the CHARTERED INSTITUTE of LOSS ADJUSTERS

CILA

Fraud and Property Claims

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On behalf of the CILA Anti-Fraud Special Interest Group

(This paper updates a previous paper that was written by Neal Davies-Fletcher in 2017)

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CONTENTS

1. Introduction

While this paper has been prepared to assist candidates sitting the CILA Advanced Diploma examinations it should be of benefit to all general property adjusters and claims handlers.

In all cases you should follow your own employer's guidelines on fraud investigation and refer to your line manager or obtain legal advice when in doubt.

We would also recommend that you should have access to a copy of 'Property Insurance Law and Claims' published by the CILA when studying for your examinations or as a general reference point for day to day claims handling.

Whilst many property adjusters may pass a claim, where they recognise fraud indicators, to a specialist within their company it is still important for all property adjusters to understand the principle of fraud and its investigation.

2. What is fraud?

There are various dictionary definitions of fraud but a common one is detailed below:

'Noun: *Wrongful or criminal deception intended to result in financial or personal gain'.*

The Association of British Insurers defines fraud as:

'Insurance fraud is when someone invents or exaggerates a claim, or does not tell the truth in order to obtain cheaper cover.'

Recent legal interpretation of fraud in respect of insurance claims:

Court of Appeal: Versloot Dredging BV v HDI Gerling Industrie [2014] EWCA Civ 1349

Para 117 'Since the above hearing The Law Commission has published (July 2014) a finalised draft bill dealing with, inter alia, fraudulent claims, which is in the same form as an earlier draft produced before the hearing. The draft bill provides that ***"If the insured makes a fraudulent claim under a contract of insurance - (a). The insurer is not liable to pay that sum":*** *clause*

12 (1) (a); ***but does not define "fraudulent claim"****. The Report takes the view that* ***it is for the Court to decide what amounts to a fraudulent claim*** *(22.6).*

This is confirmed in para 99 of the Explanatory Notes to the Insurance Act 2015:

Section 12: Remedies for fraudulent claims

99. The section does not define "fraud" or "fraudulent claim". The remedies will apply once fraud has been determined in accordance with common law principles. (22)

(22) For example, see the test for fraud in Derry v Peek (1889) LR 14 App Cas 337.

When is fraud proven? Derry v Peek 1889 LR 5 TLR 625

http://www.bailii.org/uk/cases/UKHL/1889/1.html

This was a House of Lords decision in relation to information given in a company prospectus.

Lord Herschell:

First, in order to sustain an action of deceit, there must be proof of fraud, and nothing short of that will suffice.

Secondly, fraud is proved when it is shown that a false representation has been made

(1) knowingly, or
(2) without belief in its truth, or
(3) recklessly, careless as to whether it be true or false.

The Fraud Act 2006

http://www.legislation.gov.uk/ukpga/2006/35/contents

The Fraud Act 2006 simplified the existing law with the purpose of securing more convictions for fraudulent activity.

The Act extends to England, Wales and Northern Ireland. The Act **does not** extend to Scotland except section 10(1) which amends the Companies Act 1985, where it increases the maximum

custodial sentence for fraudulent trading to 10 years. (Please also read **The Law in Scotland** on page 8 of this document.)

Section 1

Creates a new general offence of fraud and introduces three possible ways of committing it. The three ways are set out in sections 2, 3 and 4.

Section 2 – Fraud by false representation.

(1) A person is in breach of this section if he –

(a) dishonestly makes a false representation, and
(b) intends, by making the representation –
(i) to make a gain for himself or another, or
(ii) to cause loss to another or to expose another to a risk of loss.

(2) A representation is false if –

(a) it is untrue or misleading, and
(b) the person making it knows that it is, or might be, untrue or misleading.

Section 3 – Fraud by failure to disclose information.

A person is in breach of this section if he—

(a) dishonestly fails to disclose to another person information which he is under a legal duty to disclose, and
(b) intends, by failing to disclose the information –
(i) to make a gain for himself or another, or
(ii) to cause loss to another or to expose another to a risk of loss.

Section 4 – Fraud by abuse of position.

(1) A person is in breach of this section if he –

(a) occupies a position in which he is expected to safeguard, or not to act against, the financial interests of another person,

(b) dishonestly abuses that position, and

(c) intends, by means of the abuse of that position –

(i) to make a gain for himself or another, or

(ii) to cause loss to another or to expose another to a risk of loss.

The Explanatory Notes that accompany the Fraud Act give additional guidance including:

In relation to 2 (1) (a):

Definition of dishonesty

The current definition of dishonesty was established in R V Ghosh [1982] Q.B. 1053.

The judgment sets out a two-stage test.

1/ whether a defendant's behaviour would be regarded as dishonest by the ordinary standards of reasonable and honest people, and if yes

2/ whether the defendant was aware that his conduct was dishonest and would be regarded as dishonest by reasonable and honest people.

In relation to 2 (1) (b):

The person must make the representation with the intention of making a gain or causing loss or risk of loss to another. The gain or loss does not actually have to take place.

In relation to 3 (a):

Of relevance to insurance is the Law Commission's Report on Fraud:

"7.28…Such a duty may derive……, from the fact that the transaction in question is one of the utmost good faith (such as a contract of insurance)….."

The Law in Scotland

In Scotland, criminal fraud (as opposed to civil) is mainly dealt with under the common law and a number of statutory offences. The main fraud offences in Scotland are:

Common law fraud

Fraud is committed when someone achieves a practical result by the means of a false pretence. In other words, where someone is caused to do something they would not otherwise have done by use of deception.

Proving an intention to deceive is essential in all cases, and can often be inferred from the actions of the accused.

Uttering

The crime of ‘uttering’ occurs when someone tenders ‘as genuine’ a forged document to the prejudice of another person. Forging a document only becomes a crime if it is shown to have been tendered (to an individual or the public at large) with an intention to defraud/cause someone prejudice.

Civil fraud

Fraud can also feature in a civil context as a delict (or tort) allowing recovery of loss, for example where a party is induced to enter into a contract through fraudulent misrepresentation. As with criminal fraud, the false statement must be made with the relevant intention; however, unlike for the crime of fraud, recklessness or negligence is sufficient for civil fraud.

3. Claims investigation

UNDERLYING PRINCIPLES

In our day-to-day jobs we are required to investigate all classes of insurance claims, particularly property claims, on behalf of our principals.

