



Fraud Investigation

A practical guide to the key issues and current law

Autumn 2009


Crawford[®]

Kennedys

Legal advice in black and white

OVERVIEW

In 2003, we published the first edition of *Fraud Investigation – A claims handler's guide*.

The decision to create the fraud guide stemmed from the need to have one simple reference source on fraud investigation for claims handlers. The document was intended to provide an overview of the key issues in relation to fraud investigation, including a history of insurance fraud and the current state of play.

From the many insurance industry acknowledgments received, there is no doubt that claims handlers have found the fraud guide to be an extremely useful reference point. It is partly with this in mind that we have produced this third edition. Another key driver for producing this latest edition has, of course, been the current global recession, which has coincided with a large increase in fraudulent insurance claims. In July 2009, the Association of British Insurers said, for example, that the value of fraudulent claims had risen 30% from 2007-2008. In difficult times, human behaviour patterns change; people who would normally behave honestly may consider instigating an insurance claim as a way of resolving their financial problems. Sadly, desperate people do desperate things. In light of these unprecedented economic circumstances, we felt it was appropriate to produce a new version of the guide to assist insurers combat financial crime, whilst always treating their genuine customer with fairness and integrity.

Fraud Investigation – A claims handler's guide, Autumn 2009 incorporates changes in both legislation and case law, as well as additional comment and observation since the production of the original guide in 2003.

Fraud has been a problem for the insurance market from its early days. Since that time, the insurance market has changed considerably. There is an ever-increasing requirement to provide excellent customer service, manage total claims costs, reduce the lifecycle of claims and meet claimants' legitimate expectations. Within the insurance market, insurers have to respond quickly and fairly to policyholders and claimants, which is only right. However, it is also imperative that claims are validated properly to ensure that the premium pool, which is funded by all policyholders, is not depleted by the fraudulent activities of the (ever increasing) few.

Throughout the guide, we take a look in more detail at what constitutes fraud but it is fair to say that *the most common type of fraud in all classes of genuine insurance business is the inflation of otherwise genuine claims*. Trying to understand what is fraud in this area was another driver for publishing such a guide.

This review is about information gathering and the inevitable background of relevant case law. We consider the who, what, why, when and how of investigation and link this to marshalling an enquiry with an outcome in mind.

Fraud investigation, as much as any claims activity, is about the tactics and looking for the 'pressure points' in the story that is being relayed. These pressure points are the areas of vulnerability that must be probed by the investigator if the allegation of fraud is to be sustained. These areas can see several different lines of enquiry being reviewed, for example, quantum, the circumstances, the policy declaration and warranties. As a general rule, seeking to defeat a fraudulent claim by the use of warranties is a path that can be fraught with difficulties and needs careful planning and execution.

Speaking back in the early 1980s, the President of the Chartered Institute of Loss Adjusters (CILA) was asked at a conference what was the difference between a claim for negotiation and a fraudulent claim.

He provided this view: *"A claim that was two times overstated was probably a claim for negotiation. A claim that was 10 times overstated was probably bogus and fraudulent."*

When asked about a claim that was five-fold overstated, his response suggested that it was down to the skill of the claims handler. The point he made was a simple one. The case law that was current at the time, which was founded in the case of *Lek v Mathews* [1927], was that exaggeration was fraud unless it was so insubstantial as to be *de minimis*. What he highlighted was that fraud comes at us in many shapes and sizes.

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On the other side of the Atlantic, Jim Crawford (founder of Crawford & Company in 1941) put the role of the claims handler simply:

“Meritorious claims should be paid promptly and pleasantly. Fraudulent, exaggerated or un-meritorious claims should be resisted vigorously.”

To deal properly with fraudulent claims requires evidence and hard facts. This guide looks at the framework against which these should be obtained and how un-meritorious claims can and should be resisted.

ABOUT THE AUTHORS

CRAWFORD & COMPANY

Based in Atlanta, Georgia, Crawford & Company (www.crawfordandcompany.com) is the world’s largest independent provider of claims management solutions to the risk management and insurance industry as well as self-insured entities, with a global network of more than 700 locations in 63 countries. The Crawford System of Claims SolutionsSM offers comprehensive, integrated claims services, business process outsourcing and consulting services for major product lines including property and casualty claims management, workers’ compensation claims and medical management, and legal settlement administration. The company’s shares are traded on the NYSE under the symbols CRDA and CRDB.

Bobby Gracey is Vice President of Global Counter Fraud Solutions at Crawford & Company. Bobby joined Crawford & Company in 2003 and, in collaboration with Robin Wintrip, was responsible for the design, implementation and operational management of their Counter Fraud Solutions (CFS) service in the UK. Following its successful UK launch, Bobby was tasked with replicating the CFS model across Europe, the Middle East and Africa in 2006 and later promoted to Vice President, with responsibility for global strategy and thought leadership in the fraud arena.

Since joining Crawford & Company, Bobby has taken the global debate on claims fraud to all six continents of the world and visited 16 countries to raise industry awareness. His passion for the subject stems from a belief that *“where there are volume claims, there is also volume fraud”*. He also fully understands the commercial impact that claims fraud costs can have on the profitability of an organisation.

Bobby is a well-known figure in the insurance fraud market and a regular contributor to trade publications. He has recently been involved in various projects assisting insurers develop best practice and implementing global fraud strategies aligned to robust operational responses.

The original version of the fraud guide was short-listed for the ‘Innovative Marketing Campaign of the Year’ at the Institute of Financial Services’ Financial Innovations Awards in 2004 and the guide also played a significant part in Crawford & Company’s Counter Fraud Solutions services being short-listed for nomination for ‘Loss Adjuster of the Year’ at the British Insurance Awards in 2004.

Crawford’s Counter Fraud Solution service continues to deliver substantial financial savings for the UK insurance industry, with further development and market-leading innovation to follow.

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A Claims Handler's Guide

KENNEDYS

Kennedys (www.kennedys-law.com) is a top 50 law firm in the UK, with eight offices nationally and six overseas offices. As a specialist insurance practice, Kennedys has always specialised in combating fraudulent claims on behalf of insurers. Our fraud expertise is focused on the following areas: banking, commercial, employers'/public liability, factoring, household, life and health, mortgage, motor claims, property and travel claims.

Our expertise has been enhanced in the last 12 months by the Davies Lavery merger and, more recently, with the arrival of several partners from the insurance teams at Dewey LeBoeuf, DLA Piper, Hextalls and Mayer Brown. Consequently, we now have over 30 partners with specialist fraud experience on behalf of insurers. Given the importance of suspected fraudulent claims to our clients, control of all suspected fraudulent claims is maintained by partners, with tasks being delegated to assistants as appropriate.

Kennedys advise and act for insurers on all aspects of suspected fraudulent claims, including:

- Adequacy of evidence obtained and further lines of enquiry
- Protection of enquiries by legal privilege
- Application of policy conditions
- Additional grounds for repudiation, including policy avoidance for pre-inception non-disclosure/misrepresentation
- Drafting letters of repudiation
- Conducting formal policyholder interviews
- Interests of innocent co-insureds and joint insureds
- Strategy and tactics
- Liaison with police regarding criminal investigation and prosecution
- Conduct of litigation against fraudulent claimants
- Recovery of payments made to fraudulent claimants, including tracing and obtaining freezing orders
- Preparation of cases for Financial Ombudsman Service review

Both Kennedys and Crawford & Company are members of the Insurance Fraud Investigators Group (IFIG). Kennedys is also a corporate member of the Fraud Advisory Panel (FAP).

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INTRODUCTION

It is always important to remember the simple fact that fraud occurs whenever a suitable opportunity presents itself. Sadly, the current economic situation is a perfect breeding ground. Crawford's own data indicates that the incidence of insurance fraud has risen dramatically over the past year. For example, property personal lines fraud cases have increased by 21% in certain sectors, with a 15% increase in commercial fraud from 2007 to 2008.

Since the first publication of *Fraud Investigation – A claims handler's guide* there has been many new industry initiatives. For example, the launch in 2006 of the Insurance Fraud Bureau – a not for profit organisation funded by the insurance industry, specifically focused on detecting and preventing organised and cross-industry insurance fraud. It has been a great success as an operational response to fraud and is becoming ever more sophisticated. Their cross-industry data sharing especially has set an important precedent in the motor area.

As fraud management solutions have evolved over the past few years, we are very much of the view that to successfully combat fraud a business must adopt a top down strategy in terms of understanding what risk actually means to their business. This process involves appropriate measurement of all claims handling staff and then the careful selection of eligible high risk claims.

Once identified, eligible high risk claims should be placed in a segregated claims handling environment where they can be better validated without the general pressures of process driven volume claims handling.

Indeed, within the industry there is now real focus on managing and containing fraud risks and the issue could best be described as being 'business imperative' given the direct correlation between managing claims cost and thus ensuring the fraudulent activities of the minority are not paid for by the majority of genuine policyholders. This ethos is further influenced by the fact that reducing financial crime, including fraud, is now one of the Financial Services Authority's four statutory objectives.

Given that fraud is such a dynamic subject, risk can be determined in many ways. Historically, we may have attempted to identify fraud using milestones such as recently incepted policy, adverse claims history, location of loss, occupation etc. Whilst these markers are very much relevant we should also not disregard the behavioural traits, which could be resistance to process, uncooperative manner, detailed understanding of complaints procedure. Recent surveys also suggest that the opportunist fraudster is more likely to be of white collar background and reasonably well educated which is perhaps not where the industry was previously looking.

Most businesses now have a mix of static 'fraud indicators or red flags' on all claims files supported by data mining technology of both internal and external data sources. Staff training is also provided to assist claims handlers with their interpretation of the risk exposure whilst arming them with an escalation process into a dedicated counter-fraud department. We are also seeing a greater use of field investigation and cognitive interviewing.

Whilst these tools are effective it is important to learn from the experience of managing risk so that fraud indicators/red flags are regularly updated to reflect recent trends and patterns displayed by the fraudster.

Without this regular evaluation of what fraud risk looks like to each and every business, the opportunity to commit fraud will be even greater than it already is. In other words, the industry should never rest on the subject of fraud, as from past experience the fraudster certainly does not!

If a business adopts a strategy involving regular review of fraud indicators/red flags, this will then enable it to legitimately move from being in the world of 'fraud detection' to a more sophisticated world of 'fraud prevention'.

In addition to understanding the importance of identifying fraud indicators, the industry is now learning more about the behavioural characteristics displayed by a fraudster. As a result many successful conversation management tools, such as voice stress analysis and cognitive interviewing have been established to enable fraud risks to be reviewed within a customer focused environment.

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We are regularly asked, “When does fraud occur in a claim?”

Historically, the industry has built tools around notification of loss which are certainly of advantage, and provides front line resistance; however, our experience would suggest that the actual answer is *fraud can occur at any time*. Another analogy would be to conclude that fraud will occur when opportunity prevails. An example of this could be when an insured has suffered a genuine incident and, due to poor claims handling, realises that it would be easy to overstate the claim value. The appointment of inappropriately trained and measured staff, particularly in the supply chain, can present the opportunistic fraudster with the greatest chance to succeed. This is often the case when there are many claims handlers involved in claims processing. Alternatively, we could be dealing with a policyholder who is intimating a claim in respect of a deliberate fire so the exposure to fraud is evident from the notification of the loss. This is perhaps better described in the following equation:

$$\text{Incidence of fraud} = \frac{\text{the inclination} + \text{the opportunity}}{\text{the resistance}}$$

“It is effective resistance which successfully manages fraud, whilst maintaining high levels of customer service.”

In addition to the various fraud products and solutions which now exist, the industry is also better regulated today in terms of fraud management due to the influences of the Financial Services Authority (FSA) and the creation of industry bodies such as the Insurance Fraud Investigators Group (IFIG), the Insurance Fraud Bureau (IFB) and special interests groups at the Chartered Institute of Loss Adjustors (CILA), the Association of British Insurers (ABI) and the Chartered Insurance Institute’s Faculty of Claims.

Given the influence the FSA has had on all businesses, we consider that, following the regulation of general insurance on 14 January 2005, there has been an increasing awareness by all that the FSA means business and of course it is in the interests of the insurers and their policyholders to take fraud seriously.

The FSA handbook SYSC 3.2.6R requires firms to *“take reasonable care to establish and maintain effective systems and controls ... for countering the risk that the firm might be used to further financial crime”*. The FSA are seeing good high-level sponsorship of fraud management at executive level, in response to what is perceived as a growing problem.

Fraud is more than just a financial crime issue; it is a reputational one for individual firms and industry as a whole. The FSA’s review indicated that senior management of many large firms recognise fraud is presenting a growing challenge and reputational risk to their business. This is attributable to various factors, including mounting fraud losses in some product areas, greater competitive pressures to drive costs down, increased regulatory attention on fraud issues and of course the recent global recession. Consequently, fraud is now being considered at a strategic level.

As financial services’ operating profit margins continue to reduce, the costs of fraud have become more apparent to senior management and reductions in these fraud costs have a more material effect on firms’ bottom lines. The extensive and growing publicity given to fraud in the media and concerns about the extent of fraud within the UK in general also mean that senior management are more focused on fraud issues than in the past. The Association of British Insurers, for example, calculates that the annual cost of insurance fraud is approximately £1.6 billion which represents £40-50 in every premium. However, wider commercial concerns and cost/benefit issues continue to make raising fraud issues an uphill task, especially in a climate where some insurers may be tempted to cut costs by reducing their investment in fraud management capabilities and the analytical tools used for fraud metrics. That said, it is agreed by all that it is no longer acceptable to pass on the cost of fraud claims to the consumer, and by implementing effective counter-fraud solutions, this will have a significant impact upon improving bottom line profitability.

Many have taken steps to improve their fraud management capabilities. At some firms, mounting fraud losses have driven a more urgent and fundamental reorganisation of fraud management, whereas at others these developments have been more

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evolutionary. Where volumes of detected frauds are low, but nonetheless could have a very significant impact on the firm, there is a risk that senior management could 'take their eye off the ball'.

There is an increasing recognition that detailed fraud data and analysis is critical. But firms that under-invest in anti-fraud systems, controls and processes suffer relatively high levels of fraud losses.

As previously mentioned, reducing financial crime is one of the FSA's statutory objectives. They expect firms to take reasonable care to establish and maintain effective systems and controls to counter the risk that a firm might be used to further financial crime. Some firms still do not have a counter-fraud strategy; some consider themselves immune to fraud. This is either because of their client base or because they cannot even contemplate that any of their employees are involved in fraud.

Most of those firms undertaking anti-fraud activity have seen an increase in the amount of fraud detected, especially at present, and a large number share data with other insurers in the market. Firms are improving their data mining abilities by sharing information and are using cognitive interviewing techniques when dealing with customers.

For claims units, good practice would be to maintain segregation of duties so that claims handlers are not able to register, handle and authorise payment for the same claim. Where this is not possible due to the size of the firm, we would expect a firm's internal audit function to be sufficiently robust to be able to check systems and controls with a view to preventing fraud.

The influence of the FSA continues to ensure that the industry maintains its focus as failure to protect the genuine customer could lead to large financial fines.

It is increasingly recognised that the embedding of anti-fraud measures is vital to ensure that a proper assessment of fraud issues is carried out at all stages of the process. Effective training plays an important role. Indeed staff education programmes are vital and need to be effective. This is supplemented by a rising tendency to create and expand anti-fraud teams to support the general business and to carry out the more specialist investigation work necessary to track and eradicate fraud. Insurers also need to review how they measure staff and ask themselves the question: are fraud metrics a key competence of the business. In other words, it is just as important to identify claims fraud as it is to provide an excellent journey for the genuine customer.

The maintenance of high quality fraud data is essential to assist the management of firms' fight against fraud. Sharing of information with others in the sector, like the Insurance Fraud Bureau does, aids an assessment of the effectiveness of anti-fraud measures adopted. There are encouraging signs of increased industry co-operation and strong support within firms for this. Nevertheless, more needs to be done in this area – not only to share raw data but also to exchange information on the perpetrators of fraud. The increasing range of ways in which fraud can be recognised in turn improves a firm's risk management.

System and controls should be thoroughly reviewed and can lead to material benefits. The alternative is that firms will be a soft target for fraud they almost certainly aren't aware of.

Internal fraud is also under the spotlight with increasing focus being given to recruitment techniques to ensure that adequate checks are made before candidates are employed. Firms should also be aware of the risks for existing staff who may behave fraudulently including by inducement or under duress. This can be supplemented by professional 'whistle blowing' procedures where ethical standards are breached.

We should also consider that, as fraudsters find ever more ingenious and sophisticated methods to operate, the levels of resource available need to keep up with, and preferably stay ahead of, the threat.

For the industry at large, the words and work of the FSA, CILA Anti Fraud Group, IFB, IFIG and ABI should be very much welcomed, as they have provided us with comfort that all efforts to design and operationally implement counter-fraud solutions was very much the right thing to do. Going forward, we should now be concentrating our efforts on how we can evolve the industry from

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one which currently detects fraud, to one which can now prevent fraud at policy inception, by better understanding what 'risk' could look like.

Turning to the physical claims handling of high risk/fraud claims it is worth bearing in mind the following key ideas:

Most insurance fraud cases will not be pleaded in a criminal court but in a civil court. The majority of our experiences of civil courts as claims handlers lead us to the conclusion that evidence must be provided to tilt the scales in our favour on the basis of a balance of probabilities.

This is still the case where fraud is alleged but the courts have consistently made clear that the balance of probabilities will see the burden of proof shift, such that those making the allegation of fraud must present a case and evidence to support it to a standard commensurate with the seriousness of the allegation.

Finally, in relation to your business committing to the development of its fraud strategy, please remember the importance of planning. Also, know your customers and understand where your leakage exists and commit budgets for the appointment of special counter-fraud resources. This approach will not only be to the benefit of your genuine customers but also to the bottom-line of the businesses profit and loss accounts.

WHAT IS FRAUD?

Fraud, as we have commented, can come in many shapes and sizes and whilst a fuller definition will be considered in reviewing legal definitions it is fair to say that fraud is usefully described as:

"Theft by deception – the dishonest obtaining of property by deception."

The case of *Konstantinos Agapitos v Agnew* (2002) is considered in more detail when we review the legal background to fraudulent claims. However, for the claims handler an interesting contrast emerges from that decision. This is the contrast between a fraudulent claim and the use of fraudulent devices to pursue a claim. One of the key statements can be considered thus:

"A fraudulent claim exists when the insured makes a claim, knowing that he has suffered no loss, or only a lesser loss than that which he claims (or is reckless as to whether this is the case). A fraudulent device is used if the insured believes he has suffered the loss claimed but seeks to improve or embellish the facts surrounding the claim, by some 'lie'."

What does this mean for the claims handler?

Perhaps, most clearly, it is that in gathering evidence the handler must be aware all the while that they will need to understand the type of fraud with which they are dealing. The impact of whether a claim is fraudulent or whether a fraudulent device has been used is one for the lawyers to resolve with the claims handler. In gathering evidence an open mind must be kept throughout.

If we accept that fraud can appear in many different shapes and guises what might these be? Examples of insurance fraud can include:

- The loss that did not happen – most common in the travel business.
- The contrived loss – particularly injury claims.
- The deliberate loss – commonly seen as arson but other methods exist.
- Genuine loss but overstated – probably the most common across all claims books.
- Genuine loss excluded but made to fit the policy – often seen in personal lines where security requirements exist.
- A loss where the goods claimed for were not owned by the insured.

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It is possible to think of examples of each of these and it is surely the case that other types of insurance fraud exist. Whatever type that is facing the claims handler, facts and evidence must be gathered and pleaded. Of these examples given above perhaps the last can be explained by one of the most interesting examples of an organised fraud.

Example of an organised fraud

One of the most notorious organised frauds in the industry in the past five years has been the alarming increase in staged motor accidents which was one of the main considerations behind the creation of the IFB and a cross-industry collaborative approach.

Some examples include:

From their vehicle, fraudsters will typically select a fairly new vehicle with one or two people or maybe a family inside. They will then deliberately collide with it, either by side-swiping it or by braking hard in front of the vehicle, and then they will claim against the insurance policy for whiplash or other injuries.

The IFB's Chairman, John Beadle, recently commented in a BBC interview:

"Staged accidents are extremely dangerous and cost honest drivers millions of pounds each year but they also put innocent motorists in danger."

Typical examples of insurance fraud

One recent case, for example, involved the loss of a high value wrist watch, for which a two year waiting list is widely acknowledged by jewellers and the manufacturers. However, examination of bracelet links revealed that the watch was in fact a high quality replica which the policyholder had shown to friends and had been photographed wearing. Without the necessary documentation, the claim proved problematic for them to validate. Following the discovery that a replica watch was being passed off as genuine, in order that the policyholder would benefit by some £10,000, further background enquiries indicated undisclosed convictions on the part of the policyholder. The insurers of course repudiated this claim and cancelled the policy.

In another instance allegedly high value Persian silk rugs suffered extensive water damage following a supposed flooding incident. Yet, upon examination, it transpired they were actually cheap Indian copies purchased at a well-known discount furniture chain. Again a lack of suitable pre-loss valuations to evidence these values or sight of the original dealer's receipts proved a stumbling block for the would-be fraudster.

Fraud – more definitions

The question of fraud is addressed in the claims conditions of the Association of British Insurers (ABI) standard fire policy in the following terms:

"Fraud – If the claim is fraudulent in any respect or if fraudulent means are used by the insured or anyone acting on his behalf to obtain any benefit under this policy or if any damage is caused by the wilful act or with the connivance of the insured all benefit under this policy shall be forfeited."

A typical domestic policy wording is:

"Fraudulent claims – If you, or anyone acting on your behalf, make a claim knowing it to be false or fraudulent in amount or any other respect, this insurance shall be invalid and the claim should be forfeited."

The impact of both clauses is that if fraud is detected the whole benefit of the policy is lost. The policy can be voided but there is still the question of how this happened. However, we need briefly to consider the position of the courts.

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Later in this guide a more detailed review of the case law will be undertaken. We have already reviewed various types of fraud that might exist and it is fair to say that exaggeration of claims is deemed to be the most consistent type of fraud across all general insurance books. The issue is that the courts, as suggested earlier, can allow 'a bargaining position' in a claim to be established. The question is the extent of this bargaining position.

The very fact that the policyholder made a doubtful or even exaggerated claim does not always readily lead to an inference of fraud.

The courts have on occasions suggested that in cases where nothing is misrepresented or concealed the loss adjuster is in as good a position to form a view of the validity or the value of the claim as the policyholder. It is often suggested that in putting forward a claim the policyholder may be merely putting forward a starting figure for negotiation.

The courts have accepted that if they considered a sample of insurance claims on household contents they would doubt that they would find many which stated the loss with absolute truth. The courts' view is that where the falsity that is stated is readily apparent there will be no false representation. This takes us to the issue of gross exaggeration that was highlighted within the introduction.

The courts again have taken the view that people often put forward a claim that is more than they believe they will recover because they expect to engage in some form of negotiation. It seems proper that if the claimant knows that the sum being tabled is in excess of the value of the property damage then that should be fraud. However, things have not always been as simple and these aspects are considered in more detail later when we review the legal background to exaggerated claims.

A final consideration in the question "what is fraud?" is the position of a barrister who is asked to plead fraud on the part of insurers.

The Bar Council Code of Conduct Part VII s.704 states that:

*"A barrister ... must not draft any statement of case, witness statement, affidavit, notice of appeal or other document containing ...
... (c) any allegation of fraud unless he has clear instructions to make such allegations and has before him reasonably credible material which as it stands establishes a prima facie case of fraud;"*

Under s.708 it is also expanded to state that a barrister, *"... when conducting proceedings in court ... must not suggest that a victim, witness or other person is guilty of crime, fraud or misconduct or make any defamatory aspersion on the conduct of any other person or attribute to another person the crime or conduct of which his lay client is accused unless such allegations go to a matter in issue ... which is material to the lay client's case and appear to him to be supported by reasonable grounds."*

The question of what is "reasonably credible material" has been defined to mean evidence in a form that can be put before a court. This means witness statements which should be capable of being submitted to support the pleadings in court. This is a critical focus of attention for the claims handler.

It is possible for a barrister to consider pleading fraud if he is of the view that evidence will emerge during a trial which will allow a case of fraud to be pleaded. However, this is not an attractive route. Furthermore, if an allegation of fraud is not to be pursued and the allegation cannot be maintained, then it is vital that the other side in the litigation should be informed as soon as the allegation of fraud is to be dropped.

A barrister is bound by a code of conduct at the Bar of England and Wales to ensure that they have before them reasonably credible material establishing a *prima facie* case of fraud before pleading fraud.

It is not the role of the barrister to devise facts which will assist in advancing an insurer's case and it is essential that the barrister does not make any allegation of fraud without clear instructions to make such allegation. It is however legitimate for a barrister to

draft a pleading, affidavit or witness statement containing specific facts, matters or contentions included by the barrister subject to their lay client's confirmation as to their accuracy. The need for the claims handler to provide specific particulars to support an allegation of fraud will inevitably dominate their enquiry.

There has been debate as to whether the evidence that is provided needs to be in an admissible form and opinions have differed as to the role of the barrister here. It has been said that the material needs to be of such character as to lead responsible counsel to conclude that serious allegations could properly be based upon it and whilst there is an inevitable subjectivity about this it is clear that the preferred route is to obtain admissible material evidence. The case of *Medcalf v Weatherill and Another* [2002] has considered this aspect in some detail and perhaps one of the key comments that emerges is this, "where a person's reputation is at stake, the pleader should not 'trespass' ... a hair's breadth beyond what the facts as laid before him and duly vouched and tested, will justify".

Thus in answering the question, **what is fraud?**, it is clear that there is a strong evidential requirement which must be supported by hard facts. The nature of fraud is many and various and the claims handler must ensure that they gather facts with an open mind before concluding the nature of the fraud before them.

WHO COMMITS FRAUD?

Research in the UK over recent years has shown a variety of different attitudes emerging. It is fair to say that underlying these is the fact that policyholders view claims fraud as a victimless crime. There is also a belief that a significant percentage of fraud remains undetected due to ineffective boardroom priorities, budgetary support and operational staff process and measurements. Corruption indices also highlight different cultural and regional variations in relation to fraud.

It appears, however, to be an almost universal view that in any population:

- 10% of people are inherently honest
- 10% are inherently dishonest and
- the other 80% could go either way

Research by Datamonitor suggested that 50% of the people interviewed knew someone who had committed an insurance fraud. One in 10 people admitted that their last claim was fraudulent.

A major UK composite insurer carried out research which suggested that:

- 69% of people agreed that most people would make a dishonest claim if they could get away with it
- 88% of people agreed that inflated claims were dishonest
- 18% agreed that dishonest claims had little impact

Similar research in Australia found that about 94% of people in a survey agreed that lodging a fraudulent claim was dishonest but half would do nothing if they became aware that an insurance fraud had been committed. The research in Australia also suggested that 10% of claims were fraudulent.

The latest ABI research, published in July 2009, reinforced the Australian results which would suggest that claims fraud has a similar profile, in terms of frequency outside of the UK. The same research suggested that the cost of undetected fraud within the general insurance sector totalled £1.9 billion per year and that this cost added £44 to the average insurance policy purchased by consumers. It also indicated that 13% of general insurance claims, by volume, are fraudulent which represents 10% of the claims value.

At Crawford in 2008 we undertook our own research in the area of conversation management utilising SCORE (Scientific Customer Orientated Risk Evaluation) on claims under £1,500 in value that had previously been processed by supply chain

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companies on the Accidental Damage and All Risk perils. Prior to commencing the research, we established that no complaints had been intimated to the insurer. Pre-negotiated discounts were secured, however, no fraud claims had ever been detected by the suppliers. Our findings established:

- **51%** of claims (previously it had been 100%) were sent to supply chain companies for payment.
- Of the remaining **49%**, 27% of customers 'walked away', 13% were forwarded to field investigations for further attention and 9% were reduced in terms of quantum.
- Complaints rose from zero, but remained under 1%.
- A significant financial return was achieved whereby the insurer enjoyed incremental indemnity savings in excess of 58%.

What motivates people to commit fraud is never totally clear. It may be pressure, opportunity or a form of rationalisation. This could be described as need, greed and the desire to get value from insurance. There also appears to be some evidence that there can be peer pressure to make a fraudulent insurance claim, namely the pressure that this is an accepted norm.

The desire to get value from insurance is often described as 'the Christmas Club mentality': *"I have been paying my premium for the last 20 years and I have never made a claim so I deserve one now."*

Those who have studied fraud suggest that three principal types of fraudsters can be identified:

1. Opportunistic fraudsters:

These are perhaps most commonly seen in insurance claims. They are fraudsters who, as the name suggests, only perpetrate one fraud in one arena and that is in response to a particular set of circumstances arising. Examples include:

- The loss that did not happen – normally the most common
- Genuine loss but overstated
- Genuine loss excluded but adapted to fit the cover
- Loss where goods not owned by insured

2. Repeat fraudsters:

This might be someone who has had a particular claims experience in the past, for example, an inflated estimate paid without enquiry who decides they will try for a little bit more on a second occasion.

3. Organised fraudsters:

This would include the earlier example of valuation fraud and some of the personal injury rings, the members of which create and set up 'accidents' with a view to recovering personal injury damages.

Research around the world has tended to suggest that fraudsters are often driven by ego, they plan to 'beat the system'. An underlying reason for this is that fraudsters are not untypically well-educated and have a perception of intellectual superiority that allows them to believe they can 'play the game and win'. Other key drivers include:

- Need – lack of money, possibly the result of unemployment
- Greed – I would like more money or property to improve my lifestyle
- Desire to get value from insurance – recover money paid in premiums
- Peer pressure – the accepted norm – friends and colleagues are seen to have made successful fraudulent claims
- Credit crunch/periods of inflation
- It is perceived to be easy money!

Male graduates aged between 36 and 45 years have often been cited as the most common group from which fraudsters are drawn. This runs counter to many views that have pervaded the insurance industry over the years.¹

¹This is, however, consistent with the author's personal experience.

A Loss Adjuster's Perspective

In terms of insurance fraud it is probably true to say that the average offender could be from any cross section of the community and not always restricted by gender or economic group. The factors previously outlined suggest a particular propensity but no more than that. Criminal or repeat fraudsters will often commit insurance fraud along with other types of crime. Organised criminals will invest considerable time and effort to obtain funds by fraudulent means.

