be fair and reasonable in the circumstances of the case to impose a greater or substantially different obligation on the intermediary to that owed by the insurer.
>
> 92. Overall, taking into account the law, industry codes and standards of good practice applicable to this complaint, I am not persuaded that Halifax ought fairly and reasonably to have provided the additional information Mrs C it should have done"

104. In accordance with DISP 3.6.4R, the Ombudsman correctly took into account the common law, and the applicable industry codes. The Ombudsman followed the common law as understood in England, not Australia.

105. I accept the Defendant's submission that the Claimant's case on the scope of an insurer's pre-contractual duty of utmost good faith is misconceived. It is contrary to the underlying basis for the Court's decision in *Plevin v Paragon Finance* [2014] UKSC 61. Moreover, the duty of utmost good faith has been tentatively described as a duty to disclose "circumstances which decrease the risk to the assured" see *Colinvaux's Law of Insurance, 11th ed,* at 6-035.

106. In *La Banque Financier de la Cite SA v Westgate Insurance Co Ltd.* [1989] 2 All ER 952, the Court of Appeal held that an underwriter was not required to disclose all facts which might influence an assured in entering into a contract, as such a duty may require it to disclose, for example, the fact that other insurers offered similar cover but at a lower premium. It provided the following statement of principle, at [990]:

> "In our judgment, the duty falling upon the insurer must at least extend to disclosing all facts known to him which are material either to the nature of the risk sought to be covered or the recoverability of a claim under the policy which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer."

107. On a fair reading of the decision, I consider it is apparent that the Ombudsman appreciated that the Claimant was relying upon the duty of utmost good faith in respect of other limitations and exclusions in the policy, as well as the low claims ratio (see, for example, paragraphs 23 and 120).

108. The Defendant correctly submitted that the alleged breaches of good faith based on exclusions/limitations in the policy were academic because the same issues were found to be substantial flaws for the purposes of DISP App. 3.

109. In my view, the Ombudsman's reasons for his conclusions met the required standard.

110. Therefore the Claimant's submission based upon the duty of utmost good faith does not succeed.

Final conclusions

111. I grant the Claimant permission to apply for judicial review in respect of the ground upon which permission was refused by HH Judge Bidder QC, as the point was arguable. However, for the reasons set out above, the Claimant's claim is dismissed on all grounds.