Victim Inequality and Offender Impunity: The Asymmetric Outcomes of Motor Insurance Fraud

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Submitted for the Degree of Doctor of Philosophy

March 2018

This thesis is submitted in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy of the University of Portsmouth
Abstract

This research examines whether the funding of IFED, a dedicated police unit, set up to deal exclusively with allegations of insurance fraud brought by those insurers providing the funding, has impacted the ability of non-insurer victims of insurance fraud to gain access to justice.

The first stage of the research sought to identify and quantify the nature of fraud and its impact on both the insurance industry and on non-insurers. It included a desk-top review of the credit-hire sector, the local bus sector and large fleet-operators. The second stage involved a self-completion questionnaire to build econometric and experiential data from the credit-hire sector before effecting semi-structured interviews with twenty-nine witnesses working within or proximate to the area being investigated and conducting research and further interviews in respect of five case-studies.

An emergent theme was the use by the insurance industry of data, predominantly driven by uncorroborated estimates, that showed the industry to be impacted hugely by fraud, a conclusion that they had deployed to inspire a media and lobbying campaign to seek regulatory change protective of their business model whilst also gaining exclusive access to a dedicated police resource. Whilst no direct harm was reported by non-insurer victims because of the existence of IFED there was evidence of criminal offenders migrating to victims less capable of soliciting a police response and so gaming the system to gain impunity.

The research posits an objective methodology for scoring the economic, societal or criminological validity of a privately-funded public-police initiatives with implications for future partnerships in other areas where business can contribute to the cost of law enforcement to assess whether enforcement success can feed directly through to the profit line but without inspiring victim inequality or offender impunity.

Whilst the Police had, prior to the Fraud Review and the creation of IFED, demonstrated limited enthusiasm for investigating allegations of fraud, the creation of IFED, accompanied with the effects of austerity measures on policing, has had a meaningful and detrimental impact on the ability of certain non-insurers to deal with insurance fraud relative to the protection available to insurers. The identity of the victim made a difference. The partisan approach to a single victim-set may be contributing to the growth of insurance fraud facilitated by organised criminals and increasing the likelihood of impunity for offenders committing acquisitive vehicle offences involving the rental and credit-hire industries.
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Acknowledgments

This thesis would not have been written without the encouragement of Professor Mark Button and several years of patient and consistent support as my knowledge grew, the research evolved, and the writing started – and sometimes stopped! I am extremely grateful for his insightful guidance, support and signposting along the way. I am also grateful to those who supported this research especially my former employer as well as members of the insurance, legal and credit-hire industries, the media and police. I should add that this thesis would not have been written without the inspiration of my daughter, Laura and the tolerance of my wife, Debra.
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<tr>
<td>ABI</td>
<td>Association of British Insurers</td>
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<tr>
<td>AFI</td>
<td>Annual Fraud Indicator</td>
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<tr>
<td>ACPO</td>
<td>Association of Chief Police Officers</td>
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<tr>
<td>ADMIRAL</td>
<td>Admiral Insurance Group plc</td>
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<tr>
<td>AIS</td>
<td>Automotive and Insurance Solutions Group plc</td>
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<tr>
<td>AJAG</td>
<td>Access to Justice Group</td>
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<tr>
<td>APPGIFS</td>
<td>All Party Parliamentary Group on Insurance and Financial Services</td>
</tr>
<tr>
<td>AFI</td>
<td>Annual Fraud Indicator</td>
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<tr>
<td>APU</td>
<td>APU Ltd</td>
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<tr>
<td>ATE</td>
<td>Insurance policy for legal expense cover bought ‘after the event’ (an accident)</td>
</tr>
<tr>
<td>AX</td>
<td>Accident Exchange Ltd</td>
</tr>
<tr>
<td>BIBA</td>
<td>British Insurance Brokers’ Association</td>
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<tr>
<td>BIS</td>
<td>The Department for Business Innovation and Skills</td>
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<tr>
<td>BRTF</td>
<td>Better Regulation Commission Task Force</td>
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<tr>
<td>BTE</td>
<td>Insurance policy for legal expense cover bought ‘before the event’ (an accident)</td>
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<tr>
<td>BTP</td>
<td>British Transport Police</td>
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<td>BTPA</td>
<td>British Transport Police Authority</td>
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<tr>
<td>CEA</td>
<td>Comité Européen des Assurances</td>
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<td>CFA</td>
<td>Conditional Fee Agreement</td>
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<td>CHC</td>
<td>Credit-hire Company</td>
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<td>CHO</td>
<td>The Credit Hire Organisation</td>
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<td>CIFAS</td>
<td>A UK-wide fraud and financial crime prevention service</td>
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<td>CLP</td>
<td>City of London Police</td>
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<td>CMA</td>
<td>Competition and Markets Authority</td>
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<td>CMR</td>
<td>Claims Management Regulator</td>
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<td>CNC</td>
<td>Civil Nuclear Constabulary</td>
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<tr>
<td>CNPA</td>
<td>Civil Nuclear Police Authority</td>
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<td>CPS</td>
<td>Crown Prosecution Service</td>
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<td>CSEW</td>
<td>Crime Survey England and Wales</td>
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<td>CUE</td>
<td>Claims and Underwriting Exchange</td>
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<td>DAC</td>
<td>DAC Beachcroft</td>
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<td>DCPCU</td>
<td>Dedicated Cheque and Plastic Crime Unit</td>
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<td>DFT</td>
<td>Department for Transport</td>
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<td>DLG</td>
<td>Direct Line Group plc</td>
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<td>ECD</td>
<td>City of London Police Economic Crime Directorate</td>
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<td>EMB</td>
<td>EMB Consultancy</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>FOI</td>
<td>Freedom of Information request</td>
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<td>GTA</td>
<td>Association of British Insurers General Terms of Agreement</td>
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<td>HMIC</td>
<td>Her Majesty’s Chief Inspector of Constabulary</td>
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<td>ICC</td>
<td>In Car Cleverness Ltd</td>
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<td>IFA</td>
<td>Institute and Faculty of Actuaries</td>
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<td>IFB</td>
<td>Insurance Fraud Bureau</td>
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<td>IFED</td>
<td>Insurance Fraud Enforcement Department</td>
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<td>IFIG</td>
<td>Insurance Fraud Investigation Group</td>
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<td>IFT</td>
<td>Insurance Fraud Taskforce</td>
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<td>IFR</td>
<td>Insurance Fraud Register</td>
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<td>IPO</td>
<td>Intellectual Property Office</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<td>LASPO</td>
<td>Legal Aid, Sentencing and Punishment of Offenders Act 2012</td>
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<tr>
<td>LMA</td>
<td>Lloyds Market Association</td>
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<td>MIB</td>
<td>Motor Insurer’s Bureau</td>
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<td>MOJ</td>
<td>Ministry of Justice</td>
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<tr>
<td>MET</td>
<td>Metropolitan Police</td>
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<td>NAVCIS</td>
<td>National Vehicle Crime Intelligence Service</td>
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<td>NCA</td>
<td>National Crime Agency</td>
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<tr>
<td>NFA</td>
<td>National Fraud Authority</td>
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<td>NFIB</td>
<td>National Fraud Intelligence Bureau</td>
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<td>NPCC</td>
<td>National Police Chief’s Council</td>
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<td>OFT</td>
<td>Office of Fair Trading (now the Competition and Market Authority)</td>
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<td>ONS</td>
<td>Office of National Statistics</td>
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<td>PCC</td>
<td>Police and Crime Commissioner</td>
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<td>PNC</td>
<td>Police National Computer</td>
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<td>PPCOA</td>
<td>Ports Police Chief Officers’ Association</td>
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<tr>
<td>PIPCU</td>
<td>Police Intellectual Property Crime Unit</td>
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<tr>
<td>SFO</td>
<td>Serious Fraud Office</td>
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<tr>
<td>SPR</td>
<td>Strategic Policing Requirement</td>
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<tr>
<td>TSC</td>
<td>House of Commons Transport Committee</td>
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Declaration

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

Word count: 81,199
Chapter 1 Introduction

The research

This thesis is concerned with the impact of the Insurance Fraud Enforcement Department ("IFED"), a dedicated police unit established in 2012 to deal exclusively with allegations of fraud brought by its insurance company funders. IFED was one of a series of government initiatives intended to address the growth and expense of fraudulent whiplash claims which insurers had problematised from around 2008 (Oliphant, 2016, p. 1). Other measures included reforms to the civil justice system, which are also addressed in this thesis, in order to locate insurance fraud within the broader policy debate. The thesis does not seek to address IFED’s operational performance; it explores the impact on non-insurer victims of insurance fraud and examines if offenders might find it easier to avoid arrest and prosecution after IFED’s creation.

Since 2008, recession has challenged the UK economy and austerity measures have decimated public services. Police funding via the central grant paid to local authorities reduced by 25% between 2010/11 and 2014/15 and the police workforce fell by 37,400 between March 2010 and March 2015 (Johnston & Politowski, 2016, pp. 18–20). The cocktail of fewer police officers and consumer illiquidity inspired some people to commit insurance fraud when resources for the investigation and enforcement of all crime were declining (ABI, 2009; Gee & Button, 2015; Gill & Randall, 2015; Goss & O’Neill, 2009; “Recession ‘fuels insurance fraud,’” 2009). IFED was part of a government response to the plea that fraudulent or exaggerated insurance claims, and specifically those associated with whiplash, were something the police were generally unwilling to investigate and that insurers were incapable of resolving alone (ABI, 2006, pp. 4–6, 2008b, p. 1).

Five ‘constituencies’ were central to the research:

- motor insurers, communicating predominantly through the collective voice of their trade body, the Association of British Insurers ("ABI");
- the police;
- non-insurer victims of insurance fraud\(^1\);
- the Establishment (parliament and the government acting through its administrative and regulatory agencies); and

\(^1\) e.g. car hire companies, self-insured fleet operators and bus companies
• the media.

About the Researcher

The Researcher is a former police officer, was chairman of the Credit Hire Organisation, ("CHO") and was formerly chief executive and chairman of Automotive and Insurance Solutions Group plc ("AIS") which had several subsidiaries including a credit-hire and counter-fraud business. Through the non-insurer credit-hire subsidiary he has been a victim of motor insurance fraud and experienced multiple refusals from IFED, and several other police forces, to investigate those offences detected by the counter-fraud subsidiary. Professionally, he had engagement with some of the organisations in the study but acknowledged he only had a position of potential dominance through managerial or commercial influence in two of twenty-nine candidates in the semi-structured interview population that participated in the research. Whilst through the data collection procedure he might have been able to develop stronger commercial relations with some participants he does not believe that was an outcome and, in any event, had retired from his executive and trade responsibilities a year before this research concluded. That aside, he acknowledges from the outset that his experiences introduced a possibility for subjective interpretations of the phenomenon being studied and created a potential for bias (Locke, Silverman, & Spirduso, 1998). Balancing that risk, the Researcher’s standing in the industry offered significant advantages for the study:

• Privileged access to data and to the potential respondents.
• Familiarity with the research environment.
• His experience and reputation provided the potential for enhanced rapport and more meaningful disclosure in the semi-structured interviews.
• His inside knowledge brought an enhanced ability to gauge the reliability of responses.
• Potential for impact from the research, because of his background, was enhanced.

These arguments, although not strong enough to eliminate the possibility of a lack of critical perspective, do provide positive reasons why the Researcher was prepared to neglect the warning not to conduct a qualitative research "in one’s own backyard" (Creswell, 1998). Thick and rich descriptions of the issues, and the reliance on experiential experts drawn from senior positions in the environment being studied, helped to build a holistic view and control some of the backyard research issues. To the extent that it doesn’t, the Researcher is explicit in the thesis about where he stands and how his insider/outsider status might impact on the research (Dwyer & Buckle, 2009; Mercer, 2007).
Research Aims

Reporting of insurance fraud has come largely from journalists repeating, often verbatim, ABI media releases. Consumer awareness has been raised through television programmes often highlighting audacious offences renowned for their televisual rather than their academic value. There is literature addressing the potential impact from the Government dismantling the claims eco-system by which consumers gain access to justice in the UK (Quill & Friel, 2016) but there is no independent contemporary research relating to the cost of motor insurance fraud and nothing empirical demonstrating the linkage between fraud, the cost to insurers and the direct relationship of that cost to insurance premiums. Confronted with a lacuna, this research sought to explore the topic of motor insurance fraud and then look at the five constituencies to:

- Identify how each constituency interacts to influence the outcome for an insurance claim.
- Chronicle the interplay between insurers, government and the police, identifying their respective roles in the changing social, economic and political environment.
- Explore how the insurance industry procured direct access to its own dedicated police resource.
- Investigate other sectors with exclusive access to a police resource for their own commercial advantage.
- Consider the growth of ‘multi-lateralised policing’ where non-governmental entities have either agreed to provide security services or assumed responsibility for their own protection consequent from the changing role of the police.
- Evaluate the opportunities, risks and consequences for stakeholders and victims of private-police partnerships.
- Consider the position in the USA where insurers have publicised ‘industry crises’ to reduce the ability of victims to obtain compensation.

Non-insurer victims of insurance fraud

It is important to understand how a non-insurer can be a victim of insurance fraud and how an asymmetric response by the police to an allegation from a non-insurer, as opposed to that from an insurer, might create harm.

IFED is a police unit within the City of London Police (“CLP”) intended to tackle high volume and organised criminality and work exclusively with the insurance industry on its strategic priorities to change the public perception of insurance fraud (City of London Police, n.d.-c, p. 4). It is, simply put, an insurer funded department of the CLP dealing exclusively with offences where its funders are
the victims. That such a specialist unit might portend a degraded police response to insurance fraud to the detriment of non-insurer victims sounds an improbable scenario on which to base a research project especially when, as a matter of semantics, the only entity likely to be impacted by insurance fraud should be an insurer. But, if non-insurer entities were as susceptible to insurance fraud, then a lack, or denial, of access to a police response risks creating two harms. One is victim inequality where the victim’s identity limits the ability of that non-insurer victim to pursue a remedy. The second is when fraudsters realise that if the identity of their victim reduces the likelihood of a police response, and so improves their prospects for success, they may ‘game the system’, and target non-insurers in anticipation of avoiding prosecution. Those two harms, victim inequality and offender impunity, are incompatible with any coherent strategy aimed at reducing fraud by increasing detection and prosecuting offenders. And as to whether non-insurers can be victims of insurance fraud, the answer is yes. Large vehicle fleet-operators often carry significant policy excesses\(^2\), effectively self-insuring the insurance risk to the limit of that excess. Logically, they are as prone to the ills of insurance fraud as insurers and whilst the creation of IFED may have made it easier for insurers to pursue criminal sanctions against transgressors, it may also have made it harder for non-insurer victims of insurance fraud to do the same.

IFED is novel. It represents only the economic interests of its ‘club members’ although there may be wider societal benefits from a privately funded initiative which addresses, if only partly, an under-invested area of policing. It was created during a period when the police faced challenges in delivering their core service obligations whilst responding to evolving species and types of crime as diverse as historic child sexual abuse, terrorism and cybercrime (Association of Chief Police Officers, 2012, p. 27; Button, 2011, p. 254; Button, Blackbourn, & Tunley, 2015, p. 2; City of London Police, 2011a; Doig & Levi, 2013, p. 149; Her Majesty’s Chief Inspector of Constabulary, 2014c, p. 24). The effect of funding cuts imposed since 2009 make for uncomfortable reading and highlight a challenge for all victims of any crime. The Office of National Statistics ("ONS") (Travis, 2017) revealed the largest annual rise for police recorded crime in a decade in the 12-months to March 2017 but downplayed their results, in comparison with the Crime Survey of England and Wales ("CSEW"), by noting that "police recorded crime data are not designated as national statistics" (Office for National Statistics, 2017, p. 6). Sarah Thornton, head of the National Police Chief’s Council ("NPCC") was more definitive protesting that "with officer numbers at 1985 levels, crime up 10% in the last year and police work becoming ever more complex, this additional pressure is not sustainable ..."

\(^2\) a policyholder’s financial liability if a claim is made against their insurance policy. For motorists, it may be up to £1,000 per claim; for fleet operators, a six-figure sum.
leaving police forces unable to cope” (Mendick, 2017). Of relevance to this research, the ONS (2017, sec. 46) also reported that insurance fraud fell by 20%, or 2,158 offences, in the 12-months to March 2017, largely because of a decrease in the number of offences reported by CIFAS\(^3\), but acknowledging it was too early to determine if the reported fall reflected a genuine reduction. Notably, extrapolating the 20% fall of 2,158 offences suggests that just 10,791 offences of insurance fraud were recorded in the period, a figure dramatically at odds with reported levels of insurance fraud from the ABI making this research germane.

**Compensation culture**

Whilst not a primary focus of the study it is relevant at this point to record that the ABI has portrayed their members as victims of the ‘compensation culture’ (ABI, 2006, p. 3), a pejorative term which, according to Collins (2017) had its genesis towards the end of 1999. The trend for recorded UK usage of the phrase is represented below.

![Figure 1.1: Media use of the term 'compensation culture'. Source: Harper Collins (2017)](image)

The phrase is typically deployed to infer that claims from innocent accident victims for compensation arising from the tortious conduct of another, for example, the guilty driver in an accident, are unjustified, exaggerated, frivolous or fraudulent implying the victim should be criticised for his misfortune rather than compensated for it (Better Regulation Task Force, 2004; Constitutional Affairs Committee, 2006; Montague, 2012). In 2003, Walker (2003, p. 8) characterised it as an ethos wherein “all misfortunes short of an Act of God are probably someone else's fault, and that the suffering should be relieved, or at any rate marked, by the receipt of a sum of money”. According to Williams (2005, p. 500), there is “anecdotal and other evidence of varying degrees of quality that can be found to support or deny” its existence as a problem dependant “on who is asked”, a conclusion mirrored in a government commissioned report in 2003 (Office of Fair Trading, 2003, para. 10.4), which reported “very little analysis of what this term means, let alone

\(^3\) a UK wide fraud and financial protection service
proof that such a culture exists”. That compensation culture has found a place in the vernacular is unedifying when the Better Regulation Commission Task Force (“BRTF”) (2004) failed to find evidence of it, suggesting that it was a myth largely perpetuated by the media. Monbiot (2004) complained that “compensation culture has usurped political correctness, welfare cheats, single mothers and New Age travellers as the right’s new bogeyman-in-chief. According to the Confederation of British Industry, the Conservative Party and just about every newspaper columnist in Britain, it threatens very soon to bankrupt the country”.

A risk exists that the motivation for insurers reporting on compensation arising from tort claims, with the simplicity of the compensation culture messaging needed to secure coverage, means the media is likely to obscure the complexity of the issues. Williams (2005) remarked, "loose talk of a ‘compensation culture' no doubt helps to sell the very sorts of newspapers that purport to despise it most". Analysing the influence of mass media on the law, Haltom and McCann (2004, p. 11) argued that “alluring stories that circulate in the media about law often pervade and profoundly reshape – or distort – legal policymaking and ordinary legal practice itself … stories routinely produced, reproduced and reconstructed through the complex circuitry of mass-mediated culture.”

Former Prime Minister, David Cameron, in his foreword to a report by Lord Young of Graffham (2010, p. 5) opined, albeit in relation to health and safety matters, that “a damaging compensation culture has arisen, as if people can absolve themselves from any personal responsibility for their own actions, with the spectre of lawyers only too willing to pounce with a claim for damages on the slightest pretext.” Young (ibid. p. 19-21) was more circumspect, defining the problem as one of “perception rather than reality” and clarifying that “the broad consensus amongst stakeholders was that they did not believe that there was a growing compensation culture in the UK.” Hand (2010, p. 2) noted that sensationalist stories about compensation awards make good copy with "national newspaper articles concerning the compensation culture having increased exponentially since the mid 1990s," while statistics conversely demonstrating "a broad decline" in the number of claims during the same period. His conclusion was that “to better redress the popular misconception, more attention should be paid both to the statistics that are available … and to the collection and publication of court data … to highlight problems as they arise as well as give the lie to media hype” (ibid. p. 14). In 2011, Lord Dyson, then Master of the Rolls, also dismissed the notion of a UK compensation culture as a false perception and myth created by the media. Giving the Holdsworth Club lecture “… (Lord Dyson MR, 2013) he said, “I doubt very much whether we are likely to see – in the medium term at least – any reduction in news stories expressing concern about our compensation culture …” He went on to suggest that “all of this may also require a substantive
educative effort on the part of government, the courts and the legal profession to counteract the media-created perception.

Messages from America

An analogue to the adoption of the compensation culture messaging may exist in the emergence of the Tort Reform Movement and its relationship to the American insurance industry from 1970 (Bogus, 2003; Daniels & Martin, 1995; Feinman, 2005; Halton & McCann, 2004; Howard, 2002; Huber, 1990; Huber & Litan, 1991; Koenig & Rustad, 2003; Olson, 1992; Schuck, 1991). US tort reform started as a movement spearheaded by insurers and large corporations to attack the justice system and change rules of law by influencing public perceptions and sponsoring legislation limiting personal injury lawsuits (Funderburk, 2008; Justitia, 2016). According to Hubbard (2006, p. 438), for more than 40 years “repeat players on the defence side of tort litigation” sought to reform tort doctrine in their favour. Feinman (2005, p. 19) attributed the successes of the movement to “its political influence, power lobbying, aggressive litigation and production of an elaborate public campaign of misinformation that convinces people that reducing their rights is actually in their own interest.” These are some of the themes that emerged during the research for this thesis.

Initially, the ad hoc campaigns sought to highlight a series of ‘industry crises’ primarily related to the cost and declining availability of liability insurance as the risk-return ratio became increasingly unattractive for insurers. In the 1980s, the movement developed a more aligned approach to the push for reform against a backdrop of considerable debate about the goals of the movement, the equity and efficiency of the doctrinal reforms it sought, and the methods it used (Hubbard, 2006). Hubbard argued that legislation, politics, money, and rhetoric played an increasing role in the resolution of the argument about the proper role of tort liability in American society. Between 1990 and 2006 the level and intensity of the debate increased with the ongoing long-term struggle fought by two loosely allied groups. On one side were defence-oriented groups like liability insurance companies, defendant lawyers and business groups, which were interested in tort reform as the solution to a broad economic crisis in tort liability law and insurance. On the other side were two groups: The first was claimant lawyers, occasionally joined by a variety of consumer rights organisations, claiming to represent the position and interests of potential victims. The second were academics and criminologists using the rational model to criticise the claims of the Tort Reform Movement (Hubbard, 2006, p. 469).

Having set the scene, and if the experiences of the US Tort Reform Movement and the adoption of its messages in the UK were the primary focus of this research then, at this point, it might be appropriate to embark upon a review of the literature within which the research is bound. Typically,
the literature review is given a separate chapter “to identify the gap that the research will occupy, the theoretical framework in which you work and the practical precursors which nestle around your original contribution” (Carter, Kelly, & Brailsford, 2012, p. 26). However, the Researcher felt that having a separate chapter risked detaching the literature from the research and so has adopted, as suggested by Dunleavy (2003, pp. 59–60), a more sophisticated ‘opening out’ approach to the literature. Whilst this is an approach seldom used in the social sciences and “radically at odds” with what supervisors believe is “expected or the norm” (ibid.) it has substantial advantages. Whilst there is literature addressing the Tort Reform Movement and the wider issues of UK fraud and the evolution of the police and private-public police partnerships, the primary focus of the research is the very recent creation of IFED and its impact on insurer and non-insurer victims of fraud. There is limited literature, if any, on that, or on the recent and emerging changes to the basis on which the civil-justice system will allow honest accident victims to be compensated. The issues addressed in the thesis also rely on an analysis of matters impacting the five constituencies identified earlier and to review the literature, as it impacts all of those constituencies in the conventional ‘focus down’ manner would risk making it harder to engage with the issues when compared with an approach where the results of the research mesh directly with the literature as it is embedded throughout the thesis. The latter approach has, therefore, been adopted because it allows the reader to engage with the research results and the relevance of other people’s work in a more grounded manner. Thereafter, the thesis adopts a conventional structure as summarised below.

**Structure of the thesis**

Existing research relating to motor insurance fraud, and to IFED in particular, is limited and because the data surrounding the offence and the police strategy for resolving it are either confidential or unverifiable, addressing the research question posed a more significant challenge than originally anticipated. Accordingly, the investigative strategy required a variety of approaches to expose a range of substantive themes and ideas hopeful of advancing knowledge of the subject whilst promoting a coherent debate in which to frame a structured and appropriate response. The general approach to the research design and methods is set out below but, in a similar way to the literature review, the rationale for the research methodology unfolds in sequence in each subsequent chapter.

**Summary of research design and methods**

According to Ayiro (2012, p. 3), research is the orderly investigation of an issue with the purpose of adding to established knowledge and/or providing possible interventions for desirable solutions. It can mean ‘re-search’ implying that the subject matter is already known and needs to be studied
again. Alternatively, and as in the case of this research, the expression can be used without a hyphen when it means investigating a new problem or phenomenon with a defined motive.

This research utilised a mixed methods approach using qualitative and quantitative methodologies relying upon:

- a series of semi-structured interviews;
- a cross-sectional survey;
- a number of case studies; and
- desktop research (Johnson, Onwuegbuzie, & Turner, 2007, p. 123) “for the purpose of breadth and depth of understanding and corroboration”.

Greene (2008, p. 20) champions the mixed methods approach because it promotes better understanding and produces greater equity of voice although Bazeley (2010, p. 432) cautions the need to ensure the outcomes are properly integrated “in such a way as to become interdependent in reaching a common theoretical or research goal, thereby producing findings that are greater than the sum of the parts”.

The investigative strategy required a variety of approaches to expose a range of substantive themes and ideas hopeful of advancing knowledge of the subject whilst promoting a coherent debate in which to frame a structured and appropriate response and involved five stages of enquiry:

- Reviewing the existing eco-system;
- Self-completion questionnaire;
- Semi-structured interviews;
- Case studies, and
- Desktop research.

Summary of known ethical concerns

Three principal issues of ethical concern were recognised with the research.

Insider Research: The first is that by virtue of the Researcher’s former employment and industry standing, he was an insider (Merton, 1972). Whilst this may create advantages and disadvantages for the research it required certain ethical issues to be addressed. The Researcher’s involvement with data collection in the third and fourth phases of the investigation defined above was different to that in the second when the survey was administered and data collected using the
standardised procedures. Whilst any data analysis was performed using statistical analysis techniques the results were interpreted based on the established values for the statistical significance of each function. The survey predominantly sought to establish the prevalence of frequency and outcome of certain key research questions in the target population and to collect and aggregate some factual empirical data about the size of the motor insurance fraud problem amongst the population surveyed. In the third and fourth qualitative phases the Researcher did assume a more participatory role due to the “sustained and extensive experience with participants” (Creswell, 2014, p. 184) and a personal involvement with the research topic. Brown (2000) discusses the positions occupied by people carrying out police research and identifies a number of ‘positions’ that might be taken by people conducting research. He categorised them as ‘inside insiders’, ‘outside insiders’, ‘inside outsiders’ and ‘outside outsiders’. In this study, the Researcher believes he occupied a position closer to being an insider which carries with it the risk that greater sympathy is expressed to the causes of the group being investigated; he is clear that he could not assert to be a value free observer.

**Case Studies:** The second issue related to the case study subject matter all of which relied on information available in the public domain or derived from the personal involvement of the interviewee and which may have constituted evidence used to secure a conviction. Conversely, where a conviction was not pursued, or the police declined to investigate, then the information disclosed in the case studies might be of a confidential and/or sensitive nature requiring absolute anonymity and confidentiality. The cases studies and cameos involved a narrative analysis based on several first-hand reports of a series of individual insurance frauds perpetrated by a single individual or group of connected individuals. The impacted parties are credit-hire companies, transportation operators and insurers. The narrative utilises publicly available information and data provided by those impacted parties and by solicitors and counter fraud specialists involved in the incidents. The Researcher had no direct involvement in any of the case studies. All the incidents will have resulted in a concluded investigation and, in some cases, a prosecution. None of the studies involve on-going criminal investigations or prosecutions. Only those entities that have been a victim of the reported offences, and only those individuals who have direct knowledge of the events and who attempted, successfully or otherwise, to persuade IFED, and/or other police forces to act, were asked to participate in the case study review. Any information provided, to the extent that the case studies involved offences where no prosecution was pursued, was coded, as are the entities involved in the case, and anonymity is preserved to protect the identities of all of those involved – victim, investigator and offender. All of the participants in the interviews supporting the case studies were responsible for counter-fraud activities within their organisation. However, the code
of ethics published by the British Society of Criminology was reviewed and, as a result, a sentence was included in the information sheet for participants, and as part of the second interview schedule for the case studies, which provided that “any offer of confidentiality may sometimes be overridden by law” (British Society of Criminology, 2006, p. 2). No such concerns arose.

**General Ethical Concerns:** The third issue is bounded by the generic guidance issued by the British Psychological Society (2010). The research involved the collection of confidential organisational information but limited personal data. It was critical that disclosures did not cause harm to the participants or their organisations (ibid sec.4). Ethical risk analysis for the research was performed (ibid, sec.3) but the analysis, in a simplified form, did not include risk probability and consequence (hazard) ratings as they would introduce unnecessary complications. All the participants were experienced, professional volunteers. They were trained in, and accustomed to, maintaining confidentiality either as insurers, counter fraud specialists, solicitors, police officers and managers or directors within commercial organisations. They were not vulnerable individuals. Nevertheless, there is always a low residual vulnerability risk from inappropriate disclosures:

- breach of confidentiality by improper disclosures;
- disclosure of career limiting criticisms;
- disclosure of proscribed behaviour of organisation; and
- disclosure of information, which is ‘sub-judice’ or part of an on-going criminal investigation.

The following arrangements to protect the participants and the researcher in all ethnographic elements ensured that the risks were minimal:

- Coding arrangements ensured anonymity.
- Permission to participate was sought from host organisations/employer in addition to employee target participants.
- Participants demonstrated awareness of the risks and their responsibilities by reading and signing the informed consent forms.
- Participants could withdraw at any time or withdraw permission to use data before the data gathering phase concluded.
- Participants were warned against the risks of inappropriate disclosures.
- The Researcher was alert to the need to detect when inappropriate disclosures were imminent, and could interrupt the interviews or dialogue and change focus or terminate, and could discard inappropriate data.
Data management

The data collected from each stage of the research was stored and managed in compliance with the Data Protection Act 1998. All field data was collected electronically, or digitised post collection, and stored on a PC, backed up onto an external hard-drive and not publicly accessible. No data was located on any server and none of the original data was shared. Participants had the right to access their own data and could withdraw permission for its use at any time during the data gathering (British Psychological Society, 2010, p. 15) and the original data will be destroyed 12-months after completion of the thesis. The identities of individuals and organisations was coded to create anonymity in the raw data. Role and organisation descriptions are sufficiently vague to prevent traceability, for example, ‘national journalist – fraud’, although in some instances, the interview output rendered complete anonymity of the host organisation impossible, for example where a member of the IFB set out their approach to data analysis. In some cases, anonymity was expressly waived. The coding used to reference interviewees is set out in Table 2.1 in the next chapter. Each participant was identified by code comprising a letter to signify which interest group they inhabited and a sequential number. Interviewee contributrs are referenced by their alphanumeric code; for example, M1 is the first interviewee from the media grouping.

A summary of the remaining chapters follows:

Chapter 2: The measurement of insurance fraud

The ONS estimate (2017, p. 4) of 11 million fraud and computer misuse offences is double the headline estimate of all other CSEW offences (ibid. p.3) providing a stark indication of the scale of the fraud problem. Insurance fraud, however, was only referenced for the first time in the CSEW 2016 (ibid. p. 43), when a 10% increase in insurance fraud offences4 was reported predominantly from an increase in insurance application frauds from individuals attempting to get a cheaper policy by fraudulent means. Whilst greater clarity and granularity may evolve with future CSEW reports, it is currently unhelpful to researchers and policy makers that insurers, predominantly through the ABI, have chosen to limit publicly available information on fraud to a variety of non-verifiable statistics to populate their media releases. Chapter 2 focuses, inter alia, on the integrity of the data supporting the insurer case for extensive regulatory and policy change.

At least since 2006, fraud has been a corrosive force in society challenging policy makers and providing diverse research opportunities for academics (Attorney General, 2006). Whilst there is

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4 10,322 (2% of all fraud offences)
literature on the wider topic of fraud, and some research providing direction on the narrower topic of insurance fraud, there is little data capable of independent corroboration of either the quantum or constituent elements of insurance fraud in the UK. Between 2008 and 2017 insurance fraud was one of many industry crises publicised by the ABI including:

- the increasing frequency of whiplash claims as a percentage of accidents (ABI, 2011b, 2012b, 2012d, 2013a, 2013b, 2014d, 2014g, 2016b, 2016c);
- the rising expenses associated with settling claims based on the increased volume and value of claims generated (ABI, 2013b, 2013c, 2014d, 2015d; Dalton, 2013);
- the costs of providing replacement vehicles to innocent road accident victims (ABI, 2013c, 2015d, 2015i; Dalton, 2013);
- the right of claims management companies or solicitors to recover costs for acting for an innocent victim (ABI, 2011c, 2014d, 2015a; Dalton, 2013);
- the impact of application fraud (ABI, 2012c, 2014e, 2015a, 2015c, 2015d, 2015h, 2016c; Dalton, 2013); and

The ABI (2017) complained about the difficulty their members had managing their profit and loss account throughout the period of research. One press release sought to justify a 14% increase in motor insurance premiums because “cold callers and ambulance chasing lawyers are still finding ways to exploit the system” and, unrelated to fraud, “the Government has doubled Insurance Premium Tax”. In July 2017 the BBC (2017) reported motor insurance premiums at a “record high” but at least one media source (Moore, 2017) accused the ABI of strategically deflecting blame from the actions of their own industry and denying the reality that premiums are set by insurers “based on how much they think they can get away with charging ... with the aim of making as much money as possible”. Whatever economic pressures insurers faced in 2017 was nothing relative to the challenges they faced in 2009 when the ABI (2009) reported that 2,000 fraudulent claims, worth £14 million, were detected every week. Chapter 2 attempts to substantiate those claims. It offers an analysis of the nature of insurance fraud, narrates the history and typology of the offence, explores the identity of offenders and their attitudes, reviews the literature and discusses the increasing awareness of insurance fraud and the challenges it appeared to pose for insurers, consumers and society generally. Insurers have quantified their experience of fraud, and placed some reliance in influencing the political debate and the formulation of policy, on a single piece of
empirical work published by the ABI (Goss & O’Neill, 2009). The Researcher examines the methodology behind that research in order to assess its impact on the political debate and evolving policy whilst also highlighting the role the report went on to play in shaping the messages that insurers sent to government, to regulators and to the media.

Chapter 3: The Police

Chapter 3 considers whether an insurer-funded police force was necessary or desirable. To do so, the history and evolution of the police is chronicled, the literature reviewed, and the question posed as to whether yesterday’s policing model is economically, politically or practically sustainable and, more importantly, whether the police have now lost their monopoly. The history, nature and increase in privately-funded public-policing, and the debate surrounding the arrangement, is also considered as is government policy associated with responsibilisation, the growth in private security and the increasing trend towards multi-lateralisation in the face of economic under-funding of the police generally. Recognising the potential for further public-private partnerships, or the need to review the suitability of existing arrangements, this chapter also offers an objective risk-scoring model, a tool to identify, create a stimulus to debate and remedy potential weaknesses in the funding, impact or governance of privately-funded policing models like the British Transport Police (“BTP”), the Ports Police Force, the Dedicated Cheque and Plastic Crime Unit (“DCPCU”) and IFED.

Chapter 4: Non-insurer victims of insurance fraud; credit-hire.

One of the threads highlighted by insurers in their campaign for a more concerted societal response to fraud was the impact, frequency and cost of ‘credit-hire fraud’. Chapter 4 explores the credit-hire industry, outlines the services provided for consumers and the relationship the industry has with insurers, solicitors and the Establishment5 and examines the ambiguity relating to the term ‘credit-hire fraud’. In addition, and absent empirical evidence as to the nature, cost and response to fraud where the credit-hire company claims victimhood, this chapter also explores whether, and how, members of the credit-hire industry might themselves be victims of insurance fraud. Focusing on two case studies the study explores whether industry members feel either empowered or denied the right to claim victimhood and to participate in the wider fight against insurance fraud and, to the extent they cannot, whether such segregation impedes the effectiveness of the fight against fraud as well as increasing the exposure to loss for the victim.

5 Parliament and the government acting through its administrative and regulatory agencies
Chapter 5: Other non-insurer victims of fraud

Chapter 5 extends the analysis to other non-insurer victims, specifically bus companies and large vehicle fleet operators, where the motor insurance risk is often self-insured. The chapter explores the perspective of a counter-fraud specialist who has identified links between organised criminal activity and criminals targeting credit-hire and self-drive hire companies, and includes two sectoral case studies and one other case study exploring the outcome of an insurance fraud which IFED, the Metropolitan Police (“MET”) and the National Vehicle Crime Intelligence Service (“NAVCIS”) declined to investigate. It subsequently became the focal point of an international investigation into an organised crime ring exporting high value prestige vehicles to East Africa.

Chapter 6: Making a crisis

The extent to which an individual’s common law rights might have been impacted during the period of research is considered in Chapter 6 as is the basis on which insurance claims are made and how, since 1995, these claims have challenged the profitability of motor insurers. Much of the research for this chapter was either desktop driven or based on reviewing the literature and exploring the interaction between the ABI, media and the Establishment. The chapter charts the changes introduced to impact the claims eco-system between 2009 and 2017 and the role of the lobbyist (Van Schendelen, 1994, pp. 3–22) and the many factors driving the creation of criminal justice policy. A case emerged during the research phase that the government support for the ABI went beyond the facilitation of IFED as a tool to deal with insurance fraud but extended to a wider range of responses inspired by the Government’s reliance on a fiction that “Britain had become the whiplash capital of the World” (Ministry of Justice, 2012, p. 3). This chapter reviews the evidence behind that claim and advances a case that the data and arguments presented to government were irredeemably flawed, never challenged and were deployed to conflate whiplash and insurance fraud as part of an agenda to remove the common law entitlement of consumers to damages following an accident.

Chapter 7: Discussion, conclusions and recommendations

The final chapter draws together the thesis conclusions, examines the extent to which the research aims were achieved, and identifies the research limitations and opportunities for further research.
Chapter 2 The Measurement of Insurance Fraud

Introduction

This chapter explores the experience of insurance companies, a primary target for insurance fraud. It analyses offences classified as insurance fraud and explores the identify of offenders and their attitudes. Because the research is concerned with motor insurance fraud it also narrates the history and typology of that offence, reviews relevant literature and discusses the increased reporting of insurance fraud and the significant challenges it poses for insurers, consumers and society generally. More importantly for the research, it considers how insurers have quantified their exposure to fraud by placing reliance on a single piece of empirical work published by the ABI in 2009. The chapter also includes a review of the methodology employed in that research and questions the reliability of the conclusions. Insurer messaging, specifically the extent to which it is reliant on apparently ‘trusted data’ is also considered together with its wider impact on media, policy and the law. In addition, and adding depth, opinions from people operating within or reporting on the insurance market also feature.

Research Methods

The primary technique for obtaining the richest data set possible was a series of semi-structured interviews carried out with twenty-nine representatives of seven targeted interest groups comprising:

- the media (national and insurance market press, radio, and television);
- insurers and the ABI;
- those providing counter fraud support for the insurance (defendant) industry including the Insurance Fraud Bureau (“IFB”)
- those providing counter-fraud services for the credit-hire (claimant) industry;
- members of the credit-hire industry including the director general of the CHO;
- other non-insurer victims/potential victims of fraud including bus companies and self-insured fleet operators; and
- police officers or former police officers engaged in the detection and investigation of fraud.

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6 ‘Claimant’ and ‘defendant’ are terms used in litigation in England and Wales (different terms apply elsewhere). The labels are used in insurance claims even before litigation is commenced to identify ‘sides’. The ‘claimant’ brings a claim, the ‘defendant’ defends it. Credit-hire companies usually act for the claimant, the person claiming innocence in the road accident; the defendant will usually be an insurer acting for the tortfeasor.
The Researcher considered that semi-structured interviews were an important component of the research methodology. The interviews comprised a qualitative phenomenological study where the results intended to develop a "complex, holistic picture, analyse words, report detailed views of informants, and conduct the study in a natural setting" (Creswell, 1998, p. 15). However, as Cohen (1985, p. 82) cautioned, “like fishing, interviewing is an activity requiring careful preparation, much patience and considerable practice if the eventual reward is to be a worthwhile catch”. Interviews are the quintessential qualitative method (Westmarland, 2011, p. 89). In determining whether to use structured, unstructured or semi-structured interviews, the latter was chosen because of a desire to elicit a personal response, irrespective of their native interest group, to the same core issues from each interviewee so as to facilitate a more meaningful comparison both amongst, and between, the seven targeted interest groups. That proved an effective and successful approach.

Westmarland (ibid. p. 117) defined semi-structured interviews as “the sort of research where the whole game plan has not been cast in stone” and the type of questions asked are focused on areas of interest rather than closed questions relying on a ‘yes’ or ‘no’ answer. As Layder (1993, p. 116) observed, the method is an efficient way of obtaining qualitative information on the phenomenon being studied and, as Dawson (2002, p. 28) remarked, it allows a degree of latitude for unexpected disclosures or fresh issues to arise in the course of interviews and for supplementary questions to be raised. Morse (1994, p. 228) argued that the optimal interviewee “is the one who has the knowledge and experience the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study”.

Every interviewee, from each of the seven targeted interest groups, had a relevant professional interest in insurance fraud and had experienced, or was experiencing at the time of the research, the phenomenon being explored; they were experiential experts. The research sought to identify the extent of consensus, or discord, amongst the different interest groups where the members of those groups were all actively engaged in the identification of, and response to, motor insurance fraud but with each of them potentially harbouring a different perspective, or bias, about fraud, the role of the police or the expected or desired outcome for victim and offender. In utilising several different interest groups, and seeking responses from those groups to the same question set, it was anticipated that the outcome might identify aligned, or non-aligned, perspectives, prejudices, aspirations or experiences specifically in respect of:

- the perceived nature and true scale of motor insurance fraud;
- the response to the insurance fraud problem from insurers, government and the police;

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• the ability of insurer and non-insurer victims to access police resources, through IFED or elsewhere, for reporting and investigating offences; and
• outcomes based on the identity of the victim, for victim and offender.

Conducting the interviews

The host organisation of the prospective participant was contacted by telephone and the nature of the research and the desire to approach their employee to participate in the study explained. A letter followed that call seeking agreement to approach the targeted employee and, if they consented, to them participating in the study. If approval was given, a written briefing, invitation and consent form was provided to the target participant, copies of which appear at Appendix B. The interviewees, and identified target group, are set out at Table 2.1 below.

All interview data is anonymous and untraceable unless the interviewee consented to their identity being disclosed. The code in the right-hand column is the descriptor used to reference each interviewee throughout the thesis.
Table 2.1: Semi-structured interview schedule

<table>
<thead>
<tr>
<th>Interest Group</th>
<th>Organisation and Summary Role</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td>Insurance media publisher</td>
<td>M1</td>
</tr>
<tr>
<td>Media</td>
<td>National journalist – fraud</td>
<td>M2</td>
</tr>
<tr>
<td>Media</td>
<td>Mainstream media producer – consumer facing</td>
<td>M3</td>
</tr>
<tr>
<td>Insurer</td>
<td>ABI - manager</td>
<td>I1</td>
</tr>
<tr>
<td>Insurer</td>
<td>IFB - director</td>
<td>I2</td>
</tr>
<tr>
<td>Insurer</td>
<td>Insurer - head of fraud</td>
<td>I3</td>
</tr>
<tr>
<td>Insurer</td>
<td>Insurer - head of fraud and IFED steering group</td>
<td>I4</td>
</tr>
<tr>
<td>Insurer</td>
<td>Insurer - retired head of motor claims</td>
<td>I5</td>
</tr>
<tr>
<td>Insurer</td>
<td>ABI - former head of public relations</td>
<td>I6</td>
</tr>
<tr>
<td>Insurer (Defendant) Counter Fraud Support</td>
<td>Solicitor - head of fraud</td>
<td>DF1</td>
</tr>
<tr>
<td>Insurer (Defendant) Counter Fraud Support</td>
<td>Counter fraud operator - managing director</td>
<td>DF2</td>
</tr>
<tr>
<td>Insurer (Defendant) Counter Fraud Support</td>
<td>Counter fraud operator - analyst</td>
<td>DF3</td>
</tr>
<tr>
<td>Insurer (Defendant) Counter Fraud Support</td>
<td>Telematics expert</td>
<td>DF4</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Counter fraud operator - director and retired police detective</td>
<td>CF1</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Solicitor - managing director</td>
<td>CF2</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Counter fraud - bounty hunter; recovers stolen vehicles for a fee</td>
<td>CF3</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Solicitor - managing director</td>
<td>CF4</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Counter fraud - former head of fraud / retired detective</td>
<td>CF5</td>
</tr>
<tr>
<td>Credit-hire (Claimant) Counter Fraud Support</td>
<td>Counter Fraud - former fraud investigator and retired police officer</td>
<td>CF6</td>
</tr>
<tr>
<td>Credit-hire Sector</td>
<td>CHO - director general</td>
<td>CH1</td>
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<tr>
<td>Credit-hire Sector</td>
<td>Credit-hire company - managing director</td>
<td>CH2</td>
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<tr>
<td>Credit-hire Sector</td>
<td>Credit-hire company - logistics director</td>
<td>CH3</td>
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<tr>
<td>Credit-hire Sector</td>
<td>Credit-hire company - head of complex debt</td>
<td>CH4</td>
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<tr>
<td>Non-Insurer Victims</td>
<td>Transportation company - head of claims</td>
<td>N1</td>
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<tr>
<td>Non-Insurer Victims</td>
<td>Car rental company - head of insurance</td>
<td>N2</td>
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<tr>
<td>Non-Insurer Victims</td>
<td>Chairman of Motor Accident Solicitors Society</td>
<td>N3</td>
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<tr>
<td>Non-Insurer Victims</td>
<td>Solicitor representing non-insurer large fleets</td>
<td>N4</td>
</tr>
<tr>
<td>Police/Prosecution</td>
<td>Police officer - engaged in investigating insurance fraud</td>
<td>P1</td>
</tr>
<tr>
<td>Police/Prosecution</td>
<td>Expert witness retained by several police forces</td>
<td>P2</td>
</tr>
</tbody>
</table>

The interviews were used to identify and categorise substantive statements and relevant themes (Gillham, 2005, p. 136) and to obtain some data on each interviewee’s organisation, the industry to which they belonged and, particularly, their opinions and attitude to the research environment. The shortest interview took fifty-five minutes, most lasted less than ninety minutes but one lasted three hours. All occurred at a location and time of the interviewee’s choice and in all cases, written consent was given, interviews were recorded and subsequently transcribed.
verbatim. One interviewee requested, and was given, a copy of the tape recording and a copy of the transcript.

Agar (2008, p. 153) argued that “transcription is a chore” whilst Oliver et al (2005, pp. 1273–1274) observed that it is “a pivotal aspect of qualitative inquiry” but also cautioned that “in the haste to begin data analysis, it can be easy to use a transcription style that fails to match one’s research objectives or concerns over participant confidentiality”. They conceptualised the exercise as a point on a continuum with naturalism at the end where everything is transcribed as fully as possible and de-naturalism at the other where idiosyncratic elements of speech are removed. Except for the three-hour interview, which included some extraneous discussions, the naturalist approach of transcribing the meetings in full, including stutters, pauses and involuntary vocalisation was adopted. Notes were also made during the interviews to mark where non-vocal indicators impacted on the content of the interview or gave weight to a specific response. The first few minutes of each interview involved putting the interviewee at ease, setting out the background to the research question and dealing with confidentiality and security of data. Based on their respective organisational status, the interview population was commercially mature, which may have been a factor in a lack of concern about interviews being recorded even though some contributors may have been conscious of the tape recorder, if only initially. All participants were given the opportunity to identify during the interview any matters that were confidential and which they would not wish to be disclosed or later attributed to them. They were also invited to pause or terminate the recording if they felt the interview had gone awry or were uncomfortable with the discussion or any other part of the process. Reiner (2000, p. 224) argued that this seldom happens because of the momentum generated by the interview once it has begun.

As the method was reflective it was anticipated that participants would draw on memorable events and might relate their answers to significant fraud cases or offences both before and after the formation of IFED. That dynamic engagement in the interviews occurred in all but one interview with M3 who would only respond to questions in writing. Those responses lacked the richness inherent in discussions with other interviewees. The aim with all participants was to obtain data relating to:

- their understanding of the cost of motor insurance fraud to the insurance industry;
- whether they perceived insurers were the only victim of motor insurance fraud;
- their view on the situation confronting non-insurer victims of insurance fraud;
- their knowledge, and opinion, of the government and police response to the issue;
- how they saw the role that IFED in the fight against motor insurance fraud;
• if they felt that IFED should accept reports of fraud from non-insurers where the offence fitted their reporting criteria;
• any experience as a victim of insurance fraud and/or dealing with IFED;
• their view of the allocation of police resources to fraud; and
• their opinions about whether a solution might require a greater ‘private response’ to motor insurance fraud.

Using a semi-structured interview technique meant that each interview could cover a wide range of issues and interviewees were able to expand upon and, in some instances, as Dawson (2002, p. 76) predicted, take the discussions in an unexpected but fruitful direction. The volume and breadth of data generated from the target interviews exceeded expectations and interviewing participants from seven different interest groups was informative. Not only was the data rich in terms of the differing perspectives to the problem of insurance fraud and the range of theoretical solutions, but the responses were driven by more than one interest group and, at times unexpectedly, included elements of accord from participants in typically competing groups. The themes that emerged are explored in this and subsequent chapters and are supported with relevant extracts from the interviews. A supplementary objective from the semi-structured interviews was to identify cases involving fraud. These went on to form a series of case studies outlined more fully in subsequent chapters.

Problems experienced during the interviews

Despite being effective the research presented some challenges. It was expected when selecting the seven interest groups that they, and the targeted organisation within them, would be representative of a victim and/or would be active in, or reporting on, counter-fraud activities and so would be keen to share their experiences. That was the case with all but one organisation participating in the interview process who, after six weeks of discussion, chose to withdraw their oral contribution and replace their participation with a written response. They expressed concern about the three broadcasters that they worked with reacting negatively to their contribution if it was considered ‘off message’. The response was unexpected but it did highlight the potential influence of the media with its content partners.

There was also a challenge with the police. The Researcher wanted, for background, to explore the stimulus and aspirations leading to the formation of IFED by interviewing Commander Steve Head, Head of the Economic Crime Directorate (“ECD”) at the CLP and national police co-ordinator for economic crime until he retired in September 2015. Disappointingly, he failed to respond to
multiple requests to participate. Similar approaches were made to Detective Superintendent Maria Woodall who had responsibility for Operations and Funded Units within the ECD, including IFED. The Researcher met her twice in a business context and she was initially receptive to participating. The request was confirmed in writing but, after several attempts to arrange the interview, the Researcher was told that she could not get time with Commander Head to discuss the request. A written approach was also made to Dave Wood, former DCI and head of IFED, following a hearing of the All Party Parliamentary Group on Insurance and Financial Services (“APPGIFS”) in which he and Superintendent Woodall gave evidence. Mr. Wood also failed to respond to multiple requests. Two other target police participants also declined to assist and one Police and Crime Commissioner (“PCC”) failed to respond to four separate participation requests. The police officers were middle ranking officers engaged in fraud investigation with the West Midlands Police. The Researcher considers that the choice of research question, specifically focused on whether the creation of IFED had an impact on victims of crime, represented a philosophical challenge to the CLP that they could not see past and that a different research question framed less at IFED may have generated a more engaged response. In addition, the fact that IFED was funded by insurers may have meant that the decision not to engage (or the lack of a decision to engage) was driven by commercial considerations. All other interviewees participated willingly and with informed consent.

Whilst it would have been helpful to hear from CLP about the drivers for the IFED initiative, whether it was considered analogous to CLP relations with, for example, the banking industry and how they regarded insurance fraud and, specifically fraud committed against non-insurers, their decision to make no contribution to the research at all was a disappointment. It was not wholly unexpected, however, and the Researcher is clear that their lack of engagement did not impact the efficacy of the research or the validity of the conclusions ultimately reached.

**Interview coding**

Following guidance from Creswell (2002), qualitative analysis of the interviews involved:

- preliminary exploration of the data by reading the transcripts and writing memos;
- coding the data by segmenting and labelling the text;
- using codes to develop themes by aggregating similar codes together;
- connecting and interrelating themes; and

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7 10/02/2015; hearing relating to the interaction between motor insurance fraud, IFED and the credit-hire industry.
• constructing a narrative.

The textual data obtained through interviews was coded and analysed for themes using NVivo, software designed for analysing unstructured data. Coding means categorising segments of data with a short name that simultaneously summarises and accounts for each piece of data and, as Thomas (1993, p. 43) remarks, gives meaning to the story recounted by the interviewee motivated by the objective that “we take the collection of observations, anecdotes, impressions, documents, and other symbolic representations of the culture we studied that seem depressingly mundane and common, and we reframe them into something new”. It is a process that is intense and iterative requiring the researcher to ask analytical questions of the data gathered. It is also the pivotal link between collecting data and developing a theory to explain it (Charmaz, 2006, pp. 42–46). The second phase in the coding exercise is focused coding, used to synthesise and explain larger segments of data requiring decisions about which initial codes make the most analytical sense to categorise data both incisively and completely. Charmaz (2006, p. 55) advocates that “by studying the data, you make fundamental processes explicit, render hidden assumptions visible, and give participants new insight”. During initial coding, she argues that simple questions should be posed:

• ‘What is the data a study of?’ (Glaser, 1978, p. 57; Glaser & Strauss, 1967)
• What does the data suggest?
• From whose point of view?
• What theoretical category does this specific datum indicate? (Glaser, 1978)

Desktop research was also an important element of the research methodology. Scott (1990, p. 1) argues that the handling of documentary sources is assumed to be the provenance of the professional historian whilst the sociologist has generally been identified with the use of questionnaires and interview techniques even though documentary investigation was the main research tool of the classical sociologists. Langlois and Seignbos (2009, Chapter 1) observed that “documents are the traces which have been left by the thoughts and actions of men of former times ... there is no substitute for documents: no documents, no history”. Scott (1990, p. 12) regards a document “in its most general sense, a written text” irrespective of the medium on which it is held and whether that medium is parchment, digital or something in between. He adopts an analytical classification methodology using two dimensions of authorship and access to generate a typology of modern documents. Authorship refers to the origin of the documents and is dependent on the separation of personal, public and official documents whilst access refers to the availability of the documents to people other than their authors. As well as mining evidence for the cases studies, the desktop research involved examining a large volume of published material and some confidential
documents dealing with the social, political, legal, financial and economic factors leading to the inception of IFED and, particularly the role of the ABI in its funding, governance and direction. It also included the statistical analysis of secondary empirical data that appeared to underpin the reporting of motor insurance fraud with specific reference to the quantification of detected and undetected offences such as that reported by the ABI or the National Strategic Fraud Authority (“NFA”). Access to all this documentation provided an indirect method of obtaining information; instead of asking direct questions of an interviewee; answers were effectively sought from respondent documents, a process termed content analysis (Robson, 1993, p. 273). Table 2.2 defines the type of documents used in this study, classified in accordance with Scott’s analytical classification methodology.

<table>
<thead>
<tr>
<th>Access</th>
<th>Personal</th>
<th>Official - Private</th>
<th>Official - Public</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Closed</strong></td>
<td>Diary entries and notes from those involved in the investigation of the case studies</td>
<td>Counter fraud industry security briefings</td>
<td>Correspondence between the ABI and Ministry of Justice (“MOJ”) regarding formulation of govt. policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Details of joint initiatives within the CHO</td>
<td>Minutes from debrief with National Crime Agency (“NCA”) on conclusion of Operation Navigate</td>
</tr>
<tr>
<td><strong>Restricted</strong></td>
<td>Witness statements in matters involving the arrest and prosecution of an offender</td>
<td>Company financial accounts</td>
<td>Report of police action on the investigation of fraudulent insurance claims</td>
</tr>
<tr>
<td><strong>Open - archival</strong></td>
<td>Internet blogs</td>
<td>Press releases from IFED, IFB, ABI, MOJ and others</td>
<td></td>
</tr>
<tr>
<td><strong>Open - published</strong></td>
<td></td>
<td>Newspapers</td>
<td>Hansard record of parliamentary debates</td>
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<td>Published reports and statistics</td>
<td>Acts of Parliament</td>
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<td></td>
<td>Research briefs</td>
<td>Judgements and proceedings</td>
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<td>Television and media coverage</td>
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<td>Internet material</td>
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Table 2.2: Desktop research – document classification

Before commencing the interviews, a review of the available literature and published empirical evidence was undertaken. It was focused on identifying:

- The nature and reported quantum of motor insurance fraud.
- The creation, governance, defined objectives and reported results from IFED.
- The experiences of non-insurer victims of insurance fraud.
- The history of public-private police partnerships.
- The approach of government in the period between the Fraud Review and the final report of the Insurance Fraud Taskforce (“IFT”) in 2016.
Insurance fraud

Significant attention has been given to the impact and consequences of insurance fraud but the conundrum postulated in the 2006 Fraud Review (2006, p. 5) remains a challenge today: “...most measures of fraud have not been carried out according to a robust methodology, and measure different things, so adding them up to produce an overall total is misleading”. In January 2016, after a review that was expected to champion solutions aimed at driving a long-term reduction in the amount of insurance fraud, the IFT (2016, p. 5) acknowledged that the majority of consumers are honest, that their insurance applications and claims are legitimate and that making a claim can be daunting and stressful. They offered only anecdotal rather than empirical conclusion, acknowledging that insurance fraud exists “on a continuum from application fraud to bogus, fictitious or intentionally inflated claims, right through to sophisticated organised crime” and that the problem was “deeply rooted”.

A historical perspective

Fraudulent and exaggerated claims have troubled insurance markets for years (Tennyson, 2008, p. 1188). Morley et al (2006, p. 163) highlighted that as well as being of high magnitude, the complexity of insurance fraud made detection difficult with the discovery of one scam often inspiring more aggressive and effective counter measures from the offender especially where the fraud was part of an organised campaign. Add to that challenging environment the lack of agreement on a common definition of insurance fraud and some of the pace in confronting it may be explicable. Some attempts have been made at providing a definition. Gill et al. (1994, p. 73) chose “knowingly making a fictitious claim, inflating a claim or adding extra items to a claim, or being in any way dishonest with the intention of gaining more than legitimate entitlements” but also highlighted the lack of empirical research on the topic as a stimulus for their own survey. Neither was there agreement within the industry as to the best working definition (Doig, Jones, & Wait, 1999, p. 22). Some insurers considered the offence was exaggerating a claim whilst others were pre-occupied with classes of systematic fraudulent activity like staged accidents or application fraud, relying on false documents or misrepresented information at the proposal stage. Part of the problem may be the insurance industry’s reluctance to discuss the issue in public other than through sometimes irreconcilable press releases.

Profiling the fraudster

Arriving at a simple profile for an insurance fraudster is equally challenging. Smith et al. (2011, p. 140) adopted the division of insurance fraud suggested by the ABI:
• Opportunistic fraud in general retail insurance by exaggerating or inflating genuine claims and, in a minority of cases, completely fabricating them.

• Opportunistic fraud in commercial general insurance where the same means are employed by a commercial, rather than a retail policyholder.

• Organised fraud involving policies taken out by criminal gangs for the explicit purpose of committing fraud.

Tennyson (2008) identified the same distinction arguing that claims fraud may be a result of deliberate planning or casual opportunity motivated by pure profit seeking, a sense of entitlement, desperation, or resentment. Gill et al (1994, p. 80) ascribed personal circumstances and a resentment of insurance companies as determinants and the IFT (2016, p. 75) noted a “perception among some consumers that insurance is ‘fair game’ and that insurance fraud is a legitimate way of making some money”. By 2009, the ABI (Goss & O’Neill, 2009, p. 9) had evolved their nomenclature and, perhaps to embellish future messaging, coined three media-friendly labels to publicise recessionary led increases:

• Desperation fraud, committed by those making ends meet, the recession having had the most profound impact.

• Lifestyle fraud, committed to maintain a standard of living and, arguably, more prevalent after the recession.

• Entitlement fraud, where honest individuals rationalise that years of paying premiums without a claim justifies a dishonest claim in harsher economic times.

The identity of the target merits comment. Smith et al. (2011) noted similarities between benefit fraud and exaggerated or false insurance claims as did the IFT (2016, p. 20), recognising the determined, callous and committed traits of the fraudster whether focused on defrauding the state or defrauding insurance companies. Gill et al. (1994, p. 80) saw resentment towards insurance companies, by both legitimate and fraudulent claimants, going some way to explain why insurance fraud has evolved, for some, into an “acceptable misdemeanour”. Goldstraw-White (2012) recognised a similar trait noting peoples inclination to feel more tolerant where the victim is a faceless insurance company. Academic research on the offender is evolving but Karen Gill (2014) cited the limited number of meaningful convictions for insurance fraud offences as a restricting factor on the categorisation of insurance fraudsters especially when those offending because of a feeling of entitlement don’t generally consider their actions to be offensive. Earlier, Clarke (1990, pp. 4–5) had identified three types of fraudster:
• The opportunist taking advantage of a genuine loss to commit fraud, e.g. by claiming for items not actually stolen in a burglary alongside items that were.
• The amateur who starts as an opportunist but goes further, e.g. by claiming for items stolen in a fictitious burglary.
• The professional who will engage in systematic frauds, individually or as part of organised networks. Clarke contends there is considerable anecdotal evidence that the professional operates in the motor insurance market.

Useful as they are, these categorisations don’t make it easier to spot an insurance fraudster in the street and trying to distinguish a fraudster from a genuine claimant based upon personal and social characteristics alone is also difficult. Research from Dodd, cited by Morley et al. (2006, p. 165) categorised a sample of fraudulent claims suggesting characteristics that make fraudsters, for the most part, entirely indistinguishable from genuine claimants. Button et al. (2014) provided a profile of a household insurance fraudster based on an analysis of 33,189 dishonest household insurance claims, revealing marked differences in the profile of fraudsters to some of the published profiles of occupational fraudsters and suggested that “‘Routine Activity Theory’ emphasising the connection between crime and the everyday life and circumstances of offenders, is a useful lens through which these results can be examined.” It is also arguable that some fraudsters possess entrepreneurial characteristics, noticeable from the variety of ways in which motor insurer fraud, the most common and costly component of insurance fraud, can be committed at a number of stages before or after taking out a policy of insurance (ABI, 2015).

**Types of motor insurance fraud**

**Application fraud**

Application fraud occurs in a variety of scenarios e.g. where an applicant:

- misrepresents salient facts to obtain a lower quote;
- withholds information or engages in a deception at the time the policy is incepted; or
- fails to notify a change during the policy life cycle in respect, for example,
  - of the use to which the vehicle is being put,
  - where it is kept,
  - the main driver’s identity, or
  - of a motoring offence.
In practice, these acts of deception which might impact the perceived risk, and so the pricing too, often only come to light following a claim making it difficult to quantify the cost impact from the underlying fraud. Extrapolating potentially lost premium from unidentified omissions or failures from an unquantified population of dishonest policyholders where the risk assessment may have resulted in a lower premium being charged for the risk is a Herculean task. Insurers have, however, respond to the challenge. The Insurance Fraud Register ("IFR") (Insurance Fraud Bureau, 2014) and ‘MyLicence’ (ABI, 2014f), a DVLA search tool, allow insurers to validate key data points about a driver, reducing the opportunity for application fraud. Additionally, with better tools providing greater clarity over the underwriting risk, insurers can now decline a risk in the event of detected material non-disclosure or, if they underwrite high-risk business, accept the risk at a higher premium. Such a granular approach of underwriting risks ‘one policy at a time’, is not without its critics. Ericson et al. (2000) cautioned against the moral hazard of un-pooling risks to maximise the insurer return per policyholder particularly where higher rates are charged without explicit pricing disclosure. The counter-argument is that intelligent underwriting helps insurers to reduce fraud at the inception stage and earn the appropriate premium for the risk to the pooled benefit of all policyholders whilst avoiding the possibility that any individual with an adverse history may be excluded from obtaining cover at any price.

Research from Lexis Nexis (2015) highlighted the increasing trend of application fraud, specifically where internet users could test the price points of several insurers and then omit or adjust data to improve the quote. It is not an offence that lends itself to exposure through the medium of television but it is perceived by some as unstoppable. I4 said:

“... people start their journey committing fraud ... they lie to the insurance company to obtain insurance ... the volume based activity associated with application fraud (we do 120 million quotes a year) is huge.”

The availability of aggregator price comparison websites\(^8\) have made applying for insurance easier. They allow simultaneous access to multiple insurers through a single Internet portal avoiding inconvenient multiple keying. Standardising the information required for a quotation has allowed insurers to track and detect inconsistencies in supplemental or substituted information by indexing the quote with the applicant’s postcode, registration number, driving licence number or IP address. This allows an insurer to follow a consumer’s journey through several different price aggregators, and/or their own website, and assess whether an application is being manipulated by reference to

\(^8\) e.g. www.confused.com
sequential changes made to elicit the best price. Many consumers use aggregators because they want to modify the information they submit to reduce the quoted premium and some amendments are permissible means to do that. For example:

- selecting a higher excess;
- deleting an additional driver;
- not protecting the no-claims bonus;
- eliminating supplementary legal expense insurance; or
- determining whether to use a car for commuting.

These are legitimate choices where the insurer and consumer are effectively ‘bargaining’ over risk and reward. However, certain actions may infer an intention to subvert the normal rating and pricing algorithm. For example, a consumer:

- might alter his occupation;
- change where the car is kept overnight from ‘on the street’ to ‘garaged’;
- reduce his predicted annual mileage;
- substitute the identity of the main driver; or
- change his address to that of a relative.

These are key pricing risks and so any post-quote manipulation of the initial responses given may suggest an attempt at application fraud to secure, by deception, a lower quote than the risk justifies. Equally, there is a possibility that the counter-fraud algorithms may misinterpret the behaviour of an honest, computer-literate consumer enjoying the ability using technology as an enabler to secure better value. It may be, for example, that changing a previous response about where a car is parked at night from ‘on the road’ to ‘garaged’ is genuine where the premium saving is large enough to persuade the applicant to empty his garage and use it to park his car. I1 said the ABI ranked application fraud as their second priority, the first and third being to ensure their detected and undetected fraud figures were as robust as possible. They claimed that over 200,000 suspicious applications for insurance were withdrawn in 2015, albeit without the insurer incurring a loss (2015h). The estimates, however, are not robust with the CSEW (2016, p. 43), citing figures provided by the National Fraud Intelligence Bureau (“NFIB”), attributing a rise in insurance fraud as a proportion of all fraud offences between October 2015 and September 2015 to increased levels of application fraud but only reported a total of 10,429 instances of all insurance frauds.
Ghost broking

Ghost broking involves criminals falsely advertising to be insurance brokers and selling bogus insurance policies. They leave road users vulnerable to a population of uninsured motorists defrauded of the cost of the premium paid. I saw ghost broking as a declining problem for insurers.

Crash for Cash

Probably the most widely-reported and prolific species of claim fraud, euphemistically referred to as ‘Crash for Cash’, the IFB (2013, p. 4) estimated that these dishonest claims cost the insurance industry £392 million annually. Button and Brooks (2016) decompose them into five different types:

- The exaggerated claim - an accident where the quantum of damage, personal injury or other claimed losses are inflated.
- The induced accident or ‘slam on’ - an offender targets an insured vehicle and then performs a manoeuvre, such as an emergency stop, where the other driver cannot avoid a collision for which he is likely to be held liable.
- The staged accident - two drivers conspire to cause a collision often where the driver agreed to be at fault is in a hired vehicle.
- The fictitious staged accident - similar to the staged accident except the accident never takes place; the damage occurs in a sterile environment away from prying eyes.
- The fictitious paper accident - a fictitious incident that generates claims in the same manner as the staged or fictitious staged accident.

Recently, the ‘Crash for Cash’ label evolved into ‘Flash for Crash’ (Ward, 2013), where the fraudster on a major road flashes his headlights to the innocent driver waiting to emerge from a side road who then pulls out into the path of the offender. He then claims that he flashed to let the other motorist know he was there, as advised in the Highway Code. And to highlight the entrepreneurial nature of fraudsters (and the linguistic ability of journalists), ‘Crash for Ready Cash’ (Vahl, 2015) is a more recent iteration where, after an induced accident, the fraudster confronts the victim at the roadside claiming the damage caused is repairable at a cost below the victim’s policy excess, an amount too small to justify involving insurers. The damage is, in fact, pre-existing but the fraudster demands a cash payment even offering to accompany the victim to a cash point. The victims, often women, and the accidents, usually in the evening when people are keen to get home, show the level of pre-mediation often inherent in these offences. Of more concern is the fraudster’s intention to avoid pursuing a claim through insurers, effectively by-passing insurer counter fraud defences, by seeking a sum below the victim’s excess. It raises the question of who
advocates for the non-insurer victim of fraud if the insurance industry, through their counter-fraud strategies, have simply pushed the fraud problem downstream and, in these cases, left the innocent motorist as a non-insurer victim to the limit of their excess level? Vahl (2015) characterised the incidents as “the equivalent of highway robbery” although the police were less energised as narrated by CF1:

“I witnessed a guy pull sharply in front of another car on a slip road and braked to cause a very minor collision ... the rear of his car was already damaged and the lady who “hit him” had barely a scratch ... It was quite late and I was suspicious ... I stopped to help and videoed what followed. The male wanted the lady to give him £200 for the damage to avoid involving her insurer and the police and when she said she had no money he offered to follow her to a cash point. I got involved at that point and the guy bolted.

I reported the incident to the BBC. The video ended up on Facebook and two other women contacted me ... subject of the same scam, perpetrated by the same bloke, driving the same car. I am a former police officer and ... collated the evidence and spoke with IFED. I was unsuccessful in persuading them to become involved, there being no loss to any insurer. I did, however, embarrass a provincial force into investigating but after the incident was shown on TV, the index car was found abandoned. Eventually the police traced the offender and arrested him. He was identified in a police ID parade (by me and the other victims) and the case officer told me that they had linked together several other similar offences.