CILA – Role of the Loss Adjuster

The CILA website describes that the role of a loss adjuster is to:

1) Verify whether the policy covers the loss or damage

2) Verify the amount (if any) the policy should pay out

Policy requirements

Whether it is a domestic or commercial claim the policy will require the policyholder to provide at their expense all **reasonable** details and evidence which we may ask for.

However, when investigating any property claim we have to balance the requirements of the FCA and achieve the objective of the ABI on fraud.

The Financial Conduct Authority (FCA)

https://www.handbook.fca.org.uk/handbook/ICOBS.pdf

We need to comply with the FCA's rules on insurance claims handling, which are set out in Insurance: Conduct of Business 8 (ICOBS) requiring amongst other things that insurers must:

1. *Handle claims promptly and fairly;*
2. *Provide reasonable guidance to help a policyholder make a claim and also provide 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.*

If at any stage in the claim process the policyholder complains about the investigation of the claim, then this should be dealt with in accordance with your principals and the FCA revised rules on complaint handling with effect from 30 June 2016.

The FCA defines a complaint as:

> *'Any expression of dissatisfaction, whether oral or written, and whether justified or not, from or on behalf of an eligible complainant about the firm's provision of, or failure to provide, a financial service'.*

Provided you have followed the above guidance the complaint should be an opportunity to reinforce to the policyholder our role as loss adjusters and the reason why we cannot accept the claim until all reasonable evidence has been provided.

Association of British Insurers (ABI) objectives on fraud

'Reducing and deterring fraud remains a priority for the insurance industry. Our industry has a zero-tolerance approach to weeding out the cheats'.

The latest ABI figures available are for 2019, and at the time of publication the ABI commented:

> After three years of falling claims fraud volumes, 2019 saw a slight increase. The total volume of claims fraud rose by 5% to reach 107,000 - remaining relatively consistent with both 2017 and 2018. The fraud repudiation rate, which looks at fraudulent claims as a percentage of claims notified, also increased by a small amount this year. Underlying this increase are rises in both motor claims fraud volumes and property claims fraud volumes, while other lines of business have seen decreases. There were significant increases in fraudulent property claims, with those seen in commercial property rising by 33% and domestic claims fraud increasing by 29% to

23,944 - the highest value seen since 2013. Of particular note also is the increase in application fraud which rose by circa 200%.

CIDRA - The Consumer Insurance (Disclosure and Representations) Act 2012

The Consumer Insurance (Disclosure and Representations) Act (CIDRA) 2012 applies to consumer insurance and sets out what happens if a consumer gives incorrect information to their insurer. CIDRA also deals with group insurance in which the proceeds of the policy may be paid to beneficiaries who are not the insured (for example, a policy taken out by an employer for the benefit of its employees). CIDRA came into force in April 2013.

CIDRA only applies to consumer insurance contracts. These are defined as insurance bought by individuals for purposes wholly or mainly unrelated to their trade, business or profession. This definition deliberately follows the general approach of European law. The definition of insurance is left to the common law.

CIDRA follows the practice of the Financial Ombudsman Service (FOS) and abolishes the consumer's duty to volunteer information (often referred to as the duty of disclosure and fundamental to the Marine Insurance Act 1906). Instead, the insurer must ask appropriate questions and the consumer must answer them honestly and carefully. CIDRA imposes on the consumer a duty to take reasonable care not to make a misrepresentation. This also applies when a policy is varied or renewed. The standard applied is objective, being that of the reasonable consumer taking into account all relevant circumstances (such as the type of insurance and how it was sold). The particular characteristics of the individual consumer are only relevant if the insurer knew, or ought to have known about them.

Where the consumer gives incorrect information, CIDRA distinguishes between three types of misrepresentation:

1. Reasonable.
2. Careless.

3. Deliberate or reckless.

Misrepresentations that are careless or deliberate and reckless are described as "qualifying misrepresentations" for which the insurer will be compensated if it can show that it would have acted differently had it known the true facts. There is no remedy if the consumer's misrepresentation was reasonable.

For a misrepresentation to be deliberate or reckless, the insurer must show that the consumer both:

Knew that the statement was untrue or misleading, or did not care whether it was or not.

Knew that the matter was relevant to the insurer or did not care whether it was or not.

Two presumptions assist the insurer:

1. The consumer is presumed to have the knowledge of a reasonable consumer.
2. If the insurer asks a clear question, the subject matter of the question is presumed to be relevant.

If the misrepresentation is deliberate or reckless (essentially fraudulent), the insurer may avoid the policy and can generally keep the premium.

If the misrepresentation is careless, the insurer's remedy depends on what it would have done had proper information been provided:

If the insurer would have declined the risk altogether, it can avoid the policy and refuse any claim but should return the premium.

If the insurer would have written the policy on different terms then those terms apply from inception. These terms may include different limits or exclusion clauses.

If the insurer would have charged a higher premium, any claim can be reduced pro rata to the underpayment.

These provisions represent a very considerable change to the Marine Insurance Act 1906 under which the only applicable remedy is the possibility for insurers to avoid the entire policy, regardless of the circumstances of the misrepresentation.

In addition, CIDRA provides that misrepresentations by a beneficiary under a group scheme will affect that individual but not the other members of the scheme. It abolishes "basis clauses" which incorporate all representations as insurance warranties. In contrast, the Marine Insurance Act 1906 provides that breach of a warranty automatically discharges the policy, regardless of whether it is relevant to the risk insured.

Finally, CIDRA gives some guidance on whether an intermediary is acting as the agent of the policyholder or of the insurer when the policy is being agreed.

Since CIDRA came into force, research carried out by the Chartered Insurance Institute and confirmed by discussion with the FOS indicates that consumer disputes involving questions of misrepresentation have become rarer. Instead, disputes arise over the wording and extent of the cover provided.

The Insurance Act 2015

The Insurance Act 2015 came into force in August 2016. ***It regulates both business and consumer insurance*** and covers the following topics:

- The pre-contract duty of disclosure for all non-consumer insureds: it introduces the new duty to make a "fair presentation" of the risk.
- The insurer's remedies for breach of the duty of fair presentation.
- Basis of the contract clauses.
- Remedies for breach of warranty.
- "Irrelevant" risk mitigation clauses.
- The insurer's remedies for fraud.
- Contracting on different terms.

The Insurance Act 2015 retains some provisions of the Marine Insurance Act 1906, codifies some of the developments that have occurred since 1906 and introduces new legal concepts. The key provisions are the introduction of the new duty to make a fair presentation, the provision on warranties and similar terms risk mitigation clauses, and insurers' remedies for fraud.