HOW CAN YOU IDENTIFY FRAUD?

The persistent theme of this guide is that to address fraud what is needed is evidence and hard facts. What tools could the claims handler use to identify fraud? These could include fraud indicators, databases, gut instinct, peripheral investigation, body language and behaviour.

All of these factors have a role in the equation of considering whether a case is fraudulent. Ultimately, however, it comes down to just one fact, is the case before the claims handler fraudulent or not? It is not enough to know about an individual's propensity towards fraud or the fact that they may have had previous fraudulent claims.

All of the tools that are used to risk factor potentially fraudulent cases cannot of themselves prove fraud in an individual matter. Risk factoring is, however, a very powerful tool for directing resource towards potentially fraudulent claims or those claims needing more detailed enquiry.

Gathering the evidence needs a strategy of enquiry and potentially a strategy of persuasion. The strategy of persuasion is about sending signals to a potential fraudster that they are unlikely to win on this occasion and that an exit route with some dignity retained might well prove the right course for them to take. Of course the exit route to withdraw a claim needs to be provided.

In terms of gathering evidence and probing of fraud, it all starts with the event whether that be fire, theft or other accident. The direct cause of the event and the consequent financial damage need to be carefully considered. It is probably true to say that in establishing a case for fraud three key factors should be demonstrated. These are:

- The method
- The means
- The motive

The investigator must show how the fraud was perpetrated, the way in which it was perpetrated and why the fraudster wished to do it. There is a demanding level of proof in a civil case of fraud as has already been set out.

Before considering how evidence is gathered, we can consider for a moment some of the tools that are available to assist in assessing fraud.

Tools for assessing fraud

Exchanges/databases

At underwriting levels there are underwriting exchanges and databases which allow potentially high risk policyholders to be filtered out. At this level, knowledge of the policyholder can be invaluable. A typical example is in travel cases where an insurer may well be aware that items claimed within a travel claim are inconsistent with anything that has ever been declared in the context of the household contents policy to the same insurer. Using fraud management databases either across the industry or across a company can enhance fraud detection processes and information gathering. Consolidation of data on fraudsters across the whole of the insurance industry is not an easy task and remains an attractive approach.

Anti-fraud campaigns need to underpin many industry initiatives. In September 2002 the ABI issued new guidelines aimed at helping reduce household fraud problems. These guidelines allow insurers to report claims where there is a suspicion of fraud to the police. Databases such as Hunter, which lists known and suspected fraudsters and Claims Underwriting and Exchange (CUE),

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which holds details of claims from member insurers for several years, allow multiple claims to be detected. The CUE model is in respect of Home, Motor & Personal Injury and it is hoped that a Travel database will be available for the industry in the near future. CUE Motor is also linked to IFB. Suspicious Hunter cases can be matched against The Credit Control Fraud Avoidance System (CIFAS) that lists fraudsters for all areas by name and address. Other approaches are to consider a claim against knowledge of the claimant's background. Profiling using marketing databases or similar provide some measure of an analysis as to a claimant's likely position and allows the claims handler to form a view as to what is realistic within a claim.

The dilemma that all of these databases pose is that databases of themselves do not provide evidence that will unequivocally prove a case in a court of law. Lie detectors have been likewise promoted as being a tool to address insurance fraud but similarly do not provide the level of evidence required. The other issue is the sizeable management of false positives.

All these tools do, however, provide a consistent methodology for claims handling and allow the claims handler to form a view as to which path a claim should be routed for optimal claims handling. The dilemma then is to ensure that the investigator retains an air of dispassionate review as they consider the claim itself and seek to gather evidence which will confirm the claim as one for payment or rejection.

Fraud indicators

The role of fraud indicators in all of this is a critical one and also one where again the investigator must be thoroughly aware that indicators provide no definitive proof that a fraud has been committed. Fraud indicators must be used with care. There may be very good explanations for any of the indicators that give cause for concern. It must not just be assumed that since a number of indicators are revealed by enquiries that there has been fraud. However, there is evidence that fraud indicators are particularly beneficial in allowing an insurer with a book of business to focus where their investigative costs are best spent.

Research in Canada has confirmed in the study of motor insurance frauds that certain indicators are strongly correlated with a higher probability of fraud in a file or particular case. The use of fraud indicators may make the difference between a file being investigated or a file being transmitted for investigation and increase the probability of success in investigation.

Perhaps one of the indicators that stands out most clearly as a pointer for fraud is that the policyholder or claimant is extraordinarily familiar with insurance and insurance repair jargon. This indicator was the trigger for an investigation some 15 years ago into a multiple insurance fraudster whose proposal forms showed no previous claims. His knowledge of insurance at interview was surprisingly deep for someone who had advised "no previous claims". There were one or two other indicators and, by a market circular, it became clear that this particular fraudster had a vast number of claims throughout the market. Each of these claims was resisted by collaborative work.

Another good example of fraud indicators can be found in travel claims. Some indicators and an associated case study are considered overleaf.

A typical set of fraud indicators for travel could be:

The claim	<ul style="list-style-type: none">• The value of the claim relative to the planned holiday – incomplete/inconsistent documentation – items stolen could not fit into the luggage described (this would also apply to spaces described).• Age/condition/quality of items stolen not consistent with the remaining items.• Receipts have no store logo on them.
The claimant	<ul style="list-style-type: none">• Reluctant to provide specific accident/theft details.• Over-pushy for a quick settlement – is willing to take a substantially reduced settlement.• Unusually knowledgeable about insurance.

As already described, the indicators are part of an objective review of a claim but of themselves do not reveal fraud.

A Loss Adjuster's Perspective

What might this mean in practice?

Fraud indicators are at the heart of every fraud investigation. For example, we can consider several claims triggered for investigation. Firstly, a claim of \$80,000 was not consistent with a backpacking holiday. The backpacking trip included the policyholder taking with them a laptop valued at \$8,000. The policy inception 10 days after departure and the claimant was unusually familiar with police and claims procedures.

The indicators led to the claimant being selected for personal interview. At the interview the claimant was not very knowledgeable about his alleged occupation and the claimant's alleged private address was not consistent with the electoral roll. There were inconsistencies in relation to how the laptop was acquired and unusual features in relation to receipts and valuations.

Efforts to trace the police station at which the theft was reported led to a dead end, in fact the police station could only be found in a leading soap opera. Other enquiries of the market showed that a claim of this type had been an annual event for the claimant as a fundraising exercise. It seemed that an original or genuine event gave the knowledge and lack of resistance to the first claim led to a desire on the part of the policyholder to pursue further claims. The fraudster moved from being an opportunistic one to a repeat fraudster.

A separate claim from another area involved a fire in a commercial warehouse. A significant claim was submitted by claim form. At the initial telephone notification of claim the extent of damage was not fully described. The size of the claim reported on the claim form returned to insurers three days later meant that an immediate site visit was arranged and the policyholder was interviewed. In the interview the circumstances were very poorly described and the claimant was very vague about the sequence of events that had led to the alleged arson attack on their premises.

More detailed work had shown that there were considerable difficulties in terms of the volume of goods destroyed relative to the storage area. The goods just could not fit in the warehouse, furthermore, the weight of debris recovered from the fire-ravaged warehouse was not consistent with the quantity of goods alleged to have been stored. The forensic report revealed further discrepancies in the story. Financial motives were discovered and various claims in different names were uncovered. The value of the claims was substantially overstated and fraud was pleaded on this basis, not causation. A prison sentence followed.

In both cases simple fraud indicators led to a specific on-site investigation and here probably lies the key to gathering evidence for fraud. Personal investigation or personal interview remains a fundamental of the investigator's tool kit. Investigation techniques continue to evolve and are considered below.

Personal interviews

Personal interviews can be greatly assisted by knowing that language skills are available when necessary and using the internet and data mining which allows wide search capabilities. Using the internet it is possible to check a claimant's story about a location that may not be known directly to the interviewer and provide essential visual clues. This allows an interviewer in some cases to be "live" with the claimant as they describe, for example, the shopping trip during which they lost valuable jewellery.

Before closing this section, a final word – whilst gut feeling is often described as playing a critical part in an investigation, it is not admissible as evidence. The tools that have been described above must all be referenced against a dispassionate review of the evidence that will emerge from interview and enquiry.

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GATHERING THE EVIDENCE

Whatever process is used to gather the evidence, it all starts with the initial telephone call advising a claim. This telephone call offers a unique opportunity to capture information before there has been a chance to rehearse the story. What is required is an approach that ensures that the incidence of fraud or the propensity for fraud is reduced at this time. There is a universal equation that the:

$$\text{incidence of fraud} = \frac{\text{the inclination} + \text{the opportunity}}{\text{the resistance}}$$

If we are gathering evidence, it is important that we revert to the critical technique of focusing on the individual matter before us and not the individual. It will be evidence in relation to the claim that will in most cases foil the fraudster. It is not the place of this guide to address in detail how forensic enquiries in relation to cause are carried out. However, accident investigation techniques which base themselves around 'root cause' analysis demand particular investigative techniques and skills. These techniques and skills, in particular the use of open interviewing techniques and listening techniques, are well suited to the investigator seeking evidence in other arenas.

In the following pages we will provide a review of interviewing techniques and perhaps the key message to take away is the who, what, why and when. Careful consideration of the timeline of any incident and of individual witness' stories is one of the most powerful tools in combating fraud.

Whatever process is used to consider fraud investigations, it has to be defensible. In looking specifically at the claim and the circumstances of an individual claim, the claims investigator will be able to defend their activities in a court of law by focusing on the key tests of method, means and motive. Evidence gathered in a consistent way allows a rigorous defence to be mounted in the event the approach is challenged.

In the process we must anticipate the following:

- **Fraudsters need to be expected to be asked questions**

They need to prepare their storyline. They develop their storyline and they rehearse and rehearse. What fraudsters often have trouble with is the details of a story. For example, they may well have rehearsed how a particular item was stolen but not thought about the colour of the item. Thus when challenging the fraudster, however well rehearsed their story is, if the fraudster can be taken away from the central story to other questions that are then challenged again and again, it is likely they will not remember what they have said.

Conversation management of this type is achieved by control, concern and credibility. This allows the policyholder to be managed with empathy and respect but allows 'meta messages' to be sent to the fraudster that makes clear that in the circumstances, resistance to what is being put forward will be made by the claims handling organisation. The structure to the process includes 'exit doors' for the claimant. Not all frauds can be definitively proven but the fraudster who understands that there will be further hurdles to be passed before a claim is paid may wish to withdraw while their dignity is still intact. Our personal research has shown that up to 35% of customers may take the dignified route if the conversation management process is followed.

The following is an example of a three phase view structured approach:

- **Phase 1** – review and timeline the claimant's story, use a risk factor chart and data mining. If the score is outside limits go to ...
- **Phase 2** – re-interview and re-examine evidence. Compare to phase 1 – does it make sense? If the answer is no, go to ...
- **Phase 3** – visit the claimant, review evidence, compare to phases 1 and 2.

A Loss Adjuster's Perspective

By using such an approach, evidence is gathered at all times in the claims handling process. A consistent risk factored approach arises and a defensible method is used.

- **Underpinning this process is an understanding of behavioural psychology**

A method, means and motive approach may also be described as property, indemnity and circumstance. By the use of applied psychology and behavioural assessment we can learn to probe areas of the evidence that it is apparent from various signposts such as physical signposts, body language and verbal disassociation give the fraudster discomfort and uncertainty.

We can go back to our earlier case study of the high value wristwatch claim and consider the separate issues highlighted below.

- **Property** – did the insured have good title to the alleged high value wristwatch?
- **Indemnity** – was the alleged high value wristwatch genuine?
- **Circumstance** – did the insured provide detailed information in relation to the circumstances of the loss?

In this particular case a fourth factor emerged which was the issue of *policy liability* following the identification of material non disclosure.

The signs that are recounted should not be taken as definitive evidence but rather can be used as indicators of where problems in a particular story might lie. They give a feel as to the vulnerable areas in what has been outlined and presented to the investigator and where more detailed probing might be useful.

This approach can be coupled as already commented with the use of meta messages from the investigator, such as the investigator providing clarity as to the next steps that would need to be gone through on the part of the policyholder to take the claim forward towards settlement. Clarity as to the point of evidence that needs to be probed further can provide similar benefits. A combination of meta messages and an understanding of physical signposts and other nervous signals allow the skilled investigator to hone their enquiry.

Examples of nervous signals and signposts include silence fillers, hesitant delivery, quickened pace, tone of voice and speech errors. Deception strategies and themes include one word answers, a reluctance to talk, unrealistic memory, unreasonable attitude and avoidance and association.

For the investigator, it is about listening to what is said or, in many cases, listening to what is not said.

Let's look at a few examples.

Use of broad language	Q: Did you secure your front door when leaving home? A: I always lock my door. This suggests the individual is not entirely comfortable answering this question directly.
Use of negative language	<i>"I have done nothing wrong", "I am not a criminal".</i> This tells us something and it is probably an answer to a question yet to be posed. However, the individual is not saying they are honest. We can look for the use of generalisation statements <i>"as a general rule ...", "in most cases ...", "I usually ..."</i> These phrases allow the fraudster to distance themselves from whatever it is that they are saying and they are not showing 100% commitment to what is about to be said.
Use of qualifying language	This works in a similar way by blaming poor memory for not telling you the complete truth. Examples of this can include <i>"to the best of my knowledge ...", "at this point in time ...", "as far as I can recall ..."</i> .

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Omission	This can be offered using phrases such as “ <i>I think ...</i> ”, or “ <i>I believe ...</i> ”.
To hide other circumstances	The fraudster might wish to unnecessarily bolster his language/statement with phrases such as “ <i>to be honest ...</i> ”, “ <i>to tell you the truth ...</i> ”, “ <i>I swear to God ...</i> ”. In these cases one shouldn't necessarily believe what the fraudster is about to say.
Edit information in and out	Phrases such as “ <i>later on ...</i> ”, “ <i>before I knew it ...</i> ”, “ <i>the next thing I remembered ...</i> ” show that something has been left out of the account or that this happened very quickly. Language may be further extended by considering the use of associative language. Here somebody might describe possession of their own in more generic terms. An example might be: “ <i>I left my Rolex by the swimming pool but when I returned I found the watch was gone.</i> ” In this case the interviewee seeks to distance himself in emotional terms from the loss of the watch.

Again, none of these behavioural triggers and indicators can be deemed to be definitive but they give an idea of questions to be posed. The behavioural indicators will lead to an overall risk assessment.

However, the interview process will allow specific evidence to be developed. Concise interviewing skills allow speedier risk evaluation and clearer information and planning. As the investigator talks to the claimant about their claim, they have understood what is said and the way it is said. We have now addressed the context in which it is said and therefore you are gathering evidence from the first contact using conversation management techniques possible for evidence to be gathered in a structured fashion which allows the investigator to focus on the key evidential points and seek to investigate and challenge these.

Behind these processes it is fair to say there exists a simple truth. It is this:

Genuine customers have no difficulty disclosing detail about something which has really happened ... the fraudster really struggles!

WHAT TO DO WITH THE EVIDENCE

Before moving on to a more detailed examination of the legal issues a number of points merit comment.

Fraud case studies inevitably have been described in this guide and in each instance, these have turned on a progressive and structured gathering of evidence. Several reported legal cases have made clear the need for those investigating to be transparent about the nature of their enquiries.

Matalan Discount Club v Tokenspire Properties [2001]

In the reported case involving potential breaches of warranty, *Matalan Discount Club v Tokenspire Properties*, the loss adjuster interviewed employees of one of the involved parties seeking information as to what would be evidence of a breach of warranty. The employees gave evidence which was explicit. The backdrop to the matter was that as the loss adjuster was taking these statements, solicitors had been instructed and the whole issue of policy cover was under consideration. The adjuster interviewing employees did not warn cover was in question and the statements gave weight to matters which would have a significant bearing on policy cover. The policyholder had not been advised that this was the case and certainly the Judge expressed considerable disquiet about the manner in which the information was obtained.

Commercial Union v Baghbadrani [2000]

This case revealed similar concerns that solicitors were guiding loss adjusters in the content of their correspondence to the policyholder before revealing their appointment. Whilst the case for fraud was sustained, there were some question marks raised as to the approach that had been adopted. The need to keep an open and impartial mind is an obvious conclusion – stick to the facts.

Elsewhere evidential issues in a fraud case will often lead to the issue of a letter of repudiation on the grounds of non-disclosure or warranty issue. For the adjuster it is clear that specialist advice on this point is essential.

In closing, this section reference is made to the following case:

Grave v GA Bonus [2002]

In this case the trial Judge was faced with allegations of fraud made by insurers who were considering the complicity of the policyholder in the commission of an arson. The court found in favour of insurers as they were able to show that other possible causes of the fire were capable of being discounted and that arson was the most probable cause of the loss. A direct motive was demonstrated. To recap, the policy provided cover in respect of damage resulting from fire including arson provided the arson occurred without the authorisation or connivance of the claimant.

The conclusion of a joint report prepared by fire experts was that there was only one seat of fire and that the fire was probably caused by some human agency, but it was impossible to state how it had started.

The principal issues were really as follows:

1. Was the fire started deliberately?
2. If so, was it started by or on behalf of the Defendants?

The issue at trial was whether the Defendants satisfied the standard of proof that was required in the case and whether the Defendants had eliminated all other possible causes so that the only realistic explanation was that of arson or whatever defence was relied upon.

It was clear in giving the judgment that the burden of proof rested with insurers and that a high burden remained. A combination of evidence was provided including critical financial evidence and this was deemed persuasive. There was significant physical evidence and whilst attempts had been made by the policyholder to simulate a point of entry to give a false impression that a burglary had been committed, this simulated point of entry in itself meant that there was no other credible explanation other than a simulated break-in was connected with the fire. All the evidence was deemed by the Court of Appeal to point towards the insured as opposed to a third party being responsible for starting the fire. The conclusions were that the fire was started deliberately and that acts were carried out to suggest that the fire had been started by a third party. The issue in relation to cause turned entirely upon evidential points and was supported by financial examination.

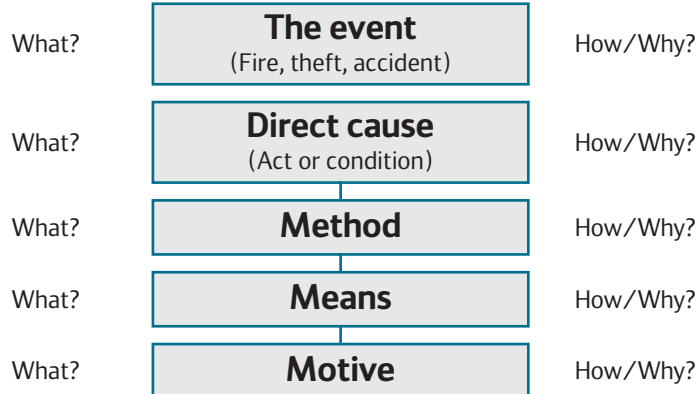
This case from an investigator's perspective clearly shows the critical importance of placing evidence before the courts that is persuasive and which allows the insurer, when pleading fraud, to discharge the burden of proof that is upon them.

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A SUMMARY

To summarise this overview of investigation the graphic below most aptly sums up what we have reviewed.

Gathering the evidence probing fraud



To close we would quote another leading CILA council member:

“A lot of time and effort can be wasted chasing shadows.”

In this section of our guide we have not sought to consider the application of the use of policy warranties towards defeating fraud claims. We have sought to consider the use of evidence and the gathering of evidence. We now turn to consider some of the key legal issues.

Fraud Investigation

A Lawyer's Perspective

INTRODUCTION

Following the publication of the second edition of *Fraud Investigation – A claims handler's guide* in the summer of 2006, the Fraud Act 2006 finally came into force on 15 January 2007 and an email update was sent at that time to all those who received the summer 2006 edition. However, it would be an understatement to say that had been the only major development in the law and practice relating to fraud investigation since then. Indeed, it is probably fair to say this period has seen an unprecedented level of Government intervention, and it is far from over. Accordingly, and bearing in mind the economic downturn we are currently experiencing and the likely impact of this on levels of fraud, it seems timely to provide an updated edition of the guide.

The Fraud Review

As part of a manifesto pledge, the Government has for some years now been pursuing a co-ordinated approach to tackling fraud. So, back in October 2005, whilst the Fraud Bill was still being reviewed by Parliament, the Attorney General and Chief Secretary commissioned the Fraud Review. It was asked to recommend ways of reducing fraud and the harm it does the economy and society – looking at the totality of the problem, rather than just specific aspects. For this reason, it was fêted as “...*the first comprehensive and holistic review of fraud and anti fraud efforts in England and Wales.*”² It was asked to consider three questions:

1. What is the scale of the problem?
2. What is the appropriate role of Government in dealing with fraud?
3. How could resources be spent to maximise value for money across the system?

The Fraud Review Final Report, which was published on 27 July 2006, could not answer the first question, so its first recommendation was that fraud should be measured on a consistent basis across the economy. As for (2), it stated that Government has two key roles:

1. To protect public money from fraudsters.
2. To protect consumers and businesses against fraud, meaning it should use the mechanisms of the State, such as law enforcement, regulation and criminal justice to prevent, detect, investigate and punish fraud.

Its second key recommendation was that the Government should establish a National Fraud Strategic Authority (NFSA) to devise a national strategy for dealing with fraud and ensure it was implemented. This authority should be manned by a multi-disciplinary team of experts from the public and private sectors and should also house a unit established to measure the scale of fraud. The partnership between the public and private sectors was regarded as critical, not least because much of the effort then devoted to countering fraud, especially fraud investigations, rested in the private sector. The NFSA was also tasked with putting together a working group of organisations to mount a public awareness campaign about fraud prevention, and disseminating examples of best practice.

The Fraud Review also proposed the establishment of a National Fraud Reporting Centre (NFRC) for businesses and individuals to report fraud, so it could then identify trends and improve the effectiveness of the overall anti-fraud response – again, this was to be a public/private collaboration. It also suggested the formation of a National Lead Force for Fraud (Lead Force) based on the City of London Police (COLP) Fraud Squad, which would house the NFRC and its intelligence and analytical capability, and be a centre of excellence for other fraud squads, disseminating best practice and advising on complex enquiries in other regions.

On 10 October 2007, the Government announced £29 million of new funding (between 2008-2011) to implement the Fraud Review's key recommendations, which had been announced in March 2007.

The Lead Force, the NFRC and the National Fraud Intelligence Bureau (NFIB)

On 1 April 2008, the COLP were appointed as the Lead Force, capitalising on their expertise in policing economic crime in South-East England. The goals of the Lead Force are to support the NFSA in implementing the national fraud strategy; to provide

² Government Response, 15 March 2007

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national fraud investigation and intelligence capacity to help regional police forces; to maintain the NFRC as a resource; and to develop a national fraud investigation accreditation process incorporating a national Centre of Excellence.

Since spring 2008, they have recruited additional fraud investigators and support staff to assist them and have also developed the NFRC, which should address the present under-reporting of fraud by facilitating telephone and web-based reporting. It is being piloted this year, ahead of its expected launch in 2010. A National Fraud Intelligence Bureau (NFIB) is also being developed within the COPL, to analyse and then disseminate to law enforcement and regulatory agencies the information received by the NFRC and other organisations, private and public. As of this May, the Lead Force was investigating 71 fraud cases, representing estimated losses to the victims of £1 billion.

The National Fraud Strategic Authority (NFSA)

On 1 October 2008, the NFSA was officially launched as a new executive agency of the Attorney General's Office. Its strategic priorities were to:

- Tackle the key threats of fraud which pose greatest harm to the UK.
- Act effectively to pursue fraudsters, hold them to account, and improve the support available to victims.
- Reduce the UK's exposure to fraud by building the nation's capability to prevent it.
- Target action against fraud more effectively by building, sharing and acting on knowledge.
- Secure international collaboration necessary to protect the UK from fraud.

Its immediate focus was the development and delivery of the UK's first National Fraud Strategy. Another was the development of Multi-Agency Co-ordination (MAC), by which the NFSA would bring together various private, regulatory and enforcement agencies to tackle specific fraud threats. The first MAC initiative focused on staged motor vehicle accidents. A second addressed boiler room investment fraud.

Mortgage fraud

The NFSA has also devoted a lot of effort to the issue of mortgage fraud, which has been revealed sharply by the recession. It has launched a Mortgage Fraud Task Force, bringing together all those groups involved in the mortgage process to review how they could best work together and, on 28 November 2008, published its first progress report, *'Fighting Mortgage Fraud Together'*.

In this, it identified four key areas for improvement to increase the market's resilience to fraud: designing-out fraud risks inherent in different mortgage products/processes; enhancing safeguards within firms to make fraud easier to identify; ensuring integrity within the key professional sectors; and raising the risk to fraudsters by more effective detection and prosecution. These efforts produced real results in the form of initiatives including the following:

- The Financial Services Authority (FSA) and the Council of Mortgage Lenders re-launched their *'Information from Lenders'* scheme in July 2008, allowing lenders to advise the FSA when they remove a mortgage intermediary from their panel for suspected or proven fraud, so the FSA can then take appropriate regulatory action. The FSA also launched a new *'Information from Brokers'* scheme, to encourage brokers to report suspicions about other brokers or lenders' business development managers. By March 2009, there had been a 25% rise in the number of reports of suspicious brokers, the prohibition of more than 25 brokers and the imposition of fines in excess of £350,000. The FSA has also passed cases to the police for further investigation or prosecution.
- The Council of Mortgage Lenders also introduced a *'Disclosure of Incentives'* form in September 2008 to ensure the conveyancing and valuation processes collated the true value of new-build properties. They also worked with the British Bankers' Association to produce enhanced guidance to help lenders identify and remedy weaknesses in their mortgage lending processes.
- An innovative pilot scheme was established between lenders and HM Revenue & Customs to verify the validity of HMRC documentation produced by mortgage applicants. Where false documents are unearthed, HMRC also advise lenders to

report to the Serious Organised Crime Agency (SOCA) under the Suspicious Activity Report regime. By November 2008, this had prevented over £16 million worth of fraudulent transactions.

- CIFAS extended access to its Staff Fraud Database to mortgage intermediaries, allowing them to check at the recruitment stage whether new staff had previously committed internal fraud within an organisation.
- The Law Society issued guidance to ensure legal professionals are better able to spot the warning signs of mortgage fraud.

The Lead Force, which had earmarked mortgage fraud as an early priority, has also investigated several sophisticated and highly organised mortgage fraud networks. The NFSA are due to undertake a full review of the impact of their work in this area in November 2009. However, their success so far has already prompted them to say they will adopt this approach as a model to address other fraud issues in the future.

Criminal justice reforms

In the meantime, the Government has also pressed ahead with the criminal justice reforms recommended by the Fraud Review. During 2008, the Attorney General's Office issued two consultations: *'The Introduction of a Plea Negotiation Framework for Fraud Cases in England and Wales: a Consultation'* and *'Extending the Powers of the Crown Court to Prevent Fraud and Compensate Victims: a Consultation'*. The first sought views on a formal framework to allow early plea negotiations to take place between the prosecution and defence in fraud trials and for such agreements to be presented to the court. The second called for views on proposals to allow the Crown Court new powers to prevent fraudsters practising as estate agents, solicitors and financial services providers; to wind up companies used as vehicles for fraud and to better compensate victims of crime.

On 18 March 2009, the Attorney General announced that these proposals would be implemented – prosecutors were immediately issued with new guidelines encouraging earlier and more transparent discussions about guilty pleas and the powers of the Crown Court will be extended by legislation as soon as there is time in Parliament.

The National Fraud Strategy

On 19 March 2009, the Attorney General, Baroness Scotland QC, launched the first National Fraud Strategy, saying:

"This Strategy represents an emphatic response from the Government and the wider economy, to the misconception that fraud is a 'victimless crime'. Fraud costs every person in the country £231 per year. I am very aware of the financial and personal misery frauds, such as e-mail scams, identity theft, mortgage and credit card fraud, through to Ponzi schemes and share sale frauds, can inflict on consumers and businesses."

The three-year Strategy highlights four strategic priorities – and, within them, the high-level objectives to be achieved and first phase of initiatives:

- Enhancing the building and sharing of knowledge about fraud – which includes the establishment of the National Fraud Reporting Centre (NFRC) and National Fraud Intelligence Bureau (NFIB), and the NFSA launch of a collaborative programme to measure fraud loss across the economy. This will provide a benchmark against which to measure progress.
- Tackling the most serious and harmful fraud threats – which includes the launch of the first national control strategy concerning mass-marketing frauds and the NFSA's assessment of the highest risks during a recession.
- Disrupting and punishing more fraudsters whilst improving victim support – which includes the criminal reforms announced the previous day.
- Improving the nation's long-term capability to prevent fraud – by building supportive partnerships within the counter-fraud community and raising public awareness of fraud in ways that work.

The NFSA, which is now headed by Dr Bernard Herdan, is due to report on the progress made against these strategic priorities twice a year. It is also responsible for adapting the Strategy to meet evolving threats.

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In May 2009, the NFSA published its business plan for 2009-10, in which it emphasised that, following a year establishing the organisation and developing the Strategy, it is now focusing on delivering its work programme, which involves 14 key priorities for 2009-10. To reflect its new direction, it has changed its name to the National Fraud Authority (NFA).

The Serious Organised Crime Agency (SOCA)

The SOCA is an intelligence-led agency established in April 2006 and, whilst its primary objectives concern Class A drugs and organised immigration crime, given the extent of organised crime's involvement in fraud, this is another of its key priorities. It aims to devote about 5% of its resources to fraud. Consequently, it has recently worked with Nigerian authorities to identify documents earmarked for use in fraud; participated in a national exercise to target addresses identified from business sector data as identity crime hot spots; and shared intelligence from an operation which intercepted over 4,000 false identity documents, which led to the recovery of £750,000 by HMRC, to name but a few initiatives. It is continuing to work with the NFA and the Lead Force.

Concluding thoughts

Throughout this introduction, we have touched on the current recession and its likely effect on fraud levels. The potential enormity of the fraud problem going forward, has recently been recognised in the National Fraud Strategy, which stated that:

"The speed at which fraudsters move and adapt makes them a formidable force to combat. Factors such as increasingly powerful technology and the global economic downturn are creating new reasons to commit fraud – and new methods to commit it."