Over a year later ... I was advised that the CPS declined to recommend the offender be prosecuted ... suggesting I consider a civil prosecution. To add insult to injury, the vehicle used by the offender was also uninsured when the offences were committed.”

**Fraud and the media**

In their submission to the Fraud Review (2006, p. 10), the ABI recommended developing a media campaign to educate consumers about the perils of insurance fraud. Whether that was an attempt to alert them to the type of risks detailed above, invoke the atmospherics for a moral panic, pick up on the successes of the Tort Reform Movement in the US (Halton & McCann, 2004) or was just born out of frustration from experience, the inclination to mount a media campaign to challenge the notion that insurance fraud was an acceptable offence was echoed by the CLP (2011b) years later, re-affirmed in a conference speech on behalf of the ABI in 2013 (Kerr, 2013) and then resurrected as one of the recommendations of the IFT (2016, p. 77). The ABI strategy envisioned a media campaign labouring the risk of detection and imprisonment for insurance fraudsters with an aspiration to make the offence as socially unacceptable as driving whilst drunk or without insurance. I1 highlighted the impact of ‘Claimed and Shamed’, a programme from the BBC about insurance fraud.

“There’s been five series ... It goes out at the mid-morning Jeremy Kyle type audience, which is quite good without trying to sound patronizing, and it has had the best viewing figures
for that time of morning ... it’s had a big impact ... we are not there yet, but we’re chipping away at this hackneyed misconception that fraud is a victimless crime.”

Gaining access to parts of the media proved difficult for the Researcher. M3 replaced his oral contribution with a brief written response, expressing concern about the three broadcasters he worked with reacting negatively to his contribution if it was ‘off message’. Asked for his definition of motor insurance fraud, he provided a narrow, almost myopic response claiming it to be “when an individual or group seek to profit financially via insurance by either deliberately causing a collision, exaggerating one, or completely fabricating an event”, a view he said he derived “from working with a range of insurers, APU and the police.”

If the figures are accurate, with general insurance fraud reported at £1.32 billion detected and £2.1 billion undetected (ibid. p. 5), insurance fraud is undoubtedly newsworthy and with graphic portrayal of detected crimes, Crash for Cash has become a staple of both the print and television media although M2 was less convinced:

“I’ve seen it over the years, they just churn out the same old stuff ... the Daily Mail pick it up and the next thing is there’s a story about ‘one legged lesbian working class mothers are creating more whiplash claims’. And they just believe it’s news... You don’t have to test these claims very far to show it’s nonsense. It’s not true! The figures are complete nonsense and they are just being used to drive the media coverage from those daft enough to publicise them.”

According to Greer (2010), the news media are a defining feature of the justice landscape providing “key indicators of the nature and extent of crime, the appropriateness and efficacy of criminal justice, and the wider state of the nation”. Hall et al. (1978) suggested that the media continually reproduce the ideas of the ruling class and that news production is oriented in the purported name of “journalistic objectivity and impartiality” to appeal first to the accredited experts who represent and command institutional power leaving powerful groups in a position to “establish an initial definition or primary interpretation of the topic in question” (ibid. p58) prompting Greer (2010, p. 494) to observe that “once the primary definition has been established it is extremely difficult to override, and future debate is contained within a forum of ‘controlled discourse’ governed by the primary definers”. Hall et al. (1978, p. 59) argued that:

“The media, then, do not simply ‘create’ the news; nor do they simply transmit the ideology of the ‘ruling class’ in a conspiratorial fashion. Indeed, we have suggested that, in a critical sense, the media are frequently not the ‘primary definers’ of news events at all; but their structured relationship to power has the effect of making them play a crucial but secondary role in reproducing the definitions of those who have privileged access, as of right, to the media as ‘accredited sources’. From this point of view, in the moment of news production, the media stand in a position of structured subordination to the primary definers.”
Changing attitudes

It is unarguable that insurance fraud is a problem and that the effect may have increased since 2008 as fraudsters exploited systemic weaknesses to follow the money. Quantifying the extent of the problem is harder. Since the late 1980s attitudes have changed with individuals increasingly prepared to engage in misrepresentation for personal gain and a preparedness to attempt to defraud ‘well-off’ institutions (Doig et al., 1999, p. 19). For all insurers, but for motor insurers more than life or commercial underwriters, Clarke (1990, p. 4) identified a minority of consumers who saw insurance companies as reasonably anonymous and a wealthy target for fraud. The ABI’s published research (Goss & O’Neill, 2009, p. 11) (“ABI Research Brief”) claimed that 7 to 11% of adults admit to making a fraudulent insurance claim, an estimate they felt likely to be lower bound estimates assuming that some of those surveyed would not admit to fraudulent behaviour even when anonymity was assured. The self-justification for committing insurance fraud, as identified by Clarke, appears to have persisted until 2010. More recent ABI research (O’Neill, 2010, p. 13) suggests 40% of adults regarded claims fraud as either borderline or acceptable. Karstedt and Farrall (2006, p. 13) claimed 22% of people would consider padding an insurance claim, suggesting a relatively high tolerance towards insurance fraud. According to another insurance survey (Bachelor, 2009) reported in January 2009, 1.4 million adults considered insurance fraud more acceptable than they did 12 months earlier and almost 5 million people (about 10% of the adult population) saw nothing wrong with making a false insurance claim.

The slow progress in defining what constitutes fraud in a dynamic, complex and adversarial environment makes implementing a coherent industry-wide reporting methodology difficult. If it is impossible to measure precisely the financial impact then that lack of clarity must frustrate a proper assessment of the effectiveness of any counter measures and the appropriate allocation of resources since “measurement is the first step that leads to control and eventually to improvement. If you can’t measure something, you can’t understand it. If you can’t understand it, you can’t control it. If you can’t control it, you can’t improve it” (Harrington, 1997). The ABI publish the only available empirical data on motor insurance fraud although it is, apparently, an aggregation of data from several insurance companies utilising a method reliant on multiple estimates with no published protocol or control regulating the exercise. The IFT appear not to have tested the methodology underpinning the ABI calculations and yet the headline numbers are routinely reported through the media and shared with government and so are relied upon, and repeated, in many other reports and publications on the subject. In the foreword to the IFT report (2016), Harriet Baldwin MP, Economic Secretary to the Treasury, and Lord Faulks QC, Minister of State for Civil Justice, asserted that:
“insurance fraud has been estimated to cost policyholders up to £50 each per year, and the country more than £3 billion ... pushing up the prices of essential products, such as motor and home insurance, with consequences for everyone through an increased cost of living. Valuable public resources, such as those in our NHS and in the courts, are spent on dealing with fraudulent cases.”

The researcher discovered that finding evidence to support a cost to policyholders of “£50 each per year” AND the basis for a cost to the country of “more than £3 billion” was impossible.

Lies, damned lies and statistics

The ABI (2015j) reported having detected 67,000 fraudulent motor claims in 2014 with an aggregated value of £835 million, 12% higher than the number of claims detected in 2013. £835 million represents 63% of the £1.32 billion uncovered fraudulent general insurance claims reported in the same year, an increase of 3% from the 2013 report. These are just the reported figures for detected fraudulent claims with the ABI not offering any estimate of a value for undetected fraudulent claims. The difference between the reported cost of detected and undetected fraud will prove to be important in the analysis that follows. The 12% increase in detected fraudulent claims may have indicated the industry’s ability to identify and thus avoid fraud was improving. Indeed, I6 claimed “the increase in the detected fraud figure is partly because we’re better at detecting it.” Conversely, there may have been no improvement in the detection rate, the reported increase in detected claims to 67,000 merely the product of an increased claims incidence and a constant detection rate. It could also have been a combination of the two or even a third alternative that we just don’t know what the figures truly represent. For the Researcher, that was the scenario which motivated his research.

Fraudulent claims - detected or undetected?

The ABI’s use of the undefined labels of ‘detected’ and ‘undetected’ fraud requires clarification. It is not clear, for example, if the detected claims reported in 2014 generated payments to dishonest claimants, effectively cash outflows of £1.32 billion, or if it identifies claims that were determined to be fraudulent, or potentially fraudulent, before payment was made so enabling a £1.32 billion cash outflow to be avoided. The second of those two alternatives appears more feasible since the NFA (2013, p. 41) referenced a much lower cash outflow of just £39 million in the 2013 Annual Fraud Indicator (“AFI”), a figure they credited to the ABI in respect of “identified insurance fraud (where claims are paid before they have been identified as fraudulent)”. If £39 million was the true extent of cash outflow for fraudulent general insurance claims, then the problem may be nowhere
near as significant as the market, the media or government, might believe. It still suggests an industry under attack but, perhaps, because of the vulnerability in its own processes and systems as the investment in counter-fraud measures had yet to mature to a level consistent with the emerging threat.

In 2009, the ABI (2009, p. 5) implied that detected general insurance fraud did represent savings to insurers from repudiated detected claims with increased detection ascribed to:

- greater awareness of the fraud risk;
- dedicated fraud teams being introduced;
- increasingly sophisticated IT and systems; and
- cognitive interviewing techniques and voice-stress analysis software.

A series of tables supported the narrative and elements from Table 1, 5 and 6 of the ABI Research Brief are summarised in Table 2.3 below.

<table>
<thead>
<tr>
<th>Distribution Channel</th>
<th>Annual Motor Premium (£m) (source: Table 1)</th>
<th>Repudiation Rate by Value (source: Table 6)</th>
<th>Detected Fraud (£m) (Calculated)</th>
<th>Repudiation Rate by Volume (source: Table 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>£8,100</td>
<td>3.56%</td>
<td>£288.36</td>
<td>0.94%</td>
</tr>
<tr>
<td>Commercial</td>
<td>£2,700</td>
<td>4.55%</td>
<td>£122.85</td>
<td>0.74%</td>
</tr>
<tr>
<td>Total</td>
<td>£10,800</td>
<td>3.89%</td>
<td>£420.12</td>
<td>0.92%</td>
</tr>
</tbody>
</table>

Table 2.3: Detected (repudiated) motor insurance claims 2008 (Source: ABI 2009)

Three observations emerge from this data:

- Detected (repudiated) motor insurance fraud in 2008 was £420.12 million.
- No estimate of claim volume was provided but repudiation, by volume of claims, was below 1%.
- There was no analysis of fraudulent claims resulting in cash outflow before the fraud was established.

If the ABI Research Brief was the foundation for subsequent reporting then, by 2016, confidence in the data should have been high. Indeed, having given the IFT estimates that annual insurance fraud losses had reached £3 billion, confidence in both the provenance and fidelity of the data should be non-negotiable it being used to inform, shape and drive criminal justice policy.
Neither the data, nor opinion, support that outcome. In interviews conducted for this research, there was almost universal disbelief in the reliability of ABI data and, what the numbers meant and how the ABI could quantify undetected fraud. CF2 said:

“... the very idea of £2 billion of undetected fraud is a misnomer; how can you put a statistic on something that you don’t know?”

P1 concurred:

“... if it’s undetected how can you put a figure on it? I keep on getting asked about these numbers by the media ... I can’t find anyone at the ABI who can give me a proper answer. It’s embarrassing ...”

I1 disclosed the quantification exercise had not been repeated since 2009 because of the expense associated with it, a peculiar admission from an industry purportedly haemorrhaging £3 billion annually\(^9\). He confirmed that £835 million of the reported £1.32 billion figure was detected motor insurance fraud that he felt was “pretty solidly based”. On the issue of undetected fraud, he said:

“I know you saw the 2009 report\(^{10}\), which was the last time we actually looked at it ... the figure that we have for undetected fraud is about £2.1 billion, that relates to 2008, and that is not an ABI figure, that is a National Fraud Authority figure ... it’s a combined ABI/IFB figure which includes IFB data on crash for cash” (emphasis added).

His explanation of the calculation for undetected fraud placed reliance on the AFI and it seemed that the reference to the statistic being an NFA figure was intended to infer that the NFA, a government agency, had either produced, or at least validated, the £2.1 billion as being a legitimate, reliable and proper estimate. They had done no such thing. In a footnote referencing the source of the £2.1 billion figure, the NFA (2013, 40) attributed its estimate of undetected fraud to data supplied by the ABI and the IFB. It appears the reference by both the ABI, and later by the IFT, to a statistic reported by the NFA was parallel referencing of uncorroborated data the ABI had originally supplied and was now relying on the NFA to give it independent legitimacy. I1 was visibly uncomfortable when challenged on this point and offered no coherent explanation. Parallel referencing of uncorroborated data was a common practice identified throughout the desktop research.

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\(^9\) The ABI may have invited proposal in 2016 to re-visit the work done in 2009
\(^{10}\) The ABI Research Brief
The ABI Research Brief 2009

Goss and O’Neill (2009, p. 17) set out their method for estimating undetected insurance fraud in an appendix. Understanding the methodology deployed is helpful in assessing the reliability of the estimates deployed by the ABI from 2009. What follows is a worked example of the Researcher’s interpretation of the way in which Goss and O’Neill produced their estimates of detected and undetected fraud. It requires values for three variables subsequently used in an equation. The variables and the three steps involved in calculating them are set out below:

- Detected Fraudulent Claims (“DFC”),
- Undetected Fraud Risk Multiplier (“UFRM”).
- Average Fraudulent Claim Value (“AFCV”).

**Steps in the calculation**

1. Individual insurers report their detected fraud rate - the number of fraudulent claims detected as the percentage of total claims. The ABI aggregate individual responses and then estimate the DFC for the market by applying the aggregated percentage from all participating insurers against the total claims reported by all insurers. Whilst each insurer will have known the percentage of total claims detected as fraudulent, the precision of the aggregated industry total relies on all insurers contributing and adopting the same measurement philosophy. Conversations the Researcher had with insurer and IFB employees confirmed that there was no pre-agreed process to ensure uniformity of reporting.

2. Calculation of the second variable, the UFRM was subjective. Each insurer’s perception of the number of undetected fraudulent claims was aggregated by the ABI and then reported as an aggregated variable termed the undetected fraud rate. The UFRM, the second variable in the equation, is the undetected fraud rate divided by the detected fraud rate. For example, if the detected annual fraud rate was 2% and the estimated undetected fraud rate was 10% (based on their calculation of all insurers’ aggregated perception of undetected fraudulent incidents in their market) then the UFRM would be 5 i.e. 10% divided 2%, the value used in the worked example below.

3. The AFCV is another aggregated value. Individual insurers multiplied their average cost per claim by the sum of (a) the proportion of fraudulent claims that are invented and (b) the proportion that are exaggerated by (c) the degree to which exaggeration occurs in these
claims. The result is the AFCV which appears to be the product of a process as subjective and obtuse as the calculations set out in the first two steps above. The AFCV in the ABI Research Brief was £1,100.

Using the variables arrived at from the steps set out above, Goss and O’Neil calculated that

**Undetected Fraud** = ((DFC x UFRM) x AFCV) (ibid. p.17). A worked example using this equation to calculate the value of undetected fraud appears below; the values shown are for illustrative purposes only.

- **DFC** (detected fraudulent claims) 10,000
- **UFRM** (undetected fraudulent risk multiplier) 5
- **AFCV** (average fraudulent claim value) £1,100

\[(10,000 \times 5) \times £1,100 = £55 \text{ million}\]

Whilst the logic for this calculation appears arithmetically uncontroversial it is at risk of distortion and/or bias for several reasons. The UFRM requires that insurers submit their own numerical indicator of detected fraudulent claims without reference to an objective definition of a detected fraud. Inconsistent measurement will generate inconsistent results. Participants were also required to estimate their own UFRM based on their perception of undetected risk relative to the number of fraudulent claims detected in their company. That assessment is an entirely subjective measure relying on estimating something that, by definition, has not been detected. The application of the calculated UFRM in the first and, as it transpires, only result of this methodology, may have created a baseline for insurer’s estimating undetected fraud that subsequently influenced each insurer’s attitude against the level of provisions it needed to make against the risk of future undetected fraudulent claims. There is a probability that whenever the calculated industry value for detected or undetected fraud was high, a prudent actuary would perceive his future risk as likely to increase or, as a minimum, to be no better than in previous years compelling him to invoke at least the same or higher estimate of the risk of undetected fraud for future calculations divorced from the true position. The tension between a prudent actuary and a wholly subjective methodology will likely result in higher reporting of undetected fraud. Equally, the approach to providing for the risk of increased costs of fraud is heightened if the industry fears the risk of a fraud epidemic. It would be a very brave actuary who determined, in those circumstances, to reserve for the risk of fraud less prudently than his peers.
What emerges is the potential for a circular and self-perpetuating upward only view where insurers might make increasing financial provisions against the prospect of future undetected fraud crystallising substantive losses against current revenue. In accounting terms, the output of that prudent approach to provisioning would either be a reduction in profits or an increase in premiums. Significantly, the cycle of financial uncertainty equalises when the real claims experience for an accounting year is determined. As soon as there is visibility of the real cost of fraudulent claims paid out then that figure will be reflected in the profit and loss account and the excess accounting provisions, or reserves held in respect of potentially fraudulent claims, can be released. Because insurers account for premiums and claims in respect of policy years, and because most general insurance claims are either settled or investigated within a year or two of the policy year end, the use of estimates when real audited data is available is perplexing.

**Postscript**

The ABI Research Brief concluded that detected insurance fraud had increased by, on average, 30% a year between 2004 and 2008 (ibid. p.4). If there was a true increase in the detected fraud rate it is possible that it may not be because of an increase in the number of fraudulent claims being committed; it just might mean that insurers are better at codifying or detecting the offence. However, a prudent actuary may impute the effect of that increase into their perception of their total fraud risk, specifically undetected fraud, such that the calculated UFRM may be higher than the simplicity that the logic originally intended. Consider the position using the worked example above but calculating the value of undetected fraud using amended hypothetical values reflecting the detected fraud rate increasing by 25% from 2% to 2.5% and so detected fraudulent claims increasing to 12,500. This could arise from insurers allocating increased or smarter resources to dedicated detection teams. But assume also that actuaries take the reported increase as a portent of increased fraud activity generally rather than a result of process improvements. As a best case, they may choose not to link the growth in detected fraud to a corresponding increase in the perception of the risk of undetected fraud and leave the UFRM at 5. The net effect of the increase in detected claims increases the estimate of undetected claims from 50,000 to 62,500 simply from applying the UFRM of 5 to 12,500, rather than 10,000 detected claims. The estimate of undetected fraud increases from £55 million to £68.75 million.:

- **DFC** (detected fraudulent claims) **12,500**
- **UFRM** (undetected fraudulent risk multiplier) **5**
- **AFCV** (average fraudulent claim value) **£1,100**
((12,500 x 5) x £1,100) = £68.75 million

In a more pessimistic scenario, actuaries may be persuaded anecdotally that the incidence of fraud, rather than its detection rate, is increasing and accordingly determine to increase their perception of risk applying to undetected fraud from 10% to 15%. The net effect of that actuarially driven adjustment would produce a revised **UFRM** of 6 (15% divided by 2.5%) revising the estimate for undetected fraudulent claims to 75,000 (from 50,000), a real increase of 50% which moves the estimate for undetected fraud from £55 million to £82.5 million.

- **DFC** (detected fraudulent claims) 12,500
- **UFRM** (undetected fraudulent risk multiplier) 6
- **AFCV** (average fraudulent claim value) £1,100

((12,500 x 6) x £1,100) = £82.5 million

**Testing the data**

The integrity of the ABI figures is paramount. They have:

- fuelled a long running media and PR campaign;
- potentially misdirected the response to fraudsters;
- supported increased insurance premiums and insurer profitability;
- defined the fraud agenda;
- catalysed the ABI partnership with the CLP; and
- influenced, and driven, broader government policy decisions by shaping the political debate.

History is one source of validation for the ABI estimates. Doig et al (1999, p. 20) referenced figures from the Crime and Fraud Prevention Bureau Annual Report 97 which reported insurance fraud at 3.6% of annual premiums in 1996 although without any granularity and no sense of the scale of any underlying undetected problem. Goss and O'Neil (2009, p. 1) concluded that detected general insurance claims fraud in 2008 was £730 million (2.2% of premiums) and undetected general insurance claim fraud was estimated to be the equivalent of 6% of total premiums (effectively applying a **UFRM** of 3). By 2014, detected general insurance claims fraud was reportedly £1.32 billion, of which £835 million was associated with motor insurance (ABI, 2015j). Against £10.5 billion of reported motor insurance revenue (ABI, 2014b), £835 million represents detected fraud.
of 7.9% of annual premiums. Adding in the claimed £2.1 billion cost of undetected fraudulent claims suggests total detected and undetected fraud running at 28% of annual premiums, which sounds infeasible when compared with the average loss rate of 3.9% reported in the 2017 Annual Fraud Indicator (Button, Gee, & Mothershaw, 2017, p. 14) or the global average loss rate of 5.6% (Gee & Button, 2015, p. 10).

The separate and most detailed analysis of general insurance detected fraud published by the ABI (2015c) is helpful. Of the reported £835 million of detected fraudulent motor insurance claims, only £140.5 million was characterised as ‘proven detected fraud’, with the balance (£697 million) being categorised as ‘suspected detected fraud’; by deduction, 84% of reported detected motor insurance fraud was based on suspicion and not proof and so it appears that even the figure attributed by the ABI to detected fraud is less certain than its label might imply. An extract of the published data appears in Table 2.4 below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Value of Claims Fraud (£000)</th>
<th>Volume of Claims Fraud</th>
<th>Fraud Rate by Claims Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proven Suspected Total</td>
<td>Proven Suspected Total</td>
<td>Rate by Claims Value</td>
</tr>
<tr>
<td>2004</td>
<td>78,961</td>
<td>14,325</td>
<td>1.82%</td>
</tr>
<tr>
<td>2005</td>
<td>181,657</td>
<td>20,538</td>
<td>2.95%</td>
</tr>
<tr>
<td>2006</td>
<td>206,930</td>
<td>20,374</td>
<td>2.95%</td>
</tr>
<tr>
<td>2007</td>
<td>258,197</td>
<td>23,654</td>
<td>3.17%</td>
</tr>
<tr>
<td>2008</td>
<td>352,976</td>
<td>33,710</td>
<td>3.86%</td>
</tr>
<tr>
<td>2009</td>
<td>412,921</td>
<td>39,831</td>
<td>4.91%</td>
</tr>
<tr>
<td>2010</td>
<td>468,175</td>
<td>40,652</td>
<td>5.34%</td>
</tr>
<tr>
<td>2011</td>
<td>541,328</td>
<td>44,058</td>
<td>6.44%</td>
</tr>
<tr>
<td>2012</td>
<td>613,646</td>
<td>44,617</td>
<td>6.88%</td>
</tr>
<tr>
<td>2013</td>
<td>811,352</td>
<td>50,859</td>
<td>6.20%</td>
</tr>
<tr>
<td>2014</td>
<td>140,464 697,029 807,493</td>
<td>9,691 57,215 66,903</td>
<td>9.31%</td>
</tr>
</tbody>
</table>

Table 2.4: General detected fraud by line of business (Source: ABI 2016)

The use of large aggregated numbers when talking about insurance fraud fuels a very serious message which may be why the reported numbers are so high. Glenn Marr (2014), a former director of the IFB and former police officer, referred to the accuracy of the ABI figures as estimates to be “viewed/treated accordingly” and that “the methodology used to produce these estimates could undoubtedly be improved upon and refined”. His views were echoed by others.

I4 said, in relation to a meeting that he had had with David Hertzell of the IFT:

“... he’s quite aware the industry is using estimates and that work needs to be done to strengthen the data … they do get used widely in the public domain, and with the media, which is something I am very, very uncomfortable with.”

DF1 said:
“it’s just a big number used to get attention ... If it really is £3 billion, then measured against £10 or £11 billion of motor insurance turnover that’s 25% of industry turnover which is an absolute nonsense.”

M2, complained:

“They are complete rubbish. Everyone knows they are made up ... not actually representative of the quantum of fraud because the sums are never paid out. I had this out with James Dalton of the ABI a couple of years ago ... It’s all very well talking about £800 million of detected fraud but if it was detected then you haven’t paid out. Why are you using these ridiculous large numbers? The figures are all bullshit.”

I3 concurred:

“None of the figures are right; every insurer, and I’ve raised this at the ABI last year, they’ve all got different versions of what should go into each piece of the puzzle and on that basis, the aggregated figures coming out of the ABI can’t be right.”

M1 said:

“... it’s all basically put a finger in the air and grab a number isn’t it? You see these figures from the ABI and they’re quoted all over the place; you read the white papers and industry reports and see the figures in the media and no-one ever questions their validity ... the stuff about detected and undetected fraud ... it’s just guesswork, isn’t it? ... and when you get to a figure of £3 billion, it sounds impressive and ridiculous at the same time but it certainly managed to get the Government interested.”

There appears to be no agreed and consistent method by which the insurance industry reports the volume or cost of detected or undetected fraud. Clarke (1990, 2) highlighted the wide variation in available evidence 25 years ago and little progress, or consistency, can be found since. For example, Aviva Insurance (Hyde, 2014) claimed that less than 2% of the 910,000 claims handled by them in 2014 were fraudulent, demonstrating that insurers can quantify precisely their exposure. In addition, the ABI (2016d) published ‘pay out’ rates for the most common claims during 2013 and 2014. With data from 19 insurers covering 4.3 million motor claims they revealed that 99% of claims were successful with an average pay-out of £2,160. Commenting on the figures Huw Evans, Director General of the ABI, said:

“we cannot earn trust without being more transparent about how many claims are paid and why a minority of claims are usually declined. Contrary to popular belief, insurers want to pay honest claims.”

Superficially at least, these figures imply that only 1% of motor claims were declined (not ‘honest claims’), wholly inconsistent with the previous ten years of messaging. The IFT (2016, p. 16) provided a stark warning in their report that increasing levels of insurance fraud may compel a
change from a ‘trust’ to a ‘verify’ society. That warning may also apply in respect of the ABI statistics which appear widely mistrusted by some and incapable of verification by anybody. I4 said:

“the use of undetected fraud as a term is something that I don’t agree with and don’t quite understand either ... the industry needs to do a lot more around this quantification of fraud losses generally ... It needs some investment and we need to move away from what are now just crazy estimates that we’ve been relying on for several years ... the industry needs to get a number which is a more resilient number and has a lot more integrity attached to it. We’ve been using estimates for too long.”

The answer to all of this may lie elsewhere. Ericson (1993, p. 540) contends that insurance claim fraud is a case of ‘making crime’. Pointing to comments from a US insurance industry executive he highlights the irony that the increasing focus on the detection and reporting of claims fraud, and the refusal to pay claims, is integral to keeping premiums down in an environment where increased claim costs can no longer be passed on to consumers by way of higher premiums. The parallel with the UK insurance market is intriguing. During the deepest global recession for a generation, insurers avoided regulatory criticism for imposing significant increases in motor premiums because of the Establishment’s acceptance of their exposure to several industrial crises of which fraud was one. Insurers in the UK were, arguably, wrestling with a different variant of the same problem reported by Ericson. Whilst there wasn’t a regulatory cap on premiums, the resentment directed towards the banking and finance sector for the role in crystallising the recession created resistance to insurers increasing premiums at a time when government were telling consumers (Cameron, 2009) that “we’re all in this together”.

UK Motor insurers had been loss making since 1994 (Transport Committee, 2011a) but during a period of government imposed austerity, it was difficult for them to sustain price rises sufficient to stem their recurring losses. Creating a groundswell of government support may, if the explanation from the US was correct, have given UK insurers the necessary resolve to aggressively publicise the scale of insurance fraud as a driver for justifying increased premiums to improve profits. The sight of increasing insurance premiums was a stimulus for the 4th Report of the House of Commons Transport Committee (“TSC”) on the Cost of Motor Insurance (ibid p.5). They reported:

“Many motorists have had an unpleasant surprise in recent months in discovering that the cost of their motor insurance has increased significantly [with] average quoted premiums for comprehensive cover increased by 11.7% in the third quarter of 2010 and by 29.9% in the year to October 2010. The average of the lowest three quotes from 90 providers (known as the “Shoparound” average) increased by 39.3% in the year to October 2010.”
Of perhaps greater importance was the message to government (ibid. p.7) that premiums would continue to increase because insurers needed to make up for several recent lean years and that insurers spent around £1.20 for every £1 collected in premium. Whilst an increased risk of fraud may have been a component part of the reported ‘claims outgo’ insurers faced, it bears mention that as claims experience in each policy year becomes a firm number in the insurer’s accounts, and if the predicted exposure to undetected fraud is too high, then the insurer’s audited financial results in future years will be flattered by a release of reserves no longer required against potential fraud losses that didn’t materialise. A corresponding increase in reported profitability will then follow and, in the case of public companies, so will a rising share price and increased dividend payments to shareholders.

In 2014, Direct Line Group plc (“DLG”) and Admiral Insurance Group plc (“Admiral”), who between them write 25% of motor insurance policies in the UK, revealed a record rise in profits despite the insurance industry’s alarm call over the unrelenting tide of fraudulent insurance claims (Thompsons Solicitors, 2015). DLG paid an 8.8p per share final dividend after operating profit for the year rose by 14% to £497m and the final dividend took DLG’s total pay-out to shareholders for 2014 to 27.2p, 32% more than the 20.6p paid for 2013. In total cash terms, DLG shareholders received dividends of £407m and the results statement confirmed that profits had been boosted by releasing £278.4 million of reserves in respect of motor risks “driven primarily by favourable experience on bodily injury claims across recent accident years” as well as the Government’s Legal Aid, Sentencing and Punishment of Offenders Act (“LASPO”) (Direct Line Insurance Group PLC, 2014, p. 42). The release of reserves was confirmation that provisions made in previous accounting periods were higher than had been required. In 2015 (Direct Line Insurance Group PLC, 2015, p. 34), the trend continued with a further release of £266.8 million of motor insurance reserves and an increase in profit before tax to £507.5 million. Admiral (2015, p. 15) reported a profit from UK car insurance of £398m and announced a 49p final dividend worth £135m to shareholders because the company had been able to make “higher reserve releases” as a result of “positive claims development in particular from the 2011, 2012 and 2013 years”. They promised shareholders could look forward to more “jam tomorrow” because an upward turn in premiums was already delivering profitability that would be reported in the coming two or three years because of the company’s “cautious approach to recognising underwriting profit”. In the 2015 financial year (Admiral

11 Profit is the amount by which premiums exceed claims and cost outgo
there was a reserve release in respect of UK car insurance of £84.6 million (2014: £66.8 million) and the Chief Executive, when declaring a dividend to shareholders of £377 million, invited those shareholders to “trust me, money from back year releases actually spends exactly the same as any other money. And there’s more where that came from” (ibid. p.8).

Definitions revisited

Tom Jones, head of policy at Thompsons Solicitors (2015), claimed the results from the two insurers were yet more evidence that the scare stories about the scale and cost of fraud were misleading:

“The endless claims of fraud, from whiplash to crash for cash and the huge £multimillion sums attributed to it have been exaggerated to get reforms that help insurers make ever-larger profits and motorists to think that premiums have to stay high.”

I1 confirmed that the 2009 results in the ABI Research Brief had been “grossed up for inflationary pressures and stuff like that.” It may follow, therefore, that the estimate of general insurance fraud by insurers are themselves evidence of exaggerated claims. Jones (2014b) said:

“Until the ABI adequately explains its definition of fraud and is transparent, their claims aren’t worth the paper they are written on. Trotting out unsubstantiated figures that include – unless they prove otherwise – any mistake or oversight made by motorists is reminiscent of some tin pot dictator’s factory production figures. They mean nothing at all and there is no way to check them.”

Judith Gledhill (2014a), also of Thompsons, raised another concern:

“Figures released by the ABI and IFED state that there were as many as 59,900 ‘dishonest’ motor claims ‘detected’ in 2013 but that only 85 people had been prosecuted since 2011. If the ABI’s figures are accurate and if we are in fact in the midst of a fraud epidemic, it begs the question why there are so few prosecutions? The way this latest announcement reads you’d … be forgiven for thinking that insurers have paid out millions of pounds to dishonest policy holders when, in fact, the only multimillion pound payments they’re making is to their own shareholders. The fact is, the insurers are crying crisis because it helps them politically and no one is challenging the accuracy of what they say.”

The ABI (2015c), perhaps belatedly with much of the agenda for reform to the compensation system having been delivered by this stage, softened the tone of its message clarifying that the information collected annually “does not provide anything more than an indication of the level of detected fraud impacting on the insurance industry” and “reporting on and measuring all cases of fraud encountered by insurers presents some challenges.” Whilst arguably helpful, that concession brings back into consideration the debate about what detected and undetected actually means and what are the true cost of fraudulent claims paid out. Commenting on the delta between the
significant number of allegations of fraud and the relatively small number of convictions, postulated that detected fraud is a complex subject to analyse and that it is not simply about convictions:

“there are not a lot of convictions ... a handful of cases ... so detected fraud is based on what we define as ‘proven known conventional frauds’. It’s a combination of what we call ‘known frauds’ and ‘suspicious activity’ and suspicious activity will form the majority of that.”

He went on to explain that the ABI had published its definitions following questions raised by the Transport Committee (Insurance Fraud Bureau, 2015, p. 9):

“‘Suspicious activity’ involves claims where a claim handler having an actual suspicion of fraud (e.g. manual fraud indicator(s), tip off, system generated “high risk” referral etc.) challenges the applicant/claimant by letter, telephone call or instruction of an investigator etc., to clarify key information, provide additional information or documentation etc., and the applicant/claimant subsequently:

• Fails to co-operate or provide further documentation; and/or
• Formally withdraws the application/claim (by phone, e-mail or letter) without a credible explanation; and/or
• Allows all communication with the insurer to lapse despite the insurer’s reasonable attempts to re-establish contact; and/or
• Accepts (without a credible explanation) either a substantially reduced settlement offer in respect of a claim, or a substantially increased premium in respect of an application/renewal (other than in cases where there has been a careless misrepresentation).

‘Proven known conventional frauds’ are those that fall into the descriptions in the Fraud Act 2006, and mirror the definition adopted by the insurance industry in relation to the Insurance Fraud Register. They include:

Any party seeking to obtain a benefit under the terms of any insurance-related product, service or activity who can be shown, on a balance of probabilities, through its actions, to have made or attempted to make a gain or induced or attempted to induce a loss by intentionally and dishonestly:

• Making a false representation; and/or
• Failing to disclose information; and/or
• Having abused the relevant party's position.
In addition, one or more of the following outcomes has taken place which relates to the fraudulent act:

- An insurance policy application has been refused;
- An insurance policy or contract has been voided, terminated or cancelled;
- A claim under an insurance policy has been repudiated;
- A successful prosecution for fraud, the tort of deceit or contempt of court has been brought;
- The relevant party has formally accepted his/her guilt in relation to the fraudulent act in question including, but not limited to, accepting a police caution;
- An insurer has terminated a contract or non-contracted relationship/ recognition with a supplier or provider;
- An insurer has attempted to stop/recover or refused a payment made in relation to a transaction;
- An insurer has challenged or demonstrated that a change to standing policy data was made without the relevant customer’s authority.

Also, the relevant party must have been notified that its claim has been repudiated, or relevant policy or contract voided, terminated, or cancelled, for reasons of fraud and/or it is in breach of the relevant terms and conditions relating to fraud within the relevant policy or contract” (ibid.).

Bringing an insurance claim is rare for most innocent consumers and a challenging process that can be both daunting and stressful. Appreciating a matrix of conditions under which that claim can be categorised as either detected fraud or suspicious activity where the final test appears to be whether the policyholder gives up without a fight is an arbitrary basis upon which to determine dishonest conduct. In 2015, the Financial Ombudsman (2015) received 7,361 complaints against motor insurers, up from 5,784 recorded in 2011 and in May 2015 they reprimanded motor insurers for treating genuine mistakes as fraud and for not explaining clearly, and precisely, what they expected consumers to tell them when making a claim. The difference in understanding between an inexperienced and innocent motorist and the experienced claim handler is vast. Access to voice analysis software, risk scoring algorithms, industry fraud databases and counter fraud support to a claim-handler primed to look for evidence of suspicious activity can place policyholders at a significant psychological disadvantage. Reported below is the experience of N4:

“Hill Dickinson’s ... came to demonstrate their Netfoil database. I thought it was unlikely to be helpful and so I told them to put me in their database and I came up as a red flag, high profile alert. I said, “Jesus Christ, I’m a solicitor; what have I set myself up for here?”
It was because I had a wakeboard that was damaged by EasyJet, my son put a load of paint all over a carpet about five years before that and a lady went into the rear of me. So, I’m on there, three times and you think: I can’t control the airline completely destroying a wakeboard in a bag but they input my data into a database without my knowledge; I’d forgotten about the paint claim - a couple of hundred quid after my excess, and a lady hit me in the rear. How does that make me a high-profile risk?

So now, if I have an accident or another claim then I am thinking am I going to come up on this thing? Worse than that, I would never have thought to tell an insurer about these claims if asked about previous claims, not because I was failing to make an honest disclosure, simply because I had forgotten”.

The Government reaction

Lobbying

Besides relying on estimates of the extent of insurance fraud and using the media to raise awareness, the ABI has also carried out a successful lobbying campaign. CH1 observed of the ABI that:

“their annual subscription income is £25 million; they’re extremely well-funded, they’ve been around for decades, they’re well connected into government, and MPs know only one side of the story, about where insurance fits in the piece and are completely blind to the facts ...”

Commercial lobbying is ubiquitous in Britain, the third biggest market in the world after Washington and Brussels (Thompson & John, 2002, pp. 4–5). Cave and Rowell (2014, pp. 1–7) define the practice as “a serious hidden feature of British politics ... thousands of people whose paid job it is to influence the decisions taken by our politicians without scrutiny...reframing a narrow commercial interest as synonymous with the national interest”. Lord Razzal, a politician of some forty years, said that “lobbying is absolutely fundamental to the way we legislate in the UK, right across the board ... very often the way to get changes to proposed laws is simply to e-mail them over. Do politicians take any notice of the overtures of lobbyists? Absolutely; the government takes a ‘huge amount’ of notice.” (Policy Exchange, 2012).

DAC Beachcroft (“DAC”) is a law firm that works with insurers, advertises its health advisory services and boasts of their unrivalled knowledge of the workings of Westminster with two former senior cabinet ministers employed. One of them, Conservative peer Lord Hunt of Wirral, led a debate on changes to the NHS in the House of Lords in 2012. While he declared his work for DAC,
campaigners insisted he should have gone further. Spinwatch\(^\text{12}\) said Hunt reminded his fellow peers during the debate that he was “a partner in the national commercial law firm - Beachcroft. However, he does not mention that Beachcroft also offers lobbying services to private healthcare companies” including the provision of “expert support for clients seeking access to key policy makers or developing campaigns to influence the development of regulation” (“NHS reforms D-day: 40 peers have ‘financial interest’ in NHS privatisation, Mirror investigation shows,” 2012). The media also allows lobbyists to focus their messaging to influence government, specifically to reinforce the impression that a narrow interest has the support of the majority (Zetter, 2011, p. 94). In fact, Zetter (ibid. p. 93) references an ABI lobbyist claiming, “a cabinet minister who reads a page lead – generated by your campaign – in the Financial Times over his breakfast cornflakes is more likely to give that campaign serious consideration.” Oborne (2008, p. 249) argued that politics and journalism have “effectively ceased to be separate disciplines” with journalists providing collaboration to politicians such that they do not now report political events in “a detached and fastidious way.”

In theory, lobbying is benign; every citizen should have the ability to lobby their MP to ensure their views are heard. Commercial lobbying is, however, more problematic. Cave and Rowell (2014, p. 9) claim that commercial lobbyists acting for particular, narrow interests distort our system of government to such an extent that it no longer serves the interest of the wider public - “paid lobbyist are drowning out everything else as a corrupting force that undermines democracy.” In recognition, Cameron (2010) made a pledge “to sort it out”:

“I’m talking about lobbying ... we all know how it works. The lunches, the hospitality, the quiet word in your ear, the ex-ministers and ex-advisors for hire, helping big business find the right way to get its way. We don’t know who is meeting whom. We don’t know whether any favours are being exchanged. We don’t know which outside interests are wielding unhealthy influence. This isn’t a minor issue with minor consequences. I believe that secret corporate lobbying...goes to the heart of why people are so fed up with politics. It arouses people’s worst fears and suspicions about how our political system works, with money buying powers, power fishing for money and a cosy club at the top making decisions in their own interest ... when it’s open and transparent, when people know who is meeting who, for what reason and with what outcome, lobbying is perfectly reasonable [but] lobbying in this country is getting out of control.”

\(^{12}\) Spinwatch - (http://www.spinwatch.org/index.php/about/who-we-are.)
Despite his commitment, Cameron did nothing visible to challenge the influence of lobbyists, a hidden corrupting force the influence of which, according to John (2002, p. 52), increases “when it goes largely unnoticed by the public”.

Policymakers and criminological expertise

As the black art of lobbying was in its ascendancy, Haggerty (2004) saw the rigours of criminological expertise in the formulation of policy was increasingly regarded as less useful by policymakers in the transition from criminological theory to criminal justice policy. Today, newer approaches to policy making require broad consultations (Wheeldon & Heidt, 2007, p. 314). Brodeur (1999, p. 134) summarised the ‘not inconsequential’ changes:

“Knowledge implies validity, whereas research has in itself no such implications research can either be good or bad. It is thus easier to marginalize its role in decision making than to play down the importance of knowledge. In addition to research, there were some thirteen other factors to be taken into account. A significant number of these factors were indicators of perceptions: public opinion polls, focus group findings, the opinion of various groups having a stake in the issue, petitions, and submissions. Other factors were expressions of various interests: pressure from private enterprise lobbies, from single issue coalitions and from various institutions such as the churches. There were finally the traditional economical and political considerations.”

Haggerty (2004, pp. 211–215) recognised the decline in the long-standing relationship between criminal justice policy and the advice of criminologists to the rise of neo conservative policies in the US, Canada and the UK which allowed crime to be manipulated as a political issue and increased private sector involvement having changed the nature of the relationship between criminological theory and practice. Wheeldon and Heidt (2007, p. 314) argued that:

“without a strong theoretical basis for and internal coherence within new criminological approaches, policy influence may be gained at the price of its integrity. While cooperation with the state is required to influence policy, the fear of theory co-optation by agencies of the state remains a significant concern.”

Regulatory and legislative support for insurers

In respect of motor insurance fraud, whether a by-product of the concerns articulated by Wheeldon and Heidt and/or lobbying activity aided by media coverage on the issues,13 the media discourse presented through the media has been in unsophisticated terms and highlighted a

13 see Chapter 6
situation in which the responses were “a central area for presentations by politicians” (Christie, 2004, p. 38) in which regulatory support for the insurer agenda has been significant:

- An investigation by the TSC into the cost of motor insurance and the incidence and cost of whiplash claims (Transport Committee, 2011a).
- The Legal Aid, Sentencing and Punishment of Offenders Act 2012 outlawing referral fees for personal injury claims.
- An OFT market study leading to a two-year Competition and Markets Authority ("CMA") investigation into the private motor insurance market (Competition and Markets Authority, 2014).
- A review by the Claims Management Regulator ("CMR") into Claim Management Companies and whiplash claims (Ministry of Justice, 2015).
- Introduction of statutory requirement for Courts to dismiss claims for personal injury where fundamental dishonesty is established\(^{14}\).
- Proposed legislation to increase the threshold at which costs are recoverable in injury claims effectively consigning innocent accident victims to be litigants in person.
- Proposals to remove the right to any compensation for road accident induced whiplash (Rose, 2015).
- A review into the control of claims for soft tissue injury by the Ministry of Justice ("MOJ") (Milligan, 2016).
- The IFT review.

**The Insurance Fraud Task Force**

The IFT (2016, p. 15) intended “to investigate the causes of fraudulent behaviour and recommend solutions to reduce the level of insurance fraud in order to ultimately lower costs and protect the interests of honest consumers.” Reporting in January 2016, they highlighted a number of issues:

- the propensity for insurance fraud to fund organised crime;
- the tendency for fraudulent claims to clog the courts and deny access to justice for honest claimants;

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\(^{14}\) Criminal Justice and Courts Act 2015, s57.
• the risk to consumers from orchestrated road accidents and the follow-on emergency service demands;
• the impact on public services e.g. wasted GP appointments from bogus claimant’s validating an injury;
• social nuisance from persistent cold callers persuading people to make or exaggerate a personal injury claim;
• the frictions costs on businesses targeted by fraudsters;
• that fraud is socially corrosive if society is forced to move from a trust to a verify model increasing frictional processes and cost for everybody.

Not one of the 26 recommendations (ibid. p. 77) questioned the reliability of the data provided by insurers and nor was any common basis proposed on which the levels of detected and undetected motor insurance fraud could be defined, monitored or reported upon in the future. The absence of any base measurement, and the lack of any reliable indicators designed to assess the effectiveness of any implemented recommendations, falls foul of the rule that if you can’t measure it then you can’t manage it as well as ignoring the IFT’s resolve to consider “the potential long-term benefits against the potential long-term costs” when assessing the merits of any possible solutions (ibid. p. 75). It also highlights the danger that any policy initiatives will not be curative of the perceived harm, a concern actually expressed by the ABI (2006, p. 1) as part of the Fraud Review in 2006, when they suggested that it would be optimal if priorities and resources were “based on an accurate assessment of the risk of, and harm caused by, fraud”.

Uncertainty remains

The concerns of an unquantified basis for reporting on insurance fraud were emphasised by the TSC many years after the Fraud Review (Transport Committee, 2011c, p. 2):

“the Government should act to ensure that there exists better data about fraudulent or exaggerated personal injury claims so that there is a stronger evidence base for policy decisions. Since the Government has cited the ABI’s figures for dishonest claims in 2013 it should explain how the figures have been arrived at and how dishonest claims have been defined.”

The Government’s response was evasive but suggestive that policy makers were prepared to utilise unverified evidence on trust from an industry that would likely benefit financially from any policy changes (ibid.):

“The Government does not centrally collect information on fraudulent or exaggerated personal injury claims and therefore may refer to data collected via industry sources. Such
figures have not been verified by the Government ... The Committee has requested an explanation of the ABI data on the number of dishonest claims in 2013. This question is best answered by the industry ... However, for clarification, the Government understands the process to be based on an ABI survey of its membership, which requests data in response to a list of scenarios in which it is believed fraud is likely to be involved.”

Concerns were also raised in a parliamentary debate when Andy Slaughter MP (Hansard, 2015, p. 17) said:

“We have to take action based on evidence, and we have to realise that there are many vested interests. Yes, the claims management companies have interests and we must be on guard against fraud, but we must also be aware of the interests of the insurance industry, which are not always at one with those of the motorist or consumer. It does not always follow that what the industry asks for is beneficial not just to victims or potential victims, but to motorists as a whole. I hope that we can crack down on fraud and relieve the consumer of the burden of calls—I get them myself on many issues—but I also hope that, on this as on other matters, we will bear in mind that the interests of victims and those with meritorious claims for personal injury should be respected.”

Thompsons Solicitors (2014b) have been critical of the provenance of the ABI’s data especially to the extent that it appears to have influenced Government policy against the interests of consumers:

“Everything we see suggests that the industry regularly puts out figures that are exaggerated or false to shore up the impression of a “fraud epidemic”. They do so to bolster government moves to restrict access to justice for injured people when policy must be based on reliable data.”

The IFT didn’t provide the clarification that the TSC sought from government as to the provenance of ABI data although it wasn’t asked to do so. The IFT (HM Government, 2016, p. 15) commentary was limited to an unchallenged re-statement of the ABI claim:

“The ABI has collated statistics from its members and estimates that the size of detected insurance claims fraud was £1.32 billion in 2014. Meanwhile, it has been estimated that the level of annual undetected insurance fraud is in the region of £2.1 billion.”

These figures appear unreliable. £1.32 billion was the figure disclosed by the ABI (2015j) in July 2015 for detected general insurance claim fraud of which £835 million was attributed to motor claims. The significance of the word detected was mentioned above in the section analysing the ABI Research Brief. The source of the £2.1 billion referenced by the IFT for undetected insurance fraud is harder to dissect. The IFT (2016, p. 15) attribute the figure to the ‘Annual Fraud Indicator’, National Fraud Authority, 2014’. The NFA closed in March 2014 and the final AFI was published in June 2013 (National Fraud Authority, 2013). The IFT may have intended to reference the 2013 report and the 2014 reference in their footnote may have been a typographical error. If it was, then
the second error is that the £2.1 billion figure was not the result of research by the NFA but was in fact provided to the NFA by the ABI and the IFB. The footnote in the AFI (ibid. p. 39) states:

“Based on figures provided by the Association of British Insurers (ABI) and the Insurance Fraud Bureau (IFB), insurance fraud is estimated to cost £2.1 billion a year. This estimate breaks down into £1.7 billion in hidden fraud loss, £392 million in organised ‘Crash for Cash’ fraud, and £39 million in identified insurance fraud (where claims are paid before they have been identified as fraudulent).”

It will assist the reader if the figures (£2.1 billion, £1.7 billion, £392 million and £39 million) are kept in mind.

I2, an IFB employee, clarified the composition of the £392 million reported by the IFB in respect of organised Crash for Cash (2013, p. 5), which matches the £392 million referenced in the AFI. On the others, he said:

“The IFB don’t have detected and undetected numbers. It’s not one of our KPIs. It’s not one of our measurements in any way ... we don’t have it as detected and undetected because we quite often don’t know. We can see within our system what a fraudulent network looks like but we do not definitively know whether that claim has been paid or not.”

In fact, the £392 million figure is not the amount of money lost by insurers as a result of paying out on fraudulent crash for cash claims. I2 explained that it is a software generated estimate based on what the IFB believe the size of the problem to be based on data within the system and calculated from an exercise last performed in 2012. He said:

“The £392 million figure that we have was produced for a piece of work that we did in 2012. We’re currently working at the moment to work out how we annualise that figure and how we monitor it on an ongoing basis because having a figure that’s three years out of date is not the best.”

He also confirmed a potential overlap with the figure reported by the ABI because the £392 million IFB figure may contain incidents that have already been identified by the impacted insurers in data they provide separately to, and which is then consolidated by, the ABI. Based on data the NFA confirmed was supplied by the ABI and IFB, and removing the IFB estimate of £392 million from the total (ignoring any duplication on consolidation), it follows that the balancing figure of £1.7 billion (£2.1 billion less £392 million) must have been disclosed to the NFA by the ABI, as must the figure of £39 million in respect of “identified insurance fraud (where claims are paid before they have been identified as fraudulent).” Missing is any corroboration of the incremental £1.32 billion figure reported by the IFT as the quantum of detected fraud. Further analysis of the ambiguity surrounding the data relied on by insurers is provided in Chapter 6.
Whatever the reality, a concept that appears elusive from the published data, the problem of insurance fraud, and of motor insurance fraud particularly, has resonated with government and demands a response. The early research by Clarke (1990) shows that insurance fraud is not a novel phenomenon; it has, perhaps, just come of age in a period when the motivation, means and opportunity have not previously been met by an appropriate and robust response. Whilst the commentary on the topic stretches back over thirty years however, the increased contemporary focus on the cost of insurance fraud has now generated the political and economic imperative to trigger a concerted, aggressive and apparently sustained and evolving response from government. One of those responses has been the creation of IFED, a police unit with the vision of altering “the misconception that it is acceptable to commit insurance fraud by bringing offenders to justice and confiscating their assets” (City of London Police, 2012). It is an example of the vision of partnership put forward by Levi et al. (Michael Levi, Burrows, Fleming, & Hopkins, 2007) and, in the next chapter, the implications and benefits of such a public-private police-partnership will be considered.

Conclusions

This chapter explored the history and typology of the offence of insurance fraud, reviewed relevant literature and explored how insurers have quantified the problem. It also examined the reliability of the only publically available empirical research on the subject, the ABI Research Brief. The insurance industry’s apparent vulnerability to incursion, their success in influencing policy making, the role of the lobbyist and the media were also introduced and the motivation for the messaging was considered against a strategy which allowed insurers to raise premiums with relative impunity during a recession and then, in later years, to release reserves, recognise increased profits and make significant dividend payments to shareholders. The reaction from government was assessed, particularly through the investigative and regulatory instruments at their disposal, in respect of policy making and formulation of criminal and civil justice policy. Opinions from stakeholders in, or adjacent to, the insurance market were considered with criticism of the reliability of the data on which change was being proposed from parliamentarians, solicitors and some elements of the media. The chapter also introduced the recent contribution of the IFT which recommended a variety of initiatives to address the incidence and impact of insurance fraud between 2016 and 2019 but also noted the absence of any robust empirical analysis by them for assessing the cost, benefit or impact on insurers, consumers or society from the panoply of recommendations made.
Chapter 3 The Police

Introduction

This chapter provides a framework for discussions about whether a private police force funded by insurers acts to the detriment of non-insurer victims of fraud. Whilst uniform patrolling is the visible face of policing, criminal investigations involve the assistance of detectives who accept responsibility for investigating reported crimes who will, typically, formulate a theory about who committed the crime and then set about building the case to support an arrest and prosecution. James (2011, p. 14) highlighted how “members of the detective force shared the conviction that unlike the uniform branch they were dealing with ‘real’ crime” but perhaps the most demanding part of a detective’s job is developing expertise in the legal requirement for collecting and reporting on evidence to understand how the prosecutor will use that evidence and the challenges it will face in court. One experienced detective chief inspector said, perhaps prophetically, and over thirty years before IFED was conceived, “criminal investigation work is the sort of work any good Prudential insurance man could do” (Mclure, 1981) raising the question of whether an insurer-funded police force was necessary at all.

The chapter also considers the history and evolution of the police and reviews the literature considering whether yesterday’s model of policing is economically, politically or practically sustainable and, assuming it isn’t, what that means for the police monopoly. It also addresses the history, nature and increasing occurrences of privately-funded public-policing. The Government’s involvement in issues of responsibilisation, growth in private security and multi lateralisation in the face of economic under-funding of the police generally are also considered, as are the implications for victims. A high-level assessment of IFED, in the context of other privately funded policing models such as the BTP, Civil Nuclear Constabulary (“CNC”), the Ports Police Force and the DCPCU is provided and the essence of those entities is contrasted with IFED’s funding and operational relationship with insurers. The concept of a method for assessing privately-funded public-police initiatives is introduced but the chapter leads with a discussion of the state of policing in the current day with assessments from Her Majesty’s Chief Inspector of Constabulary (“HMIC”) (2016, 2017) depicting the evolving political drivers behind policy and reporting.
Policing today

HMIC (2016, p. 6) reported that “crime is ever-changing at local, national and international levels as criminals have adapted to and embraced the technological advances of the 20th and 21st centuries’ with technology allowing offenders to plan and organise themselves in ways which were unthinkable even 25 years ago”. The impact and inertia created by motivated dishonest individuals is an impediment to chief officers trying not to operate in a reactive paradigm. The intensive resource need for investigating offences as diverse as child sex exploitation to terrorism all impact the agenda for police priorities in a service that has had to cope with less money to undertake more complex and challenging work.

M2 provided a helpful cameo:

“the chiefs say budgets are tight; we need bobbies on the beat. We’ve got problems with domestic violence and the real problem at the moment is paedophilia and grooming rings. I spoke to one chief officer and he asked me: ‘how many paedophiles do you think we have on our books that we have to watch? ... it was 1,800; nobody understands the extent of the pressures forces are under.”

In an interview with Bernard Hogan-Howe, then Chief Constable of Merseyside, M2 recalls being interrupted by him:

“Bernard, fraud, really important ... He said, ‘don’t bother me with your frauds’, these are his exact words. ‘I’ve got guns, knives, drugs, youngsters trying to kill each other ... which of those things shall I drop to deal with your frauds? It’s tricky, isn’t it? What do you say?’”

More recently, pressures have increased. HMIC (ibid. p. 14) reports that between 2010 and 2015, “central government funding for the police service in England and Wales has fallen by £1.7 billion or 19% in cash terms and overall gross revenue expenditure for the police has fallen by 18% in cash terms”. Between 2010 and 2016, the police workforce has reduced by 18% (Her Majesty’s Chief Inspector of Constabulary, 2017, p. 13) with the number of police officers reportedly at the lowest level in 30 years (Smith, 2017). Perhaps because of the disparate but continual challenges, HMIC (2016, p. 17) issued a curious admonishment that “the prevention of crime is the responsibility of every citizen; the police are engaged by the community to give their full attention to it, but it is everyone’s business”.

Between 2010/11 and 2014/15, measured crime fell by 28% (Office for National Statistics, 2015a). Over the same period, the number of police officers reduced by 9% with police staff falling by 14% (Home Office, 2015a). HMIC claimed in 2016 that continuing falls in measured crime, reported in the CSEW for the year ending March 2015, had helped the police service to cope with
reduced budgets although that analysis appears less convincing when later figures revealed that there was a 6% increase in police recorded crime in the year ending September 2015 although possibly a rise “following improved compliance with national recording standards by police forces” (Office for National Statistics, 2015b, sec. 1).

In 2017, the consequence of policies implemented by successive governments since 2009 made for uncomfortable reading. The ONS (2017, p. 6) reported the largest annual rise for police recorded crime in a decade (Travis, 2017) albeit explicit comparing their report and the CSEW remarking “police recorded crime data are not designated as national statistics”. Reliable information on which to support policy or decision-making by government or chief officers is challenging as certainty about what is being measured evolves. The 2016 CSEW (Office for National Statistics, 2016, p. 7) attributed an estimated 7% increase in offences in the year to “improvements in crime-recording practices and processes by the police and an increase in the willingness of victims to come forward and report offences” (ibid. p.18). Only the number of bicycle thefts showed a downward trend reducing by 27% to 291,000 in the year to March 2016 (ibid. p. 10) and to 94,487 in the year to March 2017 (Office for National Statistics, 2017, p. 21), something P1 attributed to Mayor Boris Johnson’s prioritisation of cycle theft and it becoming an objective for the Metropolitan Police Safer Transport Team.

Recently, the CSEW (Office for National Statistics, 2017, p. 2) reported a 7% reduction in the number of estimated offences excluding the statistics on fraud and computer misuse attributing the disparity between the CSEW report and the 10% increase in police recorded offences to “a range of factors, which vary by crime type, including continuing improvements to recording processes and practices, expanded offence coverage and also genuine increases in some crime types”. Neither the CSEW, nor the most recent HMIC reports, address adequately the police approach to investigating and prosecuting fraud. Historically, the CSEW had excluded fraud from its headline estimates although questions were added to the survey in 2015 and estimates derived from fraud and computer misuse offences, excluding business related fraud, were reported experimentally for the first time in 2016 (Office for National Statistics, 2016, p. 6). The estimate then was of 5.6 million such offences between October 2015 and June 201615 and confirmation of a 5% increase in the annual number of fraud offences recorded in England and Wales (up to 627,825) due largely to the number of offences referred by CIFAS, which increased by 16%. In its

15 Total fraud offences cover crimes recorded by the National Fraud Intelligence Bureau via Action Fraud, CIFAS and Financial Fraud Action UK. Action Fraud record fraud offences on behalf of individual police forces. Data is from Table A5 of the CSEW 2016 dataset.
subsequent survey (Office for National Statistics, 2017, p. 3), CSEW reported an estimate of 5.2 million fraud and computer misuse offences for the year caveating that it was too early to determine if that figure reflected a genuine reduction when CIFAS reported an increase in fraud offences to 649,770 offences (ibid. p. 21), albeit noting a fall in “insurance fraud” of 20%, with the total offences recorded by the NFIB at just 8,059 offences (ibid. p. 46).

Button and Tunley (2015, p. 49) argue that “fraud is one of, if not the most costly crimes to the United Kingdom ... yet the response to it from the government and the criminal justice system, bar the exception of benefits fraud, has not matched the magnitude of the problem”. The word fraud appears just once in the HMIC 2015 report (2016, p. 76) in a table analysing how forces deal with referrals from the NFIB for digital crime and three times in the most recent report (2017, p. 19, 26 and 53) in the context of the police response to online crime.

Whilst HMIC are engaged in reviewing the performance of the police service against strategic priorities they rely upon the existence of a police and crime plan, issued by the PCC for each police area, which sets out, inter alia:

- the police and crime objectives;
- the policing which the chief constable is to provide;
- the available financial and other resources; and
- how the chief constable’s performance will be measured.

The Chief Constable must have regard to the police and crime plan in exercising his functions, perhaps even more so because they are provided for by parliament, have a legislative and democratic basis and represent the principal priorities of local people for whose protection the police exist; they carry considerable weight (Her Majesty’s Chief Inspector of Constabulary, 2016, p. 31). Of thirty police and crime plans reviewed from 2015, fraud featured rarely, the exception being for the CLP, the national police lead on economic crime.

In addition to the local focus from PCCs, the Home Secretary is obliged\textsuperscript{16} to issue a Strategic Policing Requirement (“SPR”). First issued in July 2012, and updated in March 2015 (Home Office, 2015b), PCCs and Chief Constables are required to have regard to the SPR which sets out the Home Secretary’s view of the national threats the police must address and the appropriate national policing capabilities that are required to counter those threats. Key threats include terrorism,

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\textsuperscript{16} Police Reform and Social Responsibility Act 2011 s77
serious and organised crime (obliquely referencing fraud), child sexual abuse or exploitation, public disorder, civil emergencies and cyber threats (ibid. pp.7-8).

Managing police performance

HMIC has evolved its annual assessment of police forces to include a review of “their effectiveness, efficiency and legitimacy and are judged on these categories (or pillars) based on inspection findings, analysis and the Inspectors of Constabulary’s’ professional judgment across the year.” Operating under the acronym PEEL (2014a, p. 4), it is interesting that HMIC still references, albeit inferentially, the founding principles as part of the commitment of the police in current times. Indeed the Government (Home Office, 2012) still claims those Peelian principles to be as relevant today as they were when drafted, representing, as they still quote, a philosophy of policing “unique in history and throughout the world because it derived not from fear but almost exclusively from public co-operation with the police, induced by them designedly by behaviour which secures and maintains for them the approval, respect and affection of the public” (Reith, 1956). There are nine principles (Peel, 1829), two of which are noteworthy because of their potential conflict with the right of public access to what is now, with the creation of IFED, a privately-funded police gatekeeper. They are, (emphasis added):

“5). The police seek and preserve public favour, not by catering to public opinion, but by constantly demonstrating absolutely impartial service to the law, in complete independence of policy, and without regard to the justice or injustice of the substance of individual laws; by ready offering of individual service and friendship to all members of the public without regard to their wealth or social standing, by ready exercise of courtesy and friendly good humour; and by ready offering of individual sacrifice in protecting and preserving life.

7). The police at all times should maintain a relationship with the public that gives reality to the historic tradition that the police are the public and the public are the police: the police being only members of the public who are paid to give full time attention to duties which are incumbent on every citizen in the interests of community welfare.”

They also merit mention because of conflicting comments in two recent HMIC reports. The first addressed the Government’s 2010 budget review requiring police forces in England and Wales to deliver £2.5 billion of savings between 2010-2014. HMIC (2014b, p. 33) found it impressive that whilst protecting their “front line crime-fighting capacity as best they can” they “re-organised themselves to be more efficient and continued to provide an effective service to the public”. The second report (2014a, p. 147), however, highlighted the disparity of service provision across police forces and, specifically and incongruously in light of the earlier comment, expressed concern that criminal damage and car crime were on the verge of being decriminalised because forces had
“almost given up” even though “the investigation and detection of crime is core business for the police”. More recently, faced with having to save £400 million from their budget by 2020, on top of £600 million saved in the previous four years, the MET issued a Crime Assessment Policy (The Crime Prevention Website, 2017) in October 2017 empowering police officers to decide whether to investigate a lower level crime e.g. shoplifting, car crime, criminal damage, some minor assaults and some burglary and theft offences where the value of the crime was less than £50.

Private policing and ‘responsibilisation’

The police remain a comforting and familiar feature of modern life. Bittner (1974, p. 30) saw their key purpose being “to stop something that ought not to be happening and about which someone had better do something now”. Underneath that broad statement sits a more diverse portfolio of responsibilities including:

- fighting crime (Manning, 1978, pp. 7–32);
- maintaining order and keeping the peace (Kelling & Moore, 1988; James Wilson, 1978);
- delivering a public service (Eck & Rosenbaum, 1994, pp. 3–23);
- solving wide ranging societal problems (Eck & Spelman, 1987; Goldstein, 1979, 1990; Kelling & Moore, 1988);
- enforcing the law for victims (Bittner Egon, 1970, 1974; Muir, 1977); and
- being uniquely placed and authorised to employ force “to compel specific responses from citizens” (Klahm & Tillyer, 2010, p. 215).

According to Miller (1977, p. 81), the Police are “the most conspicuous representatives of the political and social order” or as Reiner (2010, p. 3) claims “a body of people patrolling a public place in blue uniforms with a broad mandate of crime control, order maintenance, and some negotiable service functions”. Jones and Newburn (1998, pp. 18–19) defined policing as an activity that has been widely adopted and pertaining to “those organised forms of order-maintenance, peacekeeping, rule or law enforcement, crime investigation and prevention and other forms of investigation and information-brokering”. Whilst the image of the police is synonymous with the modern state, an important criminological debate about the extent and nature of contemporary changes in the delivery, practice and orientation of policing is underway and significant shifts have already occurred in public policing accompanied by a substantial expansion in private sector security services (Braithwaite, 2000; Garland, 2001; Johnston, 2000; Shearing, 2001). Zedner (2006, p. 81) believes that it is increasingly likely that the current model of the police “may come to be seen as a historical blip in a more enduring schema of policing as an array of activities undertaken
by multiple private and public agencies, and individual and communal endeavours”. Reiner (2010, p. 3) cites Shearing and associates as the main exemplar of theoretical perspectives on policing with his argument for a complete paradigm shift, from ‘policing’ to ‘security governance’ and Button and Brooks (2016, p. 211) contend that, when privatisation and responsibilisation are so high on the agenda, the insurance sector makes for an interesting case study.

The interplay between public and private policing has generated a significant volume of literature from leading criminologists (Bayley & Shearing, 2001; Benson, 1994; Braithwaite, 2000; Button, 2002; Gans, 2000; Garland, 1996; Grabosky, 2007; Hope, 2001; Johnston, 1992; Jones & Newburn, 2002; Levi & Maguire, 2012; Loader & Walker, 2001; O’Malley & Hutchinson, 2007; Reiner, 2010; Rigakos & Greener, 2000; Spitzer & Scull, 1977; Swanton, 1993; Zedner, 2006) and most currently accepted theoretical generalisations on the state of British policing conclude that there is an innovative and on-going blurring of the boundaries between the public and the private sectors (Williams, 2008, p. 190). Bayley and Shearing (2001, p. 1) noted that, in most democratic states, private-police outnumber public-police and most citizens spend more time in locations where visible crime prevention and control are provided by non-governmental groups rather than by the public-police. They also offer a convenient and concise perspective on the potential direction of travel (ibid. p.1):

“Policing is being transformed and restructured in the modern world. This involves much more than reforming the institution regarded as the police, although that is occurring as well. The key to the transformation is that policing, meaning the activity of making societies safe, is no longer carried out exclusively by governments. Indeed, it is an open question as to whether governments are even the primary providers. Gradually, almost imperceptibly, policing has been “multilateralised”: a host of non-governmental groups have assumed responsibility for their own protection, and a host of non-governmental agencies have undertaken to provide security services.”

This transformation has involved several threads increasingly rooted in the assessment of performance against cost and the optimal allocation of limited resources.

Lessons from history

Policing before the 18th century was in the hands of the community enabled through the medieval institutions of hue and cry and ‘possee comitatus’ or unpaid watchmen. In England, policing remained largely in private hands until the early 19th century when Spitzer and Scull (1977, p. 19) referred to a point where “personal needs and interest began to take the place of ‘public spirit’ as the mainspring of social control”. Policing had the character of a contract negotiated between victims who sought protective, investigative or enforcement services and independent agents who were willing to supply those services for a fee or reward, not too far removed from the
ABI’s current funding of IFED. Between 1825 and 1975, Williams (1998, p. 190) charts a shift in the gathering of police functions into a period he claims Zedner described as “the period of the criminal justice state when the state’s claim to the monopoly of force was exercised through the new police”. Williams questions the portrayal of this new era as one of an impermeable public-sector monopoly by highlighting certain practices including the payment of rewards to members of ‘new police forces’, from both prosecution and trade associations, such as the Birmingham Jewellers Association. He also pointed to the existence of police forces solely under the control of companies including those policing the railways and ports. Zedner (2006, p. 26) offers a retrospective comparison between the emerging trends in modern day policing and the similarities with practices in the late 18th century. Spitzer and Scull (1977, p. 19) offered a similar perspective on the trend towards privatisation and the parallels with historical policing for profit initiatives and Bayley and Shearing (2001, p. 2) concurred whilst insisting that the restructuring taking place today is following a different form because contemporary societies are organised differently.

