Financial Advisers Disciplinary Committee **2018 FADC 009**

IN THE MATTER OF:	**Financial Advisers Act 2008**
BETWEEN:	**FINANCIAL MARKETS AUTHORITY**
	Complainant
AND:	**T**
	Respondent
Committee Panel	Hon Sir Bruce Robertson (Chairman) Geoffrey Clews Peter Houghton
Counsel:	Michael Hodge for the Complainant Donald MacRae for the Respondent
Date of Hearing:	25 March 2019
Date of Decision:	29 March 2019

DECISION OF THE COMMITTEE AS TO CODE STANDARD BREACHES

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A. EXECUTIVE SUMMARY

1. The Financial Advisers Disciplinary Committee ("**the Committee**") finds that the Respondent has breached a Code Standard ("**CS**") under the Code of Professional Conduct for Authorised Financial Advisers ("**the Code**"). Its findings are summarised as follows:

    (a) The Respondent breached CS 8 of the Code;
    (b) The breach is established in respect of two clients, Mr P and Mr W, whose identities are permanently suppressed;
    (c) It consists of the Respondent having failed:
        (i) To make reasonable inquiries as to the medical circumstances of Mr P; and
        (ii) Once aware of a past medical issue affecting existing insurance for Mr W, to act consistently with the requirements of CS 8.

2. The parties are entitled to file submissions on disposition of the matter (ie the penalty that should be imposed and any related matters). Submissions should include the party's preference for disposition to be dealt with by way of a further hearing or on the papers, and whether the party wishes to call any further evidence in support of its submissions. The Committee already has the Complainant's submissions on disposition and the Respondent's submissions should be filed within 15 working days of the date of this decision (on or before **Tuesday 23 April 2019**). The Complainant has indicated that censure and/or a monetary penalty would be the appropriate disposition and no costs are sought.

B. REASONS FOR DECISION

B.1 THE COMPLAINT AND ITS PROGRESS TO HEARING

3. A complaint against the Respondent was referred by the Financial Markets Authority ("**FMA**") to the Committee by letter dated 29 June 2018, alleging a number of CS breaches in respect of seven clients. By letter dated 18 February 2019 the referral to the Committee was amended so that it related to a single alleged CS breach in respect of two clients.

4. Having received the original referral, on 25 July 2018 this panel of the Committee found that a hearing was necessary and resolved that a Notice of Complaint should be served. Subsequent conferences led to the matter being timetabled and to the amended referral. Although the issues have been refined in the amended referral, the continuing contest over factual matters meant that a hearing was still required.

5. The complaint now alleges a breach of CS 8 in relation to the Respondent's dealings with two clients, Mr W and Mr P. An agreed summary of facts was settled but each party reserved the right to adduce evidence and to test the evidence offered by the other. The main factual assertions made and tested by each party are summarised in the next section of this decision.

6. Witness statements were received from the following:

    (a) Mr W, the first of the two clients of the Respondent;
    (b) Mr P, the second client;
    (c) Michael Brian Hewes, a manager in the Complainant's Supervision Team;
    (d) The Respondent;
    (e) Kevin McKernan a Registered Financial Adviser; and

(f) Brian Klee, a senior insurance professional.

7. All witnesses were available at the hearing, and those who testified orally confirmed their statements and then gave further evidence either in chief or under cross examination. Mr McKernan, one of the two witnesses for the Respondent, was not required for cross examination and his statement of evidence was received unchallenged, save for the submissions made about it on behalf of the Complainant.

8. A substantial amount of documentary evidence was provided to the Committee in support of the referral and no objection was taken to the reliability of that documentary record. The material was presented in the form of an agreed bundle and has been treated as evidence admitted by consent.

9. Both parties filed comprehensive written submissions and the Committee had the benefit of oral submission during a daylong hearing. It thanks counsel for the quality of their submissions and assistance in answering the Committee's questions.

B.2 FACTUAL FINDINGS

The Respondent's business

10. At all relevant times, the Respondent was an Authorised Financial Adviser ("**AFA**") and he acknowledged in evidence that he was obliged to abide by the Code. Indeed his position is that he knew of his obligations under CS 8 and had fulfilled those. The complaint arose from advice given by the Respondent to the clients, Mr P and Mr W. It focussed on the extent to which the Respondent had inquired about the past medical history of each client and alleged that, as a result of inadequate inquiry, the two clients had been left in a position where the cover obtained for them by the Respondent was susceptible to being cancelled for non-disclosure and that this actually occurred in the case of Mr W.