"...Tougher economic conditions will change the nature of fraud risks confronting the business, public and voluntary sectors. For example, otherwise law-abiding people facing increasing financial pressures may be driven to commit fraud or corruption out of desperation. Inevitably, fraudsters will find new ways to exploit the vulnerabilities and pressures people suffer during a recession."

This extract includes a general example of how the recession might lead to an increase in fraud. More specific examples that spring to mind include:

- Greater numbers of individuals faking car accidents and 'slips and trips' or claiming against contents insurance for items not actually lost/damaged/stolen (or for more than was genuinely lost), as they find themselves struggling financially.
- Others making claims against employers for injuries not sustained at work or exaggerated work-related illnesses, especially when they anticipate losing their jobs.
- Likewise, struggling firms might be tempted to inflate business interruption claims or claim for fabricated thefts.
- An increase in claims arising from arson, as individuals and failing businesses destroy homes and premises they can no longer afford.

These are just a few of the more obvious scenarios, which have been seen in previous recessions and are already coming to the fore as the downturn bites. In many instances, they are opportunistic frauds carried out by desperate individuals, rather than the work of organised gangs, although they will obviously seek to exploit the recession too. But what statistical evidence is there to assess whether fraud really is thriving in this downturn? So far, the ABI alone has reported that:

- During 2008, fire damage increased by 16% compared with 2007, reaching a record £1.3 billion. Of this, commercial fire damage cost £865 million (15% more than in 2007) and damage to homes cost £408 million, a 17% increase on the previous year.
- Record levels of fraudulent insurance claims are being uncovered, with 2,000 detected each week, valued at £14 million.
- 107,000 fraudulent insurance claims were exposed in 2008, up 17% on 2007. Their value rose by 30% on the previous year, reaching £730 million. Dishonest home insurance claims were the most prevalent, whilst fraudulent motor insurance claims represented the highest value at £360 million. Overall, 4% of all claims by value (life insurance excepted) were fraudulent, compared to 3% the year before.

- These findings should also be considered in the context of the ABI's latest research released this July, which found that fraud costs the industry £1.9 billion a year, up 24% from £1.6 billion two years ago.

Whilst it is still too early for official figures assessing the impact of the downturn as it has deepened this year, many loss adjusters and insurers have already reported sharp rises in the number of potentially fraudulent claims being investigated since the credit crunch began. Indeed, some have even suggested that, during the first quarter of 2009, numbers almost doubled against that period in 2007. That said, on a positive note, these figures are mostly detection rates and there has, undoubtedly, been a significant improvement in both the detection and prevention of fraud by insurers in recent years. According to the ABI, insurers detected £480 million worth of fraud in 2006, £80 million more than in 2005 and three times what they detected in 2003, when the ABI began collecting this information. Hopefully, the plethora of initiatives outlined above and over the following pages, will build on these advances.

DEFINING FRAUD

The legal definition for fraud dates back to the 1889 case of *Derry v Peek* [1889] 14 AC 337:

"Fraud is proved when it is shown that a false representation has been made:

- *knowingly, or*
- *without belief in its truth, or*
- *recklessly, without caring whether it be true or false."*

It is a broad definition of general application; there is no specific definition of fraud used only in an insurance context. The type of conduct which can be characterised as fraudulent in insurance cases is extremely wide and includes:

- Deliberately inflating claims.
- Claims where no loss has occurred at all.
- False statements about the circumstances of the loss.
- False statements regarding compliance with contractual conditions.
- False descriptions of the subject matter of the insurance.

THE BURDEN AND STANDARD OF PROOF

The burden of proving fraud is on the insurer; that is, the emphasis is on the insurer to prove an allegation of fraud, rather than on the insured to disprove it. The level of proof required to meet this burden is described as the degree or standard of proof. The usual standard of proof in a civil court claim is on *'the balance of probability'*, which, in simple terms, means that something can more likely than not be considered true.

In fraud cases, the courts acknowledge that the burden on insurers derives from the civil standard of proof but have emphasised that the more serious the allegation made, the higher the degree of probability to be established.

In the Court of Appeal case of *Hornal v Neuberger Products Ltd* [1957] 1 QB 247, Lord Justice Denning said:

"A civil court, when considering a charge of fraud, will naturally require for itself a higher degree of probability than that which it would require when asking if negligence is established. It does not adopt so high a degree as a criminal court, even when it is considering a charge of a criminal nature; but still it does require a degree of probability which is commensurate with the occasion."

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TRIAL BY JURY

In a civil court claim, a person against whom the 'charge of fraud' is made can apply to the court for the case to be tried before a jury (s.66(3) of the County Courts Act 1984 and s.69 of the Supreme Court Act 1981). However, these Acts include some exceptions to that right, such as when the court is of the view that the trial requires a prolonged examination of documents or accounts or any scientific or local investigation which cannot conveniently be made with a jury.

In the case of *Grant v Travellers Cheque Associates Ltd* [1995], the Court of Appeal decided that the word 'fraud' in the phrase 'charge of fraud' in the County Courts Act 1984 must be founded on the tort of deceit. The tort of deceit is committed where an insurer has been taken in by a false representation and acts on the fraud to its detriment, for example, by paying money to the fraudster.

The Court of Appeal considered whether a claimant was entitled to a jury trial as of right and, if not, whether the Judge in the lower court had exercised his discretion appropriately, when he refused to order trial by jury in *Breckton v Direct Line Plc* [2006] EWCA Civ 921. The Court of Appeal commented in that case that attempted fraud was not sufficient to trigger any right to a jury trial under the County Courts Act.

REFORM OF THE CRIMINAL LAW ON FRAUD

In April 1998, the Law Commission was asked by the Home Secretary to consider whether the law on fraud was comprehensible to juries; adequate for effective prosecution; fair to potential defendants in criminal cases; could meet the need of developing technology; and, finally, to make recommendations to improve the law in these respects. The Law Commission published its report, *Fraud (2002) Law Com No. 276, Cm 5560*, on 30 July 2002.

In the report, the Law Commission recommended that a single general offence of fraud be introduced and that the eight offences of deception created by the Theft Acts 1968-96 should be repealed. In their place, it was recommended that two new statutory offences be created – one of fraud and one of obtaining services dishonestly.

In May 2004, the Home Office circulated a consultation paper. Consideration of the responses to this consultation process resulted in the draft Fraud Bill. Parliament thoroughly debated the wording of that Bill and the Fraud Act 2006 finally came into force on 15 January 2007.

The Fraud Act 2006 applies where a fraudulent offence in its entirety commences on or after 15 January 2007. Any offences or suspected fraudulent actions which take place entirely, or in part, before 15 January 2007 will be prosecuted under the previous legislation. It applies in England, Wales and Northern Ireland. Scots law already had a general offence of fraud.

Repealed offences

The following eight offences under the Theft Acts 1968-78 and the Theft (Amendment) Act 1996 are replaced by the Fraud Act 2006:

- Obtaining property by deception (Theft Act 1968, s.15)
- Obtaining a money transfer by deception (Theft Act 1968, s.15A)
- Obtaining pecuniary advantage by deception (Theft Act 1968, s.16)
- Dishonestly procuring the execution of a valuable security (Theft Act 1968, s.20(2))
- Obtaining services by deception (Theft Act 1978, s.1)
- Securing the remission of an existing liability to make a payment (Theft Act 1978, s.2(1)(a))
- Dishonestly inducing a creditor to wait for payment or to forgo payment with the intention of permanently defaulting on all or part of an existing liability (Theft Act 1978, s.2(1)(b))
- Obtaining an exemption from or abatement of liability to make a payment (Theft Act 1978, s.2(1)(c))

New statutory offence of fraud

In the context of criminal law, the new general statutory offence of fraud is committed where a person dishonestly does any of the following:

- Makes a false representation (s.2)
- Fails to disclose information, when under a legal duty to disclose (s.3)
- Abuses a position of trust (s.4)

The test for dishonesty derives from *R v Ghosh* [1982] 2 All ER 689. In effect, was what was done dishonest by ordinary standards of reasonable and honest people? If yes, must the accused have realised that what he was doing was dishonest according to those standards? If yes, the dishonesty test is satisfied. With the s.2 offence of making a false representation, it is enough if the suspect knew the representation *might* be false.

In each of the three scenarios, the person must have acted dishonestly and with the intention of securing a gain, or loss or risk of loss to another. One important change is that the gain, or loss, does not actually need to have taken place. Therefore, a significant aspect of the new regime is that it is no longer necessary to prove a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss, rather than the consequences of the behaviour.

The sentence for each of the three types of offences under the new general statutory offence of fraud is not more than 12 months' imprisonment or a fine, or both, from the Magistrates' Court, and not more than 10 years' imprisonment or a fine, or both, from the Crown Court.

New statutory offence of obtaining services dishonestly

The second new statutory offence of obtaining services dishonestly, which replaces obtaining services by deception, is a 'theft-like' offence (s.11). It is committed where a person obtains services by any dishonest act with intent to avoid payment. This person must know the services are chargeable or might be. It cannot be committed by omission but only where the dishonest act was done with intent not to pay for the services. It extends to those who obtain services by providing false information to computers and machines. This has a maximum five-year sentence.

Other offences

The main advantage of a properly defined crime of fraud is to simplify the criminal law in respect of fraud. The Fraud Act 2006 was also intended to keep up with advances in technology. For instance, a new offence of possession of articles for use in frauds was introduced at s.6 of the Fraud Act 2006. This concerns possession or control of any article for use in the course of or in connection with any fraud. It applies everywhere, including the suspect's home address. A general intention to commit fraud will suffice. The maximum sentence for committing a s.6 offence is five years.

In order to seek to combat, say, credit card fraud, s.7 contains an offence of making or supplying articles for use in frauds. A s.7 offence concerns making, adapting, supplying or offering to supply any article, knowing it is designed or adapted for use in the course of or in connection with fraud, or intending it to be used to commit or facilitate fraud. The maximum sentence from the Crown Court is 10 years.

There is an offence under s.12 of the Fraud Act 2006, where an offence under that Act has been committed by a corporate body and it was committed with the consent or connivance of a director, secretary or similar officer or anyone purporting to act in such a capacity. That person will be guilty, under s.12, of the same offence as that carried out by the corporate body.

Finally, under s.9, it is an offence knowingly to be a party to the carrying on of a fraudulent business, where the business is not carried on by a company or corporate body. Therefore, this would concern, for example, sole traders, trusts and partnerships. The maximum sentence for a s.9 offence is 10 years.

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Common law offence of conspiracy to defraud

Although the Law Commission also advocated, in 2002, that the common law offence of 'conspiracy to defraud' be abolished, the Attorney General preferred that the common law offence derived from case law be retained, at least for three years. A review as to whether it should be abolished is anticipated in 2010.

The Attorney General believed that the common law offence would remain useful in certain circumstances. Firstly, conspiracy to defraud would feasibly be used by the prosecution for sentencing purposes, as prosecuting under statutory offences would not, in some circumstances, lead to an appropriate sentence. Secondly, use of the common law offence of conspiracy to defraud may enable wider admissibility of evidence. Sometimes when statutory offences are used, the trials might be severed, dealing with distinct aspects. In contrast, using the offence of conspiracy to defraud could lead to a trial in which all the alleged matters of criminality are aired. This is particularly helpful when there are several people accused in relation to a complex fraud.

In January 2007, the Attorney General published guidance for prosecutors, which was intended to restrict the use of the common law offence to cases that were clearly not adequately covered by the new legislation on fraud. It is intended that the case lawyer will record in writing why it would be appropriate for the common law offence to be used – the supervising lawyer will then review this.

Conclusion

The Fraud Act 2006 applies to England, Wales and Northern Ireland. Where the fraudster commits the entire Fraud Act offence within England, Wales or Northern Ireland, no problem arises. However, where the fraudster, say, makes the representation abroad but intends to make a gain (or loss) which will occur in England, Wales or Northern Ireland, the Criminal Justice Act 1993 (as amended by Schedule 1 of the Fraud Act 2006) will apply, so that a s.2 charge will lie only if there is an *actual* gain or loss within England, Wales or Northern Ireland. Given that the purpose of the Fraud Act 2006 is to concentrate on the dishonest behaviour and intent, rather than the consequences, this seems out of step with the overall purpose of the 2006 Act.

Finally, in 2006, the Government introduced the Fraud (Trials without a Jury) Bill, which is intended, if and when it becomes law, to allow for criminal trial by a High Court Judge alone.

To summarise, the Government has sought to make some radical changes in order to keep one step ahead of the fraudster but, ultimately, its success will depend on the consistency and skill of those prosecuting the fraudsters.

INSURANCE CONTRACT LAW REFORM

Reform of the law in the area of insurance contracts and the principle of utmost good faith is fast approaching.

On 1 September 2002, the British Insurance Law Association (BILA) sent a report to the Law Commission recommending that it would be desirable to bring into force a new Insurance Contracts Act. BILA's view was that the starting point for reform, in respect of insurance contracts other than marine, aviation and transport, should be the enactment of the recommendations relating to non-disclosure and breach of warranty contained in the 1980 Law Commission report No.104, Cmnd 8064. A draft Bill for a new Insurance Contracts Act was attached to the 1980 Law Commission report and, in broad terms, BILA agreed its wording.

In the context of fraud, BILA agreed in 2002 that in the event of fraudulent (or reckless) material non-disclosure or misrepresentation, the insurer should still be entitled to avoid from the outset and keep the premium.

If the insured is not fraudulent, i.e. is innocent or negligent, BILA recommended, in 2002, that the remedy for material non-disclosure or misrepresentation should be determined by whether or not the insurer would have entered into the contract only if other conditions applied. Consequently, if the insurer would not have entered into the contract, the insurer should be entitled to avoid but with a return of premium. If the insurer would have entered into the contract applying other conditions had it known

the information which had not been disclosed at the proposal stage or the truth of the misrepresented information, the insurer would not be able to avoid but would not be liable for the loss proximately caused by the undisclosed or misrepresented information or it would be entitled to vary its liability to reflect the change in, for example, premium that would have applied if there had been no material misrepresentation or non-disclosure.

In 1980, the Law Commission had concluded that using the principle of proportionality, as in France, for example, would be unworkable. Put simply, if a non-disclosure has led to a policyholder paying, say, 50% of the correct premium, then only 50% of the claim should be paid under the principle of proportionality. Since 1981, the Ombudsman has applied proportionality in appropriate cases.

In January 2006, the Law Commission and the Scottish Law Commission (referred to collectively for ease throughout this guide as the Law Commission) published a scoping paper, aimed at identifying problematic areas of insurance law.

The Law Commission remains particularly concerned that it is possible for a policyholder to act reasonably and honestly, yet still find the insurer has the right to avoid the policy.

The Law Commission developed its preparatory thinking for a first consultation paper through the following issues papers:

- Issues Paper 1: Misrepresentation and non-disclosure (September 2006)
- Issues Paper 2: Warranties (November 2006)
- Issues Paper 3: Intermediaries and pre-contract information (March 2007)

In its July 2007 consultation paper, the Law Commission invited comments by November 2007 on provisional proposals to modernise the law relating to misrepresentation, non-disclosure and breach of warranty. Summaries of the comments received on the proposals relating to consumer insurance reform and business insurance reform were published in May and October 2008 respectively. As there was a strong consensus that consumer insurance law was in need of urgent reform, the Law Commission is giving priority to drafting a report and draft Consumer Insurance Bill, which are now due to be published in autumn 2009. It will be a number of months after the draft Bill is published before the finalised Bill could be ratified by Parliament as a new Act.

This guide sets out the law prior to the anticipated new Act and the thinking behind the changes that have been debated.

To summarise, in terms of civil insurance related fraud, the Law Commission proposes that:

- The categories for material misrepresentation/non-disclosure shall be innocent, negligent and deliberate/reckless, so the use of the word fraudulent is likely to be dropped in practice in this context. The reason behind this appears to be because use of the word fraud can be emotive.
- The Law Commission no longer proposes to prevent an insurer of consumer life assurance from relying on any non-fraudulent misrepresentation after the policy has been in force for three (or five, as also mooted) years. Although other jurisdictions have similar 'non-contestability periods', this concept has been dropped altogether during the consultation process.

Any Consumer Insurance Act is likely to apply to policies that, for example, incept from a specified date. This would mean that, post reform, insurers could be assessing one claim under the old law and the next under the proposed new law.

The Law Commission is considering how to define consumer and business (i.e. commercial) insurance, not least because the proposed reforms will afford more protection to consumers and there is the difficult issue as to how mixed use policies will be categorised. In the consultation process, the Law Commission had provisionally proposed that the consumer regime should apply to all individuals who entered into an insurance contract wholly or mainly for purposes unrelated to their business. The Financial Services Authority (FSA) defines a consumer as a natural person who is acting for purposes that are "*outside his trade, business or profession*" (see ICOBS rule 2.1.1(3), introduced in January 2008) and clarifies this, in ICOBS Guidance 2.1.3, by stating:

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“If a customer is acting in the capacity of both a consumer and a commercial customer in relation to a particular contract of insurance, the customer is a commercial customer.”

It remains to be seen exactly how the Law Commission will approach mixed use policies, such as where home contents insurance also covers the contents of a home office, but we anticipate that the less sophisticated insurance buyers are likely to be afforded the more generous protection available for consumers. Indeed, in April 2009, the Law Commission published a further issues paper on micro-businesses (usually, but not always, defined as businesses with less than 10 employees), asking whether they should be treated like consumers for the purposes of pre-contractual information and unfair terms, in light of research showing that many of them do not have specialist insurance knowledge and are increasingly purchasing their insurance online, without a broker, much like consumers. Again, the Law Commission is exploring how micro-businesses should be defined. Responses to this paper were requested by 17 July 2009 but, as of August 2009, no summary has been published.

As for other businesses, having found that there was support for reform of pre-contractual business insurance law, the Law Commission has promised a further issues paper, this time focusing on larger business insurance.

Further details of the possible changes to the law are set out below and at pages 45-59.

DUTY OF UTMOST GOOD FAITH

An insurance contract is a contract *uberrimae fidei* – in utmost good faith – and a fraudulent claim must be considered in this context. As a general rule, the policyholder is required to tell the truth and to disclose all material facts on the proposal form. The Law Commission proposes that where a consumer, as opposed to a business, applies for an insurance policy, the law should be reformed so that the duty to volunteer material facts be abolished by a new Consumer Insurance Act.

Non-disclosure is omitting to provide information relevant to the underwriting of risk. A misrepresentation is giving a wrong/misleading statement in a proposal form or other form of presentation to an underwriter.

If the law is reformed, clear questions in consumer insurance applications will be the order of the day and the focus will be on material misrepresentation, rather than material non-disclosure or misrepresentation. Whilst insurers of consumer insurance will still, under the possible reforms, be able to ask general ‘sweeper’ questions, insurers will need to be realistic about their practical effect. If there is a dispute as to whether a fact should have been disclosed, under the possible reforms, the test is likely to be whether a reasonable applicant would understand that the question was asking for the information in issue. If not, there would be no remedy available to the insurer.

It is not suggested that the residual duty to disclose be abolished for business insurance. Instead, it is proposed by the Law Commission that a business policyholder should be under a duty to volunteer material information when it enters into an insurance contract. There are three reasons for this: firstly, there is often no proposal form for business insurance; secondly, where business insurance covers a wider variety of unusual risks, as is often the case, it would be very hard for insurers to ask questions about all relevant matters; and, thirdly, the risk of business insureds not realising they have a duty to disclose is lower, as more applications are made through full-time professional intermediaries.

It is well established that the principle of utmost good faith applies to the information given at the application stage, when the insured initially enters the insurance contract. However, whether there is a continuing duty of good faith at the claim stage, after a policy has commenced, has been a matter of debate and subject to conflicting decisions by the courts. The Law Commission is planning to publish an issues paper on post-contractual good faith in 2010, as part of the process for considering legal reform in this area.

The case of *Manifest Shipping Company Ltd v Uni-Polaris Shipping Company Ltd & Others* [2001] 2 WLR 170 (otherwise known as 'The Star Sea') involved a marine insurance claim. The House of Lords decided that the duty of utmost good faith does not come to an end when the contract has been made. Different degrees of openness are required of the parties, depending on the stage the contractual relationship has reached.

Lord Hobhouse observed that, "...*utmost good faith is a principle of fair dealing which does not come to an end when the contract has been made.*" However, "...*the content of the obligation to observe good faith has a different application and content in different situations.*" In the claims context, the duty is restricted to an obligation not to make fraudulent claims; as Lord Scott stated, all that is required is "*honesty in the presentation of a claim*".

The duty to disclose, in the absence of any express policy terms to the contrary, is complete once the contract has commenced.

The law post-*Manifest Shipping* can be summarised as follows:

- There is a continuous duty of good faith both pre- and post-contract.
- However, the duty differs and is more onerous pre-contract than post-contract.
- As regards disclosure, subject to any express policy terms to the contrary, the duty to disclose is complete once the contract is concluded and the duty thereafter is one of honesty in the presentation of the claim.
- If a claim is fraudulent, then the insured cannot recover anything for that claim.
- A grossly negligent claim, falling short of recklessness, does not count as fraud. In *Manifest Shipping*, the insured was at most grossly negligent in bringing the claim and, therefore, the claim was not fraudulent.

Insurers' remedies for a fraudulent claim are:

- Cancel the contract, i.e. it will be regarded as at an end. The insured loses entitlement to the fraudulent and non-fraudulent parts of the claim.
- Keep the premium.
- Claim damages, under the tort of deceit.

This leaves open the question of whether insurers could avoid the policy from inception following a fraudulent claim due to public policy or a breach of the post-contractual duty of good faith.

***K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters & Others* [2001] EWCA Civ 1275**

A few months after the *Manifest Shipping* decision, the Court of Appeal was asked to decide an issue relating to an alleged post-contract breach of the principle of utmost good faith in *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters & Others* [2001].

The assured ship repairer, who was alleged to have carried out negligent repairs, gave its solicitors a forged document, which it believed would help ensure that the negligence dispute would be within the jurisdiction of the English courts. The document was not relevant to the insurers' ultimate liability under the policy with the ship repairer.

The Court of Appeal did not agree that the remedy of avoidance of the policy could be used. The reasoning was that avoidance should only be permitted in post-contract situations, where it was analogous to circumstances where the insurer had a right to terminate for breach. This involved proving that the fraud was material (which was not the case, as it did not affect the insurers' ultimate liability) and that the gravity of the fraud, or its consequences, was sufficient to enable the insurers, if they wanted to, to terminate for breach of contract. Here, the fraud had been directed to the ship owners, who were claiming against the insured ship repairers for alleged negligent repairs.

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In *AXA General Insurance Ltd v Gottlieb & Gottlieb* [2005] Lloyd's Rep IR 369, which is considered in detail on page 32, the Court of Appeal held that, by making a fraudulent claim, the insured forfeited the whole claim to which the fraud relates but other unrelated claims in the same policy year were unaffected. However, since AXA did not argue that the policy should be avoided from inception, due to the breach of the post-contractual duty of good faith, the issue cannot be regarded as finally resolved.

EXAGGERATED CLAIMS

When making a claim, there will sometimes be a tendency for the insured to present a claim in a manner that maximises the amount to which they think they are entitled under their policy. When doing so, the insured might be tempted to inflate the size of their loss to secure a larger settlement that goes beyond what they are entitled to under the policy. This raises the question: at what point does an exaggerated claim become fraudulent?

In order to be a fraudulent claim, two elements need to be present:

- There must be an intention to obtain an advantage or put someone else at a disadvantage.
- The amount claimed must not be merely a bargaining position.

A claim may be extravagant but not fraudulent if the claimant is merely taking a bargaining position, as opposed to intending to recover more than that to which they are entitled. Note the comments below from Mr Justice Thomas in *Nsubuga v Commercial Union* [1998] 2 Lloyd's Rep 682:

"...one has to accept as a matter of commercial reality that people will often put forward a claim that is more than they believe that they will recover. That is because they expect to engage in some form of 'horse trading' or other negotiation. It would not generally in those circumstances be right to conclude readily that someone had behaved fraudulently merely because he put forward an amount greater than that which he reasonably believed he would recover. He would have to put forward a claim that was so far exaggerated that he knew that in respect of a material part of it, there was no basis whatsoever for the claim."

The concept of claimants taking bargaining positions was also acknowledged by the Court of Appeal in *Orakpo v Barclays Insurance Services & Another* [1994] CLC 373. For example, Lord Justice Hoffman said:

"One should naturally not readily infer fraud from the fact that the insured has made a doubtful or even exaggerated claim. In cases where nothing is misrepresented or concealed, and the loss adjuster is in as good a position to form a view of the validity or value of the claim as the insured, it will be a legitimate reason that the assured was merely putting forward a starting figure for negotiation. But in cases in which fraud in the making of the claim has been averred and proved, I think it should discharge the insurer from all liability."

The majority decision of the Court of Appeal was that an insured is under a duty to act in good faith not only in relation to statements made in the proposal form but also claims under the policy. Where it was established that the claim had been made fraudulently, the insurers were entirely discharged from liability for the claim under the policy, even where there was no express fraudulent claims clause in the policy.

***Orakpo v Barclays Insurance Services & Another* [1994] CLC 373**

Mr Orakpo was the owner of a large house divided into 13 bedsitting rooms. He insured the property and cover was provided by a number of companies. In 1985, the building was dilapidated, although in early 1985 Mr Orakpo described the property in the proposal form as being in a good state of repair. In July 1985, the Local Authority served a repair notice, but the repairs were not carried out. In January 1987, frost damage to pipes caused flooding and subsequent damage. At that time, three tenants were in occupation. In October 1987, storms damaged the roof to the property, causing further extensive damage. The last tenant left shortly after that and vandals caused damage. In March 1988, Mr Orakpo made a claim against his insurers, which included the damage attributable to storm and burst pipes, works attributable to dry rot and vandalism, works

relating to contents and maintenance, professional fees and a claim for loss of rent for two years and nine months of about £77,000 plus VAT. The total loss pleaded in the statement of claim was about £265,000 plus interest.

The High Court found that there was material misrepresentation regarding the state of repair in the proposal and the part of the claim based on loss of rent was grossly exaggerated. The size of the loss of rent claim, as presented to insurers, assumed that all 13 bedrooms would have been fully occupied for the two years and nine months, however, there were only three tenants.

Mr Orakpo's appeal was unsuccessful. On the non-disclosure point, the Court of Appeal agreed there was no estoppel and insurers' defence of misrepresentation was successful. The majority of the Court of Appeal agreed that the claim was fraudulent, therefore, the insurers were discharged from liability under the policy – it did not matter that there was no express fraudulent claims clause. It was acknowledged that the claim was grossly exaggerated. In particular, Lord Justice Hoffman and Sir Roger Parker said it was substantially fraudulent. Therefore, nothing was payable to Mr Orakpo.

It is a standard term in most insurance policies that, if any claim is made which is false or fraudulent, all benefit under the policy will be forfeited. However, the outcome when there was no such express term was unclear until the case of *Orakpo*.

Deciding whether something is sufficiently exaggerated to be fraudulent can be difficult. Fortunately, the court decisions within the last few years have given some guidance. The overriding impression is that, whilst the court acknowledges that there is a practice of taking a bargaining position, it is more sympathetic to insurers' plight in seeking to deter insurance fraud.

Galloway v Guardian Royal Exchange (UK) Ltd [1999] Lloyd's Rep 209

This was a case involving a claim under a home contents policy after a burglary. The insured submitted a claim for just over £18,000. It was genuine up to £16,000 but the remaining £2,000 was fraudulent: the insured claimed the replacement value of a computer supported by a receipt, which was false. Lord Woolf said that, in determining whether the non-disclosure is material, one must look at the whole of the claim, and that 10% (£2,000) in that case was substantial and tainted the whole. Lord Justice Millett took a slightly different view of what is meant by substantially fraudulent. He said the correct approach was to consider the fraudulent claim as the only claim and consider whether it was sufficiently serious to justify stigmatising it as a breach of good faith.

Therefore, the decision that Mr Galloway was entitled to no payment at all was upheld.

The courts' apparent policy of discouraging fraud can be further illustrated by the decision in *Direct Line Insurance Plc v Khan & Another [2001]*.

Direct Line Insurance Plc v Khan & Another [2001] EWCA Civ 1794

Direct Line paid out £69,000 under a buildings and contents policy to the Defendant husband and wife following a fire at their house. Approximately £8,000 of the claim was a fraudulent attempt to gain payment for rent on alternative accommodation which, in fact, the First Defendant, Mr Khan, owned. Direct Line argued that because of this fraud the whole claim was forfeited.

Mr and Mrs Khan were noted as joint policyholders. Mrs Khan argued that, since the fraud was perpetrated solely by her husband and she did not know about it, her contractual relationship with Direct Line was not affected, and that to deny her entitlement to the legitimate element of the claim (i.e. the heads of claim other than the rent claim) was contrary to the Unfair Terms of Consumer Contracts Regulations 1994, reg. 3 (1994 Regulations).

The Court of Appeal held that the First Defendant's actions were carried out on his behalf and as agent for his wife, the Second Defendant. Therefore, the Second Defendant was bound by such actions, being unable to show that the First Defendant had acted outside that agency. Secondly, the Court of Appeal said that the rule in *Galloway* was not a term of the contract but a 'rule of law' and it was outside the purpose and spirit of the 1994 Regulations for them to apply to rules of law.

Consequently, neither Mr nor Mrs Khan was entitled to any part of the claim.

Fraud Investigation

AXA General Insurance Ltd v Gottlieb & Gottlieb [2005] Lloyd's Rep IR 369

This was a case in which the court considered whether interim payments paid by AXA before any fraud was committed, were recoverable by AXA.

Mr and Mrs Gottlieb made four claims in respect of property damage. Interim payments were made by AXA in respect of all the claims and before any fraud. Subsequently, in two of the claims, Mrs Gottlieb fraudulently pursued a claim for alternative accommodation and submitted a forged electrician's invoice.

The court decided that AXA could recover the interim payments in respect of the two claims tainted by fraud, but not the payments made on the other two claims, which were not the subject of any fraud.

The Court of Appeal highlighted that: *"There is no obvious reason why the consequences of making a fraudulent claim should depend upon the timing of any payment in respect of any genuine part of the claim."*

It appears that the Court of Appeal were mindful of potentially discouraging interim payments, should insurers have been found to be unable to recover them if a fraud were subsequently committed in respect of that claim.