The deployment of public-police resources to private entities was termed ‘additional constables’ in the 19th century, and then as ‘special policing duties’ in the 20th. Williams (2008, p. 191) asserts that private payments to public police forces are something that never went away. He recounts that, in the 19th century, private payments appear to have been for long-term secondments, often for protecting property, whilst in the 20th, the characteristic practice increasingly involved large numbers of officers, for a short time, securing public order. There was never a time when British police were not for hire “to anyone acceptable who could pay.” He cites Lansdowne who said that, in 1870, Scotland Yard’s detectives might be sent from London “on the application of any individual in the country who chose to carry the cost” in the UK “or even out of it”. Williams (ibid. p. 201) recounts that the deployment for special policing duties fell out of use in the 1950s because of a shift from the protection of property to the maintenance of public order and most special policing duties were accounted for through the detachment of officers to duties at football matches, festivals, and other public events. He offers evidence of one long-term contract which the police were keen to exit. In 1959, per documents retrieved from the national archive, the Chief Constable of Durham approached the Home Office with a request to terminate the arrangement “under which members of the county force are in fact employed by ICI and paid for this purpose”. The Home Office refused, pointing out that it was the Chief Constable’s responsibility to manage the arrangement (ibid. p. 200). At a private security industry seminar in 1971, senior police officers expressed a negative view of payment for services because, “if industry or the individual were required to pay directly, they would want to have some say in the operation of the police within their domain and it is unlikely that Mr Palfrey [Chief Constable of Lancashire] or any
other like-minded Chief Constable would be willing to accept this. The Chief Constable might also be faced with the dilemma of deciding to whom to give protection those who could pay or those who could not”. Some of the tensions evident today appear to have a precedent. Viewed from a different perspective, one focused on the perception of justice and the requirement for integrity from those entrusted with the responsibility to bring suspects before the court, a 2005 Court of Appeal decision helps distinguish the argument about funding the public-police to one beyond the economics of payment for security resources (Wilson & Hernstein, 1985, p. 8). *R v Hounsham & Ors* [2005] EWCA Crim 1366 involved a case where three insurers had paid sums to the Hampshire Police Force to fund the arrest stage of a fraud investigation. The Court held:

“... in our judgment, soliciting by the police of funds from potential victims of fraud, or any other crime, quite apart from being ultra vires police powers, is a practice which is fraught with danger. It may compromise the essential independence and objectivity of the police when carrying out a criminal investigation. It might lead to police officers being selective as to which crimes to investigate and which not to investigate. It might lead to victims persuading a police investigating team to act partially. It might also lead to investigating officers carrying out a more thorough preparation of the evidence in a case of a "paying" victim; or a less careful preparation of the evidence in the case of a non-contributing victim. In short, it is a practice which, in our judgment, would soon lead to a loss of confidence in a police force's ability to investigate crime objectively and impartially.”

Gans (2000) explored the legal framework of privately-funded public-policing observing it was an area generally neglected in the literature other than through a focus on the administrative issues by Reiss in 1987 and a report critical of the law, by Weatherill, in 1988 (ibid. p 204). Gans identified that guidance had only been given by the courts on the question of the legality of privately-paid public-policing on a handful of occasions (ibid. p. 185) citing a decision in *Glasbrook Brothers Ltd. v Glamorgan County Council* [1924] 1 KB 879; [1924] 1 All ER 579 holding that the police could decide whether they might charge for a service based upon the discretion of the senior police officer if he believed those services were additional to those justified in the circumstances. Gans claims Weatherill regarded the difficulties of defining the duties of the police as a barrier to the fairness of privately-paid public policing and cites Weatherill as having reported that, in 1964, “without any parliamentary debate” the Police Act 1964 was amended such that:

“the chief officer of police of any police force may provide, at the request of any person, special police services at any premises or in any locality in the police area for which the force is maintained, subject to the payment to the police authority of charges on such scales as may be determined by that authority.”

Because this provision was enacted, both common law and legislation are permissive of the right of the police to charge for special police services. There is, however, no legislated definition of what ‘special police services’ include and the provision of those services is restricted to the
‘locality of the police area’ in any event. Johnston (1992, pp. 64–70) expressed concern that the lure of “paying customers” might corrupt the public ethic as the police might hone and market their services to those capable of paying for them. He accepted, however, that fragmented, diverse, networked policing is here to stay but that the challenges involve those of democratic governance including, but not limited to, the basis on which victims might be able to seek a fair share or voice their concerns about changes that impact upon the quality of their lives (2000, p. 324). This is one of the issues considered in this thesis.

Victims, victimhood and social order

It was the Government’s adoption of the crime/victim survey in the 1980s that elevated the role of victims. These surveys tend to have focused on persons rather than business although there were crime surveys covering corporate victims in 1994, 2002 and in 2012 to 2015 (Home Office, 2017; Hopkins, 2016; Mirlees-Black & Ross, 1995) predominantly addressing the retail sector. Goodey (2005, p. 2) identified that these surveys helped quantify and define the nature of crime beyond police statistics allowing the Government to claim it was “doing something about it” although that was more of an administrative achievement than a victory for victims:

“In an age where increasing importance was given to meeting service standards for consumers of public services, customer satisfaction became a driving force in both rhetoric and practical actions [and crime surveys] commonplace barometers of victim services.”

Research on victims of crime has increased over the last 20 years (Button, Wakefield, Brooks, Lewis, & Shepherd, 2015; Hopkins, 2016; Kury, Redo, & Shea, 2016) together with an increasing focus by policy-makers on their needs (Goodey, 2005; Spalek & Campling, 2006; Walklate, 2017). The EU Victims’ Directive 2012/29/EU was adopted by the UK in 2012 to promote improved standards on the entitlements, support and protection available to victims of crime. A number of victim-centric outcomes have all followed an impetus to give “space to the victim’s voice” (Walklate, 2017, p. 191) including:

- restorative justice and restorative sentencing (Roberts & Stalans, 2004);
- re-orienting the work of criminal justice professionals (Mawby, 2007);
- improving the experience for victims appearing in court with special support for vulnerable victims (Fairclough & Jones, 2017); and
- reparation and compensation for criminal injuries (Miers, 2007).

Corporate victims are generally excluded from victim-oriented policies like the state compensation scheme or those offering assistance to victims and witnesses in court even though
cases directed against businesses have an impact on the people who work within them and who have to deal with the consequences (Dignan, 2005). Businesses are also outside the definition of a victim in the EU Victims’ Directive and research relating to organisations as victims is less prolific with more emphasis focused on organisations as offenders (Braithwaite, 1984; Croall, 2007; Snell & Tombs, 2011; Whyte, 2015). But organisations can be victims and losses sustained through fraud evidence how commercial victimhood can occur. Doig and MacAuley (2008, p. 185) noted the creation of the Serious Fraud Office (“SFO”), in 1986, to provide a lead for law enforcement resources investigating serious fraud at a time when “lesser frauds were not being investigated” something Levi (2013, p. 282) argued was “shifting the economic burden of crime investigation onto victims” when public organisations had traditionally devoted resources to dealing with fraud, large or small, without police involvement. Clarke (1990, p. 18) anticipated that the state was unlikely to offer any assistance with privatisation, a “part of the ruling ideology”, leaving police forces to concentrate on conventional crimes. By 1996, a Home Office commissioned report (Morgan, McCulloch, & Burrows, 1996) suggested that the police stop investigating frauds which did not directly harm the general public, a view shared by Clarke and Wheeler (1990) who felt that, where big business were the victim of larger frauds, investigations should be dealt with by the victim since they involve a different set of relationships between offenders and victims with less obvious direct harm or “blood on the streets”. Twenty years later, addressing the plight of individuals rather than corporate entities, Walklate’s (2017, p. 190) observation that ‘victims are not free to buy the service they would prefer but are subject to that service considered appropriate for them” resonates for either class of victim. Nonetheless, the subject of commercial victimisation remains on the periphery of mainstream victimology (Maguire, 2012, pp. 208–244). While governments have to be seen to act so as to protect businesses and whilst trade bodies generally strive to support the economic interests of their members (Burrows & Hopkins, 2005) it is arguable that the limits of academic research about commercial victimisation is a result of businesses being regarded as undeserving and without the capacity for true victim status (Hopkins, 2016, p. 162). Croall (2007) distinguished between deserving and undeserving victims of crime as an issue that impacts both individual and corporate victims citing Levi (1999), for example, who compares a wealthy investor who can be blamed for making risky investments as less deserving than older people victimized through pensions frauds. Christie (2004, p. 18) defines the “ideal victim” as “a person or category of individual who when hit by crime most readily is given the complete and legitimate status of being a victim”, the hypothetical ‘little old lady’, and argues the ideal victim:

- should be weak;
- carrying out a respectable project;
• are not to be blamed;
• have been victimised by a big/bad offender;
• the offender is unknown; and
• the victim is powerful enough to make his or her case known without threatening strong countervailing vested interests.

Arguing that businesses could ever qualify as ideal victims when academics have often cast them as offenders is challenging, especially when they are usually economically active and demonstrably capable of ensuring their own security needs (Burrows & Hopkins, 2005). However, the notion of victimhood has been reconstructed according to Green (2007, p. 452) as businesses have argued “that a crime against business is a crime against all of us” highlighting the negative effects of crime against society emphasising the wider social impacts, for example, by suggesting that shoplifting increase the price of retail goods or insurance fraud has the same impact on insurance premiums (ABI, 2011c). Whyte (2007) recognises a view from some that businesses have attained sympathy in government policy discussions by characterising themselves as a “victimised business” by reference to the economic losses they face. Green (2007, p. 453) argues this has inspired a movement against business-crime, responsibilisation perhaps, on an unprecedented scale through the proliferation of government-business partnership. Hopkins (2016, p. 162) disagrees and feels that merely identifying that businesses suffer from high rates of victimisation does not automatically mean they should be considered as ideal or deserving victims and that there is support for a contention that by positioning themselves as they have, business has contributed to a more generalised hegemonic notion of victimhood where large corporate entities might ideologically re-position themselves as “always the victim and never the victimisers” (Sim, 2004). Whilst Sim was addressing the State as victim, the corporate analogue is distinctly possible when as Coleman (2004) claims “the clamour for more public-private sector resources to be diverted towards crime control grows, corporations are progressively empowered to dominate the law and order debate” and influence what should and should not be policed. It also brings into focus the plight of other victims less able to influence the direction of government policy. Garland (2001, p. 98), for example, highlighted how an historic solidarity with the victims of social and economic dislocation is giving way to a “condemnatory view of claimants, many of whom are now viewed as members of a culturally distinct and socially threatening ‘underclass’, in which all of the pathologies of late modern life are concentrated”. Linking this research to the direction of policing, Whyte (2015) argued that the act of policing is one that not only promotes order but also reproduces the boundaries of what can, and should, be policed. As Neocleous (2003) identified, policing fabricates the social order. At its simplest, as Spitzer (1993) claims, it minimises any disturbance to the
capitalist corporate regimes of production and consumption as part of the complex political economy of control tending to sustain, rather than undermine, the dominant role of the corporation in the hierarchy. At its most complex is the question of victimhood and the adherence to the Peelian principles. Whyte (2015) maintains that where the social order is fabricated to protect corporate interests that it is rare to see obvious forms of collusion between police forces and corporations because no criminal justice system could legitimately claim to be consistent and impartial were the articulation of private interest through policing to be obvious. History may tell a different story.

**The emergence of private security providers**

The era of the ‘criminal justice state’ needs to be considered as a period of evolution (Johnston, 1992) although Zedner (2006, pp. 86–87) felt that contemporary trends in policing did not signal a departure from historical practice with the arrival of a new epoch but more of a parallel to previous historical practices. She argued government, with an increasing sense of realism, has conceded that commercial policing increasingly satisfies a need they can no longer sustain. The assumption that taxation could provide a base to sustain the level of policing society demands is now challenged and, in parallel with a protracted period of conservative political dominance, has driven a desire to distribute the burden of policing responsibilities. Even before the start of the 2008 recession, Johnston (2003, p. 202) felt the police had capitulated to private security providers helping to meet public and corporate demands for protection not capable of being satisfied under conditions of fiscal restraint. Support comes from what Rigakos and Greener (2000, p. 183) report as a revolutionary speech when, in 1998, as Chief Constable of Surrey Police, Ian Blair addressed the Association of Chief Police Officers (“ACPO”) and confirmed that the tide of privatisation was underway and “... within ten years, it is possible that a substantial proportion of the police function may be absorbed by other local authorities and by an unregulated private sector.”

**Privatisation and pluralisation**

One argument for reducing the role of the state is that the private sector is more efficient, an argument not restricted to the UK. Murphy (2004, p. 1) studied the Canadian police and reported:

> “another period of transition characterised by growing political pressure for greater fiscal and operational accountability demanding costs are cut, efficiency and productivity improved to deliver ‘value for money’”

This drive for more efficient private-sector services has been part of a growing trend although the sustainability of the initiatives, or the metric by which ‘value for money’ is assessed may have
been compromised with a trend of recent failures in the UK outsourcing model pioneered in Britain by Margaret Thatcher in the 1980s. The country has since been the leader in Europe, and second only to the United States globally, in its use of companies such as Carillion, G4S, Serco and Capita to provide essential services because successive governments of different parties have argued that private companies are more efficient at running services and that the outsourcing system allowed infrastructure investments to be made without adding considerably to the state’s debts. Carillion’s collapse, with debts approaching £1.5 billion, has ignited a row over the system of outsourcing public services to competing private companies reliant on government work for a large part of their income. (Holton, Pal, & Leary, 2018). For example, Police forces are failing to meet standards for forensic science, making miscarriages of justice inevitable, the government’s forensic regulator has said, highlighting her growing concerns about the failure of some forensic firms used by the police to meet basic quality standards with the routine outsourcing of criminal forensic work to unaccredited laboratories. Some laboratories are not subject to independent oversight making it possible that innocent people could be wrongly convicted and offenders escaping justice (Devlin & Dodd, 2018).

Grabosky (1996, p. 5) envisioned that law enforcement would re-define itself to monitor “the overall crime control system, broadly defined” and would engage in fine tuning – “manipulating incentives, accrediting private competencies, and auditing third party performance in order to facilitate the constructive contributions of non-government interests.” He thought that traditional law enforcement agencies would become less prominent on centre stage whilst remaining authoritative and ‘unobtrusively influential’ from a position off-stage but set out the risks that he anticipated from the trend towards pluralisation:

- Accountability - the greatest risk in devolving law enforcement functions to private interests.
- Market failure – under-supply or excessive price demands leading to distributional asymmetry where governments rely on market mechanisms as the solution.
- Gatekeeper failure – private service provider become susceptible to, or financially dependent upon, a continuing engagement, distorting the purity of the service provision or leading to a conflict of interest.
- Erosion of civic commitment - a risk that a sense of public duty or civic obligation will be lost and that cultural values will regress to a society of mercenaries as citizens witnessed in the eighteenth century, and
• Lack of policy coherence – relying on decentralised and independent interests may precipitate an imbalance in enforcement activity.

Bayley and Shearing (1996, p. 585) saw the evolving systems of crime control characterised by the pluralising of policing:

“the state’s monopoly has been broken by the creation of a host of both private and community-based agencies that prevent crime, deter criminality, catch law-breakers, investigate offences, and stop conflict”

Jones and Newburn (2002, p. 142) questioned the certainty of that perspective levelling criticism at the extent to which the degree of change is exaggerated and the level of continuity in any transformation is underplayed but do recognise, at least in the UK, that a broader social transformation is underway and that privatisation is part of the change.

**Privatisation**

Privatisation, at its simplest, replacing public sector workers with identical private sector workers (Donahue, 1988, p. 64), is central to the way the police have reacted to economic and organisational challenges and a shrinking of the state. In the process of ‘load shedding’ and ‘contracting out’, functions including touchline security for football matches, responding to intruder alarms, policing private shopping centres or escorting cash in transit have been abandoned by the police and, in the case of certain other tasks previously regarded as core, such as prisoner transport, court security, forensic investigation and even some of the work in managing custody facilities, dealing with enquiries in police stations and investigating crime, responsibility is retained but the services have been contracted out. Button and Johnston (2011, p. 64) go further, highlighting that the police have effectively relinquished their role in investigating fraud by obliging a complainant to provide prima-facie evidence of the fraud before they will engage. They say, consequently, many private organisations have used private investigators to investigate and produce compliant evidence packs before reporting to the police and a by-product has been improved clear up rates for fraud because the police can cherry pick the better-prepared and most compelling cases for prosecution. In other areas this has led to the emergence of employee supported policing where impacted organisations have provided resources for qualified individuals to become special constables with a focus on offences faced by the employer (Button & Wakefield, n.d.; South Yorkshire Police, 2015). Garland (1996, p. 453) identified that agents of the state no longer claim that they can “do it alone”, arguing that the increasingly complex nature of crime meant conventional law enforcement responses were no longer adequate and required supplementary organisational forms to deliver control. He also observed that Australian
government agencies had started to contract with private security companies for fraud investigation services. But it is not just the divestment of services that has impacted the police service, it is also the imperative to adopt private sector practices (latterly termed ‘New Public Management’) driven by the Conservative Government from the late 1980s, evolving the police force into a ‘modern police service’ with the introduction of policing by objectives, a bastardisation of Drucker’s managing by objectives, requiring objectives be set consistent with the financial budget and measured using effective key performance indicators (“KPIs”) (Panzarella, 1984). It is not coincidental that income generation became an objective for chief constables.

### Payment for services

The Police are now able to charge for services they might have historically provided for free, such as recovering a stolen vehicle to a place of safety, and have received explicit authority to raise an additional 1% of their budget through commercial sponsorship (Button & Johnston, 2011, p. 67). Whilst the drive for greater economic efficiency is less controversial to spectators if it helps preserve the visible ‘bobby on the beat’ to deliver no less protection, the reality is that privatisation does have ethical, societal and practical consequences for the control of crime. Zedner (2006, pp. 81–83) defined the police as “constables in the employ of the state whose task is to deliver up criminals to the criminal justice system” and argued that the re-emergence of a market in crime control “arises from neo-liberal political thought and from the growing dominance of the economic analysis of crime and crime control”. Instead of regarding crime as the product of pathology, delinquency or deviancy, she argues that econometric analysis has impacted on traditional sociological thinking and re-categorised crime as “a routine activity”, the result of “opportunity” and an inevitable consequence of modern life in which costs and risk are now part of a solution to an economically driven problem. Evidence of that approach is visible form a trial by NAVCIS of a ‘pay as you go’ scheme for commercial victims of vehicle theft. For 21% of the value of the recovered stolen car, NAVCIS would accept notification of the theft, record the vehicle as stolen on the Police National Computer (“PNC”) and pass the report to a provincial force for investigation. The point where the police service is funded centrally has apparently been passed. In the 2015 Spending Review (Treasury Committee, 2015, para. 1.81-1.82), following earlier savage budget cuts, the Chancellor promised “real terms protection for police funding” with commitment to a £900 million increase in funding by 2019-202 but only if all police forces decide to increase their precept to the maximum extent possible. He also offered flexibility for those forces with the lowest council

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17 an instrument allowing a PCC to levy a charge on residents through council tax bills
tax bills to raise income from the precept by up to £5 per household, rather than 2%, allowing them to raise “up to an additional £12 million per year”. Against an evolving picture of declining resources, a dictate to police by centrally determined objectives (not necessarily local demand), a desire to preserve the image of the bobby on the beat, load shedding, contracting out, policing by objectives, a more commercial approach to generating revenue and positioning themselves as victims, it is perhaps not difficult to see how insurers have managed to procure their own police resource. The fact that they did so at an average annual cost of just £4 million is noteable (Transport Committee, 2014, p. 18). Fraud, insurance fraud particularly, has become a focus of the state, part of the social order and positioned inside the boundaries of ‘what can and should be policed’, despite the comments from one Chief Constable cited by Button and Tunley (2015, p. 58):

“the investigation of fraud is extremely expensive in terms of hours spent obtaining statements and preparing a prosecution case ... Our strategy identifies priority areas and police resources are directed towards those priority areas. Fraud is not one of them.”

Responsibilisation, the insurance industry and the evolution of security

O’Malley (1992) proffered that, with “the spiralling costs of social insurance, the state now promotes personal responsibility and private insurance”. Insurers have always had incentives they can deploy to improve their commercial position by reducing their exposure to risk (Doyle & Barry, 2003). Using lower premiums as a motivator for rewarding collaborative attitudes, insurers provide incentives to policyholders to invest in deterrents. Indeed, they can compel them to invest in security measures and do provide advice, define standards for, and monitor the quality of security provision for alarm systems and vehicle security devices. Zedner (2006, p. 86) contends that the industry acquired that power because the state is mission focused on reducing its role as the ultimate underwriter of the hazards of everyday life; societal risks need to be spread and the government concluded that social insurance was, economically, the most effective means of ensuring the safety net. Successive governments have reacted in this way because, by setting crime as a central platform of their political mandates, they have created an ever-deepening fiscal and political black hole and have focused on responsibilisation strategies as a means of channelling the obligations of the state downstream. Initiatives like neighbourhood watch schemes and community safety activities, for example, whilst also part of the public-private partnership between the police and the community, share roles with citizens that were once reserved exclusively for the state. As insurers have become underwriters of more of the risks faced by society, their demands to be allowed to control the effects of the proliferation of that risk have also grown and the creation of IFED may, in part, be an inevitable response to those demands. Garland (1996, p. 463) was critical
of the consequences of responsibilisation of non-state agencies and “the routinization of crime prevention” because of the risk of disparities in the social provision and distribution of security which, if not guaranteed to all citizens by the sovereign state, will be distributed by market forces.

More affluent consumers will procure security in the private market rather than the state providing it based on need. The consequence of that, Garland fears, is that the least powerful members of society will lack the resources to buy security or the flexibility to adapt their routines or organise effectively against crime. The same argument has merit for businesses. Hope (2001, p. 23) argues from an actuarial standpoint that as society feels increasingly insecure about the guaranteed provision of “the public goods” of everyday safety we are forced to rely on our own “individual and collective resources and strategies to acquire the private goods” necessary to remedy the perceived security deficit. Loader (1997, p. 388) is critical of the sustainability of a market for private security where demand, and therefore price, will increase and restrict access to those without the capital to compete in that market leading to distributive injustice where the distribution of wealth defines the distribution of safety and which Hope argues encourages the “clubbing’ of private security” (Hope, 2000). In the 18th century, when the expense of prosecution was a major obstacle to bringing offenders before a court, men of property would club together to share the expense of detaining and bringing offenders to trial (Hay & Snyder, 1989, pp. 27–29). Membership of these associations, an “expression of the “clubbability” of Englishmen”, foretells the likely transformation of security into a ‘club good’, defined by Hope (2001, p. 212) as “one that remains collectively available to members of the “club” but where non-members’ permanent access to the good can be wholly or partially denied, controlled or charged”. The communal acceptance of responsibility and mutuality of these associations in achieving the shared objectives of members, typically engaged in the same trade, became an important driver for enabling their members to apprehend and prosecute offenders, recover stolen goods, obtain compensatory damages and the recovery of their own costs (ibid. p. 212). The potential moral hazards of clubbing public, rather than private security, foretells a real risk either of distributive injustice or exclusion of non-members.

**Review of privately-funded public-police partnerships**

Stenning and Shearing (1979, p. 261) viewed the private security industry as a rapidly expanding form of social control; a “quiet revolution” in our social arrangements for policing which finds its roots in fundamental economic, social and political changes occurring within our society. Zedner (2006, p. 92) argued that “if it is the case that the modernist project of promoting policing as a public good is being replaced by something akin to eighteenth-century notions of policing and protection as club goods or tradable commodities, then worrisome consequences follow” including the failure to provide a policing service available to all. Whilst taking visible and decisive action against
offenders and, equally importantly, being seen to take such action has proved popular with communities and the police’s political masters, James' (2014) concern about the ramifications for society arising from changes in access to, and the orientation and goals of, the state police merit further enquiry. Reiner (2010, p. 25), discussing the disparity in the treatment of different groups and the market failure in the post neo-liberalist world, saw a problem for policing; the change violates the public service mandate of the police and contradicts the principle of equality before the law. He remarked that “inequality of treatment is a barnacle on the boat of so-called public policing”. A potential inequality of treatment for non-insurer victims of fraud was a motivator of this research.

With the combined legacy challenges faced by the police, as well as those identified in the SPR, and with austerity defining a limit to resource security then it must be right to search for more efficient, cost-effective, but socially acceptable arrangements to target and investigate crimes and prosecute offenders. But, privately-funded police partnerships, like IFED, may foretell the regression of policing to that of a club-good where non-members’ access to security can be wholly or partially denied. Privately-funded police partnerships existed before the creation of IFED, raising a legitimate enquiry about whether IFED has characteristics that are inherent in, or synonymous with, other privately-funded public-policing arrangements where the police employ dedicated investigative and coercive powers, derived from the state, with reliance on their infrastructure and support operations but, in each case, do so in alignment with the very narrow commercial interests of their funder.

**Equity, Funding and Governance**

IFED may be the first current-day initiative in which only the commercial funder, the insurance industry, is entitled to report offences for investigation whilst others, who may well be victim to the same species of offence, are left without a remedy, effectively abandoned by the state. There is no objective measure by which the value or efficacy of privately-funded police initiatives can be assessed, either economically, socially or by reference to their impact on crime, but current budgetary constraints, and the reality that the police have long since lost their historic monopoly, imply that private-funding might be an appropriate opportunity for other such police initiatives. A potentially valuable area of future research would be the development of an objective scoring methodology based on the risks identified from the literature, some of which has been referenced above. Reiner (2010, p. 25) notes the disparity in the treatment of different groups as being “a perennial problem of policing contradicting the principle of equality before the law” and violating the public service mandate of the police. Zedner (2006, p. 92) feared that the “modernist project
of promoting policing as a public good is being replaced by something akin to eighteenth-century notions of policing and protection as club goods or tradable commodities” and that worrisome consequences will follow if the state police do not provide a public service available to all. Johnston (1992, pp. 64–70, 2000, p. 324) highlights the risk that a commercial model where the police might charge for services could leave the needs of those who cannot pay unsatisfied or reliant on a public service with inferior resources available to respond. He also asserts the more material danger of a change in relationship between the public and the police if there are two levels of response (one to public demand and the other to demand provided on a commercial basis). He references this presenting “serious implications for what one might call ‘the judicious exercise of discretion’ as well as for the public’s perception of how that discretion is exercised”. Grabosky (1996, p. 5) felt that if “governments loosen the reins of enforcement, relying instead on decentralised and independent interests, there may be a loss of policy coherence or an imbalance in enforcement activity” by which the public will suffer through the governmental abdication of the rule of law. Garland (1996, p. 463) highlights the problem created by the responsibilisation of non-state agencies and the likelihood that they will create “huge disparities in the social provision and distribution of security” and once that ceases to be “guaranteed to all citizens” and distributed without reference to need then the least powerful members of society will suffer. Peel (1829) defined the need for the police to constantly demonstrate “absolute impartial service to the law, in complete independence of policy”” and “to all members of society” and the Court of Appeal, in the Hounsham case, highlighted five potential harms that might follow the funding of the police by a victim of crime:

- The essential independence and objectivity of the police is compromised.
- Police officers might become selective as to which crimes to investigate based on the source of complaint.
- The police investigating team might cease to act partially.
- A “paying” victim might benefit from a more thorough preparation of the evidence than a non-contributing victim.
- The practice would soon lead to a loss of confidence in a police force’s ability to investigate crime objectively and impartially.

As a basis for developing a scoring methodology, three potential risks were isolated from the literature as possible detractors from, or supporters for, police units funded and controlled by a commercial entity. Those risks relate to Equity (especially in terms of access to justice), Funding and Governance and are referenced going forward as “the Hounsham Risks”:
• **Equity** – are all victims impacted by offences, within the sphere of the police unit, treated equally and can they access justice without reference to their economic power?

• **Funding** – does the unit have security and certainty of funding, shielding it from interference in operational or policy decisions at times when the funding is due to expire?

• **Governance** – does the governance structure provide for independent decision making enshrined in regulation, statute or otherwise?

Whilst questions of Funding and Governance are objectively referable to documentary evidence, Equity, the consequences of inappropriate mechanisms underpinning the initiative, necessitates a subjective assessment from the downside risk of harm emanating from the arrangements. It invites consideration of how the particular initiative views potential victims of the offences it intends to address even to the extent that stakeholders, as well as non-stakeholders, might be denied access to justice because of an inadequate funding levels relative to the extent of the threat posed by those offences. What follows then is a review of the origins, structure, purpose and impact of several privately-funded public-police initiatives aiming to identify the characteristics of those partnerships, their susceptibility to the Hounsham Risks, and a visual representation on a continuum between the public-police at one end of the spectrum and the contrasting characteristics of private-policing at the other with the established public police model being the model against which other initiatives are assessed (Figure 3.1 below).

![HOUNSHAM RISK MATRIX](image)

**Figure 3.1: Hounsham Risk Matrix**
British Transport Police

Debate about the rail industry, safety, policing and criminal law is recurrent. In 1830 the Liverpool and Manchester Railway opened as the first public railway to transport goods and passengers by locomotive, an occasion marred by the first railway fatality. The accident, and difficulties controlling the crowd on the day highlighted the need for policing the railway and within months of the introduction of the MET, the first railway police force emerged with duties including the maintenance of law and order on the railways. As the railways stimulated urban development, responsibility extended to the conduct of labourers and management of disorder and criminality in shanty towns. The early railway policemen were sworn in as special constables under a statute passed in 1673 but, by 1921, The Railways Act amalgamated over one hundred railway systems ofwhich about 20 had organised police forces (British Transport Police, 2014). In January 1949, the British Transport Commission Police was created from the existing railway police forces, canal police and several minor dock forces. The British Transport Police Authority ("BTPA"), funded by the train operating companies, was formed in 2004 as a consequence of The Railways and Transport Safety Act 2003 which provided a statutory framework for the funding, governance and exercise of functions of the BTP, ultimately referable to, and amendable by, the Secretary of State. Today, the BTPA negotiate payments from the train operating companies and sets the budget to ensure that "train operators, their staff and passengers get the best value from BTP" (ibid.). If not the first, the BTP is the largest example of a privately-funded UK public-police partnership. To the public, it probably appears no different to that of a provincial police force but its funding arrangements and range of interactions with society is.

Reid (2003, p. 496) highlights a risk that the legal and funding structure of the BTP might raise issues of independence especially if the BTP is tasked with establishing criminal liability against one of its funders because of gross failure to maintain adequate safety systems. There is no basis for believing that to be more than a low risk. The BTP investigated the rail crashes at Southall, Ladbroke Grove, Hatfield, Selby and Potters Bar, incidents highlighting the catastrophic consequences of fatalities from railway accidents and demonstrate why the need for trust in the investigating authority is paramount but also how that independence is assured. That assurance is not just in respect of catastrophic events. The BTP were responsible for investigating 392 people fatally injured in 2002, 256 involved suicide or trespass on railways with 45 other railway related deaths (ibid. p. 499) without any criticism of their impartiality or independence from their funders. Whilst there is very little railway-specific criminal law (ibid. p. 496) BTP officers also deal with similar crimes to provincial officers including, for example, assault, theft, criminal damage and general anti-social behaviour including public order offences. Those activities associated with the prevention of
vandalism or disorder extend beyond the economic interests of their funders to the extent that they might make woman, and the elderly in particular, afraid to use the railways, especially at night (Bradley, 2016, p. 328). Ensuring the public feel safe and reassured is a primary police responsibility (Her Majesty’s Chief Inspector of Constabulary, 2012; Mesloh, 2006; Skogan & Hartnett, 1997), a responsibility that Braithwaite (2013) highlights from the significance the UK rail network occupies in the nation’s infrastructure. Its vulnerability to terrorist threats, which brings with it a sense of fear for commuters, means that a key priority for transport policing is to ensure that “fear of crime” is low. Research on this topic indicates how fear not only affects those who have been victim to criminal activity but also those who have not been directly exposed to it (Warr, 2000). More recent advances have highlighted variability in fear of crime based on the context-dependent characteristics of the everyday environment (Solymosi, Bowers, & Fujiyama, 2015) insofar as an individual is unlikely to fear being victim to a terrorist attack at home but may fear it when commuting to work. To assuage this concern, the Government announced in 2011 that “the security of the railways and London Underground” should be further enhanced by the development of a BTP armed capability to be deployed as appropriate in response to the terrorism threat level at any given time.

The BTP appears clear about its contemporary role; managing any threat to the continued operation of the railway network, from terrorism to vandalism, across a confined and delineated footprint, with a dedicated and specialist police service, expert in dealing with the particular needs of the railways. They have committed to protecting and serving the railway environment and its community, keeping levels of disruption, crime - and the fear of crime - as low as possible (British Transport Police Authority, 2012). In terms of the threat to independence, Hamelin and Spenlehauer (2014, p. 428) claim the main cause of dissatisfaction amongst its funding partners are that:

“They see the BTP’s core constabulary side, counterterrorism activity and crime clear-up, as too heavily emphasized, when they would prefer greater focus on deterrence, prevention and education as a means of promoting train use and diminishing such petty crimes as graffiti or vandalism”

Parliament debated the issue of funding ahead of the formation of the BTPA. Despite a preference expressed by HMIC that the BTP should be directly funded by government in order to guarantee an arm’s length relationship with the railway industry, parliament determined that the BTPA, as an independent authority, would be able to address the “perception of partiality in terms of the force being too weak or too tough” on the railway companies providing the funding and that the continued role of direct funding, by the industry, would maintain pressure for efficiency
(Hansard, 2003). Suggesting the broader risks explored in this thesis existed ten years ago, it is notable that one chief officer pointed out that “the police service provides a public good. It is not a private security organization for a train operator” (Department for Transport, 2006, p. 13). It is outside of the scope of this research to test whether the funding arrangements put in place have allowed the BTP to act impartially and it may prove academic in coming years. In 2017, the Scottish Government (2016) passed legislation to merge the BTP within Police Scotland claiming an ambition to “maintain a specialist national railway policing unit within Police Scotland, which is accountable to the people of Scotland, build on the excellent skills, knowledge and experience of BTP and enhances railway policing in Scotland through direct access to the local, specialist and national resources of Police Scotland”. However, assessed against the Hounsham Risks it appears that the current BTP model scores positively against the risks for Equity, Funding and Governance (Figure 3.2 below).

Civil Nuclear Constabulary

There is a similar statutory framework for the funding, governance and exercise of functions of the Civil Nuclear Police Authority (“CNPA”) and the CNC, ultimately referable to, and amendable by, the Secretary of State as provided for within the Energy Act 2004. A private funding arrangement exists between the CNPA and those nuclear operating companies that provide nuclear research and energy. The CNC and CNPA, the CNC’s governing authority which reports to the Department of Energy and Climate Change, were established in April 2005 (Civil Nuclear Police Authority, 2014). With over 1,000 highly trained officers and staff, the CNC is a specialist armed police service with a key role in national security. They are dedicated to protecting 14 civil nuclear sites across England, Scotland and Wales and safeguarding nuclear material in transit (ibid.). If there
were an attempt to seize nuclear material to construct a dirty device, then the initial deterrent and prevention of such an activity lies with the CNC.

The CNPA (2006) defines three principal strategic aims:

- Protect nuclear material and facilities on designated licensed sites and in transit throughout the UK and beyond.
- Manage in a way which gets the best use from all its resources through best value initiatives.
- Maintain and improve understanding between the constabulary, its nuclear customers, the public, other stakeholders and the government.

Rogers (2007, p. 239) identifies the power of a CNC constable as quite specific and limited by the Energy Act 2004 to all places within a relevant nuclear site, and everywhere within five kilometres of such a location, as well as at every trans-shipment site or every other place where it seems expedient to be located in order to safeguard nuclear material in transit. They are also uniquely placed and authorised to use force “to compel specific responses from citizens” (Klahm & Tillyer, 2010, p. 215; Klockars, 1985). Rogers questions whether the CNC should be considered as a police force when compared with traditional forces and raises the risk that “not being police or military, but an amalgam of both … [they] may stray beyond strict legality from time to time” referencing a 2007 report of the police ombudsman for Northern Ireland which found that, on occasions, police who consider themselves ‘special cases’ may assume they are above and beyond the law (2007, p. 240). In respect of the Hounsham Risks, if this is correct, then it may pose a risk in terms of Equity but, to the extent that a member of the public will ever require the assistance of a constable from the CNC, the benefits to society from the attainment of the CNC’s mission statement (Civil Nuclear Police Authority, 2014) are difficult to impugn:

“In partnership with the civil nuclear industry, national security agencies and regulatory bodies the CNC will deter any attacker whose intent is the theft or sabotage of nuclear material and deny access to it. If material is seized or high consequence facilities compromised the CNC will recover control of the facility and regain custody of the material”

As with the BTP, assessed against the Hounsham Risks, it appears that the model under which the CNC operates scores positively against the risks for Equity, Funding and Governance.
Port police forces

Emsley (2015, p. 19) recounts how the Manchester Guardian carried an article in March 1944 quoting from the annual report of the Liverpool Steamship Owners Association:

“pilferage of essential supplies, whether those coming into this country or going overseas to our forces or those of our allies, is an offence no less serious than looting ... and the small fines or short sentences that magistrates impose on its detection are no real deterrent to a profitable business. Participants in that business should be so dealt with as will ensure its discouragement. It will continue unchecked so long as its rewards are out of proportion to its risks.”

In his study of crime at the workplace, Mars (1982, p. 36) categorised dockers as “wolves” working in “wolf packs” who fiddled, stole and supported one another. Colquhoun (1806, pp. 213–287), writing from his experience as a police magistrate addressing the problem of “plunder in the dockyard” saw dockers:

“with a very few exceptions ... nursed from early life in acts of delinquency ... so extensive there are unquestionably many different shades of turpitude; but certain it is, that long habit, and general example, had banished from the minds of the mass of the culprits implicated in these offences, that sense of the criminality of the action ...”

In the early 19th century dock police were recruited to prevent cargo being smuggled out of the docks but the opportunity for a poorly paid work force to supplement their income was rife. Emsley (2015, p. 21) narrates the history of dockyard theft through the 20th century observing the scale of losses during the second world war persuaded the authorities of the need to deploy special police units, including Military Police officers, to supervise the loading and unloading of ships and to ensure the safety of military supplies. Military Police were never sworn as constables and so could neither arrest nor police civilians, limiting their ability to manage crime involving non-service
personnel to reporting suspected offenders to the civilian police. Emsley recounts that even with the increased police presence the nature of the offences changed little from the days of Colquhoun and the wolf packs were far more effective than the civil and military police. With the volume of military supplies, food and provisions moved across the docks during an extended period of shortages and rationing, a booming black market emerged and:

“the docker wolf packs maintained their cohesion ... Ultimately it was not legislation, policing or prosecutions that ended fiddling ... but containerisation and the break-up of the traditional communities that for generations had lived, in extended families, close to those docks in which all of the menfolk had found work.”

Traffic through the docks peaked in the early 1960s. After that, containerisation, larger ships requiring deeper water to dock, and other technological changes, as well as a switch in Britain's trade following EEC membership, resulted in a rapid decline and rationalisation of the UK ports network (Royal Docks Trust, 2008). Today, there are eight Port police forces in England and Wales and two in Northern Ireland. Their 240 constables have a responsibility to maintain the safety and security of port estates for the benefit of port authorities, their users and the public. Each force is led by a chief officer who can participate in the work of the Port Police Chief Officers’ Association (“PPCOA”) which meets to discuss matters of common interest. Maritime ports of entry have specific security policing risks and continue to be the subject of detailed review by government and so chief officers may also cover the role of Port Facility Security Officer as provided for by the International Ship and Port Security Code 2004. Most forces include some civilian staff and they may also be responsible for security personnel within the port. Frequently, businesses like car manufacturers, importers or freight operators have semi-permanent premises on the port estate and their employees are involved in routine daily business and access to ports and movement within them must still be controlled. Whilst commercial security is not in itself a policing function, it delivers benefits to tenants and the estate in general when goods are often of considerable value or transportable hazardous or dangerous substances and usually outside the supervision of their owners. Just as in the 1940s, such property can still be at greater risk of theft, damage or misuse than property in ordinary private premises. The Port police forces therefore give permitted users of the protected areas confidence that their property and security is protected although not to the same extent as a Home Office police force. Border control, immigration and duties and taxation at ports rests with other government agencies, as they would at airports. Nonetheless, the Port police are perceived by their funders as providing a resource saving to the port itself, filling a gap between outright reliance on security personnel, closed circuit monitoring and other protection methods, and the need to call on local police. Jurisdiction for Port police forces is generally limited to the relevant area of private property and, in some cases (e.g. docks and harbours), the neighbouring
area. This narrow geographical limitation and the small size of each force, means they are typically reliant on the local territorial police to assist with any serious matter, the statutory responsibility for law and order remaining with the territorial force. The Government reviewed the arrangements for port police within England and Wales in 2001. Following an investigation carried out by the Department for Transport (“DFT”) (Department for Transport, n.d.) it was concluded that:

“Despite their somewhat curious independent status, they have not become an historical anomaly but have modernised to emulate Home Office forces...The question of whether ports should have their own police forces at all should of course be a matter for the individual port authorities, but there is a strong consensus that all port police forces should strive to meet recommended national police standards in all aspects of their operations.

Considering the Hounsham Risks, whilst not as directly regulated as either the BTP or CNC, the DFT does have close departmental links to Port police forces, and has assumed responsibility for them because they are established under harbour legislation\(^\text{18}\) for which the DFT is ultimately responsible. However, it has no direct sponsorship role. The Home Office is responsible for standards and general legislation in relation to the police service and to the powers and responsibilities of constables. It is also generally responsible for the policing of seaports and airports particularly in relation to security and border management matters. As such they will inevitably deal with Port police as well as local police forces in port areas. The PPCOA liaises with Home Office, NPCC (formerly ACPO) and DFT officials as necessary and their close working relationship ensures their ports policing activity supports the National Maritime Security Strategy and is integrated into the mainstream policing. Forces are subject to performance monitoring but the chief officer and his force have operational independence, in keeping with their status as constables and their separate allegiance to the Crown. Some port authorities have separate committees and are encouraged to co-opt suitable members of the local community, such as a magistrate or a senior local police officer, to bring specialised knowledge of law enforcement functions to their monitoring or supervisory roles. The Ports police authority or board have statutory responsibility for setting annual budgets and ensuring that best value is achieved (ibid.).

\(^{18}\) Harbours Docks and Piers Clauses Act 1847; Dover Harbour Consolidation Act 1954; The Dover Harbour Revision Order 2006; Port of London Act 1968; Tees and Hartlepool Port Authority Act 1966; Mersey Docks and Harbour (Police) Order 1975 SI No. 1224; Falmouth Docks Act 1959
Police Intellectual Property Crime Unit (“PIPCU”)

PIPCU is one of several initiatives operated by the CLP but is probably more accurately identified as a government sponsored initiative rather than a privately-funded police force. Nonetheless, PIPCU defines itself as a law enforcement gatekeeper for a range of interventions against online intellectual property (“IP”) crime which accepts intelligence and evidential packages from stakeholders to an agreed minimum standard, recommending appropriate action where there is evidence of criminality (City of London Police, n.d.-a). The CLP and the Intellectual Property Office (“IPO”), part of the Department for Business, Innovation and Skills (“BIS”), established PIPCU in 2013. The IPO provided funding of £2.56 million at launch and a further £3.0 million to fund through to 2017 (City of London Police, 2016a; Police International Property Crime Unit, 2014) to run an operationally independent law enforcement unit dedicated to tackling serious and organised intellectual property crime (counterfeit and piracy) affecting physical and digital goods. PIPCU’s focus is on offences committed using an online platform. The unit launched with 19 detectives, analysts and researchers, based at the ECD at the CLP where it draws on expertise and experience already in place. According to the CLP, PIPCU planned to integrate its activities with other key stakeholders, including industry, national and international law enforcement (i.e. HMRC, UK Border Agency, Trading Standards, Europol, National Crime Agency), the IPO intelligence hub and other public authorities to maximise effectiveness and minimise duplication of effort (City of London Police, n.d.-b). A core component of PIPCU’s operational activity is its tactical partnerships with several private and public-sector organisations (City of London Police, n.d.-d):
• BIS invests in skills and education, promotes trade, boosts innovation and supports those starting or growing a business. BIS also protects consumers and reduces the impact of regulation.

• The IPO is an executive agency of BIS responsible for intellectual property rights in the UK, including patents, designs, trademarks and copyright.

• The Alliance for Intellectual Property is a UK-based coalition of 24 trade associations concerned with ensuring IP rights are valued in the UK and a legislative regime exists to enable the value and contribution of these rights to be fully realised and protected.

• The Anti-Counterfeiting Group, whose members make the products consumers use every day, seek protection for their investment and creativity so supporting UK growth and safeguarding the consumer.

• IFPI represents the recording industry worldwide, comprising some 1,300 record companies in 66 countries and affiliated industry associations in 55 countries, and

• FACT is the UK’s largest content protection organisation, protecting the intellectual property of its members across the film, TV, sports rights and technology sectors.

Intellectual property crime includes the piracy or counterfeiting of goods which, for organised criminals, can be highly profitable requiring only a small investment to reap massive return. It occurs on a global scale and where the Internet or other digitally enabled networks are involved, it is more difficult for authorities to contain and prosecute (“Intellectual Property Crime,” 2016). According to a survey of IT managers in 27 countries (Ashford, 2014), only one in five manufacturers reported a loss of IP as a result of cyber-attack in 2014. However, figures produced by Ofcom (Kantar Media, 2013, p. 16) revealed that more than 1.58 billion protected files were downloaded illegally in the UK in 2013, 20% of all protected downloads, with 760,000 ‘high-volume infringers’ responsible for 80% of offences. The Government claimed a direct link between economic performance and IP theft with every 1% increase in IP crime estimated to cost 1% of GDP, about £1.7 billion (Curtis, 2014). Zourek (European Commission, 2014) said:

“IP enforcement policy ought to be focused on the fight against commercial-scale IP infringement activity, which is most harmful for the EU economy. The overall result should be a reorientation towards a ‘follow the money’ approach, that will deprive commercial-scale infringers from the significant actual and potential revenue flows that incite them to develop such activities against the interest of society at large.”

In 2015 (“Interview: Inside PIPCU’s anti-counterfeiting drive,” 2015) PIPCU estimated that UK consumers spent at least £90 million a year on counterfeit goods, many of which are found online driving the main strands to PIPCU’s work:
• seeking and shutting down websites involved in IP crime;
• arresting and prosecuting IP crime suspects; and
• targeting the sources of income of those involved in IP crime.

In the 18-months to August 2015, PIPCU made 34 arrests for counterfeiting and piracy and reports having suspended over 5,500 websites selling fake luxury goods with brands affected included Burberry, Longchamp, Oakley, Tiffany and Thomas Sabo (Nurton, 2015). Consumer protection in relation to counterfeiting involving physical goods has historically rested with trading standards and consumers still retain a remedy for instances where they become an innocent victim in that regard. However, PIPCU is part of a wider supra-state initiative against online offending with a determination to undermine the distributive efforts of organised criminals responsible for massive value destruction. A four-year £5.56 million government investment appears a reasonable use of resources when a 1% increase in IP crime costs the UK economy £1.7 billion (Curtis, 2014) and since the initiative is driven and funded by the government rather than by stakeholders with vested interests, the Equity and Governance risks appear low. There is, however, as with any sponsorship agreement the risk that the funding arrangement is short-term and that the police modify their behaviour towards the funder as the expiry date for funding approaches. Whilst less of a risk where the Government is the funder, certainty of funding is critical to ensure that a long-term approach can be taken to address the criminal threat. The Minister for BIS (Hansard, 2017) confirmed further funding for PIPCU up to 2019 and also that “discussions are currently underway on options to ensure the future sustainability of the Unit beyond that date”.

Figure 3.5: Hounsham Risks (PIPCU)
DCPCU

The DCPCU is a police unit, fully sponsored by the banking industry, to investigate, target, arrest and prosecute offenders for organised cheque and payment card crimes. It followed a successful pilot which ran from 2002 to 2004 and operates through a steering group chaired by the Home Office (Hansard, 2004; The UK Cards Association, 2009, p. 10) ensuring a degree of control divorced from the sponsoring stakeholders. It comprises officers from the MET and the CLP working alongside banking industry fraud investigators. Prior to IFEDs creation, DCPCU was exemplar of the need for a private police partnership; a well-funded industry with strong technology platforms facilitating the economic activities of every consumer, business and other legitimate entity, but highly vulnerable to attack through digital and conventional channels when most police forces refused to prioritise cheque and payment card offences, being too labour intensive for local forces but not high profile enough for central organised crime units (Michael Levi & Maguire, 2012, p. 212).

DCPCUs creation was a response to rapidly growing payment card crime between 1999 and 2001, attributed to the growth of organised crime and the lack of a dedicated police investigatory capacity. Since its formation in April 2002, DCPCU reports (Financial Fraud Action UK, 2014) c. £40 million annual savings from reduced fraud activity, from annual funding of £5 million, a similar level to that being invested by the ABI in IFED. They also recovered approximately 700,000 counterfeit cards, resolved 346,000 compromised card numbers and secured 346 convictions on fraud related matters – an average of more than one successful prosecution per fortnight over the last decade (DCPCU, 2010). A wider perspective on its impact is the link to serious and organised crime. Investigations by the Unit have established that a significant proportion of fraud is committed by criminal gangs which have strong links to other types of serious criminality, including people trafficking, drugs and violent crime (ibid.).

The UK banking industry has to underwrite the cost of credit card and cheque fraud19, as an effective benefit for their account holders. This makes it hard to argue that consumers are impacted or denied access to justice because of the deployment of specialist police officers into the industry to improve the detection rate of organised criminal gangs that DCPCU claims is responsible for much of the UK’s cheque and card fraud. That said, the return on investment for the banking industry, who report saving £40 million p.a., for an investment of £5 million, suggests a poor reward

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19 Consumer Credit Act 1974 s75; The Payment Services Regulations 2017 s76; Banking Conduct of Business Sourcebook (para. 5.1.12)
to risk ratio for the taxpayer and possibly too low a price being paid for the services supplied. Unlike PIPCU, the initiative is funded by stakeholders with a vested interest in the outcomes. There is no regulatory framework, the initiative being a sponsorship arrangement facilitated through section 93(2) of the Police Act 1966 which grants the PCC, formerly the police authority, permission to accept sponsorship on terms ‘that would be appropriate’. Some control may be exercised through the governance arrangements in place from a steering group which the Home Office chairs and, as mentioned above, victims do benefit from a variety of regulatory protections. There is, however, as there is with the sponsorship agreement for PIPCU, a risk that the funding arrangement is short-term and devoid of parliamentary oversight and that the police might modify their behaviour towards the operational demands from their funders as the expiry date for funding approaches. However, this appears a remote risk with the initiative now in its 15th year, with two police forces participating, with statutory retail protection in place and with the links between credit card and cheque fraud and serious criminality established; it would appear unlikely that the DCPCU is perceived by the banking industry as a short-term solution.

**HOUNSHAM RISK MATRIX**

From Public to Private Policing

<table>
<thead>
<tr>
<th>Risk Type</th>
<th>The Police</th>
<th>STP</th>
<th>CNP</th>
<th>Ports Police</th>
<th>PIPCU</th>
<th>DCPCU</th>
<th>IFED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Increased Risk</td>
<td>Higher Risk</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Increased Risk</td>
<td>Increased Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>Governance</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Low Risk</td>
<td>Increased Risk</td>
</tr>
</tbody>
</table>

Public to Private Policing Continuum

**Figure 3.6: Hounsham Risks (DCPCU)**

**IFED**

IFED has similar governance arrangements to DCPCU and is also a beneficiary of sponsorship permitted by the Police Act. It is overseen by a strategic board which meets quarterly and which is chaired by the Head of Fraud and Financial Crime at the Home Office (City of London Police, 2016b) but, similarities with DCPCU diverge in respect of the other risks. The case for DCPCU is supportable with the audited economic loss sustained by the banking industry whilst the losses sustained by the insurance industry appear, in neutral language, less precise. And whilst victims of cheque and credit card fraud are compensated by the banking industry who then investigate and pursue any offender
to recover their loss, the insurance industry working with IFED does not offer the same protection to non-insurer victims of fraud as will be outlined in following chapters. IFED was launched during a period of economic recession when fraudsters saw the industry as a soft target knowing that there was little chance they will be caught and brought before the courts. It was a period when police budgets were under pressure and insurance fraud was not a high priority for the police in the same way, perhaps, that the banking industry had struggled to engage local resources in 1999; too labour intensive for local forces but not high profile enough for central organised crime units. The insurance industry has adopted a governance structure for all of their counter-fraud utilities to oversee and provide strategic oversight for the direction of the IFB and IFR together with IFED suggestive of a holistic approach to the deployment of their own resources and that of the state (Insurance Fraud Bureau, 2017) but the perceived Hounsham Risks, emphasising the risks to Equity and Funding and Governance are displayed below.

Figure 3.7: Hounsham Risks (IFED)

Five years post launch there is limited literature that objectively assesses IFED’s effectiveness although there has been significant support from government, the ABI, lobbyists and the media, for its potential to do so. Although Levi and Maguire (2012, p. 209) report that it was only after “much deliberation and unwillingness to pay twice for policing” that the motor insurance industry agreed to fund the unit. In 2013, the ABI (UK Parliament Transport Committee, 2014) reported that their total committed investment in IFED between 2012 and 2017 would exceed £20 million. They also claimed (ibid. Annex B, p. 18) that between 2012 and October 2014:

“IFED has made 462 arrests, secured 84 convictions in court, and issued 139 cautions. It currently has around £29 million of fraud under investigation...[and] has also coordinated
two national 'days of action' in respect of 'ghost broking' and credit-hire fraud in which a total of 47 people were arrested."

The creation of IFED, in light of the experience from other historic private-police initiatives, suggests more than economic expediency. That crime will always migrate to follow the population (or the opportunity) and that it now exists in a global and sometimes virtual digital world, suggests that addressing criminality is inconsistent with historic regional police force boundaries predicated on local funding and the imperative to respond to local priorities. The use of vehicles in crime, for example, and the redistribution of criminal proceeds into organised crime groups and even terrorism has created a problem for government wrestling, at least financially, with the conflict between resourcing local policing and the insidious threat to the economic fabric of the nation from large scale organised crime. To a degree, society faced the same challenges in the early 19th century with the dawn of the railways but without the neo-liberal ideology that has suffused the management of the police since. Tidball (2015), identified links between ‘transnational’ insurance fraud where assets are moved around the world, through links with organised crime. He estimated insurance fraud at $80 billion in the United States, “second only to narcotics trafficking” and cautioned that there exists “growing symbiotic connections among cartels trafficking drugs, terrorists, cyber thieves, mob syndicates and organised insurance fraud ... [taking] a collective effort between the insurance industry, consumer groups, elected officials and federal, state and local law enforcement to effectively bring about meaningful change” (ibid. pp. 24-26). Subsequent chapters in this thesis explore further the events leading to the creation of IFED, the relationship between insurance fraud and organised crime and the extent to which the “collective effort” envisaged by Tidball has resonance in the UK.

Conclusions

This chapter asked whether the creation of a private police force, funded by insurers, impacted non-insurer victims of fraud. It chronicled the changing role of the police and questioned whether the Peelian principals can still represent a vision of the police that is either economically, politically or physically achievable in a world where policing is by objective. A review of the debate around the history, nature and increasing use of privately-funded public-policing was preceded by a discussion about government, responsibilisation, the growth in private security and the increasing trend towards multi-lateralisation in the face of economic under-funding of the police. Some of the issues inspiring the creation of IFED were trailed after an exposition of similar issues in other privately-funded policing models. The concept of an objective methodology for assessing those models based on the Funding, Equity and Governance of the police unit involved, by reference to the Peelian principles and several academic and jurisprudential reference points, was introduced.
The chapter concluded with a portent of the interaction between insurance fraud and more serious organised crime which is developed in later chapters.
Chapter 4 Non-Insurer Victims of Fraud - Credit-Hire

Introduction

One of the threads insurers highlighted in their campaign for an Establishment response to insurance fraud was the frequency and cost of credit-hire fraud. This chapter looks at the evolution of the credit-hire industry, identifies what services a credit-hire company (“CHC”) provides for consumers and explores the relationship the credit-hire industry has with insurers, solicitors, consumers and the Establishment. It also examines the use of the descriptor, ‘credit-hire fraud’, and questions whether it is a label, created to taint and so undermine the credit-hire industry as part of a strategy to reduce the legitimate expense it creates. In addition, with no empirical evidence available about the amount and type of fraud suffered by credit-hire industry, this chapter also explores how a CHC might be a victim of insurance fraud and reports on the results of a self-completion survey which investigated whether respondents felt empowered or denied the right to claim victimhood, and how that impacted their ability to participate actively and collaboratively in identifying and reducing the amount of fraud impacting the insurance industry.

Research methodology

A self-completion questionnaire and series of case studies were deployed to assist understanding of the perception of fraud victims. A critical part of the research focused on the credit-hire industry, arguably a potential ‘non-insurer’ victim of fraud. Whilst it claimed annual turnover of c.£600 million (The CHO, 2012), and some in the sector operating businesses with 50,000 hire vehicles, knowledge about the industry is limited with the sector comprising four very large operators and a large number of small businesses with no published research. Accordingly, a questionnaire was designed to conduct a cross-sectional survey amongst industry members to assess whether they believed they were exposed to insurance fraud and to understand their reaction to the response they received from insurers and/or the police if they were ever victims.

“The collection of standardized information from a specific population by means of questionnaire or interviews” is a useful means to obtain data for exploratory research (Robson, 1993, p. 43). According to Leedy and Omrod (1989, p. 142), a questionnaire should seek to elicit information that cannot be observed. In this study the purpose was descriptive, the aim being to understand the prevalence of ‘frequency and outcome’ of certain matters from the perspective of
a credit-hire company or their associated solicitor. The survey was also intended to be counting or evaluative, hopeful of gathering empirical data about the size of the motor insurance fraud problem experienced by each respondent so as to aggregate all of the data to quantify the extent to which the entire industry fell victim to the offence. There are advantages to using questionnaires to collect data (Oppenheim & Oppenheim, 1992, p. 102). The key strengths and weaknesses are summarised below (University of South Alabama, 2016).

**STRENGTHS**

- They are good for measuring attitudes.
- Interviewee bias is avoided.
- They are inexpensive to administer and quick to turn around.
- Perceived anonymity by respondents may be high improving the openness of the response.
- For well-constructed and validated questionnaires, they have moderately high measurement validity.
- Close-ended items can provide the exact information needed by the researcher and provides easy data analysis.
- Open-ended items can provide detailed information in respondents own words and support further exploration in the research and so are useful for exploration as well as confirmation.

**WEAKNESSES**

- They must usually be kept short.
- Reactive effects may occur as interviewees try to show only what is socially desirable.
- There may be non-response to selective items because of mistrust from the survey population.
- People may not recall or have access to important information.
- Response rates may be low for e-mail questionnaires reducing the value of the information obtained.
- Data analysis may be time consuming for open-ended items.

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20 Some CHCs divide their processes between hire and claim settlement and partner with a solicitor who will handle claim settlement.
• Measures need validation.

Westmarland (2011, p. 74) highlighted other weaknesses including access to people, the real sources of data and, more particularly, the proposed respondents having access to files or data that may be confidential or restricted for a variety of reasons. In fact, data acquisition proved difficult because several of the targeted respondents were employees of publicly listed companies and were either unable, or unwilling, to divulge potentially price-sensitive information. This weakness was more than offset by the compensating benefits of the method which allowed absolute control for the survey over the target population, the questions asked, and the basis on which the results could be analysed. The questionnaire was also inexpensive to administer and created a data source capable of statistical analysis and integration with the outputs from the qualitative elements of the research.

**Designing and testing**

O’Muircheartaigh (1997, p. 1) provides, as a definition of errors in surveys, “work purporting to do what it does not do”. Whilst survey quality was not an absolute there was still a requirement that it should be designed, built and evaluated in line with other facets of the survey (Couper, 2000, p. 466). A preliminary qualitative assessment was undertaken with one current and two former credit-hire industry employees who later assisted in the pilot testing but took no other part in the research. The aim of that assessment was to determine the nature and phraseology of the questions and to assess whether the target audience would be able, and willing, to respond (Brace, 2013, pp. 8–11). The resulting device was a self-developed questionnaire containing items requiring a response in various formats:

• multiple choice;
• asking either for one option or all that apply;
• dichotomous answers like “Yes” and “No”;
• self-assessment items, measured on a 5-point Likert-type scale; and
• responses requiring numerical completion relating to the number of incidents incurred or their financial cost.

The questionnaire comprised twenty-two questions organised into three sections and elicited data about:

• the size of the insurance fraud problem experienced by each participant;
• the attitude of insurers and their response when a credit-hire company identifies fraud; and
• the experience of engaging with the police (including IFED) and, specifically, the initial response, willingness to record a reported insurance fraud and indications of any subsequent investigation and prosecution.

**Executing the questionnaire**

Pilot testing is the most important step in the survey (Suskie, 1988, p. 48), the goal being to validate the instrument, test its reliability and ensure it is error-free. The questionnaire was tested with those who assisted in the design phase, a process that helped to establish stability and internal consistency reliability, and face and content validity of the questionnaire. The Researcher was Chairman of the CHO when the research was conducted and, aspiring to obtain the views of senior members of the industry, his position was advantageous. He had the last known working e-mail addresses for the managing director or senior partner of all the potential participant entities in the survey which was directed to:

• senior employees of forty-five credit-hire companies who were CHO members;
• ten associated solicitors who were members of the CHO and acted for credit-hire companies in the negotiation of credit-hire claims; and
• five credit-hire companies who were not CHO members.

The survey questionnaire used Survey Monkey and was web-based (accessed through the URL https://www.surveymonkey.com/s/7G73NQ2). A web-based instrument was useful because the responses automatically populated a database and the results were easily transferrable into numeric data in Excel and SPSS formats. Participants were invited to contribute through an e-mail invitation. Informed consent was obtained with a form posted on the website, effectively the opening page of the survey. To obtain their positive consent, participants had to click on a button accepting that “by moving to the next screen you signify your agreement to participate in the survey.” The survey invitation, consent and questions and available responses are at Appendix A. About 50% of those invited to participate in the survey provided a response. 92% of respondents were members of the trade body and 8% were non-members.

**Analysing the responses**

The questionnaire design should aim to achieve specific research objectives rather than just gather potentially helpful data (Leedy & Ormrod, 1989, p. 43). The quantitative data obtained from the survey was coded and then analysed using SPSS, a statistical software programme. Whilst
designed to enable complex statistical testing, the relatively small number of responses and diversity of individual respondent experiences, which was specific to the size of the company from which the data was obtained, meant that many of the statistical tests were either too complex or incapable of being executed. SPSS did, however, enable a rapid basis for assessing the data and for displaying some of the key results graphically.

Case studies were also an important component of the research. Insurers, government and the police invest significant private and public resources to represent and promote the insurance industry’s definition of insurance fraud and the extent of their victimhood through, as was argued in Chapter 2, a reliance on untested and unreliable data. Eisenhardt and Graebner (2007, p. 26) contend that “sound empirical research begins with strong grounding in related literature, identifies a research gap, and proposes research questions that address the gap”. In this research, the case study approach was chosen, and was of value, because of the lack of independent research or literature on the phenomenon being studied. A case study is a type of ethnographic design (Creswell, 2002; Tomkinson, 2015), an exploration of a “bounded system” or an activity or process over time, through detailed, in-depth data collection involving multiple sources of information (Creswell & Maitta, 2002). Patton (2002) suggests they are valuable in creating a deeper understanding of particular people, problems or situations in comprehensive ways and Yin (1994, p. 13) advocates that they are a useful research method “when the boundaries between phenomenon and context are not clearly evident”. Stake (2000, p. 19) believed that they “are likely to continue to be popular because of their style... and, moreover, because of the universality and importance of experiential understanding, and because of their compatibility with such understanding, case studies can be expected to continue to have an epistemological advantage over other inquiry methods as a basis for naturalistic generalization”.

Theory building from case studies is an increasingly popular and relevant research methodology providing “one of the best (if not the best) of the bridges from rich qualitative evidence to mainstream deductive research” (Eisenhardt & Graebbner, 2007, pp. 25–30). There are questions about whether it is rigorous enough as a research methodology (Sato, 2016, p. 50) but whilst single case studies can define the existence of a phenomenon (Sigglekow, 2007), multiple case studies provide a stronger basis for constructing theory (Yinn, 1994) because the propositions are more grounded in varied empirical evidence (Eisenhardt & Grabiner, 2007, p. 27). Case studies are part of a strategy focused on understanding the dynamics present within single settings which can inspire theory construction that is highly verifiable (Eisenhardt, 1989). Authors who cite Eisenhardt reference her work “as a source to give authority to their choice of case and study method...and still
regarded as seminal for her approach” (Ravenswood, 2011, p. 685) allowing opportunities to explore a significant phenomenon under rare or extreme circumstances (Weick, 1993; Yin, 1994).

Pursuing case study research involves the use of several disparate collection methods including analysis of a variety of different documents and types of documents combined with interviews, and data analysis methods to provide coding for triangulation purposes (Dubé & Paré, 2003). This method has received some criticism insofar as the emergent findings might not be generalizable especially when compared with findings from survey research. To the extent that the aim of science is prediction and control Kaplan (1964, p. 91) argues that nomic or nominological generalizations must be “truly universal, unrestricted as to time and space and must formulate what is always and everywhere the case, provided only that the appropriate conditions are satisfied”. The classic concept of generalizability, as defined by Kaplan, suffers from a number of deficiencies which Lincoln and Guba (2000, pp. 29–36) argue give way to a better concept of naturalistic generalization. Stake (1978, p. 5) argued that case studies will often be the preferred method of research because “they may be epistemologically in harmony with the reader’s experience and thus to that person a natural basis for generalization”, the meaning intended by the term ‘naturalistic generalization’.

One of the risks of using case studies as part of a research methodology is the risk of bias from case selection. This can be mitigated by combining real time and retrospective cases as part of the same study (Leonard-Barton, 1990). Dubé and Paré (2003) advocated a list of attributes for evaluating rigour in positivist case research which they defined as “a listing of what the state of the art of positivist case research deems to be major considerations” rather than a ‘how to do’ list. In this study, the research relies on five cases of which two involved a credit-hire company, two involved a ‘non-insurer’ transportation entity and one involved interactions between insurers, the police and a credit-hire company and, subsequently, international security agencies and the UK government. In addition, several additional cameos were obtained during the interviews which, whilst not fully investigated, were verified. Where they assist understanding of the subject matter these cameos have also been included in the thesis. In terms of the selection of the cases studies, the basis for inclusion was:

- The first two involved similar instances of insurance fraud perpetrated against a credit-hire company victim. One case was selected because it occurred before, and the other because it occurred after, IFED was formed. The objective was to discern if different outcomes ensued for the victim and offender from offences committed and reported before and after IFED’s creation.
• The second two case studies adopted a similar analytical approach but focused on the experiences of a large bus company and a firm of solicitors acting for multiple corporate entities who self-insure their fleet and who managed motor insurance claims brought against their corporate clients. During the interviews for the second two studies, the participants claimed that they had long since abandoned any reliance on the police for assistance when they had made allegations of fraud and so the distinction between outcomes before and after IFED was considered insignificant in circumstances where the respondents felt disenfranchised from a state sponsored remedy. Despite this unexpected response, a different perspective to the findings reported from the first two case studies was obtained, reducing the risk of the research outcomes being impugned as a consequence of the Researcher’s former involvement in the credit-hire sector.

• The final case study explored the link between insurance fraud impacting non-insurer victims, the links to global organised crime and the insidious consequences for society when a non-insurer victim of insurance fraud is unable to report an offence to the police.

**Objective selection criteria of case studies**

The case studies were selected against the following objective criteria:

• each case was not part of an ongoing criminal investigation;
• regarding the first two case studies, one must have arisen pre, and one post, January 2012;
• each study must involve motor insurance fraud where the victim was a business or organisation, not an individual;
• the aggregate value of the offences in each case exceeded £100,000;
• each of the first two cases involved a series of offences, committed by the same individual or group of individuals acting in concert;
• in each case, the offence was reported to the police, even if no investigation or prosecution ensued.

The case studies were inspired from the semi-structured interviews after which desktop research was used to assimilate the publicly available information, media reporting and collateral evidence and, once reviewed and where it added value to the studies, further semi-structured interviews from those involved as victims or investigators followed. Each of the case studies:

• adopted a narrative approach to chart the identification of the offences of insurance fraud committed in each case;
• explored the inter agency/entity collaboration between non-insurer victim, insurer and police;
• reviewed the case to assess whether it was integrated and demonstrated a shared approach to the investigation, detection and prosecution of the offender; and
• reported the outcome from any subsequent arrest, trial and conviction.

The case studies add value to the research. They provide powerful information on the frustrations and difficulties of preventing motor insurance fraud and the arbitrary approach of the police towards investigation and prosecution. They also offered some perspective on the behavioural traits of the offenders and the overlap between insurance fraud and other more serious offences as well as highlighting the difficulties in detecting, pursuing and prosecuting insurance fraudsters.

The origins of credit-hire

An insurer’s liability to its policyholder is limited to the range of losses for which cover is purchased and is detailed in the policy documents. In the case of a comprehensive motor policy, these ‘insured losses’ will typically include:

• the replacement value of the vehicle in the event it is stolen or damaged beyond economic repair; or
• In the event of an accident, the recovery from the scene and repair of the damaged vehicle; and
• indemnity for the legal costs of defending any claim, and liability for damages awarded to the ‘not at-fault’ motorist, where the policyholder is deemed ‘at-fault’ for the accident.

The credit-hire industry originated in 1981 (The CHO, 2012) principally because motor insurers had left a gap in the market. Those who were not at fault in an accident were entitled to restitution for all of their recoverable losses at common law and not just their insured losses. The additional ‘uninsured losses’ might include:

• independent legal advice;
• funding and/or managing repairs to the damaged vehicle;
• negotiating a total loss settlement if the vehicle cannot be repaired economically;
• pursuing damages for loss of earnings, diminution in value of the damaged vehicle or personal injury;
• recovery of any policy excess paid where repairs were effected through the motorist’s comprehensive insurance policy;
• seeking re-instatement of any no claims bonus;
• mobility whilst the damaged vehicle was not roadworthy or being repaired; and
• any comprehensively insured loss unavailable to the motorist with third party only insurance cover or because he elects not to claim on his own insurance policy to avoid losing any no claims bonus entitlement.

CHCs identified the gap, understood the entitlement to restitution at common law and recognised the not at-fault motorist was being denied his lawful entitlement and that insurers were happy to benefit financially from not meeting the obligations of their negligent policyholder where he was the at-fault driver.