11. At the relevant times the Respondent advised members of the building and construction industry on insurance, including income replacement, health, trauma and life cover, together with strategies to reduce their exposure to ACC levy costs. He had made something of a specialty of this, having advised a great many builders on their insurance options. Mr P was a contract builder working for the same construction company for which Mr W was a project manager. Both engaged the Respondent to advise them on insurance options suitable to their circumstances. They were seeking a personalised service within the language of the Code and the Respondent clearly understood he was being asked to supply such a service. After the relevant times the Respondent decided to move out of this field of work and sold two of his "builder" client lists to another adviser.

Some documentation not available

12. The sale of those lists has led to some difficulties in that a complete record of documentation is not available for one of the clients concerned in the amended referral, Mr W. It appears that the paper record may have been destroyed after it was transferred by the Respondent. Some but not all of the record was recovered.

13. The Respondent candidly accepted that he could not swear to the content of that part of the record for Mr W that was not available to him or the Committee, but he testified to his best recollection of what the record would have contained. The Committee had the benefit of a complete record of the documentation relating to the other client, Mr P. The Respondent confirmed that his documentation

followed standard forms and, indeed, that he was prone to using a stock phrase in the documentation when noting a clear medical history on his standard "fact find" document. Despite some documentation not being available, we are satisfied that the agreed documentary record and the evidence presented at hearing is sufficient for us to reach a conclusion on whether a CS breach occurred.

14. Before analysing whether a CS breach has been made out, we summarise next the factual conclusions we have reached about the Respondent's dealings with the two clients. We begin with Mr P, whose case is relatively straightforward.

Factual findings relating to Mr P

15. Mr P provided a statement of evidence and was cross-examined by Respondent's counsel. We found him to be a credible witness who answered the questions put to him candidly and honestly. Our findings as a result of that evidence, and the evidence of the Respondent affecting Mr P, are:

    (a) Mr P met with the Respondent on three occasions. At the initial meeting, the Respondent sought to complete his "fact find" for Mr P. On that document he noted that, "No illnesses or injuries of note" had been disclosed. At a second meeting his statement of advice ("**SOA**") was presented and Mr P took this away to consider. A third meeting then occurred at which applications were completed by Mr P with the Respondent, including an application to PartnersLife for insurance cover. All three meetings occurred on the building site where Mr P worked. Despite the efforts of Respondent's counsel, Mr P left us with the clear impression that these meetings were relatively quick, not least because they occurred on a work site and during a work day, where he was under time pressure. The Respondent did not convince us otherwise. Indeed, for two of the meetings where an outlook event reminder was exhibited, the time allocated for the meetings in the Respondent's diary was only 30 minutes. Had it been his routine for more time to be expended on such meetings, we would have expected a contemporary record such as an electronic diary to show this.

    (b) During these meetings some discussion occurred about Mr P's medical history. Mr P accepted this under cross examination, at least to the point of agreeing that this could have been so. He said an ankle injury was not noted because "it did not seem to be that big an issue," but it was not clear whether this was because of positive advice from the Respondent that it could be ignored or because Mr P decided it was not significant enough to be included, because of what he was told by the Respondent about expected disclosure.

    (c) Mr P had past medical conditions, including the ankle injury. There was some argument over whether those conditions could have led to an exclusion or limitation of cover, had they been disclosed as a result of the Respondent's dealings with Mr P. In fact when they were disclosed in a later application for cover advanced for Mr P by his new adviser, no exclusion or limitation of cover followed. Whether or not an underwriter might have limited cover is a red herring. The issue is whether disclosure could have been obtained by reasonable inquiry. We have concluded that the matter of the ankle injury and Mr P's other medical conditions "did not come out" because Mr P was not made sufficiently aware of the need for full disclosure. Mr P did not strike us as someone who would have been consciously trying to keep things from an insurer contrary to the advice of the Respondent. We have concluded that whatever was not included in his application to PartnersLife came about because of the way the Respondent dealt with Mr P over the issue of medical disclosure.

(d) As to that, there was clearly some consideration of the checklist of conditions contained in the PartnersLife application form, but the essential difference between the evidence of Mr P and the Respondent lies in the time taken to review the list and the effort made to explain the need for disclosure and implications of not fully disclosing medical matters.