Payments that had already been made in respect of the two tainted claims were made on the assumption that an obligation to indemnify existed or would arise. Once that obligation is forfeited, any payments made have no basis and are recoverable as payments made on a false premise or for a consideration which wholly failed.

Danepoint Ltd v Underwriting Insurance Ltd [2005] EWHC 2318

This was a claim following a fire. The insured (a) relied on a contractor's repair 'invoice' to substantiate repairs which were necessary as a result of the loss but which had not been carried out by the contractor and (b) supplied false information to inflate a loss of rent claim beyond the loss it had actually incurred. Judge Peter Coulson QC gave the insured the 'benefit of the doubt' in relation to the false repair 'invoice' but found the inflation of the loss of rent claim to be fraudulent. He found the entire claim to be tainted by fraud and rejected the insured's plea that the consequences should be restricted to forfeiting only the fraudulent head of claim.

The treatment of fraudulent exaggeration as part of a genuine claim in third party personal injury cases is substantially different from that in first party insurance claims. In first party claims, the insurer can rely on the contract of insurance itself, as well as the insured's duty of utmost good faith. However, some defendants appear to be attempting to merge the principles applied in first party claims with those of third party injury claims, possibly encouraged by the words of Lord Justice Laws in *Molloy v Shell UK Ltd* [2001].

Molloy v Shell UK Ltd [2001] EWCA Civ 1272

Mr Molloy was a scaffolder employed on an oil platform in the North Sea owned by Shell when he fell sustaining injury, in 1996. The accident was genuine and liability was admitted. Mr Molloy alleged that he had not been able to return to work as a scaffolder when, in fact, he had returned to scaffolding in July 1997. Notwithstanding this, he sought past and future loss of earnings of more than £300,000.

At trial, Mr Molloy was awarded just £18,897 in damages and failed to beat a Part 36 payment into court made by Shell. However, the trial Judge only awarded Shell 75% of its costs from the date of the payment in, so it appealed.

In the Court of Appeal, Lord Justice Laws observed that Mr Molloy's approach was, *"...nothing short of a cynical and dishonest abuse of the court's process."* He went on to say, *"...I entertain considerable qualms as to whether, faced with manipulation of the civil justice system on so great a scale, the court should once it knows the facts entertain the case at all save to make the dishonest claimant pay the defendant's costs."* (emphasis added). Accordingly, Shell was awarded its costs in full from the date of the Part 36 payment.

However, this attempt to merge the two separate areas of third party claims and first party insurance claims has very recently been rejected by the Court of Appeal in *Shah v Ul-Haq & Others* [2009]. Lady Justice Smith, who gave the leading judgment, stated that:

“There is a well established common law rule that if a genuine claim made under an insurance contract is dishonestly exaggerated, the whole claim will be dismissed ... However, this rule is limited to claims brought under insurance contracts, which are, of course, contracts of good faith.”

Lord Justice Toulson supported the comments of Lady Justice Smith but explained the principle in a slightly different way:

“There is a special rule of insurance law that an insured cannot recover in respect of any part of a claim in a case where the claim has been fraudulently exaggerated or where a genuine claim has been supported by dishonest devices ... Different views have been advanced to explain the jurisprudential basis of the rule, but it is unnecessary to consider them because it is clear that the principle (whatever its foundation) is special to fraudulent insurance claims...”

***Shah v Ul-Haq & Others* [2009] EWCA Civ 542**

Mr Ul-Haq and his wife, Mrs Parveen, were involved in a genuine accident when Mrs Shah drove into the rear of their stationary car at traffic lights. They claimed for minor whiplash injuries. However, a whiplash claim was also made by Mr Ul-Haq's mother, Mrs Khatoon, who claimed to have been in the car at the time as well. Mrs Khatoon's claim was supported by both Mr Ul-Haq and Mrs Parveen. At trial, the Judge held that Mrs Khatoon had not been in the car at the time of the accident.

Mrs Shah sought to have all three claims struck out, notwithstanding that two of them were genuine, on the grounds that there was clearly a fraud by Mr Ul-Haq and Mrs Parveen in supporting the dishonest claim of Mrs Khatoon and, furthermore, that the court had a discretion to strike out a genuine claim under rule 3.4(2) of the Civil Procedure Rules – even at the end of the hearing. Mrs Shah failed at first instance and also on appeal.

In the Court of Appeal, Lady Justice Smith said, *“...it is well established that a claimant will not be deprived of damages to which he is entitled because he has fraudulently attempted to obtain more than his entitlement. Should the position be different where the claimant's attempted fraud consists of lying to support the claim of another person rather than lying to enhance the claimant's own claim? I can see no logical justification for suggesting that the claimant who lies about another person's claim should be treated more severely than the claimant who lies about his own claim.”*

The Court of Appeal held that it would not be appropriate to strike out the genuine claims, especially where the trial Judge had been able to deal with the proceedings fairly, thereby distinguishing the case from the scenario in *Arrow Nominees Inc & Another v Blackledge & Others* [2000] EWCA 20.

The Court of Appeal acknowledged that: *“...everyone knows that fraud is a scourge of our time”*, but said that the appropriate way to change the law to solve the problems of insurance companies dealing with fraudulently exaggerated third party claims was a matter for Parliament, rather than judicial intervention.

The decision in *Arrow Nominees* [2000] was also looked at even more recently in the Court of Appeal case of *Zahoor & Others v Masood & Others* [2009] EWCA Civ 650. This was not an insurance case but simply concerned a commercial/contractual dispute between the two parties. However, the comments of the Court of Appeal are helpful in interpreting how the courts should deal with strike out applications where fraud is involved in the presentation of a case.

Fraud Investigation

Zahoor & Others v Masood & Others [2009] EWCA Civ 650

Mr Zahoor was a steel expert and metallurgist who owned a 4.9% shareholding in a steel trading group called Metalsrussia Group Holdings Ltd. Mr Masood was an old friend of Mr Zahoor from their schooldays in Pakistan and owned various financial service companies in the US. Mr Masood was effectively the finance director of the Zahoor companies from 1996 to 2003, when the two friends fell out.

The case revolved around several claims between the two parties relating to a claim by Mr Masood for shares in one of the Zahoor companies, a claim for unpaid salary and a costs claim, as well as an action in Guernsey. The trial Judge found that both parties had attempted to deceive the court by forging documents relating to various agreements and share transfers and held that both sides had lied in their evidence. Consequently, he found both Mr Masood and Mr Zahoor guilty of forgery and perjury. He referred the papers to the relevant authorities for them to consider whether to prosecute for a criminal offence.

At first instance, the Judge rejected Mr Zahoor's application to strike out Mr Masood's claim without deciding its merits. Instead, the Judge made detailed findings in a reserved judgment, in which he concluded that he should grant relief to Mr Masood. Mr Zahoor appealed on the basis that the Judge should have thrown out the case, given Mr Masood's proven misconduct.

Lord Justice Mummery, giving the judgment of the Court of Appeal, reviewed the previous judgment in *Arrow Nominees* and found, "... *this decision is authority for the proposition that, where a claimant is guilty of misconduct in relation to proceedings which is so serious that it would be an affront to the court to permit him to continue to prosecute his claim, then the claim may be struck out for that reason.*"

He went on to say, "*We accept that, in theory it would have been open to the judge, even at the conclusion of the hearing, to find that Mr Masood had forged documents and given fraudulent evidence, to hold that he had thereby forfeited the right to have the claims determined and to refuse to adjudicate upon them. We say 'in theory' because it must be a very rare case where, at the end of a trial, it would be appropriate for a judge to strike out a case rather than dismiss it in a judgment on the merits in the usual way.*"

"*One of the objects to be achieved by striking out a claim is to **stop** the proceedings and **prevent** the further waste of precious resources on proceedings which the claimant has forfeited the right to have determined. Once the proceedings have run their course, it is too late to further that important objective.*"

He added, "[*The trial Judge*] said ... *that he would have struck out all the claims if he was dealing solely with the misconduct of Mr Masood. As we have said, we think that it was too late to take that course. But the judge was wrong to hold that the fact that the defendants had also been guilty of misconduct was a reason for him not to exercise the power to strike out the claims on the grounds of Mr Masood's misconduct. In our judgment, the defendants' misconduct was irrelevant. On the assumption that it was not too late to consider striking out the claim, the sole question was whether, **by reason of Mr Masood's forgeries and fraudulent evidence**, the claimants had forfeited the right to have an adjudication of their claims. The answer of that question did not involve an exercise in weighing the misconduct of the claimants against that of the defendants. The defendants did not start the proceedings. They did not seek relief from the court. They were merely defending the claims brought by the claimants.*"

THIRD PARTY LIABILITY CLAIMS

When dealing with suspected fraudulent third party liability claims, there are several issues to be considered:

- The burden of proof
- Surveillance evidence
- Cost sanctions
- Other remedies available to defendants

The burden of proof

An issue which has caused problems for practitioners in civil fraud claims – by which we mean a general, all-encompassing definition of “*an intention to deceive for the purpose of gaining an advantage*”, and which applies equally to cases of manufactured or staged accidents and those where there has been a genuine accident but the claimant is intentionally exaggerating the level of injury or loss – is the level of proof required.

Where the defendant alleges fraud, the burden then falls on them to prove fraud on the balance of probabilities, i.e. the civil burden of proof, rather than the criminal burden of proof where it has to be proved beyond all reasonable doubt.

In *Cooper v P&O Stena Line Ltd* [1999] 1 Lloyd's Rep 734, the case put forward by the Defendant was that, on the evidence of its medical report, the Claimant had been fabricating his symptoms. However, no specific allegation of fraud had been made in the pleadings prior to trial and the Judge held that any allegation of malingering amounted to an allegation of fraud and should have been expressly pleaded. The Judge also penalised the Defendant for taking this approach by awarding costs against it on an indemnity basis. However, that case was dealt with under the old rules of the Supreme Court, which were replaced by the Civil Procedure Rules (CPR) in 1999.

The decision in *Cooper* troubled defendant practitioners, since it was interpreted by some District Judges dealing with fast track whiplash cases allegedly caused by low-velocity impact car accidents as meaning that, in the absence of a specific pleading of fraud, defendants could not challenge the circumstances of the accident or cross-examine the claimant's medical expert.

Subsequently, in *Kearsley v Klarfeld* [2005], the Court of Appeal gave some guidance, albeit *obiter*, regarding whether it was necessary to plead fraud, in light of the CPR, in cases involving low-velocity impact claims. Now, providing the defendant sets out its case clearly and the claimant knows the reasons for the claim being resisted, it is not necessary to formally plead fraud where the defendant does not consider there is sufficient evidence to do so.

***Kearsley v Klarfeld* [2005] EWCA Civ 1510**

Mr Kearsley allegedly injured himself in a low-velocity car crash. The Defendant admitted liability for the accident but disputed causation of Mr Kearsley's injury. The Defendant set out his case clearly in the defence: he alleged that Mr Kearsley's vehicle was travelling at only a few miles per hour; his engineering expert advised that, at 3mph, Mr Kearsley's vehicle would have caused minimal force to be applied to Mr Kearsley; and his medical expert expressed the opinion that it was very unlikely Mr Kearsley had suffered any injury – consequently, the likelihood was that Mr Kearsley was fabricating his symptoms.

In the Court of Appeal, Lord Justice Brooke, giving judgment, said: “*In pre-CPR days the rules made it obligatory to plead the material facts a party relied on for his claim or his defence. These might include an allegation of fraud ... In the Practice Direction to CPR Part 16 specific reference is now made to the need for a claimant to set out the any allegation of fraud in his particulars of claim ... but the requirements for the contents of a defence are not reduced to that level of specificity...*”

The Court of Appeal held that the case advanced by the defendant satisfied the requirements of rule 16.5 of the CPR in relation to making clear what the defence was, and there was no need to specifically plead fraud just to ensure he could question the evidence and medical causation.

It is also important to remember that, in any claim, the claimant must prove their case on the balance of probabilities. In this regard, it is helpful to bear in mind the decision of the House of Lords in *Rhesa Shipping Company SA v Edmunds (The Popi M)* [1985], which dismissed the ‘*Holmesian Fallacy*’.

Fraud Investigation

Rhesa Shipping Company SA v Edmunds (The Popi M) [1985] 1WLR 948

The Claimants were the owners of a ship built in 1952, which was insured against the perils of the sea. By 1976, the ship had become seriously run down and sank in the Mediterranean in good weather whilst in a main sea lane in deep water, with water entering through a large hole in its side.

The shipowner brought a claim against underwriters contending that the ship's loss was caused by, amongst other things, a collision with a submarine. Underwriters alleged the hole was caused by the ship's poor condition.

At first instance, the court rejected underwriters' contention and found in favour of the owner's *'highly improbable'* suggestion of a submarine collision.

However, on appeal, Lord Brandon, giving the majority decision in the House of Lords, said:

"My Lords, the late Sir Arthur Conan Doyle in his book 'The Sign of Four', describes his hero, Mr Sherlock Holmes, as saying... 'how often have I said to you that, when you have eliminated the impossible, whatever remains, however improbable, must be the truth?' It is, no doubt, on the basis of this well-known but unjudicial dictum that Bingham J decided to accept the shipowners' submarine theory, even though he regarded it ... as extremely improbable..."

"...the legal concept of proof of a case on a balance of probabilities must be applied with common sense ... If such a judge concludes, on a whole serious of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense."

Accordingly, the burden of proving, on the balance of probabilities, that a ship was lost by the perils of the sea, is and remains throughout on the shipowner. Although it is open to underwriters to suggest and seek to prove some other cause of loss, against which the ship was not insured, there is no obligation on them to do so. Furthermore, the court can always conclude, even after a prolonged inquiry involving a mass of expert evidence, that the proximate cause of the ship's loss, even on a balance of probabilities, remains in doubt. The consequence of this would be that the shipowner would have failed to discharge the burden of proof which lies on them.

As can be seen from the above, even if the defendant fails to prove fraud, it does not automatically mean that the claimant will succeed in obtaining damages.

Surveillance evidence

The obtaining of video evidence and its disclosure raises several issues for insurers. The first surrounds the obtaining of surveillance evidence in light of the Human Rights Act 1988, which incorporates Articles 6 and 8 of the European Convention on Human Rights with regard to the right to a fair trial (which applies equally to defendants and claimants) and the right to respect for an individual's private and family life, respectively.

In *Jones v University of Warwick* [2003], the Court of Appeal had to consider the issue of video evidence obtained in a manner contrary to Article 8. It held that such evidence would be allowed, although it penalised the Defendant in costs by making it pay for having to apply to the court for leave to rely on the surveillance video and for the two subsequent appeals.

***Jones v University of Warwick* [2003] EWCA Civ 251**

Mrs Jones injured her wrist at work and claimed a significant continuing disability, seeking special damages exceeding £135,000. Liability had been conceded but the Defendant claimed she had recovered from the effect of the injury. The Defendant's insurer instructed surveillance evidence to be obtained. Unfortunately, the enquiry agent gained access to Mrs Jones' home by pretending to be a market researcher and covertly obtained video footage indicating her wrist was functioning normally. The Defendant accepted that its enquiry agent was guilty of trespass.

The Court of Appeal held that, even though the Defendant's insurer was not a public authority, the court (which was a public body) could not exercise its discretion in a manner incompatible with Mrs Jones' Convention rights. However, the court also held that it should seek to reconcile the public interest in protecting the rights of the individual, with the right of both parties to a fair trial. Consequently, it allowed the video footage to be used at the trial.

The timing of the disclosure is also important. The spirit of the overriding objective of the CPR is for any evidence relied on in support of allegations of exaggeration to be disclosed early. However, the disclosure of video evidence too early enables a claimant to limit its damage by telling their medical expert they have "good" days and "bad" days.

In *Uttley v Uttley* [2002] PIQR P12, the High Court held that it was reasonable for the Defendant to delay disclosure of his surveillance evidence until after the Claimant had disclosed his medical evidence and updated his witness statement supporting his physical limitations.

Cost sanctions

The courts have shown, on many occasions, that they are prepared to exercise their wide discretion in relation to costs, especially where fraudulent exaggeration is proved, by penalising claimants on costs. In *Painting v University of Oxford* [2005], the Court of Appeal looked beyond the sum awarded and the amount of the defendant's Part 36 payment in order to determine "who was the real winner" of the litigation.

***Painting v University of Oxford* [2005] EWCA Civ 161**

Mrs Painting injured her back in an accident at work. Liability was agreed on the basis of an 80/20 split in her favour. She sought £500,000 special damages. Originally, the Defendant paid £184,000 into court. However, following the obtaining of video evidence, the Defendant applied for and obtained permission to withdraw all but £10,000 of the monies in court.

Mrs Painting had not sought to accept the Defendant's payment into court, either before or after the monies in court were reduced. At the assessment of damages hearing, Mrs Painting was awarded approximately £25,000, after a deduction for contributory negligence.

The trial Judge held that Mrs Painting had deliberately exaggerated the extent and duration of her symptoms and the Court of Appeal described her conduct as 'fraudulent'. Notwithstanding this, the trial Judge held that, since she had beaten the Part 36 payment of £10,000, she was entitled to all of her costs. The Defendant appealed.

The Court of Appeal found that the trial Judge had concentrated too much on the payment into court and had ignored the bigger picture of "who was the overall winner". Crucial to this, was that the Claimant had been fraudulent, had refused to consider negotiating a settlement and had not attempted to make any offers herself. Accordingly, the Defendant was awarded its costs from the date of the payment into court.

Other remedies

Whilst third party claimants who suffer a genuine personal injury but fraudulently exaggerate the nature and/or extent of their injury/losses, will receive some damages for the genuine aspect of their claim, this does not prevent defendants from taking alternative action to penalise them.

Fraud Investigation

As Lord Justice Toulson recently said in *Shah v Ul-Haq & Others* [2009] EWCA 542:

“... I would add that everyone knows that fraud is a scourge of our time. On the judge’s findings the claimants were guilty of serious criminal offences, including conspiracy to defraud and conspiracy to pervert the course of justice. If, as has been suggested, such fraudulent claims have reached epidemic proportions, it may be that prosecutions are needed as a deterrent to others.”

Indeed, the police are becoming more interested in prosecuting fraudulent cases reported to them by insurers. However, it is often a question of the resources the police have available at that time.

An alternative route is for the defendant to bring civil proceedings for contempt of court and this was successful in the personal injury cases of *Caerphilly County Borough Council v Hughes & Others* [2005] and *Walton v Kirk* [2009].

Rule 32.14 of the CPR allows for a person to be prosecuted where they make, or cause to be made, a false statement in a document verified by a statement of truth, in circumstances where they do not have an honest belief in its truth. In order to succeed, the applicant must prove the contempt to the criminal standard. They must prove beyond all reasonable doubt, in respect of each statement:

- The falsity of the statement in question.
- That the statement has, or if persisted in would be likely to have, interfered with the course of justice in some material respects.
- That at the time it was made, the maker of the statement had no honest belief in the truth of the statement and knew of its likelihood to interfere with the course of justice.

However, as can be seen from the *Walton v Kirk* case below, strong evidence will be required to prove contempt, although where it is proven the court will take decisive action and penalise a contemptible claimant.

***Caerphilly County Borough Council v Hughes & Others* [2005] Unreported**

Mr Hughes brought proceedings against the Council for a knee injury arising out of an alleged fall on a defective area of pavement for which the Council was responsible. Mr Verity and Mr Rowlands gave witness evidence in support of his claim. However, after the trial, evidence came to light that Mr Hughes had sustained a knee injury whilst playing football on the same day. The Council was able to produce a team photograph taken an hour after the alleged accident showing Mr Hughes kneeling on his injured knee in a team line-up before the match, in which he scored! The Council brought committal proceedings against all three men for contempt of court.

The court was satisfied, on the criminal burden of proof, that Mr Hughes had not sustained any injury in the street on the relevant day. Further, the witnesses knew that their evidence was false. Mr Hughes was sentenced to 14 days’ imprisonment and ordered to pay costs of £15,000, whilst Mr Verity and Mr Rowlands were each fined £1,500.

In sentencing Mr Hughes, Mr Justice Silber said, *“There is evidence that a very large number of false claims of this kind are made against Councils and it is Council taxpayers who bear the costs. Those who in future make fraudulent witness statements in order to pursue fraudulent claims can expect immediate prison sentences substantially longer than the one imposed on you.”*

Walton v Kirk [2009] EWHC 703(QB)

In 2001, Mrs Kirk was involved in a minor road traffic accident with Mrs Walton's vehicle, which allegedly caused her to suffer a whiplash injury with neck pain radiating into her shoulders. Liability was not disputed. She reported severe neck pain which, by October 2002, had deteriorated to a point where she could no longer work as an administrator.

In January 2005, Mrs Kirk's solicitors served a schedule of special damages claiming in excess of £800,000, with substantial sums in respect of past and future loss of earnings and care. In response, Mrs Walton made a Part 36 payment in February 2005 of £25,000 plus the benefits repayable to the Compensation Recovery Unit of approximately £9,000. The offer was not accepted.

Both parties instructed medical experts and reports were subsequently exchanged. Mrs Kirk's consultant physician and rheumatologist concluded that she had developed fibromyalgia and was significantly disabled. In her witness statement, she made no reference to any pre-existing health problems but said she now found it difficult to climb stairs; had weakness in her hands, wrists, arms, knees, shoulders and elbows; required a wheelchair and/or elbow crutches; was unable to drive a manual car and could not go shopping unaided.

However, video surveillance was obtained by Mrs Walton's insurers, showing Mrs Kirk driving, walking and shopping in her everyday life, without apparent difficulty. In light of the surveillance evidence, Mrs Kirk agreed to accept the payment into court out of time, although even after this Mrs Walton's insurers continued to obtain further surveillance evidence.

The claim was eventually settled in early 2007. However, Mrs Walton subsequently issued an application seeking Mrs Kirk's committal for contempt in November 2007.

The committal proceedings were heard by Mr Justice Coulson at the Liverpool High Court in March 2009. In his judgment, he stated that, "*Exaggeration of a claim is not, without more, automatic proof of contempt of court. What may matter is the degree of exaggeration (the greater the exaggeration, the less likely it is that the maker had an honest belief in the statement verified by the statement of truth) and/or the circumstances in which any exaggeration is made...*"

Having reviewed what he considered to be, essentially, 12 separate allegations of contempt, he rejected all but two (involving the filling out of claims for state benefits), giving the benefit of any doubt to Mrs Kirk. The Judge did not consider it appropriate to impose a custodial sentence, as this was not proportionate, nor appropriate given her physical and emotional state. However, he felt it necessary to deter such conduct, so he ordered her to pay £2,500 for the contempt. In relation to costs, since Mrs Walton had been unsuccessful in relation to all but two of her allegations of contempt, Mrs Kirk was only ordered to pay 50% of Mrs Walton's costs.

Walton v Kirk provides an important legal precedent for defendant insurers to use against fraudulently exaggerating claimants. However, insurers should ensure that considered and objective advice is obtained before issuing contempt applications, as they can prove costly where only partially successful.

POLICYHOLDER FRAUD ON JOINT AND COMPOSITE POLICIES

The courts treat joint and composite insurance policies very differently in matters where there has been a fraud on the part of the insured. Composite and joint insurance policies are those where the interests of two or more parties in the same subject matter are covered under the same insurance policy.

With composite insurance policies, the interests of the parties are separate and, if one of the parties commits a fraud, that will not affect the rights of the other parties under the policy. By contrast, under a joint insurance policy, if one of the parties commits a fraud, both of the parties will be adversely affected. The insurer will be able to avoid the joint policy.

Fraud Investigation

The difference in the treatment of joint and composite insurance policies can be seen in *Direct Line Insurance Plc v Khan & Another* [2001] EWCA Civ 1794 (which is also commented on at page 31) and *Arab Bank Plc v Zurich Insurance Company* [1999] 1 Lloyd's Rep 262.

***Direct Line Insurance Plc v Khan & Another* [2001] EWCA Civ 1794**

The Defendants, Mr and Mrs Khan, took out an insurance policy with the Claimants for their house and contents, against risks including fire. They were named as joint policyholders. Mr Khan submitted a fraudulent claim for rent for alternative accommodation after a fire at their home.

Having discovered the fraud, the insurers sought to recover all of the sums paid under the policy in respect of the fire. The insurers were successful in their application and the court rejected the argument that Mrs Khan could still recover under the policy. As the Defendants were joint policyholders, it did not matter that her husband, without her knowledge, had committed the fraud.

***Arab Bank Plc v Zurich Insurance Company* [1999] 1 Lloyd's Rep 262**

The Defendant insurers provided professional indemnity insurance to John D Wood Commercial Ltd (JDW), a company which carried out property valuations. The managing director of JDW had provided the Claimant bank with a series of excessive commercial property valuations. The Claimant had relied on these valuations and, as a result, it suffered a loss.

JDW went into liquidation and the Claimant sought an indemnity from JDW's insurers under the Third Party (Rights against Insurers) Act 1930. In its defence, the insurers contended they were entitled to avoid the policy on the basis that the managing director of JDW had acted fraudulently in completing the proposal form for the insurance policy and had also carried out the property valuations fraudulently.

The High Court disagreed with this argument, on the basis JDW had the benefit of a composite policy, which stated that the dishonesty of one director would not be held against another insured who was not a party to that dishonesty. Whilst the managing director of JDW had acted fraudulently, there were other JDW directors who were not a party to the fraud.

FRAUDULENT DEVICES

In *Konstantinos Agapitos & Another v Agnew & Others* [2002], the Court of Appeal considered the effect of a fraudulent device. Lord Justice Mance contrasted a fraudulent claim and a fraudulent device as follows:

"A fraudulent claim exists where the insured claims, knowing that he has suffered no loss, or only a lesser loss than that which he claims (or is reckless as to whether this is the case). A fraudulent device is used if the insured believes that he has suffered the loss claimed, but seeks to improve or embellish the facts surrounding the claim, by some lie."

***Konstantinos Agapitos & Another v Agnew & Others* [2002] 2 Lloyd's Rep 42**

The owners of a passenger ferry made an insurance policy claim after a fire. There was a condition in the policy regarding 'hot work', which became central to the dispute when court proceedings were started. On the pleadings, the insured asserted that hot works began on 12 February 1996. At a later stage in the proceedings, the insured disclosed signed witness statements from two workmen that said hot work had been carried out from 1 February 1996, which was significant to the policy condition regarding hot work. As a consequence of this development, insurers asked for permission from the court to amend the defence to allege fraud.

The request was denied by the court (and also on appeal). Following the principles in *Manifest Shipping* [2001], the court emphasised that, once proceedings were started, the parties were governed by the court rules and the rules of litigation.

Mr Justice Park noted that sometimes litigants lie to improve a good claim and said, *"Does he lose the case because he lied? The answer is: no. If his case is a good one anyway, he wins. It is deplorable that he lied, but he is not deprived of his victory in consequence."* He said the position was not different because the litigants were insured and insurer.

The Court of Appeal decided that the law relating to fraudulent insurance claims applied to the use of fraudulent means or devices to promote a claim, as well as a claim which was deliberately exaggerated from the outset. Using fraudulent devices was described as a sub-species of making a fraudulent claim, in that the claim could be forfeited; however, no question of avoiding the policy from the beginning arose. A fraudulent device was described as:

“...any lie, directly related to the claim to which the fraudulent device relates, which is intended to improve the insured’s prospects of obtaining a settlement or winning the case, and which would, if believed, tend, objectively, prior to any final determination at trial of the parties’ rights, to yield a not insignificant improvement in the insured’s prospects...”

However, although the insurers were unsuccessful in their request to amend the defence to allege fraud, the case was referred back to the trial Judge in the Commercial Court, who decided in favour of the insurer on the grounds the insured had, at the relevant time, been in breach of the hot work warranty.

The concept of fraudulent devices was considered later in *Eagle Star Insurance Co Ltd v Games Video Co (GVC) SA* [2004] 1 Lloyd’s Rep 238. Following the loss of the Defendant’s vessel, the Defendant provided Eagle Star with documents evidencing what the Defendant claimed were sums paid for the vessel. Eagle Star challenged the genuineness of the documents. It was established that the documents were false and the Defendant knew the vessel’s value was considerably less. The court decided that the insured had used fraudulent devices to advance their claim, with the intention and expectation that insurers would accept the documents at face value and pay the claim. Therefore, Eagle Star were entitled to avoid the policy contract, as well as being entitled to be discharged from liability due to the use of fraudulent devices.

Contrast this with the position in *Danepoint Ltd v Underwriting Insurance Ltd* [2005], where the Judge gave the “benefit of the doubt” to the insured in respect of a falsified invoice made out to the value of repairs which were justified, but had not actually been carried out.

The court’s approach to fraudulent devices is also seen in *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV & Another* [2004] EWHC 2632 (QB). Here, the Commercial Court responded favourably to the insured’s argument that an alleged failure by them to disclose certain information to an insurer did not constitute a fraudulent device, even though it dismissed their application to strike out or summarily dismiss this aspect of the insurer’s defence. Essentially, Mr Justice Cooke refused their application because Lord Justice Mance’s comments in *Agapitos* were incidental, rather than central, to the decision made in that case and because this was a developing area of the law, which made strike out/summary dismissal inappropriate. However, Mr Justice Cooke in *Marc Rich* expressly stated that *“were the matter to come before me at trial, my inclination would be to say that Lord Justice Mance is right in the approach that he has adopted”*, meaning he would prefer the insured’s arguments that non-disclosure during the insurer’s investigations did not constitute a fraudulent device.

In *Stemson v AMP General Insurance (NZ) Ltd* [2006] UKPC 30, the Privy Council allowed the insurer to rely on a fraudulent device defence. Following a fire at the insured property, the insured lied to the investigator about his intention to sell the property. That was a fraudulent device and remained so even though the insured admitted his true intention before the insurer’s rejection of the claims.

A recent case shows that submitting a fabricated document to an insurer does not necessarily constitute fraud. In *Direct Line Insurance Plc v Fox* [2009] EWHC 386 (QB), the Defendant policyholder had the benefit of a building and contents insurance policy. During the period of the insurance cover, a fire occurred in the kitchen of the house, which caused extensive damage to the property and its contents. The Defendant made a claim under the policy and the insurer accepted it.

