Ordnance Survey®

ifig INSURANCE FRAUD INVESTIGATORS GROUP

Using geography in the fight against insurance fraud

A research study undertaken by Ordnance Survey in conjunction with the Insurance Fraud Investigators Group (IFIG)

Contents

Trademarks

Executive summary

Following last year's successful research study, Ordnance Survey undertook a follow-up study with the members of the Insurance Fraud Investigators Group (IFIG). Almost 170 insurance fraud investigators (IFIs) were asked 19 questions, a mixture of multiple-choice and open-ended questions, to determine how geography is used in detecting and combating insurance fraud (IF). The research also looked at whether the current economic climate is having an effect on IF.

The Insurance Fraud Investigators Group

Insurance Fraud Investigators Group is a members' organisation dedicated to the detection and prevention of insurance fraud. It is a non-profit making organisation, created to tackle the growing problem of insurance fraud in the UK and disrupt insurance fraudsters. It has over 260 members which include insurers, lawyers, loss adjusters, and investigation agencies, all of whom are committed to preventing insurance fraud.

Stephen Teeling, Deputy Chairman of the Insurance Fraud Investigators Group (IFIG), says: 'Levels of insurance fraud show no signs of abating but it's encouraging to see that it also continues to rise up the organisational agenda. It's clear from our members that increasingly, organisations are putting a fraud strategy in place and focusing on the fight against fraud. We're getting better at detecting it, but there's still a long way to go as it's a problem that is unlikely to go away.'

Summary of findings

	Top answer	Second answer	Third answer	Fourth answer
Areas of biggest increase in IF since start of 2010	Motor	Personal injury	Household	Commercial Motor
How do you currently use geography in your role?	Hot spot/ pattern analysis	Verifying customer information	Detection at claim stage	Building up evidential cases for prosecution
Top key issues facing/affecting IFIs over the next year	Credit crunch/ recession fuelling fraud	Resources	Fraud at policy inception	MoJ reforms

- Almost 80% of IFIs use geography in their current role; most respondents using it for hot spot/pattern analysis, verifying customer information, and detection at claims stage. Interestingly, almost 25% more IFIs are now using geography to build up evidential cases for prosecution.
- The main barrier to data sharing is the *Data Protection Act* (DPA)/internal policy or culture, according to 60% of IFIs, followed up by a lack of understanding of the DPA.
- Two-thirds of respondents said their company is investing in new fraud detection systems, a slight increase on last year. Most of the investment is in staff/human resources, followed by fraud detection systems.
- Almost 80% of respondents said they thought there had been an increase in fraudulent claims in 2010, with motor being the area most respondents said was growing (doubled from 2009). Personal injury was the second area where IFIs have seen growth since the beginning of the year. All other classes had been selected by a similar number of respondents. Income protection is the class showing the least growth. Other answers given were: 'health expenses/medical', 'benefit/public sector', 'Mobile phone insurance' and 'casualty'.
- Almost 60% of IFIs are concerned most about inflated/exaggerated (opportunistic) claims, further backed up by over 80% seeing an increase in this type of fraud, followed by completely bogus claims (75%) and 52% stating serial claimants.

- Over 90% of respondents said that insurance fraud had stayed the same or moved up their organisation's agenda.
- Nearly 80% said that aggregators/brokers should take more of an active role/responsibility to prevent fraud and the majority stating that more stringent checks should be implemented at the policy inception stage.
- Unsurprisingly, 66% of respondents continue to see the recession to fuel fraud over the next 12 months as a major concern; however, the second concern likely to face IFIs is resources, closely followed by fraud at policy inception. MoJ reforms were fourth, jumping up 15% from last years' report.
- IFIs are expecting the Jackson review to have no effect on the number of fraudulent claims, with 67% expecting the number of fraudulent claims to stay the same and 20% saying fraudulent claims will increase.

Background

Following last year's successful research study, Ordnance Survey undertook a follow-up study with the members of the Insurance Fraud Investigators Group (IFIG). Almost 170 insurance fraud investigators (IFIs) were asked 19 questions, a mixture of multiple-choice and open-ended questions, to determine how geography is used in detecting and combating insurance fraud (IF). The research also looked at whether the current economic climate is having an effect on IF.

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Members include insurers, lawyers, loss adjusters, and investigation agencies all of whom are committed to preventing insurance fraud. IFIG now has over 260 company members covering the vast majority of the insurance industry and insurance fraud investigators.

Stephen Teeling, Deputy Chairman of the Insurance Fraud Investigators Group (IFIG), says: 'Levels of insurance fraud show no signs of abating but it's encouraging to see that it also continues to rise up the organisational agenda. It's clear from our members that increasingly, organisations are putting a fraud strategy in place and focusing on the fight against fraud. We're getting better at detecting it, but there's still a long way to go as it's a problem that is unlikely to go away.'