(e) It is not entirely clear when the checklist was considered but, whatever the position, Mr P has a ready comparator for his dealings with the Respondent, namely the depth with which his current adviser has gone into the same matters that the Respondent says were canvassed in his dealing with Mr P. This comparison is very clear to Mr P. He referred to the work his present adviser has done as having been "much more in depth" and that the adviser had asked for a "detailed list" of past conditions, which led him to disclose matters not covered in his dealing with the Respondent. He says in effect that depth and detail were not part of the Respondent's approach.

(f) By contrast, the Respondent's evidence about how he dealt with the issue of medical disclosure emphasised that in *every case* he would go line-by-line through the list of medical conditions in the PartnersLife application, reading each of them out loud to the client and getting a response to each. He noted that the perceived in depth approach attributed to Mr P's new adviser was likely to be because he was trying to do in one meeting what had taken the Respondent three meetings with Mr P. That seems to us to miss the point. The issue is whether, in whatever meetings were undertaken with Mr P, reasonable inquiries were made by the Respondent in terms of CS 8. The comparatively short time spent in each of the three meetings the Respondent had with Mr P meant that the opportunity for inquiry was likely to be limited.

(g) The medical disclosure issue arises first at the initial meeting the Respondent had with Mr P. That is the meeting at which the Respondent made the entry on his fact find document that there were no illnesses or injuries of note. It arises again when the PartnersLife application form had to be filled in. We have concluded that whatever consideration was given to the list of conditions in the application form was insufficient to have impressed on a client like Mr P the need for full disclosure. We have concluded that the asserted line-by-line examination of the list of conditions as a prompt for past medical history may have been what the Respondent aspired to, but it did not occur in this case. Had it done, we doubt that Mr P would have been as clear in his comparison with what he saw as his new adviser's in depth consideration of medical history.

Factual findings relating to Mr W

16. Again, Mr W provided a written statement of evidence and he was extensively cross examined by Respondent's counsel. We consider that Mr W was cavalier in a number of aspects of his evidence and surprisingly glib about matters as important as medical disclosure. On some matters we therefore prefer the evidence of the Respondent. Our factual findings affecting Mr W are:

(a) The Respondent met Mr W at the corporate offices of the company for which he was a project manager and later at his home. Despite what Mr W said in evidence, the meetings were not on-site and not under the same type of time constraint as with Mr P. Mr W stated in evidence that he "would never have given more than 30 minutes to any meeting" at the time. By contrast, the Respondent said that Mr W did not have any apparent difficulty allowing the time needed to go over matters comprehensively. While there are indications that Mr W is likely to

have been impatient over matters of detail, on the crucial matter of his Sovereign medical history (referred to next), we are satisfied that he made time to discuss this with the Respondent and these discussions are likely to have at least touched on medical issues more generally.

(b) When the Respondent first met Mr W, the latter was covered by Sovereign Assurance under a policy covering term life, income protection and mortgage protection. The policy was subject to an exclusion for "disease, disorder of or injury to the Lumbar Sacral Spine, its Intervertebral Discs, Nerve Roots or Supporting Musculature," ("**lumbar exclusion**"). According to the Sovereign documentation, this was as a result of Mr W having disclosed to Sovereign muscular back pain over the four months preceding his application. At hearing Mr W said that he had only referred to a back ache as the result of his having put up a curtain rail. It is possible that the Sovereign representative simply fitted this to a category in Sovereign's standard application. Whatever the position, Mr W discussed the lumbar exclusion with the Respondent at their first meeting, because the existence of the lumbar exclusion was referred to in the SOA prepared by the Respondent after that meeting. The fact find document that would have been prepared at the first meeting was not available because it has been destroyed.

(c) Unknown to the Respondent Mr W had an extensive medical history that he had not disclosed to Sovereign and which was not disclosed to the Respondent until well after Mr W's application to PartnersLife for cover to replace the Sovereign policy. It seems very likely to us that Mr W's decision to withhold information about this history was because he was well aware that he might not obtain cover or might obtain cover that was significantly limited if he was truthful about it. He was prompted to "come clean" on these matters, first when he later suffered an event affecting his arm that required medical attention and, secondly, when he wanted to take up an advantageous offer for medical cover for him and his family. Even at those stages, Mr W seems to have been less than forthcoming on medical issues, until he absolutely had to be. Because of the extensive medical history ultimately disclosed by him, PartnersLife withdrew all cover on Mr W.