The nature and size of the market

CHCs range in size from large, well-respected public companies, like Redde plc, to small sole traders. In many cases they operate under the auspices of the General Terms of Agreement (“GTA”) (ABI, 2001), a protocol created by the ABI to reduce friction and minimise the costs involved in settling claims by pre-agreeing standard hire charge tariffs, imposing obligations on the CHC to monitor and control the hire period and, in doing so, reduce the likelihood of expensive litigation. Most CHCs are also authorised by the Financial Conduct Authority and regulated by the Prudential Regulation Authority and, if they handle claims involving the award of compensation for personal injury, they may also be authorised by the MOJ. They obtain their business by referral from many sources including insurers, motor manufacturers/dealers, body repairers, insurance brokers, solicitors, affinity groups and claim management companies. A commission payment is typically made to the referring source but the referrer may also be motivated to enhance their customer’s journey following an accident, either to capture incremental business and/or add value to an existing customer relationship. Motor dealers for example welcome the referral commission and the prospect of generating incremental revenue from supplying replacement parts and carrying out the repair to their client’s damaged vehicle if the policyholder is persuaded not to process his claim through his comprehensive insurance policy, a consequence of which is that the damaged vehicle may be moved to the insurer’s own repair network.

The credit-hire industry is represented by a trade body, the CHO. Its members are reported to generate annual hire revenue of c. £600 million (The CHO, 2012) which is a cost ultimately born by the insurance industry. Almost 90% of CHO members are regulated and/or authorised and operate
in a legitimate and transparent manner complying with an industry code of conduct supported by a statement of consumer rights21 (The CHO, 2015). Probably because of the £600 million aggregated cost generated by the industry, the tension between it and the insurance industry is palpable. It was recognised, for example, in a judgment given by Lord Justice Aikens (Vasani Pattni and First Leicester Buses Limited and Darren Bent and Highways and Utilities Construction [2011] EWCA Civ 1384, 2011):

“These appeals are fought on two new fronts in the secular war that has now been conducted for over 20 years between the motor insurance market and credit car hire companies who provide an innocent victim of a motor accident ("an RTA") with a replacement vehicle whilst his is being repaired.”

The economics of the sector may offer an explanation or stimulus for insurer behaviour. The CMA (2014) highlighted the financial pressures pleaded by motor insurers who reported facing a perfect storm of:

- decreasing premiums from increased price competition;
- lower investment returns from depressed interest rates;
- reducing claims incidence negated by higher claim costs;
- a higher value per claim driven by the compensation culture; and
- a belief that insurers could provide mobility to accident victims at a lower cost than the amounts charged to them by the credit-hire industry.

The motor claims eco-system is complex

Ironically, insurers were always a significant referrer of not at-fault motorists to CHCs because:

- insurers didn’t typically have the infrastructure to deliver an immediate customer-focused response and an effective uninsured loss recovery service to an accident victim, or
- they are motivated by the referral commission income, motor insurance being inherently loss-making.

There were 2.8 million motor insurance claims in 2012 from which insurers earned an estimated credit-hire referral commission of c. £100 million22 (ibid. p. 2-12, 6-10). Even to an insider, insurers’ engagement with credit-hire companies appears schizophrenic. Whilst the commission opportunity

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21 See Appendix C
22 £84 million estimated from a range of £67 to 178 million
is an attractive non-premium addition to their premium revenue, it also represents an unattractive cost. The majority of credit-hire claims (and so the majority of referral commission forming part of those claims) are settled by the insurance industry who could provide mobility to accident victims at a lower cost than the amounts charged to them by the credit-hire industry if they could:

• establish an effective claims management process compatible with the current CHC offering,
• were prepared to guarantee mobility to every accident victim; and
• do so at an annual cost less than £500 million (c. £600 million of cost generated by CHCs less c.£100 million of referral commission earned).

Following a 2-year market investigation, the CMA declined to deliver the economic change demanded by insurers; pricing controls and/or reduced consumer entitlement in a proposal that would have eliminated the credit-hire industry. From their econometric analysis, the CMA (ibid. p. 9) concluded that, whilst the cost of credit-hire services added £3 to the annual cost of every motor insurance policy, they couldn’t identify a more economically efficient mechanism which preserved the significant collateral benefits the credit-hire industry routinely delivered to consumers. Their final report (Competition and Markets Authority, 2014) proposed no change to the process where innocent motorists could pursue at common law their claim for restitution for the cost of mobility.

Credit-hire fraud

Most CHCs are as susceptible to the actions of insurance fraudsters as are insurers. However, in addition to those companies operating ethically as CHO members there are a significant number of predominantly unregulated credit-hire entities operating outside of the trade body. Some of these businesses have been identified as fraudsters, some have been prosecuted and many others often enjoy a very short commercial lifespan, disappearing and then re-emerging in a different corporate guise as a means of avoiding detection and prosecution. One organisation that manages c.150,000 insurance claims a year on behalf of insurers highlighted the challenge with unregulated credit-hire companies. DF2 explained that:

“… with the GTA stuff we’re reasonably okay because the entity we’re dealing with is generally a reputable CHO. Of the 958 third party representatives we receive claims from - and you will know that only about 60 CHOs are actually GTA signatories, the rest of them aren’t – so … you’d get a company, say ABC Credit-hire Ltd and then you’ll get another company called ABC London Credit-hire Ltd … you’d have two entities, the same address, slightly different names, but, in fact, the same company”
Part of the motivation to avoid detection arises because some of the criminally motivated entities have been engaged in organised crash for cash.

**Case Study – Project Saisir**

The Researcher has personal experience of being a corporate victim of insurance fraud whilst he was Chief Executive of a Group of businesses with a subsidiary company specialising in counter fraud, APU Ltd (“APU”), a vehicle tracking and telematics business (In-car Cleverness Ltd (“ICC”)) and a GTA registered credit–hire business, Accident Exchange Ltd (“AX”). He was not, however, engaged in the investigation.

Between 2007-2009 the management team at AX became concerned about several separate credit-hire transactions involving many different customers introduced by a variety of referrers. The concern arose because of:

- the unusual geographical movement of the hire vehicles;
- the coincidental relationship between the hirers and the at-fault parties in some claims and the witnesses in others;
- difficulty in agreeing settlement for some of those claims with insurers; and
- the hirers frequenting locations where, from APUs intelligence, known fraudsters operated.

APU notified Aviva, AX’s motor fleet insurer, of their concerns. In turn, Aviva shared their concerns about the credibility of many of the hirers. They provided details of an on-going investigation they were conducting with the MET, Operation Saisir, which had failed to gain traction through want of credible evidence. Concerned that the hire cars might subsequently be stolen or damaged, and because of the questions raised by the available intelligence about other transactions involving the hirer or his linked associates, APU arranged for one of the hire cars to be covertly recovered.

It transpired that one of the hirer’s, “Offender 1”, was operating multiple phantom car-hire businesses, the ‘virtual fleet’ for which was obtained from legitimate credit-hire companies, including AX, following multiple staged or contrived accidents. AX had been an unwitting victim in several such claims. To execute his fraud, the offender would take delivery of a hire car from a first claim that was dishonest. He would then stage, or invent, other accidents and would produce rental documents to support invoices which he would then use to substantiate and pursue his fraudulent claims against insurers as if the bogus not-at-fault driver from his contrived accident had hired a car
from him. The registration numbers used on the rental documentation were those from the vehicles originally hired by AX or other credit-hire companies, a ruse that he deployed because he believed it gave the fraudulent transactions from his phantom car-hire business an air of credibility because the hire cars were registered to reputable CHCs. Following the covert recovery of the AX vehicle, vital incriminating documentation was found in the boot which was used to support the MET investigation. It included copies of rental documentation from scores of fabricated claims and provided the vital evidence that the offenders were operating a fraudulent phantom credit-hire business. The rental documentation, when matched with bogus invoices, also identified that the same rental vehicles had ostensibly been hired to several different people simultaneously with multiple invoices for the same vehicle covering the same time periods deployed in differing claims against multiple insurers. Because AX had telemetry in their hire vehicles, ICC were also able to provide crucial evidence on the movement of the hire vehicle during the periods being investigated which assisted the police in confirming the identities and addresses of other suspects visited by each of the hire vehicles, including dishonest body repair and vehicle recovery operators and solicitors who were also engaged in the activity.

It transpired the offenders had been suspected over a two-year period involving over 250 fraudulent claims. 52 arrests were eventually made although only 30 people were charged. After the trial, in which Offender 1 and his associates were convicted and imprisoned, the investigating officer told APU that the intelligence and co-operation provided was the catalyst that brought their investigation to life; without APU’s evidence those responsible may have remained active and avoided conviction. Offender 1 was imprisoned for seven years and three months having been found guilty of staging hundreds of road traffic accidents to make insurance claims which would have totalled £6.5 million if the fraud had not been uncovered. His accomplice was found guilty of conspiracy to defraud and was sentenced to four years and ten months, it being proven that between 2007 and 2008 the syndicate had submitted over 250 fraudulent insurance claims through their London-based accident management company. What followed, however, in terms of the media reporting of the operation highlighted an element of disrespect that exposes the distant relationship between the insurance industry and the credit-hire sector. After the offenders were sentenced, reports in the insurance press (Insurance People, 2012) attributed the results of the police investigation to the efforts of the IFB airbrushing out the pivotal contribution of APU:

“Phil Bird, director of the IFB, says, “this investigation demonstrates the sophistication of the insurance industry’s counter-fraud activity. It also shows how insurers are working together, through the IFB, to help the police disrupt organised criminal activity”
In a later press report (Prosser, 2013) the MET were quoted and the account was more inclusive reporting that Offender 1:

“was brought to justice with the help of evidence compiled by Asset Protection Unit Ltd (“APU”), the counter fraud subsidiary of a large credit-hire company.”

**CF5**, a retired detective employed by APU, drove the intelligence gathering for Project Saisir:

“Dave Hindmarsh had a department, which was just starting off in the Met. I managed to contact them and they came up … We took them through the file of everything we had … and they were bowled over. We then fed them other information from the telematics data and also recovered another car … in the boot there were personal belongings that we had returned to an individual who turned out to be Offender 1.

I had a phone conversation with him … Initially he denied who he was but eventually he said ‘look you know who I am and what I’m about, stop messing me around and just send my stuff back’ (or words to that effect) and then hung up.

I think the IFB took all the credit for it. You know, and I know that the IFB just processes data and doesn’t do any real investigative work. Without our intelligence, the case couldn’t get out the starting grid and so it was a bit frustrating to be airbrushed out of the stories that followed.”

Project Saisir highlights some unusual atmospheric factors. The insurers involved reported in both versions of the published story that they avoided the £6.5 million loss. AX was, however, less fortunate. They lost revenue because the initial accidents giving rise to the first hire proved to be fraudulent and the charges were, therefore, not recoverable, but they also incurring operational and fleet costs associated with all of the fraudulent transactions. Some of the vehicles were returned damaged and significant time and manpower, running into several man months for which it was never compensated, was invested in the recovery and subsequent investigation. The distinction between an avoided loss and an incurred loss have significant implications for a victim, only one of them, the incurred loss, resulting in real pecuniary damage.

The success of the MET operation pre-dated IFED’s creation and is illustrative of the ability and value of an insurer, CHC and the police working collaboratively, intelligently and with a common purpose in the fight against fraud. If the insurer’s use of the term ‘credit-hire fraud’ is intended to be a label to categorise the actions of offenders like Offender 1 then it is aptly chosen. However, concerns emanate from within the credit-hire industry that the label is applied pejoratively and is likely to, or actually does, impugn the reputation of all CHCs making it harder for those CHCs to build credible relationships with the police when they are victims themselves. Evidence of that flows from the second cases study where the credit-hire industry was subjected to another wave of organised criminal activity in 2014, after IFED became operational and where the disconnect
between the victim and the police was even more disturbing than the IFB’s decision to erase the positive contribution of AX and APU to the prosecution.

**Case Study – Project Atlanta**

Offender 2 stole many hire cars, collectively valued at more than £500,000, over a nine-month period in 2014/2015 by creating a complex scam designed to outwit the police. It was eventually foiled by APU. At least eight different CHCs were impacted by his actions and three of them provided evidence as part of this research. Offender 2 stole the identities of innocent people, took out fake motor insurance policies and even posed as a care assistant who had been a genuine victim of several car crashes. He was caught after a sting operation carried out by APU when he tried to hire a second car from AX. He had hired from AX previously, his original deception having been successful, and stole an Audi A4 which was never recovered. In April 2016, Offender 2 was sentenced to two years in prison after pleading guilty to a specimen charge of “conspiracy to make false insurance claims and steal courtesy cars.” The Judge defined him as part of “a sophisticated criminal enterprise which duped insurers and stole cars with a view to moving them on for profit.” In fact, the victims were CHCs and not insurers, but the Judge noted the significance of the offences adding that “fraud is a prevalent crime which has a large impact on the motoring public and Offender 2 played a significant role in this” (“£200k hire car thief is jailed for two years,” 2016).

Offender 2 used false identity details and created fictitious accidents to make hire car bookings with CHCs. Before delivery of the hire car, he would change the delivery location, typically asking for cars to be handed over in the North of England, often at medical facilities where he claimed to be working as a locum medic or, alternatively, claimed to be visiting sick relatives. He fabricated crashes in the South of England, East Midlands and West Midlands and after obtaining the hire car would quickly dispose of it before adopting a different identity and targeting another hire company. CF1 reported that:

“He had figured out what he thought was a fool-proof way to steal cars. AX lost one car and he came back for a second attempt using a different identity but relying on a similar M.O. in terms of the accident circumstances, the fact he had only recently purchased his car and that he had also only recently incepted his own insurance cover.

We flagged the claim as suspicious and after an industry-wide alert went out we identified five or six similar thefts where other credit-hire companies had been targeted. I don’t know to this day where those cars ended up or whether they were involved with organised crime; I’d guess they were. I know that Burnley Police were looking at charging with at least nine charges of thefts of cars and attempted thefts of cars. I also understand that this guy has been operating in this way for probably three or four years at least and was thought to be exporting the vehicles he stole to France for onward distribution in Eastern Europe.”
**CF3** said:

“We had him from Accident Exchange, Al, Kindertons, Prestige and Hertz. He’s moved stuff to France and usually does it from a unit in Tysely which is where I think your first Audi went.”

Asked if he was still active, **CF3** replied:

“Do bears crap in the woods? We were asked to get involved twice more; one was between the two arrests we were involved in and the other was after the second. It’s like I say. The risk and reward for him is easy. Your Audi was worth about £30k to you. He’ll make that easily if he exports the car.”

Unrelated to Offender 2, **CF1** explained that many of the vehicles lost by CHCs were never recovered and were often stolen for export or for the sum of the parts. He provided a photograph of a BMW 3 Series that was hired to a Romanian working in the UK. The car sent a telemetry alert indicating it was being tampered with just a few hours after the hire started. Within two hours of that alert the vehicle was located in a warehouse in Essex where it had been dismantled for the value of its parts which were loaded on a truck ready to be moved abroad. The photographs below indicate the audacity, ingenuity and efficiency of organised criminal gangs and the limited resource needed to cannibalise a car to maximise its disposal value in a matter of hours.
Figure 4.1: Cannibalising a hire car for parts
Reverting to the Project Atlanta case study, **CF1** explained how Offender 2 was arrested and the reaction from IFED:

“This guy was a one-man crime wave! We set up an operation where we did a staged delivery on another claim, because all we got was a false identity. We actually had this guy arrested in Preston by the local police and on that day, well, ... let me just rewind it a little bit, even before we did that, I tried to refer the matter to IFED thinking this is a cross border problem and Offender 2 knew this. He knew police forces are restricted in responding in just their geographic area.

He knew the industry. He got false credit cards to pay for the insurance premiums before he made a claim and I referred it to IFED for their help. I thought that as the national lead for insurance fraud they would want to be involved in this; even the local police were saying, this is an IFED job, you need to refer it to IFED. The response from IFED was bizarre ... I was told that this isn’t insurance fraud so refer it to the local police.

The sting operation went well and after his arrest (when he attempted to steal the second car from AX), we contacted IFED, as did the local police. We both expected them to want to get involved because we had got this guy who has, as I say, taken out insurance policies using a stolen credit card with the intent of committing criminal offence, staged an accident using an innocent victim’s details as the guilty party and he was locked up with false documentation and evidence of his involvement in other similar frauds. I was expecting IFED to turn up to the interview and help the local police but they didn’t and they said they weren’t going to turn up.

Moving on a couple of weeks and whilst he was on police bail, Offender 2 came in again from another staged delivery on the back of another fraudulent claim where, again, we had him arrested. Moving on a couple of weeks, he did the same again with another credit-hire company who notified me. We did another staged delivery and he was arrested again doing the same thing - different identity, different address and with him reporting being involved in an accident in a different car. It was clear that he had no intention of stopping.

I tried to refer it again to IFED. I’ve even fed the intelligence into IFED through the IFB, and nobody came back to me. In desperation, we even asked our insurer, Aviva, to feed the intelligence through knowing how IFED perceived the credit-hire industry as part of the problem and not part of the solution but they hit the same brick wall.”

On the role of IFED, he continued:

“IfED’s acceptance criteria means that they will only take reports from the insurance industry and only then where there is a clear line of enquiry; my experience is that IFED don’t want to do the big investigations, they want the easy hits”.

**CH2** recounted her experience with Offender 2:
“The only reason we picked up on him was because I’d seen an intelligence report from Netfoil and, thankfully, the member of staff that was dealing with that claim picked up on something not looking right.”

CH2 also reported giving evidence to the APPGIFS. Commenting on the reaction from Jonathan Evans MP, Chair of the group, she said:

“It was very clear that he was heavily influenced with the sound bite he had from IFED. He was adamant that DCI Wood had told him IFED never refused to look at an allegation of fraud and therefore we were being untruthful even when IFED had specifically written and told Neil Thomas that they would not deal with the allegation around Offender 2 because it wasn’t reported by an insurer. The fact that he asked Neil to prove it was understandable but it showed, I think, that the establishment already had determined outcomes based on what others in the establishment, like DCI Wood, told him. That’s what we’re up against…”

CH3 was also a victim of Offender 2 using an alias. He reported that:

“he took a Mercedes C220 Sport. Contact was made on 8th January 2014, everything checked out and we delivered the hire in that week … it was the only Mercedes on fleet that didn’t have a tracker, the car went missing and we told the police but we heard nothing from them. To be honest Steve, it seems that with the Police, there is just no point … and we don’t see IFED as an active player or adviser or body that we can go to or get support from really.”

Credit-hire industry – insurer messaging

If Projects Saisir and Atlanta are indicative of the threat from credit-hire related fraud perpetrated by people such as Offender 1 then a reference by Otto Thoresen, Director General of the ABI (2014, pp. 19–21) referring to IFEDs “days of action” in respect of “credit-hire fraud” is understandable when considered against the determination of IFED (City of London Police, 2012, p. 4) to work “closely with the insurance industry on its strategic priorities”. Taking the most cynical assessment, however, it is probable that the term was coined as part of the ABI’s determination to again undermine the credibility of the credit-hire industry, an industry responsible for generating £500 million of annual net cost for insurers. The credit-hire days of action were aimed at arresting a small number of dishonest credit-hire operators. DF1 said:

“In terms of the day of action and the coverage it got, it did exactly what the insurers wanted, I guess. It painted an entire industry as the bad guys because it was on the radio and an important MP was there and “the police don’t make mistakes” so it just supported the insurers message that credit-hire is a bad thing.”

_____________________________

23 Netfoil - an intelligence database from Hill Dickinson Solicitors available to the insurance, legal and credit-hire sectors.
CF1 was equally sceptical”

“... it’s around trust and different people’s perceptions of the credit-hire industry ... my experience is that the insurance industry are weighted against the credit-hire industry. I’ll give you a quick example; when IFED did a recent focus on fraud, they trailed it as credit-hire fraud. I think insurers are getting confused with their messaging, perhaps deliberately, and that’s picked up by the media and the public, so the public are almost subliminally persuaded that the police are saying the credit-hire industry is fraudulent, which is far from the truth ... a lot of insurers see it as a cost and so use different tactics to damage the reputation of the industry.”

Credit-hire exposure to fraud

None of the above alters the presumption that there must be dishonesty within at least some of the 958 claimant entities identified to have traded with duplicate identities when only 60 or so are regarded as legitimate GTA subscribers. Organised fraud can involve claims being pursued through criminal networks involving disreputable or dishonest repairers, phantom hire-companies, solicitors, engineers or doctors but, whilst the ultimate target may be an insurance company standing behind an at-fault driver, Projects Saisir and Atlanta demonstrate that the victims of insurance fraud can also be the honest and reputable CHC. When individuals unrelated to the targeted CHC submit apparently plausible but, with hindsight, fraudulent claims to that CHC, they can obtain the use of a hire vehicle by deception often with the intention of using it as a route to further criminal gain. They may seek compensation for fictitious multiple whiplash claims, for example, or claim compensation by way of a cash in lieu payment for repairs to a car allegedly damaged but which has incurred no accident damage at all, whilst the CHC stands to sustain a loss if the fraud is suspected and the uninsured loss claim is challenged before the insurer settles the hire claim. Dishonest advantage may also involve the theft of the hire-car or the subsequent use of the vehicle in other crimes, exactly as Offender 1 did. Alternatively, it might involve a fraudster crashing the hire vehicle into another vehicle of a friend or relative so he can claim damages from the hire company’s insurer on behalf of the ‘innocent’ friend or relative. This scenario is one consistently challenging the conventional rental industry, according to N2, where “every customer is an accident waiting to happen and for which we end up picking up the bill”.

None of the scenarios in which the CHC is an innocent actor lessens the energy of those representing insurers to cast the credit-hire industry as part of the problem. Support for the proposition that insurers targeted the credit-hire industry as part of their cost reduction strategy can be found in their engagement with government (Fuller, 2015):

“Credit-hire was on the agenda at a high-level government meeting yesterday (9 December 2015) ... The meeting included representatives of several groups including the Ministry of
Justice, other high-level government officials and senior members of the motor insurance sector. Sources have told Post it was a “constructive and positive” meeting that covered the whiplash reforms proposed in the 25 November Autumn Statement and concerns around credit-hire.

Head of communications at the ABI, Anthony Wright said: "We can confirm that the ABI facilitated a private meeting between senior ministers and senior representatives of the top motor insurers to discuss various issues relating to the cost of motor insurance.”

The influence of solicitors as lobbyists

DAC act routinely for insurers in resisting credit-hire claims and in recent years have extended their portfolio to include the identification and detection of fraudulent insurance claims. In 2013, they produced a granular codification (DAC Beachcroft, 2013, p. 29) aimed at targeting the source of fraud, which they ultimately perceive as emanating from the CHC. It identified nine categories which they recommended insurers utilise in their screening together with their proprietary risk indicators and bespoke strategies to manage or resist the quantum of credit-hire claims. The nine screening categories were:

- **Phantom Hire** - a claim presented by a credit-hire company for a hire that did not take place.
- **Phantom Hirer** – a credit-hire claim where the hirer does not exist or is unaware a claim has been submitted in his name.
- **Phantom Hire Vehicle** – a credit-hire claim where the hire vehicle does not exist or was in the possession or control of another during the alleged hire period.
- **Phantom Hire Organisation** – a claim involving a non-verifiable CHC.
- **Simultaneous Hire** - claims where the same hire vehicle was in use during the same or overlapping periods.
- **Artificial Exaggeration** – a claim where duration has been artificially “improved” or where vehicle damage has been artificially worsened to extend the hire period.
- **Staged/Contrived** - credit-hire claims with concerns the accident has been staged or did not happen and generally involves policyholder collusion.
- **Induced** - credit-hire claims where an innocent policyholder’s vehicle has been induced into collision with the third-party vehicle.
- **Credit-hire Fraud Rings/ Networks** - networks of organised fraudulent activity generally denoted by an Operation Name.

Detecting insurance related fraud has long been an objective for many solicitors’ keen to demonstrate their counter-fraud expertise as a differentiator and means of securing more insurer
generated work. It has helped sustain the ‘secular war’ as credit-hire claims became subject to increased scrutiny and potential rejection based on a desktop review ahead of engaging with those representing the not at-fault motorist. The counter fraud sector’s effectiveness to deal with the increased detection of fraud may have peaked by July 2014 as one leading firm, Hill Dickinson, made 39 of its counter-fraud group redundant (Ganage-Stewart, 2014) whilst at the same time reporting an increase in the level of instructions received of 15%. Keoghs, another solicitor firm that work with insurers providing outsourced claims management, fraud detection and investigation services, also produce an annual motor fraud index. In the 2014 edition (Keoghs, 2014, pp. 4–6) they identified high-risk areas by postcode and suggested using that analysis as a means of assessing if a claim might be contrived. They also summarised their view of the range of evolving fraud risks:

- for the first time in several years, the majority of fraudulent claims were linked to fraud rings;
- the current market was “consolidating and volatile”;
- staged claims accounted for 26.25% of fraudulent claims in 2012 compared with 40.33% in 2011;
- in the same period, claims involving organised fraudsters grew from 23.2% in 2011 to 34.37%;
- induced claims grew from 5.9% to 10.1; and,
- the number of fraudulent claims defined as ‘miscellaneous or credit-hire’ increased from 8.7% of the total in 2011 to 10.2% in 2013.

Mixing credit-hire with other claims analysed as ‘miscellaneous’, which the report does, is unhelpful in identifying the materiality or frequency of alleged fraud involving credit-hire but, perversely, helpful in ensuring that the issue of credit-hire remains identified as a potential source of fraud whatever the evidence. Without doubt, the imperative of reducing fraud is well-established on the dashboard of defendant solicitors and insurers.

**An historic perspective**

Whilst today, data around insurance fraud is more prolific and the conclusions inferred from it more insightful, looking back to the late 1980s, Clarke (1990, p. 2) identified two factors driving the recognition of fraud by insurers; their willingness to take steps to detect it and then, assuming success, deciding whether to record it as fraud. He observed that most insurers applied low cost measures to identify dishonest claims and would deal with them by rejecting the claim or, where it was discovered afterwards, or considered inimical to the cost of claims generally, increase
premiums to compensate in subsequent years. Clarke identified the priority for insurers was protecting their interests, and those of honest policyholders, by resisting suspicious claim and refusing further cover with only the most flagrant offenders being reported for criminal investigation. Where fraud was a problem he reported the preference was to raise premiums, to avoid the costs of effective fraud control and verification systems, and to minimise the damaging publicity from civil litigation in disputed claims. By the mid 1990s the increased deployment of computerised registers enabled some insurers to start measuring and focusing more diligently on identifying potential fraud and, according to Dixon (1997, p. 236) for the ABI to claim a 2.5% reduction in the cost of fraudulent claims between 1994 and 1995. By 2009, the ABI claimed a combination of factors driving improved fraud detection rates (Goss & O’Neill, 2009, p. 6) from

- dedicated fraud teams;
- new and sophisticated IT-based processes including rules-based scorecards and predictive analytics for automatically flagging suspect claims;
- voice stress analysis, conversation management and cognitive interviewing techniques; and,
- increasing adoption of commercially available databases and software solutions.

The economic downturn started in 2008 probably influenced the drive for efficiency too. By 2012, Gee, Button and Brooks (2012), felt the insurer engagement with the fraud agenda had improved albeit that the response rate to their survey was less than 100% and they did observe that those that did respond were more likely to be positively engaged with the fraud agenda and so potentially skew the result. That aside, it was reported, inter alia, that 100% of those responding had arrangements in place for promptly reporting suspected fraud and 94.3% had a policy setting out how to detect possible fraud.

**N4** commented on his experience with insurers:

“... one of the best bits of advice we ever got was from a guy at AIG, ‘don’t target your guys with fraud savings ... as soon as you start targeting them with fraud savings, they all start saving that level’.

So, if you say, save me a million pounds, they’ll say, I’ve saved a million pounds and most insurers put these figures out there. If you look at what they’ve saved because of captures and as a result of fraud, in theory it’s made up. You get a claim with five potential injuries and you only pay out on three does not mean the other two were fraudsters ... none of our guys are targeted because it encourages manipulation; it’s just not factual.”
Ericson (1993, p. 540) argued that insurance claim fraud was a case of “making crime”. Pointing to a comment from a US insurance industry executive, he highlights the irony that the increasing focus on the detection and reporting of claims fraud is integral to keep premiums down in a regulatory environment where increased claim costs can no longer be passed on to consumers by way of higher premiums. The parallel with the UK insurance market is intriguing. In the depths of recession insurers managed to avoid criticism for imposing double-digit percentage increases in motor insurance premiums because of increasing levels of fraudulent claims prompting a comment from the TSC (2011a, p. 5) that:

“premiums would continue to increase because insurers needed to make up for several recent lean years; that insurers currently spent around £1.20 for every £1 collected in premiums; and that the underwriters of motor insurance had been loss-making since 1994.”

DAC (2013, pp. 7–11) were critical of the maturity of insurer fraud avoidance strategies citing the UK Claims Director for Zurich Insurance, that “[credit-hire fraud] needs a tough line from the judiciary, and an appetite to tackle the problem head on.” Other insurer commentators reported an increase in “credit-hire only fraud, which predominantly follows the approach of false documentation, staged accidents or induced accidents. Off the back of this, we’ve seen an increase in organisations inflating the costs of their claims in order to maximise their profit margins” (ibid. p.13). The latter reference appears to be an attack on CHCs based on DAC’s screening categorisation although such a conclusion might be unfounded before a claim is properly investigated. Ben Fletcher (ibid. p. 5), director of the IFB, suggested a more balanced view, which touches on the nature of the research:

“...In other examples, credit-hire companies become the victims of ‘crash for cash’ gangs, where hire vehicles are obtained following a ‘crash for cash’ and used to commit other serious crimes.”

This was an isolated outcome from the DAC report; an insurer-related source acknowledging that CHCs can become innocent victims of fraudulent claims although DAC did advance an argument (ibid. p.27)

“a credit-hire organisation is uniquely placed to be a first line of defence to the opportunistic fraudsters who use credit-hire organisations’ own fleets vehicles to commit fraud”.

Resistance from insurers to engage with the credit-hire industry on the issue of fraud became a recurrent feature in the research. 16, DF1, DF3, DF4, CF1, CF2, CF3, CF4, CH1, CH2, CH3, CH4, N1, N2 and N3 all expressed similar views that it was because of the indirect economic benefits of supressing the effectiveness of the credit-hire industry. DF1 felt that by maintaining the impression
that the industry was dishonest, and so making it harder for CHCs to settle claims, insurers would deliver improved profitability absent the ability to increase insurance premiums as suggested by Ericson. He said:

“part of this has been ... that since the formation of IFED, if you can get the Daily Mail behind the government and behind the insurance industry then you are going to create an environment where insurers have got the power to determine exactly how they play in the space and how they control the normal economic threats. The thing that confuses me is that ... there are bad guys out there who need to be stopped and brought to justice. I am not convinced that same perspective exists with insurers; I think they are motivated solely by their profit and loss.”

CH2 said:

“I would like to be able to say to an insurer, “OK; we’ve done these checks, this is the evidence we’ve got so let’s share it.

I’d like to allow registered access to the information so that we all share the same warnings and alerts and can deal with the challenges we face and prevent whoever it is, getting access to assets or value that he should not have access to ... but that won’t happen will it ... insurers have too much data which they don’t want us to have and they seem quite happy hanging us out to dry when they know we’ve inadvertently become involved in a dodgy claim that they have no intention of settling?”

N4 said:

“Everybody’s so paranoid about fraud that they just don’t help or share. I think the only person that helps is the fraudster who relies on that disorganisation from those paying the claims ... I can’t help thinking though that insurers like concealing their hand knowing the irrecoverable costs they are pushing into our side of the supply chain.”

Credit-hire companies – experience of fraud

So, what of fraud perpetrated against CHCs in circumstances where they become unwittingly deceived? There is no literature addressing the circumstances in which CHCs might be victims of fraud and there has been no discernible appetite by insurers, or IFED, to engage the credit-hire industry in the fight against it. After repeated requests for assistance, Detective Superintendent Woodall from the CLP declined to participate in the research. Further, in a business meeting with the Researcher\textsuperscript{24}, she indicated that IFED was not an available route for the credit-hire industry to

\textsuperscript{24} 8\textsuperscript{th} April 2015
pursue fraudsters although she did say CLP would be happy to take data to feed in to their intelligence systems through Action Fraud\textsuperscript{25}.

As well as a lack of literature, there is also no published data quantifying the levels of fraud against credit-hire companies. There is, however, evidence from individual CHCs of the police, including IFED, declining to investigate allegations of fraud where the complainant is a CHC (Finnegan, 2014). To resolve the information deficit, a cross-sectional survey was undertaken, to investigate outcomes from the perspective of the CHC or, if they sub-contracted the claim management process, their associated solicitor. The survey also aimed to gather some empirical data on the size of the motor insurance fraud problem to the credit-hire industry and, more specifically:

- the quantum of insurance fraud impacting the credit-hire sector;
- the relationship between insurers and CHCs in respect of allegations of fraud in cases where the insurer suspected an insurance claim submitted by the CHC was fraudulent and sought to reject it;
- the attitude of insurers towards the credit-hire sector;
- the relationship between the police and CHCs in respect of allegations of fraud where the hire company had been deceived by a client acting fraudulently and sought to report an offence; and
- the attitude of the credit-hire industry to the police and the impact, or perceived impact on the credit-hire industry, following the creation of IFED in 2011.

The survey was opened on 7\textsuperscript{th} March 2015 for twenty-one days with the final response received on the 24\textsuperscript{th} March 2015. The survey document appears at Appendix A and the responses to the survey questions are analysed below.

**Survey response - analysis**

From sixty invitations to participate, twenty-nine completed responses (48\%) were received. Nineteen further responses were ignored because they were incomplete or duplicated\textsuperscript{26}. An analysis of the respondent demographic appears in Table 4.1 below.

\textsuperscript{25} Action Fraud; a central point for reporting fraud (http://www.actionfraud.police.uk)

\textsuperscript{26} The duplications were identified by the IP address from which the survey responses were submitted and those that were incomplete were aborted too early in the survey to make the data of any value.
To assist in the data analysis, CHCs were asked to indicate the size of their business by reference to:

- turnover,
- size of fleet, and
- number of claims processed annually.

Three variables were selected because, like conventional car-hire companies, a CHC may operate a mix of vehicle types which, in the case of those operating in the prestige sector where the typical per diem rental rate for hire is high, can produce anomalies between reported turnover and the size of fleet operated or number of claims processed. Using a combination of the three chosen variables, the respondents were classified as either small, medium or large in size based on the divisions set out in Table 4.2. No analysis was carried out in respect of those five solicitors responding, effectively, as agents for those CHCs who sub-contracted their claim settlement work.

### Table 4.1: Respondent demographic by source

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<th>Respondent Demographic</th>
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<tr>
<td></td>
<td>Count</td>
<td>%</td>
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<td>Credit Hire Company (&quot;CHC&quot;)</td>
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<tr>
<td>Solicitor acting for a CHC</td>
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<td>17%</td>
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<td>Total</td>
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### Table 4.2: Respondent demographic by size

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</thead>
<tbody>
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<td></td>
<td>Value</td>
<td>Count</td>
<td>Value</td>
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<td>Annual turnover</td>
<td>&lt;£5m</td>
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<td>£5m - £20m</td>
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<tr>
<td>Size of rental fleet</td>
<td>&lt;500</td>
<td>15</td>
<td>501 - 2,000</td>
</tr>
<tr>
<td>Claims processed annually</td>
<td>&lt;5,000</td>
<td>15</td>
<td>5,001 - 20,000</td>
</tr>
</tbody>
</table>

By reference to the preponderance of small operators in the sector, the credit-hire industry is a relatively immature industry. The largest provider is Enterprise Rent a Car, a global operator that includes credit-hire turnover as a component of its total revenue but doesn’t publish any segmental analysis. In the period to July 2014 Enterprise reported UK turnover in excess of £500 million (2014).

The CHO represents the majority of survey respondents but the response rate in respect of the small number of companies who were not members of the CHO, but were invited to participate in the survey, was broadly similar. Responses were received from about 50% of invitations sent in
respect of those who were or were not members of the trade body. The respondents and whether they were members of the trade body is analysed in Table 4.3 below.

<table>
<thead>
<tr>
<th>CHO Member</th>
<th>Total</th>
<th>CHO by size</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>92%</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>8%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>100%</td>
<td>15</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.3: Respondents analysed by CHO membership

**Credit-hire experience of insurance fraud**

As previously outlined, CHCs can experience fraud in many ways. At its most simplistic, they may have been deceived into providing a hire car to a fraudster believing him to be a genuine accident victim when the accident was a staged or phantom accident and where the fraudster gains pecuniary advantage using the vehicle without payment or possibly by stealing the hire car. Alternatively, it may be that the CHC has acted in good faith in providing a hire car only to be alerted by the insurer against whom they seek to recover their hire charges that the claim is perceived by that insurer to be fraudulent. In fact, it may or may not transpire that the claim is fraudulent but the adoption of an immediate defensive stance by the insurer will have multiple effects:

- It might impact the expense the hire company incurs by reference to the time taken to fully investigate the claim, obtain evidence and litigate in order to obtain a settlement; or
- to avoid these potential additional costs, the CHC may terminate the hire writing off any recorded charges and recover their hire vehicle.

The chart at Figure 4.2 below illustrates the extent to which CHCs report having experienced claims being rejected by insurers because of allegations of fraud. All medium and large CHCs reported having experienced rejection and most small companies concurred.
Figure 4.2: Do insurers reject claims by alleging fraud

Whilst insurers choosing to allege fraud doesn’t seem controversial, especially if fraud is as endemic as the ABI suggests, the point at which they choose to notify the CHC of a potential fraud possibly is. A CHC will typically hire a car to an accident victim for a period up to three weeks whilst their own vehicle is repaired. Depending on the hire car, the rental income generated per transaction can range between £300 and £2,500 and the hire car will have a value of between £8,000 and £150,000. The CHC is at risk from the prospect of not recovering their revenue and from the expensive asset being damaged or stolen during the period their client’s car is being repaired. The point at which an insurer advances any allegation of potential fraud, therefore, could be critical to the avoidance of any loss by the hire company if an allegation has merit.

Comments from interviewees post completion of the survey emphasised the significance of the timing of notification. CH3 said:

“One of the things we experience is that we put a car on hire and then, at some stage, an insurer will allege fraud but their handler says, ‘we can’t deal with you or talk about the claim because it’s been passed to our fraud team’... we used to say ‘if the insurer says it’s fraud, then it must be fraud’ and so we’re stuffed, won’t make a recovery and we wrote it off.

We got a bit more assertive about it over time and were surprised to see that insurers would back down and we started to get these claims settled. It’s an easy word to use if you are an insurer isn’t it? Say ‘fraud’ and everyone just backs away for fear of being accused of being involved.”

When asked if he considered it might be a tactical ruse to avoid paying claims he replied:
“Possibly … I am not convinced they are that intelligent but it may be. Our industry is relatively young, insurers have had to face with paying hire charges they probably would rather not pay and so it may be just a tactic or part of a plan to make it harder for businesses like ours to survive. You’d think they might have learnt how to communicate more intelligently … when I am talking to our recoveries department, if they are trying to settle bigger files above £5,000 that alleging fraud is almost a reflex reaction – ‘we can’t pay because we are investigating and I can’t tell you what or why’”.

CH2, when asked when insurers would typically notify her about a fraud allegation responded:

“Always after you’ve invoiced … That’s the unbelievably frustrating thing because if you have a claim referred to the insurer’s investigation department then, obviously, we could have an alert on the hire straight away and will seriously question whether we leave the client in hire. Likewise, if we are having conversations and they say there is information we have but we can’t talk to you about it then we will have a look at the claim more closely to see where we are but that refusal to say “well, this is why we’re investigating and we think you need to be careful as well” why can’t they do that when the failure to work together only benefits the fraudster and harms us all?”

The Director General of the CHO said:

“…it’s a horrible virtual circle. The insurers have more data than we do on fraud … You then get the issue about whether that data is on known fraud or suspected fraud, which is inevitable. It regularly happens where we would be unaware of the data that might attach to an individual when we put them in a car. And five months later, when we’re still chasing payment, we’re told, ‘we’re not paying it because we think it’s fraudulent, because of undisclosed reasons’. And our members just don’t get paid.

The co-operation between us and insurance companies is poor. I understand some of the issues why they can’t data share but we’ve been talking to insurers for four years about improving our data sharing, and nothing’s happened; our members are the only losers and the fraudster wins every time.”

Whilst those responses might have been anticipated some insurers agreed. I4 commented:

“…if I had a frustration it would be the credit-hire industry sits on data, our industry sits on data, the claimant law firm community sits on data and I hear a lot of people in the claimant law firm community are quite perturbed about how much it’s hurting them; they waste large amounts of money dealing with dishonest clients. We should all be saying, well, can’t we just have something we all feed into and we all benefit from? And there’d be a lot of people saying that couldn’t happen, I’m in the camp where it should happen, you know, we just need to find a way of doing it. “

Reverting to the survey, the analysis revealed that insurers communicated most allegations of fraud to the CHC after or near the end of the hire period. At this point, assuming the hire car had not been stolen, the CHC will have incurred the costs and expense of providing their service and, if the claim was fraudulent, would suffer the greatest revenue loss. Only one small CHC respondent reported insurers having provided full disclosure at the start of the hire period at which point they
could have managed their risk of exposure accordingly. The chart at Figure 4.3 below indicates the respondent’s experience of this phenomenon.

![Figure 4.3: At what point do insurers communicate allegations of fraud?](chart)

**Figure 4.3: At what point do insurers first allege fraud**

It is noteworthy that in less than 20% of claims where insurers had originally alleged fraud was the allegation pursued by them or the claim proven to be fraudulent.

In addition, most respondents reported difficulty in engaging with insurers to share intelligence to help reduce the incidence of fraud. The responses are summarised in Figure 4.4 below and indicated that most small, medium and large credit-hire companies disagreed or strongly disagreed with the assertion that insurers engaged adequately to reduce the incidence of fraud.

![Figure 4.4: perception of intelligence sharing by insurers](chart)
In terms of the frequency at which insurers raised allegations of fraud in claims managed by CHC’s there were a majority of small, medium and large companies that reported the incident rate had increased or stayed the same. When so few allegations are pursued or proven, the consistency in terms of the allegations being notified suggests either overuse of the mechanism or the selection for the allegations on the same volume of claims being driven by some other operational metric e.g. the likely size of the claim based on the vehicle hired, the postcode location of the claimant or the identity of the CHC, as a means of impacting the operational efficiency of the CHC in the expectation that they might abandon the claim. The analysis appears in the chart at Figure 4.5 below.

![Chart showing change in incidence of insurer fraud allegations](chart)

**Figure 4.5: Change in incidence of insurer fraud allegations**

In terms of losses experienced by the credit-hire industry, all four of the large companies surveyed, 67% of medium CHCs and 62% of smaller CHCs reported having suffered a loss having fallen victim to a fraudulent event (see Figure 4.6 below).
The average fraud loss reported varied between small, medium and large CHCs with the analysis set out in Table 4.4 below. The mean for all respondents was £5,768.16 per incident with medium size CHCs reporting a far higher mean loss of £12,500 and larger companies a smaller loss of £2,690.48. It may be that the scale at which larger companies operate allow for stronger counter fraud measures to be implemented whilst smaller companies have a smaller fleet and might impose greater control over the quality of the hirer or simply be less exposed to fraud based on their smaller market share; the variance, however, may merit further investigation.

<table>
<thead>
<tr>
<th>CHC by Size</th>
<th>All</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average fraud value per incident</td>
<td>£5,768.16</td>
<td>£4,397.85</td>
<td>£12,500.00</td>
<td>£2,690.48</td>
</tr>
</tbody>
</table>

Table 4.4: Average fraud loss per incident

Credit-hire engagement with the police

The Police are not regarded by CHCs as an effective ally in the fight against fraud. CH3 said:

“We do report things but I don’t have that much faith in the police. In the end, we just have to give up. The police are not interested in helping...”

Commenting on his impression of the level of engagement by both IFED and local forces with his members, the CHO Director General said:

“I’m tempted to use the words defensive and frictional although it’s limited interaction, at this stage. One of the reasons for that is that I can only talk to IFED about individual circumstances that my members report back to me. But where I have seen examples of a
member having definitive, even video recorded evidence, of an individual engaging in systematic and repetitive fraud and... where those members have reported this to IFED the responses have been “we only investigate fraud reported by insurance companies” which, is a little bit shocking, to think that if you don’t directly fund that particular police activity, they won’t investigate it.”

Ten respondents confirmed having been victims of frauds and having approached the police to report the offences. Table 4.5 below identifies that eight of ten confirmed the police accepted a report of at least ‘some’ of the incidents they reported and in the case of two out of ten CHCs there was an arrest and prosecution.

<table>
<thead>
<tr>
<th>have you had a fraud loss?</th>
<th>Total</th>
<th>small</th>
<th>medium</th>
<th>large</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>no</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>if so, were the police willing to accept your report of an offence and investigate it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes, for all reported offences</td>
</tr>
<tr>
<td>not for all reported offences</td>
</tr>
<tr>
<td>no</td>
</tr>
<tr>
<td>offences not reported</td>
</tr>
<tr>
<td>total</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>how often did an arrest and prosecution ensued?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

Table 4.5: CHC engagement with the police post fraud allegation

Those respondents, who had suffered a loss through fraud but were unable to persuade the police to investigate were asked to identify as many reasons that they were given for the refusal from a list of options. Table 4.6 lists the options and indicates the number of references made to each option.

<table>
<thead>
<tr>
<th>why could you not report to the police?</th>
</tr>
</thead>
<tbody>
<tr>
<td>civil matter - sue the hirer</td>
</tr>
<tr>
<td>claim on your insurance policy</td>
</tr>
<tr>
<td>no resource to investigate</td>
</tr>
<tr>
<td>referred me to IFED</td>
</tr>
<tr>
<td>referred offence to IFED who declined to act</td>
</tr>
<tr>
<td>insurance fraud is not a force priority</td>
</tr>
<tr>
<td>insufficient evidence to investigate</td>
</tr>
<tr>
<td>come back with more evidence</td>
</tr>
<tr>
<td>total</td>
</tr>
</tbody>
</table>

Table 4.6: Reasons given by police for refusing to investigate a fraud

The most common response was that insurance fraud was not a force priority followed by a lack of available resources and a suggestion that the complainant should contact IFED. The chart at
Figure 4.7 presents the same results graphically and show the similarity of responses for small medium and large companies save that one smaller CHC reported a rejection due to insufficient evidence. In addition, five smaller respondents said they did not know why the police declined to act.

![Figure 4.7: Reasons given by police for refusing to investigate a fraud](image)

Turning to those incidents where an attempt was made by the CHC to report a fraud, and the police refused to even record the offence, respondents were given a similar list of response options to choose from. The next table, 4.7, summarises the responses and the chart at Figure 4.8 presents the same results graphically.

<table>
<thead>
<tr>
<th>Why would the police not record the crime?</th>
<th>Total</th>
<th>CHC by Size</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mentions</td>
<td>Small</td>
</tr>
<tr>
<td>Civil matter - sue the hire</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Claim on your insurance policy</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>No resource to investigate</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Referred me to IFED</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Referred to IFED who declined to act</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Insurance fraud is not a force priority</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Insufficient evidence to investigate</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Come back with more evidence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Record crime for insurance purposes</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Offence not in force area</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4.7: Reasons given by police for refusing to record a fraud
Figure 4.8: Reasons given by police for refusing to record a fraud

When asked if it had become harder for CHCs to engage the police to investigate fraudulent claims since the formation of IFED the majority thought it had although with less conviction than the response to earlier questions about the propensity for insurers to allege fraud.

20% of small CHCs, 60% of medium and 75% of the large companies responded that it had become harder for the credit-hire industry to engage the police since the formation of IFED. The bias towards larger companies expressing a more critical view may be a function of their greater exposure to fraud due to their size and the number of transactions handled annually and their relative maturity and commitment to best practice in eliminating risk. Based on publicly available accounting records, the largest four suppliers in the sector accounted for more than 80% of the industry’s annual turnover. The results are presented at Figure 4.9 below.
CF1, a former detective, outlined how his perspective had altered since retirement when comparing how he would have reacted to an allegation of fraud by a CHC compared with the experience he now has of engaging with the police:

“I think back then, first your complaint would have been recorded as a crime … we’d have understood, yes, it is a crime as opposed to civil debt. It would have been analysed and investigated by the person taking the report and then it would have been allocated to an investigator. I think the difference, and my experience reinforces this, is that if the same crime were reported today, I’m not confident that, firstly, it would be recorded and, secondly, that it would be investigated. I base that on a conversation I’ve had with serving police officers where we’ve been told to report things to Action Fraud but then I’ve also been told that West Midlands have a policy of filing more than 60% of reported frauds that come to them for action from Action Fraud”

As well as the perception that it has become harder to engage the police, most CHCs responding to the survey expressed a view that the ABI relationship with IFED had helped promote a negative view of the credit-hire industry (see Figure 4.10 below).
Most respondents also felt that the relationship between the ABI had created a situation where insurers benefitted to the detriment of the credit-hire industry. The responses are represented graphically in the chart at Figure 4.11.

One of the issues explored in the research is whether the perceived detriment applies to other non-insurer victims of fraud, specifically bus companies like Stagecoach and First Group and self-insured corporate entities operating large fleets. N4 said in interview:

“My experience is that the large corporate companies I deal with are not able to get anything reported into IFED because they don’t contribute to it so they won’t have their cases accepted. They don’t generally report it to the police because they know after long
years of experience that the police just aren’t interested. I think it’s probably no longer a frustration; it’s probably something they’ve come to accept.”

N1, head of claims for a transportation company, gave a similar response. He said:

“... we, and our insurer, have never been able to get IFED to look at anything big that we have felt should involve the police. The feedback from Travellers has been that the loss needs to be well into six figures before we can get them interested and because our excess is at that level anyway, it’s doubtful we’ll ever reach their claim threshold.”

There are two case studies featured in the next chapter which explore in more depth the experiences of these two sector respondents as non-insurer victims of fraud.

**Conclusion from survey data**

It had been an aim of the survey to quantify the extent of fraud being suffered by the credit-hire industry because of the absence of published research on the subject. However, the nature of the questions, deliberately framed to protect respondents from having to disclose sensitive information, impacted on the ability to obtain granular data which might have allowed the Researcher to quantify the scale of the fraud problem. In addition, one of the larger CHCs, Helphire, declined to complete the survey at all, their Chief Executive unwilling to disclose what he felt was commercial and potentially market sensitive information. That aside, just under 50% of the population responded to the survey from a mix of small, medium and large companies and the results were, therefore, compelling and of value as a basis for identifying the issues to be explored in the subsequent qualitative interviews.

The results indicated a fragile relationship between insurers and CHCs in cases where the insurer alleged a claim submitted by the CHC was fraudulent, often failed to disclose why and occasionally sought to reject it. The survey also identified a perceived resistance from insurers to communicate and share intelligence on fraud issues. It also highlighted a disconnected relationship between the police and the credit-hire industry and CHCs in respect of their willingness to accept reports of fraud allegations where the credit-hire company had been deceived by a client acting fraudulently although in a number of cases there was evidence of investigations being carried out. A lack of meaningful communication between CHCs, the ABI, insurers, the police and IFED was the deficiency which, if resolved, might improve the prospects for identifying and prosecuting those engaged in organised crime, a theme that emerged through some of the case studies and qualitative interviews.
Conclusions

This chapter identified that the credit-hire industry evolved to fill a demand for consumers arising from a disengaged insurance industry over a period of thirty years. It detailed the nature of the services that CHCs provide for consumers and exposed a relationship between the industry and insurers that the judiciary has likened to a ‘secular war’. Examples were detailed of solicitors using evolving counter-fraud strategies to assist insurers reduce the cost of credit-hire claims, as part of their overall claims cost, in an environment where, ironically, the insurance industry benefits from an annual credit-hire commissions of £100 million but also shares the £600 million cost of credit-hire. The ambiguity of the term ‘credit-hire fraud’ was explored and the emerging regulatory interest in the sector was noted with the TSC and CMA both encouraged to review the cost of private motor insurance because of insurer concerns about profitability. The chapter also provided commentary on the limited empirical data available on the quantum of fraud impacting the credit-hire industry and whilst the output from a cross-sectional survey did not advance knowledge in respect of quantum, it did identify tensions between CHCs and insurers and the police; insurers lacked any appetite to collaborate to reduce the incidence of fraud and the police were reluctant to record or investigate fraud reported by CHCs and more reluctant post the creation of IFED. The chapter also offered two case studies that highlighted the extent to which CHCs are targeted by, and are victims of, insurance fraudsters, the advantages of collaboration and the pivotal role that a CHC can play in helping to expose organised criminal activity using intelligent ‘real-time’ telematics data.
Chapter 5 Other Non-Insurer Victims of Fraud

Introduction

The previous chapter looked at the credit-hire sector and the perception CHCs had of their exposure, as victim, to offences involving insurance fraud. Two cases studies contrasted the experience of CHCs impacted by fraud before and after the creation of IFED. This chapter explores the position for other non-insurer victims of fraud, focusing on the experiences and approach of bus companies and businesses operating large vehicle fleets where the insurance risk is largely self-insured. Typically, those entities find it economically beneficial to retain responsibility for a high policy excess and to deal with the cost of claims brought against them up to the amount of the excess without the indemnifying background insurer’s involvement. In one case the excess was £5 million. The chapter includes the outcomes from the semi-structured interviews with participants from both sectors, and desktop analysis supporting two cases studies using the experience of bus companies and large fleet operators. The chapter also relates the perspective of a counter-fraud specialist who has identified links between those offenders targeting CHCs and car-hire companies with serious organised criminal activity. A further case study then chronicles the events surrounding a fraud committed against a CHC which involved the acquisition of a high-value vehicle as part of an uninsured loss claim which was reported to but rejected for investigation by the MET, IFED and by NAVCIS but which then became the focal point of an international investigation into an organised crime ring stealing and exporting high value prestige vehicles to East Africa. The case study includes a summary of the de-brief at the end of the investigation.

Self-insured and co-insured fleets

In this thesis, the term ‘self-insured’ defines those entities that behave as an insurer by taking the full economic risk of insuring a motor vehicle together with those organisations that share the initial economic risk with their insurer by settling claims brought against them up to a specified excess limit before expecting a background insurer to pay claims beyond that amount. Whilst an alternative to conventional motor insurance, self-insuring requires policyholders to assume skills and competencies normally provided by an insurer. As a minimum, and before assuming the risk, estimating the potential ‘per claim’ cost and the probability of their employee being involved in an accident relative to the age, history and driving experience of all of those people likely to drive as well as the annual mileage covered and the claims history in prior years. To be viable, the expected costs of self-insuring need to be lower than the cost of conventional insurance arrangements where
an insurer will price and manage the risk and deal with the expense of any claims. Self-insurers pay something and, in some cases, everything, for every collision and accepting that open-ended risk requires a cultural change to risk and for line managers, and those settling claims, to focus the business on the cost of collisions and preventing them (“Insurance: 10 fleet questions answered,” 2010). CH4 confirmed his company’s excess level to be £25,000 and N1 and N2 confirmed theirs to be £100,000. N4, a solicitor acting for larger corporate fleet operators, reported several of his clients were “effectively self-insured but carried ‘long-stop’ cover with a background insurer in the event of a catastrophic claim”. He reported clients often carrying excesses as high as £1 million and, in one case, £5 million. These self-insurance arrangements mean that many commercial entities are exposed to the same financial risks arising from motor claims as an insurer might be and so, logically, they are as exposed to the risk and cost of fraudulent claims.

Case Study – UK bus sector

The UK bus sector is a mainstay of local and regional transportation. In 2016, of 38.4 million UK registered vehicles, 167,000 were registered as buses and coaches (Department for Transport, 2017a) with just 50,000 operating as Public Service Vehicles in the local bus sector (Department for Transport, 2016, p. 197). Whilst a small proportion of the 38.4 million vehicles on the road in 2016, those 50,000 vehicles facilitated 5.04 billion passenger journeys travelling over 1.5 billion miles on local buses and generated annual revenues, inclusive of government support, of c.£5.6 billion (ibid. pp. 35, 184, 189).

Most bus services, and several rail franchises, are run by regional subsidiaries of a few large transportation concerns including Arriva, FirstGroup, Go-Ahead, National Express and Stagecoach. In a report prepared for the DFT, KPMG (2016) identified that these businesses focus on profit and revenue growth with the primary objective of managing operating costs including “pension, fuel, accident claim and bid costs.” Although they recognised accident claims impacted on operating costs, the authors were silent on quantum (bid. P.58). Analysing the published accounts reveals that Stagecoach (2015, p. 12) monitor, as a KPI, the number of blameworthy accidents per million miles; in 2015 it was 19.7 for regional operators and 28.5 for operations in London with an increasing number of accidents, mostly from low speed manoeuvring incidents, attributed to a larger proportion of newer and less experienced drivers. No mention is made of the cost or number of accidents attributable to fraud or to any loss arising as a result. First Group (2016) are silent about accident rates, cost and experience of fraud in their bus network and Arriva, owned by Deutsche Bahn, publish nothing of assistance to the UK market. Go-Ahead (2016, p. 26) monitor the number of bus accidents resulting in a notification being made to a claims handler for every
million miles they operate but, unlike Stagecoach, their KPI includes cases where they are both at-fault and not at-fault, preventing any comparison between the two operators. Go-Ahead reported 37.3 notifications per million miles and claimed bus accidents overall have reduced since 2011 despite their involvement in not at-fault accidents having increased. National Express (2015, p. 44) offer no analysis in their annual report save that the number of accidents have reduced and they have invested in safety and driver-aid technology, demonstrating their commitment to driving up safety standards. The DFT (2016, p. 34) reported that, in 2016, there were 117 recorded passenger casualties for every billion-passenger kilometres travelled on local buses and a total of 39 billion-passenger kilometres travelled suggesting the number of accident casualties at just 4,563.

N1 is the head of claims for a large bus operator with a “significant six-figure” policy excess making him responsible for settling most of the claims incurred. He identified that fraud faced by bus companies:

- involves accidents,
- is largely committed by opportunists,
- can take a variety of different forms, and
- is always difficult to repudiate.

He identified several challenges, considered below, where he described feeling increasingly powerless to respond and “abandoned by the police and the justice system” in obtaining a remedy against offenders. N1 had given up reporting offences to the police “a long time ago” because “we don’t ever have the cases they are interested in.” Asked about IFED, he said that he had little support from his background insurer, an IFED funder, because “our insurer never sustains a loss - we never reach the claim threshold (the limit of our six-figure excess)” and so the insurer has never been persuaded to make a referral.

Challenges faced

N1 was clear about the commercial imperative of his company needing “to carry a lot of people to pay for the claims we get even before dealing with the loss from fraud”. He reported:

- a limited opportunity to mitigate the fraud risk;
- a disinclination for the police to investigate at a time when the incidence of fraudulent claims was rising; and
- with limited resource, and no easy basis for co-operation across the sector, decreasing opportunities to avoid fraudulent claims.
He identified three species of fraudulent threat characterising the major challenges facing bus operators:

**Threat 1: Other road users and staged accidents**

As with the insurance sector, N1 saw motorists involved in staged accidents as the biggest challenge with cars pulling in front of buses and causing a collision by braking sharply the principal modus operandii and little the bus operator could do to address it:

“... we have CCTV footage and you can see somebody has pulled in front of the bus, but that doesn’t prove it’s fraudulent. You can sometimes get rid of the claim if you can see his brake lights come on before the collision but ... these claims are not valuable enough individually to pursue them as a fraud.”

He felt the courts were unsupportive of bus operators if civil litigation ensued. The claimant’s solicitor would typically refuse to accept the bus company’s video footage and characterise it as only one inconclusive part of the story:

“|go around all the bus companies and I say to people ‘we don’t really have a justice system, we have a system that rules in favour of who the judge prefers on the day, depending on what his mood is.’ And, that’s the reality of what we face ... Sometimes, it’s easier and cheaper to just settle the claim.”

He confirmed that staged accidents are an increasing challenge because “the same individual might do it five times a week in different parts of the country – a different bus company every day.” Pointing to the fact that his company was a very lean business with limited counter-fraud resources and a very large and dislocated geographical footprint he said that “unlike insurers, we wouldn’t even try to exchange information with other bus companies where we suspect a staged accident; there’s just too much work involved and it would be too difficult to marry everything up.”

In fact, N1 was ambivalent about data sharing contrasting the mixed results he might get from using CUE with the unfiltered and large volume of alerts he saw from the IFB:

“Every claim goes to the Compensation Recovery Unit to get what benefits have been paid. We then get feedback from CUE to say, ‘this person has had five claims, here are the insurers, and here are the reference numbers. The address that they live at has maybe had 15 claims, and here are these’, and you would then consider them, and try to identify if the

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27 CUE, the Claims and Underwriting Exchange, a central database of incidents reported to insurers which may or may not have given rise to a claim and intended to make it harder for people to commit claims fraud or misrepresent claims history.
previous claims are linked to your claim ... if you had a whiplash claim, for example, a day after Arriva had had one, you would then be saying, ‘well, the symptoms of the two must be so closely linked that, if they’re both genuine, we probably both should only pay half of the damage’. But, that’s possibly as good as it’s going to get.”

Despite having access to the data held by IFB he was critical of its utility to him:

“I find it very difficult to keep up. The number of alerts that you get ... trying to get through them is almost impossible. Sometimes an insurer or a compensator, like us, will run through a claim until it gets to the end and they’ve successfully dealt with it, or successfully not dealt with it, I suppose ... and they’ll report it to the IFB. But some of the alerts are just cheat line calls, so ... members of the public will phone in and say, ‘my neighbour’s making a claim for such and such’. Those are a lot less reliable, somebody with a grudge ... there’s all kinds of reasons. A lot of the time they just end up being nothing ...”

Contrasting N1’s experience, First Group have reported success in several staged crash investigations although a review of those reports shows that the losses arising from those claims were incurred by insurers, and not by First Group. That may have triggered the police intervention despite media reports giving an impression that First Group had triggered the police response. One case involved a Sheffield-based accident claims company run by Offenders 3 and 4 who deliberately crashed into a bus carrying 26 passengers as part of a £500,000 crash for cash scam (Edwards, 2013). Investigations following the crash led to a wider inquiry involving a further 10 incidents in Halifax, Sheffield and Rotherham which exposed many fraudulent claims against several insurance companies. DC Mark Wooton, from South Yorkshire Police (ibid.) said

“The fraud involved false claims for personal injury, vehicle damage, over-inflated recovery and storage costs, together with extortionate and false claims for hire vehicles ... involving a professionally-planned, highly-organised group of individuals” (including the bus driver) who set out to commit fraud by making deliberate false claims and pocketing the money for themselves.”

Offenders 3 and 4 were sent to prison for four and a half and three and a half years respectively and the bus driver received a 20-month custodial sentence.

Another First Group case involved a £1.3 million crash for cash fraud where the mastermind (“Offender 5”), was jailed for six and a half years along with fourteen co-conspirators who received sentences up to three years’ (Holmes, 2015a). According to the trial judge:

“this was a carefully organised and skilfully executed fraud. In order to get more bang for their buck, the conspirators packed a scheduled bus with all their friends and relations and then a car gently collides with the bus. There would be little or no damage to the car but multiple bus passengers would, in the coming days, develop whiplash, would go to see a friendly claim manager who would refer them to a solicitor who in turn would send them
for a medical examination. The doctor would be told that the crash caused them to jolt their necks resulting in pain.”

Despite the incidents, all involving scenarios in which a car would collide with the side of a First Group bus, the true victims were the respective insurers of the cars in each collision, rather than First Group. A total of 218 fraudulent personal injury claims were submitted when, in each case, the driver of the car causing the collision would admit full liability leaving the passengers on each bus to submit personal injury claims to his motor insurer. (Holmes, 2015b).

**Threat 2: Passenger demographic**

Another threat reported by N1 was the challenge of regional hotspots and the demographic from which claimants are drawn:

“Liverpool, the Preston area, Yorkshire can all be quite bad … A lot of the time it’s where there has been a heavily unionised industry, you’ve got the economic desolation and the entitlement mentality … people who are union members, or were union members, have the backing of some historically related firms of solicitors.”

He specifically references Thompsons Solicitors who are acknowledged elsewhere in this research as staunch critics of the ABI and government lobbyists:

“Thompsons are actually quite a good firm … but … sometimes the claims that they’re bringing are only being brought because there’s a union backing, and they’re rubbish; the only way to get rid of them is to pay them something to go away. And, that’s just the way life is…”

N1 identified a number of claims scenarios which he believed were driven by the nature of the local population.

**Whiplash claims**

“We had one incident where we had our bus collide with a vehicle, an Arriva bus in Liverpool. The damage to our vehicle was a broken windscreen wiper on the front of the bus and the damage to the Arriva vehicle was negligible, pretty much nothing. Well, the Arriva driver claimed for whiplash … and we then had 32 passengers between the two vehicles who have made claims for varying degrees of injury …

We gave up with the police and decided to reject the claims and then defend the civil litigation that followed. Our defence was, ‘we just don’t accept these people were injured’. We didn’t go as far as to say it’s fraud, but we almost got there; the difficulty is there are reputational risks of alleging fraud and it not being proved.

It ended up that we had 16 or 17 cases that continued to trial, including the Arriva driver … they were all very low value cases, but what we wanted to do was call each claimant as a witness to prove their injuries … the judge wouldn’t allow it. Instead, we ended up with eight conjoined cases and the judge refusing to allow us to join each claimant individually to cross
examine them all over their injury. His reasoning was, ‘they say they have been injured, there is a medical report from an expert, what reason would the claimants have to lie?’ Of course, it’s blindingly obvious; they’re going to get some money if you rule in their favour and we don’t dispute that they’re absolutely entitled to money if they’ve been injured. The issue was we didn’t believe that they had actually been injured and so we wanted to put them to proof but he wouldn’t allow it.

So, damages on all the cases that were settled was £27,000 (not enough to exceed our excess) but third-party costs paid to date are £250,000 and we have yet to receive cost schedules from about half a dozen. Our estimate of what we will pay ... a further £203,000, plus our own solicitor costs ... these are cases that should have been thrown out; we can’t see how these 32 people would have been injured in such a low velocity impact where the only damage to both buses was a windscreen wiper. The same solicitor acted for several of them, and once they had the one, you know, once they knew that one had settled, they were never going to give up on the rest.”

N1’s belief that the civil justice system let him down was telling especially when compared with the reports from First Group. The insurers in that case had managed to enlist the support of the police to pursue a criminal investigation for incidents that centred on First Group buses but, and N1 pointed this out, it was the insurers of the cars that had driven in to each bus who were the force behind the criminal investigations and the bus company were just used to add colour to the headline.

Delayed claims for other injuries

Whiplash is not, according to N1, the only challenge around opportunistic suspicious claims:

“What we see quite a lot is the guy who has been on our bus, the driver has braked, the passenger hasn’t said anything to the driver, and the next day the claim comes ... the driver knows nothing about it [and] we take it to trial. The claimant will say, a, b, c, happened and I fell over and I broke my wrist, or whatever it was. Our driver says, ‘I don’t know anything about it’.

We’ll lose that; we can’t risk taking it to trial because we’ll lose it and pay additional costs. So, initially, we’ll resist it and make it hard work for the claimant. ‘Have you got your bus ticket?’ to which he’ll say, ‘no, it was a multi journey ticket’. So, we’ll ask him for a photograph of himself so we can check the CCTV to make sure he was on the bus – you’d be surprised how many people claim even when they weren’t. We just try and make life harder, and some of them will go away, but if they’re persistent we will pay them simply because we know that we won’t be able to avoid paying them ... it’s probably cheaper than taking them to trial and losing and, of course, because it’s opportunistic, the police are not interested.”

Ticket fraud

Another emerging fraud risk is the use of forged multi-journey tickets. As bus companies retired conductors and restricted the driver’s role to driving, multi-journey tickets, as distinct from electronic payment cards like Oyster, were introduced. In 2010, Offenders 6 and 7 were jailed for
48 weeks each (suspended for two years) having created hundreds of forged bus tickets to sell on at knockdown prices. Offender 6 hatched the plot with his IT student stepson to create the fake bus tickets at their home in Newcastle-upon-Tyne. Prosecutors said the fraud could have cost bus company Stagecoach up to £168,000 after the Court heard the pair procured 17,000 individual blank tickets and then doctored them on a computer (Willey, 2010). N1 explained that:

“because the sector is moving to multi-journey tickets, more than getting on the bus and asking for a single into town … people have been going around pubs in some of the bigger cities, with 50 copied mega bus or mega rider tickets … we have revenue inspectors carrying out checks but that usually only catches the individual who bought the ticket cheap thinking it was legitimate and not the fraudster who sold it.”

First Group has collaborated with South Yorkshire police specifically targeting fare evasion in an operation following an earlier arrest for possession of articles used in the manufacture of forged bus tickets. Revenue Inspectors, supported by Special Constables, conducted a week of action. They checked 362 buses, issued 34 penalty tickets and seized six forged bus tickets. In addition, special constables conducted 27 stop searches as part of the operation, issued two fixed penalty tickets for drugs offences, seized six forged bus tickets in connection with the ongoing police investigation, and ejected one passenger for drinking alcohol on a bus whilst the Revenue Inspectors revoked eight mobility passes being used by other people, identified 107 non-payment/ticket irregularities and issued 32 Standard Penalty Fares. (South Yorkshire Police, 2015). In a potentially useful response to the threat posed by opportunistic fraudsters, First Group (South Yorkshire Passenger Transport, 2008) reported that “two of our drivers, who have gone through South Yorkshire Police's training, provide support for the Revenue Protection team in the form of Special Police Officers.”

The initiative to promote an integrated approach between the South Yorkshire Passenger Transport Executive and South Yorkshire Police originated in 2008 under the banner of Employee Supported Policing intended to improve safety and security on the transport network and deliver visible benefits for customers, staff and the wider community. Through increased visible police on and around the transport network, it was anticipated that passenger perception would improve and the levels of crime and anti-social behaviour reduce. Under the scheme, paid time-off was granted to support 50% of the time required by employees for the initial police training and 50% of the minimum number of shifts which must be undertaken per year.

It might appear that First Group are more fortunate or more proactive than N1’s employer, that they have a better relationship with the police or just that they have suffered higher levels of incursion and have used their success in court to drive better media coverage (or any combination of these factors). Unfortunately, First Group declined to participate further in the research. The
Employee Supported policing initiative did appear unique to First Group and when asked whether he thought it might pre-dispose the police to co-operate more in the investigation of fraud made by bus companies, N1 was less certain of whether it was a case of insurance companies driving the police interest and the bus company making the headlines:

“We have had our fingers burnt ... I think fingers burnt is probably too strong, but we’ve attempted to identify cases to the police in the past, and got nowhere; it’s pointless. It’s a waste of time putting the information together and hoping the police will pick it up knowing they probably won’t; it’s time that could be spent doing something else.”