The Insurance Act 2015 is a default scheme for business and non-consumer insureds. However, as it is based on best practice and was widely supported by the market, it is unlikely that insurers will wish to contract out of it on a regular basis. It may however be appropriate to do so if the risk insured is very specific or complex. In addition, the new regime is probably not appropriate for many reinsurance contracts. If the insurer wishes to contract on different terms and a term is "disadvantageous" to the insured, the insurer must:

- Take sufficient steps to bring the term to the insured's attention.
- Ensure that the term is clear and unambiguous.

This is a deliberately flexible test. For example, what is sufficient in a sophisticated market with well informed and advised parties will not be adequate if the insured is a small business buying cover online.

Duty of disclosure

The Law Commissions retained the obligation to volunteer relevant information for all insureds who are not consumers (duty of disclosure). However, the Insurance Act 2015 also included new provisions relevant to the duty of disclosure. The duty to make a fair presentation of the risk incorporates both the law on non-disclosure and representation. The duty also includes waiver provisions similar to those of the Marine Insurance Act 1906. An insured will have complied with the duty to make a fair presentation if it has provided enough information to put the underwriter on notice to ask further questions. Additionally, the Act gives some guidance on how information must be disclosed and who must provide it. The new duty recognises that gathering information in large organisations involves a lot of processes and aims to recognise the impact of Information Technology (IT).

The duty of disclosure deals with both the substance of the information provided and its form. The insured must:

- Disclose all "material circumstances" which it knows or ought to know.
- Failing that, provide sufficient information to put the underwriter on notice to ask further questions.

The insured cannot comply with its obligation through merely providing information on every possible fact and circumstance. A fair presentation of a complex risk requires adequate signposting to draw the underwriter's attention to the relevant facts.

The insured:

- Knows information known by its senior management.
- Knows information known by the persons arranging the insurance.
- Ought to know information that would reasonably have been revealed through a reasonable search.

"Senior management" is defined as the persons who "play significant roles in the making of decisions about how the insured's activities are to be managed or organised". Senior management will often be the board of a company. However, the definition is wider as some insureds will not be companies. The individuals arranging the insurance can include, for example, the insured's risk manager or broker (although a broker is not obliged to disclose confidential information obtained through a business relationship unconnected to the relevant contract of insurance).

The Marine Insurance Act 1906 included some limitations to the insured's duty of disclosure which have been maintained by the Insurance Act 2015. An insured does not have to disclose information if the insurer knows it, ought to know it or is presumed to know it. The insurer knows what is actually known to its underwriter or their agent. The insurer ought to know both:

- Information that should have been passed on to the underwriter (for example, by a surveyor or the claims department).
- Information that the insurer holds in its systems provided that it is "readily available" to the underwriter.

The insurer is presumed to know information that underwriters writing the relevant class of business should know. The Commissions did not think that the law should protect the naïve or poorly trained underwriter. Instead the Commissions sought to reinforce good professional standards.

If the insured fails to make a fair presentation, the insurer always has a remedy provided that it can show that it would have acted differently had it known the truth. If the insured is deliberate or reckless, the insurer can avoid the policy and keep the premium. If the insurer would not have written the risk then again it can avoid the policy but must return the premium. For all other breaches of the duty of fair presentation, the following applies:

- If the insurer would have imposed additional terms or limits, these are imposed from inception.
- If the insurer would have charged a higher premium, the claim is reduced pro rata.

Although the duty of fair presentation is based on the existing law, policyholders and their brokers would be wise to review their existing practices, for example:

- Processes for gathering information.
- Whether there is a reasonable search and how this is documented.
- Whether discussions with the board or senior management are adequate.
- Whether discussions between the insured and their broker are adequate.

Insurers will also have to review their processes and address the following questions:

- Are underwriters sufficiently well trained and knowledgeable to ask the right questions? Insurers are expected to have a reasonable degree of knowledge about the type of business they are underwriting.
- Is knowledge properly passed across the organisation?
- Is communication with an agent or surveyor sufficient?
- Are communications between the claims departments and underwriting adequate?
- What is held in the insurer's systems and can underwriters access what they need?
- What evidence will there be on what underwriters might have done if a fair presentation had been made?

Warranties and fraud

The provisions on warranties and fraud of the Insurance Act 2015 apply to both business and consumers*.*

The new act follows CIDRA and abolishes basis of contract clauses (see above, The Consumer Insurance (Disclosure and Representations) Act 2012). Any term that seeks to turn information provided when the policy was purchased into an insurance warranty will have no effect. However, the new Act does not define "warranty" and existing definitions will continue to apply.

In the case of a breach of warranty, the policy will be suspended while the insured is in breach but will be restored once the breach is remedied. For example, if an insured is obliged to inspect an alarm system but fails to do so, cover is suspended until the inspection is carried out.

Warranties and terms that seek to mitigate risk will not be effective if the insured can show that non-compliance "would not have increased the risk of the loss which actually occurred in the circumstance in which it occurred". A risk mitigation term is one that "tends to reduce the risk of" loss of a particular kind, at a particular location or particular time. It is not a term that defines the risk as a whole such as an age requirement in a motor policy. For example, a sprinkler warranty will apply if there is a fire, but not if the property suffers a loss by flood from an adjacent river.

These changes are a departure from the current law under which a warranty discharges the insurer from any liability under the policy from the date of breach, regardless of whether there is a connection between the breach of warranty and the loss that occurred.

If the insured makes a fraudulent claim, the entire claim is forfeit (including any honest part of the claim) and the insurer can keep the premium. The insurer will remain liable for any genuine claims before the fraud, but has the option to terminate the policy from the date of the fraud. More details this can be found on page 39 under the *Remedies Available section* of this document.

The Enterprise Act 2016

http://www.legislation.gov.uk/ukpga/2016/12/contents

This received Royal Assent in May 2016 and amends the Insurance Act 2015 requiring the following section to be inserted after section 13:

Implied term about payment of claims

(1) It is an implied term of every contract of insurance that if the insured makes a claim under the contract, the insurer must pay any sums due in respect of the claim within a reasonable time.

(2) A reasonable time includes a reasonable time to investigate and assess the claim.

(3) What is reasonable will depend on all the relevant circumstances, but the following are examples of things which may need to be taken into account —

(a) the type of insurance,

(b) the size and complexity of the claim,

(c) compliance with any relevant statutory or regulatory rules or guidance,

(d) factors outside the insurer's control.