Objectives

- To determine how geography is used in detecting and combating IF.
- To identify the key issues facing IFIs over the next 12 months.
- Identify if there has been a shift in trends since 2009's results.
- Identify if there has been an increase in IF since the beginning of 2010 and where increases have been seen.

Methodology

Administered by Ordnance Survey using an online survey, 19 questions were asked to 167 IFIG members. Respondents were asked to respond to a mixture of multiple choice and open-ended questions. Results were analysed and published in a report, which was sent to the respondents who took part in the study. All respondents were insurance fraud investigators or linked to insurance fraud investigation.

Summary of findings

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- Almost 80% of respondents said they thought there had been an increase in fraudulent claims in 2010, with motor being the area most respondents said was growing (doubled from 2009). Personal injury was the second area where IFIs have seen growth since the beginning of the year. All other classes had been selected by a similar number of respondents. Income protection is the class showing the least growth. Other answers given were: 'health expenses/medical', 'benefit/public sector', 'Mobile phone insurance' and 'casualty'.
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- Nearly 80% said that aggregators/brokers should take more of an active role/responsibility to prevent fraud and the majority stating that more stringent checks should be implemented at the policy inception stage.
- Unsurprisingly, 66% of respondents continue to see the recession to fuel fraud over the next 12 months as a major concern; however, the second concern likely to face IFIs is resources, closely followed by fraud at policy inception. MoJ reforms were fourth, jumping up 15% from last years' report.
- IFIs are expecting the Jackson review to have no effect on the number of fraudulent claims with 67% expecting the number of fraudulent claims to stay the same and 20% saying fraudulent claims will increase.
- Just under 50% of companies are investing less than 25% of their resources to tackle fraud.
- i2 is the most popular new system to be used in the fight against fraud.

Respondents' comments

What can aggregators/brokers do to prevent fraud?

'Aggregators proactively working with insurers to prevent fraud'

'Data mine the information supplied to support the application'

'Credit checking upon application'

'Checks should be made on data for physical address, for example electoral role, credit checks'

'Technology to quickly identify common data, for example email addresses, credit cards'

'Increased awareness/training'

'Better detection at an early stage and more fraud awareness training'

'More mandatory questions, better bank card checks'

'Validation of policyholder: track IP addresses/phone numbers'

‘Checking of policyholders' history against CUE and tracking of changes to declarations at quote and buy’

‘Analysis – red flagging of input data changes. (Flagging customer experimentation)’

‘Difficult. Profit sharing scheme with the brokers? Provide an Inducement to self-policing?’

On barriers to data sharing

‘Competition’

‘Individual commercial interests and internal issues within Insurers’

On memorable/unusual claimants

Broker's agent issuing fraudulent health policies with large monthly premiums to 'policyholders' unaware of the policy – the purpose to gain high commission in a short period, then disappearing.

17 personal injury claims after our insured hit a minibus, there was no damage to the minibus, and it wasn't carrying 17 passengers!

Recently, claimant took a new credit card with a £14 000 limit. Spent all credit limit on high value goods (high value clothing, watches and electronics). Says he took them all (four high value Brietling and TAG watches, 2 x iPods, 2 x iPhones) wearing the high value clothing to a sports centre. Played sports then put everything in the sports bag, which he ‘lost’ on his way home!?!

The claimant sustained very nasty head injuries, allegedly as a consequence of walking into a scaffolding left unprotected – detailed enquires turned up the transcript of the 999 call. It transpired that the claimant was assaulted in the early hours by a person wielding a clothes line – claim refused.

A typical bogus road traffic accident; alleged to have hit oncoming third party on a narrow country lane, with no witnesses. Driver and passenger so ill prepared for interview that they gave entirely conflicting accounts to the extent that, although they were in the same vehicle, they claimed to have been travelling in opposite directions.

Member of the public seen pouring bath oil onto the floor before 'slipping' on it and hurting her back. All caught on CCTV!

A 15-seater bus claim where 24 people were claiming to be on it and injured.

Policyholder who said he drove through a normal puddle in the road and the engine seized. We obtained photographic evidence which showed he was actually taking part in an off-road 4x4 rally event and pictured broken down in a mass of water that was higher than the bonnet of the vehicle.

I think it would be seven personal injury claims in a two door metro that can only fit four people maximum.

Looked into a recent claim where research revealed that the parties involved had many mutual friends on Facebook and were not unknown to each other as they stated. They were ‘gangsters’ in the Birmingham area.

Emails between two parties discussing staging an accident to get money from the insurers were found by an audit of work computers and passed to the insurer to investigate. It led to a clear trail of who was involved, how they intended to set it up and the sums paid to stage accidents. The subsequent claims were investigated, damage found to be inconsistent and personal injury claims were repudiated. Emails were submitted in evidence and the seven involved were prosecuted in court and found guilty.