(d) When dealing with him over the Sovereign lumbar exclusion, the Respondent says he was told by Mr W that he had never actually had a back injury at all and that the exclusion was the result of him having had a slight back ache, which he had mentioned to the interviewer who was dealing with his application by video. We accept the Respondent's evidence that Mr W insisted that he would not allow an application to PartnersLife to be advanced with any mention of a back problem because to do that would be a misstatement by him.

(e) Mr W's position on this changed during his evidence. In his statement of evidence he said that he did not recall the Respondent asking him about the lumbar exclusion and that the Respondent must have obtained this information from Sovereign. Under cross examination Mr W accepted that it was possible he and the Respondent discussed the back injury at the first meeting and conceded that "his (the Respondent's) recollection is better than mine." He later said that he expected that all of the information held by Sovereign would automatically come across to PartnersLife so that the latter would know of the back issue anyway.

(f) Mr W's approach to medical disclosure seems to have been that he would include information if *he* considered it was relevant. In cross examination he confirmed that if he did not think a matter was relevant he would not have discussed it with the Respondent. This and his remarkably cavalier approach to reading the detail of his medical history, even when sent it by

the Respondent, persuade us that he was being deliberately guarded in his dealings with the Respondent until he judged it important to be more open and that, consistently with that approach, he insisted that no mention of a back injury or ailment should be included in his PartnersLife application, despite the Sovereign lumbar exclusion.

(g) The Respondent says, and we accept, that he took Mr W at his word about the fact that he did not have a back injury and so included no reference to it when making Mr W's application to PartnersLife. Despite the fact that he was aware by the time of the PartnersLife application that Sovereign had limited its cover, the Respondent allowed that application to proceed on the basis that Mr W averred that he had not had cover "declined, deferred or offered with special acceptance terms," the latter of which would have caught the Sovereign lumbar exclusion. When asked about this by the Committee, the Respondent candidly accepted that he had overlooked this.

B.3 INTERPRETATION OF CS 8

17. This CS requires that an AFA take reasonable steps to ensure the suitability to a client of a personalised service. It is common ground that the service being provided by the Respondent was personalised and that CS 8 applied to it.

18. The relevant version of the Code is that issued on 1 May 2014. The Code was revised with effect from 1 December 2016. The events covered by the amended referral to the Committee took place prior to that date.

Purpose of and approach to the Code

19. The Background section of the Code places it firmly in the context of the overarching purpose of Financial Advisers Act ("**FAA**"):

> ... to promote the sound and efficient delivery of financial adviser and broking services, and to encourage public confidence in the professionalism and integrity of financial advisers and brokers.

20. One of the key ways in which to achieve the purposes of the FAA is to require AFAs to comply with a code that sets minimum standards of professional conduct. The overarching purpose of the Act is expressly said to provide the spirit underpinning the Code.

21. The introduction to the Code describes the meaning and effect of a CS. Given some of the argument heard by the Committee, it is worth setting out these statements fully:

> Each standard in this Code consists of an overarching principle identified as a Code Standard together with additional provisions that contain further detail about the application of the Code Standard.
>
> Unless otherwise stated, the *additional provisions do not limit the application of the overarching principle under which they are stated*, or the application of any other Code Standard. AFAs must apply the Code Standards in a way that encourages public confidence in the professionalism and integrity of financial advisers. (our emphasis)

The principle and additional provisions of CS 8

22. CS 8 appears under the section of the Code devoted to minimum standards of client care. The overarching principle is expressed in terms that:

> When providing a personalised service to a retail client an Authorised Financial Adviser must take reasonable steps to ensure that the personalised service is suitable for the client.

23. This statement of principle is then followed by a number of additional provisions, which explain how the principle is applied, though still having regard to the spirit underpinning the Code.

24. The additional provisions that the Committee considers are particularly relevant to this case are:

> An AFA is only required to determine suitability under this Code Standard based on the information provided by the client *and information otherwise known to the AFA. However, the AFA must make reasonable enquiries to ensure the AFA has an up-to-date understanding of the client's* financial situation, financial needs, financial goals and *risk profile*, having regard to the nature of the personalised service being provided.
>
> Where a client:
>
> (a) declines to provide some or all of the information required under this Code Standard, an AFA *must* take reasonable steps to ensure the client is aware that the personalised service is limited and specify those limitations; ... (our emphasis)

25. The CS requires that reasonable steps be taken to ensure suitability of a personalised service. The commentary to the CS explains the AFAs must make reasonable inquiries to ensure an up-to-date understanding of the client's financial situation, financial needs, financial goals and risk profile. In the context of this case, dealing with insurance advice, we consider that the risk profile in question is not just the client's tolerance for investment or insurance risk but the risk profile they present *as a potential insured*.