(4) If the insurer shows that there were reasonable grounds for disputing the claim (whether as to the amount of any sum payable, or as to whether anything at all is payable) —

(a) the insurer does not breach the term implied by subsection (1) merely by failing to pay the claim (or the affected part of it) while the dispute is continuing, but

(b) the conduct of the insurer in handling the claim may be a relevant factor in deciding whether that term was breached and, if so, when

(5) Remedies (for example, damages) available for breach of the term implied by subsection (1) are in addition to and distinct from—

(a) any right to enforce payment of the sums due, and

(b) any right to interest on those sums (whether under the contract, under another enactment, at the court's discretion or otherwise).

PRACTICAL ASPECTS OF CLAIM INVESTIGATION

In most cases the policyholder will quickly be able to provide the requested information to enable the claim to proceed to settlement.

However, we need to be aware that fraud can occur at any stage during the claim process.

When Fraud can occur:

- **Policy inception**

  Where there has been misrepresentation or withholding of material fact.

- **Mid-term or renewal**

  For example, an item added to the policy when in fact it was lost or stolen prior to it being insured.

- **Claim Stage**

  Either there has been a deliberate loss or no loss has occurred

- **Later discovery that a loss had not occurred or was a smaller loss**

  A fraud is committed where the policyholder, later discovers that an item was not lost or the loss was substantially smaller than first thought, but does not advise his insurance company.

  Agapitos & Anor v Agnew & Others (2002) EWCA Civ 247

Types of fraud

- **No loss**

  Where there simply was no loss.

- **Deliberate loss**

  Where the policyholder has deliberately caused the loss or damage in order to submit a claim.

- **Fraudulent exaggeration**

Deliberately inflating a claim is fraud but case law determines that the dishonest element must be substantial either in proportion to the claim or in isolation. Substantial means the dishonest part must be more than minimal.

Case law suggests a small degree of exaggeration for the purpose of claim negotiation is permitted –

Nsubuga v CU (1998) and Orakpo v Barclays Insurance Services (1995)

'A long line of authority establishes that if an insured makes a fraudulently inflated claim under the policy he forfeits any lesser claim which he could properly have made. An owner who claims $10,000,000 knowing that the claim could not possibly be worth more than $9,000,000 recovers nothing.'

As Lord Hobhouse observed in *The "STAR SEA"* at para 62,

'*The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.'*

This was also commented on in Para 9 Supreme Court Versloot Dredging v HDI Gerling [2016] UKSC 45

All of this said, always check the wording of the fraud condition in the relevant policy, as interpretation can vary.

- **Fraudulent Means or device**

Development of case law

***Agapitos & Anor v Agnew & Others [2002] EWCA Civ 247* – Court of Appeal decision.**

http://www.bailii.org/ew/cases/EWCA/Civ/2002/247.html

This was a claim bought under a Marine Insurance policy, but the decision applies equally to property claims.

On the 19th February 1996 there a fire on the passenger ferry "Aegeon".

The fire occurred while the ferry was laid up in Greece undergoing maintenance work and as a result of 'hot work's being undertaken. The claim itself was considered valid but false representations were made as to when the hot works commenced on the vessel.

Section 17 of the Marine Insurance Act 1906 relates to 'utmost good faith'. A contract of marine insurance is a contract based upon the **utmost good faith**, and if the utmost good faith be **not** observed by either party, the **contract may be avoided** by the other party.

The appeal related to three issues, the main two being:

1. Whether and in what circumstances the common law rule and / or section 17 of the Act 1906 apply in the event of use of fraudulent means or devices to promote a claim which may prove at trial to be in all other respect valid.
2. Does the application of that rule cease with the commencement of litigation.

Lord Mance

'…., I would suggest that the courts should only apply the fraudulent claim rule to the use of ***fraudulent devices or means*** *which would, if believed, have tended, objectively but prior to any final determination at trial of the parties' rights, to yield a not insignificant improvement in the Insured's prospects - whether they be prospects of obtaining a settlement, or a better settlement, or of winning at trial".*

Three tests are applied:

1. the device must be directly related to the claim; and
2. the device must have been intended by the assured to promote his prospect of success, and
3. it must not be irrelevant but such that, if believed, it would have tended to yield a not insignificant improvement in the assured's prospects of success prior to any final determination of the parties' rights.

Between them these conditions ensure that only relevant lies, told to deceive and objectively capable of doing so, will lead to forfeiture.

***Versloot Dredging BV v HDI Gerling [2016] UKSC 45* – Supreme Court Decision**

http://www.bailii.org/uk/cases/UKSC/2016/45.html

This was again a claim bought under a Marine Insurance policy, but the decision applies equally to property claims.

On the night of 28/29 January 2010 the cargo ship “DC Merwestone” left port in Lithuania.

It was freezing cold when they left port and the crew had used the emergency fire pump and lines to blast chipped ice away from the hatch covers before opening them.

This set in motion a chain of events which resulted in the ingress of water which flooded the engine room. A claim was bought under the policy for the cost of repairs at 3.4 million Euros.

At the court of appeal it was concluded that the owners had a valid claim and were not responsible for the actions of the crew or the condition of the vessel that night, but held that the claim was lost a result of the collateral lie told by owners.

A ‘reckless untruth’ was told regarding the activations of the bilge alarm.

The judge commented that he reached that conclusion with regret because he regarded it as unjust.

The question at issue on this appeal [to the Supreme Court] was what constitutes a fraudulent claim. Three possible situations were identified:

1. The whole claim may have been fabricated. In which case, irrespective of whether a fraudulent device had been used, the insurer would not be liable to pay the claim.
2. There may be a genuine claim, the amount of which has been dishonestly exaggerated. This is a typical case for the application of the rule. The insurer is not liable, even for that part of the claim which was justified.
3. The entire claim may be justified, but the information given in support of it may have been dishonestly embellished, either because the insured was unaware of the strength of his case or else with a view to obtaining payment faster and with less hassle.

The appeal was concerned with embellishments of this kind. They are generally called "fraudulent devices". Lord Sumpton, explained the expression is borrowed from a standard clause avoiding contracts of fire insurance from the 19th and early 20th century which he considered was archaic and did not adequately describe the problem. He used the expression 'collateral lies', by which he means a lie which in turns out when the facts are found to have no relevance to the insured's right to recover. The question being considered was 'whether the insurer is entitled to repudiate a claim supported by a false statement, if the statement was irrelevant, in the sense that the claim would have been equally recoverable whether it was true or false.'