Regarding strategy, he said:

“... we’d far rather just fight the claims that we get than trying to pursue the claimant for a prosecution ... if we make their life sufficiently difficult so that they’ve either given up the claim or, if they’ve been claiming £50,000 and they’ve only gotten £1,000, or whatever, then we’ve done our job. And, in future, they should think twice about doing it again to us which is as good a sanction as we think we’re going to get ...”

**Threat 3: The Bus Driver**

The bus driver played a role in the First Group case involving Offender 4 in Sheffield and N1 identified the role of the driver as a potential fraud threat:

“We had one case where our bus driver ... he was working for us in Manchester, but he’d worked for First in Bradford ... he had an incident where he collided with the rear of a car and, initially, we never really thought an awful lot about it. Then, we did the CUE check and we identified that the people that were claiming all lived round about where he lived in Bradford. He was driving a route in Manchester and we thought this is a bit odd ... we dug into it a bit and discovered he’d been sacked by First Group and he’d had two or three similar incidents there, where all the people lived in a block round about where he lived. And, we thought, this just can’t be right.

We did a full investigation, packaged it all up and then sent it off to the Police who said, ‘it might look a bit iffy, but we don’t think there’s evidence of any wrongdoing here; what you have is circumstantial at best and coincidental at worst.’ They just weren’t interested ... it left a sour taste and, after that, we got a bit disillusioned.”

N1 narrated details of another case involving a driver who had claimed damages in excess of £100,000 alleging negligence against his employer after tripping on some rubbish left on the bus by another driver. Since the claim is ongoing it would be inappropriate to publish the detail but N1 did volunteer that there was an increasing investigative focus on the potential role of the driver in accident fraud.
Failing to Mitigate

Whilst N1 provided a helpful account of the challenges faced by the sector it was clear the strategy for mitigating against the risk was not part of a uniform cross-sectoral approach and, in some respects, was typified by capitulation rather than mitigation. It may be that, save for the intelligence circulated by CUE, the nature of the incursion is too sporadic to control where the fraud

- is often opportunistic;
- involves no pre-existing relationship with the claimant;
- is targeted against geographically disconnected regional bus depots;
- may involve collusion between fraudster and driver;
- is not met by any integrated intelligence strategy;
- unlike accidents involving two separately insured cars where fraud is suspected, there is no counter party with aligned interests; and
- One off acts of opportunistic fraud are very difficult to identify and trace.

It was noted that, despite N1 being a self-insured entity for most claims, he defined himself as a compensator. He was clear about the lack of sector co-operation on fraud issues and opined that the collaboration between CHCs seemed stronger, better aligned and more productive. He attributed the different approach to the lack of geographical overlap amongst bus operators when each operator faces threats native to its own geographical market within which it has no competition from other suppliers. Market intelligence about individual threats has a local bias and was unlikely, he felt, to be replicated by those same offenders operating in different localities although that seems inconsistent with the risk of bus operators being victims of organised fraud. N1 also pointed out that most bus operators are publicly listed businesses facing challenges of governance, commercial confidentiality and compliance with competition regulation and so limiting the opportunity and motivation to share best practice. That view extended to sharing intelligence with insurers. He thought bus companies and insurers could “rub along OK” but was less supportive of the “prominence” of the IFB and IFED and the publicity that they generated and was unsupportive of the motivation behind the media noise:

“We shy away from that … our energy should be spent dealing with claims and, where we can avoid them, we should avoid them … I also think, all these programmes and stories … encourage people to say, ‘he got caught because he did this, this and this, I could do that and not get caught.’”
Reputational risk also figured high on N1’s agenda and was a barrier to mitigating some of the risk of fraud, something he felt would apply to his publicly listed peers. Alleging, but then failing to prove fraud, was very high risk:

“You don’t want the reputation that you plead fraud and then lose. You end up with the reputation that you will say fraud at the drop of a hat and the impact on our brand in local markets where we are almost monopoly suppliers…”

He also expressed concern about the prospects of success:

“The whole civil procedure regime is a bit of a lottery; who you have as a judge on the day, what sort of mood he is and where the court is based. Liverpool is probably not the best place … and if you do it once and fail then you make it harder the next time …”

In terms of reducing claims, legitimate and fraudulent, he felt that absent sector co-operation there was some commonality of approach emerging:

“As with all bus companies, we’ve invested in this telematics stuff, with the intention of making the ride smoother and avoiding harsh breaking, harsh acceleration, all that sort of thing … part of the reason is, obviously, so that the customer has a more comfortable ride, but if you don’t accelerate away from a stop quickly, and you don’t rev up to the traffic lights and then stand on the brakes, you’ll use less fuel. So, that’s a money saving thing. You would also imagine you would have less people falling about the bus if the driver knows his driving style is being monitored so it should save money on claims although that’s not been proven yet.”

Regarding the IFB he expressed frustration at the volume of alerts:

“I had the lady from IFB up the week before last … telling me about all these new initiatives; people taking information that’s come in and cross fertilising it to see where there’s links between them. That’s all great, but you then relate it back to what you’re doing, and the fact that someone has made a claim against me, and has also made a claim against Admiral, doesn’t mean that they’re doing anything wrong. It could mean they’re just unlucky … they could very well have had two accidents for which they need to make a claim. The fact people have had more than one claim may get your tentacles up but, that’s the best that you can say …”

In terms of IFED he said:

“we are responsible for providing over 1 billion bus journeys a year but don’t see IFED as part of our solution for identifying or prosecuting fraudsters … our insurers are happy to leave us with the problem whilst ever the loss is within our excess level. You asked the question whether they have affected our approach to fraud and the answer is probably ‘no’.”
Case Study – corporate fleet operators

Assessing the size of the self-insured fleet market is challenging although it is likely to involve business users. In December 2016, there were 31.8 million motor cars on the DVLA register (Department for Transport, 2017a), 9% (c. 2.8m) of which were company registered (Department for Transport, 2017b). In addition, there were a further 3.9 million light commercial vehicles registered of which 47.1% (c. 1.8m) were company registered (Department for Transport, 2017c) and 0.5 million heavy goods vehicles (Department for Transport, 2017d) which are probably all company registered and bring the total company registered vehicle population to in excess of 9 million vehicles. Sadly, the population size doesn’t assist in quantifying the number of businesses operating those 9 million company registered vehicles or the number that might self-insure their vehicle fleet but while the size of the self-insured market may be enlightening, it was not an objective of the research. Nonetheless, the two sectoral case studies which did form part of the research highlight the experiences of two different sectors each with significant and declared exposure to self-insured risks. With 9 million cars, light commercial and heavy goods vehicles registered to companies, a propensity for some corporate fleet operators to self-insure is high.

N4 is a solicitor managing claims for clients that include car-hire companies and large publicly owned businesses, as well as a number of government agencies. Some of his clients carry policy excesses of £1 million and one has an excess of £5 million before a background insurer becomes financially liable. Corporate fleets can be very active and N4 referenced a client operating 48,000 vehicles “covering over 100 million miles a year”. His exposure to road accidents embraces “everything from the driver phoning up at the roadside and saying, ‘I’ve had an accident’ to the capture element28 and the resultant claim that goes right up to any level deductible … effectively we do everything for the vast majority of our clients including pre and post repair.” It also involves the identification, investigation, rebuttal and potential prosecution of fraudulent claims:

“it’s something we’ve always done. One of our best results came from one of the handlers. A driver made a comment that the third party was having a laugh at the scene of the accident, quite a serious accident. The handler thought ‘something’s not right’ so we started an investigation. We proved that the total loss had been a total loss three other times all linked to different credit hire organisations and to different law firms as well with giant spider diagrams and the key fraud indicators exposing a massive fraud.”

28 Capture, or intervention: where the agent or insurer of the at-fault driver engages the innocent motorist taking control of his claim to exclude an agent acting for him and so limit the financial exposure of the at-fault driver.
Working with insurers

N4 reported effective collaboration with each of his clients’ background insurers when dealing with issues pertinent to that client’s interest but a “generally unproductive” relationship where the relationship with the background insurer was absent, even though he might be investigating suspicious or fraudulent claims, “a genuine cancer from which honest claimants are suffering but a subject which insurers – big, disorganised and process driven - used too much for PR purposes”. He was critical of insurer’s approach to data sharing blaming paranoia and widespread concern with breaching data protection protocols an approach he felt that only benefitted the fraudster “who relies on their disorganisation”. He was also critical of the effectiveness of industry databases like CUE:

“Netfoil claim they have 90% of industry claim data but I can point to over 200,000 records they don’t have ... and CUE has a massive hole in it. They are not getting a feed from most large self-insured corporates ... and won’t open it up to the wider market. The big insurers have control of it but they forget that a lot of activity includes the corporates and missing so much data only gives the fraudster another advantage.”

Like others he was critical of the reported cost of motor insurance fraud:

“I don’t trust any of it ... we’re asked for our fraud reports because we have to feed into all the insurance for each of our clients because as a mandatory insurance they still have those reporting obligations, but the way they ask for it to be presented is ridiculous. There’s no way it can be accurate; some of them want it to be underplayed because they don’t want it to be seen that they have a fraud issue and some of them want it to be over played so they can show huge savings.

It’s all just data but it’s also interpretation of fraud as well and that’s where we get into dispute with insurers. The vast majority of people will exaggerate an injury even if they were honestly injured in the first place. So instead of a three-month whiplash it goes to six months. We don’t class that as fraud, or record it as fraud, it has just become part of dealing with claims. Our identification of fraud is the more serious stuff it’s, you’ve got the lady on the bus claiming for injury when she wasn’t even on the bus, it’s that level of blatancy. If it’s somebody claiming that they’re in a wheelchair but they’re out doing a marathon, then that is fraud.

We have to have a sensible definition in order to get the level from which we can measure success in terms of real savings generated otherwise we’d be like the insurers where 50 per cent or more of every claim is considered fraudulent ...”

N4 identified being involved with 200 active files involving “provable and serious fraud” from 7,500 claims his firm defended annually, a 2.6% run rate. He explained:

“If we put every single exaggeration of a whiplash in there or every single person trying to get an extra scratch on their car fixed or people who found they could get a repair done within the terms of their excess so withdrew their claim ... well, we don’t, but most insurers
would push all of that into their reporting to get the stats up and to make things look really scary.”

IFED, the Police and the Judiciary

The police response to fraudulent claims reported by N4 was consistent with that reported by N1 as well as those responding on behalf of the credit-hire sector:

“We’ve had a case in Wolverton, a big Asian community. I went down there to try and track this guy down that was making this injury claim to see whether he was genuinely injured. I was just being nosey really.

I turned up at his house and there were suitcases all lined up outside the front of it. So, I thought we’ll spend a couple of days and get the house watched. It turned out it was a halfway house for immigrants coming in; they’d come in, be told how to stage an accident, get all their paperwork sorted out and then these guys were buying the claims off each of these immigrants, paying them a thousand pounds and saying, ‘right, all you’ve got to do is turn up for the medical’. Then they’d get put on to benefits. The through traffic of people was ridiculous. There were probably 30 or 40 people in the house at any one stage, sleeping in there for two or three days. Then they’d do what they were paid to do and get carted off to somewhere else and start off again. Unbelievably well organised.

We reported it to the police and never heard a thing. We repudiated the claims but it’s really frustrating. You sit there knowing what’s going on but the police won’t do anything about it. They eventually told us that they might get immigration involved but none of the suspects were illegal. They were Europeans here justifiably.

If you take the 60,000-foot view on this you have to ask why IFED would not want to be involved. It is clearly organised crime with cross-border implications which leads to drugs, prostitution, people trafficking, firearms, terrorism and all the other issues. The local police ... gave us no support at all and we often have the same experiences when we’re just redirected through to, you know, there’s now this insurance based cell called IFED and you should make contact with them.

I’m a big fan of the police but they are massively under resourced. I think, and I’m not defending IFED either, but again those guys are massively under resourced as well. You’ve got to get the insurers to part with more cash, haven’t you but if they’re paying, nobody else gets a look-in? And you can’t get the insurance industry to work together at the best of times so imagine trying to get them to do it on any scale; it’s impossible!”

On IFED he said:

“we’ve tried to get files put through our background insurer to go into IFED but we haven’t had any success ... they say they want the fraud rings and not individual cases which just leaves us back with the police who really don’t have the resource or inclination.”

When asked about the insurer response, he literally shrugged his shoulders:

“they say there’s just too much fraud and too little resource. Our corporate clients get frustrated and the bigger ones will try and use their size to push the insurer but they get the
same response; your case is one of thousands and it’s not up there on the most serious list or involving a fraud ring.”

N4 narrated his experience of resisting claims by alleging fraud in the defence in any proceedings. He also explained about his approach to civil actions alleging contempt of court where the claimant was acting fraudulently:

“we’ve done it on a couple of cases ... it’s just really expensive. Most clients agree to start the process but when they realise how much it’s going to cost they just drop it. We’ve had success in a couple of cases where they’ve gone through and the judge has asked the Crown Prosecution Service (“CPS”) to take it to the next stages, but it’s all cost and in the vast majority of the cases, even when we win, we actually lose financially because they’ve got no assets. Most of these guys are so well organised that they get their house put in somebody else’s name and they don’t have a car. They drive round and live quite a lavish lifestyle and yet they own nothing and that’s where we really struggle. It’s ironic, it’s very organised but of no interest to IFED because there is no insurer championing the issue and the offences aren’t big enough.”

In terms of the judiciary:

“historically a bit pointless although we’re starting to see a change and most judges, if they think that something’s up, will kick the entire case out whereas in the past they’d say, ‘right, you’ve been naughty on that bit but let’s give you a load of money here’ which sent the wrong message to the police as well but we are now seeing the courts starting to get harsher on people although it seems to be a bit regional.

We see a harder line south of Birmingham but not so much in Liverpool, Warrington, Birkenhead, the kind of places we’re not seeing a great deal of success at the moment. I think that’s because a majority of the judiciary there have come through claimant solicitor group leading to a little bit of claimant bias although there is an improving trend. The best defence we currently have is resisting claims whilst we invest investigate them thoroughly and make it difficult for Claimant’s where we suspect fraud.”

Asked whether IFED had made it harder for self-insured entities to access justice he said:

“I don’t think they’ve made it any harder but they haven’t made it any better either. I just think it is hard for self-insured entities to get access to justice. I think First Group, the bus company, managed to get a couple through because of the big exposure they had to multiple claimants but I’m not really aware of any corporates, or the people who work for the corporates, that have had much success. And whilst ever the local police forces can point to IFED as the specialist resource I don’t think things will improve.”

**Civil private prosecutions**

A lack of appetite for, and poor resourcing of, public prosecutions in fraud cases, has resulted in certain species of fraud having become almost decriminalised both in terms of public perception and the likelihood of those involved in such activity facing a criminal sanction. Privately brought
criminal prosecutions are one route by which defrauded commercial entities have been able to apply for a criminal sanction against offenders where the police have been disinclined to engage. High profile cases such as Regina (Virgin Media Ltd) v Zinga [2014] EWCA Crim 52, demonstrate that private prosecutions, when conducted properly, can achieve the private aims of the prosecutor whilst remaining in the public interest. In the Zinga case, Virgin conveyed a strong message to the public that it would deal robustly with breaches of its IP rights whilst at the same time achieving long custodial sentences and a substantial confiscation order against the defendants. In the right cases, and properly conducted, a private prosecution can have a number of advantages over action in the civil courts:

- availability of tough sanctions including suspended, or immediate custodial sentences for fraud cases of moderate value/seriousness and above;
- deterrent effect; both in respect of the defendant and his associates and the wider criminal fraternity;
- availability of measures for compensation/confiscation; backed by custodial sentences in default;
- positive publicity - a message to the market that fraud will not be tolerated; and
- costs recovery from convicted defendant, or public funds; the latter even if unsuccessful.

A number of organisations have evolved to fill the lacuna facing corporate victims of fraud but the process for executing a successful private prosecution is involved (Button, Lewis, Brooks, Shepherd, & Wakefield, 2014, p. 11; Edmund & McMahon, 2014).

The law

CF1 shared an advice from counsel which clarified the basis on which private prosecutions can be pursued. The Prosecution of Offences Act 1986, created the Crown Prosecution Service (“CPS”) and, specifically, retained the right of an individual, corporate or interested party, to conduct a private prosecution qualified by the power of the Attorney General who may take no active role, may allow the prosecution to continue with the CPS taking over conduct, or may discontinue it. Criminal proceedings brought privately differ from the pursuit of a defendant in the civil courts in a number of significant ways, the most significant of which is that whilst in a civil case the primary duty of the legal team will be to protect the best interests of its client (subject to duties not to mislead the Court etc.), a private prosecutor must serve the public interest in preference over the interests of its client. This obligation manifests itself in three areas as set out below:
• An investigator involved in evidence gathering for a prosecution must, within reason, follow up all lines of enquiry, whether they point to the guilt or innocence of the suspect.

• A prosecutor is under a duty to disclose all material that undermines its own case, or may assist the defence case. This is an absolute requirement and does not depend on client instructions.

• If the prosecutor is an individual and a witness in the proceedings, they must not have their evidence contaminated by other evidence relied upon in the case. There is accordingly likely to be material that the prosecutor’s representatives are aware of, but about which they cannot inform their client.

Private prosecutions remain sufficiently rare that defence teams will make objection to them in principle. Defendants will attempt to establish that the prosecution amounts to an abuse of the Court’s process or that it is being pursued to further private interests, which would be more suited to the civil courts, or that it has been handled in an unfair or partial manner. These are all arguments that might receive a sympathetic hearing from a traditional judge accustomed to criminal prosecutions being initiated by the police and prosecuted by the CPS. Because of this, it is expected that a private prosecutor will seek to abide by the Code for Crown Prosecutors, the Attorney Generals Guidelines and other guidance for public prosecutors. Finally, when assessing costs risk, under the Prosecution of Offences Act 1985 the prosecutor can recover from public funds those costs deemed “reasonably sufficient” to compensate for expenses incurred in proceedings for an indictable offence even if the prosecution (if properly brought) results in acquittals.

The test for prosecution

When determining whether an allegation of criminal behaviour is suitable to be prosecuted, the CPS applies the Full Code Test which consists of two elements, the evidential test and the public interest test:

• There must be enough evidence for a reasonable prospect of a conviction in respect of the charge contemplated. This involves the prosecutor making an objective assessment of the available evidence, including any defences that the suspect has, or might advance. This should include consideration of the admissibility and reliability of the evidence, as well as the credibility of witnesses.

• Public interest factors in favour of prosecution must outweigh those against. It is necessary to weigh such factors as the seriousness of the offence(s) alleged, the extent
of the suspect’s culpability, the harm caused to the victim, any impact on the community at large and whether prosecution will be a proportionate response.

N4 emphasised that it was vital that a private prosecution is not contemplated unless the two-stage test can be demonstrated to be met and comfortably exceeded. One of the first steps a defence team are likely to take will be to inform the CPS that the prosecution is on-going and invite them to discontinue it. For this reason, it is often in the interests of a private prosecutor to liaise with the CPS prior to laying Information in order to pre-empt and deal with any issues that might otherwise be raised during the proceedings. However, N1 and N4, on behalf of his corporate clients, were reluctant to prosecute because of the cost involved in funding an investigation to the point of launching the prosecution and because of the perception that the judiciary were not as supportive as if the prosecution followed a police investigation. There is evidence that on both grounds their assessment is incorrect. Insurers have reported successes in bringing private prosecutions in cases where IFED had declined to act. In 2014, AXA Insurance reported having secured a conviction for fraud against Paul Gustar following his attempt to claim £100,000 damages for an injury allegedly sustained at work (2014). Gustar received a suspended three-year prison sentence and HHJ Harvey Clarke remarked

“This insurance company is entirely justified in bringing this prosecution [and] its purpose has been to deter insurance fraud. I must pass sentence in recognition of this ... I want the message to go out – that it was appropriate and the insurers acted entirely properly in bringing this prosecution against you ... you are a fortunate man. Leave with your wife. Next time I shall show no mercy.”

Some of the energy driving the use of private prosecutions has been the realisation from a number of solicitors that their costs for bringing such a prosecution may be awarded by the trial judge out of the public purse. CF1 provided an example where Hill Dickinson Solicitors worked with the CHO, the insurer and a rental company to pursue a successful private prosecution against Offenders 8 and 9 (Accident Exchange Ltd, 2017; Rose, 2017b). Having pled guilty to fraud by false representation at Snaresbrook Crown Court, Offender 8 admitted that on 12th September 2014, he crashed his Toyota MR2, which was dressed up to look like a Ferrari F430, into his friend’s hired Audi A1. Offender 8 and his accomplice, Offender 9, convinced his insurer to pay out £29,000 after claiming his car had broken down on a bend before being hit, and that he did not know the driver. As the at-fault vehicle was insured by a hire company, Offender 9 would incur no personal cost by accepting liability for the accident and could split the insurance pay-out with Islam. Already in a replacement hire car organised by his accomplice following the accident, Offender 8 tried to claim for another credit hire car from a separate company which was detected by Hill-Dickinson’s Netfoil...
database and was his undoing. The accomplice, Offender 9, received a 12-month custodial sentence suspended for two years, and was ordered to compensate the victims more than £10,000. Offender 8 was sentenced to 8-months imprisonment. HHJ Dawson commented on the private prosecution, saying:

“If it wasn’t for the investigation by one of the companies, it [the fraud] may well have been missed. Almost immediately after the crash, you both launched into a sophisticated fraud. This is not a victimless crime; we all end up paying more for car insurance. It also undermines the trust from insurance companies in the public, which causes delay in genuine payments. More fraud makes it more difficult for honest people to be paid.”

The judge ordered that prosecutor be awarded its costs from central funds in the sum of £17,062 as the sum that properly reflects what is involved in both prosecuting and investigating.

**Fraud and the links to organised crime**

Insurance fraud committed against bus and fleet operators usually crystallises a pecuniary loss measured in terms of the damages paid for repairs, hire charges or personal injury. This is somewhat different to the losses incurred by CHCs and the insurance industry because bus and fleet operators will rarely, if ever, be exposed to the theft of their own vehicle as a direct consequence of a fraudulent motor insurance claim. In the hire sector, however, theft by conversion is a constant risk. It happens when somebody hires a car legitimately, or at least with the appearance of legitimacy, but doesn’t return it at the end of the hire in accordance with the contractual obligation in the hire agreement.

**CF2** described himself as a ‘Bounty Hunter’ although a more accurate descriptor would be an investigator. His primary role is recovering vehicles stolen by conversion from hire companies where the theft liquidated an expensive asset that could fund other forms of crime. He explained the economic dynamic and why he felt fraud involving the theft of motor-vehicles from car-hire companies had become endemic:

“I saw that you’ve got a Range Rover Sport outside worth about £65,000 … it’s worth about £5,000 to a criminal paid to steal it to order.

He might have started as a joyrider but he’s moved up the hierarchy now and worked out how to turn his hobby into a lucrative career. He won’t be on his own; whoever he is working for will know that he has a market for your Range Rover and will pay another £1,000 to somebody to doctor some paperwork and then will probably pay another £25,000 to put the car in a container, ship it half-way round the world, bribe the staff at the dockside in order to get the import paperwork right and then use the balance to pay the import duty as if it was a legitimate import …
The car will cost the criminal gang, because that’s how these things are organised, about £30,000 all in to steal and he’ll sell that Range Rover in a country where the import duties are prohibitive or supply is impossible, for between £75,000 and £100,000, making himself a good return … and it all links to organised crime or to terrorism. The money paid for the car is probably the proceeds of crime and the eventual purchaser is probably part of a criminal organisation in Africa, the Middle East, Romania or Turkey.

One thing with vehicle crime is there’s always a build-up of vehicles or movement of vehicles before any sort of terrorist explosion and we’ve seen that over the years; Madrid, flurry of vehicles going down there, 7/7 - you just can’t get it across to people, you know, the expensive vehicles that were going out to East Africa to be re-cycled into funding for terrorism.

People think that vehicle theft is opportunistic, and some of it might be, but the real threat is targeting expensive cars, usually owned by hire companies who won’t have any form of telematics installed because they have so many cars on fleet and change them so often.”

N2 was the insurance lead for an international hire-company who confirmed “a relentless battle” fought with customers hiring a vehicle who then report the vehicle stolen, complete with the keys, or who simply disappears along with the car. He frequently instructed the Bounty Hunter when the police refused to do anything other than record the vehicle as stolen. He reported that geography was a problem for hire companies because of their national, and sometimes international, footprint where it was possible to hire a car in Burnley and return it in Berlin. Dealing with the challenge of fraud was difficult and he described fraudsters as “almost entrepreneurial … chameleon like in the way their methods of obtaining the vehicles changed to avoid detection.”

CF2 highlighted the problems of a deficit of intelligence and the challenge of geography:

“It’s hard enough getting the Police to take an interest in crime reported in Warwickshire when the asset has been spotted in Staffordshire – they call that a cross border challenge. But it’s harder still when there is just no police resource available.

Imagine this scenario; someone hiring a car for a week from Hertz at Gatwick Airport just flown in from Poland. A week later, the car isn’t returned, the identity of the hirer proves to be false and the credit card used to pay for the transaction was stolen. Which police force would be interested in having that on their books as a crime to investigate knowing the car could be anywhere in Europe or beyond and they see Hertz as a big company with deep pockets who can stand the loss.

If you can link the theft to organised crime then you might get a Regional Organised Crime Unit interested but there’s always a patsy being paid £5,000 to steal the car and get it through the channel tunnel and then a handoff to Mr Big which makes the intelligence difficult to co-ordinate unless there’s an arrest. And that’s where it all falls down. Not investigating cases that might lead to an arrest which might expose a major criminal ring is a hopeless response to the challenge from international organised crime when acquisitive vehicle crime involving fraud is such a money-spinner.”
There is some support in the literature for his pessimistic assessment about the impact of organised crime in recent years. In 1995, an international police congress opened with an overview of the emergence of organised cross-border crime networks and the challenges for providing a coherent solution “when the police response to cross-border organised crime networks would inevitably involve the creation of cross-border police networks, challenging existing legal structures in the area of admissibility of evidence and creating a demand for extraterritorial police powers.” One of the risks identified was “the greater prospects for white collar crime and fraud, as it was low-risk and high profit” (Tupman & Zabyelina, 2015, p. 134). Twenty years on, organised crime features prominently in most countries political and criminal justice agendas in recognition of the threat it poses to public order, national security or economic stability (Sergi, 2015, p. 182). The UK government (Secretary of State for the Home Department, 2011, pp. 9–10) estimated around 6,000 criminal groups in 2011 comprising “38,000 organised criminals impacting on the UK … highly adaptive, exploiting every available opportunity, system and technology to invent new or varied forms of crime” and who operate across boundaries, both in terms of crime type and geography, and who engage, inter alia, “in fraud, acquisitive and economic crime … which can be used to fund and enable other serious and organised criminality”. Cohen (1977, p. 103) saw organised crime in terms of a set of criminal actors and a set of structured criminal activities, all regulated by the organisation generating the criminal behaviour “simultaneously engaged in coping with problems of resource procurement and allocation, personnel recruitment and socialisation, solidarity, discipline, disposal of outputs, legitimacy, reconciliation of conflicting goals and interests, and so on”. Ernst (2015, pp. 137–138) regarded organised crime as an economic activity empowered by rationally constructed criminal enterprises pursuing profit where “the chain of activities … is boiled down to immediate working steps involved in the generation and processing of illicit proceedings”. Cornish (1993, p. 31) had suggested earlier that organised crime should be analysed as end products or outcomes of a causal chain of separate actions “moves ‘strung out along an axle, rather as kebabs are skewered on to a stick’” and Tremblay et al (2001, p. 561) analysed permanent retention motor vehicle thefts as involving “a sequence of moves (theft of the vehicle, concealment, disguise, marketing and ultimate disposal), each move having a specific mix of casting, location and props requirements [where] participants can play each move or scene in a variety of ways: cars may be stolen in parking lots or obtained by providing rental agencies with stolen identities. Vehicle identification numbers may be altered or their chassis transferred from a crashed vehicle to a stolen one (‘body switching’) … and ‘rehabilitated’ vehicles may be sold to a foreign dealer, a local garage shop or advertised in local newspapers”. Levi (2007, p. 612) summarised the organization of crime results from the interaction of opportunity, offender and potential offender motivation, skills,
incentives and the network for committing crime ranged against the potential for detection or disruption created by the police or criminal law. He saw it as “a dynamic process that evolves as offenders adapt (or fail to adapt) to their changing environment” and highlighted Gannon and Doig’s (2010) critique of the investigation of fraud between 1998 and 2008 and the reality that forces will move ever-declining resources “away from work other than ‘front-line policing’ and ‘signal crimes’ such as homicide and phone hacking associated with News International” (Levi, 2007, p. 612). It is against this backdrop, the acceptance of the propensity for insurance related fraud involving non-insurer victims, the nature of the harm created and the ineffective response to the threat, that the final case study is concerned.

Case Study – the links to organised criminality

Talking about Operation Navigate CF1 said:

“this is the first time an operation has been run involving such a level of International and cross agency co-operation and it is a real example of how private industry, leading edge technology and investigative expertise can assist law enforcement. It should set the template for future operations targeting organised criminals that are intent on stealing mobile assets.”

A total of twelve insurers, including Admiral, Allianz, Aviva and Zenith, and two hire companies were victims of the organised crime ring responsible for the theft of vehicles collectively valued in excess of £1 million in 2015. The resulting operation with the National Crime Agency (“NCA”) is an example of the positive outcome from a ‘joined up’ response between victim, police and security services, but is also an indictment of the current response mechanism where the police repeatedly declined the opportunity to investigate an offence which subsequently resulted in the dismantling of a criminal network importing stolen cars from the UK into East Africa.

The Catalyst for the investigation

In April 2015, APU received an alert that a high value Lexus motor vehicle being tracked and protected by them had left the UK. APU provides security and recovery services for a number of corporate operators and car-hire organisations and for all of the vehicles owned by AX. On this occasion, the hire care had been provided to an individual whilst his own car was being repaired, the hirer having claimed to be the not at-fault victim in a collision. He had claimed to be a director of a business with details that appeared to be correct and had also offered confirmation of insurance cover for his damaged vehicle which appeared to be legitimate. Subsequent investigations, after the APU alert was triggered, revealed the claim was fraudulent. CF1 explained:
“We reviewed the tracker logs to see where the vehicle went after it was delivered ... We identified that it had been taken straight to a container yard and that it had remained there until it had been transported to the port before leaving the country. It was obviously put into a container and whilst we suspected the worst, the vehicle was fitted with our own security system which allowed us to track the vehicle at all times, wherever it was and even if it was in a container.

We obviously reported the theft of the vehicle to our insurer who said they wouldn’t involve IFED because it appeared to be just a single incident of theft. So, we reported the crime to the Metropolitan Police, or at least we tried to ... Increasingly we have found that the police won’t take reports of vehicle crimes from hire companies and we’ve been left to ... carry out our own investigations. On this occasion, the Met would not accept our report. We had a relationship with NAVCIS and so I contacted them for assistance. They eventually wrote to me [14th May 2015] and I was slightly gobsmacked .”

NAVCIS were prepared to record the theft and enter the vehicle as LOS (lost or stolen) on the PNC and forward the crime report to the local force for a fee calculated at 21% of the value of the vehicle, approximately £9,000, if recovery was made. CF1 declined the offer but then explained:

“several weeks later, after a lot of persistence from one of my team, the Met agreed to take the report when we told them the vehicle had landed at a container port in the Middle East. That said, they told us they couldn’t do anything about it and suggested we fly to Oman and recover the vehicle ourselves.

I spoke to NAVCIS again and they directed me to the UK Ports Authority suggesting that I might find out who had shipped the container containing the Lexus. That way we could identify the consignment number and track that to the ship on which it had been loaded to alert the authorities in Oman who could seize the container. We shared that information with the NAVCIS intelligence team at the Port, and shortly afterwards the NCA made contact. It was a case right place and right time really.”

The De-Briefing

At the Operation Navigate de-briefing29 it was reported that under the UK National Control Strategy, Organised Vehicle Crime had been escalated to Priority Threat status because, since Autumn 2014, there has been a large increase in the number of expensive vehicles stolen and not recovered. During Q1 2015, conservative estimates valued the loss at over £100 million with keyless theft and car-key burglary the main modus operandi. Incidents had clustered around wealthy areas of London/South East and a significant number of vehicles were believed to have been exported to Cyprus from Southampton docks. A high number were also exported to Eastern Europe using an overland route but Africa remained the prominent export location, particularly Uganda, Kenya, the

29 16/07/2015; NCA, London with representatives from APU, NCA, NAVCIS, Interpol, Metropolitan Police, Home Office and Foreign and Commonwealth Office
Democratic Republic for Congo and Tanzania. Apparently, pressure had been exerted on the Mayor of London, based on the volume of high value 4x4 vehicles being stolen with residents concerned that:

- detection rates were poor;
- insurance premiums were rising;
- vehicle security systems were ineffective;
- residents had personal security concerns; and
- the inadequate police response was unacceptable when criminals appeared aware they had little risk of arrest and prosecution.

50% of vehicles reported stolen were stolen from the MET force area and pressure from the Mayor’s office was pushed downstream to the MET and upstream to the Home Office. It was disclosed that no UK Police Force had vehicle crime as a priority with their focus and resource being directed towards child sexual exploitation and cyber-crime, an extension of the conclusions reached by Ganon and Doig (2010) and Levi (2007) that forces will move ever-declining resources “away from work other than front-line policing and signal crimes”. The Home Office representative at the debrief was concerned about the failure of the police to regard the threat as a priority crime and the Foreign Office representative signalled concern about how the economies of East African states, diplomatic and political partners of the UK, were being destabilised by the emergence of high value organised crime for which the UK was doing little to stop. The export of stolen vehicles from the UK to Uganda was referenced as an historic problem. In 2014, five cars stolen from the UK were recovered in Kampala by Ugandan Police but efforts made by them to have the vehicles repatriated to the UK were unsuccessful. The police investigations had been filed in Uganda, owners had been compensated by insurance companies in the UK and there was no single agency responsible for investigating the thefts. The Home Office were surprised at the evidence of insurance companies failing to recover stolen vehicles where compensation had been paid in circumstances where the net result was increased future insurance premiums for policyholders, an expense that could have been mitigated if the vehicles had been repatriated.

In March 2015, officers from the NCA met with Interpol and NAVCIS to discuss the East Africa problem and the three agencies agreed to work together on a project focusing on exported stolen vehicles headed to East Africa. The theft of the Lexus was opportune and when the vehicle arrived in Oman and CF1 had spoken with the port intelligence officer in the UK, the NCA approach had been triggered. They had identified an opportunity to carry out an operation using the Lexus and, with APU’s co-operation (and their security technology) saw an opportunity to develop their
understanding about how the illegal activity was facilitated and to identify and disrupt the criminal networks responsible. **CF1** explained:

“we agreed to support Operation Navigate and provided intelligence on the movement of the vehicle throughout the operation. The vehicle was traced from the Middle East to Mombasa and the NCA Liaison Officer, using trusted Kenyan and Ugandan police and security services personnel, monitored the container as it passed through customs controls ... certain customs officials were complicit in the offence and facilitated the movement of the goods into the country. In Kenya, the goods were partly declared as furniture to avoid paying duty. At the border in Uganda, the goods were described as motor vehicles but the bill of lading didn’t mention the country of origin.”

The path of the vehicle is shown at Figure 5.1 below:

![Figure 5.1: Operation Navigate - target vehicle movement](image)

After clearing the Ugandan border, the vehicle was finally tracked to Kampala, Uganda, where the syndicate ring-leaders were arrested and the container carrying the Lexus was seized. However,
the operation had also unearthed a substantial vehicle crime hub, leading to a compound containing 36 stolen vehicles including Range Rovers, Audi Q7s and BMW X5s collectively worth more than £1 million. CF1 was asked by NCA to travel to Uganda with a team to fit APU security devices to each of the recovered vehicles to safeguard their repatriation to the UK such was the concern that the vehicles would be ‘stolen back’ on the journey from Kampala to Mombasa. He said:

“this case is a feather in the cap for APU ... but also very pleasing that all parties involved were able to achieve some tangible success despite being led thousands of miles across the world in what was considered an impossible task by the Police. The failure of the Metropolitan Police to record the vehicle as stolen when first reported and the suggestion by NAVCIS that we should pay £9,000 for the privilege were disappointing ... it was also disappointing that the insurers involved had simply given up and declined to assist in the repatriation exercise ... we’re told that, at least for the time being, the criminal network behind the syndicate has been dismantled and Uganda, previously one of the primary destinations for cars stolen from the UK, has been effectively shut down.”

There were no criminal prosecutions arising from the investigation in the UK and none are outstanding in Africa.

**Vehicle manufacturers**

An unexpected revelation from the debriefing was the ability of vehicle manufacturers to assist in the recovery of vehicle assets. DF4 is an expert in the interpretation of vehicle movement based on the analysis of vehicle telemetry data. He has assisted several police forces and provided expert evidence in serious or fatal road accidents where he has reconstructed the events leading up to the collision using data. He assisted in tracking the sting vehicle in Operation Navigate and subsequently identified that the manufacturer of one of the stolen vehicles has evolved, over the period since 2014, a data warehouse containing all of the vehicle movement data for all newly registered vehicles of that brand, including a number of those recovered in Kampala. He discovered that, not only were the manufacturer able to identify the exact location of each vehicle at any time since manufacture, but they were also able to identify when replacement keys were provided by a dealer, even in Uganda, and on what date, and on whose authority, and why those replacement keys were supplied. It was DF4’s opinion that all manufacturers of high value prestige vehicles have access to similar tracking data which has, historically, not been made available to police forces, insurers or to their customers to facilitate a more effective recovery of stolen vehicles because of:

- data protection restrictions, which vary in the territories in which their vehicles are sold or operate, make use of the data problematic (echoing the cross-border concerns of Tupman and Zabyelin (2015));
• a reluctance to disclose the existence of this facility because of the negative ‘big-brother’ connotation for customers; and

• simple economic reasons - manufacturers will generally sell a new vehicle every time one is stolen from a customer after the insurance company pays out if the stolen vehicle is not recovered.

DF4 said in interview:

“We all know that retro-fit telematics devices have become quite common place with insurance companies using the data to try to control the driving behaviour of young drivers or to reconstruct accident circumstances but the idea that a vehicle manufacturer can locate the whereabouts of a stolen 4x4 in Kampala when it was originally sold and registered in Central London, that they will allow it’s Uganda based dealer to request and will then issue a replacement key for the vehicle, even though it was stolen in the UK, and yet they do nothing with that data to assist the owner, the insurer or the police is just beyond words.”

CF1 reported that as a consequence of Operation Navigate, a working group was established with representatives of the police, government and the Society of Motor Vehicle Manufacturers and Traders to oversee and implement action around sharing information and best practice, local policing responses, technical opportunities and what the response should be in relation to advances in technology aimed at overcoming the security of vehicles and assisting criminals.30

Conclusions

This chapter extended the analysis of the experience of non-insurance victims of insurance fraud to large fleet operators, specifically bus companies and businesses, operating large vehicle fleets where the motor insurance risk is predominately self-insured using two further cases studies that highlighted how those sectors engaged with fraud and with insurers and the police where they had been the victim. The case studies exposed the link between insurance fraud, specifically where vehicle acquisition was involved, and organised crime and a further case study explored the issue in more detail. It addressed a fraud, committed against a CHC, which the police refused to record as a crime but which became the focal point of an investigation into an organised crime ring exporting high value prestige vehicles to East Africa. The debrief from the concluded NCA operation highlighted the inherent deficiency by which vehicle crime, in circumstances where insurance fraud was an enabler of the offence, were addressed by the police. Whilst the output from a single case study is never sufficient to mandate change, this study does demonstrate the consequences of

30 Source: NCA, July 2015
offences including acquisitive vehicle crime as their aim, however, the vehicle was acquired. It also demonstrated the consequences for a victim based on the attractiveness of the offence to the investigating authority when:

- accepting a report of the theft of the CHCs car was a burden to the MET possibly consequent upon the lack of resources to investigate an unsolvable crime;
- IFED were never likely to be engaged even though the offence was part of a fraudulent insurance claim, either because the offence was not one identified by a supporting insurer or because they could not have anticipated the extent and scale of the fraud;
- for NAVCIS, their engagement motivation was entirely financial; £9,000 for recording the entry on the PNC, filing a crime report and sending it to the MET, and,
- in the case of the NCA, their appetite to investigate was entirely coincidental on the report of an expensive 4x4 motor vehicle headed for East Africa fitting the remit of the investigation commenced by NAVCIS, Interpol and the NCA in March 2015.

More than anything, the case study identified a theme that has emerged throughout the research, that the prospects for the criminal are far more favourable than for the victim who only avoided disenfranchisement by a matter of coincidence. Sergi (2014, pp. 71–72) also articulates the tension between the availability of resources to deal with a national threat which is part of organised activity but committed at a local level and the need to synchronise national and local policing strategies and ventured that the NCA may yet be “another exploitation of the rhetoric around organised crime for political interests” (Sergi, 2011). Whether similar political interests drove the formation of IFED is a topic covered in the next chapter.
Chapter 6 Making a Crisis

Introduction

In Chapter 1, five ‘constituencies’ were identified as central to the research question. They were:

- motor insurers, communicating predominantly through the collective voice of their trade body, the ABI;
- the police;
- non-insurer victims of insurance fraud;
- the Establishment (parliament and the government acting through its various administrative and regulatory agencies); and
- the media.

The thesis has, so far, considered three of those constituencies and intimated the power that resides in the media but has yet to address the role the Establishment played in the creation of IFED and more importantly, the relationship that insurers cultivated with government in order to advance their agenda. How the findings from the topics addressed so far intertwine and impact upon the research question is a matter discussed in Chapter 7. Before proceedings it may be helpful to review some of the temporal landmarks identified so far:

- Policing before the 18th century was in the hands of the community and afterwards was marked by a period when the expense of prosecution saw local businesses and trade organisations club resources to investigate offences and prosecute the offenders.
- Historically, the Police have accepted payment for services but usually for supplying ‘additional constables’ or officers to police a specific event or for investigative roles.
- The Police Act 1966 allowed Chief Constables to solicit sponsorship for policing activities.
- Motor insurance has been unprofitable since at least 1995.
- In 1999 Legal Aid for the pursuit of personal injury claims was replaced by the ability of solicitors to act for claimants on a ‘no win, no fee’ basis and to recover uplifted costs for sharing the risk of recovery with the claimant. Claim volumes may have increased as a result.
• The Government accepted the conclusions from the Fraud Review in 2006 that fraud was a serious problem requiring a collaborative approach to find, and fund, a solution.

• Insurers have contended with fraud for decades largely accepting the loss incurred through fraud as an unavoidable cost of doing business.

• In their submissions to the Fraud Review, insurers had expressed
  o disquiet about the lack of police engagement and the unwillingness of the CPS to prosecute offences they had detected and avoided, and
  o unease with funding police investigations because it would mean they were paying twice for the same service and was, in any event, something the Courts had criticised in 2005.

• The Police have been challenged by multi-lateralisation from a neo-liberal impetus to shrink the state.

• DCPCU was held out by the Government as an example of a privately-funded public-police partnership delivering value for the business sector and the state whilst providing the capacity for the police to focus on offences that might not ordinarily be investigated.

• The recession in 2008 prompted a prolonged period of austerity with significant implications for business, consumers and public services.

• Fraud has evolved, in both frequency and cost, stimulated by the impact of the recession on consumers.

• The imperative of shrinking the state was given fresh impetus by the size of the national debt.

• At the same time, motor insurers were caught in a perfect storm
  o investment returns which ordinarily supplement their premium income, plummeted, and
  o price aggregators which were originally perceived as a better route to market, had made the market competitive and driven motor premiums down to unsustainable levels.

• Policing was impacted by budget cuts experiencing a reduction in the workforce over the period of the recession. Fraud was not a priority and insurance fraud even less so.

• In 2009 the ABI issued a first report containing a number of uncorroborated estimates, highlighting their exposure to detected and undetected fraud.

This chapter now proceeds to address how insurance claims are made and how they became central to increases in the cost of insurance premiums and affected insurer profitability. It explores
the dialogue between the insurance industry and the Establishment and considers how the ABI inspired regulatory change not just in respect of fraud but for other costs in the claims eco-system e.g. solicitor fees, damages for personal injury and the cost of credit-hire claims. Much of the research for this chapter was desktop driven and part of the output is a narrative of events from 2004 to late 2011, when the launch of IFED was announced. However, the engagement by insurers with government continues to evolve beyond the date of this thesis. The research identified that the CLP drove the case for IFED and that insurer representations on fraud coalesced with other more economically significant issues to create what Cohen (2002) had defined as a moral panic, what Hubbard (2006, p. 438) saw over 40 years in the USA as “repeat players on the defence side of tort litigation” seeking to reform tort doctrine in their favour to reduce their operating costs and which Feinman (2005, p. 19) claimed was a critical element by which insurers attacked the civil justice system and changed rules of law, by influencing public perceptions through “political influence, power lobbying, aggressive litigation and production of an elaborate public campaign of misinformation that convinces people that reducing their rights is actually in their own interest.” This chapter considers the evidence in light of those arguments, and challenges whether crises around insurance fraud may have been part of a wider imperative to improve insurer profitability by depriving consumers of their common-law rights to legal redress in tort. Whilst not part of the original research objective, the evidence revealed the issues around fraud were so intertwined with the issue of insurer profitability driven by costs associated with personal injury claims that the breadth of submissions to government could not be ignored.

The right to compensation

It is enshrined in common law that an injured party has a right to pursue a claim for compensation for losses sustained following an act of negligence. It is a compulsory EU requirement for drivers to have motor insurance in force that provides protection for the innocent victim seeking to claim those compensatory damages. The 1988 Road Traffic Act and European Community directives require an insurer to satisfy, on behalf of their policyholder, any judgement for damages awarded by a court where the tortfeasor is determined to have been so negligent\(^\text{31}\). For insurers, paying damages for bodily injury claims represents a significant cost although, if they consider any claim to be spurious or fraudulent, they can test their conviction by inviting the injured party to litigate. The innocent party has the evidential burden of establishing, on the balance of probabilities, that the other driver was negligent. If liability is accepted or proven, then an

\(^{31}\) Consolidated and codified into the 6th Motor Directive 2009/103/EC
independent medical expert will confirm the injury, opine whether it is consistent with the accident circumstances and give a prognosis for recovery. Whiplash is a common injury for which damages are claimed. It is caused by an abnormal flexion-extension motion or force applied to the neck causing movement beyond the neck’s normal range that pulls and strains the neck muscles and ligaments (E-medicine Health, 2016). It is a real phenomenon estimated to cost the NHS £8 million a year to treat (ABI, 2011b; Straw, 2011), a relatively small sum compared with the additional workload claimed by the British Medical Association\textsuperscript{32} and reported by one insurer from diagnosing and treating whiplash injuries (LV= Liverpool Victoria, 2015). Whilst it can cause short-term discomfort it can also have serious long-term consequences but there is an absence of authoritative medical guidance in respect of diagnosis and treatment of the condition. Suffering through whiplash is difficult to disprove and the cost of litigating a challenge can be more expensive than the cost of paying compensation as indicated by N1 in the previous chapter. Despite stories of opportunistic claimants routinely exploiting the challenge insurers face in verifying such claims there is no published evidence attributing any increase in the level of claims to the actions of fraudsters. Nonetheless, the IFB’s disapproval may be why the ABI later categorised the condition as ‘the fraud of choice’ (2014g).

\textbf{Conditional Fee Agreements (no win – no fee)}

Some of the reported increase in soft-tissue injury claims were probably driven by regulatory change introduced in 1999 after which insurers encouraged their innocent policyholders to make a claim as a means to generate non-premium referral income from solicitors. Before then, claimants could access legal aid to pursue personal injury claims. In 1999, the government amended the process allowing a winning claimant to recover a success fee, an uplift to their solicitor’s costs in addition to the recoverable standard costs\textsuperscript{33} as well as the cost of an ‘After the Event’ (“ATE”) insurance policy, which indemnified the claimant for costs if their claim failed. ATE policies were marketed by solicitors and these incremental recoverable costs became integral to the ‘no win – no fee’ Conditional Fee Agreement (“CFA”) between a claimant and his solicitor. They were intended to ensure that, absent legal aid, legal advice and the ability to access justice and pursue a claim for damages would remain open to consumers.

\textsuperscript{32} According to figures from the BMA (July 2014) GPs spend 1.72 hours on average seeing patients they suspect of inventing or exaggerating an injury to claim compensation every month equating to 887,520 hours a year (close to one million).

\textsuperscript{33} Access to Justice Act 1999
The agenda for change

Eventually, an argument emerged that the permitted increase in recoverable solicitor costs had a motivational effect on solicitors, and others associated with accidents, to generate increased claim volumes predominantly involving whiplash related injuries. In October 2011, in evidence to the TSC (2011b, p. 38), Jonathan Djanogly MP\(^34\), claimed

\[
\text{“one individual indicated that, in 1999, claimant’s solicitor’s costs were awarded at 56%. By 2010, the average claimant costs represented 142% of the sums received by the injured victims. The same person said that, whilst average damages paid increased since 1999 by 33%, average claimant costs paid had increased by 234.”}
\]

Djanogly was correct. CFAs did create favourable economic outcomes for solicitors championing a consumer’s rights to compensation but it had become increasingly destabilising for insurers. Djanogly said “the problem is that, if you are a claimant and you have no chance of losing, then you are almost obliged and you are almost crazy not to sue” (ibid. p.38).

Motor insurance has been unprofitable since 1995 (ABI, 2011a), and Djanogley highlighted the increased frequency of injury claims and the growth in associated claimant costs from 1999 to 2010, as part of a systemic problem. He inferred the resulting cost burden imposed on insurers was driven by the compensation culture rather than a legitimate entitlement to compensation. In response, Andrew Dismore of the Access to Justice Group (“AJAG”) cautioned against conflating whiplash with fraud highlighting that insurers don’t pay meritless or dishonest claims (Transport Committee, 2011b, p. 29), an argument made several years earlier by the ABI (2004, p. 1), and validated in 2013 when they reported 59,899 incidents of detected motor insurance fraud in which insurers had declined payment, so avoiding potential fraud losses estimated at c.£811.3m (ABI, 2014c).

Locating the trigger points which stimulated support for regulatory change favouring insurers, including the eventual creation of IFED, required desktop investigation to identify tactics and/or strategic initiatives promoted by insurers. Those were found, predominantly, by reviewing the content of messaging to consumers and the Establishment, and by also considering the hidden lobbying of government. Research sources included:

- the evolving messaging from 62 ABI press releases issued during the review period (Appendix D);
- publicly available empirical data\(^35\);

\(^34\) Under-Secretary of State, MOJ
\(^35\) including claim data published, and sold, by the ABI
written submissions to government, parliament and various regulatory enquiries including the CMR, ITF, TSC, OFT, and CMA and oral submissions to the TSC and CMA;

evidence of support from associated undertakings – consultants, brokers, solicitors or advisers;

the semi-structured interviews conducted in 2015; and

e-mails between the ABI, Keoghs and the MOJ identifying ‘hidden lobbying’ conducted in furtherance of the ABIs commercial objectives.

The results of the investigation revealed that the creation of IFED was one of a number of connected outcomes from a range of economic and regulatory issues being canvassed by insurers and which extended beyond the scope of tackling organised insurance fraud. In their media releases the ABI characterised claimants, solicitors, claims management companies, medical experts, motor engineers, repairers and CHCs in pejorative terms like “the compensation cowboys” (ABI, 2015g) or those “firms and lawyers who drive up unmeritorious claims” (ABI, 2015f) and the interaction between press releases and the resultant newspaper coverage merits consideration. Halton and McCann (2004, pp. 175–176) described the law in the United States as “virtually eviscerated” by sponsored media stories of legal disputes where the press “artificially equalise relationships between parties that are often highly unequal in material resources and social power … with the damage, pain, anguish and costs of injuries suffered by ordinary people” either de-emphasised or ignored. They saw this “effacement of injury” as something that reduced sympathy for claimants, obscured the proper foundation of their claims and had the effect of reversing the narrative logic where the party at fault for the injury, or their insurer, is wrongly portrayed as the “real victim” of the acts of deceitful claimants and their solicitors. They also saw it as invidious that dominant media brands were able to deliver what purported to be “knowledge in print” encountering few challenges to the content from less critical minds as the messages, subtly but steadily, seeped into reader’s consciousness (ibid. p.178). Mud sticks, even if the justification for flinging it is dubious (Oliphant, 2016, p. 20) and as Halton and McCann point out, “purported rebuttals never gain the same currency” (2004, pp. 104–106) and the result, is an ignorant public, who are “helpless targets of a one-way flow of carefully filtered and orchestrated communication” (Neuman, Marion, & Crigler, 1992). The desktop research identified that the ABI’s press releases featured regularly as articles in the mainstream media. Whether the intention was to use the media to instil the public with a sense of panic from the threat of the uncontrollable risks from insurance fraud and that something must be done, or whether they were just part of the mood music is debatable but a schedule of 62 releases that were reviewed appears at Appendix D and a summary of the more emotive straplines under which those releases were deployed is at Figure 6.1 below.

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In Cohen’s analysis (2002, pp. vii–viii), moral panics are “lying dormant but hard to recognize - invisibly creeping up the moral horizon; they are damaging in themselves – but also merely warning signs of the real, much deeper and more prevalent conditions. They are transparent (anyone can see what’s happening) – but also opaque: accredited experts must explain the perils behind the superficially harmless.” For the ABI, the flow of orchestrated communication was synchronised with government and regulatory announcements and expounded by “accredited experts” including political lobbyists, analyst, solicitors and industry leaders to ensure the message was not lost. But it was about more than just the media.

### About lobbying

Every UK voter can lobby their MP to try to communicate their position on issues as part of the democratic process, however ineffective it might prove. Corporate lobbying however, typically funded by large commercial organisations or industry trade bodies, is a different proposition. Harris and Lock (1996, p. 314) characterised corporate lobbying as an extension of marketing and public and media relations. Van Schendelen (1993, p. 3) draws a slight distinction between corporate lobbying and commercial political campaigning defining the former as “the informal exchange of information with public authorities, as a minimal description on the one hand, and as trying informally to influence public authorities on the other.” He defines commercial political campaigning as more extreme, “mobilising opinion to exert pressure on public authorities for commercial gain or competitive advantage.” Cave and Rowell (2014, p. 80) observed that the influence of lobbyists

<table>
<thead>
<tr>
<th>Abi Media Releases - Month of Issue and Title</th>
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<tbody>
<tr>
<td>2008/11 - ABI reveals whiplash epidemic</td>
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<tr>
<td>2008/12 - Rise in front end fraud putting insurance cover in jeopardy warns the ABI</td>
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<tr>
<td>2009/03 - National fraud crackdown must end the victimless crime myth says the ABI</td>
</tr>
<tr>
<td>2009/04 - Recession Britain insurers detecting record amounts of fraudulent claims ABI</td>
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<tr>
<td>2009/07 - Deception Exaggeration and Invention ABI publishes report on the rising cost of insurance fraud ABI</td>
</tr>
<tr>
<td>2010/01 - Zero tolerance policy towards fraud now needed says the ABI</td>
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<tr>
<td>2010/07 - Bogus Britain insurers expose over £300 fraudulent claims every week</td>
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<tr>
<td>2011/05 – Britain’s pain in the neck culture must be reduced says the ABI</td>
</tr>
<tr>
<td>2011/07 - No hiding place for cheats as drive to reduce insurance fraud moves up a gear</td>
</tr>
<tr>
<td>2011/07 - You could not make it up but some did Insurers detecting more fraudulent claims than ever over 2500 worth 18 million every week</td>
</tr>
<tr>
<td>2011/09 – Tackling the compensation culture</td>
</tr>
<tr>
<td>2012/09 - Leading retailers and business groups join forces with the ABI in calling for an end to the have a go compensation culture</td>
</tr>
<tr>
<td>2012/04 - The UK’s pain in the neck culture must end says the ABI</td>
</tr>
<tr>
<td>2012/09 - ABI lifts the lid on the 1 billion a year insurance fraud industry as the insurance fraud register is launched</td>
</tr>
<tr>
<td>2012/09 - Insurance Fraud exposed</td>
</tr>
<tr>
<td>2012/09 - Phantom passengers and phoney injuries behind record rise in motor insurance fraud says the ABI</td>
</tr>
<tr>
<td>2012/12 - Government on the right road to tackling the UK whiplash epidemic says the Association of British Insurers</td>
</tr>
<tr>
<td>2013/03 - Fair, independent, objective – ABI publishes proposals to curb the UK’s whiplash epidemic</td>
</tr>
<tr>
<td>2013/04 – Brace yourself — UK is the biggest pain in the neck in Europe</td>
</tr>
<tr>
<td>2013/07 - The con is on not - industry clampdown on insurance cheats uncovers frauds worth £21 million every week</td>
</tr>
<tr>
<td>2014/05 - Insurance cheats feel the heat – value of fraudulent claims uncovered by insurers hits record level</td>
</tr>
<tr>
<td>2014/09 - Motor insurance application fraud backfiring on nearly 3,500 motorists a week according to the ABI</td>
</tr>
<tr>
<td>2014/11 - Overhaul in assessing whiplash claims set to put the brake on the fraud of choice</td>
</tr>
<tr>
<td>2015/07 - You could not make it up, but they did. Savings for honest customers as insurers expose £3.6 million worth of insurance frauds every day</td>
</tr>
<tr>
<td>2016/01 - Insurers will do whatever it takes to protect honest customers against insurance fraud</td>
</tr>
</tbody>
</table>

**Figure 6.1: Sample of ABI Media Releases; Nov 08 to Jan 16**
increases when lobbying happens quietly which, ironically, makes it harder to identify those occasions when policy change has been aligned to hidden commercial political campaigning and where the aim of the lobbyist is commercial advantage. They also argue that there is a darker side to lobbying, “one that involves a selective approach to the truth, media manipulation, the undermining of opponents and other dubious practices” and all of it hidden from view (ibid. p. x.).

Because lobbyists are rarely seen at work, it is difficult to assess whether, and to what extent, any particular lobbying effort has benefited the sponsor by impacting government policy. Van Schendelen (1994, pp. 3–22) divides lobbying tactics into direct and indirect methods, a distinction that allows any evidence to be assessed as to whether it is synonymous with the characteristic below. He identified direct methods as:

- personal visits,
- personal letters,
- phone conversations,
- informal contacts, and
- participation in hearings or public action groups.

He identified indirect methods as:

- developing friends inside the system,
- accessing assistants of decision-makers,
- targeting mid-level civil servants,
- participation in or production of studies and reports,
- using brokers or consultants,
- building affiliations with interest groups to widen the support for the agenda,
- supporting political party’s election campaigning, and
- using the media and other publicity to build the message.

There is an ironic parallel between identifying the outcome achieved by lobbyists and the challenge of proving an allegation of fraud in court. In the latter, a suspicion may only be supported by circumstantial evidence of several disconnected events and so counsel will present an argument inviting the judge to draw an inference from his narrative that the only logical conclusion from all of the (limited) evidence is one of fraud. Inference is often necessary with lobbying too because “lobbyists are a bit like Borrowers: they leave their footprints all over government policy but are hidden from sight” (Cave & Rowell, 2014, p. xi). Helpfully, evidence of how the ABI lobbied
government was available to the Researcher allowing inference to be drawn about the path trodden and the previously well-hidden footprints of the ABI. All of Van Schendelen’s direct and indirect lobbying tactics were present from the combination of previously hidden documents and publicly available material and demonstrated the intimate engagement between the ABI and government. They expose a persistent focus by insurers, certainly up to the end of the period covered by this thesis, determined to eradicate regulatory and statutory impediments in order to improve profitability by deploying:

- uncorroborated and unchallenged evidence of the magnitude of insurance fraud, with
- a media campaign focused on the perils of “a whiplash epidemic” fuelled by “compensation cowboys” bringing “fraudulent whiplash claims” for “cheats” as part of “the UK’s pain in the neck culture”, and
- hidden lobbying to build government support for regulatory change.

The conclusion that government relied upon untested evidence and partisan submission to inform policy decisions and develop regulation, legislation and fundamental change to common law gives force to Cameron’s (2009) admission that “secret corporate lobbying goes to the heart of why people are fed up with politics”.

How did the ABI see things?

I6, a former ABI employee, referred to the three pillars of lobbying; “a really good evidence base, a good story to tell from the evidence and a message that provides clarification that everyone is paying for the problem identified.” The second pillar, the need to find a good story to tell, is essential in creating a moral panic if, as Cohen (2002, p. 1) argues, it is to be “presented in a stylised and stereotypical fashion by the mass media” so that “editors, bishops and politicians and other right thinking people” can man the barricades. The assertion that industrial scale insurance fraud was costing the industry £billions whilst threatening the continued supply of motor insurance at an affordable price was the panic that insurers created to attract the media, and then the government, to accept the warning messages that insurers could not solve the problem of the incidence and cost of whiplash claims alone. According to Paul Evans of AXA Insurance (Transport Committee, 2011b, sec. Ev 5), an accredited expert capable of explaining the perils, “we have to ask Government to help us to solve the problem ... it is just too big”. That the story was not supported by a good evidence base, I6’s first pillar, was irrelevant. The ABI data was unchallenged and so, ipso facto, it

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36 Supplied to the Researcher by N3 pursuant to an FOI request
assumed its own authoritative provenance. But there was a bigger imperative behind the fraud headline for the ABI, one aimed at driving the government towards structural and commercial change by eliminating certain common-law rights and marginalising, to the extent they were eliminated from any debate, those in the supply chain that were supporting consumers and impacting the insurer’s economic model.

John Parker became the ABI’s head of general insurance in 1994 and in 2003 claimed that “well over 60% of the ABI’s time is spent lobbying ... to influence the government and the media, while adding value for our members” (“John Parker - Lobbying for industry change,” 2003). He saw lobbying as an effective tool because “you can’t just turn up and talk to a government department...you have to build good long-term relationships with stakeholders.” Cave and Rowell agreed (2014, p. 8):

“politicians rely to a great extent on lobbyists to do their job. Coming up with good, workable policy is a costly process that requires research and detailed knowledge, time consuming activities that the civil service is increasingly hard pushed to provide, but in which the lobbyist is willing to invest. Lobbying, seen from this angle, looks positively public spirited”.

In 2003, Parker was focused on legal costs, something that he said accounted for 40% of the value of a claim paid. Perversely, and highlighting the perils of uncorroborated data, his figure was substantially lower than the figure later relied on by Djanogly in 2011 when he reported that costs accounted for 56% of the value awarded in 1999 (Transport Committee, 2011b, p. 38 Ev 12).

Motor insurance is the only compulsory insurance product, one that Jack Straw MP (ibid. p. 29 Ev 8) characterised as a product where parliament “gives insurers a profit – that is the idea – in return for delivering not a private good but a public good”. Straw supported the insurer contention that the uncontrollable costs of motor claims, and specifically claims for bodily injury, had generated substantial premium increases for the law-abiding motorist for no public benefit. He identified that whilst increasing premiums to counter substantial recurring losses was an emerging trend, it would, inevitably, “price people out of the ability to follow the law.” If that argument was meant to attribute a change in market forces in 2010 to be the cause for insurer losses, it was weakened by an ABI press release (2011a) highlighting that the motor insurance sector had not been profitable since 1995. When commercial entities remain in markets with unattractive financial outcomes and capital flows that are harmed by recurrent losses there is usually another motivation for not exiting in favour of generating a return on capital elsewhere. It may be, for example, that structural and endemic market issues, such as the legal costs problem highlighted by Parker in 2003, might be transformational for the sector if they were resolved by regulation.
**Government focus on organised crime**

Unrelated to any insurer intervention, in 2004 (Home Office, 2004, p. 15) the Government identified a range of fraud offences committed by organised criminals and resolved to identify instances where businesses were vulnerable in order to develop a combined strategic reaction to tackle the problem. Insurance fraud did not feature in the document. At the same time, the Home Office outlined a plan to improve the performance of local police forces and their focus on fraud. Initiatives included the CLP working more closely with the SFO and what was described as an innovative approach to expanding the CLPs remit to the South-East region with a combination of money from Government and from the City of London (ibid. p.16). Business fraud was highlighted as a candidate for new opportunities between the public and private sector and the important precedent of the DCPCU was emphasised whereby the banking industry had contributed to the cost of law enforcement “because success from effective law enforcement fed directly through to the bank’s bottom line” (ibid. pp. 15-16). The warnings of Hay and Snyder (1989, pp. 27–29) and Hope (2001, p. 212) as to how privileged access to justice by some, at the risk of it being denied to others, appeared absent from government thinking as they advocated policing as a club good. The ABI (2004) welcomed the government’s approach, highlighting the lack of police resource and their appetite for dealing with fraud as the principle obstacle faced by insurers. They acknowledged their own investment in counter-fraud activities, and the ultimate sanction of the right to reject suspicious claims, but the ABI were concerned at the lack of deterrents and criticised the rarity of prosecutions and the missed opportunities to identify more widespread criminal activity. They advocated that any increased police resources should, in part, be directed to prosecuting insurance fraud and to assist insurers sending a message that fraud is unacceptable. More significantly in light of the research question addressed in this thesis, the ABI (ibid. p. 2) urged Government to develop:

> “an integrated national plan to combat fraud ... across public and private sectors, in a way that would, to some degree, mirror the strategic approach to money laundering by disrupting criminal activity through recognising the benefits of sectors working towards a common goal”.

By employing indirect lobbying tactics to build relationships inside the system, suggest affiliations with interest groups to widen the support for the agenda and using the media to build the message, the ABI was informally seeking to influence both government and the police to provide greater resources in areas they felt would be more effective. They were explicit in proclaiming that insurance fraud was a crime which, they said, on personal household and motor policies alone, had an estimated cost of £1 billion with c. 40-50% of that sum related to deliberate premeditated attempts to commit fraud usually by fabricating the circumstances of a claim, many
of which they said linked to “organised criminal gangs involved in other types of serious criminality” (ibid. p. 1). The ABIs use of a large and uncorroborated estimate is unhelpful for academic researchers. Their published statistics for detected (and avoided) motor insurance fraud revealed that insurers avoided £78.9 million in proven or suspected dishonest claims in 2004 (ABI, 2012a) leaving an unexplained delta of £921 million. In 2005, the ABI (2012a) reported detected motor insurance fraud had more than doubled to £181.66 million. When questioned on the integrity of that data, I6 said that the focus on fraud was, at that time, “an issue in a slightly undefined type of way” and “not really supported by any robust industry data”. At around the same time, the insurer’s experience with police fraud investigations and their disposition to fund a police response was evolving. The Court of Appeal judgement in the Hounsham case had criticised the insurer involved and influenced insurers who, when the ABI made their submission to the Fraud Review (ABI, 2006), advocated the effectiveness of current expenditure “would be significantly improved if law enforcement agency priorities and resources were based on an accurate assessment of the risk of, and harm caused by, fraud”. By 2006, the ABI estimate of the undetected insurance fraud risk had grown from £1 billion to at least £1.5 billion and they recommended (ibid. p. 5):

“the establishment of regional anti-fraud squads along the lines of the City of London Police... (representing Wales, Scotland, Northern Ireland, Northern and Southern England) housed within a local police force... with local expertise”.

More importantly, the ABI rejected private sector funding of police investigations because:

- the industry already invests significantly in fraud detection and investigation;
- insurers are invested in the IFB, a private sector response to organised insurance fraud;
- prosecution is a public interest issue and should not depend on the ability to pay; and
- according to the Court, private sector funding is not good practice.

I6 added some colour to the reluctance of insurers to privately fund explaining that “the government are always saying to the ABI, ‘you benefit from it so why don’t you pay for it?’ ... whole swathes of things, flood defences ... Fire and Rescue Service ...?”

Change the way you look at things and the things you look at will change

In 2006 (ABI, 2012a), just £206.9 million (prior year £181.66 million) of the £1.5 billion of claimed exposure to fraud was identified as detected insurance fraud leaving £1.3 billion of the

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37 In subsequent references to detected claims, the research assumes that the sums identified relate to potential losses that were detected and avoided and so did not constitute a loss incurred through fraud.
exposure unaccounted for. indicated concern from industry chief executives that insurers were identifying avoided fraudulent claims but the police were not responsive and recalled the ABI were keen to “create more publicity around fraud” but lacked the data to make their argument to government for “a real case for change.” Fraser, cited by Harris and McGrath (2012, p. 77) summarised the challenge that was soon to focus the ABI:

“selling the policy issue in the government marketplace is parallel to selling a product or service. It is essential to plan, package and present the issue to convince the decision maker, often a legislator or government policy maker. The most cost-effective technique is to show the number of supporters (and voters) on your side.”

In terms of packaging the message, the ABI (Insurance Fraud Bureau, 2006) started by sponsoring the creation of the IFB as a means to highlight the scale of insurance fraud and to provide insurers with the first iteration of empirically generated but still partly estimated data for organised fraud. With software developed by BAE Applied Intelligence it used meta data analysis to detect cross-industry motor insurance fraud activity and then applied an imputed value per incident to produce an estimate of the likely value of claims arising from crash for cash incidents.