26. Assuming that reasonable inquiries are made, an AFA may rely on what he or she is told by the client. But, importantly, the AFA cannot ignore information otherwise known to them. Contrary to the position put to us by and for the Respondent, CS 8 does not say that an AFA can simply accept what he or she is told by the client and act accordingly. If they have personal knowledge that is inconsistent with the information being given by the client, something more will be required to ensure that the AFA has the required up-to-date understanding of (amongst other things) the client's risk profile and is acting consistently with the spirit underpinning the Code.

27. If information required to fulfil a personalised service is not given by the client, or advice on suitability is not sought, specific steps follow to record the relevant limits of the AFA's advice. This shows the importance of full and complete consideration of the client's personal circumstances and the expectation that this will form part of an AFA's analysis as to suitability, unless expressly excepted.

28. None of this is prescriptive of the way CS 8 should apply. The Code of 2014 was described to us as being prescriptive of what it required from AFAs. The 2016 version was described as being more a statement of principles to be fleshed out. The Committee does not consider the 2014 Code to be prescriptive. It is clearly couched in terms of overarching principles, the application of which is described on a non-exclusive basis and in the expectation that the overarching spirit of the Act should be applied under the Code. It is descriptive rather than prescriptive.

B.4 APPLYING CS 8 TO THE FACTUAL FINDINGS

Mr P

29. Medical disclosures were not made in Mr P's application to PartnersLife. Those disclosures were made subsequently, to another insurer, after Mr P's new adviser asked him for a complete list of past medical issues. Those matters were not disclosed to PartnersLife because they were not elicited by the Respondent, not because they were withheld by Mr P. That is either because they were not asked about directly or because the way and the time in which the Respondent sought information from Mr P did not make the importance of full disclosure clear enough to him.

30. Knowledge of those matters was necessary to arrive an up-to-date risk profile for Mr P. It is irrelevant that the subsequent insurer chose not to limit cover, in the same way as PartnersLife had not, and so arguably that the risk profile presented by Mr P was the same with or without the disclosures. The issue is whether the Respondent can be said objectively to have made reasonable enquiries about Mr P's risk profile at the time the application to the former insurer was made. It is clear that more could reasonably have been done to ensure up-to-date knowledge of risk profile, in fact as little as to request a complete list of prior medical issues. Because this was not done, we find that **a breach of CS 8 in respect of the Respondent's dealing with Mr P is made out**.

Mr W

31. The Respondent knew that Mr W's Sovereign policy had been subject to a lumbar exclusion. This was information he was obliged by CS 8 to take into account when assessing the suitability of the PartnersLife product he was recommending to Mr W. He chose not to act on the information he knew, but instead to take Mr W at his word, that he had never had a back injury at all. In our view the Respondent was drawn into an error of judgment as to how he should deal with Mr W because of his misapprehension that CS 8 allowed him simply to rely on what his client said. That error led to a breach of CS 8 on two grounds.

32. Given the environment of the Respondent's meetings with Mr W, it is much more likely that the Respondent would have had the time to cover with Mr W the medical checklist he said he would routinely work through. We accept the Respondent's evidence that there were extensive discussions with Mr W over the issue of the Sovereign lumbar exclusion. Mr W said that he would not have given anyone more than 30 minutes for a meeting but, as a senior project manager for his company, we consider he would have had, and would have allowed, more latitude. As to the other matters that might have been covered in a review of the medical checklist, we have concluded that Mr W withheld from the Respondent the other medical conditions about which he eventually made disclosure. At the relevant time there was no information about these that the Respondent independently held. It was suggested in cross examination of the Respondent and submission on the Complainant's behalf that he ought to have been on notice that Mr W could have been withholding other information, because of his determination not to acknowledge a back injury to PartnersLife. We regard that as a step too far and so have confined our consideration of matters to the issue of the known lumbar exclusion.

33. On that matter, by his actions the Respondent simply could not meet the requirements of CS 8. This is the first basis for our conclusion that a breach has occurred. Whether the PartnersLife cover he recommended was suitable to the circumstances of Mr W had to be determined on the basis that a prior insurer had chosen to impose an exclusion, whatever Mr W might have asserted or wanted. In the

face of Mr W's assertions, contrary to the clear record of the Sovereign lumbar exclusion, further inquiry was required before the Respondent could possibly have been able to conclude that the PartnersLife product for which an application was about to be made was suitable to Mr W. Suitability in this context does not mean the best outcome assessed according to the subjective wishes of the client. It means the best outcome taking account of the full circumstances of the client, determined after reasonable inquiry. The Respondent allowed himself to be suborned by Mr W's strong assertions when he should have tested the matter further or taken alternative steps to which we now refer.