Lord Sumpton, concluded:

'*this is the first time that the House of Lords or the Supreme Court has had the opportunity to resolve the question whether the fraudulent claim rules applies to justified claims support by collateral lies*.'

'I have reached the conclusion that the rule does not apply to such claims.'

He accordingly allowed the appeal and entered judgement against the insurers for the sum of 3.2 million Euros.

The second situation, referred to by Lord Sumpton, may apply where a 'fake invoice' is submitted for an amount that the insured was not entitled to recover. A FOS decision on the 01 December 2016 follows the principle. In summary, RSA paid a claim at £1,900.00 and agreed that in addition they would pay the VAT element on submission of a VAT invoice. The insured then submitted a 'fake invoice'. If RSA had accepted the fake invoice, it would have been induced into paying an additional 20 per cent of the claim in respect of VAT which wasn't actually due to the insured.

FOS decision: 'Even though part of the claim was genuine the fraud 'taints' the whole claim and so RSA doesn't have to pay any of it. That means I think RSA's entitled to recover the money which it's already paid the insured in respect of this claim.'

Fraud indicators

Most loss adjusters and insurers will have their own ‘set’ of indicators as a means of identifying a claim that has concerns or is considered suspect in some way. They should be used with caution as they in itself are not proof of fraud.

Examples of fraud indicators include the following:

- Recent or proposed change in risk
- Claim made within 6 weeks of renewal
- Claim made within 6 months of inception
- Gaps in insurance history
- Policy alteration to subject matter of claim prior to claim intimation
- Non disclosure of material fact
- Delay in notifying police/insurer
- High frequency of previous claims
- Altered documentation
- Incorrect VAT number
- Change in story
- Significant overstatement
- Loss incompatible with lifestyle
- Circumstances inconsistent/incompatible with damage/loss
- Lack of forced entry
- Arson/willful fire raising (Scotland)

Waiver, estoppel and reservation of rights letter

These should always be considered at the very early stages of any claim where you consider that liability may be in doubt or where you suspect fraud.

- **Waiver**

This is where an insurer, either by words or action, indicates to a policyholder that it does not intend to enforce it's legal rights even though it has a right to avoid the policy or decline indemnity and is aware that it has such a right.

- **Estoppel**

  Is where even though insurers were unaware that they had grounds to avoid the policy or decline the claim, but again by either it words or actions, or those of its appointed representative e.g. the loss adjuster, give the policyholder reason to believe that the claim would be accepted under the policy and the policyholder acted upon that information to its detriment.

- **Reservations of rights letter**

  To avoid the effects of 'waiver' or 'estoppel' you may issue a 'reservation of rights' letter which clearly states that insurers rights are reserved and none of their statements or actions should be understood as waiving its rights generally including their right to rely on any further matters that might arise during the course of any further investigations.

  However, a reservation of rights letter should not be issued as a matter of routine and you should always refer to your principal's guidance on this matter.

Furthermore, you should be aware of the 'Statement of Principles' issued by AIRMIC (Association of Insurance and Risk Manager) and agreed with various insurers:

Statement of Principles - These apply on notification of a potential loss or series of potential losses under a contract of insurance reasonably anticipated to exceed £2.5m ("the Potential Loss") from the date of first notification of the Potential Loss to the insurer for a period of 90 days ("the Period").

During the course of your investigation you may need to verify the information provided by the insured with the police and requests to the police must be undertaken in accordance with the Memorandum of Understanding:

ACPO (now NPCC) / ABI Memorandum of Understanding (MOU): June 2014

Information from the police must be applied for compliantly, in accordance with the agreement between The National Police Chiefs Council and the Association of British Insurers; the agreement is known as the ACPO / ABI agreement.

ACPO / ABI agreement: phoning the police

The agreement confirms what information the police will and won't routinely provide **if contacting them by phone**, as follows:

- They will only confirm that a crime reference number is in the correct format
- They will not provide any other information relating to the incident itself
- They will never provide details of criminal convictions even if the policyholder agrees for this information to be supplied

Therefore, to be compliant with the agreement, if phoning the police only ever ask them if the crime reference number is in the correct format.

ACPO / ABI agreement: obtaining additional information

There are two options for obtaining additional information. Both involve completing and submitting a form, as follows:

- **Appendix D (a):** This form should be used when the insurer wishes to obtain confirmation of the following information about either lost property or a crime: lost property / crime reference number; date and time the offence was reported; the aggrieved or reporting person. Forces are asked to make the insurer aware if this information is not available. There is a charge for this, which varies between police forces. Forces will endeavour to respond within 10 days.
- **Appendix D (b):** This report is usually referred to as the 'police report'. The form should be used when the insurer requires information in addition to that provided via an appendix D (a) application. The charge for this will be the charge for a crime report, which varies from force to force, and forces will endeavour to respond within 30 days.

Experience tells us this is not usually the case and it can take longer (sometimes a fair bit longer).

As noted, both reports will incur a charge, and this will usually be passed to the insurer as a case disbursement, as such it is important to ensure you have insurer approval before applying for police reports.

The process for obtaining information from the police is subject to ongoing review as at May 2021, but at present it is as described above, and as captured in the full agreement:

https://www.abi.org.uk/~/media/Files/Documents/Publications/Public/2014/ACPO%20ABI%20MoU%20Exchange%20of%20Info.pdf

Rehabilitation of Offenders Act 1974

Under the Rehabilitation of Offenders Act 1974 certain criminal convictions become “spent” after specified periods. Generally speaking, “spent convictions” need not be disclosed when applying for a job, obtaining insurance or in civil proceedings.

As of Monday 10 March 2014, the rehabilitation periods contained in the Rehabilitation of Offenders Act 1974 (“the Act”) have been shortened substantially.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299916/rehabilitation-of-offenders-guidance.pdf

The changes apply to rehabilitation periods in England and Wales only, and will apply retrospectively, so that those convicted prior to 10 March 2014 will also be subject to the new rules.

The applicable periods for Scotland are unchanged, and the situation in Northern Ireland is still governed by the Rehabilitation of Offenders (Northern Ireland) Order 1978.

Previously the rehabilitation periods ran from the date of conviction, but the system has now changed so that the rehabilitation period is made up of the length of the sentence, and an additional “buffer” period. At the end of the buffer period, the conviction becomes spent.

The changes in relation to custodial sentences see a significant reduction in the rehabilitation period, even when you consider that the new buffer period runs from the end of the sentence, rather than from conviction. It should also be noted that now a conviction resulting in a custodial sentence of up to 4 years can one day be spent, rather than custodial sentences over 30 months never becoming spent, as was the case previously.