The parties made a secondary written agreement, which provided that the settlement sum would be paid to the Defendant and then the VAT element for the work that was to be carried out at the property would be paid, subject to the Defendant providing the insurer with a VAT invoice.

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The Defendant provided the Claimant with a VAT invoice, which purported to be from the company which had carried out the work at the property. However, when the Claimant queried the authenticity of the invoice, the Defendant retracted it and said he did not wish to recover the VAT element under the claim.

On the basis of this invoice, the Claimant tried to rely on a condition under the buildings insurance policy that stated that, if any claim or part of a claim is made fraudulently or falsely, the policy would become void and all of the benefit under the policy will be forfeited.

The court held that the Defendant, in presenting the invoice to the Claimant, had simply submitted a misleading document in order to satisfy part of the secondary agreement and was, therefore, not entitled to recover that part of his claim. However, the Defendant's dishonesty did not have the effect that he would have to repay to the Claimant all of the sums which had already been paid to him under the insurance policy.

This case can be distinguished from *Direct Line Insurance Plc v Khan & Another* [2001] EWCA Civ 1794 and *AXA General Insurance Ltd v Gottlieb & Gottlieb* [2005] Lloyd's Rep IR 369, which are referred to in the earlier exaggerated claims section. In *Direct Line Insurance Plc v Fox* [2009], the claim had already been settled and the false invoice was provided in connection with the secondary written agreement. The case turned on its facts and should not be interpreted as a relaxation of the existing law on fraud.

Handling and assessing lies

As has been shown in both the law courts and in numerous surveys, many people are willing to lie to insurers. The *Agapitos v Agnew* case provides a powerful response to people who tell lies to insurers during the investigation of a claim. At a practical level, it is important for investigators to keep thorough and detailed records of their communications with insureds. Audio recordings are often useful. Wherever possible, verbal statements should be confirmed in written statements, signed if possible, or in confirmatory letters to the insured. Investigators' notes of conversations should be accurate, legible, timed and dated, and stored securely.

As was shown in the *Eagle Star v Games Video* case, fraudulent devices can take the form of fabricated documents. Accordingly, all documents received from the insureds or their representatives must be kept securely and with a record of when they were received. In addition to the storing and recording of communications, it is vitally important that such communications are reviewed in the light of material received subsequently. However, as Lord Justice Mance stressed in *Agapitos*, it is not every lie that will constitute a fraudulent device. Consequently, where lies are detected, their purpose and intended effect must be considered carefully.

PLEADING FRAUD

Details of the professional code of conduct rules which apply to a barrister who is asked by an insurer to plead fraud in court proceedings are set out at pages 6-7 (paragraphs 704 and 708 of Part VII of the Bar Standards Board Code of Conduct).

The Solicitors' Code of Conduct 2007 contains similar provisions. Rule 11.01(3) states:

"You must not construct facts supporting your client's case or draft any documents relating to any proceedings containing:

- (a) any contention which you do not consider to be properly arguable;*
- (b) any allegation of fraud unless you are instructed to do so and you have material which you reasonably believe establishes, on the face of it, a case of fraud."*

In addition, rule 16.4(1)(e) of the Civil Procedure Rules (CPR) and paragraph 8.2 of the Practice Direction which supplements CPR Part 16 provide that:

“The claimant must specifically set out the following matters in his particulars of claim where he wishes to rely on them in support of his claim: (1) any allegation of fraud...”

There is no specific corresponding provision in the CPR in respect of the drafting of the defence but rule 16.5(2)-(5) states:

“(2) Where the defendant denies an allegation [in the particulars of claim] –

(a) he must state his reasons for doing so; and

(b) if he intends to put forward a different version of events from that given by the claimant, he must state his own version.

(3) A defendant who –

(a) fails to deal with an allegation; but

(b) has set out in his defence the nature of his case in relation to the issue to which that allegation is relevant, shall be taken to require that allegation to be proved.

(4) Where the claim includes a money claim, a defendant shall be taken to require that any allegation relating to the amount of money claimed be proved unless he expressly admits the allegation.

(5) Subject to paragraphs (3) and (4), a defendant who fails to deal with an allegation shall be taken to admit that allegation.”

In view of rule 16.5(5), defendants should, where there is sufficient evidence to plead a positive case, state that their view is that, for instance, the accident (or other insured event) did not happen at all and set out the information relied on. Where there is insufficient evidence for this approach to be taken, at that stage, the alternative is to put the claimant to ‘strict proof’ of their pleaded allegations. This could include the claimant proving that the accident happened, and the circumstances in which the accident took place.

THE COURT OF APPEAL'S APPROACH TO A TRIAL JUDGE'S DECISION ON FRAUD

The Court of Appeal will be slow to reverse a decision which has been made by a trial Judge in respect of fraud. This point was made in *Gross v Lewis Hillman Ltd & Another* [1970] Ch 445. Here, Lord Justice Cross said that the court should not find someone fraudulent if the trial Judge, who has seen and heard that party, has acquitted them of fraud unless it is convinced the trial Judge was wrong. He said:

“A Court of Appeal is not entitled to disturb findings of fact made by the trial judge, which depend to any appreciable extent on the view that he took as to the truthfulness or untruthfulness of a witness whom he has seen and heard, and the Court of Appeal will not do so unless it is completely satisfied that the judge was wrong.”

INSURERS' STRATEGY IN DEALING WITH SUSPICIOUS CLAIMS

If insurers are confronted with a suspicious claim, it is likely to be easier for them to establish that part of a claim is exaggerated, than it is to establish that the whole claim has been concocted for the purpose of defrauding insurers. For example, alleging that a burglary has been staged by the insured for the purpose of making a false claim is a very serious allegation, with a correspondingly high standard of proof required. Alleging that one aspect of a claim has been inflated, or the claim has been artificially maintained, is less serious and may prove an easier allegation to sustain.

It may be that the insured provides an unlikely story to support their claim and that there is little evidence either to substantiate the claim or repudiate it. In this situation, rather than alleging fraud, it might prove a better approach for insurers to point out that it is for the insured to prove their claim and argue that they have not done so on this occasion.

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***Whitehead v Hullett* [1946] 79 Ll L Rep 410**

The court stated that the insured must provide reliable evidence to support his claim. In this case, the insured's company were defendants in a legal action in the Chancery Division of the High Court in London. The insured alleged that he had taken a diamond necklace with him in the inside pocket of his waistcoat when attending court. The courtroom was crowded and, when leaving, he said he checked his pocket to find that the necklace was not there. Insurers, rather than alleging fraud, denied that the insured had suffered any loss. The Judge agreed that the insured's story was unlikely and his claim failed.

Another advantage of this strategy is that it might avoid adverse publicity for insurers. A possible downside, however, is that where insurers successfully defend a claim on this basis, without proving fraud by the insured, it does not follow that they are entitled to, say, rescind the policy or recover damages.

In any case, insurers should tread carefully when they suspect fraud on the part of their policyholders, even where there appears to be good material to justify those suspicions. A premature or incomplete presentation of such suspicions may well jeopardise an insurer's position in a subsequent dispute with its policyholder.

Insurers should have clear and well-understood referral lines, so that claims or adjusting staff (whether they be internal staff or external suppliers) know when and to whom they should report suspicions about fraudulent activity. Ideally, insurers should have dedicated, specialist personnel to whom those suspicions can be reported, who understand the need for further investigation and how that should be conducted. Customer care departments should also be involved in order that they can respond appropriately to any complaints made by the policyholder who has become subject to suspicions and, possibly, an investigation (and who is likely to experience sudden delays in the processing of their insurance claim). Documentary or computerised underwriting files should be marked in order to prevent inadvertent renewal of cover while a fraud investigation or dispute is ongoing.

It is important that fraud investigations are undertaken by personnel who have genuine expertise in undertaking such work. It is a dangerous type of work in which to dabble. Insurers must have regard to complex legal, evidential, regulatory and reputational issues. A poorly conducted investigation may prejudice the insurer, impinge detrimentally on a criminal prosecution and leave fraudsters with ill-gotten gains. This need for specialist expertise applies at all stages of the process: to the insurer's internal claims handling and investigative management and staff; external investigators (often part of larger loss adjusting practices); forensic examiners; those charged with interviewing the policyholder and witnesses; public relations personnel; and solicitors and barristers.

Insurers have a high hurdle to clear in trying to prove allegations of fraud. Such allegations should be made sparingly. Judges and regulators understand the commercial challenges faced by insurers in trying to deal with fraudulent activity by policyholders. However, they also understand the seriousness of fraud allegations and that a finding of dishonest wrongdoing can have severe repercussions for a policyholder; not only might that person forgo the benefits of an insurance policy but a finding of fraud might also lead to a criminal prosecution, jeopardise the policyholder's employment and damage their reputation in their local community. The process of trying to persuade a Judge or the Ombudsman that a person has behaved in a fraudulent way starts as soon as suspicions arise. Evidence must be identified and secured. The policyholder must, as soon as reasonably practicable, be told of the insurer's concerns and be given an opportunity to respond and explain themselves.

Any temptation on the part of insurers to proceed rapidly and aggressively should be resisted. The evidence gathering process must be thorough. In suitable cases lawyers should be involved at an early stage to advise about the type of evidence that is likely to be required to prove allegations of fraud. The investigation should be carefully documented, as *the way* in which an investigation has been undertaken may well be focused on by any subsequent litigation or referral to the Ombudsman.

Whilst investigations should not be rushed, they must proceed as expeditiously as possible. Policyholders should not be left in a state of uncertainty. The insurer's detailed concerns and supporting material should be presented to the policyholder in writing at the very earliest practical opportunity. In that letter, the insurer should say what it is inclined to do (avoid the policy, reject the claim, perhaps claim back monies already paid to the policyholder) and give the policyholder a limited period of time (perhaps 28 days) to set out their detailed responses in writing. The matter can be reviewed at the end of that period and, at that stage,

the insurer may be in a position to give its decision to the policyholder, and possibly to seek remedies against the policyholder, e.g. a claim for monies paid out on the fraudulent claim.

A robust, but not aggressive, response to apparently fraudulent activity is likely to find favour with a court and with the Ombudsman; it also reflects the requirements of the Financial Services Authority (FSA) in its Treating Customers Fairly initiative. An unnecessarily aggressive stance, which is lacking in candour and which does not give the policyholder a proper opportunity to put their side of the story, may lead to criticism by the FSA or Ombudsman and avoidable adverse publicity. It may also lead to adverse costs orders in litigation.

It is advisable for lawyers to be involved by the stage at which the insurer can set out its concerns and intended response to a policyholder. Such correspondence is likely to be subjected to detailed examination in any subsequent litigation or referral to the Ombudsman. It is important for an insurer's arguments in litigation to be consistent with the concerns expressed to a policyholder. Inconsistency may suggest to the policyholder (and to the Judge or Ombudsman) muddled thinking and uncertainty on the part of the insurer. It is also important for the insurer to seek from the policyholder remedies to which it is actually entitled.

As part of this broad process, the appointed lawyers have, essentially, three roles: to examine critically the material on which the insurer has based its concerns and complaints; to advise the insurer about the merits of those concerns and complaints; and to advise on the remedies that might be available to the insurer.

DUTY OF DISCLOSURE

Dealing with fraud effectively involves identification and prevention at the earliest opportunity.

There may have been a fraudulent breach of the duty of utmost good faith at the application stage. The prospective insured has a duty to disclose – to provide information relevant to the underwriting of a risk.

If the Law Commission's proposals for reform become statutory law, then consumers who apply for insurance will not need to volunteer material information. Rather, the emphasis will be on consumer applications containing clear questions, which could include a general 'sweeper' question. Business applicants will still, under the proposed reforms, have to disclose information voluntarily on matters that are material.

Pending any statutory reform, the leading authority on the test for non-disclosure is *Pan Atlantic Insurance Company Ltd & Others v Pine Top Insurance Company* [1994] 3 WLR 677, which applied a test that can be analysed in two parts:

1. Materiality

The House of Lords approved the test for materiality previously laid down by the Court of Appeal in *CTI v Oceanus* [1984] 1 Lloyd's Rep 476:

"Everything is material to which a prudent insurer, if he were in the proposed insurer's place, would wish to direct his mind in the course of considering the proposed insurance with a view to deciding whether to take it up and on what terms including premiums."

This is the objective element of the test.

A fact can be material even if the prudent underwriter would still have accepted the risk on the same terms and at the same premium had they known the information which had not been disclosed.

The materiality test has been somewhat criticised in practice because an applicant may not know how the insurer will think. Details of the possible new test under the likely reforms, which is based on a reasonable insured, are set out below.

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2. Inducement

The second part of the current test, prior to any reforms, is that the non-disclosure must have induced the actual underwriter who wrote the risk to enter into the contract. In other words, there is a subjective element to the test. The effect is that an insurance contract cannot be avoided when the underwriter concerned paid no attention to the matters not properly stated and disclosed and, therefore, suffered no injustice because of it.

In the case of *St Paul Fire and Marine Co (UK) Ltd v McConnell Dowell Constructors Ltd & Others* [1995] 2 Lloyd's Rep 116, Lord Justice Evans said:

“As regards inducement, it is common ground that the insurer must prove that he was induced by the non-disclosure or misrepresentation to enter into a contract on terms which he would not have accepted if all the material facts had been made known to him...”

In November 2002, the Court of Appeal commented on the meaning of inducement in *Assicurazioni Generali SpA v Arab Insurance Group (BSC)* [2002] EWCA Civ 1642. Leave to appeal to the House of Lords was refused.

The relevant principles of inducement are summarised in the judgment of Lord Justice Clarke, as follows:

- In order to be entitled to avoid a contract of insurance or reinsurance, an insurer or reinsurer must prove, on the balance of probabilities, that he was induced to enter into the contract by a material non-disclosure or by a material misrepresentation.
- There is no presumption of law that an insurer or reinsurer is induced to enter into the contract by a material non-disclosure or misrepresentation.
- The facts may, however, be such that it is to be inferred that the particular insurer or reinsurer was so induced, even in the absence of evidence from him.
- In order to prove inducement, the insurer or reinsurer must show that the non-disclosure or misrepresentation was an effective cause of his entering into the contract on the terms on which he did. He must, therefore, show at least that, but for the relevant non-disclosure or misrepresentation, he would not have entered into the contract on those terms. On the other hand, he does not have to show that it was the sole effective cause of his doing so.

In his dissenting judgment, Lord Justice Ward indicated that he was concerned with the suggestion that the non-disclosure or misrepresentation had to be an effective cause, saying that if an underwriter's mind is disturbed by the non-disclosure or misrepresentation the inducement test is satisfied. His view was that any reason is sufficient if it has an actual influence on the decision taken.

It is essential, therefore, under the law developed by court judgments prior to any statutory reform, to consider materiality and inducement before deciding to avoid the policy due to non-disclosure or misrepresentation. It is important to obtain a view of the facts from an underwriter, ideally the underwriter who assessed the case in the first place, if possible. However, where that is not possible, a senior underwriter should be asked for a specialist view based on the underwriting guide or practice that applied at the time of the original proposal.

As stated at page 27, if the proposed statutory reforms take place in 2010/11, then we will be talking about material misrepresentation, rather than material non-disclosure or misrepresentation. The prudent insurer materiality test has been criticised because applicants do not necessarily know how insurers think. Accordingly, the Law Commission has proposed that a new statutory test based on a reasonable insured is introduced, in place of the prudent insurer part of the test. At this stage of the consultation process for reforms, it is believed that the proposed new test will be as follows:

The insurer must show that:

- The consumer made a misrepresentation, i.e. a statement that is inaccurate or misleading
- Which induced the insurer to enter into the contract on those terms or at all *and*
- A reasonable person in the circumstances would not have made the representation

Specifying what circumstances will be taken into account is a difficult issue but it appears that the intention of the reforms will be to look at the normal range of circumstances, not the extremes. The Law Commission proposed that the test should be an objective one, looking at issues that apply to normal consumers in the market, including the way the policy was advertised and sold and the type of policy. Additionally, it proposed that issues such as age or knowledge of English could be taken into account, so far as these matters were actually known by the insurer, but this raised practical concerns from many during the consultation process.

It remains to be seen how the Law Commission will ultimately address these points in the draft Consumer Insurance Bill, to be published at the end of 2009. The Law Commission will seek to formulate a test for what amounts to a reasonable misrepresentation. In terms of business applicants/policyholders, this will be the default regime, unless the business applicant/policyholder and the insurer agree to a different approach.

UNDERWRITING

Under the law that applies prior to any Consumer Insurance Act, when considering a claim where non-disclosure or misrepresentation may be a feature, the claims assessor should pay particular attention to the chronology of events to discover the true facts. The insurer must consider carefully the precise wording of the questions on the proposal form and the answers given to them. An insurer may avoid policies where it believes non-disclosure or misrepresentation of a material fact has taken place, but must be prepared to justify that decision in court or to the Ombudsman, if necessary. The burden of proving misrepresentation or non-disclosure rests with the insurer.

The ABI Statement of Long-Term Insurance Practice imposed an obligation on insurers to ask clear questions in proposal forms on all matters commonly found to be material (see paragraph 1.1 (d)). However, that Statement was superseded, in part, by Financial Services Authority (FSA) regulation in 2004, and is now simply an annex to the 2006 ABI Guidance on Application Form Design for Life and Health Protection Insurances. The ABI Statement of Long-Term Insurance Practice is now available from the ABI for research purposes only, because it has been withdrawn as a Statement.

Up to 5 January 2008, the Insurance Code of Business rules (ICOB) in the FSA Handbook provided that insurers must take reasonable steps to communicate in a way that was clear, fair and not misleading (see ICOB 2.2.3R and ICOB 3.8.1R).

From 6 January 2008, the Insurance New Conduct of Business sourcebook rules (ICOBS) apply and the old ICOB 2.2.3R and 3.8.1R have been replaced by ICOBS 2.2.2. In particular, the guidance at ICOBS 5.1.4 now states that:

“Ways of ensuring a customer knows what he must disclose include ... (2) ensuring that the customer is asked clear questions about any matter material to the insurance undertaking.”

Under the Law Commission's proposed reforms, it is suggested that business applicants will have to disclose information voluntarily on matters that are material but that the consumer regime will be more favourable, so that consumer applicants will need to answer the questions posed by insurers at the application stage, as referred to at page 45. Comments regarding the proposed distinction between consumer and business insurance are set out at page 53.

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The examples below illustrate some common issues, under the law that applies prior to any Consumer Insurance Act, for insurers in connection with proposal forms:

Avoid the questions in proposal forms being too limited

In a motor policy, an applicant was asked:

“How many accidents have you had in the last three years?”

The applicant answered *“none”*.

An accident 3½ years previously would be material. Will it be implied that the insurer did not want to know about it?

TEST: The test is *“would a reasonable man reading the proposal be justified in thinking the insurer had restricted its right to receive all material information, and agreed to not be told about accidents more than three years previously?”*

It is probable that quoting specific periods will limit the need to disclose.

Ambiguous questions

In a motor proposal, the applicant was asked:

“Have you or any of your drivers ever been convicted of any offence in connection with the driving of any motor vehicle?”

The applicant answered *“No”*.

He did not disclose that he had been convicted of unlawfully using a vehicle without having third party insurance (and using a vehicle without a suitable reflecting mirror!).

TEST: The test, which was applied, was *“is the answer true, having regard to the construction which a reasonable man may apply and which the applicant did in fact apply?”*

In that particular case, the court accepted that the question was ambiguous and it could reasonably be interpreted to cover offences such as careless or reckless driving, rather than offences committed whilst the car was stationary. Therefore, the answer was found to be true.

Unanswered questions

If the insurer does not make any further enquiries about an unanswered question but simply issues the policy, it may have given up its rights to avoid in respect of non-disclosure of the true answer unless it is obvious that the applicant intended a blank to mean *“no”*.

Incomplete answers

These are more likely to arise if there are several questions together. This should be avoided by separating and numbering each point.

In a life assurance proposal, the applicant was asked:

“Have you made any previous proposals to any other office or offices and were they accepted or refused?”

The applicant answered that he had been *accepted* by two offices. However, although that was correct information, it inferred that he had never been declined, whereas he had, in fact, been *refused* by five other offices.

The above question should also have asked for details of the specific types of cover and whether special terms had been applied.

Incomplete answers have been hotly debated during the Law Commission's consultation process for reform. It appears that the Law Commission acknowledges that there may be misrepresentation by omission (i.e. failing to answer a question fully). An answer may be literally accurate but may still amount to misrepresentation by being incomplete.

Whether insurer 'put on enquiry'

In a motor policy, the applicant was asked:

"How many accidents have you had in the last eight years?"

If the applicant answered '*details unavailable at present*' and no more enquiries were made, insurers could be found to have waived disclosure of all accidents.

The applicant's opinion on whether a fact is material is not generally considered

TEST: In the context of medical matters, the test is whether "*a reasonable and cautious person unskilled in medical science, and with no special knowledge of the law and practice of insurance, would believe that fact to be of any materiality or in any way calculated to influence the insurers in considering and deciding on the risk.*"

In *Life Association of Scotland v Foster* [1873], the insurers failed to prove material non-disclosure of a swelling in the groin at the date of the proposal. The applicant had a slight swelling in the groin. She did not find it painful, nor did it result in any uneasiness. She had *not* mentioned it at the medical examination. Applying the above test, the court held that there was no material non-disclosure, despite the fact that to a 'medical man' it would have indicated a rupture, which could have endangered her life.

Allegedly incorrect medical advice is still disclosable

In *British Equitable Insurance Co v Great Western Railway* [1869] 20 LT 422, an applicant did not disclose to insurers that, due to swelling of the feet, he had obtained a specialist opinion, and that the specialist's opinion was that he was in a dangerous state of health. The applicant's GP had previously told the applicant that the opinion was wrong.

A short period after the policy incepted, the man died of heart disease. The policy was avoided *ab initio* due to material non-disclosure. The court decided that the specialist's opinion should have been disclosed, even if it were wrong.

DURATION OF DUTY OF DISCLOSURE

The duty of disclosure, prior to any statutory reform, extends beyond the date of completion of the proposal form to the date of commencement of the policy, at which point the insurer and policyholder enter into a contract that is legally binding on both parties. In some cases, the policy may not come into effect and the cover does not start until the first premium is paid, in which case the duty of disclosure will continue until then. The extension of the duty of disclosure should be brought to the attention of the policyholder in the acceptance letter, the policy and on renewal.

The Law Commission's stance during the consultation process for reform has been that, when a consumer applicant becomes aware that a statement they have made has become incorrect, they should continue to have a duty to inform the insurer. The insurer should have a remedy if the applicant unreasonably or dishonestly fails to notify the insurer of the change. The Law Commission has proposed that warnings given by the insurer be taken into account when considering whether the applicant has

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acted unreasonably. In addition, the Law Commission has not suggested any change to the current law under which the insurer can include an express term in the policy contract that it wishes to receive notification of changes or new material information after the policy contract has been agreed. The express term would be subject to scrutiny under the Unfair Terms in Consumer Contracts Regulations 1999.

The recent case of *Ansari v New India Assurance Ltd* [2009], involved the interpretation of a clause that the policy would cease if there was any material alteration to the property or any material change to the facts stated in the proposal form.

***Ansari v New India Assurance Ltd* [2009] EWCA Civ 93**

The proposal form asked whether there was an automatic sprinkler system for the property and requested details. The applicant answered yes but did not provide any details about the sprinkler system. A subsequent fire claim was rejected by insurers and the policy was cancelled because the sprinkler system had not been working at the time.

The court found that the tenant had turned off the sprinkler, closed the valve at the main water supply and placed a cabinet against the control handle, so as to prevent it being opened. Furthermore, the water supply had been cut off due to the tenant's failure to pay. This did not simply amount to the sprinkler being switched off temporarily for maintenance, repairs or to prevent damage from a leak. In the circumstances, the property could not be said to have a properly functioning automatic sprinkler system. There was also evidence that the property owner was aware the sprinkler system had been turned off indefinitely and no longer provided the protection stated in the proposal form.

The court held that the information in the proposal form meant, in effect, that there was a properly functioning sprinkler system that was ready to operate in the event of a fire.

A properly functioning sprinkler system was of concern to insurers and turning it off amounted to a material change to the facts stated in the proposal form, so that the clause could be relied on to end the policy. The purpose of that clause was to protect insurers from alterations to the property or material alterations in the facts in the proposal form.

The concept of 'material' is different once the policy cover is in force. It was necessary for the court to assess whether there had been an alteration which would 'have a significant bearing on the risk'. The facts would have to change to the extent that the risk was outside that which was contemplated at inception of the policy cover.

The Court of Appeal decided that the subject matter of the insurance had been materially altered. Therefore, the clause operated to end the policy cover and the claim could be declined. This appears to be an option, with a suitably worded clause, despite there not being arguments in respect of a specific policy warranty or material non-disclosure/misrepresentation at the application stage.

REMEDIES AVAILABLE TO INSURERS

The insurer must decide whether to avoid the policy from the beginning, or allow the policy to stand, within a reasonable time of discovering the breach of good faith. If the insurer fails to make this decision within a reasonable period of time, the insurer may be assumed to have decided to waive its rights. In the next section, we deal with the steps insurers should take to protect their position and avoid inadvertently waiving their rights or reducing the options available to them.

In the absence of any contractual wording to the contrary, it is an either/or situation; either the contract is avoided from the beginning or the contract is affirmed as a whole.

The strict legal remedies available to the insurer, prior to any statutory reform, for the least and most severe forms of pre-contract breach of good faith can be summarised as follows, and details of the proposals for reform are set out later in this section.

	Pre-contract: innocent breach by insured	Pre-contract: fraudulent breach by insured
Right to avoid the policy as a whole	Yes	Yes
Right to keep the premium	No	Yes
Claim damages	No	Yes
Ignore breach and affirm contract by allowing the policy to stand	Yes	Yes
Refuse a particular claim but allow the policy contract to stand	No	No
Recover claims paid	Yes	Yes

Recovery of management time investigating fraudulent claims

As part of the remedies available to insurers, damages for the recovery of internal overheads, management and staff time expenses where time has been spent investigating a fraud can currently be recovered from a fraudster. To be able to recover, the insurer has to show that, as a result of the investigation, there has been a significant disruption to the business to the extent that the staff had been significantly diverted from their usual activities. To assist, the insurer should keep a fully detailed written record of the time spent investigating the fraud.

***R+V Versicherung AG v Risk Insurance & Reinsurance Solutions SA & Others* [2006] EWHC 42 (Comm)**

The claimant insurance company brought an action against the defendant brokers and underwriting agencies. Acting without authority, Mr Gebauer, who was a senior underwriter at the claimant insurer, granted two binding authorities (binders) to the First Defendant, to write contracts of insurance in the London market on its behalf.

Mr Gebauer kept the binders away from the knowledge of the Claimant. However, a few years later, a new director joined the claimant insurance company and this led to the binders being discovered.

It was held that Mr Gebauer and Mr Chalhoub on behalf of the defendant company had, as a result of a dishonest conspiracy, entered into the binders without the Claimant's authority and the Claimant was justified in terminating the binders.

In relation to quantum, provided the Claimant could show that the investigation had caused significant disruption to the business, it was held that it could recover the costs of wasted time spent on the investigation and mitigation of the tort. Wasted costs could be recovered notwithstanding that no additional expenditure or loss of revenue or profit could be shown.

Financial Services Authority (FSA) regulation

The ABI Statement of Long-Term Insurance Practice applied to long-term insurances of policyholders resident in the UK and insured in their private capacity only. It was superseded, in part, by Financial Services Authority (FSA) regulation in 2004, and is now an annex to the 2006 ABI Guidance on Application Form Design for Life and Health Protection Insurances. However, the Statement is now available from the ABI for research purposes only, because it has been withdrawn as a Statement on the grounds that the issues are now handled by the Financial Ombudsman Service (FOS). Paragraph 3.1 of the Statement stated:

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“An insurer will not unreasonably reject a claim. In particular, an insurer will not reject a claim or invalidate a policy on grounds of non-disclosure or misrepresentation of a fact unless:

- (i) It is a material fact; and*
- (ii) It is a fact within the knowledge of the proposer; and*
- (iii) It is a fact which the proposer could reasonably be expected to disclose.*

(It should be noted that fraud or deception will, and reckless or negligent non-disclosure or misrepresentation of a material fact may, constitute grounds for rejection of a claim.)”

The ABI Statement of General Insurance Practice was entirely replaced by the statutory regulation of general insurance by the FSA from 14 January 2005. ICOB 7.3.6(1) and (2)(a) and (b) provided:

“An insurer must not:

- (1) unreasonably reject a claim made by a customer;*
- (2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds:
 - (a) of non-disclosure of a fact material to the risk that the retail customer who took out the policy could not reasonably be expected to have disclosed;*
 - (b) of misrepresentation of a fact material to the risk, unless the misrepresentation is negligent.”**

ICOB 7.3.6R applied equally to long-term insurances as well. However, the Insurance Conduct of Business rules (ICOB) ceased to be in force after 5 January 2008.

(Under ICOB, a retail customer was defined as an individual acting for purposes outside his trade, or business or profession. A commercial customer was defined as anyone who was not a retail customer. FSA guidance suggested that would include someone insuring a buy-to-let property but there was scope for confusion. Under ICOB, a commercial customer would be treated “as if retail” if it was not clear what the customer’s status was at the time when those rules should have been complied with or when a customer was covered “in both a private and business capacity”.)

From 6 January 2008, the Insurance New Conduct of Business sourcebook rules (ICOBS) apply and old ICOB 7.3.6R has been replaced by ICOBS 8.1.1(3) and ICOBS 8.1.2(1) and (2).