To assist the delivery of the message the ABI (2008b) also published “a consumer factsheet to help consumers reduce their risk” which highlighted an increase in whiplash claims despite the Government’s casualty statistics suggesting that British roads were getting safer. It included a statement from their Director-General (ABI, 2008a) and signalled, for the first time, the unquantified connection between whiplash, fraud, and costs, a message destined to evolve and shape the nascent media and policy debate. The ABI had also commissioned the ABI Research Brief (discussed in Chapter 2) which confirmed their estimate of undetected general insurance fraud was now £1.9 billion. Detected fraudulent claims were claimed to be £730 million of which £353 million related to motor claims. These figures are breath-taking. The volume of criminal activity detected, even if it relates just to £353 million of detected motor insurance fraud, is difficult to comprehend. Referencing the work of the IFB, and also cognisant of the government focus on organised crime following the Fraud Review, the ABI Research Brief cited £200 million as the aggregate estimated value of identified organised fraud (Goss & O’Neill, 2009, p. 3). This figure equated to 10.5% of the ABI estimate for undetected general insurance fraud (ibid. p. 1.) but just 0.5% of the 2004 Home Office estimate for the “losses and harms caused by all forms of organised crime” (Home Office,

38 Source: Interview with I2
The ABI may have been punching above their weight\textsuperscript{39} considering the quantum of claimed exposure to organised fraud or they may have anticipated the government’s direction of travel at a time when the Home Office agenda was focused on the potential for business partnerships of sectors characterising themselves as victims (Green, 2007, p. 453) and extending police initiatives like DCPCU. It thought the Government recognised in 2009, “\textit{in headline terms rather than speeches}” that “the insurance industry would benefit from tackling insurance fraud, so why doesn’t it pay for it” and chief executives concluded that, without funding, “insurance fraud was not going to be investigated”.

The economic prognosis for insurers in 2009 was, however, more perilous than their estimated exposure to undetected fraud and 2010 was set to mark a watershed moment. The General Insurance Communications Committee of the Actuarial Profession (2010, p. 4) reported that motor insurance results were “\textit{worse than feared}” with 2009 one of the least profitable years on record. They blamed:

- higher personal injury claims and associated costs;
- customer facing claim management companies and solicitors;
- the recession;
- reduced investment returns and worsening economic outlook;
- eroding reserves; and
- price competition from comparison web-site aggregators.

They signalled an urgent need for insurers to raise motor insurance premiums by 20\%, a difficult, almost unimaginable outcome, during a recession which, according to Pettinger (2017), was characterised by

- rising unemployment;
- low/negative economic growth;
- illiquidity in the banking sector leading to reduced lending;
- falling house prices leading to negative wealth effects;
- reduced consumer and business confidence; and
- falling GDP compounded by fiscal austerity.

\textsuperscript{39} In the 2017 AFI (Button et al., 2017, p. 8) the authors classified confidence in the industry data for general insurance fraud as ‘Bronze’ which is “met when an attempt at identifying the cost of fraud has been made, but there may be limited confidence in its credibility.”
Raising any consumer cost by 20% against such a harsh economic backdrop was an unattractive commercial proposition but with price comparison aggregators challenging attempts by insurers to raise premiums, the recession gave insurers “fresh impetus at the same time as the industry was burning up the last of its surplus reserves” (The Actuarial Profession, 2010, p. 4). Another actuarial report from EMB Consultancy Limited (“EMB”) (2010) offered a similar analysis but, curiously, neither of the two reports identified fraud as a component of the deteriorating economic position confronting insurers though EMB (Read, 2010) later rectified the omission, ascribing the surge in insurance premiums (rather than the losses sustained by insurers) to:

- historically and artificially low premiums from fierce competition leading to low industry profit;
- a huge increase in fraud especially crash for cash;
- the impact from price comparison web-sites;
- an increase in uninsured drivers; and
- increased personal injury claims.

There are some anomalies with EMB’s claims. For example, the reference to an increase in uninsured drivers is at odds with the Motor Insurance Bureau’s (“MIB”) (cited by the ABI in their submission to the TSC (Transport Committee, 2011a))

“uninsured drivers are more likely to get caught now than ever before: improved detection techniques and enforcement of the law has resulted in a reduction in uninsured driving in the UK in the last four years. Since 2005 real progress has been made with more than 600,000 vehicles seized for no insurance, contributing to an overall 20% reduction of the number of claims from uninsured and untraced motorists.”

In addition, EMB’s reference to a ‘huge’ increase in crash for cash related fraud can only have been inspired by the IFB estimate, no other data having been issued on the phenomenon and a figure that may well have been avoided by insurers in any event thus having a limited impact on costs. Nonetheless, in 2010, the picture appeared bleak; motor insurers were in a beleaguered market in need either of re-financing or a different solution. Simon Lamble, the motor insurance product director at Confused.com (Read, 2010) said:

“Zurich publicly announced in January it was looking to increase prices by up to 20%. This signalled the action the industry has taken in a bid to get back to profit. Increasing claims

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40 EMB Consultancy assisted 19 of the top 20 UK motor insurers in product pricing (Transport Committee, 2011a, p. 76)
costs, more injury pay-outs and fraud have created a situation where providers are not making any money.”

**Lobbying; we all know how it works (Cameron, 2010)**

The ABI were definitely lobbying government by June 2010. The Guardian (Ramesh, 2012) revealed in January 2012 how insurers were given extensive access to civil servants drafting the bill that would become LASPO and which would benefit insurers materially. They identified that

“Robert Wright, the head of civil litigation funding and costs at the MOJ and the official in charge of the controversial reforms, and his team gave the ABI, regular information on their plans with officials pressing Ken Clarke, the justice secretary, to attend insurance industry events with emails telling the ABI that they were "working on" getting ministers to attend events before the Tory party conference last year.

In May 2011, the government was in talks with the insurance industry over controversial plans to force defendants to pay their costs even if they win a case – a change known as "qualified one-way cost shifting". The Civil Justice Council, the body tasked with investigating these proposals, was only informed by ministers in July.

On 8 September 2011, Wright sent the ABI a press release outlining the proposed ban on referral fees – payments for finding victims of road accidents who could sue for compensation, which the industry had long advocated – the day before it became public. Twenty minutes later, the ABI returned the favour, sending the MOJ its press release, adding it had briefed the BBC’s Today programme and they would use the information "as a basis" for interviewing the minister.

The 118 pages of official papers, record discussions between insurers, their lawyers and government officials working under Djanogly, the justice minister. Djanogly gave up regulating parts of the industry after a Cabinet Office investigation into his personal insurance holdings in October.

The legal aid bill is being debated in the Lords until Monday. Financial firms with insurance interests have given the Tories £5.4m in the last decade, £4.9m of that since David Cameron became leader in December 2005.

The prime minister has invited the chief executives from the insurance industry into Downing Street to discuss how to deal with the burgeoning costs of civil litigation.

Lord McNally, the Lib Dem peer piloting the bill through the upper house, had insisted ministers "will not pander to or give special access to ‘vested interests’ such as the Law Society and the Bar Council”.

Desmond Hudson, the Law Society’s chief executive, said: "This looks like being legislation for the insurance industry, by the insurance industry. It is an unusual and unsatisfactory notion of democracy when insurers can write the laws of the land. The Law Society has campaigned and lobbied for changes in the interests of access to justice ... the government must be even-handed with all interested parties of the bill."
But a spokesperson for the ABI said: "We have not said anything in private that we have not said in public and we have nothing to hide. We make no apology for providing evidence to policymakers to tackle the compensation culture and help reduce motor insurance premiums. The ABI, unlike the claimant lawyer lobby, has provided the evidence and analysis to support our public policy positions rather than rely on rhetoric and anecdote."

An MoJ spokesman denied that the insurance industry had been given privileged access to the ministry. "Ongoing dialogue between government and stakeholders is an important part of policymaking. It is normal business to listen to a range of views."

The e-mails at Appendix F show a clear engagement on the imperative of reducing the costs recoverable by solicitors in bodily injury claims. A more accessible summary of the key interactions appears at Appendix E. The emails are silent on the issues of fraud, organised or otherwise. Of course, there may be other hidden communications but, when considered with the publicly available submissions, those e-mails evidence that all of Van Schendelen’s (1994, pp. 3–22) indirect method of lobbying were deployed by the ABI. They suggest a degree of familiarity, almost conspiratorial intimacy, between the ABI and MOJ with the MOJ attaching an uncritical reliance on the veracity of data and legitimacy of opinion supplied by the ABI. For example, at the MOJ’s request, the ABI provided raw data from work conducted by Frontier Economics (F 292) supporting conclusions previously reached by government that the processes and costs involved in making a personal injury claim are disproportionately high, particularly in lower value claims (Department for Constitutional Affairs, 2007, p. 15). Prior to that request, and following extensive consultation, Sir Rupert Jackson had completed a report in which he proposed reforms to costs and the rules surrounding the case management of civil claims. Whilst his proposals on setting the level of costs recoverable in litigated claims were being considered, the MOJ asked the ABI to seek permission from Frontier Economics to access the underlying data from their research work and for other ABI members to provide them with “anything they can let us have … on a no names basis” as part of the work the MOJ were performing in a public consultation (F 298). Significantly, for reasons that will become evident below, the MOJ confirmed they were looking for data that included the total number and value of:

- personal injury cases dealt with,

41 The syntax ‘F number’ references the page of the document referenced in Appendix F
42 (dated 1st April 2007 and presumably covering claims for 2005 to April 2007 per the Frontier Economics report)
43 Jackson LJ reviewed civil litigation costs in the context of their effect on access to justice. The report was presented to Jack Straw, as Lord Chancellor, in January 2010. Most of Jackson’s recommendations were enacted under the coalition government post May 2010 through enabling legislation (LASPO).
• claimant’s costs paid out,
• defendant’s costs incurred, and
• damages paid.

In Chapter 2, the ABI’s parallel referencing of its own unsubstantiated data was suggested as the basis on which undue credibility was given to their estimate of undetected insurance fraud. The criticism was made because the figure reported by the NFA claimed reliance on data supplied by the ABI and IFB (National Fraud Authority, 2013, p. 48). Subsequently, the ABI, and the IFT, both referenced the NFA as authority for the quantum of undetected insurance fraud on which their arguments were based. This criticism of parallel referencing is re-made here because, two months after providing the Frontier Economics research data to the MOJ, in a speech given by the ABI to the North East Regional Group of Insurance Institutes (F294) there was a reference to the extent of the problems facing insurers:

“The estimated total cost of claims made to the insurance industry in 2009 is approximately £14 billion. This is twice the amount paid only 7 years earlier in 2002! Unless motor injuries are twice as bad as they were ten years ago there are flaws in our compensation system that need to be addressed.

These are not self-interest figures generated by the insurance industry – they are the government’s figures. And although they are now somewhat dated in that they are four years old (2006), I am sure the figures have only become worse since then.”

The salient point was the reference in the speech to the figures not being “self-interest figures generated by the insurance industry” but being “government figures”, an odd statement in light of the evidence that the raw data relied upon by the MOJ was likely provided by the ABI in July 2010. It appears, therefore, more likely that the figures were “self-interest figures” but that they were instantly given an air of independent authority by attributing them to the government. The issue of fraud was also addressed with the speaker announcing £840 million of detected fraud for 2009, a figure which he related to savings made by insurers that was not an additional cost suffered by them. The speaker also confirmed, from work carried out by the IFB, that 30,000 detected staged accidents had cost insurers c £350 million in 2009 with crash for cash something that “was a crime that increases premiums for the honest motorist”. Whilst claiming that insurers “have no problem in paying genuine whiplash claims” the speaker also highlighted the connection between whiplash and fraud, first made in 2008 in an ABI report (2008b) leading the speaker to assert in 2010 that “British necks seem to be weaker than elsewhere in Europe”.

In September 2010, in a move more than likely designed to build affiliations and widen the support for their agenda, the ABI worked with the MOJ and Lord Hunt to facilitate a lunch in the
House of Commons “for key stakeholders to discuss the recent changes and the possibility of future reforms to the personal injury compensation system” (F 302). Invitees included interested MPs including Ken Clarke and Djanogly, interested members of the House of Lords, representatives from ABI member companies and “other interested organisations”. 80 people were invited to the lunch which was held on 27th October 2010 (House of Commons Banqueting Office, 2011) although the attendee list was not published. According to the parliamentary register of interests, Lord Hunt was non-executive chairman of the British Insurance Brokers’ Association ("BIBA"), as well as a practising solicitor, non-executive director of GRP MGA Holdco Limited (involved in specialty insurance acquisition and development) and, as mentioned previously, a partner in DAC, which acts for insurers in defending motor claims whilst also claiming significant lobbying credentials including “unrivalled knowledge of the workings of Westminster” (Cave & Rowell, 2014, p. 58).

The Transport Committee investigation

It may have been merely coincidental but, on 19th October 2010, concerns about the rising cost of motor insurance had become an issue that the TSC determined it wanted to explore (2010). In an investigation that ran between late 2010 and 2015, and morphed into an investigation into the impact of whiplash on the cost of motor insurance, they initially received written evidence from 16 organisations and heard oral evidence from 19 witnesses, including the Researcher (Transport Committee, 2011a). The investigation was focused on the cost of motor insurance and the accessibility of insurance for young drivers. The incidence and cost to the insurance industry from increasing volumes of personal injury claims dominated the evidence.

EMB informed the committee that annual bodily injury claims inflation was running at 30% in 2010 with the associated costs of those injury claims representing 50% of UK motor insurance claim costs. These were significant indicators of a dysfunctional system but the provenance of the data on which EMB’s evidence was based was cited as “their representative on a working party” of the Institute and Faculty of Actuaries ("IFA") “which had unprecedented access to data supplied by companies making up almost 90% of the UK motor insurance market”. They attributed a third of the reported claims inflation to a higher number of bodily injury claims and the remainder to the higher average cost of settling claims. No support was given for the estimate that associated costs accounted for 50% of motor insurance claims but there was, again, evidence of parallel referencing. EMB cited claims fraud as a driver of the 50% increase because “the ABI valued the cost of

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44 Secretary of State for Justice and Lord Chancellor
fraudulent insurance claims at £840 million ... and it estimated that motor insurance fraud accounted for £410 million” (ibid. p.75). £840 million had already been acknowledged by the ABI in their speech to the North East Regional Group of Insurance Institutes as “savings made by detecting fraud” and not therefore, an increased cost and so EMB’s use of that figure appears wrong. In addition, EMB’s estimate of bodily injury claim inflation at 30% is incapable of corroboration from the limited publicly available ABI data (2015e) which is reproduced in Table 6.1 below46. Between 2008 and 2009 the ABI data indicates that bodily injury claims were lower by 10.21%, the average pay-out amount increased by 9.9% but the movement in gross payments was down by 1.3%. Nowhere can a figure of 30% be extrapolated.

<table>
<thead>
<tr>
<th>Year</th>
<th>Bodily injury (BI) claims notified</th>
<th>Annual movement in BI claims notified</th>
<th>Average BI claims payment amount</th>
<th>Annual movement in BI payment amount</th>
<th>Gross BI payment</th>
<th>Annual movement in gross BI payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>253,000</td>
<td>17.10%</td>
<td>£3,512</td>
<td>16.20%</td>
<td>£888.54 m</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>227,000</td>
<td>-10.21%</td>
<td>£3,863</td>
<td>9.90%</td>
<td>£876.90 m</td>
<td>-1.30%</td>
</tr>
<tr>
<td>2010</td>
<td>254,000</td>
<td>11.80%</td>
<td>£3,565</td>
<td>7.70%</td>
<td>£905.50 m</td>
<td>3.20%</td>
</tr>
</tbody>
</table>

Table 6.1: Annual personal motor claims; 2008-2010 (Source: ABI 2015)

The Researcher observed that the ABI also relied upon EMB’s estimates in their submission to the TSC (parallel sourcing again) offering no explanation as to why it was preferred over their own published data. They did clarify one statistic which was that in a review of 50,000 claims where the compensation paid was less than £5,000 that for every £1 of damages, £0.87 of claimant solicitor costs was paid, a statistic that might support EMB’s estimate that the associated claims settlement costs are 50% of UK motor insurance claim costs. However, even that argument is questionable since it ignores the significant volume of claims where no injury is involved, and so there are no associated costs even though damages are still paid in respect of other uninsured losses. It also ignores those claims where damages are above £5,000 and the costs may represent a lower percentage of the damages paid (Transport Committee, 2011a, p. 82). Relying on third party data from consultants may have helped widen the support for the ABI agenda, an indirect method of lobbying identified by Van Schendelen, or simply allowed the ABI to avoid direct scrutiny of their own figures. The ABI did draw the committee’s attention to the proliferation of claim management companies in recent years (ibid. p. 82), a concern also highlighted by the AA who accused those companies of using direct marketing techniques to generate claims that accident victims would not otherwise have made, or to make claims for injuries that had not been suffered and which, they

46 the columns headed ‘Annual Movement’ were calculated by the Researcher

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felt, “may be fraudulent” (ibid. p. 93). The Lloyds Market Association (“LMA”), identified the cost of settling personal injury claims as one of the principal factors that have “illegitimately increased insurer’s claim-spend” citing referral fees paid by solicitors, the impact on costs of ‘after the event’ insurance policies and ‘no win, no fee’ arrangements (ibid. p. 79).

BIBA were more critical of insurers. They claimed to have foretold the need for premium increases for some time, pointing out that insurers had incurred significant underwriting losses for successive years and that the soft market could not continue forever because of the reduction in investment income, the growth in the number of claims, and the intense competition and unsustainable rates from comparison sites. Those factors, together with the unquantified consequences of illegal activities including fraud and uninsured driving, led BIBA to conclude the bubble had finally burst for the insurance industry (ibid. p. 101).

On the topic of fraud, a number of organisations, including EMB (ibid. p. 75) and the AA (ibid. p. 95), referenced the data published by the ABI who simply re-stated their estimate that there was £930 million of undetected motor insurance fraud in 2009 (ibid. p. 84). Confused.com, an aggregator and subsidiary of Admiral, made similar points about the levels of undetected fraud suggesting the offence was more probable in recessionary times (ibid. p. 90) whilst the LMA cited data from the IFB with an anecdotal reference to one LMA member having reported that the number of fraudulent claims investigated had increased by 54% in 2009 compared with 2008 (ibid. p. 80). No reference was made by any contributor as to whether the increased number of investigations into suspicious claims had impacted the incidence of detected fraud.

The oral evidence followed the general thrust of the written submissions although the testimony of Nick Starling, a former Director at the ABI, and Ashton West, Chief Executive of the MIB were noteworthy (ibid. pp. 44-52). West conceded the MIB could not “put a figure on what we don’t know [and] just in case there is any misunderstanding, I am not saying that all whiplash claims are fraudulent or anything like that.”

Starling was more explicit:

_We’ve done a lot of work on undetected fraud [although] by definition, there’s a sort of “Rumsfeld” element to it. We reckon that undetected fraud across the insurance industry is about £1.9 billion, of which about half is motor. It is on quite a spectrum. At one end you’ve got the really lethal stuff which is around staged motor accidents, where a whole lot of fraudulent behaviour is involved of fraudulent doctors, fraudulent solicitors, fraudulent witnesses, everything. There is a big, big problem at that end around the staged accidents._

He also condemned the system for making claims which he said was:
“...essentially dysfunctional. If you are unfortunate enough to have someone run into the back of you it is quite astonishing what then happens. You are an extremely valuable property. People want to get at you and sell their services, whether it be claims management companies, whether it be mending the vehicle or whether it be supplying a vehicle for you to use while your car is out of action. If you are the victim of an incident which is not your fault, huge temptations are put in your way. You are constantly encouraged to apply for a personal injury claim. It’s quite understandable that particularly people who might be in difficult economic circumstances might respond to that.”

The right to claim compensation for damages arising from the negligence of another is trite law. In two conjoined appeals before the House of Lords in 1993 (Giles v Thompson and Devlin Baslington HL/PO/JU/18/253), Lord Mustill remarked upon the challenge then brought by insurers to defeat the Claimant’s right to lawful damages:

“there are many motorists who lack the inclination or the ready cash to hire a substitute on the chance of recovering reimbursement from the defendant’s insurers. Thus, there exists in practical terms a gap in the remedies available to the motorist, from which the errant driver, and hence his insurers, frequently profit”

Almost 20 years later, Starling’s criticism that innocent victims might seek legal advice in response to the government’s determination in 1999 to make legal services more accessible is understandable but perhaps only justifiable to the extent that insurers have failed to resist illegitimate claims. The linkage between the “huge temptations” he referred to with the increase in bodily injury claims and the claimed increase in fraudulent claims appears unsavoury when insurers were themselves benefitting from encouraging their own customers “to apply for a personal injury claim” in order to participate in referral fees. When asked if insurance companies were receiving referral fees, which the ABI later conceded to the MOJ had a value of up to £900 or £1,000 for a low value motor claim (F 348), Starling responded that:

“It is a dysfunctional system and people have to play the system as it exists [but] we have accepted as an industry that referral fees will have to go as part of the whole package of reform.”

The reference to the “whole package of reform” may have been a marker of the private discussions taking place between the MOJ and the ABI. No evidence was given to the committee detailing the extent to which insurers may have distorted their own cost base as a consequence of ‘playing the system’ and nor has any economic analysis ever been released to indicate the extent to which the insurer’s incurred motor losses may have been lower had they not done so. However, when asked to identify the most important measure to bring the cost of motor insurance premiums down while still maintaining insurance, the ABI did not focus on fraud, the undetected element of which Starling had claimed to be costing insurers £1.9 billion annually. Instead, he said “sort out
personal injury and do something real and fundamental about young drivers” (Transport Committee, 2011a, p. 52)

Between November 2010 and March 2011, activity appeared limited although behind the scenes, and as Christmas approached, the ABI wrote to Robert Wright at the MOJ (F 314) confirming, “great working with you this year and looking forward to us working together again in 2011.” And then, shortly after Christmas (F318) Keoghs wrote to the MOJ in respect of a meeting they had arranged and which included Djanogly attending:

“Further to our conversation of yesterday evening, I promised to provide you with details of those who have committed to our morning meeting on the 19th in Westminster. The venue is to be One Whitehall Place. The attendees will be [redacted].

All the above are highly engaged in the process, have been for some years, and will have a lot to say to the Minister. I have a longstanding relationship with Beachcroft and have worked with Lord Hunt and [name redacted] over a number of years and would be happy to co-ordinate with them.”

The TSC reported in March 2011 (Transport Committee, 2011a). The subtlety of the phraseology used in their summary suggests the insurer messaging was succeeding. The issues of access to justice, the right to fair compensation for post-accident damages and the rise in claimed insurance fraud had become fused into one sound bite as the committee concluded:

“increased premiums arise from increased personal injury claims with associated increased costs and despite that being a lawful outcome it depletes the risk of fraudulent claims for non-existent or pre-existing injuries which they believe the police should tackle by way of a dedicated police unit for insurance fraud”

The ABI (2011d) were dissatisfied with the response, nailing their colours to the mast and issuing a press release claiming the TSC had missed the point:

“The Committee has failed to recognise that the main cause of the recent increases in motor insurance premiums is ever-increasing personal injury claims and spiralling legal costs. These are often driven by claims management firms ... Legal costs alone now add an extra £40 a year to the average motor premium, and motorists should not have to foot the bill for our cost-ridden compensation system.”

On fraud, they gave a more muted response claiming that insurers were working hard to combat insurance fraud, including funding the IFB, which was working closely with the police in investigating organised motor insurance fraud.
Behind the scenes, the meeting arranged by Keoghs had taken place. A response to an FOI request (Justice Policy Group, 2011) confirmed a total of at least 9 such meetings during 2011 which are listed in Figure 6.2 below. The MOJ deemed the content of those meetings to be information it was “not obliged to provide” relying on the statutory exemption that the information exchanged in the meeting related to the formulation of government policy. Moreover, having considered further whether it would be in the public interest to provide the information, the MOJ concluded that “the public interest favours withholding the information”. It is difficult to reconcile that statement objectively when the results of the lobbying included proposals to eliminate certain common law rights.

<table>
<thead>
<tr>
<th>Schedule of Meetings involving Jonathan Djanogly MP or his officials</th>
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<tbody>
<tr>
<td>Djanogly, Keoghs and others (19/01/2011)</td>
</tr>
<tr>
<td>Djanogly’s department officials, unnamed insurance company and other stakeholders (28/01/2011)</td>
</tr>
<tr>
<td>Djanogly’s department officials, the ABI, Keoghs, the NHS litigation authority and unnamed insurance company (12/05/2011)</td>
</tr>
<tr>
<td>Djanogly’s department officials and an unnamed insurance company (18/05/2011)</td>
</tr>
<tr>
<td>Djanogly’s department officials and the ABI (24/05/2011)</td>
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<tr>
<td>Djanogly and the ABI (04/07/2011)</td>
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<tr>
<td>Djanogly’s department officials and the ABI (09/08/2011)</td>
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<tr>
<td>Djanogly’s department officials and the ABI (29/09/2011)</td>
</tr>
<tr>
<td>Djanogly’s department officials and the ABI (10/10/2011)</td>
</tr>
</tbody>
</table>

**Figure 6.2: Schedule of Meetings Jonathan Djanogly MP and others**

Part of the content of one of those meetings was subsequently leaked by Tom Harris MP in a question of Paul Evans of AXA Insurance at a TSC hearing (Transport Committee, 2011b, p. 32) about referral fees and AXA’s unilateral announcement of a ban, Harris asked:

“Was that influenced at all by an internal strategy document by the ABI which said: “Our sense is that it would help greatly if one insurer announced publicly that it would stop receiving referral fees and if others followed suit. This would give our lobbying efforts more credibility. The current ABI position that we want a ban while our members continue to receive these fees is not ideal and leaves the industry open to allegations of hypocrisy”?“

Evans pleaded ignorance but the ABI later wrote to the committee (ibid. p. 41) confirming:

“… this was not an ABI document. This information was from the minutes of a meeting Keoghs hosted with the MOJ which was attended by the ABI. The views expressed were those of a Keoghs representative and not an ABI position …”

As well as expressing publicly their dissatisfaction with the conclusions from the TSC, the ABI also sent an e-mail to the MOJ (F 320) in which they said:

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47 Freedom of Information
“I thought it was worth mentioning the ABI’s reaction to the recent Transport Select Committee report on the rising cost of motor insurance. We were disappointed to see that the Committee failed to recognise that the main cause of the recent increases in motor insurance premiums is ever-increasing personal injury claims and spiralling legal costs, part of which includes referral fees. We plan to write to your minister in similar terms this week to highlight the issue with him.”

In April (F 327), the MOJ wrote to the ABI seeking clarification of their view on referral fees and, in particular, asking what the effect might be on the cost of legal expenses policies sold to consumers before an accident (“BTE”) if referral fees were outlawed. The ABI response was unclear but they did confirm that if a claimant was involved in an accident and sustained an injury that the claimant’s motor insurer “may sell on the details of the claimant to a claimant solicitor” who will pay them a referral fee or, if the legal expenses insurer received notification of the claim in respect of a BTE policy then that insurer would engage a solicitor who would pay a referral fee to the legal expense insurer as consideration. With the removal of referral fees, and on a pure mathematical assessment, BTE insurers would lose a significant revenue stream and would, therefore, have to charge higher premiums to consumers to insure against the need to appoint a solicitor if they were involved in an accident. Nonetheless, the ABI confirmed (F 328) “put simply, insurers want referral fees banned”. The agenda had, by this point, moved away from fraud, if ever that was the true focus for insurers, and it appeared motivated by a determination to reduce the incidence and associated cost of personal injury claims, dishonest or otherwise. In a later e-mail exchange (F 332) sent the day after a meeting between Djanogly’s officials, the ABI, Keoghs, and others, the ABI wrote to the MOJ encouraged that there was “an alignment of views on the claimant’s access to justice arguments and the ‘undesirable behaviours’ driven by claims management companies” and imploring the MOJ to look next at the issue of fixed fees and the hourly rate earned by solicitors dealing with litigated claims. In addition, the ABI wrote (F 332) “we are continuing with our effort to ensure that this message is not lost on members of the public.” Of interest is a throwaway line about referral fees claiming that “insurers make no secret that they receive these fees” despite only one insurer, RBS, having ever made public disclosure of the income such fees generated (Transport Committee, 2011b, p. 49).

By now, the ABI messaging to the media was maturing (2011b; Slack, 2011; “‘UK ‘whiplash capital of Europe,’” 2011) and, because whiplash had increasingly been linked with insurance fraud, included demands for a clampdown on the UK’s “pain in the neck culture” because “the activities of ambulance chasing lawyers and claims management firms, coupled with ‘crash for cash’ staged motor accidents has increased the risk of fraudulent claims” and needs to be stopped to “reduce the unacceptable costs which whiplash currently imposes on individuals, businesses and the
Responding to the assertion that the UK was the whiplash capital of Europe, Oliphant (2016, p. 20) argues that such claims by insurers were based on unreliable data and cherry picked to support specific reform agendas to address a largely illusory problem using:

“the power of simple slogans to colonise public debate about tort law, coined by those pursuing an agenda of tort reform and enthusiastically taken up by conservative commentators because they reinforce and provide tantalising new examples to illustrate more general narratives about declining standards of personal conduct and individual responsibility”.

The principal support for the ABI’s narrative was a study by the Comité Européen des Assurances (“CEA”) (2004). Oliphant’s criticisms of the report, and so his criticism of impact induced by the ABI by its deployment were manifold (2016, pp. 14–16):

- The various national insurance associations that supplied the data were counting different things and the ‘whiplash capital’ claim relies on the CEA data, which might plausibly be interpreted as identifying a number of alternative ‘claims capitals’ but the research design and methodology are inadequate for the production of reliable data sufficient for the making of any claim of that nature.
- The data shows that Italy has a stronger claim to be ‘the whiplash capital of Europe’, with 558,000 claims for minor cervical trauma (as compared with only 375,000 in the UK) at a total cost of €2,393 (more than double the €1,080 in the UK).
- Data also shows that ‘Switzerland is the whiplash capital of Europe’: the average cost per claim linked to cervical trauma is €35,000, far higher than the €2,878 average reported for the UK – which was also behind the Netherlands (€16,500), Norway (€6,050) and Italy (€4,288) and perhaps other countries, like Spain, for which no data were available.
- The ABI claim that the proportion of whiplash claims in the UK to bodily injury claims is ‘twice the European average’ (2008b, p. 4) appears to be based on a simplistic aggregation of data from nine countries and an average calculated without reference to population size or number of vehicles.
- Despite the inference the survey was pan-European (to support the anointing of a European capital), no country in Central or Eastern Europe was included and certain Western European countries, including Austria, Luxembourg and Portugal, were excluded whilst the data for Spain was incomplete.
The report was silent on the methodology utilised by those organisations supplying the data and how divergent data may have been interpreted to cater for variants in clinical definitions of cervical trauma.

Oliphant’s criticisms were made with the benefit of hindsight in 2015 but the deficiencies did not stop David Cameron using the phrase when issuing a statement (2012) in support of the ABI’s agenda for change following an Insurance Summit held in Downing Street. In addition, he pledged to

- tackle the compensation culture;
- identify effective ways to reduce the number and cost of whiplash claims; and
- reduce legal costs by committing to reduce the £1,200 fee that lawyers can earn from small value personal injury claims.

In return, insurers committed to “pass savings made on to consumers” (ibid.).

Moving back in the timeline, a further meeting between Djanogly’s department officials and the ABI was held on 24 May 2011. The agreed draft agenda (F 341) revealed that the ABI had, by now, become complicit in policy formulation. It included:

- the ABI’s call for a referral fee ban backed by other compensators;
- addressing the recommendation from the TSC report (Transport Committee, 2011a) which (embarrassingly, perhaps) called for greater disclosure of referral fees earned by insurers;
- practical issues re: banning or capping referral fees;
- insurer concerns about QUOCS (a costs recommendation from Jackson);
- the handling of the Bill to introduce the Jackson changes to outlaw referral commissions; and
- the ABI’s view of the calibrated assessment of damages and predictable damages.

Following the meeting, the ABI confirmed (F 340) that they were “very supportive” of the MOJ’s reforms and would continue to voice their support for government when the draft Justice Bill was released. They also expressed their desire to provide data and input in the more detailed implementation work and looked forward “to keeping our dialogue open” and to setting up a date to meet with Djanogly which was subsequently arranged. On the issue of referral fees, the ABI had probably not anticipated, or possibly they had on the basis of their previous concessions to the TSC and MOJ, an editorial from Jack Straw published in The Times (2011), attributing a significant
element of the growth in personal injury claims to the actions of insurers selling policyholder details to claims management companies:

“I went to see the Association of British Insurers and senior executives of two of Britain’s largest motor insurers and asked them. A long pause, a look of embarrassment, then one of the executives said: “This is the industry’s dirty secret. It’s we, the insurance companies, who sell on this personal information.” Referral fees are now a crucial part of all insurance companies’ revenue streams.”

Something of a conundrum that nobody has sought to resolve is whether the alleged increase in bodily injury claims was attributable more to insurer behaviour than opportunistic or organised criminals. That aside, the absence of any run-on media coverage following the editorial in The Times suggests insurers may have already extricated themselves from embarrassment with government by virtue of the earlier concession communicated by Starling in his oral evidence to the TSC. The ABI messaging was subsequently refocused to address the fraud agenda. Having been accused by Straw of being part of the problem, the three pillars approach demanded a re-boot of the messaging and, in July 2011, in a release highlighting that insurers were detecting fraudulent claims worth £18 million every week, Starling provided the revised message claiming “insurers are working harder than ever to protect honest customers against fraud. The savings made by weeding out fraudulent claims would otherwise end up being paid for by honest policyholders through higher premiums” whilst making the announcement that “the first ever national police insurance fraud investigation unit” would begin its operations early next year (ABI, 2011e). That announcement was not trailed beforehand and the nature of the negotiations between CLP, government and the ABI are not in the public domain. However, 16 did narrate the discussions leading to this point emphasising that it was the Police who sold the concept to insurers rather than insurers looking to subscribe:

“What took everyone aback was that the City of London Police went about it with a, sort of, enthusiasm that I think none of us really expected. The detailed case was built up by them; they effectively said to us, we can build whatever sort of unit you want, obviously there is a minimum size, but we can build anything you want … it’s up to you to set out what you think ... the commissioner even came in to the ABI and presented to the CEOs.

I have to say they presented extremely well … they played a blinder really, they knew how to impress the CEOs and I really remember [DCI] Dave Wood giving some descriptions of how they’d done raids and the CEOs just loved it. So that is essentially the history of how it was set up and why, and after a great deal of discussion, IFED was born.”

There is no public material about which factors precipitated the arrangements with IFED but the ABI’s representations about the scale of insurance fraud, as well as the evolving compensation culture they claimed was being polluted by opportunistic and organised fraudsters, probably made it hard for them to resist the initiative. For the CLP, the insurers may have represented an attractive
source of funding in similar vein to that generated by the banking industry with the DCPCU initiative. At launch, the annual costs for IFED were set at just £3 million (City of London Police, n.d.-c) which, in value terms, should perhaps be measured against an insurance industry managing £1.8 trillion of investments and, notwithstanding complaints about the inability of motor insurers to make profit, an industry profitable to the extent that it contributed over £10 billion in taxes to the exchequer (ABI, 2013d, p. 3). It should also be assessed in terms of the price of a solution to a problem that the ABI estimated, in 2014, exceeding £3 billion a year (City of London Police, n.d.-c).

By any metric, spending £3 million for a dedicated private police unit to save up to £3 billion, whilst continuing to work with government to deconstruct consumer entitlement to compensation in tort claims, appears too low a price unless the true incidence of fraud was far lower than claimed.

The ABI continued to rely upon the ‘whiplash capital’ claim remorselessly in media releases and in wider communications to government, regulators and MPs and member insurers followed their lead (ABI, 2011b, 2012b, 2012d, 2013a, 2013b; Button & Brooks, 2016; Post Magazine, 2012; Prime Minister’s Office, 2012; Transport Committee, 2013; “‘UK “whiplash capital of Europe,”’” 2011). In fact, Helen Grant MP48 (Ministry of Justice, 2012, p. 3), in her forward to the MOJ consultation document on reducing the cost and frequency of whiplash claims, referred to Britain as “the whiplash capital of the World” reporting the growth in whiplash claims and the Government sharing the widespread concern “that this growth may be linked to an increase in fraudulent and/or exaggerated claims.” Oliphant (2016, p. 20) argued that there is a lack of reliable evidence relating to the problems of fraud and exaggeration, and expressed a fundamental concern that unreliable data has been used to drive empirically unsustainable arguments to support the insurer agenda for profit. Helen Grant’s claim was reliant on the 2004 CEA study and support from the IFA (Transport Committee, 2013, pp. 14–15). It bears mention that the IFA were cited in the earlier TSC investigation into the cost of motor insurance in support of the contention that bodily injury claims inflation was running at 30% (Transport Committee, 2011a). In terms of the later TSC investigation into whiplash, when commenting on Grant’s claim, the IFA conceded (Transport Committee, 2013, p. 90) that whilst they “had not directly analysed whiplash claims” they felt it “likely” that the UK was the whiplash capital of the world based on a comparison with data for the US, even though “we have not been able to confirm the comparability” with UK data or UK motor insurance products. Their conclusion was reached because “given the high litigiousness which we see demonstrated in the USA as observed in other insurance products, we would have expected the USA to show more

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whiplash claiming than any other country all else being equal”. They reported having used the ratio of the number of third party personal injury claims made to the number of insured accidents (as measured by the number of third party property damage claims which are made largely in respect of damage to third party vehicles) as a measure of the scale of whiplash, given that personal injury claim numbers are dominated by small whiplash type claims, and compared the computed ratios for cities in the UK with comparable sized cities in the USA. The results allowed the IFA to support Grant’s claim in spite of the fact that their analysis was deficient and had no evidence at all about the incidence of whiplash claims in the US. The TSC (2013, p. 15) also disagreed with Grant’s claim having considered the explanation of the IFA.

“Any claim that the UK is the “whiplash capital of the world” cannot be conclusively proved or disproved from the international evidence which is available. It is surprising that the Government has brought forward measures to reduce the number of fraudulent or exaggerated whiplash claims without giving even an estimate of the comparative scale of the problem.

There is considerable scope for the insurance industry to provide clearer data about the number of whiplash (and other personal injury) claims which it is confident are genuine and those which give cause for concern, ranging from the out-and-out fraudulent to those where symptoms may have been exaggerated. Industry-wide agreement about how to classify claims and the collection of data by the ABI would strengthen the case for the Government to act.

We recommend that the Government press the ABI to provide better data about fraudulent or exaggerated personal injury claims, so that there is a stronger evidence base for policy decisions.”

Whatever ensued, the effect of the increased cost of claims settlement was a clarion call in an insurer agenda which would, by November 2017, benefit from:

- Insurer lobbying to shape government policy;
- An investigation by the TSC (2011a) into the cost of motor insurance and the incidence and cost of whiplash claims;
- Consistent, above inflation, increases in motor insurance premiums (ibid. p. 7);
- The creation of a privately funded police unit available only to insurers (City of London Police, 2011c);
- The demonisation of those entities supporting innocent injured victims (ABI, 2011b).
- The passage of LASPO, outlawing referral fees for personal injury claims;
- An OFT market study leading to a two-year investigation into the private motor insurance market by the CMA (2014);

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• A review by the CMR into Claim Management Companies and whiplash claims (Ministry of Justice, 2015);
• A series of regulatory measures threatening the viability of claimant solicitors (Rose, 2015);
• An intention to remove a victim’s common law right to compensation for whiplash and mobility after an accident (ibid.);
• Renewed focus on eliminating CHCs (Rose, 2017a);
• By s57 of the Criminal Justice and Courts Act 2015, the requirement for Courts to dismiss claims for personal injury where fundamental dishonesty is established.

Conclusions

This chapter noted the loss-making record of the motor insurance industry over 16 years and, from changes introduced by government in 1999, identified the increasing presence of solicitors and other organisations (including insurers) engaged with accident victims to further their economic interest in the conduct of personal injury claims driven predominantly by the incentives that followed the 1999 Access to Justice Act. It also identified the role that lobbying had occupied within the ABI since at least 2003 and then chronicled how that effort was energised between 2006 and 2012 to persuade government that fundamental structural changes were required to protect the viability of motor insurers in the face of increasing levels of insurance fraud and escalating costs associated with personal injury claims. Whilst there was evidence that some of the fraud was attributable to organised criminals, the topic that government had been energised about in 2004, the majority of fraudulent claims relate to simple whiplash claims, the ‘fraud of choice’ that insurers asserted were driven by a ‘pain in the neck society’ inspired by ‘compensation cowboys.’ The chapter summarised a review of the public message from the ABI, an analysis of submissions responding to a number of government and parliamentary calls for evidence, and focused on a series of e-mails passing between government and the ABI which identified a parallel process of hidden lobbying seemingly intent on persuading government of the imperative for change. The Researcher also suggested in the chapter that tactics practised by insurers may well have been motivated by a preliminary desire to create a ‘panic’ amongst the establishment in order to drive some of their proposed changes in regulation and criminal justice policy. Data presented as evidence of the estimated size of the fraud problem (and how much of that was not a cost because it was detected and avoided) was scrutinised. In addition, the evolution of the definition of
insurance fraud, from organised crash for cash to the effective stigmatisation of almost anybody that might have presented a claim for damages for a whiplash injury, was considered.
Chapter 7 Discussion

Summary

At the outset of the thesis, the Researcher declared his former professional interests. He had expected the results of the study to suggest that the creation of IFED had negatively impacted non-insurer victims of fraud but that was not the entire outcome. In fact, those engaged in the car-hire, bus and fleet sectors were ad idem that IFED had made no difference to their prospects of dealing with fraudulent claims, all of them conceding they currently had limited faith in the ability or willingness of the police to engage in investigating allegations of fraud and so had developed self-help measures to avoid or resist dishonest claimants. The response from the credit-hire sector suggested that, following the creation of IFED, the local police response had deteriorated. However, none of those surveyed were able to provide many instances of a more engaging pre-IFED response and there was no comparable data available to review against the current position, this issue not having benefitted from any published prior research. In addition, the Researcher cautions that the articulated antipathy to IFED may have ensued because they were seen as merely an extension of the insurance industry and a mechanic by which the legitimacy of the credit-hire industry could be attacked.

Several CHC respondents had invested in telemetry, data sharing, counter fraud initiatives and reliance on entities like the Bounty Hunter. Ironically, telemetry data had proved a powerful weapon in the CHO response to fraud and the inability of IFED to conceive a basis to engage, let alone work with the credit-hire industry represents, in the Researcher’s view, a manifest failure to acquire intelligence that could expose systemic and organised criminal activity. Accordingly, an overarching conclusion from the research was that whilst the Police had, prior to the Fraud Review and the creation of IFED, demonstrated limited enthusiasm for investigating allegations of fraud irrespective of the sector from which the complaint arose, the existence of IFED, accompanied with the effects of austerity measures on policing, has had a meaningful and detrimental impact on the ability of certain non-insurers to deal with insurance fraud relative to the protection available to insurers; the identity of the victim did make a difference as insurers pursued a hegemonic notion of victimhood (Coleman, 2004; Hopkins, 2016; Sim, 2004) having ideologically positioned themselves as not simply always the victim but, in respect of insurance fraud, the only victim.

Further, the partisan and blinkered approach to a single victim-set may be a contributory factor in the growth of insurance fraud facilitated by organised criminals, enhancing the prospects of impunity for offenders committing acquisitive vehicle offences involving insurance fraud against
the car-hire and credit-hire sectors in circumstances where IFED declined to engage. Cornish (1993, p. 31) saw organised crime as outcomes of a causal chain of “moves 'strung out along an axle, rather as kebabs are skewered on to a stick’” and Tremblay et al (2001, p. 561) analysed permanent retention vehicle thefts as “a sequence of moves (theft of the vehicle, concealment, disguise, marketing and ultimate disposal), each move having a specific mix of casting, location and props requirements [where] participants can play each move or scene in a variety of ways: cars may be stolen in parking lots or obtained by providing rental agencies with stolen identities. The UK government (Secretary of State for the Home Department, 2011, pp. 9–10) estimated around 6,000 criminal groups in 2011 comprising “38,000 organised criminals impacting on the UK ... highly adaptive, exploiting every available opportunity, system and technology to invent new or varied forms of crime” and who operate across boundaries, both in terms of crime type and geography, and who engage, inter alia, “in fraud, acquisitive and economic crime ... which can be used to fund and enable other serious and organised criminality”. In terms of the consequences for the offender from an asymmetric response limited by victim-identity, the probability is that offenders are entrepreneurial, and as Levi (2007, p. 612) said part of “a dynamic process that evolves as offenders adapt (or fail to adapt) to their changing environment.” They appear to appreciate the reduced detection risk from crimes against non-insurer entities or, more accurately, the increased detection risk where an insurer is involved. The research highlighted an emerging propensity for offences, associated with insurance claims, but committed against credit-hire and car-hire companies to facilitate acquisitive vehicle offences because of the speed with which the asset can be liquidated and limited prospects of detection. Both of the offenders in the first two case studies engaged repeatedly against credit-hire companies but whilst Offender 1 targeted the insurer to profit from his deceit, Offender 2 used insurance fraud to defraud credit-hire companies as a means for acquiring expensive vehicle assets. The same routine was evident in the organised export of stolen vehicles to Uganda and, in the ‘crash for ready cash’ cameo, the fraudster demonstrated a chameleon-like ability to avoid engaging the critical interest of an insurer, and hence the police, by repeatedly targeting victims for low value amounts that would never trigger an insurance claim but would leave the motorist a defenceless and unsupported victim of highway-robbery.

One issue considered when framing the research question was whether the police would co-operate. Unhelpfully, only one serving and two retired police officers participated in the study and none of those were, or had previously been, engaged with IFED or the CLP. Whilst the study would have benefitted from the CLP’s engagement and contribution, their reluctance to participate was perhaps apposite - indicative of the chasm separating IFED from non-insurer victims of fraud – but
did not impact the outcome of the research which was focused primarily on the victims and offenders rather than the operation of IFED.

Two issues that were not considered but became relevant retrospectively were the effects of austerity and shrinking police resources which may have degraded the response given to victims of insurance fraud irrespective of IFED’s creation. Equally, and because the research was predominantly undertaken through qualitative investigation, there was no control mechanism to validate the level and quality of service provided by the police pre-IFED in order to measure the difference in the level of police response afterwards. Those issues aside, the aim of the research was to explore the topic of motor insurance fraud through a number of different perspectives across five constituencies. Those perspectives are repeated below and a summary of the relevant findings follows:

- Identify how each constituency interacts to influence the outcome for an insurance claim.
- Chronicle the interplay between insurers, government and the police, identifying their respective roles in the changing social, economic and political environment.
- Explore how the insurance industry procured direct access to its own dedicated police resource.
- Investigate other sectors with exclusive access to a police resource for their own commercial advantage.
- Consider the growth of ‘multi-lateralised policing’ where non-governmental entities have either agreed to provide security services or assumed responsibility for their own protection consequent from the changing role of the police.
- Evaluate the opportunities, risks and consequences for stakeholders and victims of private-police partnerships.
- Consider the position in the USA where insurers have publicised ‘industry crises’ to reduce the ability of victims to obtain compensation.

**Research findings and contribution to knowledge**

In relation to the interaction amongst each constituency to influence the outcome for an insurance claim, the engagement was poor. Chapter 2 addressed the nature, and challenged the reported quantum, of motor insurance fraud offences claimed by the insurance sector as well as offering a detailed critique of the methodology used by the ABI to report on levels of fraud where

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49 Motor insurers and the ABI, the Police, non-insurer victims of fraud, the establishment and the media.
the methodology by which the scale of undetected fraud was calculated required an estimate reliant on the cost of detected fraud. The research identified that the detected fraud figure was composed largely of suspicious or rejected claims on which no payment-out was made and the value of claims where a payment-out was actually made was far smaller than the quoted headline figure. The researcher concluded that obfuscation at worse, or lack of clarity at best, allowed the ABI to influence the media and the political agenda resulting in the formulation of policy and regulation supportive of the insurance industries commercial objectives. The chapter also narrated some of the investments in people, processes, skills and counter-fraud initiatives from insurers and highlighted industrywide initiatives, such as the IFR, IFB, MID and CUE, but also noted that insurers remain disconnected from others, including self-insured entities and the credit-hire industry. Insurers were reported to have, and did concede, even amongst themselves, a disinclination to share intelligence or to work collaboratively with other insurers or other sectors even where there is a clear and pro-active approach to tackling fraud. These issues were exposed through the self-completion questionnaire, semi-structured interviews and the case studies in Chapters 2, 4 and 5. Some insurer respondents felt that some insurers used their competence for detecting and resisting fraud, or their relative maturity in the space, as a competitive advantage that they did not wish to share or allow a competitor to leverage to their advantage. Equally, a number of insurers felt that the credit-hire industry was a threat to their overall profitability and would welcome the demise of the industry as a means to avoid the current annual net costs of credit-hire of c £500 million. From many of the interviews there was accord that there were dishonest credit-hire companies operating but insurers were reluctant to adopt a multi-tier approach by isolating the least well-regarded and collaborating with the trusted suppliers irrespective of the potential ability to utilise better relationships to reduce the incidence of insurance related fraud.

The interplay between insurers and government in the evolution of insurer-friendly policy was reliant on a mixture of messaging, relatively broad adoption of the message by the media, increasingly sensational reports of the quantum of insurance fraud, a challenged insurance sector dealing with austerity and a competitive market and the belief, unchallenged by government, that the arguments and data proffered by the ABI were unimpeachable. Exploring how the insurance industry procured direct access to its own dedicated police resource. Interviews with I1 and I6 revealed that, in spite of purportedly breath-taking losses from fraud, the ABI had not felt it worth the expense to update the earlier research. More significant was the concession made to the Researcher that the data was produced to build a good case for government who “are always incredibly keen to get hold of insurance company data”. Latterly, the ABI used its data to express a link between the number of whiplash claims received by insurers and the assertion that many were
fraudulent. The problem eventually constituted a national calamity with the ABI anointing Britain as ‘the whiplash capital of Europe’ (ABI, 2011b; Prime Minister’s Office, 2012), a plaudit that the Government (Ministry of Justice, 2012, p. 3) subsequently elevated by confirming the country to be ‘the whiplash capital of the World’. The support for both accolades was debunked by the Researcher in Chapter 6, by the TSC (2013, p. 3) and, subsequently, by academics (Oliphant, 2016).

Chapter 6 also explored how the establishment response to insurance fraud was a result of insurers conflating the two terms ‘fraud’ and ‘whiplash’ and then having blamed the increase in fraudulent whiplash claims on the legal changes introduced to the Legal Aid system in 1999 by which solicitors had been lawfully permitted to accept claims on a ‘no win, no fee’ basis. The objective for insurers became reducing costs and not necessarily reducing fraud because, in addition to their lobbying and media campaigns, insurers had already improved, and continue to improve, their resilience to fraud. For insurers, fraud has now become more of an avoidable threat carrying a cost of prevention than a genuine loss where money is lost having paid out for dishonest claims. The thesis provided a critique of the publicly available data to demonstrate that claims that Britain was the whiplash capital of Europe, and then of the world, were without proper foundation but became widely quoted by insurers, media and government and fuelled the case for regulatory and statutory change.

The Researcher concluded that it would be beneficial to the insurance industry, and for policymakers, to publish a more empirically reliable and independently audited data set, especially since the ABI utilised the 2008 data and subsequent estimates as collateral support for media releases to highlight the scale of their victimhood and to stigmatise those innocent victims of road accidents seeking lawful compensation.

Chapters 4 and 5 identified circumstances where non-insurer victims were as likely to be impacted by insurance fraud as insurers were. In doing so, the thesis provided a first study of the credit-hire sector, its members experience as victims of fraud and their relationship with the police, insurers, the Establishment and individual customers. It also outlined some of the pro-active defences employed by CHC’s, including counter-fraud databases and telemetry enabled vehicles. It demonstrated how the sector could assist in the identification and detection of fraudsters but identified that the intelligence generated was routinely ignored by insurers and the police and that there was a deficiency in the mechanism by which victim groups could interact predominantly inspired by mistrust from the insurance industry of the bona fides and credibility of other sectors.

Measurement of the cost of motor insurance fraud to the credit-hire sector was a more difficult issue to resolve. It was originally envisaged that a survey might allow the losses suffered by the
respondents to be extrapolated for the credit-hire sector in order to provide some empirical data capable of comparison with the level of fraud claimed by insurers. However, the composition of the sector, effectively the relative difference in size of its members as measured by turnover, fleet size or activity levels, with the larger entities being public companies and reluctant to disclose price sensitive information in the survey, meant that it was not possible to acquire a sufficiently robust data set to do so. However, the thesis also provided a study of the impact of insurance fraud on the self-insured corporate sector and identified the unique challenges they faced, their experience with IFED and other police agencies and the emergence of private criminal-prosecutions as a means of addressing the lack of police response to those corporate victims.

The Researcher sought to investigate the opportunities, risks and consequences for stakeholders and victims of private-police partnerships. Chapter 5 included a case study which highlighted the variability of outcome and the potential consequences for victims and upside for offenders of an asymmetric response to insurance fraud offences which involve acquisitive vehicle crime and, in the case of Operation Navigate involved cross-border organised crime. This was an important outcome from the research demonstrating the likelihood that criminals, especially those involved in more serious and organised criminal activity, will take the path of least resistance. It demonstrated the frailty of a silo mentality when the nature of the initial offence, as in the case of acquisitive vehicle crime where a credit-hire company is defrauded, may be entirely unrelated to the eventual contribution it makes to organised crime but if the offence is not attractive to IFED or other police agencies then there are consequences for society. The study also identified the proclivity of insurers to take a line of least resistance in circumstances where high-value stolen vehicles were not re-patriated on the basis that the insurance pay-out had been made and the financial loss would be recovered by way of compensatory increases in future premiums. If insurers wish to contend that insurance fraud is not a victimless crime, then they must accept that their policyholders are also victims in respect of the increase in future premiums.

The research sought to investigate other sectors with exclusive access to a police resource for their own commercial advantage and consider the growth of ‘multi-lateralised policing’ where non-governmental entities have either agreed to provide security services or assumed responsibility for their own protection consequent from the changing role of the police. Chapter 3 provided a study of the public-private police initiatives preceding the creation of IFED and identified an embryonic matrix for assessing the potential tension between the commercial objectives of its funders and the wider needs of victims plotting public-private police initiatives on a continuum where the BTP is closest to a publicly funded public police service and IFED at the other end of the continuum. It also
dealt with the police reaction to insurance fraud which was perceived as fragmented but improving. IFED did not contribute to the research and contributed less to the demands of the credit-hire industry when they had become victim of insurance fraud. This was explored through the Offender 2 case study where multiple credit-hire businesses were repeatedly impacted with vehicles lost with a value exceeding £500,000. Certain insurers who had participated in the research identified that IFED were of limited use in pursuing allegations; insufficient resources and a preference to use intelligence to determine their tasking priorities rather than responding to immediate threats was given as a reason. The response to fraud from provincial forces was considered unpredictable and dictated by local priorities and declining resources. Respondents to the survey and the questionnaire indicated assistance from provincial forces could be at both ends of the spectrum (helpful or otherwise) but generally constrained by funding, manpower, local priorities and often, just “striking lucky” in attracting a police response.

In considering the position in the USA, where insurers have publicised ‘industry crises’ as a lever to reduce the ability of victims to obtain compensation, the Researcher felt this was probably the most compelling outcome of the research. The experience in the US with action on insurance related claims driven by the efforts of the US Tort Reform Movement and the similar initiatives subsequently engaged in the UK suggested a consensus view on the tools and strategic levers necessary to influence justice policy where the financial interest of insurers are impacted. Since 2009, the ABI data has populated countless media releases in support of an insurer agenda to ‘change the law’ and drive cost out of the claim system. Exploration of the US Tort Reform Movement, which had emerged to spearhead a reduction in tort claim costs, revealed similarities to the approach adopted by the ABI from 2008 using the media, lobbyists and the Establishment to influence and build government policy intent on reducing consumer’s common law rights. The thesis provided an insight into the role of lobbyists and the media in the UK and the Researcher identified six propositions that might have inspired insurers to behave as they did:

- According to Greer (2010), the news media are a defining feature of the justice landscape providing “key indicators of the nature and extent of crime, the appropriateness and efficacy of criminal justice, and the wider state of the nation”. Hall et al. (1978) suggested that the media continually reproduce the ideas of the ruling class and that news production is oriented in the purported name of “journalistic objectivity and impartiality” to appeal first to the accredited experts who represent and command institutional power leaving powerful groups in a position to “establish an initial definition or primary interpretation of the topic in question” (ibid. p58) prompting
Greer (2010, p. 494) to observe that “once the primary definition has been established it is extremely difficult to override, and future debate is contained within a forum of ‘controlled discourse’ governed by the primary definers”. Hall et al. (1978, p. 59) argued that “the media, then, do not simply ‘create’ the news; nor do they simply transmit the ideology of the ‘ruling class’ in a conspiratorial fashion. Indeed, we have suggested that, in a critical sense, the media are frequently not the ‘primary definers’ of news events at all; but their structured relationship to power has the effect of making them play a crucial but secondary role in reproducing the definitions of those who have privileged access, as of right, to the media as ‘accredited sources’. From this point of view, in the moment of news production, the media stand in a position of structured subordination to the primary definers.”

- Whyte (2007) considered that some businesses have gained sympathy in government policy discussions by characterising themselves as a “victimised business” by reference to the economic losses they face which Green (2007, p. 453) argued had inspired a movement against business-crime on an unprecedented scale through the proliferation of government-business partnership. Hopkins (2016, p. 162) considered that by positioning themselves as they have, business has contributed to a more generalised hegemonic notion of victimhood where large corporate entities might ideologically reposition themselves as “always the victim and never the victimisers” and Coleman (2004) claims “the clamour for more public-private sector resources to be diverted towards crime control grows, corporations are progressively empowered to dominate the law and order debate” and influence what should and should not be policed.

- Haltom and McCann (2004, p. 11) argued that “alluring stories that circulate in the media about law often pervade and profoundly reshape – or distort – legal policymaking and ordinary legal practice itself … stories routinely produced, reproduced and reconstructed through the complex circuitry of mass-mediated culture.” Without doubt, if this was not an objective, the evidence in Chapter 6 shows that it was certainly indicative of the way in which the incessant communication flow generated an outcome for insurers from government and regulators.

- Feinman (2005, p. 19), commenting on the success of the Tort Reform Movement in the USA attributed success partly to “an elaborate public campaign of misinformation that convinces people that reducing their rights is actually in their own interest.” Over ten years ago, Lord Levene, when Chairman of Lloyd’s of London, complained that a
“deluge” of claims was “plundering the economy” and that “ignoring it and hoping it will go away is not an option.” He implored that people “just look across the Atlantic” where he criticised the existence of a “blame culture” as “pernicious, cancerous and ruinous” (Cave, 2004). Levene may have benefitted from focusing on the conclusions of the BRTF (2004, p. 15) which identified the total cost of claims in the UK at just 0.6% of GDP, lower than that of ten other industrialised nations, including Canada (0.8%), Australia (1.1%), Germany (1.3%) and the USA (1.9%): only Denmark spent less (2004, p. 15). That aside, the experiences of the US insurance industry working with the tort reform movement may have been a trigger for the ABI in the UK.

• Van Schendelen (1993, p. 3) identified commercial political campaigning as an extreme form of lobbying, of which the use of the media message may be a component part. Van Schendelen saw the aim as, “mobilising opinion to exert pressure on public authorities for commercial gain or competitive advantage” and has resonance donations from businesses with insurance interests have donated £4.9m to the conservative party in the period from 2005 to 2011 when David Cameron was Prime Minister (Ramesh, 2012).

• Finally, Cohen (2002) and the possibility that insurers may have been keen to create a form of moral panic, but with government and the regulators rather than members of the public, in order to highlight the threat society was facing through the risk that motorists could be priced out of insurance and so lose the ability to follow the law (Transport Committee, 2011b, sec. Ev 3) to influence the evolution of justice policy and regulation aligned to their commercial interest.

**Recommendations**

With the current de-funding of the police and the neo-liberal approach to multi-lateralisation, the benefit of funding initiatives, such as DCPCU, was recognised “as an example of an area where business has contributed to the cost of law enforcement because law enforcement success can feed directly through to business’ own bottom line” (Home Office, 2004, p. 15). Chapter 5 identified that at least one vehicle manufacturer has telemetry and data acquisition capabilities which could evolve to form a more robust method of vehicle protection than existing technology which could have material advantages to the cost of insurance and, importantly, the reduction of acquisitive vehicle crime as a staple of organised criminal activity. This opportunity merits further exploration. In addition, other sectors might benefit from privately-financed police partnerships but there is no objective methodology for scoring their economic, societal or criminological validity. Several
insurer respondents felt that IFED would benefit from greater funding or co-location with provincial forces whilst non-insurer respondents called for a more honest appreciation of the victim and an agenda aimed at crime-reduction. Chapter 3 set out the embryonic basis for a scoring methodology which the Researcher believes is worthy of further investigation. Even to the extent that insurers are funding the cost of IFED, it is impossible to know, without accurate data relating to the threat-level, whether IFED are under or over resourced or whether finding a solution is under or over invested. If the fraud threat to the UK insurance industry is measured in £ billions, then government should look to provide statutory certainty on which, and for what period, IFED is governed and funded so that it avoids any possibility that the CLP are acting partially to secure an extension of the current short-term funding arrangement. In addition, the ABI should be compelled to make the investment in updating their current estimate of insurance fraud agreeing to publish the definitions and methodology by which the data is compiled. And, finally, consideration should be given to extending participation in the IFED initiative to other corporate non-insurer entities impacted by insurance fraud.
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Appendices
Appendix A – Cross-sectional survey: invitation, consent and content

Researcher: Steve Evans  stephen.evans@port.ac.uk
Supervisor: Professor Mark Button  mark.button@port.ac.uk

Study Title: The impact of the insurance industry’s funding of a dedicated police unit on the ‘non-insurer’ victims of insurance related fraud

REC Ref No: 14/15:29

SURVEY QUESTIONNAIRE

Dear [Name]

I would like to invite you to take part in my research study by completing a web-based questionnaire. Participation is voluntary but your responses would be valued. You have been identified as a potential respondent because you are involved in the credit-hire industry and may have experience of incurring a loss through insurance fraud.

My study is part of my PhD research looking at the impact of the insurance industry’s funding of a dedicated police unit on the ‘non-insurer’ victims of insurance related fraud, like credit-hire companies. I do not need your name or any identifying details; the questionnaire can be completed anonymously and all reasonable steps will be taken to ensure confidentiality. Responses from completed questionnaires will be collated for analysis. Once this is complete and my thesis has been submitted then the questionnaires will be destroyed. Up to this stage, completed questionnaires will be stored electronically in a database on my personal computer. I will write and let you know when my thesis is submitted so that you may learn more about the results of the research if you wish.

You can access the questionnaire at https://www.surveymonkey.com/s/7G73NQ2 and I look forward to your support. If you have any concerns regarding this research please contact me, or my supervisor, in the first instance.

Yours sincerely

Steve Evans
Thank you for taking part in my research study and agreeing to complete a web-based questionnaire. Participation is voluntary but your responses are valued.

My study is part of my PhD research looking at the impact of the insurance industry’s funding of a dedicated police unit on the ‘non-insurer’ victims of insurance related fraud, like credit-hire companies. I am a student of the Institute of Criminal Justice Studies at the University of Portsmouth (Telephone 023 92843923).

You will not be asked for your name or any identifying details; the questionnaire can be completed anonymously and all reasonable steps will be taken to ensure confidentiality. Responses from completed questionnaires will be collated for analysis. Once this is complete and my thesis has been submitted then the questionnaires will be destroyed. Up to this stage, completed questionnaires will be stored electronically in a database on my personal computer. I will write and let you know when my thesis is submitted so that you may learn more about the results of the research if you wish. If you have any concerns regarding this research please contact me, or my supervisor, in the first instance.

My e-mail address is stephen.evans@port.ac.uk and my supervisor, Professor Mark Button, can be contacted at mark.button@port.ac.uk

By moving to the next screen, you signify your agreement to participate in the survey.
Online Survey Questionnaire – questions and responses

Survey length: 10 minutes

You can take part in my research study by completing this web-based questionnaire. Participation is voluntary but your responses would be valued.

My study is part of my PhD research looking at the impact of the insurance industry’s funding of a dedicated police unit on the ‘non-insurer’ victims of insurance related fraud, like credit-hire companies. I do not need your name or any identifying details; the questionnaire is completed anonymously and all reasonable steps will be taken to ensure confidentiality. Responses from completed questionnaires will then be collated for analysis. Once this is complete and my thesis has been submitted then the data derived from the questionnaires will be destroyed. Up to this stage, completed questionnaires will be stored electronically in a database on my personal computer.

If you have any concerns regarding this research please contact me (stephen.evans@port.ac.uk), or my supervisor, Professor Mark Button (mark.button@port.ac.uk).

By moving to the next screen, you signify your agreement to participate in the survey.

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<th>Section</th>
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<th>Response</th>
<th>Next Step</th>
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|         | **Question 1**  
Is your organisation a member of The Credit-hire Organisation | a) Yes  
b) No                                                                 | a) Go to Q2  
b) Go to Q2 |
|         | **Question 2**  
Please identify whether you are responding to this survey as | a) A credit-hire operator which owns, leases or sub-hires vehicles and then rents them to accident victims as part of a credit-hire transaction  
b) A solicitor acting for a credit-hire operator who does not own, lease or sub-hire rental vehicles but acts in the recovery of uninsured loss claims pursuant to a credit-hire transaction  
c) None of the above | a) Go to Q3  
b) Go to Q6-Q13  
c) Go to End Message 1 |
| A       | **Question 3**  
What was the average size of your rental fleet over the last 12 months? (If you sub-hire some or all of your fleet please count these vehicles in your answer as if they were owned.) | Enter numerical value between 1 and 99,000 | Go to Q4 |
| A       | **Question 4**  
Looking at the same 12-month period what was your combined credit-hire and intervention rental turnover? | Enter financial value between £1 and £250 million | Go to Q5 |
| A       | **Question 5**  
Looking at the same 12-month period how many individual claims or hire transactions did your organisation process? | Enter numerical value between 1 and 250,000 | Go to Q6 |
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<th>Section</th>
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| A       | Question 6  
Over the last 12 months approximately how many claims did insurers reject, or seek to reject, because they alleged that your client’s claim was fraudulent? | Enter number between 1 and 50,000 | Q7 |
| A       | Question 7  
Of the number of rejected claims identified in your answer to Question 6, how many of those claims were actually determined to be fraudulent? | Enter number between 1 and 50,000 | Q8 |
| B       | Question 8  
Would you say that insurers delayed the settlement of claims alleging that more of your claims involved fraud in the last twelve months than they did in the previous 12 months? | a) Yes  
b) No | Q9 |
| B       | Question 9  
On those occasions were an insurer alleged a claim presented by your firm to be fraudulent which of the responses below would you select as the most usual means of communication? | a) They raise the issue of fraud with you after the hire has terminated allowing you no opportunity to act to reduce any exposure you may face to irrecoverable hire charges if the claim is fraudulent.  
b) They provide a late alert to you (nearer to the end of hire than the start) which means that the potentially irrecoverable hire charges incurred may be higher than they should have been and the insurer’s determination to avoid payment of your bill will be greater.  
c) They provide an early alert to you (nearer to the start of hire than the end) in order that you can decide whether to cease any hire in order to avoid incurring irrecoverable hire charges and so that you can reduce the risk of your own vehicle being damaged or stolen.  
d) They provide full and early disclosure to you setting out the allegation of fraud in order to allow a proper investigation to be carried out with your support.  
e) None of the above | Q10 |
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<tr>
<td>B</td>
<td>Question 10: “Insurers engage with members of the credit-hire industry to share intelligence to reduce the incidence of insurance fraud”</td>
<td>Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree</td>
<td>Q11</td>
</tr>
<tr>
<td>B</td>
<td>Question 11: “The combination of the ABI and IFED has promoted a negative view of the credit-hire industry.”</td>
<td>Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree</td>
<td>Q12</td>
</tr>
<tr>
<td>B</td>
<td>Question 12: “It has become harder for credit-hire companies to engage the police to investigate fraudulent claims.”</td>
<td>Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree</td>
<td>Q13</td>
</tr>
<tr>
<td>B</td>
<td>Question 13: “The ABI relationship with IFED benefits insurers to the detriment of the credit-hire industry.”</td>
<td>Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree</td>
<td>Q14</td>
</tr>
<tr>
<td>C</td>
<td>Question 14: How many instances have you suffered in the last twelve months where your rental vehicle has been stolen, used in a criminal offence whilst on hire or has been recovered because you suspect your client to have been involved in a fraudulent event such that you have suffered a loss?</td>
<td>Enter numerical value between 1 and 10,000</td>
<td>Q15</td>
</tr>
<tr>
<td>C</td>
<td>Question 15: If you did suffer a loss as a result of an event as described in Q14 above (your rental vehicle has been stolen, used in a criminal offence or has been recovered because you suspect your client to have been involved in a fraudulent event such that you have suffered a loss) did you report the offence to the police?</td>
<td>a) Yes, b) No</td>
<td>a) Q16, b) Q19</td>
</tr>
<tr>
<td>C</td>
<td>Question 16: From your experience, would the police accept your report of an offence and investigate it?</td>
<td>a) Yes, b) No</td>
<td>a) Q17, b) Q18</td>
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<td>Section</td>
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<td>C</td>
<td>Question 17</td>
<td>From previous experience where the police have accepted your report of an offence and agreed to investigate in how many cases has an arrest followed and a prosecution ensued?</td>
<td>Enter number between 1 and 1,000</td>
</tr>
<tr>
<td>C</td>
<td>Question 18</td>
<td>Why would the police not accept the report of your offence (tick as many factors as are relevant)?</td>
<td>a) They said it was a civil matter and you should sue the hirer for damages</td>
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<td></td>
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<td></td>
<td>b) They say we should make a claim on our insurance policy to recover any losses</td>
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<td>c) They say they do not have the resource to investigate insurance related claims</td>
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<td>d) They referred me to IFED</td>
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<td>e) They referred the offence to IFED who declined to accept it for investigation</td>
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<td>f) They say that insurance fraud is not a force priority</td>
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<td></td>
<td>g) They say there is insufficient evidence on which to investigate and secure a conviction</td>
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<td>h) They advised me of the need to secure further evidence and invited me to return when I have it</td>
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<td>i) They would make a report for insurance purposes in order that I can make a claim but will not investigate the offence for any of the above reasons</td>
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<td>j) They say that the offence complained of occurred in another force area and I should attempt to report it there</td>
</tr>
<tr>
<td>C</td>
<td>Question 19</td>
<td>Why would you not report the offence to the police (tick as many factors as are relevant)?</td>
<td>a) It is a civil matter and I can pursue the hirer for damages</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) I can claim on my insurance policy for any losses</td>
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<td></td>
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<td></td>
<td>c) The police do not have the resource to investigate insurance related claims</td>
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<td></td>
<td></td>
<td></td>
<td>d) They will refer me to IFED who only take instructions from ABI insurers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e) They will refer the offence to IFED who will decline to accept it for investigation because it does not come from an ABI insurer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f) Insurance fraud is not a force priority and so it will not be investigated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>g) There is insufficient evidence on which to investigate and secure a prosecution</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>h) They will only advise me of the need to secure further evidence and to return when I have it and I do not have the resources</td>
</tr>
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Appendix B – Semi-structured interviews: invitation, consent and content
Dear [Name],

Further to our recent telephone conversation I would like to confirm your agreement for [NAME] to participate in a research study that I am engaged in as part of a PhD research project into motor insurance fraud. My research relates to the impact of the insurance industry’s funding of a dedicated police unit (IFED) on the ‘non-insurer’ victims of insurance related fraud and I am keen to interview [NAME] for my research as one of 25 respondents as set out on the attached information sheet.