Custodial Sentence/disposal	**Adults – 18 and over at the time of conviction or the time the disposal is administered.** **New Rehabilitation Period (which is the length of the sentence plus the “buffer” period outlined below)**	**Young people (under 18 at the time of conviction or the time the disposal is administered).** **New Rehabilitation Period (which is the length of the sentence plus the “buffer” period outlined below)**
Over 4 years	Never spent	Never spent
30 months to 48 months	7 years	3½ years
6 months to 30 months	4 years	2 years
Custodial sentence of 6 months or less	2 years	18 months
Community order or youth rehabilitation order	1 year	6 months

Sentence/disposal	Rehabilitation period for adults (18 and over at the time of conviction or the time the disposal is administered).	Rehabilitation period for young people (under 18 at the time of conviction or the time the disposal is administered).
Fine	1 year	6 months
Conditional discharge	Period of the order	Period of the order
Absolute discharge	None	None
Conditional caution and youth conditional caution	3 months or when the caution ceases to have effect if earlier	3 months
Simple caution, youth caution	Spent immediately	Spent immediately
Compensation order	On the discharge of the order (i.e. when it is paid in full)	On the discharge of the order (i.e. when it is paid in full)
Binding over order	Period of the order	Period of the order
Attendance centre order	Period of the order	Period of the order
Hospital order (with or without a restriction order)	Period of the order	Period of the order
Referral order	Not available for adults	Period of the order
Reparation order	Not available for adults	None

NB 1) As before, the above periods should be halved for those who are under 18 when they are convicted, with the exception that for custodial sentences of up to 6 months, the buffer period will be 18 months.

NB 2) Note that all cautions (except conditional cautions) are spent immediately. This rule was introduced on 19/12/2008 by an amendment within the Criminal Justice and Immigration Act 2008.

Examples:

- A 2 year custodial sentence given to an adult may become spent after 6 years: the rehabilitation period is the period of the sentence plus a further 'buffer period' of 4 years, giving a total of 6 years.
- A 2 year custodial sentence suspended for 2 years is spent after 6 years; the rehabilitation period is the period of the custodial sentence plus a further buffer period of 4 years giving a total of 6 years. (A suspended sentence is a sentence of imprisonment and the rehabilitation period is therefore determined by the custodial sentence, regardless of the period for which it is suspended).
- A 6 month sentence of detention given to a young person may become spent after 2 years: the rehabilitation period is the period of the sentence plus a further 'buffer period' of 18 months, giving a total of 2 years.
- A 1 year community order given to an adult may become spent after 2 years: the rehabilitation period is the length of the order plus a further 'buffer period' of 1 year, giving a total of 2 years.
- A 1 year youth rehabilitation order given to a young person may become spent after 18 months: the rehabilitation period is the length of the order plus a further 'buffer period' of 6 months, giving a total of 18 months.
- An adult who is given a fine will have to declare this conviction for 1 year from the date of conviction before it is considered spent.

Disclosure of Criminal Convictions

When buying general insurance products, consumers are asked declaration questions, and one of these is usually whether the applicant or anyone living at the property has any unspent criminal convictions.

Routinely we also ask this question at the claim stage as part of our process, either during pre-visit activity, or at the visit itself. This guidance confirms what you need to do if you get a 'yes' answer, as well as informs about next steps.

Information needed

It's fine to ask a policyholder if they or anyone living with them have any unspent criminal convictions; so there's nothing new in that regard for most of us.

The following is the detail a client would normally want to know if you receive a 'yes' answer - so this is what you should ask in response and make a note of; the responses to the first three questions need to be factual, the final one could of course be 'an interpretation', but is always useful anyway.

- The date of the conviction.
- The offence the policyholder (or member of the household) has been convicted of.
- The exact penalty received.
- Brief circumstances.

If a policyholder says that he/she can't recall the detail, ask for their best recollection.

Next steps

Armed with this information, we/insurers can begin to determine the relevance of any convictions that might be disclosed. To do that, it’s advisable to refer the claim to your investigations colleague. This is important because the Rehabilitation of Offenders Act was revamped in 2014 and interpreting the relevance of what we've been told by a policyholder can be tricky on occasions.

Important aspects that your investigations colleague will be able to advise on include:

a) Whether a conviction is spent or not

b) If there's a need to obtain criminal record information to confirm detail, via the approved 'Basic Disclosure' process

c) What to say to a policyholder

d) What to report to a client

Process/the Data Protection Act

The process we follow if we need to confirm detail is to ask a policyholder to apply for what's known as a 'Basic Disclosure', and how you do this depends on where the policyholder lives. There are three separate processes: one for England and Wales (combined), one for Scotland and one for Northern Ireland. You can follow the links below to access information and all process guidelines:

- https://www.gov.uk/request-copy-criminal-record For England and Wales
- https://www.mygov.scot/basic-disclosure/overview For Scotland
- https://www.nidirect.gov.uk/campaigns/accessni-criminal-record-checks For Northern Ireland

Importantly, doing this does not breach the Data Protection Act. We need to be mindful that it's an offence to ask a policyholder to submit what was sometimes referred to as a 'subject access request' to the police to confirm a criminal record. This request was also known as a SAR, or a SA1, or simply a criminal record check - so please don't use any of these terms, because doing so could be construed as an 'enforced subject access request', and you might be deemed to be breaking the law if you do it.

Rather, your investigations colleague will be able to advise you on what to say to a policyholder.

Basic disclosure

This section provides an overview for information purposes - please remember, it's recommended that you should consult your investigations colleague.

Any individual can apply for a Basic Disclosure about themselves, for any purpose. The document is issued to the individual, and it's then up to the individual what they do with it – in a claim situation we'd usually be looking for it to be passed to us to help liaise with underwriters.

A Basic Disclosure is obtained by following the simple process outlined via the respective websites noted above. Typically, there's a form that the individual has to complete online, and submit with some identification, all of which is clearly and succinctly set out on the website.

It's also possible to apply through normal postal services if required.

Interpreting a basic disclosure

As previously noted, we've the Rehabilitation of Offenders Act to consider, as well as policy inception date and residency. Additionally, from time to time we come across what appear to be old convictions on a Basic Disclosure, convictions we might feel are 'spent' under the Act, only to glean that something known as the 'holding on' process applies - put simply, when a person reoffends within the rehabilitation period of a prior conviction, the conviction for the further offence 'drags through' existing unspent convictions, extending their rehabilitation period until the last one is spent.

