Law Commission
Twelfth programme of law reform: Fraud by victims of personal injury

A response by the Association of Personal Injury Lawyers
October 2013 (Updated November 2013)

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. The association is dedicated to campaigning for improvements in the law to enable injured people to gain full access to justice, and promote their interests in all relevant political issues. Our members comprise principally practitioners who specialise in personal injury litigation and whose interests are predominantly on behalf of injured claimants. APIL currently has over 4,000 members in the UK and abroad who represent hundreds of thousands of injured people a year.

The aims of the Association of Personal Injury Lawyers (APIL) are:

- to promote full and just compensation for all types of personal injury;
- to promote and develop expertise in the practice of personal injury law;
- to promote wider redress for personal injury in the legal system;
- to campaign for improvements in personal injury law;
- to promote safety and alert the public to hazards wherever they arise; and
- to provide a communication network for members.

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Introduction

We welcome the opportunity to comment on the Law Commission's own suggestions for its twelfth programme of law reform, namely fraud by victims of personal injury. Fraud in the claims process is unacceptable and should be prevented. We are concerned that the Law Commission appears to be considering only one aspect of fraudulent behaviour, yet fraud can manifest itself throughout the whole claims process. We believe, therefore, that if the issue of fraud is to be examined then there should be a wholesale examination of the behaviours and practices of both claimant and defendant parties.

Should the Law Commission examine this area?

In our view, the issue of exaggeration by claimants in personal injury cases has been examined by the Supreme Court and a clear decision has been reached. There have also been decisions where claimants have been held in contempt of court and sentenced to a term in prison because they exaggerating their claim[1]. The tools are available to the defendant to challenge the evidence of the claimant if they consider it necessary.

If, despite this, the Law Commission feels that fraud is an area for consideration, exaggerated claims must not be the only issue considered. Fraud is not solely a problem concerning claimants, fraudulent practices are seen on both sides of the claims process, and in order to tackle the issues effectively, there should be a wholesale examination of all conduct. APIL supports any steps to reduce fraud, but there must be fairness on both sides.

Wider examination of fraud

Fraud in all forms results in higher insurance premiums. It must be eliminated whilst protecting honest claimants, retaining access to justice and ensuring that there is no stigma attached to bringing a valid claim. Instead of focusing solely on fraud by claimants, all malpractice should be examined, including obvious cases of fraud by the defendant, direct insurer contact and the prevalence of pre-medical offers.

Fraudulent conduct by defendants

As stated in the consultation document, *Summers* has been criticized by both academics and practitioners for not going far enough and failing to do enough to deter fraudsters. Examining fraud by claimants is not enough, however, and the Law Commission must also

[1] Airbus Operations Ltd & Anor V Roberts [2012] EWHC 3631

be prepared to examine decisions where the Courts have been lenient in cases of fraud and deceit which is not attributable to the claimant.

A case illustrating defendant fraudulent practices, where the court failed to find in the claimant's favour, is *Evans v Kosmar Villas*[2]. Here, the 17 year old claimant dived into a pool whilst on holiday, and was severely injured. The judge in the High Court found that Kosmar's lay witnesses had "variously committed themselves to an early and false joint account to save their backs" and on several issues was there the conclusion that "not only had they lied, but that they also put their heads together...and conspired together to deceive". In an attempt to avoid liability, the defendants had put up "no diving" signs after the accident – claiming that they had been there all along, and defendant lay witnesses portrayed the claimant as a drunken irresponsible young man. In addition, the defendant falsely alleged that the claimant had attended a "welcome meeting", in which he had been advised not to use the pool in the dark, and that there were pool safety signs on the inside of each apartment. The High Court found that the defendant was liable. The Court of Appeal, however, held that although this conduct is a "deeply troubling feature of the case and reflects very badly not only on the witnesses themselves but also on Kosmar", none of this could affect the legal analysis of the case. It was held that although new signs stating that diving was prohibited were put up after the accident had occurred; it was improbable that they would have prevented the accident from occurring – Mr. Evans would have dived in the pool anyway. In the same way that *Summers* could be seen as not doing enough to deter claimants from claiming fraudulently, it could be said that *Kosmar* does not deter defendants from attempting to avoid liability by falsifying evidence. Although the Court of Appeal commented on the defendants' deceit, they still found in the defendants' favour.