Participation in my research is entirely voluntary and I anticipate that [NAMES] involvement will only require 60 minutes of their time in an interview that I will conduct at a time and place of their choice. Withdrawal from the research is possible at any time prior to the data I am collecting being analysed but, in any event, the contribution to my research will be in confidence and references in my final published research will be anonymous. The information sheet provides greater clarification on this issue and I will ask [NAME] to complete a consent form when we meet.

You may contact me at the University at the postal or e-mail address above or by telephone on 08700 116719. If I could ask you to confirm in writing to me your agreement that I may approach [NAME] I would be very grateful.

Yours sincerely

Steve Evans
Dear [Name],

Further to our recent conversation I would like to confirm your agreement to participate in a research study that I am engaged in as part of a PhD research project into motor insurance fraud. My research relates to the impact of the insurance industry’s funding of a dedicated police unit (IFED) on the ‘non-insurer’ victims of insurance related fraud and I am keen to interview you for my research as one of 25 respondents as set out on the attached information sheet.

Participation in my research is entirely voluntary and I anticipate that your involvement will only require 60 minutes of your time in an interview that I will conduct at a time and place of your choice. Withdrawal from the research is possible at any time prior to the data I am collecting being analysed but, in any event, your contribution to my research will be in confidence and references in my final published research will be anonymous. The information sheet provides greater clarification on this issue and I will ask you to complete a consent form when we meet.

You may contact me at the University at the postal or e-mail address above or by telephone on 08700 116719.

I look forward to seeing you on [DATE] in [LOCATION] at [TIME].

Yours sincerely,

Steve Evans
Further to our telephone conversation, I write to confirm that I would like a member of your organisation to take part in my research study and I would like you to understand why the research is being done and what it will involve for your employee and your organisation. Please feel free to talk to others about the study if you wish and do not hesitate to ask if there is anything that is not clear.

The research is focused on the insurance industry’s funding of the Insurance Fraud Enforcement Department ("IFED"), a police unit within the City of London Police, dedicated to address high volume and organised criminality whilst working closely with the insurance industry on its strategic priorities to change the public perception of insurance fraud. Specifically, I am investigating the impact that IFED may have had on ‘non-insurer’ victims of motor insurance related fraud, including credit-hire companies, in so far as a dedicated policing unit funded by insurers (a) may impact their ability to gain access to the police, or (b) whether their susceptibility to economic and commercial harm may have increased as a result of IFED.

What is the purpose of the study?

In terms of outcomes, I hope to:

- Establish an objective measure of the extent of detected and undetected motor insurance fraud for the credit-hire industry,
- Review the existing empirical data relating to the measurement of detected and undetected motor insurance fraud for the insurance industry,
- Generate narrative data on the effectiveness and appropriateness of an insurer sponsored and dedicated police resource, and
- Document the most recent incarnation of a privately sponsored public police unit, IFED.

I also hope to evolve fraud and crime theory and develop hypotheses for further testing as well as highlighting specific policy and operational recommendations. It is intended that the research should provoke a number of journal papers and summary
reports for dissemination to policy makers, insurers and non-insurers impacted by motor insurance fraud, counter-fraud bodies and the police.

Why has your organisation been invited?

The primary technique for the research will be twenty-five semi-structured interviews. The interviews are planned with representatives of seven targeted groups comprising representatives of the media, the insurance industry and ABI, those providing counter fraud support for the insurance (defendant) industry, those providing the same services for the credit-hire (claimant) industry, members of the credit-hire industry, other non-insurer victims or potential victims of fraud and a number of middle ranking police officers. Your organisation falls within those groups and I believe that one of your employees had particularly relevant knowledge of the issues.

Do you have to take part?

It is up to you to decide if you will allow me to approach your employee to ask him to join the study. When we meet I will take them through the study, explain the contribution they will be asked to make and then I will then ask them to sign a consent form if they wish to proceed. Before then I need to discuss the nature of the information that may emerge from that discussion with your employee.

What will happen to my organisation if we agree to allow our employee to take part?

I would like to conduct an interview with your employee that will take approximately 60 minutes. Subject to their consent I will make an audio recording of the interview and will later transcribe that so that I can compare and analyse the various responses from all of the interviews I will conduct. Whilst the interview will be stored with a reference to help me identify your employees name, after the data has been analysed and if the data appears in my final thesis, it will be entirely anonymous both in terms of your employee and your organisation. I expect that my research will take a number of years to conclude but your employee’s involvement will be limited to the 60 minutes whilst I conduct the interview. You should be aware that your employee may divulge information of a sensitive or confidential nature or which concerns details of specific instances of fraud although I have targeted those employees who ordinarily manage this type of information and will be aware of the sensitivity of it. I will not be asking for any confidential data or details about current or planned criminal investigations or prosecutions.

What will my employee have to do?

I have a schedule of about ten questions and I am interested in their responses, opinions and attitudes to the questions. They relate to motor insurance fraud and do not require any specialist knowledge beyond that which they possess by reason of their current or prior position. They will not be asked to provide any information which is confidential or which would embarrass them or your organisation professionally or constitute a breach of confidentiality or breach of fiduciary duty. If I suspect that any information provided in the interview represents such a breach I will pause the interview to ensure that my research does not rely on information provided in error.

What are the possible disadvantages and risks of taking part?

Your employee will be inconvenienced for 60 minutes and may divulge information that you would not wish him to divulge. I cannot envisage any other disadvantage or risk.

What are the possible benefits of taking part?

There will be no financial reward for participation but you and your employee may well benefit from the knowledge that you are contributing to research, which may advance or improve the fight against insurance fraud, stimulate further educational research or generate policy documents or greater awareness of a problem.

Will my employee taking part in the study be kept confidential?

When your employee joins the study, it is possible that some of the data collected will be seen by authorised persons from the University of Portsmouth or by those engaged by regulatory authorities. Because my research is supervised, others may
look at the data to check that the study is being carried out correctly. All of those people will have a duty of confidentiality to you as a host organisation and to your research participant and will do their best to meet this duty.

In any event, your confidentiality will be safeguarded during and after the study. The interview will be audio recorded (with your employee’s consent) and then transcribed and analysed using a software programme called NVivo. At all times the data will be stored securely and it will be retained only until the final thesis is approved. At that point it will be destroyed. At any time before destruction, my research supervisor may review the data to ensure the study is proceeding correctly.

What will happen if my employee doesn’t want to carry on with the study?

Your employee may withdraw from the study at any time prior to providing consent and until the data from any interview has been analysed, at which time it will be anonymous but may have been integrated with other responses from other interviewees and so will be difficult to exclude from the study.

What if there is a problem?

If you have a concern about any aspect of this study, you may speak with me or write or speak to Professor Mark Button, my supervisor. We will both do our best to answer your questions. Professor Button can be reached by e-mail at mark.button@port.ac.uk or by telephone on 023 92843923. If you remain unhappy and wish to complain formally, you can do this by writing to Dr Phil Clements, the Head of Department who can be reached at phil.clements@port.ac.uk.

What will happen to the results of the research study?

I will notify you when my thesis is published although it will be several years before the research is complete. Your organisation will not be identified in any report/publication unless you have given your consent.

Who is organising and funding the research?

The University of Portsmouth is sponsoring my research.

Who has reviewed the study?

Research in the University of Portsmouth is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion.

Concluding statement

Thank you for taking the time to read this information sheet.
PARTICIPANT INFORMATION SHEET

Dear [Name]

You have agreed to take part in my research study and I would like you to understand why the research is being done and what it will involve for you. Please feel free to talk to others about the study if you wish and do not hesitate to ask if there is anything that is not clear.

The research is focused on the insurance industry’s funding of the Insurance Fraud Enforcement Department (’IFED’), a police unit within the City of London Police, dedicated to address high volume and organised criminality whilst working closely with the insurance industry on its strategic priorities to change the public perception of insurance fraud. Specifically, I am investigating the impact that IFED may have had on ‘non-insurer’ victims of motor insurance related fraud, including credit-hire companies, in so far as a dedicated policing unit funded by insurers (a) may impact their ability to gain access to the police, or (b) whether their susceptibility to economic and commercial harm may have increased as a result of IFED.

What is the purpose of the study?

In terms of outcomes, I hope to:

- Establish an objective measure of the extent of detected and undetected motor insurance fraud for the credit-hire industry,
- Review the existing empirical data relating to the measurement of detected and undetected motor insurance fraud for the insurance industry,
- Generate narrative data on the effectiveness and appropriateness of an insurer sponsored and dedicated police resource, and
- Document the most recent incarnation of a privately sponsored public police unit, IFED.

I also hope to evolve fraud and crime theory and develop hypotheses for further testing as well as highlighting specific policy and operational recommendations. It is intended that the research should provoke a number of journal papers and summary
reports for dissemination to policy makers, insurers and non-insurers impacted by motor insurance fraud, counter-fraud bodies and the police.

Why have I been invited?

The primary technique for the research will be twenty-five semi-structured interviews. The interviews are planned with representatives of seven targeted groups comprising representatives of the media, the insurance industry and ABI, those providing counter fraud support for the insurance (defendant) industry, those providing the same services for the credit-hire (claimant) industry, members of the credit-hire industry, other non-insurer victims or potential victims of fraud and a number of middle ranking police officers.

Do I have to take part?

It is up to you to decide to join the study. When we meet I will take you through the study, explain the contribution you will be asked to make and then I will then ask you to sign a consent form if you wish to proceed.

What will happen to me if I take part?

I would like to conduct an interview with you, which will take approximately 60 minutes. Subject to your consent I will make an audio recording of the interview and will later transcribe that so that I can compare and analyse the various responses from all of the interviews I will conduct. Whilst the interview will be stored with a reference to help me identify your name, after the data has been analysed and if your data appears in my final thesis, it will be entirely anonymous. I expect that my research will take a number of years to conclude but your involvement will be limited to the 60 minutes whilst I conduct the interview.

What will I have to do?

I have a schedule of six questions and I am interested in your responses, opinions and attitudes to the questions. They relate to motor insurance fraud and do not require any specialist knowledge beyond that which you possess by reason of your current position. You will not be asked to provide any information which is confidential or which would embarrass you professionally or constitute a breach of confidentiality or breach of fiduciary duty. If I suspect that any information provided in the interview represents such a breach I will pause the interview to ensure that my research does not rely on information provided in error.

What are the possible disadvantages and risks of taking part?

You will be inconvenienced for 60 minutes but I cannot envisage any other disadvantage or risk.

What are the possible benefits of taking part?

There will be no financial reward for participation but you may well benefit from the knowledge that you are contributing to research, which may advance or improve the fight against insurance fraud, stimulate further educational research or generate policy documents or greater awareness of a problem.

Will my taking part in the study be kept confidential?

When you join the study, it is possible that some of the data collected will be seen by authorised persons from the University of Portsmouth or by those engaged by regulatory authorities. Because my research is supervised, others may look at the data to check that the study is being carried out correctly. All of those people will have a duty of confidentiality to you as a research participant and will do their best to meet this duty.

In any event, your confidentiality will be safeguarded during and after the study. The interview will be audio recorded (with your consent) and then transcribed and analysed using a software programme called NVivo. At all times the data will be stored securely and it will be retained only until the final thesis is approved. At that point it will be destroyed. At any time before destruction, my research supervisor may review your data to ensure the study is proceeding correctly.
What will happen if I don’t want to carry on with the study?

You may withdraw from the study at any time prior to providing consent and until the data from any interview has been analysed, at which time it will be anonymous but may have been integrated with other responses from other interviewees and so will be difficult to exclude from the study.

What if there is a problem?

If you have a concern about any aspect of this study, you may speak with me or write or speak to Professor Mark Button, my supervisor. We will both do our best to answer your questions. Professor Button can be reached by e-mail at mark.button@port.ac.uk or by telephone on 023 92843923. If you remain unhappy and wish to complain formally, you can do this by writing to Dr Phil Clements, the Head of Department who can be reached at phil.clements@port.ac.uk.

What will happen to the results of the research study?

I will notify you when my thesis is published although it will be several years before the research is complete. You will not be identified in any report/publication unless you have given your consent.

Who is organising and funding the research?

The University of Portsmouth is sponsoring my research.

Who has reviewed the study?

Research in the University of Portsmouth is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion.

Concluding statement

Thank you for taking the time to read this information sheet and for agreeing to meet with me.
CONSENT FORM

Dear [Name]

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any point before the data is analysed time without giving any reason.

I understand that data collected during the study may be looked at by individuals from the University or from regulatory authorities. I give permission for these individuals to have access to my data.

I agree to my interview being audio recorded and to take part in the above study.

Yours sincerely

Steve Evans

Name of Participant: 

Signature:

Person taking consent: Steve Evans 

Signature:
Semi-structured interview script

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<th>Stage</th>
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<td>Your identity will remain anonymous at the time of publication of my thesis, although I will be able to identify your contribution and may discuss it with my supervisor at the University prior to publication. The recording and transcript will be destroyed after the publication of my thesis.</td>
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<td>INTRODUCTION TO RESEARCH</td>
<td>I am researching motor insurance fraud and the insurance industry’s funding of the Insurance Fraud Enforcement Department (“IFED”), a police unit within the City of London Police. Specifically, I am investigating the impact that IFED may have had on ‘non-insurer’ victims of motor insurance related fraud, such as bus companies, self-insured fleet operators and credit-hire companies, in so far as (a) their ability to gain access to justice may have been impacted or (b) their susceptibility to economic and commercial harm may have increased.</td>
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| Question 1 | Could I ask you to outline what you do professionally and could I ask you to tell me what motor insurance fraud means to you? | Ascertain from where their perception of the topic has been drawn?  
• Media  
• Employer  
• Insurer  
• IFED  
• Police  
• Government  
• Personal experience |
| Question 2 | What do you think the state or police response should be to motor insurance fraud? | Test the range of possible responses:  
• Nothing (why?)  
• It’s a civil matter and best handled by the victim’s lawyers  
• The police should investigate and prosecute  
• The state should sponsor accredited private investigators to bring private criminal prosecutions |
| Question 3 | Do you know the annual cost of motor insurance fraud? | Supplementary questions are:  
• Do you know how that figure is determined?  
• Do you think it is a reliable figure?  
If they don’t know supply the last published figure from IFED and ask the supplementary questions |
| Question 4 | Who do you think the real victims of motor insurance fraud are? | Possible threads for discussion are  
• Innocent policyholders by way of increased premiums  
• Insurers because they absorb the added cost from profit  
• Society because insurance fraud has become accepted as a victimless crime  
• Other non-insurer victims  
Seek to broaden the discussion by raising the question of self-insured motorists such as bus companies, rental companies and fleet operators. |
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| Question 5 | Do you think non-insurers like credit hire companies or fleet operators with large policy excesses are ever victims of motor insurance fraud? | Areas to probe:  
• Is non-insurer fraud ever reported?  
• Is it ever quantified?  
• Do insurers engage with credit hire companies or fleet operators against the fraudsters?  
• Are credit-hire companies a part of the fraud problem or part of the solution? |
| Question 6 | What role do you think IFED play in the fight against motor insurance fraud? | Ascertain whether they know about  
• Reported IFED successes  
• IFED Funding  
• IFED Governance  
• Strategic Priorities  
• IFED Acceptance criterion for investigation  
• Relationships with IFB and IFIG  
In addition  
• Determine if they have had any contact with IFED, IFIG and IFB and the quality or success of the interaction |
| Question 7 | Should IFED accept reports of insurance fraud from credit hire companies and investigate where the offences fit their standard acceptance criterion? | Identify whether  
• Respondents believe they do or will accept reports  
• Respondents believe they don’t but should identify whether  
• Respondents believe they do or will accept reports  
• Respondents believe they don’t but should  
• Respondent believe that IFED is an insurer only resource?  
• There is any sense of ill feeling towards credit-hire companies which impacts their credibility  
• If IFED shouldn’t or won’t accept reports then where should those reports be made? |
| Question 8 | Do you think non-insurers like credit hire companies or fleet operators with large policy excesses are ever victims of motor insurance fraud? | Ascertain insurance fraud in your force?  
• In general terms how would you define the integrity of the credit hire industry? Are they offender, victim or both  
• The acceptance criterion  
• Acceptance rate  
• Ease or difficulty of engagement  
• Result of report  
• Identify possible case studies pre and post IFED  
• How does insurance fraud figure in your force priorities?  
• Do you refer to IFED as the national lead?  
• Is insurance fraud a ‘civil’ or ‘criminal’ problem  
• What resource levels are available to deal with insurance fraud in your force?  
• In general terms how would you define the integrity of the credit hire industry? Are they offender, victim or both |

FOR POLICE RESPONDENTS THIS CHANGES TO  
Do you have any experience of insurance fraud being reported to your force and, if so, how are such reports treated?
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| Question 9 | Do you think the Police have sufficient resources to be able to cope with the range of challenges they face? | Engage on the following:  
- Attitude to reduced police budgets?  
- Perception of what police priorities should be?  
- Awareness of load shedding and reduction of responsibilities  
- Definition of what the Police represent in today's society? |
| Question 10 | Should there be a greater 'private' response to motor insurance fraud? | Explore:  
- Whether the problem is contained?  
- Whether even the IFED response is running out of capacity to manage the issue?  
- Whether there are risks of the private sector being involved either to justice or society?  
- If not privatisation then what else; what should the future of policing motor insurance fraud look like?  
- Is an industry led solution desirable?  
- Consider FACT, RSPCA, BTP in the context of ‘policing’ versus ‘the police’ |
| CONCLUSION | That's all I wanted to cover; is there anything that you think I may have missed or that you would like to add? | If no other response then conclude the interview |
Semi-structured interview script (Case Studies)
Thank you for agreeing to take part in an interview in this project which forms part of my research for a PhD. I am conducting about 25 interviews. I have already written to you setting out the basis of my research and answering some frequently asked questions as well as giving you contact details for the University of Portsmouth and me should you have any further queries. In addition, you have signed a form today agreeing to participate. I would like to ask you for permission to audio record this interview. The main reason behind this recording is to have the set of accurate data – your responses – which will be transcribed by me to facilitate, later on, the analysis of the responses obtained from this and other interviews conducted throughout the course of the project. Your identity will remain anonymous at the time of publication of my thesis, although I will be able to identify your contribution and may discuss it with my supervisor at the University prior to publication. The recording and transcript will be destroyed after the publication of my thesis. If you don’t have any further question I would like briefly to introduce you to the subject of this interview.

### INTRODUCTION TO RESEARCH

I am researching motor insurance fraud and the insurance industry’s funding of the Insurance Fraud Enforcement Department ("IFED"), a police unit within the City of London Police. Specifically, I am investigating the impact that IFED may have had on ‘non-insurer’ victims of motor insurance related fraud, such as bus companies, self-insured fleet operators and credit-hire companies, in so far as (a) their ability to gain access to justice may have been impacted or (b) their susceptibility to economic and commercial harm may have increased.

### Questions

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<tr>
<td><strong>Question 1</strong></td>
<td>When we met last time you told me about the case of [NAME] and [NAME]. Could I ask you to tell me about the background to the two cases?</td>
</tr>
<tr>
<td><strong>Question 2</strong></td>
<td>Is the information you have given me from your own involvement in the matter? If not, identify from whom and consider redacting or arranging interview with that person.</td>
</tr>
<tr>
<td><strong>Question 3</strong></td>
<td>Is any of the information you have given me confidential or something you would prefer that I do not utilise in my research? Record details to be redacted.</td>
</tr>
<tr>
<td><strong>Question 4</strong></td>
<td>FOR POLICE RESPONDEnt ONLY Do you have a view about the ABI involvement in policing fraud? Explore reduction in regional focus and impact on detection of organised crime.</td>
</tr>
</tbody>
</table>

**CONCLUSION**

That’s all I wanted to cover; is there anything that you think I may have missed or that you would like to add? If no other response then conclude the interview.
Appendix C – CHO statement of consumer rights

Code of conduct

The Executive Committee of The Credit Hire Organisation adopted the following code of conduct in 2014.

The Credit Hire Organisation Limited Code of Conduct (the “Code”).

Members must:

- Abide by the Code.
- Conduct their businesses in accordance with applicable laws and regulations to which they are subject.
- Act with integrity and behave in a way that maintains public confidence in the services credit hire companies provide.
- Run their businesses effectively and in accordance with proper governance and sound financial and risk management principals.
- Where relevant, take appropriate steps to protect any client money they may handle (eg customer insurance excesses).
- Acknowledge that credit hire companies, and their referral partners, may be the target of fraud and take appropriate steps to satisfy themselves that each claim is genuine.
- Take appropriate steps to ensure that customers understand the nature of the services they provide and respond to customer queries in a timely and appropriate manner.
- Treat all customers fairly.
- Ensure that the hire vehicles provided to customers are insured, safe, roadworthy and have been adequately maintained.
- Submit claims to insurers only after consideration that:
  - The claim is genuine.
  - The circumstances of the accident justified the hire of a replacement vehicle.
  - The customer needed a replacement vehicle.
  - The type of vehicle provided or claimed for is reasonable given the circumstances and the law.
  - The length of hire is reasonable given the circumstances and the law.
- The amount claimed is reasonable given the circumstances and the law.

Ensure their employees are adequately trained and that a specific person or group of people is responsible for keeping policies, procedures and documentation compliant with good practice, the law or any other regulation to which their business is subject.

- Keep customers informed as to the progress of the settlement of claims and provide appropriate support to customers (including, where relevant, facilitating access to legal advice) if claims are disputed.

The Executive Committee of The Credit Hire Organisation can determine compliance with the Code, and may suspend or terminate any member’s membership of The Credit Hire Organisation if it believes that any member has breached the Code or brought the integrity of The Credit Hire Organisation into disrepute.

Members agree to and accept this process of determination. Where membership is suspended or terminated, members will be notified of such and accept that there will be no refund of subscriptions and that following suspension or termination of their membership, they are not able to use the The Credit Hire Organisation logos or use any documentation which purports them to be a member of the The Credit Hire Organisation.
Appendix D – Summary of ABI press releases from the review period

1. 2008/11 - Tackling Whiplash: Prevention, Care, Compensation
2. 2008/11 - ABI reveals whiplash epidemic
3. 2008/12 - Rise in front end fraud putting insurance cover in jeopardy warns the ABI
4. 2009/03 - National fraud crackdown must end the victimless crime myth says the ABI
5. 2009/04 - Recession Britain insurers detecting record amounts of fraudulent claims ABI
6. 2009/07 - Deception Exaggeration and Invention ABI publishes report on the rising cost of insurance fraud ABI
7. 2010/01 - Zero tolerance policy towards fraud now needed says the ABI
8. 2010/07 - Bogus Britain insurers expose over 2300 fraudulent claims every week
10. 2011/01 - Motorists cutting corners risk driving illegally warns the ABI
11. 2011/03 - Transport Select Committee report on motor insurance misses the point says the ABI
12. 2011/05 – Britain’s pain in the neck culture must be reduced says the ABI
13. 2011/07 - No hiding place for cheats as drive to reduce insurance fraud moves up a gear
14. 2011/07 - You could not make it up but some did Insurers detecting more fraudulent claims than ever over 2500 worth 18 million every week
15. 2011/09 - ABI comments on Government response to Transport Select Committee inquiry into cost of motor insurance
16. 2011/09 – Tackling the compensation culture
17. 2011/09 - Leading retailers and business groups join forces with the ABI in calling for an end to the have a go compensation culture
18. 2012/04 - The UK’s pain in the neck culture must end says the ABI
19. 2012/05 - Address by James Dalton to the International Whiplash Conference
20. 2012/09 - ABI lifts the lid on the 1 billion a year insurance fraud industry as the insurance fraud register is launched
21. 2012/09 - Insurance Fraud exposed
22. 2012/09 - Phantom passengers and phoney injuries behind record rise in motor insurance fraud says the ABI
23. 2012/12 - Government on the right road to tackling the UK whiplash epidemic says the Association of British Insurers
24. 2012/12 - What next for whiplash
25. 2013/01 - Fraudulent insurance policies
26. 2013/03 - Fair, independent, objective – ABI publishes proposals to curb the UK’s whiplash epidemic
27. 2013/03 - James Dalton speech at Claims Magazine Annual Conference
28. 2013/04 – Brace yourself — UK is the biggest pain in the neck in Europe
29. 2013/05 - Motor Insurance Costs
30. 2013/07 - ABI responds to Transport Select Committee, Cost of Motor Insurance/ Whiplash report
31. 2013/07- Detected fraud statistics update
32. 2013/07 - The con is not on - industry clampdown on insurance cheats uncovers frauds worth £21 million every week
33. 2013/08 - ABI advice to help drivers avoid becoming the victim of ‘flash for cash’ scams
34. 2013/10 - IFED investigation leads to 27 arrests over sale of fake car insurance policies
35. 2013/10 - James Dalton speech at Infoline Motor Insurance Claims Forum
36. 2013/11 - ABI supports national 'ghost broking' awareness campaign
37. 2013/11 - Aidan Kerr keynote speech at Post Magazine Fraud Conference
38. 2014/03 - ABI members committed to tackling insurance fraud with £11.7m investment in Insurance Fraud Enforcement Department
39. 2014/03 - Mark Allen speech at the Marketforce Fraud Conference 2014
40. 2014/05 - Insurance cheats feel the heat – value of fraudulent claims uncovered by insurers hits record level
41. 2014/06 - ABI comments on new government plans to crackdown on insurance fraud and remove bogus claims
42. 2014/06 - Fraud Conference
43. 2014/07 - Insurers driving down unnecessary motor insurance costs – ABI responds to Transport Committee report on motor insurance
44. 2014/09 - Motor insurance application fraud backfiring on nearly 3,500 motorists a week according to the ABI
45. 2014/10 - Fraud data
46. 2014/11 - Overhaul in assessing whiplash claims set to put the brake on the fraud of choice
47. 2014/12 - ABI responds to Chris Grayling speech at the ABI Motor Conference
48. 2014/12 - Chris Grayling speech at the ABI Motor Conference 2014
49. 2015/03 - ABI comments on publication of The Insurance Fraud Taskforce interim report
50. 2015/03 - Huw Evans speech at the Experian Insurance Summit 2015
51. 2015/03 - The ABI publishes report shedding light into the thinking of insurance cheats
52. 2015/04 - Claimant solicitors urged to register to use askCUE personal injury service from 5 May to prevent fraudulent claims
53. 2015/04 - Motor insurance and civil justice reforms
54. 2015/07 - Case studies/ detected insurance frauds
55. 2015/07 - You could not make it up, but they did. Savings for honest customers as insurers expose £3.6 million worth of insurance frauds every day
56. 2015/08 - Cutting corners to get cheaper motor insurance backfiring on thousands of motorists warns the ABI
57. 2015/10 - Average cost of comprehensive motor insurance continues to rise
58. 2015/10 - Fraud
59. 2015/11 - Clampdown on the compensation cowboys
60. 2015/11 - CMC
61. 2015/11 - PI Fraud
62. 2016/01- Insurers will do whatever it takes to protect honest customers against insurance fraud
Appendix E – Extracts of correspondence between the ABI and the MOJ

(ABI to MOJ – 29 September 2010)

“The ABI is holding its periodical Legal Expenses Insurance Committee meeting next week... Do you think that there is anything you would like us to discuss with our members? If so it would be good to talk through it so I can add a point to our agenda?”

(MOJ to ABI - 13 October 2010)

“I just tried calling. I am sorry to say that neither Ken Clarke nor Jonathan Djanogly is able to attend the reception. As you will know we are keen to assist…but I am afraid it has not been possible this time.”

(ABI to MOJ – 21st December 2010)

“Great working with you this year and look forward to us working together again in 2011. All the best for the holidays.”

(Keoghs to MOJ 7th January 2011)

“Further to our conversation of yesterday evening, I promised to provide you with details of those who have committed to our morning meeting on the 19th in Westminster. The venue is to be One Whitehall Place. The attendees will be [redacted].

All the above are highly engaged in the process, have been for some years, and will have a lot to say to the Minister.”

(ABI to MOJ – 29th March 2011)

“I am sure you have had a busy couple of weeks but I just wanted to drop you a line to say we will read all the papers diligently over the next couple of days but I just wanted to let you know that the initial reaction is very positive. Our press statement is here…”

(MOJ to ABI - 29th March 2011)

“Thanks for this. It has indeed been quite busy recently. After tomorrow I am away for a while but it would be good to catch up after my return to the office on 13th April.”
(MOJ to ABI - 31st March 2011)

“Have a good time. I will fix something up when you are back. If anything urgent crops up in the meantime, I shall of course be in contact.”

(MOJ to ABI - 5th April 2011)

Thanks for your reply. One thing we are keen to understand is how insurers use referral fees and in particular what the impact on the use of BTE insurance would be if referral fees were banned. Grateful for any light you may be able to shed on this.”

(ABI to MOJ – 13th May 2011)

“It was good to see you both yesterday morning and to talk through the items on our agenda. It was encouraging to hear we share the same views on the claimant’s access to justice arguments and undesirable behaviour being driven by claims management companies...

Thanks again for your time yesterday and do let me know if you have any further questions. As you mentioned yesterday Robert [other name redacted] and I have a meeting with you scheduled for 24th May and we look forward to seeing you (and hopefully you too, Jo) then.”

(MOJ to ABI - 13th May 2011)

“Thanks for this; it was good to see you and the others yesterday. I think you were going to send us your responses to the LSB consultation on referral fees. It would also be interesting to see what your response is to the Transport Committee Report as discussed – but we can talk about that on 24th.”

(ABI to MOJ – 26th May 2011)

“Good to see you again on Tuesday and talk through the issues below. As discussed we are supportive of the MOJ’s reforms and we will continue our messaging by voicing our support for the Justice Bill when the draft is released soon.

We would welcome the opportunity to provide data and input into the more detailed implementation work that will take place over the coming months and we look forward to being engaged with this work and keeping the dialogue open.

In the meantime, we look forward to hearing from you /or a colleague in relation to setting up a meeting with our new Director general to meet Jonathon Djanogly MP in the near future.”
I will be in touch in a few weeks with a follow up. In any event I look forward to seeing you (Robert) at the FOIL (Forum of Insurance Lawyers) event on the Jackson reforms at St Pauls on the 16\textsuperscript{th} June where I notice you are one of the speakers. Looks like it might be an interesting and worthwhile event.”

\textbf{(MOJ to ABI - 26\textsuperscript{th} May 2011)}

“Many thanks for this and for a very useful meeting with you and [name redacted]. We have been in touch with Jonathan Djanogly about a meeting; he agrees and we are looking to mid-June for that…”

\textbf{(ABI to MOJ – 28\textsuperscript{th} May 2011)}

“As discussed I have attached various research reports which may assist you... I’ve looked at your question on damages but at first blush I don’t know if we readily hold that information.”

“Thanks for these and for your help generally. Very best wishes for the future; we will miss you!

\textbf{(ABI to MOJ – 24\textsuperscript{th} June 2011)}

“Further to my e-mail below I attach two flowcharts which show how claims are typically bought and sold in two different types of claims...

If you’d like to discuss this further or in more detail, I’d be happy to pop over to Petty France [the MOJ] sometime in the next couple of weeks if you are available (either before or after the ABI meeting with Jonathon Djanogly on 4\textsuperscript{th} July). I can also update you with the work that we are currently doing with our member and wider stakeholders to support the Bill whilst it goes through the various parliamentary stages, as well as work on the other aspects of Jackson to be implemented that don’t appear in the Bill (e.g. QUOCS).”

\textbf{(MOJ to ABI - 14\textsuperscript{th} July 2011)}

“Thanks for this which is helpful. As you know – and you will have seen PMQs yesterday – work is progressing on this.

...it may be helpful to meet with you and [name redacted] over the next few weeks as things develop.”
(MOJ to ABI - 15\textsuperscript{th} July 2011)

“Further to this, I think [name redacted] is chasing the referral fee figures from Aviva. Also, when we meet it would be helpful to discuss BTE promotion etc. and developments since our last meeting.”

(ABI to MOJ – 15\textsuperscript{th} July 2011)

“Lots to discuss and I agree that it would be useful to have a meeting soon; both [name redacted] and I am around over the next couple of weeks.”

(ABI to MOJ – 19\textsuperscript{th} July 2011)

“Just received your voicemail – am around for most of the afternoon so hopefully can speak to you at some point. I assume you’ve spoken to [name redacted] following our conversation yesterday (confirming our meeting on 9 August)...

On the point of referral fee figures form Aviva, the relevant member is on holiday this week but I am told the matter is in hand.”

(ABI to MOJ – 31 August 2011)

“I thought you might be interested to see the final version of the publication I mentioned at our last meeting. We have put a letter and a hard copy to your Minister in the post tonight.

I would be interested to hear if you have any update further to our last meeting; happy to discuss over the telephone or I can pop over to petty France for a catch up sometime soon if that suits? I can also update you with progress on the BTE front further to our meeting with legal expenses insurers which was held at the ABI this afternoon.

LETTER:

Dear Minister [Jonathan Djanogly MP]

I attach an advance copy of a publication that the ABI has produced in support of the steps taken to tackle the compensation culture in the Legal Aid, Sentencing and Punishment of Offenders Bill.

This publication will be sent to all Parliamentarians on Monday 5\textsuperscript{th} September to provide them with information on the problem with the current compensation culture, the costs of this to consumers and taxpayers and the solutions proposed by Lord Justice Jackson and included in the
Bill. It has been supported by a number of organisations representing a wide range of interests, from businesses to local authorities and lawyers, as well as the insurance industry.

The publication aims to show that the measures adopted in the Bill will be a real benefit to all. I hope you will find it informative and helpful.”

(MOJ to ABI - 8th September 2011 1745hrs)
Copy of government release (Curbing Compensation Culture: Government to Ban Referral Fees) embargoed until 00.01 on 9th September provided to ABI

(ABI to MOJ – 8th September 2011 1829hrs)
Copy of press release issued in response

(ABI to MOJ – 8th September 2011 1945hrs)
“Don’t know if you are still at the office – have tried to call. One important point you need to be aware of. Call me if you can”

(MOJ to ABI - 15th September 2011)
“Thanks for this. I am trying to catch up after a rather hectic few days; apart from the announcement on Friday on referral fees (and Jack Straw’s Bill on Tuesday) we are also in the Commons Committee all day on the LASPO Bill on Tuesday. It would be helpful to discuss referral fees and BTE in more detail soon.”
Appendix F – Lobbying Correspondence - 28th June 2010 to 28th September 2011

From: Taylor, Jo L
Sent: 28 June 2010 12:44
To: Wright, Robert (Civil Legal Aid)
Cc: TRIM: FW: GHR - Publication of conclusions report
Subject: TRIM: Dataset: LV
TRIM Record Number: D10/301971
TRIM Record URI: 2573720

please see the announcement by the Master of the Rolls confirming that the interim Guideline Hourly Rates set for 2010 are now to be considered final and the 'Conclusions' report by the Advisory Committee on Civil Costs which recommended this

http://www.judiciary.gov.uk/publications_media/general/guideline-hrly-rate.htm#ghrz406xo

You will note that in its report the ACCC have invited such further evidence and data as interested parties may wish to submit for its further consideration.

Jo Taylor

Ministry of Justice
102 Petty France, London, SW1H 9AJ
Telephone:
Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 28 May 2010 12:49
To: Taylor, Jo L.
Cc: Taylor, Jo L.
Subject: RE: ABI Research

Thanks for these, and for your help generally. Very best wishes for the future - we will miss you!

Robert

From: Wright, Robert (Civil Legal Aid)
Sent: 28 May 2010 12:46
To: Wright, Robert (Civil Legal Aid)
Cc: Taylor, Jo L.
Subject: ABI Research

Robert,

As discussed, I have attached various research reports which may assist you. I have not been able to track one of the Frontier reports down, and our research contact is away on AL, but I have left a message with him and hopefully can pass this on in due course.

Jo,

I've looked at your question on damages but at first blush, I don't know if we readily hold that information. I'll pass onto our stats team for follow up.

Best wishes,

Please consider the environment before printing this e-mail.

Association of British Insurers, 51 Gresham Street, EC2V 7HQ

1 The information transmitted is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon, this information by persons or entities other than
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2. The Association of British Insurers will not be liable to you or any other person or entity for any statement including but not limited to defamatory statements made by any employee acting outside the proper course of their duties.

3. This footnote confirms that this email message has been swept by Websense Hosted E-Mail for the presence of viruses and unacceptable or offensive material.

The Association also scans all incoming mail, and reserves the right to reject and return any material which is considered either to be a security risk or to contain unsuitable material.

This email was received from the INTERNET and scanned by the Government Secure Intranet antivirus service supplied by Cable&Wireless Worldwide in partnership with MessageLabs, (CCTM Certificate Number 2009/09/0052.) In case of problems, please call your organisation’s IT Helpdesk. Communications via the GSi may be automatically logged, monitored and/or recorded for legal purposes.
Analysis of personal injury legal costs

Introduction

This Research Brief summarises work conducted by Frontier Economics on behalf of the ABI.

A quantitative analysis of legal fees

The MOJ Consultation Paper finds that:

"The processes and costs involved in making a claim for personal injury are often perceived as being disproportionately high, particularly in the lower value claims. Costs can often exceed compensation, sometimes by a considerable amount". 1

This statement is supported by Frontier's findings which are based on data provided by insurance companies. Frontier collected information on over 18,200 PI claims with an instruction date between March 2005 and April 2007.

The data contains information on:

- the breakdown of the legal costs claimed and paid in each case
- the type of personal injury claim (Motor, EL and PL)
- the amount of damages awarded

Frontier focused on closed cases (where both damages and legal costs have been paid) with the damages falling within the proposed new track limits for PI claims. To do this Frontier removed all cases where the total damages awarded exceed £25,000 or fall under £1,000 as well as all cases where the costs have not yet been settled. Motor claims were also excluded if the accident occurred before October 2003 in order to focus on the effect of predictable fees (the Fixed Recoverable Costs Scheme (FRCS)).

After this "cleaning" Frontier were still left with a large dataset containing more than 15,000 observations. Below we summarise the main findings of the data analysis.

Paid versus claimed legal cost

A comparison of legal costs paid and claimed (excluding VAT) shows that the claimed costs are higher than the paid costs by approximately 30% (see figure one). This figure shows average legal costs claimed and paid as well as average damages for each type of claim (EL, PL and Motor). Despite the achieved reductions, the legal costs paid are still higher than the damages awarded in EL and PL cases (£3,821 versus £3,453 for EL claims and £4,069 versus £3,813 for PL claims). This is in line with the MOJ finding cited in the Consultation document.

1 MOJ Consultation Paper, page 27, paragraph 51-52.
Figure 1  Legal costs (claimed and paid) and damages awarded by claim type

![Chart showing legal costs and damages awarded by claim type]

Source: Frontier analysis of insurance companies' claims data.

**Decomposition of legal costs**

The total legal bill presented by a claimant solicitor to an insurance company will include the following components:

- Base costs (legal fees *per se*)
- Disbursements (such as costs of obtaining a medical report, GP's records, etc.)
- Success fees - a success fee is awarded if the claim is funded through a conditional fee agreement (CFA) and the claimant wins
- "After-the-event" (ATE) insurance premium – ATE insurance covers the claimant's liability to pay the defendant's legal costs if the claim fails

The data provides information on all these components.

**Base costs**

Figure two shows average base costs, disbursements, success fees and ATE premium for each type of claim. Base costs are on average:

- £2,069 for EL
- £2,257 for Motor
- £2,330 for PL claims

Base costs represent the largest share of total costs (55% for EL, 72% for Motor and 59% for PL).

The estimate of base costs for Motor appears to be significantly higher than the estimates obtained in other studies, in particular in Fenn and Rickman (2007) "Monitoring the Fixed Recoverable Costs Scheme" (2007). They find that base costs recovered on

---

low value (less than £10,000) non-litigated Motor claims in the post-FRCS period are on average £1,593. The discrepancy in the estimates is partly explained by the fact that the data also includes higher value claims (with damages between £10,000 and £25,000). These claims are not governed by the FRCS and, in general, tend to be more expensive. Moreover, the data does not allow litigated and non-litigated claims to be separated. The former are, again, significantly more expensive.

Other costs

Of the other three cost components, disbursements appear to be relatively similar across all claims' types, in the range of £600-700 per claim. This represents between 15% and 22% of total legal costs paid.

Success fees and ATE premiums are only paid in CFA-funded cases. Most EL and PL claims are CFA-funded, while Motor claims are mainly funded by "before-the-event" (BTE) insurance. As a consequence of that, success fees and ATE premiums are not paid in 70% of Motor cases. This is reflected in the averages:

- The average success fee and ATE premium across all Motor claims are low (£129 and £86)
- If only CFA-funded cases are included, the average success fee and ATE premium are significantly higher - £422 and £404 respectively – in line with those for EL and PL

Figure 2 Decomposition of legal costs paid (excl VAT)

Where are the savings being made?

A comparison of the legal costs claimed and paid by component allows an assessment of where the savings have been made. As figure three below demonstrates, most of the savings are made in base costs: 50% for EL, 75% for Motor and 45% for PL.
Significant savings are also made in EL and PL success fees (40% and 43% of total savings for EL and PL claims respectively). The reasons for that are the following:

- Success fees can only be claimed in CFA-funded cases and most EL and PL cases are CFA-funded
- Success fees are usually proportional to base costs; hence, a reduction in base costs leads to a reduction in success fees

**Figure 3 Savings’ decomposition**

![Graph showing savings decomposition](image)

Source: Frontier analysis of insurance companies claims data.

**Summary**

Overall, the analysis shows that:

- Average legal costs are higher than damages in EL and PL claims
- Significant savings are made in total legal costs. There is a 30% average gap between the legal costs claimed and paid
- These savings are mainly achieved in base costs and in success fees for EL and PL claims

These findings support the view expressed in the MOJ Consultation Paper that the legal costs of making a PI claim can be disproportionately high relative to damages. Moreover, the claims’ process appears to be quite ambiguous and open to various interpretations. This is reflected in the significant differences between the legal costs claimed and paid.

**Comparison of legal rates**

Establishing appropriate hourly rates in this market is not an easy task. Three alternatives are assessed:

- HMCS Guideline Rates
- Hourly rates charged by defendant lawyers
- Civil legal aid rates
Below is a discussion of these alternatives in detail.

**HMCS Guidelines Rates**

When cost draftsmen assess legal costs claimed, they use the HMCS Guideline rates as the benchmark. These rates were first issued in 1999 due to the requirement of the Woolf reform that there be a summary assessment of the costs at the end of all fast track cases and trials lasting less than one day. These rates were originally based on the actual rates used by County Courts. The rates have been revised every two years (the last two revisions inflated the 2003 rates by RPI). In 2003 geographical banding was introduced: 3 bands for areas outside of London, along with 3 bands for areas within London (see Table 1). The rates also vary by solicitors’ grade with Grade A (more than 8 years experience) being the highest and grade D (paralegals and trainee solicitors) being the lowest.

<table>
<thead>
<tr>
<th>HMCS Band 1 - Areas include Liverpool, Bristol, Oxford, etc.</th>
<th>Grade A – Over 8 years experience with at least 8 years litigation experience</th>
<th>Grade B – More than 4 years experience with at least 4 years litigation experience</th>
<th>Grade C - Other solicitors</th>
<th>Grade D - Trainee solicitors and paralegals</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMSC Band 2 – Areas include Coventry, York, Plymouth, etc.</td>
<td>£195</td>
<td>£173</td>
<td>£146</td>
<td>£106</td>
</tr>
<tr>
<td>HMSC Band 3 – Areas include Devon, Cornwall, South Wales, etc.</td>
<td>£183</td>
<td>£161</td>
<td>£133</td>
<td>£101</td>
</tr>
<tr>
<td>Outer London</td>
<td>£210-246</td>
<td>£158-210</td>
<td>£152</td>
<td>£111</td>
</tr>
<tr>
<td>Central London</td>
<td>£292</td>
<td>£222</td>
<td>£181</td>
<td>£116</td>
</tr>
<tr>
<td>City of London</td>
<td>£380</td>
<td>£274</td>
<td>£210</td>
<td>£129</td>
</tr>
</tbody>
</table>

Source: HMCS.

**Defendant solicitors’ rates**

An alternative source of information on Personal Injury solicitor rates is insurance companies themselves, which enter into agreements with defendant solicitor firms. The type of work performed by defendant lawyers is not dissimilar to claimant work. A lot of work is in fact done in parallel, as has been acknowledged in the MOJ consultation document. If anything, defendant solicitor work tends to be more difficult, because insurance companies usually employ solicitors only in complex/contentious cases, undertaking all straightforward work in-house.

Obtaining information on defendant hourly rates is not straightforward as they are bilaterally negotiated between insurance companies and solicitors’ firms and are not in the public domain. However, in the course of Frontier’s interviews with insurance companies, some of them disclosed their agreed rates. The rates usually vary by the value of claim as more expensive claims require more experience in the current system. For example, the rates are typically lower for claims with damages below £4,999 than those for claims with damages between £5,000 and £9,999. In principle, rates based on damages can be translated into rates based on grades or years of experience. From the discussions with insurers, Frontier have estimated a set of defendant solicitors’ rates for each grade (see Table 2 below).
Table 2  Defendant solicitors' average hourly rates

<table>
<thead>
<tr>
<th>Defendant solicitors' rates</th>
<th>Grade A</th>
<th>Grade B</th>
<th>Grade C</th>
<th>Grade D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£155</td>
<td>£137</td>
<td>£115</td>
<td>£84</td>
</tr>
</tbody>
</table>

Source: Frontier calculations based on insurance companies’ data.

These rates are consistently lower than the HMCS Guidelines rates. However, one should bear in mind that in exchange for lower rates, defendant lawyers are guaranteed large volumes of work. So, in theory at least, they might still be better off even if they charge lower rates.

That does not appear to be the case in practice. A comparison of profits per partner (PPP) of a sub-sample of Top 100 solicitor firms, split into those doing predominantly (i) claimant work and (ii) defendant work, suggests that claimant firms on average tend to be more profitable (PPP up to 45% higher). Clearly, this analysis has its limitations. Indeed:

- It focuses only on larger firms and ignores a fringe of firms with lower ranking (due to lack of data)
- Some key players (notably Thompson) have not responded to the Lawyer 100 questionnaire and, therefore, are not part of the analysis

Given these limitations, Frontier cannot make a definitive conclusion that the results hold for all firms, but they do provide some evidence that claimant firms tend to be more profitable.

Hence, if the purpose of the reform is to encourage the industry to become more competitive, lower rates, in line with those currently paid to defendant solicitors, may be appropriate.

Legal aid hourly rates

Personal Injury solicitors’ rates can also be compared to civil legal aid rates. Legal aid is provided by the Legal Services Commission (LSC). LSC pays for legal services for people on low income who cannot afford private rates. Civil legal aid can fund:

- Initial advice and assistance with any legal problem
- A solicitor who can speak on someone’s behalf at court hearings without formally representing them
- Legal representation in court proceedings

A wide range of civil legal work (for example, family proceedings, inheritance, adoption, clinical negligence, etc.) is not dissimilar in its nature to privately funded personal injury work. Moreover, prior to 2000, PI work was also funded by legal aid.

Table 3 below shows the legal aid rates currently paid in care and family proceedings in County courts or magistrates’ court for preparation work, for attending at the trial or hearing with and without counsel and for preparing the bill and completing the detailed assessment.
### Table 3  Hourly rates paid for civil legal aid work

<table>
<thead>
<tr>
<th>Item</th>
<th>County court rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care proceedings - Preparation work including any work arising out of or incidental to the proceedings, interviews with client, witnesses and other parties; obtaining evidence; preparation and consideration of, and dealing with, documents, negotiations and notices; dealing with letters and telephone calls which are not routine</td>
<td>£64.90 per hour (£68.20 in London)</td>
</tr>
<tr>
<td>Care proceedings - Attending without counsel at the trial or hearing</td>
<td>£71.50 per hour</td>
</tr>
<tr>
<td>Care proceedings - Preparing the bill and completing the detailed assessment</td>
<td>£35.75 - £56.95 per hour</td>
</tr>
<tr>
<td>Family proceedings – Preparation work</td>
<td>£64.80 per hour (£68.50 in London)</td>
</tr>
<tr>
<td>Family proceedings – Attending without counsel at the trial or hearing</td>
<td>£64.80 per hour (£68.50 in London)</td>
</tr>
<tr>
<td>Family proceedings – Preparing the bill and completing the detailed assessment</td>
<td>£35.70 - £56.95 per hour</td>
</tr>
</tbody>
</table>

**Source:** The LSC Manual, Volume 1, Part B.
Authors:

Any queries about this report should be directed to the authors at

Alternatively, queries about this report or other information available from the ABI can be directed to the Research Helpdesk at.

telephone

REFERENCES


Fenn, P. and Rickman, N., 2007, "Monitoring the Fixed Recoverable Costs Scheme. Part I: The effects of the scheme on the outcome of claims".

Lord Carter's Review of Legal Aid Procurement, "Legal Aid: A market based approach to reform".

Otterburn Legal Consulting, "The impact on the supplier case of reductions in criminal fees from April 2007".
Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 20 July 2010 18:21
To: Taylor, Jo L
Cc: Wright, Robert (Civil Legal Aid)
Subject: All Research

Jo

Please accept my apologies for the delay in getting this information to you but we had to go through a number of hoops to ensure that the data was anonymous and we had the permission of all insurers and Frontier to use it. However, please find attached a complete set of the raw data used in the Frontier research (and the report). I hope that this should prove useful in undertaking your analysis. Please feel free to contact me with any follow-up queries you may have.

Best regards

Association of British Insurers
51 Gresham Street
London EC2V 7HQ

From: Taylor, Jo L
Sent: 02 June 2010 15:32
To: Wright, Robert (Civil Legal Aid)
Cc: RE: All Research

We have this report. I think what we were actually looking for, if releasable, was the data which Frontier Research gathered to complete this analysis (so that we can use it to consider the effects of Sir Rupert’s proposals) Would the AJI be prepared to approach Frontier Research to release the underlying data on a no names basis (i.e. where the names of the firms providing the data was withheld but we were told the something about the type of firm - approximate size, sector etc.)

We also wondered whether it would be possible for data to be gathered in relation to other types of insured legal work carried out by your members and for PI work above £10,000.

The data we are looking for would be as follows:

- How many cases were dealt with in total i.e. how many cases in the sample and of which case types?
- How many cases (by case type if possible) were funded by BTE, CFA, LSC and prorotit fund?
- How much did paid out as claimants costs, how much as defendants costs, and how much as damages in cases. Is it possible to differentiate between special and general damages?
- How do this differ between cases settled pre proceedings, post issue but before trial and cases finalised at trial?
- Of total claimant solicitor costs, how much was base costs, disbursements, success fees and ATE insurance premiums?
- How much money was recovered in principle from claimants in cases where the claimant lost? How did this differ between cases funded on legal aid, BTE, CFA and privatised funded?

I am not sure whether Robert discussed this with you when you met. I also doubt that your members have all the information but anything they can let us have would be useful. Again, we would be happy for data to be provided on a no names basis as above.

Jo Taylor

Ministry of Justice

From: 01 June 2010 16:48
To: Wright, Robert (Civil Legal Aid)
Taylor, Jo L
Subject: RE: All Research

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300
Robert,

As discussed, I have attached various research reports which may assist you. I have not been able to track one of the Frontier reports down, and our research contact is away on AL, but have left a message with him and hopefully can pass this on in due course.

Jo,

I've looked at your question on damages but at first blush, I don't know if we readily hold that information, I'll pass onto our stats team for follow up.

Best wishes.

www.abi.org.uk

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Dear Robert

Please find attached FYI a speech I gave yesterday in Leeds covering Jackson.

Association of British Insurers
51 Gresham Street
London EC2V 7HQ
Phon
Email

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SPEECH NOTES
Check Against Delivery

Address by to the North East Regional Group of Insurance Institutes, Leeds.
8 September 2010

The Changing Face of Personal Injury Claims

Introduction

Thank you for the invitation to speak to you this afternoon. The title of today’s seminar - the Changing Face of Personal Injury Claims – is particularly well chosen. After many years of false starts and lengthy debate, we are beginning to see the prospect of real change which is welcomed by the insurance industry.

This afternoon, I will run through a number of recent developments which insurers see as changing the nature of personal injury claims.

Firstly, I will talk through the nature of the problem and address the question: why are personal injury costs increasing for insurers?

Without repeating what talked about earlier, I wanted to say a few words about the RTA portal.

Then I will turn to the Jackson review – a critical set of proposals for reform which we see as offering real benefits to insurers and claimants. Without going into too much detail, I will talk though the recommendations for reform of the civil litigation system put forward by Lord Justice Jackson in his review published in January.

I would like to say a few words about the ABI’s Code of Practice on Third Party Assistance.

And finally, I will touch on the issues of insurance fraud and what the industry is doing to tackle this problem.

The Nature of the Problem

I don’t want to bore you with graphs and statistics but if we are to truly appreciate the nature of the personal injury problem, I thought some numbers and trends might be useful. The fact is that personal injury claims are expensive and that expense is increasing.

But, more importantly, the costs of claims are rising as well. As you can see in the bar charts on the graph, for accidents occurring in 2002, the industry paid out approximately £7 billion in personal injury claims. The different colours within each bar signify the numbers of years taken for the 2002 claims to be settled – some of which have taken and extremely long indeed. The brown section at the top of the first bar shows those claims from 2002 that have taken 8 years to settle! This is far too long for claimants to receive the compensation they deserve.

For the years 2003 onwards, some of the figures have had to be estimated, because there are still claims from previous years that are yet to be settled. The opaque areas on the chart show the estimated figures paid out by insurers according to the trends in previous years. You will see that the total cost of claims increases year by year. For example, the estimated total cost to the insurance industry of claims made in 2009 is approximately £14 billion. This is twice the amount paid only 7 years earlier in 2002!
This graph illustrates very clearly the nature of the problem before us. The insurance industry is focused on delivering compensation to all legitimate claimants fairly and quickly and without incurring unnecessary cost. Unless motor injuries are twice as bad as they were less than ten years ago there are flaws in our compensation system which must be addressed.

Why are Personal Injury Costs Increasing?

There are two key reasons why personal injury costs are increasing.

Firstly and tragically, young drivers continue to cause carnage on Britain’s roads. Every day, four people are killed or seriously injured in accidents involving young drivers.

A common misunderstanding is that motor insurance is designed to cover the repair costs of a car involved in accident. Repair costs are far from the biggest cost for motor insurers. The main purpose of car insurance is to meet the cost of any claim brought against the driver by a third-party for injury or damage to their property. Claims for injury to another person can run to several million pounds.

Many young driver accidents lead to very expensive personal injury claims for insurers. Some examples include:

- A young driver, aged 21, who turned his car over whilst carrying a passenger who was a budding sportsman. The latter has been left unable to walk and with severe brain damage. This was a £6.8m claim.
- A 17 year old driver hit a child pedestrian resulting in an £8m claim.
- An 18 year old driver killed himself and very seriously injured two passengers in his car resulting in a claim of over £10m.

All of these cases are tragic. But this latter one demonstrates two key trends. Firstly, personal injury claims from young drivers are increasingly expensive. Secondly, and more generally, it demonstrates that one accident can often result in multiple personal injury claims.

The second reason insurers’ personal injury costs are increasing is the disproportionally high legal costs associated with settling claims. Frankly, the personal injury compensation system is dysfunctional and failing. It takes too long to get compensation to claimants and the legal costs of doing so are too high. This just adds insult to a claimant’s injuries.

Again, without wanting to bombard you with numbers, a few statistics demonstrate this point. On average, for every one pound paid in compensation to a claimant, an additional 42 pence is paid in legal costs.

The problem is even more stark in lower value claims.

In claims under £5,000, for every £1 paid in personal injury compensation, claimant lawyers receive an additional 88p in legal claims for motor claims. This rises to 93p for employers’ liability and public liability claims as the graph shows.

These are not self-interested figures generated by the insurance industry - they are the government’s figures. And although they are now somewhat dated in that they are four years old, I am sure the figures have only become worse since then – not better.
One final statistic – I promise! The International Underwriting Association has estimated that 10% of every motor insurance premium goes to the legal profession. This represents a market worth over £1 billion.

With all of this in mind, I am going to focus on three developments – the RTA portal, Jackson and Third party Assistance all of which the ABI believes will have a significant impact in tackling this problem.

The RTA Portal

As explained earlier, the RTA portal went live on 30 April. Having moved from the ABI’s European public affairs unit, I took over the team managing the portal’s delivery two days later. As Ashley explained, and as I am sure many in this room are more than aware, the portal did not get off to the best of starts. In fact, my first week in the job was spent understanding what went wrong and fielding calls from claimant lawyers and insurers frustrated with the new system. As one less charitable colleague said to me: “welcome to the world of general insurance”.

My focus was to get the system functioning. The team from the MIB took over operational delivery of the portal and went about fixing the problems. Although the transition to MIB’s management may have resulted in some extra delays in registrations as the team came up to speed on the system’s design, I stand by the decision to get the MIB involved. They did an outstanding job at rectifying problems and getting people registered as quickly as possible.

Within a matter of days most of those who had registered could access the system and claims were being processed. In short, the system did what it said it would do on the tin. I would, however, like to offer an apology to any of you who experienced delays and frustration in those early days.

But the benefits of the new system are clear. It reduces unnecessary legal costs and gets compensation to claimants more quickly. From the insurance industry’s perspective, the portal continues to be hugely successful.

The Jackson Review

Moving on to consider the Jackson Review – a subject that has been the subject of a much debate in the legal, insurance and government sectors since Lord Justice Jackson released his final report in January.

As I am sure you are aware, in his report Lord Justice Jackson’s proposed substantial reforms to costs in civil litigation matters potentially affecting almost every area of civil litigation - ranging from small personal injury matters to high value complex commercial litigation.

His terms of reference required him: “To carry out an independent review of the rules and principles governing the costs of civil litigation and to make recommendations in order to promote access to justice at proportionate cost”.

In his final report, Lord Justice Jackson identified and addressed the key questions and issues impacting upon the current costs of civil litigation. In particular, he asked:

- In what circumstances should the losing party be required to pay costs to the winning party?
- How and in what circumstances should the amount of any costs payable by the losing party be reduced or limited?
- How can the procedural rules be improved so as to reduce the time lawyers need to spend in the conduct of litigation and its associated cost?

You will see Jackson's key proposals outlined on the slide. I do not propose to go through each of these in detail but rather to say a few words on each.

In relation to cost shifting, His Lordship said that the 200-year old "loser pays" principle cannot realistically be abolished altogether. He suggested that it could be abandoned in some areas and replaced by qualified 'one-way' cost shifting - whereby successful claimants would recover their costs but successful defendants would not recover theirs.

On fixed costs for fast track cases, Lord Justice Jackson proposed that a fixed-costs regime for all fast track cases should be strongly considered. His report recognised that third party funding of litigation improves access to justice. But he concluded that external regulation of funders would be needed at some point as the market develops, but that a voluntary funders' code is enough for now.

I thought it would be worth saying a little more on the issue that seems to be grabbing everyone's attention - the non recoverability of success fees and ATE premiums.

Jackson recommended that success fees payable by clients to lawyers under conditional fee agreements (CFAs) should not be recoverable from the other side if the claimant wins the case. Similarly, after the event (ATE) insurance premiums should not be recoverable. Jackson also proposed an increase of 10% to individual claimants' damages, including personal injury cases, to enable them to better afford the success fees and insurance premiums. Clearly, this will have an impact on the total amounts payable by insurers.

I will say a bit more about this later.

The ABI has long campaigned for disproportionate legal costs to be stripped out of the system. A civil justice system is dysfunctional when it costs £5000 in legal fees to provide £2000 of compensation to a claimant.

We believe Lord Justice Jackson's report was a comprehensive, evidence-based and objective consideration of the civil litigation system as a whole. It took a pragmatic approach to addressing issues for both claimants and defendants and was undertaken by a senior and respected member of the judiciary. As such, its recommendations should be given the weight they deserve.

The ABI has considered very carefully Jackson's recommendations and undertaken research to assess their implications. From our perspective, the net impact of Jackson will be a reduction in the costs of the civil litigation system and an increase in its efficiency. Although it would have been easy for the insurance industry to cherry-pick the parts of Jackson that we prefer, we are not playing that game. The ABI's position on Jackson is very clear: We want the see the Jackson recommendations implemented as a package and in full. And we would like to see the government deliver this package in an ambitious but realistic timeframe.

Implementation of the Jackson recommendations should improve the civil litigation system for all involved: the court system itself, claimants and their solicitors. And yes, insurers.

The signals coming out of Whitehall are encouraging. Lord Young is undertaking a review of health and safety legislation and has highlighted the problems of the over-interpretation of regulations and excessively risk-averse behaviour. In addition, Ministers are considering reform of the legal aid system.
Jackson’s recommendations could form a third tranche of a wholesale package of reform of the legal system in England and Wales. And in the current economic climate where government departments are looking to make substantial cost savings, Jackson offers a number of potentially attractive solutions.

And progress is being made. In July, Jonathan Djanogly, Parliamentary Under-Secretary of State for Justice, announced an intention to consult this autumn on the implementation of the Jackson recommendations, especially in relation to Conditional Fee Arrangements. We were encouraged by this as it signalled that the coalition government is behind the case for reform of the civil justice system.

But Jackson is just a start - reform needs to go further. We would like to see an early review of the current level of Guideline Hourly Rates for lawyers in civil litigation. This would address one of the direct causes of disproportionate legal costs, especially in personal injury claims where a 30% disparity exists between claimant and defendant lawyer costs.

But one step at a time.

I could not leave the discussion on Jackson without saying a few words about access to justice.

With claimant lawyers seeking to defend the status quo of disproportionate legal costs and a dysfunctional system, they often argue that reform would inhibit claimants’ access to justice. This is a nice, emotive phrase deployed by claimant lawyers to distract people from the real story. There is no evidence to support the assertion, of course, so it is important to put the facts on the table.

Normally, suppliers of services have an interest in ensuring that their clients can pay their charges. Not so claimant lawyers. As Lord Justice Jackson states in his report: “the [claimant] lawyers will recover whatever they can from the other side”. Of course, this is usually without reference to the client. The first impact of any reduction in the costs recovered from a losing party would be on claimant lawyers, not upon the claimant themselves. The tenuous argument that the Jackson reforms will inhibit access to justice needs to be seen in this light.

As if this wasn’t enough, an argument put forward by claimant representatives is that the Jackson proposals would lead to some cases not being taken on by lawyers because the case had a lower prospect of success. Yet if success fees were not recoverable, they would still be payable by clients. And if clients are paying, you would expect to see much more scrutiny of the fees being charged. A competitive market would reduce the level of success fees and the level of hourly rates charged. And claimant law firms would be forced to become more efficient.

An argument that the Jackson reforms would inhibit lawyers taking on some cases is merely an argument in favour of continuing the status quo of a system characterised by perverse incentives, inefficiency and waste. The costs of this system are ultimately borne by taxpayers (through a heavy cost burden on local authorities, the NHS and government departments) and society more generally through higher insurance premiums.

The point is that the access to justice argument used by claimant lawyers is little more than a smoke screen to divert attention from the real issues. In effect, it is an argument that states that claimants can only obtain justice if the costs of the system remain bloated and excessive. So while attractive as an emotive sound-bite, the argument that reform of the civil litigation system will lead to reduced access to justice has little basis in reality.
ABI’s Code of Practice on Third Party Assistance

Leaving Jackson now, I would like to turn to the issue of third party assistance. As some of you will know, earlier this year, the ABI launched a voluntary code of practice for insurers involved in assisting third parties with personal injury claims.

Again, let’s look at why such a Code is needed. The reality is that in the vast majority of personal injury claims, there is actually no dispute about who is liable for the claim. So compensation should be able to be paid quickly to most claimants and everyone should be able to move on. But what happens is that lawyers investigate the detail of cases adding unnecessary cost and delay to a process that could – and should - be resolved cheaply and quickly.

Third party assistance is designed to improve this situation for claimants.

Third party assistance involves an insurer settling a claim directly with a personal injury claimant, without the victim receiving independent legal advice. The purpose of the Code is to set out how insurers should engage with unrepresented claimants to ensure that they are treated fairly. The Code makes clear that insurers should:

- only contact claimants by letter, phone, email or text. The insurer should never appear uninvited at the claimant’s home.
- remind claimants at each stage of the process that they have a right to seek independent legal advice
- make it clear to the claimant that there is no obligation to accept any assistance offered by the insurer
- make offers or settlements that are fair and reasonable and based on appropriate evidence.

The Code also makes clear that in certain situations independent legal advice will be strongly recommended. These include situations where the injured person is under 18 years old, where there is complexity as to who was at fault in the accident, if the claimant has a limited understanding of English or where the injury involved has a degree of complication, persistence or permanence.

Not surprisingly, the Code has come in for criticism from claimant lawyers who insist on referring to insurers helping claimants in this way as “third party capture”. Cases are cited where particular claimants have been offered one amount by an insurer yet when legally represented the insurer settles for substantially more.

Rather than arguing by anecdote, I would prefer to argue with analysis. The ABI’s research has demonstrated that of over 90,000 personal injury claims between £1,000 and £5,000:

- Claimants without legal representation receive on average £239 more than claimants with legal representation; and
- The time taken to settle claims without legal representation is on average 95 days shorter.

Inevitably, claimant lawyers will continue to criticise the Code with unfounded allegations of unscrupulous practices by insurers. Yet for some reason when asked to provide the evidence, it isn’t forthcoming.

Let’s not forget, that the claimant always has the right to seek independent legal advice when dealing with an insurer directly. We have also prepared a claimant guide to be provided at the outset of any claim process. This user friendly guide is designed to ensure that the claimant understands the process and their rights at each stage. Furthermore, the
FSA has produced a factsheet for insurers setting out their expectations when dealing with third party claimants.

Trends in insurance fraud

Now turning to insurance fraud trends. I must say that I am not the expert on this topic but I have been asked to say a few words on the subject. And sorry, there is one final graph!

As you can see, there is a clear upward trend in both the value and volume of detected insurance fraud in the UK. This expense more often than not has to be passed onto customers.

Savings made by detecting fraud amounted to £840m in 2009 from 122,000 claims. The emphasis here is on detected fraud – that is, savings to the industry. On the one hand we can say that insurers are detecting more fraud. What we do not know accurately is whether there is more fraud being committed to detect.

Anecdotally I think we all expect there to be more fraud committed as the economy falters. The recession will certainly be playing its part. But it is very difficult to objectively measure the effect beyond the underlying trend.

Two particular issues that you may have heard of are the problems associated with “crash for cash” claims and the increasing frequency of whiplash claims.

Looking first at crash for cash. The Insurance Fraud Bureau (IFB) estimates around 30,000 accidents were staged last year, costing insurers about £350m in 2009. Crash for cash has attracted a lot of press attention recently. Indeed, Leeds was confirmed as one of the top hotspots of this type of activity in the UK. The ABI is very concerned with these scams and we are working closely with the Insurance Fraud Bureau to monitor this activity and raise awareness of a crime that increases insurance premiums for honest motorists.

The other issue insurers are concerned about when considering fraud is whiplash which is a major societal phenomenon. When we published a major report on whiplash in 2008, we identified that the UK has a greater tendency to get whiplash than the rest of Europe. Since then, I don’t think that British necks have become any stronger!

Our research has revealed that over 432,000 people make a whiplash claim every year – equivalent to one in every 140 people in the UK – and amounting to nearly 1200 claims per day. And the problem is getting worse so it is no surprise that whiplash now leads to nearly £2bn per year in compensation payments – accounting for 20% of the typical car insurance premium, or £66.

While insurers have no problem paying genuine whiplash claims, part of the reason why British necks seem to be weaker than elsewhere in Europe is that the personal injury compensation system allows dubious claims to be facilitated by claims farmers and others who are exploit the slow and expensive system.

So what are we doing to tackle insurance fraud?

The prevention and detection of fraud is a priority for the ABI. The Insurance Fraud Bureau was established in 2006 and is increasing in its effectiveness and capability. We are researching the enhancement of data sharing of known fraudsters.

We are working with members to enhance the deterrents to committing insurance fraud. This is a mixture of education, case studies in the media to demonstrate that fraudsters are more
likely to get caught and making it clear that by committing fraud, you potentially severely limit your future access to insurance and other important financial products.

Professionals, particularly solicitors, are involved in enabling several forms of fraud, so we are seeking ways to make it more difficult for solicitors to abuse the system or to become unwitting victims themselves.

Insurance fraud is a pernicious act which costs all of us, as honest customers, an average of £44 per policy. I for one resent funding their gain.

Conclusion

Campaigning to reform the compensation system is a priority for the ABI. At the heart of our proposals for reform are the interests of claimants. Insurers are lobbying for a system that delivers fair compensation and early access to rehabilitation while cutting down on legal costs that make the system too slow and expensive. The key is proper, swift and full redress where there has been harm.

By implementing Jackson in full, the government would go a long way to addressing these issues.

Thank you for your time this afternoon and I hope that you found this presentation informative and I look forward to answering any of your questions.

Thank you.
Reforming the Compensation System – A Better Deal for Consumers

I would like to invite you to make some key note remarks at an ABI Parliamentary reception on personal injury compensation reform on Wednesday 27 October, entitled “Reforming the Compensation System – A Better Deal for Consumers”.