ICOBS 8.1.1 provides:

“An insurer must:

- (1) handle claims promptly and fairly;*
- (2) provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress;*
- (3) not unreasonably reject a claim (including by terminating or avoiding a policy); and*
- (4) settle claims promptly once settlement terms are agreed.”*

ICOBS 8.1.2 states:

“A rejection of a consumer policyholder's claim is unreasonable, except where there is evidence of fraud, if it is for:

- (1) non-disclosure of a fact material to the risk which the policyholder could not reasonably be expected to have disclosed; or*
- (2) non-negligent misrepresentation of a fact material to the risk; or*
- (3) breach of warranty or condition unless the circumstances of the claim are connected to the breach and unless (for a pure protection contract):*
 - (a) under a 'life of another' contract, the warranty relates to a statement of fact concerning the life to be assured and, if the statement had been made by the life to be assured under an 'own life' contract, the insurer could have rejected the claim under this rule; or*
 - (b) the warranty is material to the risk and was drawn to the customer's attention before the conclusion of the contract.”*

(A consumer, under ICOBS 2.1.1(3), means any natural person who is acting for purposes outside his trade or profession. The FSA clarifies this in ICOBS Guidance 2.1.3, by stating that if a customer is acting in the capacity of *both* a consumer and a commercial customer in relation to a particular contract of insurance, the customer is a commercial customer. However, under ICOBS 2.1.2, where the customer status in a particular case is simply uncertain whether the customer is a consumer or a commercial customer, a firm must treat the customer as a consumer.)

Steps towards reform

The perceived harshness of avoidance of the policy from the beginning where an applicant (particularly a consumer) has committed an innocent non-disclosure or misrepresentation is one of the factors that prompted the Law Commission's law reform reviews since 2006.

From January 2008, long-term protection insurers who are members of the ABI or Lloyd's have followed the ABI's Guidance on Non-Disclosure and Treating Customers Fairly: Claims for Long-Term Protection Insurance Products, which, amongst other things, promotes proportionate remedies. From January 2009, this became a mandatory ABI Code.

Turning to the Law Commission reforms, the Law Commission recognised that the FOS was adopting proportionate remedies but that only some cases fell within the jurisdiction of the FOS.

Proportionate remedies had been considered by the Law Commission in 1980 but were regarded as unworkable. The current Law Commission sees the force in introducing them through statute and a draft Consumer Insurance Bill is anticipated at the end of 2009.

The Law Commission had provisionally proposed that the status of consumer should apply to all individuals who entered into an insurance contract wholly or mainly for purposes unrelated to their business. It has considered the dilemma of mixed use policies, as its approach of looking at the main purpose of the insurance contract is different to that of the FSA (as described above in relation to ICOBS Guidance 2.1.3). It remains to be seen how consumers will be defined in the draft Consumer Insurance Bill expected at the end of 2009.

The rationale behind the overall proposals for reform is that the remedies should differ according to the conduct of the insured, and that they should aim to compensate by putting the applicant in the position they would have been in if full and accurate information had been provided at the application stage. Therefore, where there has been innocent misrepresentation, the claim should be paid and the policy remain in force; where there has been negligent misrepresentation, a proportionate remedy (detailed

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below) should apply; and, where the insured has committed deliberate/reckless misrepresentation (which is the terminology preferred to the emotive use of fraud), the remedies currently available should stand, as this is the most serious conduct.

The proportionate remedies would, under the reform proposals, depend on what would have happened if the insurer had known the full and accurate information at the application stage. Examples are set out below:

- If the insurer would not have accepted cover at all, the insurer can avoid the policy from the beginning, return the premiums and reject any claim.
- If the insurer would have accepted cover but at an increased premium, the insurer should pay a proportion of the claim, in line with the under-payment of premium. Therefore, if the premium actually charged was 50% less than it would have been had full disclosure been given, only 50% of the claim would be paid.
- If the insurer would have excluded a particular type of claim, the insurer should be obliged to pay claims that fall within that exclusion.
- If the insurer would have imposed a warranty or excess, the claim should be treated as if the policy included that warranty or excess.

The Law Commission has provided the following comments, as part of the consultation process for reform, in terms of the three categories:

Honest and reasonable (innocent)

The applicant honestly and reasonably thought that the information stated inaccurately or not disclosed was not material. Additionally, situations where, for example, the applicant was merely passing on information from, say, a surveyor and, therefore, had reasonable grounds for believing it was true, should also come within this category.

The Law Commission has proposed that the burden should be on the insurer to show that a consumer applicant who made a misrepresentation did so unreasonably.

Honest but not careful (negligent)

The applicant failed to take sufficient care to understand what the insurer wanted to know or to check their facts. Put another way, the insured did not show the degree of care required.

Dishonest (deliberate/reckless)

The applicant knew that the statement was untrue (or realised that it might be not true and did not care); and

The applicant knew that the statement was material to the insurer (or realised that it might be material and did not care whether it was or not).

OR

The applicant knew the statement to be untrue, or was reckless as to whether or not it was true; and

The applicant knew it to be relevant to the insurer, or was reckless as to whether or not it was relevant.

These two draft formulations are very similar to each other. One uses the phrase 'did not care', whilst the other uses 'reckless', which the Law Commission has regarded in the consultation paper as synonymous. Additionally, one uses the word 'material', whereas the other uses 'relevant'. It appears that the Law Commission may prefer to use relevant, as 'material' has become a term of art in insurance law, as described at page 45.

In terms of business insurance, these proposed remedies would be the default regime under the possible reforms, if the insured and insurer had not agreed other terms or other consequences. The Law Commission proposed that the business insured and insurer could contract out of the default regime by the policy or accompanying document containing a written term that either:

- The insurer would have specified remedies for misrepresentation even if the applicant was not dishonest or careless in giving information.
- The applicant warrants that specified statements are correct.

However, it is proposed that businesses cannot contract out of the proposal to abolish 'basis of contract' clauses. These are dealt with at page 57.

WAIVER AND ESTOPPEL

Insurers must take great care not to waive (i.e. give up) their entitlement to avoid the contract. This includes being careful to check their policy wording does not dilute the effect of the insurers' remedies if that is not their intention. When non-disclosure or misrepresentation is first discovered (and this may be prior to a loss occurring under the policy), the insurer must not act in such a way as to give the policyholder the impression that the contract is continuing. For example, if the insurer accepts renewal premiums whilst considering what action is to be taken, it is highly likely to have waived its entitlement to avoid the policy.

As stated earlier at page 48, another circumstance in which an insurer may be taken to have waived its rights is if a question on the proposal form is not answered at all and the insurer does not query it; similarly, if an answer is obviously incomplete. The insured is required to present the risk fairly, which means they should disclose accurate details.

Where a policy is voidable from the beginning and the insurer elects to treat the policy as void, all premiums should be returned to the policyholder, on the basis that there is no contract and no risk has been run. When there is fraud, however, the insurer can keep the premiums.

The insurer can waive their right to any or all of the remedies and allow the contract to remain in force. Within a reasonable time of discovering the breach of good faith, the insurer must decide to avoid or affirm the contract. If it does not do so, it will be assumed that the insurer has decided to waive its rights. As a general guideline, two to three months is a reasonable period. After, for example, six months without a decision, the insurer may be at risk of having waived its rights. However, this will all depend on the facts of each case.

The first method of protection when faced with a suspicious claim is to write a reservation of rights letter. If this is sent too early, it may alert the insured that all is not well and they may modify their activities, which could be prejudicial to the activities of an enquiry agent.

Insurance Corporation of the Channel Islands & Another v The Royal Hotel Ltd & Others [1998] Lloyd's Rep IR 151

The court stated that the important criteria for waiver in the insurance context is that insurers *cannot* be taken to have waived any breach of duty by the insured unless the insurer has *communicated* with the insured in such a way that he *appreciates* that the insurer was aware of the breach and it did not intend to rely on its rights in relation to it.

If the insurer elects to avoid the policy, it must not do anything which could be regarded as affirming the contract, e.g. accepting premium payments. Accordingly, insurers need to have reliable systems in place to warn against accepting any future premium payments. Enquiries to different divisions need to be channelled to a nominated person (or the in-house legal department) to avoid inappropriate comments or actions.

Estoppel is an equitable remedy devised by the courts. The insurer can be estopped from an action if the insured has detrimentally relied on something the insurer has done.

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However, the courts will not grant an equitable remedy to a person who comes to the court without 'clean hands', such as in the case of fraud.

BASIS OF THE CONTRACT

Rather than relying only on the duty of good faith, the insurer may be able to achieve a similar result (but without having to return the premium) by asserting breach of a contractual warranty. Again, care needs to be taken to ensure that any modifications in wordings to the strict legal remedy for breach of warranty do not go further than insurers intend.

The declaration at the end of the proposal form may be to the effect that answers are true or true *"to the best of my knowledge and belief"* and the proposer declares that the information given in the proposal form is true and complete and forms *"the basis of the contract"*.

The importance of declarations of this nature is that they very often constitute a warranty; that is to say, a term which the parties intended to be fundamental to the contract. Whether there has been a breach depends on the facts of the case and the extent to which the declaration is qualified. Where insurers use a 'basis of contract' clause in proposal forms, and the policy incorporates the proposal by reference, the declaration will be a warranty. A warranty has the effect of guaranteeing the answers in a proposal form to be true and complete matters of fact. Any breach, no matter how trivial (i.e. any incorrect answer), and irrespective of whether it relates to a material fact, may entitle the insurer to repudiate liability from the date of the breach.

In this way, an insurer avoids the need to prove that a particular question (and answer) in the proposal form is material. The exact wording of the declaration included in the proposal form must be considered in each case. It is common for the declaration to be in terms that answers are made *"to the best of my knowledge and belief"* and also to affirm the complete disclosure of all material facts known to the policyholder. The use of the phrase *"to the best of my knowledge and belief"* releases the policyholder from providing a warranty about facts of which he has no knowledge. Reform of the law in this area has been recommended by the Law Commission, further details of which are set out at the end of this section, but for the time being such warranties remain legally enforceable.

The FSA Handbook provided, up to 5 January 2008, at ICOB 7.3.6R that:

"An insurer must not:

- (1) unreasonably reject a claim made by a customer;*
- (2) except where there is evidence of fraud, refuse to meet a claim made by a retail customer on the grounds...*
 - (c) in the case of a general insurance contract, of breach of warranty or condition, unless the circumstances of the claim are connected with the breach; or*
 - (d) in the case of a non-investment contract which is a pure protection contract, of breach of warranty, unless the circumstances of the claim are connected with the breach and unless:*
 - (i) under a life of another contract, the warranty relates to a statement of fact concerning the life to be assured and that statement would have constituted grounds for rejection of a claim by the insurer under ICOB 7.3.6R (2)(a) or (b) if it had been made by the life to be assured under an own life contract; or*
 - (ii) the warranty is material to the risk and was drawn to the attention of the retail customer who took out the policy before the conclusion of the contract."*

However, from 6 January 2008, this has been replaced by the Insurance New Conduct of Business sourcebook rules (ICOBS) which state, at ICOBS 8.1.1(3), that an insurer must “*not unreasonably reject a claim (including by terminating or avoiding a policy)*” and, at ICOBS 8.1.2, that:

“A rejection of a consumer policyholder’s claim is unreasonable, except where there is evidence of fraud, if it is for ...

(3) breach of warranty or condition unless the circumstances of the claim are connected to the breach and unless (for a pure protection contract):

(a) under a ‘life of another’ contract, the warranty relates to a statement of fact concerning the life to be assured and, if the statement had been made by the life to be assured under an ‘own life’ contract, the insurer could have rejected the claim under this rule; or

(b) the warranty is material to the risk and was drawn to the customer’s attention before the conclusion of the contract.”

The Law Commission, in its Issues Paper 1 of September 2006 regarding reform, tentatively proposed that ‘basis of contract’ clauses should be ineffective to make all the answers given by the insured into warranties. This proposal would be mandatory for consumer insurance and, in relation to businesses, it was proposed that incorrect answer would not give rise to a remedy for breach of warranty unless there was an express term in the policy contract itself stating that, rather than simply a ‘basis of contracts’ clause in the proposal form. Comments regarding the proposed distinction between consumer and business insurance are set out at page 53.

WARRANTIES

A warranty is a fundamental term in the insurance contract which, if broken, can entitle the insurer to repudiate the policy (i.e. the policy ends) from the date of the breach, even though the breach is not material to the risk or any loss that has occurred.

There are various types of warranty. Warranties regarding the truth of statements in the proposal form are referred to at page 56, but these have been criticised by the Law Commission during the consultation process for reform of insurance contract law. Warranties can involve a continuing obligation: for example, agreeing a burglar alarm will be kept fully operational or that a sprinkler system will be periodically checked.

Where the circumstances surrounding a fire or theft are suspicious, the policy warranties should also be considered to establish whether there is evidence that a warranty has been breached, entitling the insurer to treat itself as discharged from liability under the policy from the date of breach and, effectively, terminating the contract (*The Good Luck* [1992] 1 AC 233).

***Printpak v AGF Insurance Ltd* [1999] 1 All ER (Comm) 466**

This case demonstrates that care must be taken when drafting policy wording, particularly in respect of composite insurance. Here, a factory owner claimed under a ‘commercial inclusive policy’ following a fire. Insurers repudiated liability alleging, amongst other things, arson. The burglar alarm had not been switched on at the time of the fire, in breach of a warranty. However, when asked to decide whether the burglar alarm warranty applied, the court decided that, due to the wording of the policy, that warranty only applied to Section B of the policy, which concerned theft – not Section A, which concerned fire.

The policy was divided into a number of sections, each of which related to a particular risk. The burglar alarm warranty was an endorsement. The endorsements were all stated in terms to be “*operative as stated in the policy schedule*”. This meant that the endorsement was incorporated into the relevant section (Section B theft) and not the other sections. As the endorsement was not in Section A, it could not be applied in this case. It was also described as a “*section endorsement*”.

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Insurers unsuccessfully tried to rely on s.33(3) of the Marine Insurance Act 1906, asserting that any breach of a warranty entitled the insurer to avoid the policy. Although the court accepted that the policy was a single contract, it said that the policy was not necessarily seamless. It regarded the form and wording to result in the outcome that the burglar warranty only applied to the section dealing with theft.

The same obligation can be phrased in different ways. For example, a consumer may 'warrant' to fit (and use) a mortice deadlock and this may be regarded as a warranty. However, if the policy stated that burglary claims were excluded unless a mortice deadlock was fitted (and in use) at the time of the loss, this would be treated as a temporal condition. The effect would be the same because, as long as the insurer could show that the lock was not in use when the burglary occurred, the insurer could refuse the claim. It would not be necessary for the insurer to show that the lack of a lock made any difference.

The Law Commission's thoughts on how to address warranties have changed during the consultation process. In relation to consumer insurance, it proposes that breach of a warranty in the strict sense (rather than a temporal condition) should not entitle an insurer to reject a claim unless the circumstances of the claim were connected with the breach. This is already the position under FSA rule ICOBS 8.1.2(3).

Consumer policyholders could seek protection in relation to, for example, temporary conditions that have a similar effect, under the Unfair Terms in Consumer Contracts Regulations 1999. In relation to business insurance, the Law Commission proposed that the insurer and insured should be free to vary this by agreement but, if the insurers standard policy terms are used, there should be safeguards so that the term does not make the cover substantially different from what the business insured reasonably expected.

Finally, the Law Commission proposed that, for consumer insurance, warranties should be set out in writing and be brought to the attention of the policyholder. ICOBS Rule 6 Annex 2 already states that the policy summary document should contain "*significant or unusual exclusions or limitations*".

RECENT DEVELOPMENTS CONCERNING AGENTS

Sometimes the insured wants some protection against possible misstatements or non-disclosures by an agent, such as the broker. This issue arose in *HIH Casualty and General Insurance Ltd & Others v The Chase Manhattan Bank & Others* [2003].

***HIH Casualty and General Insurance Ltd & Others v The Chase Manhattan Bank & Others* [2003] 2 Lloyd's Rep 61**

The insurers alleged that pre-contract, the brokers had made certain fraudulent, reckless or negligent misrepresentations and/or non-disclosures on behalf of the insured. The insured, Chase Manhattan Bank, defended the claim on the grounds that each insurance policy contained a Truth of Statement clause in the condition precedent section of the policy which stated "*... it being acknowledged that any mis-statement in any part of the Questionnaire ... shall not be the responsibility of the insured or constitute a ground for avoidance of the insurers' obligations under the Policy or the cancellation thereof*". The purpose of the clause was an attempt to protect Chase Manhattan Bank from any misrepresentations or non-disclosure perpetrated by their broker agents.

The Court of Appeal decided that the truth of statement clause did, in fact, exclude not only the insurer's right to avoid or rescind the policy but also their right to claim damages from the insured as a result of the insured's agent's negligence or non-disclosure. However, on the wording of this particular clause, insurers would still have been entitled to rescind the policy if there had been fraud (and claim damages for deceit). The clearest possible wording would be required to seek to exclude remedies regarding fraud.

This was upheld on appeal to the House of Lords. The House of Lords found that the Truth of Statement clause in the policy excluded liability for innocent or negligent misrepresentation on the part of the agent. They held that parties entering into a commercial contract would recognise and could make provision for the risk of innocent or negligent errors and omissions but each would assume the honesty and good faith of the other. A party to a contract could not contract that they shall not be liable for their own deliberate, dishonest or reckless non-disclosure or fraud.

The role of intermediaries, and the question of when an intermediary (insurance broker) acts as agent for the insurer or applicant/insured when providing pre-contract information, has been the subject of much scrutiny by the Law Commission as part of the consultation process for reform.

The main problem identified by the Law Commission was that policyholders often hear the consequences of mistakes or wrongdoing by intermediaries. Usually, intermediaries are regarded as the insured's agent, rather than the insurer's agent, even if they are on the insurer's panel and sell only a limited product range. The effect of this is that any misrepresentation or failure to disclose by the intermediary entitles the insurer to avoid the policy. The Law Commission favours more clarity about the agency status of intermediaries and believes that insurers are in a better position to promote good practice by intermediaries in contrast to an insured, who may only be in contact with that intermediary in relation to one insurance policy.

The scope of this guide is not wide enough to warrant a full discussion of the consultation process. In the context of fraud, if an intermediary acts as the consumer's agent, then the intermediary's actions and state of mind are imputed to the consumer. The effect of this is that, where the intermediary/agent deliberately gives false information, the insurer is entitled to treat the consumer as if they had made a deliberate misrepresentation and, therefore, avoid the policy from the beginning and reject any claim, even if the consumer is completely innocent of any wrongdoing. If the intermediary was simply negligent, the consumer would be treated as if they had made the negligent misrepresentation, even if the consumer had reasonably relied on the advice from the intermediary. The consumer's remedy would be to bring a claim against the intermediary for compensation for that negligence or deliberately false information.

In May 2008, the Law Commission published a summary of the responses to its consultation on consumer issues, which included the agency status of intermediaries and, in October 2008, a similar summary was published for business insurance.

More recently, in March 2009, the Law Commission published a policy statement on the status of intermediaries in the consumer insurance context, as it has somewhat changed its stance during the consultation process in respect of how this issue could be addressed through reforms. The Law Commission intends to include statutory principles in respect of transmission of pre-contract information only in the context of consumer insurance in the draft Bill due out at the end of 2009. An intermediary would always be considered to act for the insurer if it had authority to bind the insurer to cover, if it was the appointed representative of the insurer or it had actual express authority from the insurer to collect pre-contract information. Under the proposed new law, there will be an indicative and non-exhaustive list of factors as to whether the intermediary acts as the insurer's agent or the consumer's agent.

The Law Commission believes that this will be clearer than referring to the current case law on insurance intermediaries. Seeking to implement law reform in the area of agency through Financial Services Authority (FSA) rules was discounted because the FSA, under its rule-making powers, cannot repeal existing law, only overlay it.

REASONABLE CARE

Sometimes the circumstances surrounding the loss or event may give rise to suspicion, particularly in respect of the theft of valuables. The concern is whether the claim is genuine and/or whether the insured's actions have been reckless, which has been considered in a series of cases, including the following:

***Sofi v Prudential Assurance Co Ltd* [1993] 2 Lloyd's Rep 559**

The court considered the meaning of two policies that contained the following clause in broadly similar terms: "*The Insured ... must take all reasonable steps to safeguard any property insured and to avoid accidents which may lead to damage or injury...*"

Mr Sofi and his family were on their way to France by car. The insurer's agent had been told before the trip that they would be taking with them jewellery valued at £42,035. Arriving early at Dover, the car was parked at the foot of Dover Castle and they walked up the hill, deciding before they started on foot to leave the jewellery in the locked glove compartment of the car, as

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this was thought to be the safest place. They were only away 15 minutes, not intending to be more than 30 minutes, and during that time the car was only out of sight for 5–7 minutes. Despite this, the car window was smashed, the glove compartment broken and the jewellery was taken, along with five suitcases.

Only the items of jewellery claimed were disputed by the insurers, who appealed the first instance decision, which had not been in their favour. The Court of Appeal upheld that the property had been stolen and the insurers should pay. The principle was that the burden was on the insurer to prove a breach of the 'reasonable steps to safeguard' condition and not for Mr Sofi to prove that it had been complied with. Secondly, what was described as the "*recklessness test*" in *Fraser v BN Furman (Productions) Ltd* [1967] 2 Lloyd's Rep 1, was applied. Negligence was not sufficient, the insured had to be at least reckless. Recklessness was the failure to take any particular precaution to safeguard the property, knowing that danger existed but not caring whether or not it was averted, and this applied equally whether the condition was in a property insurance policy or a liability insurance policy.

The Court of Appeal did not consider that the decision to leave the jewellery in the locked glove compartment in these circumstances was reckless.

***Gunns & Another v Par Insurance Brokers* [1997] 1 Lloyd's Rep 173**

The recklessness test in *Sofi* was applied later in *Gunns & Another v Par Insurance Brokers* [1997]. Mr Gunns was a jeweller. One weekend, whilst he was away, his home was burgled and the safe containing jewellery was stolen. Insurers repudiated the claim of £348,000 under the home and contents policy, and a dispute arose with the brokers regarding alleged non-disclosure at the application stage.

Part of the broker's case was that the insured was in breach of a policy condition that he would take reasonable precautions to avoid loss and reasonable steps to safeguard the insured property. Before the burglary took place, Mr Gunns had been told to change the type of safe to one that was acceptable to insurers but he had yet to do so, and an independent valuation was due to take place a few days after the theft was said to have taken place. It transpired that Mr Gunns did not use the alarm system at his home and that, a few days before the burglary, he had been followed, for the second time, by a car.

The court agreed that the concept of recklessness referred to in *Sofi* applied to this home contents policy and, indeed, would be applicable to all insurance policies. It was decided that Mr Gunns' conduct was reckless, i.e. he actually recognised that a danger existed but did not care whether it was averted. Therefore, insurers were entitled to repudiate the claim.

***Hayward v Norwich Union Insurance* [2001] EWCA Civ 243**

A further recent development involved the loss of a Porsche from a petrol filling station while the owner was paying for petrol. Mr Hayward had left his keys in the ignition but had activated the immobiliser, which he regarded as effective protection against a theft. Whilst paying for the petrol, a man had jumped into the unlocked car and used a code grabbing or scanning device to override the immobiliser. Mr Hayward tried to stop the car but, feeling threatened that he would be run over, he stepped away. He claimed £66,560 for the value of the car and its stolen contents. Insurers relied on a condition that "*You should at all times take all reasonable steps to safeguard your car from loss or damage...*" and an exclusion clause in respect of "*Loss or damage arising from theft whilst the ignition keys of your car have been left in or on the car*".

Relying on *Sofi*, the Judge said that, for the insurer to be entitled not to indemnify the insured, more than negligence had to be established – there needed to be recklessness but he did not believe Mr Hayward had been reckless and also thought the exclusion should be read to mean that the keys had to be 'left unattended', which he said was not the case.

The insurers successfully appealed. The Court of Appeal said the exclusion was satisfied, because by the plain and ordinary meaning of the words in the policy, the keys had been left in the car and, therefore, it did not need to go on to consider the question of recklessness or otherwise relating to the reasonable care condition.

Before the Court of Appeal decision in *Hayward*, the Financial Ombudsman Service (FOS) published comments on its possible approach in similar cases. If the Ombudsman is satisfied that the driver behaved in a reckless fashion, he is less likely to require the insurer to meet this type of claim. Overall, the FOS's attitude is that it is not reasonable to expect policyholders to be fully aware of their obligations unless they are highlighted at sale and renewal.

The FOS will take into account all relevant circumstances, such as the car's value and its attractiveness to thieves; whether the surrounding neighbourhood indicates that a higher degree of attention is required; the degree to which the driver was able to observe the car; and the length of time the driver expected the car to be unoccupied.

If other drivers are likely to regard the driver's behaviour as reasonable, the FOS is unlikely to agree that the claim was validly rejected. For example, the FOS commented that it was unlikely to regard someone who left their car engine running while opening or closing their garage door as necessarily having behaved recklessly. Nor would the FOS regard the car as having been left, when the driver is no more than a few feet away in the context of a keys-in-car exclusion.

This appears to fit with the Court of Appeal's ultimate decision in *Hayward*. Although the car was in view part of the time and Mr Hayward still needed to pay for the petrol during this time, his Porsche would certainly be attractive to thieves.

Indeed, following the *Hayward* decision, the FOS reviewed its approach and concluded that it did not need adjusting materially. It noted that the test of going away from a car could not be precisely formulated; it had to be judged in a common sense way on the basis of the individual circumstances of each case. It added that, in practice, it could do no better than consider whether the policyholder was in reasonable proximity to the vehicle, was able to keep it under observation and would have had a reasonable prospect of intervening.

Interestingly, in June 2004, the FOS announced that, post-*Hayward*, many insurers appeared to have reworded their clauses to exclude cover for theft if the vehicle was left unlocked and unattended or if the keys were left in or on the vehicle. Consequently, in many cases, the FOS now simply has to decide whether an unlocked vehicle was left unattended.

THE FINANCIAL OMBUDSMAN SERVICE'S VIEW ON FRAUD

In October 2002, the Financial Ombudsman Service (FOS) provided an overall summary of its views on alleged fraudulent insurance claims. Whilst many of these comments endorse the accepted legal requirements, such as the need to show that the insured was trying to obtain more than they were entitled to where exaggeration is suspected, one comment, in particular, could indicate a more lenient approach towards policyholders.

The FOS stated that it would not necessarily regard a policyholder who gives the insurer a forged document to support their claim as guilty of fraud. In this situation, the FOS said it would look to see whether there is some evidence to show that the policyholder knew the document's true source. The FOS's reasoning behind this was that policyholders produce receipts for all the items for which they claim because the insurers ask for receipts, allegedly tempting some to create substitutes for lost receipts. Therefore, in the FOS's view, it is essential to not only identify that the receipt was false but also why the policyholder produced the false receipt. The question is, was it solely to substantiate transactions that really took place or did the policyholder intend to obtain more than they were entitled to? If that is as far as it goes, then it is not really going further than the legal requirements. However, it does mean that the insurer should explore the reason for the false receipt before a referral to the FOS.

Not all referrals involving allegations of fraud will be determined by the FOS. The FOS has the option to decide that the circumstances of a particular case are more appropriate to be decided by the courts.

As referred to in the earlier section dealing with remedies available to insurers, the FOS has taken a keen interest in applying proportionate remedies, where appropriate, in material non-disclosure and misrepresentation cases. Where there is clear evidence of fraud at the application stage, the FOS acknowledges that insurers can retain the premium when avoiding the policy from the beginning and rejecting any claim.

Refer to Appendix 2 for some examples of FOS insurance case studies.

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TYPICAL FEATURES OF FRAUD

The case of *Uddin & Another v Norwich Union Fire Insurance Society Ltd* [2002] includes many typical features of a fraudulent claim and provides a timely reminder of the risks of attempting to defraud insurers.

***Uddin & Another v Norwich Union Fire Insurance Society Ltd* [2002] EWHC 276 (QB)**

Two brothers had buildings and contents insurance for their shared home. Part of the house was damaged in a fire in November 1999. A claim for approximately £64,500 was made, £49,000 of which was agreeable to insurers. An interim payment of only £5,000 had been paid by the time various inconsistencies raised insurers' suspicions about the genuineness of the claim, and subsequently the claim was determined by the court. The issue at court was whether the unagreed items, £4,200 for alternative accommodation for other brothers and sisters and £10,990 for jewellery, were fraudulent. Having found that they were, and following the principles in *Orakpo*, no sum was payable by insurers and instead the £5,000 had to be returned by the insured, together with interest.

This case demonstrates the need to obtain different sources of corroborative evidence (both from witnesses and from documents) to support the allegation of fraud. Even when a signed statement was obtained by the loss adjuster from the tenant of the house where Mr Uddin's family members were alleged to have been staying, that witness subsequently completely changed his evidence, so it no longer supported the insurer's case that the family did not incur rent. However, that witness, amongst others, was openly criticised by the Judge, who favoured the insurer's case that the alternative accommodation claim was false. The alleged disappearance of the jewellery was also found to be implausible. This case also shows that trial Judges in civil claims will, when considered appropriate, recommend that the papers be passed to the Crown Prosecution Service to enable them to consider issues of perjury in the witness box and conspiracy to attempt to defraud insurers.

Indeed, the court also has a discretionary power to award exemplary damages in a case of insurance fraud, as was shown in the two recent cases of *AXA Insurance UK Plc v Thwaites* Unreported February 8, 2008 CC (Norwich) and *AXA Insurance UK Plc v Jensen* Unreported November 10, 2008 CC (Birmingham). In the first, the court declined to make such an order, as it would have been adding to a criminal penalty following the insured's conviction (and sentencing) for deception. However, in the second case, where the insured had been arrested but only cautioned, so there was no issue of a double penalty, exemplary damages of a further 50% of the basic claim were awarded to insurers.

Another classic example of a fraudulent claim is one on a motor insurance policy where there has been no accident.

***Francis & Others v Wells & Another* [2007] EWCA Civ 1350**

A personal injury claim was brought against Miss Wells by three claimants who alleged they had been injured in a road traffic accident when the car she was driving, and in which they were passengers, collided with a car driven by a Mr Senghore. Her insurers alleged the accident was staged or invented, relying principally on the fact that one of the claimants, Mr Reeves, had been involved in two other car accidents within a year, both involving Mr Senghore. At trial, the Judge found the evidence of each claimant and Miss Wells inconsistent and somewhat inadequate and noted the oddity and suspicion of three accidents involving Mr Reeves and Mr Senghore. However, he held that, without other cogent evidence of a conspiracy, unsatisfactory evidence was not enough to make out insurers' fraud and conspiracy claim and ordered that damages be assessed. Insurers appealed the decision to the Court of Appeal, which held that the trial Judge had not dealt properly with the claimants and Miss Wells' inconsistent evidence, let alone the striking coincidence of three accidents involving the same pair, and sent the case back for retrial.