Defendant insurers' business models

Another pressing consideration for review should be the effect of business models used by defendant insurers in relation to personal injury litigation. In *Fallows v Harkers Transport (A Firm)*[3] His Honour Judge Platt succinctly described a business model where "RSA [Royal & Sun Alliance Group] have chosen to set up a separate company which is a wholly owned subsidiary of the parent company, called RSA Accident Repairs Limited ("RSAARL") to undertake repairs of vehicles insured by RSA. It does so either by performing the repairs at its own repair centres or by using sub-contractors." The Judge noted that this business model "is seen on the part of RSA as perfectly legitimate and by a number of defendant

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[2] [2007] EWCA Civ 1003
[3] [2011] EW Misc 16

insurers as involving methods of business which fall somewhere between very sharp practise and outright fraud."

The Judge also explained that "this scheme could only be effective and profitable to RSA so long as RSA were able to conceal from other insurers what they were doing. This would seem to explain the quite extraordinary lengths to which RSA through its solicitors and RSAARL have been prepared to go in order to conceal the true position *vis a vis* RSAAL and its subcontractors in answer to proper requests for disclosure from defendant insurers."

The conclusion reached by the Judge in that case was "since RSAARL is wholly owned by RSA the effect of these extra charges if they are paid by defendants is simply to boost RSA Group's profits beyond the actual cost of repair by the margins inserted by RSAARL. I can find no basis in law for saying that this is a course of action which a claimant insurer is entitled to take and I do not need to repeat the public policy arguments"

There are a number of test cases relating to this business model current awaiting Judgment from the Court of Appeal but it is suggested that whatever the ultimate outcome of those proceedings this is a practice which also warrants investigation by the Law Commission and suggests that the ambit of any review should be extended to include if insurers' business models are structured to ensure maximum profit from personal injury litigation.

Direct contact by insurers

The examination of fraudulent practices should also extend to an analysis of direct insurers contact Sometime known as third party capture, this happens when an insurer handles a claim for a person who has been injured by the insurer's own policy holder. The insurer will sometimes offer a quick cash deal to the victim of the accident, which bears little relation to what the claim is actually worth, in an attempt to minimise the amount of money that the defendant insurer has to pay out. The offer is often made without evidence and without advising the injured person that they have the right to obtain independent legal advice. Some defendants are therefore deliberately ensuring that the claimant is unaware of his or her rights and so receives less money than they deserve, and would have received if they had used an independent solicitor. Injustice can be inflicted on claimants here through the under-settlement of claims, and we suggest that this is a type of fraud on the claimant, and it should be stopped.

Data Protection breaches

We are also concerned that defendant insurers and their solicitors are sharing client information with others, in breach of the Data Protection Act (DPA). We are aware that currently, defendants are exchanging claimants' medical notes and court documents between them, relying on section 29 of the DPA to do so. S 29 provides exemptions from non-disclosure for data used in the prevention or detection of crime and the apprehension or prosecution of offenders; data processed for purpose of discharging statutory functions; the assessment or collection of any tax or duty or any imposition of a similar nature. It is very unlikely that this practice falls within the exemption in section 29, and we suggest that this practice is therefore a breach of the Data Protection Act and should be prevented.

Pre medical offers

There should also be an examination of pre-medical offers. This is where the defendant makes the claimant an offer to settle his case before any medical evidence has been obtained meaning that the injury cannot be validated or accurately quantified. The offer is often made directly to the claimant either before a solicitor has been instructed or in some cases without the instructed solicitors knowledge. This means that the injured individual has no way of knowing if the offer made is reasonable or not and results in awards of compensation far below what a court would award to the claimant. Accepting such an offer also closes the case and prevents a genuine claimant from re-opening it at a later date when they realise their injuries are more severe than initially thought. This practice also has the potential to allow fraudulent cases to be settled without the necessary checks and balances that medical examination provides.

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