This event will provide an excellent opportunity for key stakeholders to discuss the recent changes and the possibility of future reform to the personal injury compensation system, in particular to discuss the recommendations of Lord Justice Jackson as outlined in his recent report on civil litigation costs.

I will say a few words along with a representative from an ABI member company. We have also invited the Rt Hon Lord Young to speak, Lord Hunt of Wirral has kindly agreed to sponsor the event and will give some opening remarks.

The event will take place in Dining Room A of the House of Commons from 12:30pm to 2pm. The audience will consist of MPs from each party and members of the House of Lords, representatives from ABI member companies, and other interested organisations.

I very much hope that you are able to join us and deliver the keynote speech. If this is not possible, I would be delighted to extend the invitation to the Parliamentary Under-Secretary of State for Justice, Jonathan Djanogly MP.

Yours sincerely,
Apologies for the delay. A copy of the letter is attached and it is leaving our office today.

Best regards

51 Gresham Street
London EC2V 7HQ

----Original Message-----
From: Wright, Robert (Civil Legal Aid)
Sent: 23 September 2010 14:06
To: Wright, Robert (Civil Legal Aid)
Cc: RE: ABI reception
Subject: ABI reception

I think we are still awaiting the letter to the Sec of State inviting him to the reception? It would be helpful to see it asap, and to know when it might be sent.

Thanks

Robert

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Wednesday 20 October ? ABI Solvency II Conference in partnership with PwC. To register, please visit www.abi.org.uk/solvencyIIconference2010

*********************************************************************************************************************

Association of British Insurers, 51 Gresham Street, EC2V 7HQ
Tel: 020 7600 3333 Fax: 020 7696 8999

http://www.abi.org.uk

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*********************************************************************************************************************
Wright, Robert (Civil Legal Aid)

From:  
Sent: 29 September 2010 10 58  
To: Wright, Robert (Civil Legal Aid)  
Cc:  
Subject: Legal Expenses - ATE/BE

Dear Robert,

I wondered if we could please have a quick chat about ATE/BE insurance policies and legal expenses insurance generally? I spoke yesterday and he mentioned that you are now dealing with this and that his focus has shifted to dealing more with legal aid matters.

The ABI is holding its periodical Legal Expenses Insurance Committee meeting next week and it would be a good opportunity for us to raise anything that you would like us to ask them.

Do you think that there is anything that you would like us to discuss with our members? If so, it would be good to talk through it so that I can add a point onto our agenda.

Kind regards,

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Wednesday 20 October – ABI Solvency II Conference in partnership with PWC. To register, please visit www.abi.org.uk/solvencyIIconference2010

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From: f
Sent: 29 September 2010 17:50
To: Wright, Robert (Civil Legal Aid)
Subject: Re: Personal injury event

Robert

Thanks: useful update. I have an internal meeting on the event tomorrow and will give you an update after that.

From: Wright, Robert (Civil Legal Aid)
Sent: Wednesday, September 29, 2010 05:06 PM
Subject: RE: Personal injury event

Just to keep you informed. I understand we won't get a ministerial response until at least Monday 11 October (what they are back from the conference).

Robert

From: D
Sent: 29 September 2010 13:24
To: Wright, Robert (Civil Legal Aid)
Subject: Re: Personal injury event

Robert

Noted and thanks. Obviously the sooner the better from our perspective so we can send invites.

From: Wright, Robert (Civil Legal Aid)
Sent: Tuesday, September 29, 2010 10:52 AM
To: Cc
Subject: RE: Personal injury event

We are still working on this with Private offices. Ministers are now unlikely to be around until after the Conservative conference next week, so it may be that we will not be able to confirm until then.

Robert

From: Sent: 28 September, 2010 11:26
To: Wright, Robert (Civil Legal Aid)
Subject: Personal injury event

Robert

Just a quick note to follow up on our email exchange last week. Apologies that the letter to Jonathan Djanogly took so long to get over to you.

Have you heard anything from his office about his availability? We need to send out the invitations this week.

J
Association of British Insurers
51 Gresham Street
London EC2V 7HQ

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 3 October 2010 17:28
To: Wright, Robert (Civil Legal Aid)
Subject: Re: ASSOCIATION OF BRITISH INSURERS - PARLIAMENTARY RECEPTION INVITATION - 27 OCTOBER 2010

Robert

A pity but understood.

From: Wright, Robert (Civil Legal Aid)
Sent: 30 September 2010 16:02
To: Wright, Robert (Civil Legal Aid)
Subject: FW: ASSOCIATION OF BRITISH INSURERS - PARLIAMENTARY RECEPTION INVITATION - 27 OCTOBER 2010

I just tried calling. I am sorry to say that neither Ken Clarke nor Jonathan Djanogly is able to attend this reception. As you know, we were keen to assist, but you will understand that the next few weeks in particular are incredibly busy for ministers and I am afraid that it has not been possible at this time.

Best wishes
Robert

Association of British Insurers
51 Gresham Street
London EC2V 7AR

Sent: 30 September 2010 16:16
Subject: ASSOCIATION OF BRITISH INSURERS - PARLIAMENTARY RECEPTION INVITATION - 27 OCTOBER 2010

I would like to invite you to attend the ABI’s Parliamentary reception on Reforming the Compensation System – A Better Deal for Consumers on Wednesday 27 October 2010. The event is being supported by RBS Insurance.

There have been several recent changes to the personal injury compensation system and a number of further reforms suggested, in particular the recommendations of Lord Justice Jackson’s recent report on civil litigation costs. We believe these reforms will improve outcomes for consumers by simplifying and speeding up the compensation process.

Lord Hunt of Wirral has kindly agreed to host this event. Lord Young, who has been conducting a review of health and safety laws on behalf of the Government, will speak at this event and a Ministry of Justice Member has also been invited to say a few words. In addition, a representative of RBS Insurance will make a short speech.

The event will take place in Dining Room A of the House of Commons from 12.30 to 2pm. The audience will consist of MPs from each party and members of the House of Lords, representatives from ABI member companies, and other interested organisations.

I hope you will be able to join us for what should be an interesting event. To RSVP, or if you have any questions, please contact

Yours sincerely
Association of British Insurers

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BOOK NOW FOR THE FOLLOWING ABI EVENTS

Wednesday 20 October – ABI Solvency II Conference in partnership with PWC. To register, please visit www.abi.org.uk/solvencyllconference2010

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Hi Robert

I will get back to you as soon as possible

Great working with you this year and look forward to us working together again in 2011. All the best for the holidays.

Robert Wright
Civil Litigation Funding and Costs
Ministry of Justice
102 Petty France
London SW1H 9AJ
Tel...

-----Original Message-----
From: Robert Wright [Civil Legal Aid] [mailto:Robert.Wright@justice.gov.uk]
Sent: 21 December 2010 15:11
To: [mailto:Robert.Wright@justice.gov.uk]
Subject: RE: ATE cover for disbursements only

Hi,

I hope things are well with you.

I wonder whether you can help with one issue in relation to our consultation paper: the prospect of ATE cover being available for disbursements only, which we discuss from para 89. We understand that some cover of this kind already exists, in relation to MIB claims, although I am not sure how this operates. We are pursuing this with other sources, but it would be helpful to know if you know of such products.

With best wishes for Christmas and the new year.

Robert Wright
Civil Litigation Funding and Costs
Ministry of Justice
102 Petty France
London SW1H 9AJ
Tel...

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Dear Robert

I have spoken to ___ at the MIB. He said that he discussed this issue in some detail with your colleague Jo Taylor only a couple of days ago and confirmed that the MIB do not offer a disbursement only ATE policy. They do have a legal expenses scheme, but it covers all legal fees, not only disbursements.

I am not aware of any similar policy being offered by any of our other members. However, I will make enquiries with them and will revert back to you when I've had some feedback.

51 Gresham Street
London EC2V 7HQ
Phone
Email:

-----Original Message-----
From: Wright, Robert (Civil Legal Aid)  
Sent: 21 December 2010 15:11  
To:  
Subject: ATE cover for disbursements only

I hope things are well with you.

I wonder whether you can help with one issue in relation to our consultation paper: the prospect of ATE cover being available for disbursements only, which we discuss from para 89. We understand that some cover of this kind already exists, in relation - we are told - to MIB claims, although I am not sure how this operates. We are pursuing this with other sources, but it would be helpful to know if you know of such products.

With best wishes for Christmas and the new year.

Robert

Robert Wright
Civil Litigation Funding and Costs
Ministry of Justice
Area 4.16-20
102 Petty France
London SW1H 9AJ

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*********************************************************************
From: Lull
Sent: 07 January 2011
To: Wright, Robert (Civil Legal Aid)
Subject: 19th January 2011

Robert - further to our conversation of yesterday evening, I promised to provide you with details of those who have committed to our morning meeting on the 19th in Westminster. The venue is to be One Whitehall Place.

The attendees are as follows:

This is a total of 9 insurers, the MIB and the NHSLA. I have already excluded two people myself where we had more than one representative per company.

In addition, from ABI were attending may agree to drop this to one to assist.

I will obviously also be attending on behalf of Keoghs. We are therefore looking at an audience of 15.

All the above are highly engaged in the process, have been for some years and will all have a lot to say and discuss with the Minister.

As the group will already be assembled at One Whitehall Place and if it assists in terms of providing a room / facilities then we would be delighted to host the Minister and he can arrive and leave as suits his diary. If this is not convenient then obviously we can come to MoJ.
I have a longstanding relationship with Beachcroft and have worked with Lord Hunt over a number of years and would be happy to liaise/co-ordinate with them on this.

I look forward to hearing from you - I am in London both next Tuesday and Wednesday and would be happy to attend for a short meeting to discuss further or I am sure we can progress by email/telephone.

With kind regards,

Keoghs LLP

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From:            22 March 2011 17:36
Sent:            Wright, Robert (Civil Legal Aid)
To:              Taylor, Jo L
Cc:              RE: IL
Subject:         Legal Expenses Insurance(1).pdf
Attachments:     Legal Expenses Insurance(1).pdf

Hi Robert

Thanks for your email and apologies for the delay in this reply. In relation to the
two specific points addressed:

(1) The ABI is very keen to promote BTE insurance and we are continuing with our work
on promoting Lord Young’s proposals in general. More specifically, we met with your
colleagues at the DCLG and the MSE yesterday to discuss how to take the insurance
related recommendations in Lord Young’s report forward, and a meeting has been set up
with a group of our members on 12 April to discuss how to progress these matters. In
the meantime, our legal expenses insurers are considering how BTE insurance can be
promoted and used more widely. Both we and our members are keen to engage the Ministry
on this issue.

(2) Unfortunately, we do not have any concrete figures on the number of people who
have BTE insurance. However, we do have some data on the number of BTE policies taken
out - up to 2008 (please see attached). The 2009 figures are currently being collated
by our statistics team and should be available very shortly.

The ABI also conducts a quarterly consumer survey. The last survey was completed last
week by over 2,500 participants and contained a number of questions in relation to BTE
insurance. Those were primarily aimed at assessing whether or not people had (or were
aware that they had) BTE cover, and was also designed to assess consumers’ awareness
of what it generally does and does not cover. I anticipate the results to be released
within the next couple of weeks or so and I will make sure that I share these with
you.

I hope this is helpful and I will get back to you in due course with (1) the 2009 BTE
data and (2) the results of the latest ABI consumer survey.

Whilst writing to you about BTE insurance and because the recommendations of Lord
Young tie in very closely with those of Lord Justice Jackson, I thought it was worth
mentioning the ABI’s reaction to the recent Transport Select Committee report on the
rising cost of motor insurance. We were disappointed to see that the Committee failed
to recognise that the main cause of the recent increases in motor insurance premiums
is ever-increasing personal injury claims and spiralling legal costs, part of which
includes referral fees. As you may recall from the ABI’s formal Response to the
Ministry’s consultation on the Jackson recommendations, we were very concerned that
this issue was omitted because disproportionate costs are at the heart of the Jackson
reforms and referral fees are an integral part of the current problem. We plan to
write to your Minister in similar terms this week to highlight this issue to him.

If you would like to discuss any of the above please feel free to give me a call.
Also, as mentioned in a previous email to your colleagues a few weeks ago, I’m always
more than happy to meet you and/or your colleagues at Petry France if you would like
to have a general chat about BTE and other issues related to the recommendations of
Jackson and Young.

Kind regards,
Hi Robert,

I am currently out of the office; I shall reply substantively to your email by COP today. BTE insurance (as well as legal expenses insurance more generally, the legal costs associated with compensation claims and reform of the civil justice system) falls into my policy area so you can contact me about these issues from now on.

I shall get back to you very shortly with a response to your questions.

Kind regards,

Policy Adviser, Compensation Systems
Direct: 020 7216 7507
www.abi.org.uk

---Original Message-----
From: Wright, Robert [Civil Legal Aid]
Sent: 22 March 2011 15:47
To: L.
Cc: Taylor, Jo
Subject: RE: BTE

I have just left a message with you about this email. It would be very helpful to have your response asap.

Many thanks

Robert

---Original Message-----
From: Wright, Robert [Civil Legal Aid]
Sent: 16 March 2011 16:00
To: L.
Cc: Taylor, Jo L
Subject: BTE

I hope things are well with you. As you can imagine, we are extremely busy in analysing the responses to the consultation paper and considering the way forward.

I was wanting your help on two specific issues on BTE insurance:

(i) whether there have been any developments on BTE. Para 267 of our consultation paper said: "Lord Young is also very supportive of encouraging BTE insurance and will be consulting with the insurance industry on developing stand-alone policies for individuals and small businesses." Clearly, Lord Young has moved on, but I wonder whether any further work or developments have taken place on this?

(ii) do you have figures for the number of people who have some sort of BTE cover? It would be helpful to have any update on the 2008 Mintel report, specifically in relation to how many motorists have some sort of BTE cover in respect of motor claims.

Needless to say, it would be very helpful to have a response as soon as possible.

With best wishes
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************************************************************************************************************
Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 30 March 2011 10:13
To: Robert
Subject: Today's announcements

Dear Robert,

I am trying to get away from the office but I am away a little bit longer. I am heading to New Zealand this weekend and will not be back in the office until Thursday 3 May. We could meet at some stage in the week beginning 3 May for a catch-up if that suits you? I will be around between these dates if you want to touch base before then.

Best regards,

Robert

---

From: Wright, Robert (Civil Legal Aid)
Sent: 29 March 2011 17:44
To: Wright, Robert (Civil Legal Aid)
Subject: Today's announcements

Dear Robert,

I am sure you have had a busy couple of weeks but I just wanted to drop you a line to say we will read all the papers diligently over the next couple of days but I just wanted to let you that the initial reaction is very positive.

Our press statement is here:

http://www.ilt.org.uk/MediaReleases/201103/Government_plans_to Reform_legal_system_will_make_a_better_deal_for_genuine_claimants_andInsurance_customers

Speak again soon.

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Association of British Insurers, 51 Gresham Street, EC2V 7HQ

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I have had a chance to liaise with various of our members and have outlined some more information below:

Referral fees are received by insurers in a variety of ways. Here are a number of examples:

- If a claimant is involved in a motor accident through no fault of their own and sustains an injury, their motor insurer may sell on the details of the claimant (as their policyholder) to a claimant solicitor. The claimant solicitor will pay a referral fee to the insurer for the introduction of the claimant.
- Legal expenses insurers also receive referral fees through the operation of BTE insurance. If a policyholder wishes to make a claim on their BTE insurance, the insurer will engage a solicitor to act for the claimant. The solicitor will pay a referral fee to the legal expenses insurer for the instruction.

The solicitor absorbs the cost of the referral fee as part of the cost of dealing with the claim. The referral fee is recovered from the defendant, and consequently their insurer, as part of the solicitor's fees, contributing to the claimant's legal costs. The referral fees therefore go full circle through the insurance industry – being received by and paid for by insurers. The payment of referral fees affects all consumers as they increase the legal costs associated with settling claims, which is reflected in increased premiums, especially for motor insurance.

UK consumers pay £2.7m a day to the legal profession through their motor insurance premiums – or £41 per policy. A large bulk of this is due to the payment of referral fees – referral fees which we say do not contribute to the value of the legal services offered to the claimant and if anything fuels the idea of a compensation culture that permits unmeritorious claims.

As I already mentioned below, insurers want referral fees to be banned despite the fact that many insurers currently receive these fees. Competition law prevents insurers agreeing collectively to stop selling claims and receiving the referral fee income. Understandably, there is no incentive, therefore, on any firm to stop receiving referral fees and there are substantial disadvantages to being the first-mover in terms of reduced income. The only solution for our members is for the Government to legislate against this practice which is why we are keen to see this happen.

In terms of the impact upon the use of BTE insurance if referral fees were banned – although we cannot say for certain what consumers will do, legal expenses insurers are keen to see an increase in the uptake of BTE insurance, and are hopeful that the confirmed changes to the civil litigation cost funding regime will encourage the use of BTE. The ABI has a dedicated Committee – the Legal Expenses Insurance Committee – and the next quarterly meeting is scheduled for the end of May. We have previously had discussions with your colleague about BTE but these ceased a few months ago – we would be more than happy to pick these up with the Ministry.

Happy to discuss further and do let me know if you'd like more information on any of the above.

Kind regards,
From: Taylor, Jo

To: [Redacted]

Subject: FW: Referral fees

Hi Jo,

Just forwarding my holding email to — got her out of office and wanted to keep you in the loop.

Will respond to you as soon as possible and please feel free to give me a call if you'd like to discuss anything.

Kind regards,

Association of British Insurers

www.abi.org.uk

From: [Redacted]

Sent: 07 April 2011 11:34

To: [Redacted]

Subject: RE: Referral fees

Hi

Apologies for the delay — am liaising with our members about this. I shall get back to you as soon as I can.

Kind regards,

www.abi.org.uk

From: [Redacted]

Sent: 05 April 2011 11:41

To: [Redacted]

Cc: [Redacted]

Subject: RE: Referral fees

Thanks for your reply. One thing we are keen to understand is how insurers use referral fees and in particular what the impact on the use of BTE insurance would be if referral fees were banned? Grateful for any light you may be able to shed on this.

regards

From: [Redacted]

Sent: 04 April 2011 16:02

To: [Redacted]

Cc: [Redacted]

Subject: RE: Referral fees

Hi
Thanks for your email and good to hear from you. I am very well thanks, hope you are too? No doubt you and your colleagues are very busy with all of the Jackson related issues - as we are!

The ABI has a very strong position on referral fees - we believe that referral fees should be removed to ensure legal costs are reset at proportionate levels without affecting access to justice. As you will be well aware, disproportionate costs are at the heart of the Jackson reforms and we believe that referral fees are an integral part of the current problem.

Put simply, insurers want referral fees to be banned. This is despite the fact that many insurers receive these fees, and competition law prevents insurers agreeing collectively to stop selling claims and receiving the referral fee income. The only solution for our members is for the Government to legislate against this practice. We were encouraged by the Government’s endorsement of Common Sense, Common Safety where Lord Young, on page 22, stated ‘it is my firm belief that the government should adopt Lord Justice Jackson’s proposals as soon as possible.” It follows that this includes a ban on referral fees. We were also pleased to see that pages 3 and 29 of the Chancellor’s Budget published on 23 March also confirmed the Government’s commitment to implementing Lord Young’s proposals.

We believe that the issue of referral fees is fundamental and that it is imperative, for the benefit of consumers and claimants, that the recommendations of Lord Justice Jackson is seen as a whole. We think that the key is to ensure that proposals are not looked at in isolation and that the Jackson package is kept intact. The ABI was delighted to see the Government’s commitment to implementing the vast majority of Jackson’s reforms, but we would also like to see a ban on referral fees to complete the package.

We have written to Jonathan Djanogly to highlight our concerns in this regard (please see attached). We have also written to Chris Grayling to make him aware of our position on this following his announcement that he will be leading on the implementation of the Lord Young’s health and safety proposals (which contains a number of insurance related recommendations and which we wholeheartedly support).

For further and more detailed information, I also attach the ABI’s submission to the Legal Services Board in response to their consultation last year (this is the same document as Annex A of the ABI’s response to the Ministry’s consultation on Jackson).

I’d be more than happy to discuss this in more detail with you/your colleagues if you would like to talk through this further, either on the telephone or in person. My direct dial is below so please don’t hesitate to drop me a line if you have any questions.

Kind regards,

---
From
Sent: 01 April 2011 10:36
To: referral fees
Cc:
St:

Hi

Hope that you are well. We saw the ABI’s press release following publication of the Government’s response to the Jackson consultation.

Any information you are able to provide on the ABI’s position on referral fees would be welcome,

http://www.abi.org.uk/Media/Releases2011/03/Government_plans_to_reform_legal_system_will_mean_a_better_deal_for_genuine_claimants_and_insurance_customers_says_the_ABI.aspx

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 13 May 2011 17:09
To: Wright, Robert (Civil Legal Aid)
Cc: Taylor, Jo L
Subject: RE: Yesterday's meeting at Petty France
Attachments: Consultation Response - Referral fees - final.pdf

Robert,

Yes sorry – please see attached.

Will make sure that the Transport Select Committee Report (in particular the recommendation on paragraph 23) is on the agenda for our next meeting.

Have a good weekend and see you then.

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk

Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

From: Wright, Robert (Civil Legal Aid) [mailto:]
Sent: 13 May 2011 17:03
To: Taylor, Jo
Cc: Taylor, Jo
Subject: RE: Yesterday's meeting at Petty France

Thanks for this, it was good to see you and the others too yesterday. I think you were going to send us your response to the LSB consultation on referral fees. It would also be interesting to see what your response is to the Transport Committee Report, as discussed – but we can talk about that on 24th. Look forward to seeing you then.

Robert

From:
Sent: 13 May 2011 16:59
To: Wright, Robert (Civil Legal Aid); Taylor, Jo L
Cc:
Subject: Yesterday’s meeting at Petty France

Dear Robert and Jo,

It was good to see you both yesterday morning and to talk through the items on our agenda.

It was encouraging to hear that we share the same views on the claimant lobby’s access to justice arguments and undesirable behaviours being driven by claims management companies. Indeed, these views are not only the insurance industry’s but those of all compensators that we have spoken to including various local authorities and, which confirmed in our meeting, the NHSLA.

We are continuing with our efforts to ensure that this message is not lost on members of the public and that it is more widely understood that these proposals can have a positive impact upon insurance premiums. As we discussed, the rising cost of motor insurance is in the forefront of everyone’s minds and we believe that Jackson’s proposals could benefit consumers without affecting the rights of genuine claimants.

As we mentioned, the missing piece of the puzzle, for us, is a ban on referral fees. Claims management companies use the current system to allow costs to be injected into the compensation system without adding any value to the claimant. It also drives undesirable behaviour and encourages claims that should not be brought. Insurers make no secret that they receive these fees and, as I mentioned, greater transparency is something which the industry can work towards but the ideal position, for the reasons above and that we discussed, would be to remove them altogether. The insurance industry would be very keen to engage in how this might work in practice.

Of equal importance is the issue of fixed fees and the hourly rate. We cannot support a system that can factor in up to 75% of the costs just to reflect a completely dis-proportionate acquisition cost. By reducing the fixed fee, you will bring some commercial reality into play and referral fees will be driven down by market forces as there will be less “fat” in the system.

We will contact our local authority contacts to discuss the QOCS drafting issue; this is, we understand, of great interest to all compensators so as to avoid a “have a go” culture. We would very much like to be involved in any discussions in this regard and we believe that we have much to contribute to the debate.

Thanks again for your time yesterday and do let me know if you have any further questions. As you mentioned yesterday Robert, nd I have a meeting with you scheduled for 24th May and we look forward to seeing you (and hopefully you too, Jo) then.

Kind regards,

- 

General Insurance and Health Directorate

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Association of British Insurers
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Legal Services Board’s Consultation Paper – Referral fees, referral arrangements and fee sharing

Response from the Association of British Insurers

1. The Association of British Insurers (ABI) is the voice of the insurance and investment industry. Its members constitute over 90 per cent of the insurance market in the UK and 20 per cent across the EU. Employing more than 300,000 people in the UK alone, it is an important contributor to the UK economy and manages investments of £1.5 trillion, over 20% of the UK’s total net worth.

Introduction

2. This is the ABI response to the Legal Services Board’s (LSB) consultation exercise in relation to the regulatory treatment of referral fees, referral arrangements and fee sharing.

3. The ABI’s interest in referral arrangements stems from a number of perspectives. We have an interest, as users of the civil justice system, in ensuring that access to justice is achieved at proportionate cost. Some of our members are defendant compensators, who ultimately foot the bill for referral fees, whilst some (including those same defendant compensators) act as intermediaries and receive referral fee income.

4. More generally, the ABI believes that reform is urgently needed to limit unnecessary costs in the civil litigation system – excessive legal costs for both claimants and defendants and disproportionate litigation costs for the Government. We believe that the costs should be proportionate to the issues and sums involved. We fully support the recommendations of Lord Justice Jackson (as endorsed by Lord Young) and have always maintained the position that a positive outcome for claimants, defendants, and consumers would be the implementation of Jackson’s recommendations as a package and in full.

5. The ABI’s response is restricted to the issue of referral fees for personal injury claims. This response does not comment on the operation of referral fees for conveyancing transactions or criminal advocacy.

Summary of the ABI’s Response

6. The Consumer Panel and LSB have suggested that there is no compelling case for banning referral fees. The ABI does not agree with this assessment.

7. The payment of referral fees comes at a disproportionately high cost to the insurance industry and ultimately consumers. The ABI believes that referral fees can be removed from the civil justice system without significantly affecting access to justice, with the added benefit of reducing legal costs. Referral fees contribute to excessive legal costs without adding any value to the services provided to the consumer. It is for this reason that we believe they should be banned, and it is with this context in mind that we answer the LSB’s questions as set out below.

Consultation questions
Conclusions – Personal injury

1. Do you agree with our analysis of the operation of referral fees and arrangements?

8. No. The ABI believes that the LSB’s consultation has focussed too heavily on the use of referral fees in isolation and not properly considered the use of referral fees in the context of the civil litigation system as a whole. We also challenge the conclusions of both the Vanilla and Charles River Associates (CRA) reports.

9. The Vanilla research report derived its conclusions in relation to personal injury claims from a pool of only 25 personal injury claimants. A sample of this size cannot be considered to be representative. In addition, of the 25 participants, only 15 took part in the group discussions and other 10 contributors were only interviewed over the telephone. Both the sample size and methodology used for this research report cannot be said to be reliable enough for the LSB to draw substantive policy conclusions from.

10. The CRA report also carried out some interviews in addition to its assessment of existing research. However, these were small in number too, comprising only 15 participants. Our concerns about the size of this pool are the same as outlined for the Vanilla research above. In addition, the CRA report draws upon the Vanilla report for its conclusions (for personal injury claims, at pages 83, 97 and 103).

11. The ABI believes that the payment of referral fees should be banned, and in tandem, legal fees must be reduced by a corresponding amount to ensure that supposed marketing or acquisition costs are adjusted to a more appropriate level. This will ensure that any transactional savings to lawyers that come from banning referral fees are passed on and directly reduce the end legal cost to consumers. Legal costs have become increasingly disproportionate over recent years – as much as 87p for every pound of compensation received (2009/2010 ABI research of over 50,000 motor personal injury claims under £5,000). The Transport Select Committee are currently considering the escalating costs of motor insurance pricing1 - referral fees have been a contributory cause to this escalation.

2. Do you have additional evidence about the operation of referral fees and arrangements that should be considered by the LSB?

Oxera

12. ABI commissioned research by Oxera2 concluded that because the legal fees charged by claimant solicitors within the personal injury market are not subject to sufficient market constraints, the expenses incurred in marketing (e.g. referral fees) are not constrained by the claimant’s willingness to pay. Within this structure, referral fees paid by solicitors represent the difference between the costs of actually processing the case and the costs that can be recovered from the defendant. Referral fees have, as shown by Figure 19 in the CRA report (page 93), increased over time, indicating that claimant solicitors have been able to drive efficiencies. This has not, however, resulted in any savings to consumers in the form of reduced legal costs, because the present costs structure has referral fees factored into the fixed costs and hourly rates. The costs system has in effect allowed solicitors to increase their referral fees/marketing spend. The result, as noted by Lord Justice Jackson in his Review of Civil Litigation Costs, is that there are too many ‘middle men’ involved, adding no value to the consumer. As Jackson says in his report:


"the present level of referral fees has grossly distorted the costs of personal injuries litigation." 

13. Lord Justice Jackson’s report was a comprehensive, evidence-based and objective consideration of our compensation system as a whole, and takes a pragmatic approach to addressing issues for both claimants and defendants. It was undertaken by a senior and respected member of the judiciary, and its recommendations should, therefore, be given the weight that they deserve. The LSB’s dismissal of Lord Justice Jackson’s recommended ban on referral fees has not, we believe, been considered carefully enough.

Access to justice and claims frequency

14. The ABI believes that the LSB has understated the effect of referral fees on claims frequency. For example, the LSB states that the recoverability of CFA success fees and ATE premiums is another factor driving claims frequency. CFA uplifts and ATE premiums became recoverable in 2000 but the insurance industry has seen an increase in the volume of motor accident claims since 2004. This happens to coincide with when referral fees were permitted.

15. The increased frequency of motor accident claims has not been mirrored in employers’ and public liability claims (EL and PL) which would be expected if success fees and ATE premiums were a major driver of claims frequency since these additional liabilities are much more prevalent in EL and PL claims. A review of the number of personal injury claims submitted in recent years shows that in 2000/2001, 219,183 EL claims were submitted. By 2009/2010 that number had fallen to 78,744. In respect of PL claims, in 2000/2001 the number of claims presented was 95,583. By 2009/2010 that number had reduced to 91,025 – a 5% reduction. Whilst we accept that workplaces and public areas may have generally become safer over the last 10 years, the statistics would indicate that employees and the public have not been pursuing additional claims as a result of the additional cost liabilities. The same can be said for clinical negligence claims which have also reduced.

16. Given this, and despite the increase in motor claims (which can be attributed to a wide range of other competing factors), we would question whether there is any real evidence that referral fees have enhanced access to justice. Indeed, the Charles River Associates research (on page 83) acknowledged that despite a steady decline in road traffic accidents (RTAs) motor personal injury claims have been increasing from 400,000 in 2000/2001 to 925,000 in 2008/2009.

17. The cost of marketing through claims management companies by way of the payment of referral fees is very high. The ABI’s Oxera research found that, for personal injury claims, marketing costs in the form of referral fees were high when compared to other comparable markets. The research concluded that marketing activity for personal injury claims was around 23-40% of base legal costs. This was compared with other professional services, where the average spend on marketing as a proportion of turnover was around 15%. For other legal services, (e.g. wills and conveyancing) marketing spends were around 18% of base legal costs. The high marketing costs for personal injury work can be attributed to the lack of market constraints for claimant solicitors’ costs.

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1 Para 3.10(d) (page 450) of Lord Justice Jackson’s Review of Civil Litigation Costs, December 2009
2 Evidence from the Compensation Recovery Unit as shown in Figure 21 (page 96) of the CRA report.
3 Data from the Department of Work and Pensions (Compensation Recovery Unit).
18. Oxera also concluded that it would be possible to reduce the marketing spend within the personal injury sector, without significantly impacting on access to justice. Therefore, it is possible that referral fees could be removed whilst maintaining access to justice.

Change to legislation

19. Since 2000, when changes to cost recovery took effect, coupled with a lifting of the ban on solicitors paying referral fees in 2004, intermediaries have been receiving referral fees to introduce people with a potential claim to solicitors. Intermediaries find potential claimants in a number of ways, including national advertising, local advertising, and as a result of their activity in another market (e.g. car hire companies). The most significant intermediaries are claims management companies. Over time, Oxera found that the level of referral fees being paid to intermediaries has increased significantly, and particularly for personal injury claims, have risen from £400 five years ago to up to £1000 now. The fees represent an increasing percentage of the costs they recover.

Quality of Claims

20. In insurers’ experience, the impact of activities of intermediaries involved in referral arrangements impacts on the genuine claimant. The referral arrangements, particularly those involving claims management companies, present opportunities for dubious firms to take advantage of claimants, solicitors, insurers, and other service providers. For example, some referral arrangements work on the promise of a minimum volume of referrals. Given the variable frequency of genuine accidents, this practice represents a higher than average risk of producing spurious or even fraudulent claims to meet agreed volumes. This combination of factors means that there is a risk that those involved in claim management companies may engage in suspect practices. This impacts upon the genuine claimant accessing justice where a spurious or fraudulent claim takes precedence, and on a defendant who must seek to rebut the spurious or fraudulent claim, or unknowingly compensates a fraudulent claim.

Quality and independence of legal service provided

21. Under the current system, the claimant will generally be referred to a legal representative who has been chosen by the intermediary, rather than the claimant. Therefore, the level of quality will depend on the extent to which the intermediary has emphasised quality in the service level agreement or contract with the legal representative.

22. The CRA research acknowledges that it is clear that introducers refer clients to particular law firms on the basis of referral fees (page 91). The independence of the lawyer is governed by the professional duty of care they owe to the claimant as client and should not be compromised by the referral process. Moreover, as legal services can be considered to provide deferred value and the claimant may not be able to observe the quality of the service either before or after, it is difficult to measure the impact of referral arrangements has had on quality.

Fraudulent claims

23. Nowhere in the LSB document are fraudulent claims discussed. The Insurance Fraud Bureau (IFB) believes that there may have been as many as 30,000 fraudulent RTA claims made in 2009. Current estimates from the IFB indicate that undetected (i.e. the true cost of) fraud total almost £2bn a year, adding, on average, £44 per insurance policy premium. The existence of referral fees may have influenced this behaviour by encouraging claims management companies to induce solicitors to accept what may be spurious claims. Doctors agree that this is a problem; a recent survey by one of our
member companies found that 93% of GPs have seen a patient in the past two years who they thought was exaggerating their injuries in order to try to make a compensation claim, and 79% said they had seen someone they suspected was making the injury up entirely.

Recommendations for improving transparency and disclosure

6. Will the proposals assist in improving disclosure to consumers?

24. Yes, provided that the standards applied are consistent and provided that the CM Regulator and the FSA apply a joined up and consistent approach. Indeed, the first two objectives in respect of to whom the referral fee is paid to and the amount should already be provided to the consumer, under section 2A (4) of the Solicitors Introduction and Referral Fee Code 1990. If the LSB does not, as it indicates in its report, believe that this is presently the case, then the issue is one of enforcement. Any rules designed to improve disclosure must be supported by a robust enforcement process in order for the aim for improved disclosure to be achieved.

7. Are there other options for disclosure that ARs should consider?

25. If the LSB wishes to ensure that there is full transparency to the consumer, provision could be made to require that the written consent of the consumer be obtained before the payment of a referral fee is made.

8. What are the issues relating to the disclosure of referral contracts by firms to approved regulators and their publication by approved regulators?

26. The ABI is concerned that the publication of these arrangements will not necessarily protect the consumer. It is also likely to place commercially sensitive information in the public domain. Competition law or data protection issues must be carefully considered.

27. Currently, the SRA/FSA can require solicitors/insurers to provide such information on request. Maintaining this arrangement would, in our view, be adequate and proportionate.

9. How should these issues be addressed?

28. Notwithstanding the ABI’s position that a ban on referral fees is most appropriate, we would suggest that to address the issue at question (8) above, the LSB should seek this information on a case by case basis as and when appropriate.

Recommendations for delivering active regulation

10. Will the proposals assist in improving compliance and enforcement of referral fee rules?

29. The ABI believes that the existing rules ensure transparency, provided they are properly enforced.

11. What measures should be the subject of key performance indicators or targets?

30. The aim here should be for the rules to be complied with in each and every referral case.

12. What metrics should be used to measure consumer confidence?
31. Strict measures such as the publication of details of enforcement action taken against firms who do not comply with the rules, and the possibility of fines for serious or persistent transgressors.

The ABI’s Conclusions

32. The ABI believes that referral fees should be removed altogether, as part of wider reform to ensure legal costs are re-set at proportionate levels. This would benefit consumers by reducing legal costs and reducing the undesirable associated activities such as persistent cold calling of potential claimants.

33. It is accepted that solicitors do need to undertake marketing and that claimants need to be aware of their rights to compensation, however, we believe that this can be done at a substantially lower cost to the consumer. For example, a centralised education campaign, supported by stakeholders, could be conducted at much lower cost than through referral arrangements, without significantly impacting the existing level of access to justice. It is argued that intermediaries such as CMCs fulfill an important social function in informing potential claimants about their rights in respect of any damages they might be entitled to. An alternative could therefore be a public campaign which fulfills the same role. Oxera’s research showed that a public campaign could be conducted at significantly lower cost than through referral arrangements, without significantly impacting the existing level of access to justice. This may also increase awareness and access for some consumers who indicate that personal injury compensation advertising actually dissuades them from claiming.

Association of British Insurers
December 2010
Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 26 May 2011 18:22
To: Taylor, Jo L
Cc: 
Subject: RE: ABI/MOJ meeting, 2:30pm 24th May at Petty France

Many thanks for this, and for a very useful meeting with you and We have been in touch with Jonathan Djanogly about a meeting; he agrees and we are looking to mid-June for that. His office will be in touch with yours.

I look forward to seeing you on 16 June, if not before.

Best wishes

Robert

From: 26 May 2011 16:52
To: Wright, Robert (Civil Legal Aid);
Cc: Taylor, Jo L
Subject: RE: ABI/MOJ meeting, 2:30pm 24th May at Petty France

Dear Robert

Good to see you again on Tuesday and talk through the issues below. As discussed, we are generally very supportive of the MoJ’s reforms and we will continue with our messaging by voicing our support for the Justice Bill when the draft is released soon.

We would welcome the opportunity to provide data and input into the more detailed implementation work that will take place over the coming months and we look forward to being engaged with this work and keeping our dialogue open.

There are a number of actions that I took away that I shall follow up with you in a couple of weeks. Those are

- I shall be in touch with additional contacts from other personal injury compensators. I am in the process of getting in touch with a few more at the moment and will keep you informed.
- I shall speak to our Legal Expenses Insurance Committee to get their views on the provision of ATE insurance for clinical negligence claims.
- I shall update you with how the Legal Expenses Insurance Committee see how the promotion of ATE insurance can work, as recommended by Lord Young and the recent Consumer Focus report.
- I have spoken to members about discussions surrounding the damages calibration tool – we are also in touch with FOIL about this and shall remain engaged on this issue.

In the meantime, we look forward to hearing from you or a colleague in relation to setting up a date for our new Director General to meet Jonathan Djanogly MP in the near future.

I will be in touch in a few weeks with a follow up. In any event I look forward to seeing you (Robert) at the FOIL event on the Jackson Reforms at St Paul’s on 16 June where I notice you are one of the speakers. Looks like it will be an interesting and worthwhile event.

Kind regards,
From: Wright, Robert (Civil Legal Aid) [mailto:Robert.Wright@justice.gov.uk]
Sent: 24 May 2011 11:52
To: 
Cc: 
Subject: FW: ABI/MOJ meeting, 2:30pm 24th May at Petty France

Many thanks for this; we have suggested some other items below, which should be self-explanatory. I look forward to seeing you here at 2.30.

Robert

From: Sent: 23 May 2011 22:21
To: Wright, Robert (Civil Legal Aid); Taylor, Jo L
Cc: 
Subject: ABI/MOJ meeting, 2:30pm 24th May at Petty France

Hello Robert and Jo,

Below is a brief list of agenda items for our meeting at 2:30pm tomorrow (Tuesday):

- Referral fees
  - ABI’s call for a ban backed up by other compensators
  - Transparency and paragraph 28 of the Transport Select Committee report
    Practical issues re banning/capping

- QOCS – drafting and implementation issues
  - Insurers’ concerns
  - Local authority contacts
  - Self-insureds

- Before the Event Insurance
  - Lord Young’s recommendation re the promotion of BTE insurance
  - Customer Focus Report on consumer analysis of legal expenses insurance
  - ABI’s dedicated Legal Expenses Insurance Committee (next quarterly meeting to be held on
31 May)

After the Event insurance
ABI views on future
Provision of ATE for clinical negligence expert reports

Bill introducing Jackson changes
Handling - email to Lord McNally of 17 May re 'concerns' in the Bill
Communications issues

Calibrated assessment of damages/predictable damages
ABI view

* Discount rate
  * Consultation

This isn't definitive by any means; happy to discuss anything else that is relevant and that you would find helpful.

I look forward to seeing you at 2.30pm.

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

Forthcoming Events
ABI Biennial Conference, 22nd June 2011, Riverbank Park Plaza Hotel, 18 Albert Embankment, London, SE1 7TJ
Bookings now open. To register please visit www.abi.org.uk/abibiennial2011

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Dear

Guideline Hourly Rates 2011

As you may be aware, the Advisory Committee on Civil Costs (ACCC) has proposed an earnings related increase to the Guideline Hourly Rates for 2011. The proposal is to increase the rates in line with the Average Wage Index (for private sector industries) which would result in an increase of 2.1% on the 2010 rates. Unless and until the rates are increased, they will remain at those agreed by the Master of the Rolls for 2010.

The proposed approach is consistent with that set out at page 8 of the ACCC’s conclusions report completed in March 2010, which can be found on the Judiciary of England and Wales website at [http://www.judiciary.gov.uk/publications-and-reports/guidance/guideline-hourly-rates/guideline-hourly-rates-2010](http://www.judiciary.gov.uk/publications-and-reports/guidance/guideline-hourly-rates/guideline-hourly-rates-2010). I enclose a hard copy of that report for ease of reference. (You may wish to note that the Average Wage Index has been used instead of the (discontinued) Average Earnings Index which was used to calculate the 2010 Guideline Hourly Rates).

The Master of the Rolls has asked that before he makes a decision on the ACCC’s recommendation, the ACCC seeks the views of key representative groups. I am accordingly writing on behalf of the ACCC to ask for ABI’s views on the principle of an annual inflation linked increase as recommended in the ACCC’s conclusions report.
The Master of the Rolls has also indicated that he would welcome information as to the possible impact of the increased rates on those who would bear the additional costs, or evidence-based justification of the proposed new hourly rates by reference to solicitors’ outgoings or level of profit. You are therefore asked to submit any representations on these points. I would be grateful for a reply by 14 June 2011.

I am writing in similar terms to the Federation of Insurance Lawyers, the Federation of Small Businesses, the Bar Council, the Civil Court Users Association, the Association of Personal Injury Lawyers, the Motor Accident Solicitors Society, the National Association of Citizens Advice Bureaux and Action Against Medical Accidents.

Yours faithfully

Mrs Jo Taylor
14 June 2011 17:33

Taylor, Jo L

TRIM RE: Guideline Hourly Rates 2011 - ABI response

Attachments:

ABI response - GHR - 14 June 2011.pdf

Dear Jo,

Good to see you at the Jaggards Costs Conference on Friday. I found it a useful and informative event and I hope you did too.

On the subject of costs, I attach the ABI’s response to your letter to on Guideline Hourly Rates dated 25 May. I should be grateful if you would confirm safe receipt.

Kind regards,

General Insurance and Health Directorate

T:
M:
http://www.abi.org.uk

Association of British Insurers
31 Gresham Street
London
EC2V 7HQ

-----Original Message-----

From: Taylor, Jo L [mailto:]
Sent: 25 May 2011 11:33
To:
Subject: Guideline Hourly Rates 2011

Please see attached letter for reply by 14 June.

A hard copy with enclosures is in the post Jo Taylor
Ministry of Justice
102 Petty France. London, SW1H 9AJ

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Dear Robert,

Thanks for your emails. We are pleased to see the work on referral fees progressing and of course will assist in any way we can.

Insurers pay for referral fees through the inflated costs of claimant solicitors, whose fixed fees and hourly rates are, we believe, currently set too high. I attach one of our latest briefings on this matter which I hope gives you some useful information on the issue. I believe that we are still working on obtaining some figures on referral fees so we shall keep you informed on that front too.

There have been developments on the BTE front in terms of coordinating a larger share of the BTE market to provide input; we are looking to have a meeting of our members and wider LEI insurers in August so I would welcome a discussion with you before that meeting.

Lots to discuss and I agree that it would be most useful to have a meeting soon: both you and I are around over the next couple of weeks. Perhaps you or a member of your team could give me a ring next week so that we can arrange a convenient date and time?

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

Further to this, I think is chasing the referral fee figures from Aviva?

Also, when we meet it would be helpful to discuss BTE promotion etc and developments since our last meeting.

Thanks

Robert
Subject: RE: Referral fee flowcharts

Hi Robert,

Further to my email below, I attach two flowcharts which show how claims are typically bought and sold in two different types of claim.

The supermarket example shows how a potential PL claim can be processed through a CMC, generating a referral fee and thus adding to the claimant lawyer’s fee.

The motor example is slightly more multifaceted in that it shows how referral fees can be passed from one organisation to another through a myriad of different routes. The interesting point to note re claims farming in the motor arena is that there is what is commonly known as a “Golden Hour” where the first organisation to obtain and sell the potential claimant’s contact and accident details receives the initial referral fee. These details can then be sold onto other organisations who themselves can potentially sell onto others, eventually ending up with a claimant solicitor. By the time the claimant solicitor buys the claim and because of this layering process, the referral fee can be substantial – frequently up to £900 or £1,000 for low value motor claims (which can only command fixed costs of £1200 when processed through the fixed costs RTA PI Scheme/Portal).

If you’d like discuss this further or in more detail, I’d be happy to pop over to Petty France sometime in the next couple of weeks if you are available (either before or after the ABI meeting with Jonathan Djanogly on the 4 July). I can also update you with the work that we are currently doing with our members and wider stakeholders to support the Bill whilst it goes through the various Parliamentary stages, as well as the ABI’s work on the other aspects of Jackson to be implemented that don’t appear in the Bill (e.g. QOCS).

Kind regards,

General Insurance and Health Directorate
Hi Robert,

Good to see you and catch up at the FOIL event at St Pauls last Thursday. I thought it was a useful and informative event.

I am conscious that I promised you the referral fee flowcharts sooner rather than later; they are almost finished and I hope to get them to you by Friday. No doubt you will be busy this week in any event after publication of the Bill today. Needless to say, all very positive in our view and we have issued the following welcoming statement:

Nick Starling, Director of General Insurance and Health, ABI said:

“This Bill is good news for the millions of honest motorists who have ended up paying more for their motor insurance due to spiralling legal costs. The removal of the ‘no win, no fee’ arrangements will go a long way to stopping frivolous claims encouraged by ambulance chasing lawyers. The Government must stay the course now and implement the proposals put forward by Lord Justice Jackson in full, including banning referral fees paid for tipping off lawyers about accidents and looking at solicitors’ fixed and hourly fees. We need to make sure we overhaul the whole system to make it fairer for genuine claimants.”

Will be in touch later this week.

Kind regards,

General Insurance and Health Directorate
material.

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Wright, Robert (Civil Legal Aid)

From:  
Sent:   14 July 2011 10:31  
To:     Wright, Robert (Civil Legal Aid)  
Subject: Out of Office: Referral fee flowcharts

I shall be out of the office in meetings for most of the day on Thursday 14 July 2011. Please contact if it's urgent.

Kind regards,

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Wright, Robert (Civil Legal Aid)

From:        
Sent: 19 July 2011 14:09
To: Wright, Robert (Civil Legal Aid)
Subject: RE: Referral fee flowcharts

Hi Robert,

Just received your voicemail – am around for most of this afternoon so hopefully can speak to you at some point. I assume you’ve spoken to (following our conversation yesterday (confirming our meeting on 9 August) and that you have the answers to your email below?

On the point of referral fee figures from Aviva, the relevant member is on holiday this week but I am told that this matter is in hand. Unfortunately, we don’t have these figures as yet but I shall let you know when we do.

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk

Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

From: Wright, Robert (Civil Legal Aid) [mailto:
Sent: 15 July 2011 17:13
To: 
Cc: 
Subject: RE: Referral fee flowcharts

Thanks for this. will be in touch about a meeting time.

On the first point, I understand your general concerns about the costs flowing from referral fees. But are there instances where insurers themselves pay referral fees - i.e. they pay for individual claims?

Also, could you expand on your point in the briefing paper: ‘A ban must be implemented properly to ensure that the problem doesn’t emerge elsewhere (bearing in mind the impending introduction of ABS)’. Does this just mean that the fixed recoverable costs in the RTA process must be reduced at the same time, or something else?

Thanks

Robert
From: Wright, Robert (Civil Legal Aid)
Sent: 15 July 2011 16:50
To: Wright, Robert (Civil Legal Aid)
Cc: -
Subject: RE: Referral fee flowcharts

Dear Robert,

Thanks for your emails. We are pleased to see the work on referral fees progressing and of course will assist in any way we can.

Insurers pay for referral fees through the inflated costs of claimant solicitors, whose fixed fees and hourly rates are, we believe, currently set too high. I attach one of our latest briefings on this matter which I hope gives you some useful information on the issue. I believe that we are still working on obtaining some figures on referral fees so we shall keep you informed on that front too.

There have been developments on the BTE front in terms of coordinating a larger share of the BTE market to provide input; we are looking to have a meeting of our members and wider LEI insurers in August so I would welcome a discussion with you before that meeting.

Lots to discuss and I agree that it would be most useful to have a meeting soon; both you and I are around over the next couple of weeks. Perhaps you or a member of your team could give me a ring next week so that we can arrange a convenient date and time?

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

From: Wright, Robert (Civil Legal Aid) (mailto:)
Sent: 15 July 2011 09:57
To: -
Cc: -
Subject: RE: Referral fee flowcharts

Further to this, I think is chasing the referral fee figures from Aviva?

Also, when we meet it would be helpful to discuss BTE promotion etc and developments since our last meeting.

Thanks

Robert

From: Wright, Robert (Civil Legal Aid)
Sent: 14 July 2011 10:30
To: -
Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 09 August 2011 11:50
To:
Subject: Hi: Meeting today

Yes, look forward to seeing you at 2.
Robert

From: 09 August 2011 11:35
To: Wright, Robert (Civil Legal Aid)
Subject: Meeting today

Hi Robert,
Just wanted to check that we’re still on for our meeting today at 2pm?
can’t make it unfortunately as he’s dealing with the ABI’s response to the riots.
Kind regards,

General Insurance and Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 15 August 2011 11:41
To: 
Cc: 
Subject: RE: Apologies

Entirely understood. We had a good meeting and hope to be in touch shortly on more detail on referral fees.

Best wishes

Robert

From:
Sent: 12 August 2011 15:09
To: Wright, Robert (Civil Legal Aid)
Cc: 
Subject: Apologies

Robert

Just a quick note to apologise for not attending our meeting this week. I am sure you will appreciate that the riots have taken up an enormous amount of time this week. But I understand from you had a productive discussion. Despite the distraction of rioting this week, please be assured that LASPO, referral fees, etc are still very much on my radar.

Have a good weekend.

Best regards

General Insurance & Health Directorate

www.abi.org.uk

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From: 
Sent: 31 August 2011 17:51 
To: Taylor, Jo L 
Cc: Wight, Robert (Civil Legal Aid) 

Subject: TRIM ABI response - Qualified one way costs shifting - insured claimants and defendants

Dear Jo,

I have discussed your email; here are our preliminary views:

**BTE insurance**
QOCS should apply in circumstances where claimants have BTE insurance. We agree that the alternative would lead to perverse incentives at a time when both the government and insurance industry are keen to promote the uptake of BTE insurance.

**Uninsured defendants**
Our view is that QOCS should still apply to those defendants who are not insured, and that where a winning defendant who is required to have insurance but who has not taken out such insurance, that the defendant should nevertheless be required to pay their own legal costs. As you say, if the position were otherwise, and the claimant continued to have to pay the winning defendant’s costs, the defendant would benefit from its own illegal behaviour. QOCS should continue to apply where a defendant has failed to take out insurance which it is by law compulsory to have. The alternative is that there will be the unintended result of appearing to favour those who fail to comply with legal requirements.

Also makes the following points from an MIB perspective:

With regards to the point made about uninsured defendants in motor cases, we agree that it does not seem right that an uninsured defendant should be in a better position than someone who had obeyed the law and taken out cover. Conversely, QOCS is a benefit to claimants who will argue that they should not be disadvantaged in cases dealt with by MIB as opposed to those dealt with by an insurer.

It must be remembered that cases dealt with by MIB under the Uninsured Drivers’ Agreement are, in law, still cases against the uninsured driver. MIB has no direct liability. Its liability is contingent upon an unsatisfied judgment being obtained against the defendant. Consequently if “uninsured defendants” are excluded from the effects of QOCS this would have consequences for claimants and defendants in all MIB cases. I am sure this was not the intention of the proposals.

I must stress that this is a provisional view. I am seeking further input into the question put and will respond with more detail as quickly as possible.

**Compulsory insurance**
There are no circumstances other than motor and employers’ liability where by law organisations/individuals must have insurance, other than very specialist lines related to the keeping of certain animals. Certainly there are none that are compulsory which impact upon these proposals other than those already mentioned.

We hope these initial views are helpful. We are both more than happy to meet to discuss these further, and as mentioned above, I am seeking further input and will respond with more detail when he is able to.

Kind regards,

General Insurance and Health Directorate
We have been considering whether QOCS should apply to claimants who have BTE insurance. As you know the government is keen to encourage the take up of BTE insurance. We are therefore minded to adopt the general principle that QOCS should apply to claimants who have BTE insurance because this would encourage claimants to take out BTE insurance (or at least would not discourage them from doing so).

The Government also accepts as a general principle, as proposed by Lord Justice Jackson, that QOCS should not apply where defendants are not either insured or a large self insured business.

However a question has emerged as to whether a winning defendant who is required to have insurance i.e. employers liability insurance or road traffic accident insurance, but who has not taken out such insurance, should nevertheless be required to pay their own legal costs. If the position were otherwise, and the claimant continued to have to pay the winning defendants costs, the defendant would benefit from their own illegal behaviour.

Instinctively it seems right that QOCS should continue to apply where a defendant has failed to take out insurance which it is by law compulsory to have.

But we would be grateful for your views and on any issues of which we may not be aware that should be taken into account in any final decision.

There may for example be particular issues for the MIB when defending proceedings in respect of an uninsured defendant.

Are you aware of any circumstances in which by law individuals or organisations must have public liability insurance cover or any other examples of compulsory insurance - other than motor insurance and employers liability insurance?

It would be helpful to have initial views by the end of the month.
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ABI Financial Media Awards 3rd November 2011
For award sponsorship and table enquiries please email Events@abi.org.uk

ABI Motor Conference 22nd November 2011,
Grange City Hotel, 8-14 Cooper's Row, London, EC3N 2BQ
Registration now open at www.abi.org.uk/MotorConference2011
For Sponsorship and Exhibitor information, accommodation enquiries and for all other conference information please email ABLevents@abi.org.uk or phone 020 7216 7487.

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purposes.
From: Taylor, Jo L  
Sent: 06 September 2011 17:10  
To:  
Cc:  
Subject: Qualified One Way Costs Shifting - request for further data

Some ABI members (in particular who I have written to separately) provided data on claimant costs which was really helpful in sense checking other data received and considering the impacts of the Jackson proposals. We are now looking for further information on the defendant side to help in formulating appropriate financial criteria for the application of qualified one way costs shifting. We wondered if your members had data available which they would be able to provide which would answer the following questions:

1. The range of [the companies] defence costs incurred in cases that are successfully defended (smallest and largest), and average costs incurred in cases that are successfully defended in different types of claim (e.g. EL, PL, RTA etc).

   (If such information does not exist e.g. because there are costs that are fixed, rather than paid for on a per case basis, would they be able to provide some indication of [the company] costs to defend a case (regardless of case outcome) and perhaps some narrative around how this varies depending on the case type and outcome?)

2. The range of costs recovered in cases where [the company] is successful in defending a claim, and the average cost recovered where the claim is successfully defended in different types of claim as above.

3. Any information held about the costs incurred by [the company] in cases where claims are withdrawn after issue, and how these costs compare to the costs in point 1. above?

It would be really helpful if any of your members can assist with the above however we are not asking them to do a special data collection exercise if they do not hold this information.

It would be helpful to have any data they may be able to provide by 19 September if at all possible. Please could you copy into your response, as I will be in and out of the office over the next two weeks.

Many thanks,

Ministry of Justice

102 Petty France, London, SW1H 9AJ
Wright, Robert (Civil Legal Aid)

From: 
Sent: 08 September 2011 17:28 
To: Wright, Robert (Civil Legal Aid)

Operations Directorate

General Insurance & Health Directorate

www.abi.org.uk

Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

**Forthcoming Events**

**Thursday 3 November 2011**

ABI Motor Conference 22nd November 2011.
Grange City Hotel, 8-14 Cooper’s Row, London, EC3N 2BQ
Registration now open at www.abi.org.uk/MotorConference2011

For Sponsorship and Exhibitor information, accommodation enquiries and for all other conference information please email ABImevents@abi.org.uk or phone 020 7216 7487

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 08 September 2011 17:47
To:
Cc:
Subject: FW: MOJ NEWS: REFERRAL FEES BAN **EMBARGOED TILL 00.01hrs ON FRI 9 SEPT**

The press notice.

Robert

From: 08 September 2011 17:45
To: Wright, Robert (Civil Legal Aid)
Subject: FW: MOJ NEWS: REFERRAL FEES BAN **EMBARGOED TILL 00.01hrs ON FRI 9 SEPT**

Final version. It is embargoed until 00.01

Ministry of Justice

Ministry of JUSTICE

News Release

Date: 8 September 2011

***EMBARGOED TILL 00.01hrs on 9 September 2011***

CURBING COMPENSATION CULTURE:
GOVERNMENT TO BAN REFERRAL FEES

Rising insurance costs will be tackled by a ban on referral fees, announced today as part of the Government's commitment to curb compensation culture.

The Government will ban the payment of referral fees in personal injury cases. The current
arrangements have led to high costs, encouraged a compensation culture and led to the growth of an industry which pursues claimants for profit. Insurance companies inevitably pass the costs they incur through increased compensation claims directly onto motorists and those with other insurance policies, unnecessarily forcing up the cost of living.

An example of a referral fee might be:

- You have an accident and you are induced through a TV advert or SMS text message to make a ‘no-win, no-fee’ claim.
- Your claim is passed between claims management companies (who advertise compensation claims for accidents), insurance companies, lawyers and others who charge each other a referral fee for ‘referring’ the claim up the line.
- The lawyer sues for compensation. If he wins, he can recover his costs and his ‘no-win, no-fee’ mark-up on his costs from the losing defendant (or often the defendant’s insurance company) which will cover the amount he paid out as a referral fee. So the lawyer may pay hundreds of pounds as a referral fee because he knows he can get the money back.
- To cover the loss, losing insurance companies are forced to raise premiums, private companies are forced to put up prices, and public authorities pass the burden on to the taxpayer.

Justice Minister Jonathan Djanogly said:

“The ‘no-win, no-fee’ system is pushing us into a compensation culture in which middle men make a tidy profit which the rest of us end up paying for through higher insurance premiums and higher prices.

‘Honest motorists are seeing their premiums hiked up as insurance companies cover the increasing costs of more and more compensation claims. Many of the claims are spurious and only happen because the current system allows too many people to profit from minor accidents and incidents.

‘Referral fees are one symptom of the compensation culture problem and too much money sloshing through the system. People are being encouraged to sue, at no risk to themselves, leaving schools, business and individuals living in fear of being dragged to the courts for simply going about daily life.

‘We will ban referral fees and we will go further. We have proposals before Parliament to end the bizarre situation in which people have no stake in the legal costs their cases bring. This will make claimants think harder about whether to sue and give insurance companies and business generally an incentive to pass the savings onto customers through lower prices.”

The Government’s proposals currently before Parliament focus on stopping losing defendants having to pay a ‘success fee’ to reimburse the claimant’s lawyer for other unconnected cases he may have lost. The Government is changing the law so that in future the person making the claim will have to pay the success fee, rather than the defendant, and that fee will be capped. The intended result is a fairer split of costs between parties, and lower legal costs overall which means lower costs to pass on to customers or taxpayers.

The proposals follow a Ministry of Justice consultation published in November 2010. Much of the evidence base for this consultation came from an independent Review of Civil Litigation Costs carried out by a senior judge, Lord Justice Jackson, and commissioned by the Master of the Rolls.

Notes to Editors
1. Please note there is no universally recognised definition of ‘referral fees’. Various agreements have been reported between many types of organisations including insurance companies, repair garages, emergency services and not all these agreements include actual fees. The scope of today’s announcement of a ban will cover the payment of referral fees in personal injury cases.


4. Lord Justice Jackson’s Review of Civil Litigation Costs was published by the judiciary and is available via their website at www.judiciary.gov.uk

5. For more details, please contact Ministry of Justice press office on 020 3334 3536.

ENDS
From: 08 September 2011 18:40
To: Wright, Robert (Civil Legal Aid)
Subject: Fw: ABI embargoed release on referral fee ban

FYI

General Insurance & Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

From: Thursday. September 08. 2011 06:29 PM
To: Wright, Robert (Civil Legal Aid)
Subject: ABI embargoed release on referral fee ban

Below quote issued now.

spoke to Today prog who will use this as basis for the intervw with you tomorrow

EMBARGOED UNTIL 00.01HRS, FRIDAY 9 SEPTEMBER 2011

ABI WELCOMES BAN ON REFERRAL FEES

The ABI welcomes today’s (9 September) Government announcement that they will ban the selling on of personal injury details – referral fees.

Otto Thoresen, ABI’s Director General, said

“We are very pleased that the Government has listened to the insurance industry’s campaign for a ban on referral fees. They add no value and encourage spurious and exaggerated personal injury claims.
“It is important that the ban must be watertight and apply across the board. Banning referral fees is an important first step in tackling our dysfunctional compensation system, and needs to be accompanied by a substantial reduction in legal costs and action to tackle whiplash if honest customers are to benefit from these reforms.”

Operations Directorate

Forthcoming Events

ABI Motor Show 2011

22nd November 2011.

Grange Circus, 8

1 Row, London, EC3N 2BQ

Regis. Operate at www.abi.org.uk/MotorConference2011

For Sponsorship and Exhibitor information, accommodation enquiries and for all other conference information, please email ABlevents@abi.org.uk or phone 020 7216 7487.

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 08 September 2011 19:45
To: Wright, Robert (Civil Legal Aid)

Don't know if you are still at the office - have tried to call.

One impt point you need to be aware of

Call me if you can -

http://www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2Y 7NQ

---------------------------------------------
Forthcoming Events

ABI Financial Media Awards 3rd November 2011.
For award sponsorship and table enquiries please email Events@abi.org.uk

ABI Motor Conference 22nd November 2011.
Grange City Hotel, 8-14 Cooper's Row, London, EC3N 2BQ Registration now open at
www.abi.org.uk/MotorConference2011
For Sponsorship and Exhibitor information, accommodation enquiries and for all other
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From: Wright, Robert (Civil Legal Aid)
Sent: 09 September 2011 17:54
To: Wright, Robert (Civil Legal Aid)
Cc: 
Subject: FW: Letter to Djanogly - Costs Council

Robert

Please find attached a letter from our Director General to Jonathan Djanogly sent this afternoon.

Best regards

General Insurance & Health Directorate

www.abi.org.uk

Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

Forthcoming Events

Thursday 3 November 2011

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 15 September 2011 13:37
To: [To field redacted]
Cc: [Cc field redacted]
Subject: RE: Tackling the Compensation Culture: The Legal Aid Sentencing and Punishment of Offenders Bill

Thanks for this. I am trying to catch up after a rather hectic few days; apart from the announcement on Friday on referral fees (and Jack Straw’s Bill on Tuesday), we were also in Commons Committee all day on the LASPO Bill on Tuesday.

It would be helpful to discuss referral fees and BTE in more detail soon. How are you fixed next week? I cannot do all day Weds; Thurs morning or Fri morning.

Best wishes
Robert

From
Sent: 31 August 2011 18:05
To: Wright, Robert (Civil Legal Aid)
Cc: [Cc field redacted]
Subject: FW: Tackling the Compensation Culture: The Legal Aid Sentencing and Punishment of Offenders Bill

Dear Robert,

I thought you may be interested to see the final version of the publication I mentioned at our last meeting. As well as the email below, we have put a letter and hard copy to your Minister in the post tonight. It will be formally launched on Monday 5th September.

I would be interested to hear if you have any update further to our last meeting; happy to discuss over the telephone or I can pop over to Petty France for a catch up sometime soon if that suits? I can also update you with progress on the BTE front further to the meeting with legal expenses insurers which was held at the ABI this afternoon.

Kind regards,

General Insurance and Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London

387
From:  
Sent: 31 August 2011 17:02  
To: 'jonathan.djanogly@justice.gsi.gov.uk'  
Subject: Tackling the Compensation Culture: The Legal Aid Sentencing and Punishment of Offenders Bill

Dear Minister

I attach an advance copy of a publication that the ABI has produced in support of the steps taken to tackle the compensation culture in the Legal Aid, Sentencing and Punishment of Offenders Bill.

This publication will be sent to all Parliamentarians on Monday 5th September to provide them with information on the problem with the current compensation culture, the costs of this to consumers and taxpayers and the solutions proposed by Lord Justice Jackson and included in the Bill. It has been supported by a number of organisations representing a wide range of interests, from businesses to local authorities and lawyers, as well as the insurance industry.

The publication aims to show that the measures adopted in the Bill will be a real benefit to all. I hope you will find it informative and helpful.

Regards,

Forthcoming Events

The ABI Financial Media Awards 2011  
Thursday 3 November 2011

ABI Motor Conference 22nd November 2011.
Grange City Hotel, 8-14 Cooper's Row, London, EC3N 2BQ
Registration now open at www.abi.org.uk/MotorConference2011

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Wright, Robert (Civil Legal Aid)

From: Wright, Robert (Civil Legal Aid)
Sent: 28 September 2011 18:20
To:
Cc:
Subject: RE: Meeting with

Would it be possible to move the meeting back by 30 minutes tomorrow afternoon, Thursday from 2 to 2.30?

I look forward to seeing you there then.

Thanks

Robert

From: 
Sent: 23 September 2011 09:14
To: Wright, Robert (Civil Legal Aid)
Subject: RE: Meeting with

Hi Robert,

That is great. I have put it in my calendar and she looks forward to seeing you next Thursday.

Thanks

Team Support
General Insurance & Health Directorate

www.abi.org.uk

Association of British Insurers
51 Grub Street
London
EC2V 7HQ

From: Wright, Robert (Civil Legal Aid)
Sent: 22 September 2011 19:10
To: 
Subject: RE: Meeting with

Hi

Would 2 on Thursday 29th, here, be OK?
Hi Robert,

I have talked to her this morning and she suggested it would be more productive to meet after the PIHLG meeting on Wednesday, as issues will be discussed there which she will be able to update you on. Are you available Thursday(29/09) between 12:00 to 16:00 or Friday(30/09) between 10:00 to 13:00? If you would like to meet with her before then, let me know, we just wish to ensure that your meeting will be as productive as possible. Look forward to hearing from you soon.

Regards

Team Support
General Insurance & Health Directorate

www.abi.org.uk
Association of British Insurers
51 Gresham Street
London
EC2V 7HQ

Hi

Further to our chat yesterday, would 11.30 am on Tuesday 27th be convenient?

Thanks

Robert

Could you please give me a call when you have a spare moment in regards to your meeting on Thursday with

My number is

Many thanks
Forthcoming Events

BOOK NOW FOR THE FOLLOWING ABI EVENTS:

**THE ABI FINANCIAL MEDIA AWARDS 2011**
Thursday 3 November 2011
For award sponsorship, table enquiries and general information on this event please email team@abi.org.uk or click here for more information.

**MOTOR CONFERENCE-22 NOVEMBER 2011-GRANGE CITY HOTEL, LONDON, EC3N 2BQ.**
BOOKINGS NOW OPEN TO VIEW THE FULL PROGRAMME AND TO REGISTER VISIT www.abi.org.uk/MotorConference2011

**SOLVENCY II CONFERENCE-8 DECEMBER 2011-GRANGE ST PAULS, LONDON, EC4V, 5AJ.**
BOOKINGS NOW OPEN AND TO REGISTER PLEASE VISIT www.abi.org.uk/Solvency2conference2011

For Sponsorship and Exhibitor information, accommodation enquiries and for all other conference information please email ABIevents@abi.org.uk or phone 020 7216 7487.

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Appendix G – Ethics approval and UPR16

Mr Stephen Evans
MPhil Student
Institute of Criminal Justice Studies
University of Portsmouth

REC reference number: 14/15-29
Please quote this number on all correspondence.

3rd March 2015

Dear Stephen,

Full Title of Study: The impact of the insurance industry’s funding of a dedicated police unit on the ‘non-insurer’ victims of insurance related fraud.

Further to our recent correspondence, this proposal was reviewed by The Research Ethics Committee of The Faculty of Humanities and Social Sciences.

I am pleased to tell you that the proposal was awarded a favourable ethical opinion by the committee.

Kind regards,

FHSS FREC Chair
Dr Jane Winstone

Members participating in the review:

- David Carpenter
- Richard Hitchcock
- Geoff Wade
- Jane Winstone
FORM UPR16
Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information)

<table>
<thead>
<tr>
<th>PGRS Name:</th>
<th>Stephen Anthony Evans</th>
</tr>
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<tr>
<td>Department:</td>
<td>ICJS</td>
</tr>
<tr>
<td>First Supervisor</td>
<td>Professor Mark Button</td>
</tr>
<tr>
<td>Start Date:</td>
<td>September 2013</td>
</tr>
<tr>
<td>Study Mode and Route:</td>
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<td>Victim Inequality: The Asymmetric Outcomes of Motor Insurance Fraud</td>
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<tr>
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<td>79,994</td>
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If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University’s Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study.

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: http://www.ukrio.org/what-we-do/code-of-practice-for-research/)

- a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?  YES X NO
- b) Have all contributions to knowledge been acknowledged?  YES NO
- c) Have you complied with all agreements relating to intellectual property, publication and authorship?  YES NO
- d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?  YES NO
- e) Does your research comply with all legal, ethical, and contractual requirements?  YES NO

Candidate Statement:
I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC): 14/15:29

If you have not submitted your work for ethical review, and/or you have answered ‘No’ to one or more of questions a) to e), please explain below why this is so:

Signed (PGRS): [Signature]  Date: 14th December 2017

UPR16 – August 2015