It can be puzzling. The bottom line is that the Basic Disclosure does the work for us and accurately discloses unspent convictions only but given it can be puzzling please always check any Basic Disclosure documents with your investigations colleague.

Basic disclosure notations

- There's usually a fee for obtaining a Basic Disclosure, typically around £25, which is payable by the policyholder. Given the sum now involved, it's recommended that you consult with the insurer on a case by case basis to ascertain whether they are prepared to reimburse this.
- The service clarifies unspent convictions only as at the time of applying for the Basic Disclosure. It does not report on convictions that are spent, police cautions and outstanding

charges that have not yet been through the court process. Further, it does not have some other police national computer information that would sometimes be included in a police force produced subject access report.

- It does not report retrospectively - for example it will not identify convictions that may have been unspent at the time of a policy inception that have since become spent.

Statement taking

When investigating a claim there are times when in may be appropriate to obtain a written statement form the policyholder.

A witness statement:

1. Should be expressed in the first person.
2. Should state the full name of the witness and the witness's place of residence.
3. Should state the witness's occupation.
4. Should usually be in chronological sequence divided into consecutively numbered paragraphs each of which should, so far as possible, be confined to a distinct portion of the evidence.
5. Must indicate which of the statements in it are made from the witness's own knowledge and which are matters of information and belief, indicating the source for any matters of information and belief.
6. Must include a statement by the witness that they believe that the facts stated in it are true.
7. Must be signed by the witness.
8. Must have any alterations initialed by the witness.
9. Must be dated.

For further guidance refer to the Ministry of Justice 'Practice Direction 32 – Evidence' and in particular Paragraphs 17 – 25

https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part32/pd_part32#witness

The role of the Insurance Fraud Bureau (IFB)

The Insurance Fraud Bureau (IFB), is a not-for-profit company established in 2006 to lead the insurance industry's collective fight against insurance fraud.

They act as a central hub for sharing insurance fraud data and intelligence, using our unique position at the heart of the industry and unrivalled access to data to detect and disrupt organised fraud networks.

They use a wide range of data and intelligence to achieve two primary objectives:

- Help insurers identify fraud and avoid the financial consequences
- Support police, regulators and other law enforcement agencies in finding fraudsters and bringing them to justice.

They also try to raise public awareness of insurance fraud scams: how they work and how to spot them, so that the chances of being caught out are reduced

4. Standard of Proof

Criminal Law

The evidence must prove the case 'beyond all reasonable doubt'.

Civil Law

The standard of proof is determined on the 'balance of probabilities'.

However, following the decision in S and M Carpets Ltd v Cornhill [1981], in civil fraud trials the balance needs to be tipped further than this:

> '*If a defendant or plaintiff is to allege fraud, then the standard of proof is somewhat higher than that ordinarily applicable to civil matters, but not as high as that relating to criminal matters'.*

The burden of proof lies with the Insurer to prove a fraud has taken place, the legal principle is 'he who asserts must prove'.

Financial Ombudsman's Service

The FOS has provided the following statement specifically for inclusion in this paper:

> *Individual policyholders and small businesses can complain to the Financial Ombudsman Service if they are unhappy with the way their claim has been handled or with the amount offered in settlement. The ombudsman can make awards of up to £150,000. Here is a link to the website where you will find a lot of information* http://www.financial-ombudsman.org.uk/
>
> *The ombudsman decides cases on the same basis as the court – the balance of probabilities. And like in the courts an allegation of fraud requires very persuasive evidence. So it isn't sufficient simply to have some concerns about a claim or to think that it is unsatisfactory in some respects and reject it without giving good reasons. You will need evidence of fraud or enough evidence to throw such doubt on the claim that the ombudsman will dismiss it as better dealt with in court where evidence can be given under oath and witnesses can be cross-examined.*

And when looking at claims you have to be realistic. The ombudsman may feel that it's unreasonable to expect a consumer to hang on to receipts for many years. There can be other ways of establishing the existence of an item – photographs for example. And if someone has suffered a burglary or a catastrophic loss, through flooding for instance, it may be unfair to expect them to produce an immediate itemised list of what they've lost. Remembering an item later doesn't necessarily mean that part of the claim is fraudulent.

Have a look at the decisions database to see how ombudsmen have treated cases of alleged fraud http://www.ombudsman-decisions.org.uk/Default.aspx

Caroline Mitchell

Lead ombudsman

13 February 2017

5. Investigation outcomes

Although the claim may have been referred for investigation due to the presence of fraud indicators there are a number of possible outcomes of those investigations:

- **Genuine claim**

  In which case the claim should proceed to settlement, subject to the policy terms and conditions, without delay to meet the requirements of the FCA and The Enterprise Act 2016 as outlined earlier.

- **Repudiation of claim – no fraud present**

  This could be because the insured has been in breach of a material policy condition or warranty; or has failed to prove their claim.

- **Claim withdrawn by policyholder**

  If you believe there is evidence of an attempted fraud having been committed, then you must ensure appropriate challenges have been made, and that the policyholder has had the opportunity to provide an explanation before treating a withdrawn claim as suspected fraud.

- **Policy avoidance**

  If you have established there has been a material non-disclosure or misrepresentation insurers may elect to avoid the policy but will need to meet the requirements of the Consumer Insurance (Disclosure and Representations) Act 2012 and Insurance Act 2015.

- **Fraudulent claim**

  Where evidence of fraud has been proven to the required onus of proof then the remedies set out in the next section may be available.

6. Remedies available

- **Typical policy wording**

  Fraudulent claims

  If any claim on this policy is in any respect fraudulent or if fraudulent means are used by you or anyone acting on your behalf to obtain benefit under this policy or if any damage is caused by your willful act or with your connivance, all benefit under this policy shall be forfeited.

  We retain the right to keep the premium and to recover any sums paid by way of benefit under the policy.

- **The Insurance Act 2015**

  http://www.legislation.gov.uk/ukpga/2015/4/contents/enacted

  The Act provides the insurers with clear statutory remedies when a policyholder submits a fraudulent claim. The main remedy in the Act is the one already established by the courts: if a claim is tainted by fraud, the policyholder forfeits the whole claim. The Act also address a current area of uncertainty: the insurer may refuse any claim arising after the fraudulent act. However, previous claims are unaffected.

  Part 4 – Fraudulent Claims

  12 Remedies for fraudulent claims

  (1) If the insured makes a fraudulent claim under a contract of insurance —

  (a) the insurer is not liable to pay the claim,

  (b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and

  (c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

  (2) If the insurer does treat the contract as having been terminated —

(a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and

(b) it need not return any of the premiums paid under the contract.