34. The second ground for our finding a breach in relation Mr W is based on specific commentary to CS 8. The stance taken by Mr W was tantamount to him refusing to provide information necessary to ensure suitability of the PartnersLife cover. When this was raised at hearing by the Committee the Respondent said he did not consider that Mr W had refused information; he had been fulsome with it, but in the sense of insisting that he had no injury. It is noteworthy that the language used in the commentary is not limited to the situation where a client refuses to supply information *to the AFA*. It simply refers to a refusal to supply information required under the CS. That in turn refers to information necessary to ensure the suitability of the service, which in our view extends to information required to ensure that the service is delivered in a form that takes due regard of all the client's circumstances, including risk profile as relevant to a potential insurer. In this case information about the Sovereign lumbar exclusion should have been provided to PartnersLife *by Mr W.* When he refused to allow his application to proceed on that basis, the requirements of paragraph (a) in the commentary to CS 8 kicked in and should have been followed by the Respondent. Specifically, at that point the Respondent should have taken reasonable steps to ensure that Mr W was made aware that the Respondent's service was now limited and to specify that the limitation was because of his insistence that the Sovereign lumbar exclusion not be disclosed.

35. It is not clear that this was done. Because the paper file for Mr W was destroyed, there is no documentary evidence of the way the Respondent recorded his position or reacted to Mr W's insistence. The Respondent suggested he may have referred to this in his standard Adviser and Customer Acknowledgement, but the language and structure of that document are inapt to convey the limitation and specificity we consider the commentary to CS 8 contemplates. Although the Respondent said that he had seldom experienced the type of refusal he encountered with Mr W, he has changed his practice since the 2016 version of the Code was issued to be more detailed in exchanges with clients over the issue of medical disclosure. We have concluded that at the time in question the Respondent probably did not take steps as contemplated by paragraph (a) of the commentary to CS 8. Our conclusion is reinforced by the Respondent's misapprehension that he could simply rely on what Mr W said and the position he took at hearing that Mr W had not refused to provide information so as to trigger the terms of paragraph (a).

36. For both the reasons referred to, we have concluded that **a breach of CS 8 in relation to Mr W has been made out.**

37. Notwithstanding that conclusion we make the following observations about the Respondent's dealings with Mr W. It is clear that the attitude and approach of Mr W placed the Respondent in a difficult position. He went as far as saying that he now thinks he was being misled by Mr W and our conclusions support that. Electing to proceed without disclosing the existence of the Sovereign lumbar exclusion lies at the heart of our adverse finding. Yet it is plain that non-disclosure of that exclusion was not, and could not have been, enough by itself to void Mr W's PartnersLife cover. That cover was lost because of the extensive non-disclosure by Mr W of his long medical history, a history which he withheld from the Respondent until well after the application in question.

38. We note this because an element of the Complainant's case suggested that, as a result of his having breached CS 8, the Respondent has left Mr W without cover. We conclude that this unfairly represents the position. Whatever the Respondent omitted to do, he has not caused Mr W's predicament. Mr W is the author of his own insurance misfortune. What can be said fairly is that, if the Respondent had taken a tougher line with his client, as we hold the Code required of him, fuller disclosure might have been made sooner and the risk of cover being declined might have been reduced.

C. DISPOSITION

39. Because breaches of CS 8 have been upheld, the Committee is required to move to the dispositive phase of its proceedings. Under Rule 28 of the Committee's Procedure Rules, it notifies the Respondent that, for the reasons set out in this decision, the Committee may take any of the actions specified in sections 101(3) and 101(5) of the FAA. The parties are requested to make submissions to the Committee on what, if any, action it should take and to advise whether that party wishes to be heard on its submissions or to call evidence in relation to its submissions. The Committee already has the Complainant's submissions on disposition and the Respondent's submissions should be filed within 15 working days of the date of this decision (on or before **Tuesday 23 April 2019**).

40. The interim order preventing publication of the name or identifying details of the Respondent is to continue until final disposition of the case and the question of permanent non-publication should be addressed by the parties in their submissions on disposition.

Geoffrey Clews
For the Financial Advisers Disciplinary Committee