Again, this case shows the importance of seeking corroborative evidence to support an allegation of fraud. Initially, Miss Wells accepted liability for the accident and judgment was entered against her but insurers then unearthed details of the other accidents, as well as making further enquiries, and successfully applied to be joined as Second Defendant to the proceedings and then to withdraw the admission of liability and set aside judgment against Miss Wells.

Another recent case – this time involving a claim on a life insurance policy where the insured had not died – may seem an extreme example but illustrates the ambition of some insured.

Patel v Windsor Life Assurance Company Ltd [2008] EWHC 76 (Comm)

Mr Patel claimed £250,000 against the defendant insurers under a life assurance policy in the name of Mr Barot, who it was alleged had died whilst in India on 2 October 2001. Insurers denied liability on the basis, amongst others, that the policy was procured as part of a fraudulent scheme to defraud insurers, as more than £1.35 million life cover had been obtained from three other insurers soon afterwards – although a fraction of the £13 million cover sought from the various insurers.

At trial, the Judge highlighted several striking features of Mr Barot's applications, including: the fact that, whilst Mr Barot signed the documentation, Mr Patel completed key sections; inconsistencies as to his income and assets; some insurers were told he was to earn £4.5 million playing the lead in a Bollywood film and the insurance was to protect the producer but others were advised it was to protect a mortgage; and Mr Patel was made the sole beneficiary of each policy without satisfactory explanation.

The Judge held that there were cogent reasons for inferring from these features that the policies were taken out in an attempt to defraud insurers. And as Mr Patel had previous convictions for dishonesty, he would not accept his evidence without corroboration by cogent independent evidence, which was lacking, so he dismissed the claim.

The trial Judge also found that Mr Barot did not die on 2 October 2001 and the steps taken to obtain a false death certificate and fake entry in the cremation register were part and parcel of the attempted fraud by Mr Patel and Mr Barot. The trial Judge accepted that Mr Barot plainly failed to disclose a material fact, contrary to his duty of utmost good faith, when applying for cover about a year before the alleged death, namely that he was seeking to defraud the insurer.

MORTGAGE FRAUD

Last year, the City of London Police uncovered £700 million of commercial and residential mortgage fraud, said to be only the '*tip of the iceberg*'. Moreover, the discovery of fraudulent loans is expected to rise further as the recession deepens, more loans are pushed into arrears and repossessions take place, thereby exposing earlier frauds.

Commentators believe the main causes of the rise in mortgage fraud are the de-regulation of financial markets and the drive towards e-commerce at the start of this decade. The Law Society and police point specifically to the abolition of documents of title and reliance on electronic records at the Land Registry. It is said that these reforms make it easier for fraudsters to use stolen or fictitious identities.

Mortgage fraud takes many different forms but the use of false or stolen identities is a key element of large-scale, organised fraud schemes. In April this year, the Law Society issued an updated practice note on mortgage fraud that identified seven common methodologies but, at the heart of most of them, the fraudsters use false identities to purchase properties at inflated prices and make off with the mortgage advance. To differing extents, the fraudsters may rely on collusion from or negligence by dishonest or naive solicitors, valuers and mortgage brokers.

Over the last few years, the Financial Services Authority (FSA) has increasingly taken action against fraudulent mortgage brokers and the Solicitors Regulatory Authority (SRA) has responded to the problem with increased disciplinary action against dishonest solicitors. It has also established a Fraud and Confidential Intelligence Bureau to allow members of the profession to report fellow professionals or their employees.

As discussed in the introduction at pages 19-20, in order to co-ordinate the response of the financial industry, regulators, professional bodies and the police, the Government established the National Fraud Strategic Authority, which came into being on 1 October 2008. Its initiatives include a pilot scheme to allow lenders to check the authenticity of HM Revenue & Customs

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documentation used to support loan applications, and disseminating common mortgage fraud typologies to the FSA, Law Society and Council of Mortgage Lenders.

However, despite all the apparent safeguards, increased knowledge and awareness, mortgage fraud remains and often leads to litigation.

The liability of solicitors

In many property transactions, the solicitor acts for both the lender and the borrower. Once the loan is approved and the certificate of title provided, the lender will pay the mortgage advance to the solicitor, who holds it in a client account on trust for the lender. The solicitor releases the funds to the use of the borrower on execution of a valid charge over the property in favour of the lender.

The nature of the solicitor's liability in a mortgage fraud case depends on whether they were a knowing participant in the fraud, or simply failed to exercise reasonable skill and care, thereby unknowingly allowing a fraud to happen. In the latter case, they will be liable to the lender for breach of contract and negligence.

Where the solicitor plays a role in the fraud, they will also be liable to the lender in the tort of deceit, for a dishonest breach of fiduciary duty and for breach of trust in paying away the mortgage money. The solicitor will be liable to pay equitable compensation to the lender for breach of trust. The defence of contributory negligence will not be available to reduce the damages recoverable by the lender.

The liability of surveyors and valuers

Valuers are typically involved in those frauds where a borrower overstates the purchase price of the property in order to obtain a greater mortgage advance. The valuer provides the dishonestly inflated or negligent valuation to the lender and the fraudster pockets the difference between the actual purchase price and the inflated mortgage advance.

The valuer will be liable to the lender in negligence on the usual principles. They will also be liable in the tort of deceit if they made a fraudulent statement regarding the value of the property.

Where a claim is brought in deceit, the lender need only show that its loss was caused by the fraudulent mis-statement and it does not need to also establish that the loss was foreseeable (unlike in negligence). Furthermore, the defence of contributory negligence is not available to a claim in deceit. It may, however, still be arguable that a discount for any failure by the lender to properly mitigate its loss should be allowed.

The strategies available to professional indemnity insurers

The strategies available to those insuring professionals involved in a mortgage fraud will include a combination of the following:

- Declining indemnity under the primary layer policy and, possibly, avoiding any excess layer policy.
- Aggregating claims under the policy arising from related frauds.
- Reducing quantum by establishing contributory negligence and/or failure to mitigate by the lender.
- Seeking a contribution from the other professionals involved in the transaction.
- Pursuing recovery of misappropriated funds and/or damages from the third parties involved in the fraud and the dishonest professional.

Declining indemnity

The level and type of professional indemnity insurance held by solicitors is dictated by the SRA's Minimum Terms and Conditions of Professional Indemnity Insurance 2009 for primary layer insurance (the Minimum Terms). They provide that the insurer is not entitled to repudiate or avoid cover on any grounds whatsoever, including non-disclosure or misrepresentation, whether fraudulent or not.

However, the Minimum Terms also provide that the policy may exclude the liability of the insurer to indemnify any particular person to the extent that any civil liability or related defence costs arise from dishonesty or a fraudulent act or omission committed or condoned by that person. Insurers have to pay where innocent partners in a firm are also sued but can reserve a right of recovery against the dishonest partner or employee.

As for surveyors and valuers, the Regulatory Board of the Royal Institute of Chartered Surveyors prescribes similar minimum policy wording requirements for professional indemnity insurance for its members.

In either case, once insurers have established that some individual insureds perpetrated dishonest acts or omissions, i.e. the key players, they may then seek to establish whether any other insureds condoned the fraudulent acts or omissions.

In *Zurich Professional Ltd v Karim & Others* [2006], the High Court examined how the dishonesty exclusion in the policy worked in relation to those who had condoned dishonest acts.

***Zurich Professional Ltd v Karim & Others* [2006] EWHC 3355 (QB)**

Karims was a family-run firm of solicitors, consisting of Mrs Karim and her son and daughter. Mrs Karim had a record of serious disciplinary offences, which precluded her from acting as a partner in the firm. The ostensible partners were her son and daughter and, together, they represented to the Law Society that Mrs Karim was no more than an employee of the firm. In reality, she was the dominant force and de facto senior partner.

The son and daughter tried to develop criminal and media practices, with very limited success. Mrs Karim had a conveyancing practice that brought in what little funds the firm earned. Unsurprisingly, however, Mrs Karim's activities resulted in several claims against the firm arising out of mortgage frauds. The firm sought indemnities in respect of those claims under their 2002/3 year professional indemnity policy provided by the Assigned Risks Pool (ARP).

In response, Zurich, as representative of the ARP, brought this action seeking declarations that the claims for indemnity fell within exclusion clause 6.9 of the policy, entitling them to decline indemnity:

"The Insurer is not liable to indemnify any Insured to the extent that any civil liability or related Defence Costs arise from dishonesty or a fraudulent act or omission committed or condoned by that Insured, except that – (a) this contract nonetheless covers each other insured..."

The court held that Mrs Karim was dishonest in respect of all the claims made against her and granted the declaration that her claims under the policy were excluded from cover as a result. The difficulty arose in relation to the son and daughter. Had they condoned her activities within the meaning of the policy, so as to also exclude their claims for indemnities?

The court found that the son and daughter must have known that they were not in control of the firm and that their mother was treating the firm's and the clients' money as her own. They must also have known that the firm's actual level of business could not sustain their salaries. They had divested themselves of their responsibility for running the firm in full knowledge of their mother's character and professional history and were profoundly reckless as to how their mother ran the practice. Accordingly, the court found that their behaviour was in itself consistently dishonest.

However, the court was not able to find that they were directly involved in or had specific knowledge of any of the fraudulent transactions by their mother that gave rise to the claims in question.

The court treated the issue as one of policy construction. It held that exclusion clause 6.9 applied where an insured 'condoned' either 'dishonesty' or 'fraudulent act or omission'. As the son and daughter had condoned their mother's general dishonesty, which allowed her to commit the specific fraudulent acts that gave rise to the claims, their claims for indemnity under the policy were also excluded by clause 6.9.

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Aggregation

Where the claims against the professional have a common borrower or theme, insurers should consider whether those claims will aggregate and whether there is a series of related acts or omissions.

Reducing the quantum of the lender's claim

A defendant professional who is liable for the tort of deceit or a dishonest breach of fiduciary duty, cannot rely on the victim's contributory negligence to reduce the claim against them. However, lenders do not always pursue claims in deceit, even where the professional's own insurers suspect or even know that their insured has committed fraud. That may be because the lender does not have the same information available to it, or because its advisors want to avoid formulating the claim in a way that may prejudice the amount of professional indemnity insurance available to meet the claim. It may also suggest the lender has discovered that one of its own employees was involved in the fraud.

Where the lender brings a negligence claim, the professional will seek to establish that the lender is guilty of imprudent lending, so that its claim falls to be reduced for contributory negligence. The most successful allegations of imprudent lending are that the lender advanced too much against too little security (over-lending); that the lender failed to verify its security, in particular the income and bona fides of the borrower; or that it approved in any event loans where it knew, for example, the transaction was proceeding by way of sub-sale. Reductions of at least 20–30% are not uncommon but, in some cases, the reduction has been as high as 50% or even 90%.

The court should also consider whether the lender has made reasonable attempts to mitigate its loss. In this regard, it will look at the time taken to repossess and sell the property and to pursue the borrower, if appropriate.

Seeking a contribution

In addition to attacking the lender, those advising the defendant professional and its insurers should also consider bringing a contribution claim under the Civil Liability (Contribution) Act 1978 (the 1978 Act) against any other professionals involved in the fraudulent transaction. Assessing the amount of the likely contribution can be a complex exercise, as the professionals may be liable to the lender on different grounds (i.e. deceit or negligence), the lender may be guilty of contributory negligence, and the professionals may have the benefit of limitation of liability clauses in their retainers with their clients.

The Commercial Court recently considered the interplay of these factors in *Nationwide Building Society v Dunlop Haywards (DHL) Ltd & Cobbetts* [2009].

***Nationwide Building Society v Dunlop Haywards (DHL) Ltd & Cobbetts* [2009] EWHC 254 (Comm)**

Dunlop Haywards (DHL) was a firm of surveyors, which fell victim to the fraudulent activities of one of its valuers, Mr McGarry. In this case, Nationwide lent £11.5 million to Goldgrade Properties Ltd on the security of commercial property valued by Mr McGarry at £15 million. In fact, Mr McGarry's valuation was fraudulent and grossly overstated and the true value of the property was between £1.3 and £1.5 million. Goldgrade was also fraudulent and defaulted on the loan. Nationwide took possession but, by the date of trial, the property was worth only £625,000.

Nationwide obtained summary judgment against DHL for the tort of deceit, with damages to be assessed. As the claim was brought in deceit, Nationwide only had to establish causation, rather than foreseeability.

In addition to claiming the usual measure of loss in lender claims – namely, the lost advance of around £10 million and lost interest on alternative advances – Nationwide sought damages for consequential losses to its business. These included staff time in checking all other loans to Goldgrade for fraud; losses caused as a result of the business being downgraded by credit rating agencies once the fraud came to light, including higher borrowing rates in the money markets; and fees and interest incurred in securing short term borrowing. The consequential heads of loss brought the total quantum of the claim in deceit against DHL to £21 million.

Nationwide also made a claim against its conveyancing solicitors, Cobbetts, alleging they were negligent in failing to detect the fraud by Mr McGarry and Goldgrade. Cobbetts' retainer with Nationwide included a clause limiting their liability to £5 million. They made a Part 36 offer just above that level, of £5.58 million, which Nationwide accepted. Cobbetts then brought a claim against DHL under the 1978 Act, seeking a contribution from it in respect of the same damage suffered by Nationwide.

In these proceedings, the court assessed the quantum of the claim in deceit against DHL and the level of Cobbetts' contribution claim against DHL.

The court held that DHL was liable in deceit for all the claimed heads of consequential loss and gave judgment against it for £21 million, less the £5.58 million Nationwide had recovered from Cobbetts.

The court's task of identifying the same damage for the purposes of Cobbetts' contribution claim was made difficult by three factors. First, DHL was liable to Nationwide in both negligence and deceit, whereas Cobbetts was only liable in negligence. The court had given judgment that the deceit claim was worth £21 million but assessed the value of a negligence claim at £13.2 million. Secondly, the court accepted that Nationwide was guilty of contributory negligence justifying a reduction of 50% in any negligence claim. Thirdly, Cobbetts had the benefit of the £5 million limitation clause in its retainer.

The court began by identifying the same damage for which Cobbetts and DHL were both liable to Nationwide as being the negligence loss of £13.2 million. The court then took account of the contributory negligence and reduced that amount by 50%, to £6.6 million to produce the figure that should be apportioned between Cobbetts and DHL. Finally, the court apportioned the loss 80/20 between the parties, which meant Cobbetts' share of the loss was £1.32 million (20% of £6.6 million). As it had paid £5.58 million to Nationwide under the settlement, it was entitled to a contribution of £4.26 million from DHL.

Pursuing recoveries from third parties and the dishonest professional

Insurers will consider whether to pursue claims to recover misappropriated funds and/or damages from those involved in the mortgage fraud. They will also consider whether to pursue claims against any individual insured who committed or condoned the fraud. After all, those individuals will not be able to claim an indemnity under the policy.

The case of *Pulvers v Chan & Others* [2007] is an example of insurers making pre-emptive recovery claims against the fraudsters, where it was clear the insured firm was liable to the lenders.

***Pulvers v Chan & Others* [2007] EWHC 2406 (Ch)**

Pulvers was a two-partner firm of solicitors. Through the activities of its conveyancing clerk, Ms West, the firm became involved in a series of more than 20 mortgage frauds, whereby various lenders lost sums advanced to buy residential properties.

In each case, the lender had intimated an intention to claim compensation from *Pulvers* and, to stave off proceedings, *Pulvers* and its professional indemnity insurers accepted liability in principle. The quantum of the claims had not been agreed or determined.

In these proceedings, *Pulvers* and its insurers sought to recover from those involved in the fraud scheme, including Ms West, the mastermind of the scheme, Mr Sinclair, four finance companies controlled by Mr Sinclair, and seven individuals who had acted as borrowers.

The court found in each case that Ms West had knowingly and dishonestly assisted Mr Sinclair and the fraud scheme by, for example, issuing certificates of title that were fraudulent. The fraudulently obtained monies ended up with Mr Sinclair or his companies and there was no evidence that either Ms West or the borrowers received any of the lenders' funds.

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Pulvers had two types of potential claim against each defendant: a direct claim and a claim under the 1978 Act, on the grounds that both Pulvers and the individual were liable to the lender in respect of the same damage.

The court began by considering the direct claims the parties might bring against each other. First, it found that Pulvers would be liable to pay equitable compensation to the lenders for breach of trust in paying away the mortgage monies it received from the lenders because the firm was responsible for Ms West's dishonest behaviour. Secondly, Pulvers would be liable in damages for negligence since it was vicariously liable for Ms West's breaches of duty, notwithstanding her dishonesty.

The court then found as follows in relation to the defendants:

- All of the defendants were liable to the lenders for the tort of conspiracy, because they had conspired to deceive and injure the lenders.
- There was insufficient evidence of the defendants' intentions to determine whether they also conspired to injure Pulvers and the court made no finding on that issue.
- Ms West was liable to Pulvers and to the lenders for dishonestly assisting a breach of trust in relation to each transaction.
- Mr Sinclair and his four companies were liable to Pulvers and the lenders for knowing receipt of trust monies paid in breach of trust. Furthermore, as Pulvers had paid the money to them under a mistake of fact, they were liable to Pulvers for money had and received.
- The borrowers were liable for dishonestly assisting a breach of trust.

The court then considered Pulvers' contribution claims against each defendant. It approached the task by first considering how the contribution between Pulvers and each defendant should be apportioned. For these purposes, the court treated Ms West as part of Pulvers. In each case, liability for the lender's loss was to be apportioned equally between Pulvers and the parties involved in that particular transaction.

The court then determined the apportionment between Ms West and Pulvers and held that Ms West was liable for all the losses and Pulvers was not liable to contribute anything. So, for example, the lender's loss might be apportioned 33% each to Pulvers, the borrower and Mr Sinclair but, as between Pulvers and Ms West, she would be liable for the entirety of Pulvers' 33% share.

LEGAL PRIVILEGE IN RESPECT OF INSURANCE CLAIMS

A party may object to a document being inspected by the other party to the court proceedings on the grounds that the document is protected by legal professional privilege. Part of the test in determining whether a document is privileged involves looking at the dominant purpose behind the creation of that document. The dominant purpose is not simply ascertained by reference to the author of the document, but also by reference to the person or authority under whose direction the document is produced.

***Guinness Peat Properties Ltd & Another v The Fitzroy Robinson Partnership* [1987] 1 WLR 1027**

The Defendant, an insured architect, wrote to its insurer giving notice of a professional negligence claim. By an obvious error, as this letter should not have been disclosed to the Claimant on the grounds of legal professional privilege, the insured's solicitors had permitted the Claimant to inspect the document. The insured was now seeking an injunction, restraining the Claimant from using or relying on this letter.

The Court of Appeal considered whether this letter was protected by legal professional privilege. It referred to communications passing between a client and its legal adviser, which are always privileged. However, in this instance, the letter was written by the insured to its insurer.

The court held that the letter was privileged, on the basis that the dominant purpose behind its creation was to assist the insurers in the conduct of the litigation, which was reasonably contemplated at the time of the document's creation. The letter had been produced, as it was a requirement under the insured's insurance policy to notify its insurers of any claim it received, so that the insurers could use the letter to obtain legal advice.

Once a document is inspected, there is a general rule which prevents a party from claiming privilege against that document. However, in this case, the Court of Appeal held that there had been an obvious error on the part of the insured's solicitors, in allowing this document to be inspected by the Claimant. It therefore granted an injunction preventing the Claimant from using or relying on the letter.

***Re Highgrade Traders Ltd* [1984] BCLC 151**

For a document to be protected by legal professional privilege, a party does not have to instruct their solicitors at the time at which the document is created. In *Re Highgrade Traders Ltd* [1984] BCLC 151, a company went into liquidation, following which there was a fire at its premises, which destroyed all of its stock. The insurers instructed loss adjusters and surveyors to carry out an investigation as to the cause of the fire. The liquidators applied for the production of these reports but this was refused.

It was held that the dominant purpose behind the creation of the reports was to obtain legal advice on contemplated litigation. Although the insurer had not instructed solicitors when the reports were created, they were privileged as litigation was reasonably in contemplation at that time and it was intended that these documents would enable solicitors to give advice as to whether the insurance claim should be resisted.

On this basis, insurers can argue forcefully that documents created in the course of investigations into claims where fraud is suspected are privileged from disclosure in subsequent litigation. This is likely to cover investigators' files and investigators' reports to insurers and any documents created by the insurers' internal personnel who are involved in the investigation.

PREVENTION IS BETTER THAN CURE

As multiple claims against different insurers are another feature of fraudulent or suspicious claims, it is vital that insurers share information in order to detect and combat fraud, whilst at the same time complying with their obligations under the Data Protection Act 1998 (DPA 1998).

The DPA 1998, which came into force on 1 March 2000, replacing the 1984 Act, regulates the holding and processing of personal data. Personal data is information relating to a living, identifiable individual. One of the eight principles in the DPA 1998 is that processing personal data needs to be lawful and fair.

One way to demonstrate that processing has been lawful is to have the individual's (the data subject's) consent. Explicit consent is required if you are dealing with "*sensitive personal data*", which includes, for example, information on the commission of criminal offences.

For personal data to be processed fairly, the data subject (or their agent) has to, so far as practicable, be given details of:

- The identity of the data controller or their representative.
- The purpose or purposes for which the personal data is intended to be processed.
- Any other information that is necessary for the processing to be fair.

Although the consent does not have to be in writing, a signed notice will represent the clearest form of evidence of what the data subject has agreed.

The DPA notice should clearly state:

- What information will be processed and to whom.
- In what circumstances.
- For what purpose.

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DPA notices must be carefully drafted to include all possible purposes for which the personal data may be processed. By explicitly referring to the intention to process information for the purposes of fraud detection and prevention (in addition to the usual purposes of, say, underwriting, marketing and claims), it is hoped that the DPA notice will deter those who may be contemplating making a fraudulent insurance policy claim, and therefore have a preventative effect.

The DPA notice with consent should mention any database register which the insurer may use at the application and/or claims stage in order to detect fraud.

In October 2007, the Information Commissioner's Office (ICO) published a *Framework Code of Practice for Sharing Personal Information*, to help organisations adopt good practice when sharing information about people. It is intended to be used mainly in circumstances where information is being shared on a routine systematic basis, rather than ad hoc situations. It can also be used by organisations that want to produce or review existing data sharing policies.

In January 2009, the ICO published a draft code of practice dealing with the wording of these oral or written DPA notices, which it refers to as 'privacy notices'. Following a period of public consultation, it recently issued the *Privacy Notices Code of Practice*, on 12 June 2009. The code emphasises that the duty to actively communicate a privacy notice is strongest where the information is sensitive or its intended use will be unexpected or objectionable. The ICO has also made it clear that it will take these standards into account when it receives a complaint that information has been collected in an unreasonable manner.

An insurer may seek to rely on the exemptions in the DPA 1998. Section 29 of the DPA 1998 sets out exemptions for the purposes of prevention or detection of crime, and the apprehension or prosecution of offenders. The insurer may be unable to obtain the required consent or decide that it would be prejudicial to its position to obtain the data subject's consent. There are four exemptions which relate to crime, three of which could apply in the insurance context. However, if an insurer wishes to rely on one of these exemptions, then it is essential that their data controller examine the facts of that particular situation before making any definitive decision to process personal data in a manner that may be in contravention of the DPA 1998.

When looking at a particular case to assess whether a s.29 exemption could apply, consider, for example, what stage enquiries regarding fraud have reached and what specific criminal offences may have been committed.

The routine use of a fraud database register would not fall within the exemption.

If a claim is declined on the grounds of fraud, it is possible that the insured may decide to ask to see what data is held on them – a subject access request. In those circumstances, the insurer may at least decide to refuse to disclose its sources of information and its fraud detection techniques.

The s.29 exemption is relied on when members of the Insurance Fraud Investigators Group (IFIG) share information between themselves. In 2008, IFIG was awarded Specified Anti-Fraud Organisation (SAFO) status by the UK Home Office, under s.68 of the Serious Crime Act 2007, which came into force on 1 October 2008. SAFO status facilitates sharing of information with public bodies, such as the Department for Work & Pensions, for the purpose of preventing fraud.

An insurer can pass information alleging fraud to the Financial Ombudsman Service (FOS) in confidence, when the FOS is considering a complaint. This is because s.233 of the Financial Services and Markets Act 2000 inserted a new subsection into s.31 of the DPA 1998 which, in effect, permits the FOS to decide not to disclose such information which it has received from the insurer, if this would be likely to prejudice the proper discharge of the function of the FOS.

It is important that the private investigators and tracing agents used by insurers operate within the confines of the law (including having a thorough understanding of data protection principles) and that they also operate to high ethical standards. In July 2007, the ABI published guidelines on the instruction and use of private investigators and tracing agents. Adoption of these guidelines is voluntary but compliance could, in our view, demonstrate good practice to the Financial Services Authority and the Information

Commissioner. The July 2007 ABI guidelines include information on details that could be included in a written agreement between the insurer and the private investigator.

If a private investigator uses methods for obtaining information which contravene the law, such as using bribery or deception, insurers and their employees are at risk of a s.55 DPA 1998 offence – irrespective of whether the private investigator's direct instructions came from the insurer or their solicitors.

Section 55 introduced a criminal offence for a person to knowingly or recklessly, without the consent of the data controller (i.e. the person who determines the purpose for which, and the manner in which, personal data is processed), obtain or disclose data or the information contained in personal data or *procure the disclosure* to another person of the information contained in personal data. This criminal offence could, therefore, apply to an individual employee. In effect, everyone involved in the chain where a rogue private investigator is involved could be at risk. This highlights the importance of insurers ensuring that private investigators clearly understand that they are only being asked to take steps in compliance with the law.

This offence can currently be penalised by a fine but, since 2007, the Government has indicated that it planned to enact legislation to introduce custodial sanctions for s.55 offences. Indeed, by virtue of s.77 of the Criminal Justice and Immigration Act 2008, it has now gone so far as to introduce legislation allowing the Secretary of State to make an order imposing custodial sentences of up to two years on indictment (or 12 months on summary conviction, save in Northern Ireland where the maximum would be six months), although no such order has been made as of August 2009.

Section 144(1) of the Criminal Justice and Immigration Act 2008 also introduced a new power for the Commissioner to impose a monetary penalty on a data controller in certain circumstances – essentially, where there has been a serious contravention of a kind likely to cause substantial damage/distress and which was either deliberate or where the data controller knew or ought to have known there was a risk the contravention would occur and be of a kind likely to cause substantial damage/distress but failed to take reasonable steps to prevent it – but, again, this provision is not yet in force.

Another means of promoting good practice is through the Security Industry Authority's plan to license and regulate private investigators, under the Private Security Industry Act 2001. However, as of August 2009, it appears that the licensing of investigators in the private sector will be postponed by the Home Office until at least 2010. Details of the plans will be posted on www.the-sia.org.uk.

SHARING INFORMATION WITH THE POLICE AND CRIMINAL PROSECUTION

Memorandum of Understanding

On 1 October 2002, a data sharing initiative between the police, insurers and loss adjusters took effect. The ABI and the Association of Chief Police Officers (ACPO) jointly issued a Memorandum of Understanding (MOU) on the exchange of information. This MOU complemented the August 1999 paper, *Acceptance criteria and guidelines for the reporting of suspected fraudulent insurance claims to the police*. The MOU on the exchange of information was subsequently updated, in January 2005, and has been under further review in 2008-9. A revised version could be available at the end of 2009.

The MOU was originally intended to deal with requests for information of the police, by insurance companies and their loss adjusters, involving property crime. However, the MOU could be applied to other categories of crime. Significantly, it only applies to issues arising from an insurance claim and not queries concerning the proposal form. Therefore, even if the claimant gives his consent, the MOU cannot be used in order to obtain details of, say, previous convictions from the police.

Since the Criminal Records Bureau's establishment in 2002, it has been unlawful for insurers to require individuals to obtain details of their previous convictions and cautions from the police by using a subject access request.

Fraud Investigation

The insurers who endorse the MOU are listed in Appendix A of the ACPO/ABI MOU, and each will have appointed a position or particular person in their organisation to act as the contact point for the police. Similarly, contact addresses and telephone numbers for the various police forces are listed in Appendix B.

Requests for information are intended to be more streamlined because standard forms are to be used. There are three different forms for use by insurers and their loss adjusters. The first two, at Appendix D, apply to circumstances where there is specific reason for the insurer/loss adjuster to check a claim but there is not enough evidence to enable the insurer to make a reasonable decision that the claimant is attempting to defraud it. For example, the value of goods allegedly stolen may appear out of proportion with the insured's financial means, and the insured is unable to prove ownership of those goods. The important point is that the claimant's explicit written consent to disclosure must be on the completed form. It is not sufficient for the insurer to refer to a general consent to disclosure, which the individual has given at the proposal or claim stage. Insurers should, in any event, notify their prospective insured at the proposal stage that, with the insured's consent, the insurer may exchange information with the police, where this is needed to validate a claim. Therefore, insurers need to check that the wording of their forms satisfies this requirement.

The settlement of the claim can be made dependent on the insured giving such explicit consent, if the insured had been notified at the proposal stage.

The first form at Appendix D(a) is to be used when the insurer wishes to confirm the crime/loss of property reference number, date and time the loss offence was reported and the name of the reporting person. The charge is £20 and the MOU indicates that the police will endeavour to respond within 10 working days. The form at Appendix D(b) is to be used when additional information is requested, when a charge of £75 will be applied and the police will reply within 20 working days, if possible. Where there are criminal proceedings in respect of the offence giving rise to the insurance claim, such as fire damage, the police will first verify with the Crown Prosecution Service whether disclosure to the insurer should be delayed, so that the criminal proceedings are not potentially jeopardised. For instance, it is unlikely that copy statements would be disclosed to insurers prior to any court hearing. The police may, however, advise if a person has been charged and/or indicate that there is no suspicion about the claimant. In practice, responses to Appendix D forms have been taking longer, sometimes by several months, than the timescales indicated but this may be in part due to the existence of court proceedings.