(3) treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

(4) in subsections (2)(a) and (3), "relevant event" refers to whatever gives rise to the insurer's liability under the contract (and includes, for example, the occurrence of a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).

- **Referral to the Insurance Fraud Register**

  Where fraud is proven placing the policyholder's details onto the Insurance Fraud Register is an option. This is a decision made by the insurer. Details will remain for 5 years from the date the Fraud Condition is met.

- **Referral to local police**

  As part of the investigation process you should seek advice from insurers as to whether or not it is appropriate to refer the matter to the local police for investigation.

- **Referral to the Insurance Fraud Enforcement Department (IFED)**

  https://www.cityoflondon.police.uk/advice-and-support/fraud-and-economic-crime/ifed/Pages/Make-a-referral.aspx

  Where a serious level of fraud was discovered it may be appropriate to refer to the IFED and their referral guide and referral form should be used.

If the claim has already been paid or partly paid then the following may also be considered:

- **Bring an action under the tort of deceit**

Insurers can bring an action to recover their outlay under the tort of deceit where insurers have been deceived.

In order to succeed in a tort of deceit the test that applies is the one set out in Derry v Peek (1889) which was set out in section A.

The Proceeds of Crime Act 2002

http://www.legislation.gov.uk/ukpga/2002/29/contents

This sets out the legislative scheme for the recovery of criminal assets including from insurance fraud. It applies to the whole of the United Kingdom although there are separate provisions applying to England and Wales, and Scotland and Northern Ireland.

Confiscation Orders: Part 2 England and Wales Parts 3 and 4 Scotland and Northern Ireland

A confiscation order may be made if the defendant is convicted of an offence and the court determines that the defendant has a 'criminal lifestyle' and has benefited from his 'general criminal conduct'.

Part 5: Civil Recovery, including cash seizure

Part 5 of POCA provides a scheme to reclaim the proceeds of crime through civil proceedings. It permits the recovery of criminal assets where no conviction has been possible, for example because individuals avoided conviction by remaining remote from the commission of the crimes from which they benefited or because they have fled abroad. Civil recovery applications are made in the High Court against property that is or represents property obtained through unlawful conduct. The relevant enforcement authority (that is, the Director of Public Prosecutions, the Director of the Serious Fraud Office and the Director of the National Crime Agency (NCA)) may make an application for a property freezing order to prohibit any person from dealing with the property.

7. Summary

	Civil Law	Criminal Law
Definition of 'Fraud' or 'insurance fraud'	None	None
How is 'fraud' decided.	'…it is for the Court to decide what amounts to a fraudulent claim.' (Quoting from the Law Commission Report) **Para 117 Versloot v Gerling [2014] EWCA Civ 1349** Section 12: Remedies for fraudulent claims 99. The section does not define 'fraud' or 'fraudulent claim'. The remedies will apply once fraud has been determined in accordance with common law principles. For example, see the test for fraud in Derry v Peek [1889] LR 14 App Cas 337 **Para 99 of the Explanatory Notes to the Insurance Act 2015.** What constitutes a fraudulent claim. Three possible situations were identified: 1.The whole claim may have been fabricated. In which case, ….. , the insurer would not be liable to pay the claim. 2. There may be a genuine claim, the amount of which has been dishonestly exaggerated. The insurer is not liable, even for that part of the claim which was justified. 'The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.' (quote from Lord Hobhouse, The 'Star Sea') 3. The entire claim may be justified, but the information given in support of it may have dishonestly embellished. The fraudulent claim rules **does not** apply to justified claims supported by collateral lies. The claim should still be paid. **Paras 1,9 and 23 Versloot v Gerling [2014] EWCA Civ 1349**	Crown Prosecution Service Guidance: **The Fraud Act 2006** **The Offences** Section 1 creates a general offence of fraud and introduces three ways of committing it set out in **Fraud by false representation (Section 2);** The defendant: • made a false representation dishonestly • knowing that the representation was or might be untrue or misleading • with intent to make a gain for himself or another, to cause loss to another or to expose another to risk of loss. **Fraud by failure to disclose information when there is a legal duty to do so (Section 3);** The defendant: • failed to disclose information to another person • when he was under a legal duty to disclose that information • dishonestly intending, by that failure, to make a gain or cause a loss. **Fraud by abuse of position (Section 4).** The defendant: • occupies a position in which he was expected to safeguard, or not to act against, the financial interests of another person • abused that position • dishonestly • intending by that abuse to make a gain/cause a loss

When is fraud proven	First, in order to sustain an action of deceit, there must be proof of fraud, and nothing short of that will suffice. Secondly, fraud is proved when it is shown that a false representation has been made: (1) knowingly, or (2) without belief in its truth, or (3) recklessly, careless as to whether it be true or false **Derry v Peek [1889] LR14 App Cas 337**	In each case: • the defendant's conduct must be **dishonest**; • his/her intention must be to make a gain; or cause a loss or the risk of a loss to another. • No gain or loss needs actually to have been made. **Dishonestly** The definition in R v Ghosh [1982] 1QB 1053 applies: • was what was done dishonest by the ordinary standards of reasonable and honest people? • must the defendant have realised that what he/she was doing was, by those standards, dishonest? The question of dishonesty' is one for the jury and submissions of no case to answer should not be acceded to based only on the issue of dishonesty.
Standard of Proof	'balance of probabilities'. "If a defendant or plaintiff is to allege fraud, then the standard of proof is somewhat higher than that ordinarily applicable to civil matters, but not as high as that relating to criminal matters'. **S and M Carpets Ltd v Cornhill [1981] 1 Lloyd's Rep. 667**	'beyond all reasonable doubt'.
Statement taking	Follow Guidance from the Ministry of Justice 'Practice Direction 32 – Evidence'; para 17 – 25	Although Investigators and sometimes Loss Adjusters take statements as part of an investigation into an insurance claim which may at some point become a criminal investigation, normally the Police or IFED would take over the investigation and complete their own statements albeit often exhibiting the previous statements as evidence.
Main Remedies	**The Insurance Act 2015** If the claim is tainted by fraud, the policyholder forfeits the whole claim. **12 Remedies for fraudulent claims**	**The Fraud Act 2006** The maximum sentence is 10 years' imprisonment

	(1) If the insured makes a fraudulent claim under a contract of insurance— (a) the insurer is not liable to pay the claim, (b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and (c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.