The third standard form, which is located at Appendix E, deals with situations where the insurer or loss adjuster has evidence to suspect a fraudulent insurance claim. The explicit consent of the claimant is not required and no fee is payable to the police for provision of the information. The request for information from the police will be made under s.29(3) of the DPA 1998, and the form should include information on why the claim is believed to be fraudulent, what information is requested and why this information is being requested. Details of the existing evidence need to be provided and it is also necessary to specify the view that if the information is not disclosed to the insurer it is likely to prejudice the investigation of a fraudulent insurance claim. Insurers must notify the police of the outcome of their investigations in order to comply with the legal basis for the disclosure and the police will notify the insurer if the claimant is successfully prosecuted or cautioned in relation to a fraudulent insurance claim.

Finally, there may be situations where the police are party to information amounting to evidence of a suspected fraudulent insurance claim. The MOU includes a separate form, at Appendix F, which the police will send to insurers with the information. Any information received in this way is specified as being held in confidence, should only be used for the s.29(3) purposes of prevention or detection of crime or the apprehension or prosecution of offenders and should not be disclosed without the consent of the police. The revised Appendix F form in the 2005 version of the MOU, expressly states that the police will be unlikely to conclude their investigations if the personal data is not disclosed.

As stated above, sometimes the response times to requests from insurers and loss adjusters has been several months, although there is generally a quicker response to Appendix D requests. The review of the 2005 edition of the MOU appears to concern whether the MOU should be amended, so that insurers and loss adjusters should first seek the individual's consent (using the Appendix D(a) or (b) form), so that if consent is denied Appendix E can then be used where there is sufficient evidence to lead

the police to suspect a criminal act may have been committed. The proposed changes may include an acknowledgement that, in unusual circumstances, such as where tipping-off the individual would jeopardise an ongoing investigation, an insurer or loss adjuster may submit an Appendix E form without first seeking the individual's consent. This would suggest that, even if the insurer and loss adjuster suspect fraud, the consent route under Appendix D(a) or (b) should be used first, which appears to potentially water down the s.29(3) route under the premise that s.29(3) contains a caveat, in practice, that there is no other means of obtaining the information, which it does not. It remains to be seen how the anticipated amendments will finally be formulated, hopefully, later in 2009.

Criminal Procedure and Investigations Act 1996

Insurers also need to be aware of the duties of the police (and prosecution generally) when gathering information from third parties, such as insurers, during an investigation in relation to criminal proceedings. The criminal investigator and prosecutor will have statutory duties to reveal and disclose information under the Criminal Procedure and Investigations Act 1996, as amended (the CPIA 1996). Third parties, such as insurers, do not have legal duties under that Act. However, any lack of co-operation or delay could have a detrimental effect on the criminal case. Examples of the reasons a third party is asked to disclose material are because the criminal investigators believe that it may include material which might affect the credibility and reliability of a witness, or material which might reasonably be considered capable of undermining the prosecution case or of assisting the case for the accused.

The criminal investigators are under a duty to pursue all reasonable lines of enquiry, regardless of whether these point towards or away from the accused, as their role is to act fairly, impartially and in the interests of justice.

To safeguard the accused person's right to a fair trial, in compliance with the European Convention on Human Rights, the CPIA 1996 incorporates a scheme designed to ensure that there is fair disclosure of material to the person accused of a criminal offence which may be relevant to a criminal investigation and which does *not* form part of the prosecution case. This is known as unused material. The CPIA 1996 also recognises and seeks to protect the interests of victims and witnesses who might otherwise be exposed to harm. Therefore, if an insurer is, for example, asked by the police to disclose material, it could object on the specified ground that to reveal the information would involve harmful disclosure of, say, a confidential procedure. The insurer would still have to retain the information in the event that the criminal court later requires the insurer to disclose some or all of the material. An insurer's representative could, for instance, be served with a witness summons requiring that person to attend the criminal court with the material. However, there is a right to make representations to a criminal court against the issue of a witness summons.

The criminal prosecutor may ask a third party, such as an insurer, to supply material (such as an original policy application, which could contain forged signatures), allow them to inspect it or to list additional material, so that they can assess whether it is relevant material which should be inspected. When the police inspect material with the third parties agreement and do not retain it, they are under a duty to record details of that material *and* to reveal it to the prosecutor.

If the third party wishes to allege that their material, if put in the hands of the prosecution, would be sensitive in that it is not in the public interest to disclose it, then the criminal prosecution will treat that material as confidential. However, if that material satisfies the disclosure test, a public interest immunity application must be considered by the prosecution to prevent disclosure of the material to the defence. Where the third party has an interest in that material and it is appropriate to make a public interest immunity application, the prosecution must notify that third party of the time and place of that application, so that the third party can make representations to the criminal court.

Fraud Investigation

WHERE ARE WE NOW?

We are currently in the grip of recession which, combined with rising unemployment, is proving a breeding ground for fraudulent claims. Law enforcement agencies, the ABI and insurers have all indicated that fraud has risen over the last year and, given that unemployment is forecast to continue rising until mid-2010, it seems likely that fraudulent claims will continue to grow.

Undoubtedly, insurers have improved their ability to identify potentially fraudulent claims, which can be attributed to increased fraud awareness by claims handlers, as well as most of the larger insurers (and some of the smaller ones) having their own dedicated counter-fraud teams, to whom suspicious claims are referred. In addition, some assistance has been obtained from the sharing of claims data, improved computer software packages, such as voice stress analysis, as well as data mining programmes – although they only assist in indicating where to focus such efforts. There is no computer programme that actually identifies fraudulent claims. This is only ascertained by experience, careful consideration and hard work.

Regulation by the Financial Services Authority (FSA) and its initiative of Treating Customers Fairly, as well as the scrutiny of the Financial Ombudsman Service, which looks at matters from a more consumer-orientated perspective, rather than a strictly legal basis, means insurers have to identify suspected fraudulent cases early and, thereafter, make a sound strategic decision on the most appropriate course of action to follow in order to obtain the optimum outcome.

Whilst the police are more interested in cases of insurance fraud, they remain constrained by limited resources and budgets. Consequently, unless a case is presented to them as, essentially, a pre-packaged conviction, they may have insufficient time or resources to assist. Accordingly, it seems that insurers will have to continue leading the way in combating insurance fraud.

On a more positive note, the courts have increasing numbers of designated civil fraud Judges who, given their more detailed knowledge of fraud, are more prepared to allow insurers some latitude in obtaining information which is likely to assist in proving fraud. However, it is essential that the evidence behind any application is put together carefully and presented in the correct manner to the Judge to stand the best chance of obtaining the required order.

Ultimately, when dealing with suspected fraudulent claims, there is no substitution for experience, supported by a sound technical knowledge of fraud and the remedies available and, just as importantly, those that are achievable on the evidence that can be obtained.

Appendices

INTERVIEWING TECHNIQUES

The intention of this section is to provide an overview of interview techniques to assist both in statement taking and general investigation of losses.

At the outset of an interview it must be understood that the purpose of interviewing is to find out information. The purpose of that information may well be to investigate the cause of an accident, to allow recovery to be pursued or for some other purpose such as establishment of quantum, ownership of goods or other policy issue. It is often the case that when carrying out interviews that the interviewee is extremely uncomfortable with the interview. This may occur either because they are aware that the information being sought may not be to their advantage or alternatively they may be concerned, particularly in the instance of a recovery, that disciplinary action or blame may follow. If this is the case, valuable information will not be given and it will become difficult to determine what has occurred.

General interviewing guidelines

1. Interview promptly (short-term memory degrades, talking with others dilutes, actual observations are rationalised) – this is a common problem for us as a business and wherever possible notes of the initial telephone contact should be taken. It may well be that a telephone interview is carried out if it is clear that there will be delays in getting to site.
2. Say you want to make informal written notes (in chronological/thought form, with no interpretation made) – these informal written notes will often, when read later by yourself, reveal items that may have been listened to but not heard. It is very easy as an interviewer to filter items in and out.
3. At the interview ask “what happened?”. Do not interrupt the statement. Make occasional notes of the discussion for later assessment.
4. Ask open, neutral, unbiased, non-leading questions for clarification.
5. Have common questions on hand for later cross-confirmations with other witnesses.
6. Try not to lead the person into giving answers they think you want to hear – this is particularly important when investigating policy information/details. It is very much the case that an interviewee will be guided by the line of questioning pursued by an interviewer unless the techniques of open questioning and listening are clearly understood.

Human characteristics

The following are human characteristics that are worth remembering during interviews:

1. Eye witnesses are not trained in observation and forget things.
2. Information is filtered entering and leaving the brain (by both the witness and the interviewer) – this is something to be particularly aware of. From time to time the witness will say something that you believe is not credible or not possible. It is worth recording that and reviewing it later. It is often the case that our notes of an incident will have recorded facts that only later we realise are important.
3. Recollection and communication are affected by emotions (such as shock, unfairness, peer pressure, embarrassment) – these are particularly the case in the incident of interviewing contractors who may have been culpable in a fire situation or similar.
4. Memory recall is not chronological, therefore review and repeat if needed – this highlights why modern interviewing techniques are focused upon hearing the story as far as possible and then testing that story. This is invaluable in fraud cases where, for instance, having heard the story it is possible to check a detail which might not be readily known to a fraudster.

Fraud Investigation

Interview preparation

Maximise the quality and quantity of the information obtained. The following techniques are useful.

1. Use a neutral location near the normal workplace (if in a commercial situation) which will be private and where you won't be interrupted. Make sure it is large enough for you both to relax – this is a particular problem in the domestic environment where quite often partners will be present and interrupt during a statement or interview.
2. Have a question list and topic areas already prepared – as a firm we have various aide memoirs that can be of assistance and it is a good idea to prepare prior to detailed interviews.
3. Have photographs, plant and operating plans, plot plans (not procedures) to help with clarification later in the interview – it is worthwhile ensuring that any plans or other documents which are presented by the witness are suitably annotated and appended to the statement.
4. Be aware of the person's background, responsibilities and involvement – it is important to have an understanding of how the person to be interviewed fits into an organisation.
5. Anticipate personal needs such as transport home, coffee, smoking.

The interview

There are four phases to the interview:

1. Develop a rapport (and trust). Develop a positive and constructive atmosphere. Recognise that the person being interviewed is under stress. Explain the purpose of the interview and what your job/role is. Say what you hope to achieve, that anything said is confidential (subject to the need to present documents in court) and ask if there are any special concerns or personal needs (transportation etc). This is the area that is probably the hardest and the most particular area is that in relation to confidentiality. I think it is fair to say that the final agreed statement is not confidential but that other matters may be raised that are to be retained as confidential.
2. Request that the person tells you what happened (a narrative statement). Don't ask questions, don't interrupt and do allow use of own words. Take notes as reminders for later questions.
3. Interactive discussion. Ask open-ended questions for clarification of information. Listen actively and repeat what was heard periodically for confirmation. Use photographs, drawings and any other documents needed.
4. Conclusion: Ask if there are any other facts or thoughts (no matter how unimportant they may seem) that the person would like to mention.
 - a. Summarise what you have heard to ensure accuracy.
 - b. At this point develop a written statement in company with the interviewee – this should ideally be a chronological summary of what happened and what you have heard – a copy should be given to the interviewee for their signature. Having concluded the interview, ask the interviewee to get back to you if they remember or think of anything else that might be helpful.
 - c. Finally, write down notes and observations on the information shared, noting any follow up questions. Evaluate key points and insights and any apparent factual conflicts with other witnesses. There may be inconsistencies apparent to you which are factual to the individuals concerned. These may reflect the individuals' different view points on the incident or different areas of what they have seen or understood. Explore these differences in a neutral way, later.

Common interview mistakes

These include:

1. Screening out information which doesn't seem to fit.
2. Interrupting people when they are talking.
3. Having too many people in the first interview (ideally, it should be one to one, providing this is seen as non-threatening).

FINANCIAL OMBUDSMAN CASE STUDIES

48/7

Commercial insurance – non-disclosure

In January 2001, there was a serious fire at Mrs Y's shop, which was insured with the firm under a commercial policy. The fire brigade thought the fire might have been caused by an electrical fault.

The firm made an interim payment to Mrs Y of £10,000 and appointed loss adjusters. In the course of their investigations the loss adjusters discovered that Mrs Y's business owed its suppliers £70,000. Mrs Y had borrowed almost £100,000 from her bank over the previous two years and had made incorrect statements when applying for the bank loans. The loss adjusters also discovered that, in her original insurance application, Mrs Y had failed to disclose that the ground floor of her shop unit was unoccupied and was not properly secured.

The firm told Mrs Y that it was treating her policy as *void*. This was because she had failed to disclose that the building was not secure and that her business was in difficulty, even though it had questioned her directly about these matters. The firm also believed that Mrs Y had committed a criminal offence in misrepresenting the purpose of the loans. Unhappy with the firm's actions, Mrs Y referred her complaint to us.

Complaint dismissed

Mrs Y denied that her business was in difficulty. She said the money she had borrowed from the bank had originally been intended for home improvements, but she had later changed her mind.

We noted that Mrs Y had run her business for several years and claimed to have run a previous business overseas. So the firm was entitled to treat her as a *commercial customer* and not a *consumer*. This meant that the firm was entitled to rely on the strict legal position. In the circumstances of this case and because of the fraud allegations, we concluded that the dispute was not suitable for our informal procedures and would better be dealt with in a court.

27/6

Farm buildings/machinery/produce – fire damage claim – non-disclosure of previous losses/claims – whether firm justified in voiding the policy and not accepting the claim

In July 2002, Mr and Mrs J arranged farm insurance cover through an intermediary. In answer to a question on the proposal form about previous losses or claims, they disclosed one claim (for losses following a straw fire in 2000). The firm issued the policy.

Only a month later, Mr and Mrs J made a claim when a fire resulted in extensive damage to their farm buildings, machinery and produce.

The firm's investigations revealed that Mr and Mrs J had a history of losses and claims in recent years. They had made a number of claims during the period from October 1993 to February 2001. And they had a total of four substantial losses and claims within the previous five years (one being the straw fire in 2000 that they had disclosed). The firm viewed the couple's failure to provide full disclosure of their losses and claims history as a misrepresentation, entitling it to cancel the policy.

Complaint rejected

Mr and Mrs J were in dispute with the intermediary about the circumstances in which the proposal form was completed, signed and submitted. It was beyond our role to determine that dispute. However, we did conclude that, in completing part of the proposal form and sending it to the firm, the intermediary was acting for Mr and Mrs J, and not as the firm's agent.

We saw no evidence that, at the time of proposal, the firm was made aware of the couple's history of losses and claims, other than the one incident Mr and Mrs J disclosed.

Fraud Investigation

It was Mr and Mrs J's responsibility to ensure that they gave complete and accurate information in response to the questions in the proposal form. We concluded that their failure to provide the full history of their substantial losses and claims within the previous five years had induced the firm to provide cover. So the firm was justified in cancelling the policy from its start date and rejecting the claim.

01/022

Motor – non-disclosure – ‘accidents or losses’ – whether policyholder required to disclose unsuccessful claims

The policyholder applied for motor insurance. The proposal form asked: *“Have you or anyone who will drive been involved in any motor accidents or made a claim (fault or non-fault including thefts) during the last five years?”* His answer was *“No”*.

When the policyholder's car was stolen, the insurer learnt that he had made a theft claim under his previous motor policy within the five year period. The insurer voided the policy from its start date and rejected the policyholder's claim. The policyholder argued that he did not have to disclose his previous theft claim because the insurer concerned had decided not to meet it.

Complaint rejected

The policyholder's answer on the proposal form was incorrect. Although the question was confined to claims and did not extend to losses not claimed for, it was clearly worded: it was not limited to successful claims, nor did it ask what the outcome was. The policyholder had pursued his previous claim all the way to a conclusion and ought to have disclosed it. The insurer was fully entitled to treat the policy as void.

01/025

Household contents – non-disclosure – ‘property stolen, lost or damaged’ – whether policyholder liable to disclose attempted break-in

The policyholder applied for household contents insurance. His local bank manager completed a proposal form on his behalf, which he signed. One of the questions asked was:

“Have you or any member of your household ... had any property or possessions stolen, lost or damaged or had any claims made against you, in the last three years (whether insured or not)?”

The policyholder remembered telling the bank manager of an attempted break-in which occurred some months previously.

The advice he said he was given in reply was that, because the intruders had not gained entry into the house or stolen anything, the incident did not count as a burglary and need not be mentioned on the form.

This previous incident came to light when the insurer appointed loss adjusters to investigate two burglaries. The insurer refused to pay either claim, and voided the policy from its start date. The policyholder was aggrieved, and sought reinstatement of the policy, payment of both claims and compensation for inconvenience suffered.

Complaint upheld

On the question as worded, the policyholder had not supplied an incorrect answer. The question would have had to be phrased differently to elicit disclosure of an attempted burglary which did not result in any quantifiable loss. Even if there had been quantifiable loss, and the policyholder had declared the attempted break-in, it was apparent from the insurer's underwriting guidelines that it would still have been prepared to accept the risk. The insurer agreed to reinstate the policy, deal with both claims, and pay compensation of £250.

FRAUD CASE REPORTS

75/08

Insurer refuses claim for a lost designer watch because policyholder cannot provide any proof of ownership

Mr B made a claim under his contents policy for the cost of replacing his designer watch. He said he lost the watch while on a mountain-walking trip one weekend. As soon as he got home he reported the loss to the police and obtained a crime reference number.

His policy covered personal belongings in and away from his home. He told the insurer that the watch had been worth over £1,800. However, he was aware that his policy had a limit of £1,500 for single items. He had therefore managed to find and buy a replacement that was similar in style to the watch he had lost, but that only cost £1,450.

The insurer said it needed to establish his ownership of the lost watch before it could consider the claim. It asked to see the original receipt. Mr B said he did not have a receipt because the watch had been a gift. He thought it highly unlikely that the friend who gave him the watch would still have the receipt. In any event, he did not feel he could ask her about it.

When the insurer said it was unable to take matters further without the receipt, Mr B complained to us.

We looked in detail at the contents policy. Like many such policies, it included a section about the need for policyholders to provide proof of ownership when making a claim.

We reminded the insurer that possession of a receipt was not the only means of establishing ownership. If Mr B was unable to ask his friend for the receipt – or for a copy of her credit card statement showing the purchase of the watch – he might be able to produce the guarantee or the box the watch had come in. Or he might have a photograph that clearly showed him wearing the watch.

We contacted Mr B and asked if he could provide any such evidence. A few days later he wrote to tell us he was withdrawing his complaint and no longer wished to pursue the matter.

42/3

Policyholder forges documents in the course of making a valid claim – insurers wrongly attempt to ‘avoid’ entire policy

Mr H was a self-employed plumber. In January, his home was burgled and he made a claim under his home insurance policy, which the firm duly paid. In May, his van was broken into and a number of personal possessions were stolen, including the tools he used for his work. He made another claim to the firm under the personal possessions section of his home contents policy.

During the course of its enquiries, the firm’s loss adjusters insisted that Mr H substantiate all his losses with original purchase receipts. Mr H was unable to find all the receipts, so he asked a friend to fake one for him.

When the firm discovered the forged receipt, it ‘avoided’ the policy – in other words, cancelled it from the start. The firm not only refused to pay for the items stolen from the van, it also tried to recover the money it had previously paid out to Mr H for his earlier burglary claim. After complaining unsuccessfully to the firm, Mr H came to us.

Fraud Investigation

Complaint upheld

The firm accepted that the theft from the van was genuine. Mr H had been foolish to obtain a forged receipt but he was not dishonestly trying to obtain something to which he was not entitled. The loss adjusters had, in fact, been rather overzealous in insisting on strict proof of purchase for all the items stolen.

We applied the rationale of *'The Mercandian Continent'* case (reported in [2001] Volume 2 of the Lloyd's Law reports at page 563) which concerned the principle of *'utmost good faith'*. Ultimately, the case held that insurers should only be able to 'avoid' a policy for fraud where the insurer's ultimate liability was affected, or when the fraud was so serious it enabled the insurer to repudiate the policy for fundamental breach of contract.

Following this rationale, we concluded that the fair and reasonable solution was for the insurer to reinstate the policy and pay the claim. In any event, it was unlikely that the firm's ultimate liability would be affected by the fraud, as Mr H's work tools were specifically excluded from the home policy. Home policies often exclude cover for contents or possessions that are for *business* rather than *personal* use.

We also pointed out to the firm that even if Mr H had been guilty of fraud, it would only have been entitled to 'forfeit' the policy from the date of the current claim, leaving the earlier burglary claim intact. It was not entitled to recover previous payments for valid claims.

42/5

Policyholder purposefully gives wrong details of stolen items – insurers able to 'forfeit' policy from the date of the claim

Mr G made a claim for goods stolen from his home during a burglary. Among the many items he claimed for were some *Star Wars* DVDs. This alerted the firm's loss adjusters to the possibility of fraud, since at the time of the burglary the films in question had not been released on DVD. The firm rejected the claim and 'forfeited' Mr G's policy from the date of his claim. Mr G complained to us, arguing that he must have mistakenly claimed for pirated copies of the DVDs, and that this mistake did not warrant 'forfeiture' of the policy.

Complaint rejected

We were satisfied that this was a clear attempt to defraud the firm. There was evidence that showed *'beyond reasonable doubt'* – more than the usual civil requirement of *'balance of probabilities'* – that Mr G was claiming for something that he could never have owned. This higher standard of proof indicated that Mr G would still be guilty of fraud, even if the pirated DVDs did exist, since he had attempted to claim for legitimate copies.

The value of the DVDs was relatively small compared with the overall size of the claim, but we did not feel this was a case of *'innocent and minimal exaggeration'*. Mr G had dishonestly claimed for something he was not entitled to. This went to the very root of the insurance contract, and was a breach of the policyholder's duty to act in *'utmost good faith'* when submitting a claim.

We also felt that this fraud, and Mr G's subsequent attempt to cover it up, cast doubt on the validity of the entire claim. The firm's decision to 'forfeit' was therefore fair and reasonable.

21/1

Household contents – exaggerated claim – whether insurer entitled to reject claim in full – whether policyholder pressed to disclaim part of loss

When Mr J was burgled, he notified the police and put in a claim to the firm. His claim – totalling £3,000 – included a DVD player, 14 DVD discs, other audio-visual equipment and jewellery.

When the firm questioned Mr J, it emerged that although he initially said that he had bought one of the stolen items (a hi-fi) for £150, he had actually bought it from his brother for £60.

The firm's investigator noticed that some of the DVDs he had listed in his claim had not yet been released in the UK. Mr J was unable to explain how he had bought them. He then admitted he had never owned a DVD player or discs, and he said he wished to withdraw that part of his claim.

The firm rejected Mr J's claim, citing the policy exclusion that enables it to do this if any part of a claim is false or exaggerated.

Mr J's solicitor then said that Mr J had been told by the firm's investigator that if he said that he had never owned a DVD player, the rest of the claim would be paid more quickly. The solicitor also said that Mr J had reported the theft of the DVD player to the police and this proved it was a valid claim.

Complaint rejected

We were unable to reconcile Mr J's statement with his solicitor's assertions. It was hard to believe that, merely to progress payment for the rest of his claim, Mr J was willing to admit he had claimed for something he did not own. The only logical explanation was that Mr J had deliberately exaggerated his loss. So the firm was entitled to refuse to make any payment.

21/3

Household contents – fraud – police not informed of full loss – whether sufficient reason for rejecting claim

Mr and Mrs B returned home from an evening out to find they had been burgled. They notified the police right away and rang the firm the next morning. The claim form they sent the firm listed 63 stolen items, with a total value of over £20,000.

The firm's investigator was suspicious about the claim and his enquiries continued for the next eleven months.

During the enquiries, the couple's insurance came up for renewal. The firm took more than two months to consider the matter and then refused to renew. The couple were unable to obtain any replacement insurance.

Almost a year after the loss, the firm rejected the claim. It said that when Mr and Mrs B reported the loss to the police, they had not mentioned all the items they later claimed for. It also said that Mr and Mrs B had not provided all the help and information it needed.

Complaint upheld

Mrs B said that she had still been in shock when she reported the burglary to the police and she had only mentioned the most obvious items that were missing. This explanation was entirely credible. Theft victims may well not be aware of the full extent of their loss within a few minutes of discovering it. In any case, Mrs B had mentioned most of the missing items when she telephoned the firm the morning after the burglary. And the couple had receipts for nearly everything.

We required the firm to settle the claim and to pay £500 compensation for its maladministration. We did not think it had handled the claim well, and it had not given Mr and Mrs B sufficient notice that it would not renew their insurance.

10/10

Fraud – motor – policyholder submitting false receipt in proof of purchase – whether insurer entitled to reject damage claim

Miss F submitted a claim after her car was damaged by thieves. The insurer's engineer decided the car was beyond economical repair and the insurer would not settle the claim without proof of the amount Miss F had paid for the car. In fact, Miss F's boyfriend had given the car to her, but she produced a receipt showing she had paid £3,800.

The investigator appointed by the insurer discovered that it was the boyfriend who had purchased the car and that he had only paid £2,700. The insurer advised Miss F that it would not make any payment because she had presented false evidence in support of her claim. It explained that the policy terms justified its rejecting a claim entirely if a claimant submitted any forged or false document. Miss F argued that her boyfriend had given her the receipt and that she had no reason to believe it was not genuine.

Fraud Investigation

Complaint upheld

The insurer's liability under the policy terms was limited to settling the claim by paying the car's market value. The insurer's aim in asking to see the receipt was not to establish the car's value but to obtain proof that Miss F had owned the car and to confirm its make, model and age. There was independent proof both of the car's existence and of Miss F's ownership of it. Clearly, we would not support any customer who produced fictitious evidence to gain more than their just entitlement, but that was not the situation here. The insurer's liability would have been the same even if Miss F had told the truth and said the car was a present from her boyfriend.

In the circumstances, we were satisfied that Miss F had suffered a genuine loss and that she had not attempted to claim more than her proper entitlement under the policy terms. We concluded that the insurer should pay Miss F the car's market value, plus interest.

REASONABLE CARE CASES/KEYS ON CAR EXCLUSION

38/6

Keys left in ignition – firm rejects claim – whether firm had highlighted exclusion clause

Mr A parked his car opposite a letterbox and jumped out to post a letter, leaving the key in the ignition. While he was crossing the road to reach the letterbox, someone stole his car.

Mr A was horrified when the firm rejected his subsequent claim on the grounds of its 'keys in car' exclusion clause. He said that the firm had never told him the policy included such a clause and, eventually, he complained to us.

Complaint upheld

By turning his back on the car and walking away from it, Mr A had fallen foul of the 'keys in car' clause in the policy. In legal terms, he had left the car 'unattended' – in other words he was not close enough to the car to make prevention of the theft likely, as established in *Starfire Diamond Rings Ltd v Angel*, (reported in 1962 in Volume 3 of the *Lloyd's Law Reports*, page 217); and in *Hayward v Norwich Union Insurance Ltd*, (reported in 2001 in the *Road Traffic Reports*, page 530).

Mr A accepted that he had left the car unattended. But he claimed that none of the policy documents that the firm had sent him (such as the policy schedule and certificate) referred to the 'keys in car' exclusion. The firm had set out the exclusion in the policy booklet but had done nothing to draw Mr A's attention to it when it sold him the policy, as it should have done in accordance with industry guidelines. We therefore felt it was fair and reasonable to assume that Mr A had been prejudiced by the firm's failure to highlight the clause. If the firm had clearly referred to the clause on the policy certificate or schedule, Mr A might well have acted differently.

And we were satisfied that Mr A had not acted 'recklessly'. Applying the test of 'recklessness' as set out in *Sofi v Prudential Assurance* (1993) – he had not even recognised that there was a risk, let alone deliberately courted it. We therefore required the firm to pay Mr A's claim.

01/010

Motor – theft – lack of reasonable care – policyholder aware of risks – whether loss excluded

In May 1999, the policyholder paid £17,000 cash for a Volkswagen Golf GTI turbo to be imported from Belgium. He arranged insurance to take effect on the anticipated delivery date. Nine days after accepting the car, he filled it with petrol. Later that afternoon, he returned to the filling station to put the car through the jet wash.

Leaving the key on the driver's seat, he went to the tap to wash his hands. The policyholder noticed a man who did not appear to have a car and who was standing in front of the jet wash.

However, the policyholder did not feel particularly concerned. As he was washing, he heard a car revving up. At first he did not realise the car was his, but then he saw it being driven out of the garage by the man he noticed earlier. The insurer rejected the theft claim on the ground that the policyholder had breached the duty to take reasonable care of his car.

Complaint rejected

The courts had decided that the duty of reasonable care was breached if the individual acted 'recklessly' – meaning that the individual recognised a risk but deliberately took no steps to avoid it or took steps that were clearly inadequate.

In this case, the policyholder saw someone loitering near his car but had left the car unlocked with the keys on the driver's seat. We were satisfied he had taken no steps to protect his car from a known risk of theft.

38/5

Car stolen from driveway – whether firm was right to reject complaint on the grounds of customer's 'carelessness'

Miss L's car was stolen from the driveway of her home while she was inside the house. She neither saw nor heard the theft. When she put in a claim to the firm, it asked her to send it her car keys. However, she was only able to produce the spare ignition key.

Taking this as evidence that the key had been in (or on) the car when it was stolen, the firm rejected Miss L's claim. It said that by failing to '*exercise reasonable care in safeguarding her car*' she had breached a general condition of her policy.

Miss L objected to this. She said that the key had definitely not been in the car when it was stolen. She had lost the key a month earlier and had been using the spare. She was adamant that she had not been '*careless*', as the firm had suggested. After the firm rejected her complaint, she came to us.

Complaint rejected

We agreed with Miss L that she had not been '*reckless*'. As we noted in our last issue, someone is reckless if they recognise a risk, but deliberately '*court*' it. Miss L had not done this, so the firm was wrong to say that she had breached the '*reasonable care*' condition.

However, the firm's policy also contained a specific (and very comprehensive) clause that excluded claims for cars stolen when the keys were left in them. The firm had specifically highlighted this clause when it sold Miss L the policy. And as we were not satisfied with Miss L's explanation that she had lost the original car key, we concluded on balance that it was likely that she had left the key in, or on, the car.

We were satisfied that the circumstances of this theft did fall within the scope of that exclusion. She could be said to have '*left*' the keys in the car because she had gone into the house, and was too far from the car to be able to prevent it being stolen. In addition, the fact that the car was parked so close to the road meant it was relatively vulnerable to an opportunistic thief. We therefore rejected the complaint.

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Kennedys

Legal advice in black and white