The case of a care home owner whose wife was claiming on the employer’s liability policy for a significant back injury caused by a slip. It transpired that the ‘owner’ was a stooge for another individual who had been disqualified from running a care home due to dishonesty offences. The frontman had been used to obtain both the local authority licence and the policy.

A claim where a person played the roles of both our Insured and the third party, bear in mind that they did actually speak to us over the phone, pretending to be someone different. We had our suspicions about the validity of the claim but it wasn't until an unusual telephone mannerism was displayed during conversations with 'Both' parties that we hit on what the issue was! Our suspicions were substantiated by investigations into previous claims wherein we discovered a link via a mobile telephone number, that is, the number being used for the third party alias was found on a previous claim/policy for the Insured.

Seeing one claimant with 'heart problems' appearing on a major reality TV show performing stunts!

Personal injury – a claimant who was a taxi driver and who was allegedly blind. He was observed still plying for hire – much to the amazement of the specialist who examined him and considered him almost totally blind.

The claimant who couldn't walk, talk or lift her arms after an accident. She was filmed walking, shopping and talking on her mobile phone.

Claim for accident damage to a motor vehicle, claimed to be a write-off and currently in storage, but when visited was parked on the driveway and undamaged.

Receiving a claim for the theft of mobile phone handset and the 'proof of purchase' receipt sent in was doctored, stating 'P-Mobile' and not 'T-Mobile' as the provider!

Claimant suffered a genuine groin injury and claimed in his psychological report he'd lost confidence/libido and couldn't maintain a relationship and so on. He also claimed he'd not worked since the accident. On his Facebook page, however, he'd posted post-accident photos of himself at parties with various girls and, later, details of his new girlfriend and comments between the two **and** details of his various jobs and the companies he'd set up. Claim eventually settled for a fraction of the amount claimed.

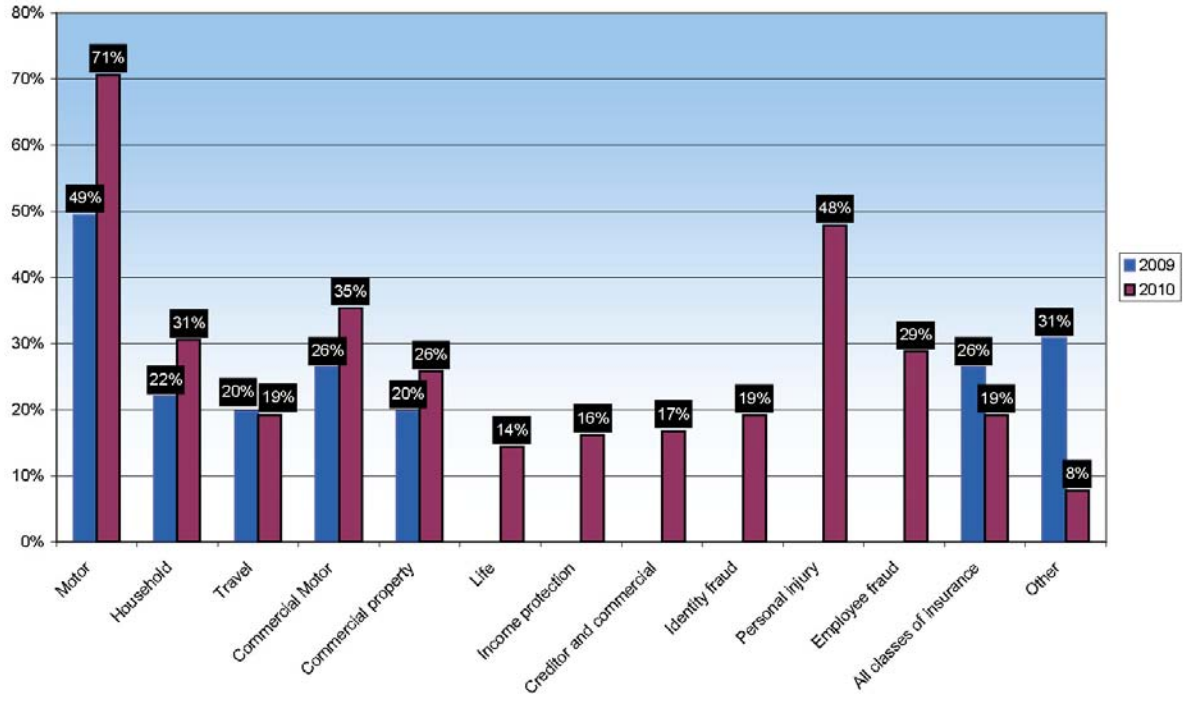
Investigating a suspicious death in India where the deceased was still alive and purporting to be a sister. Unfortunately the deceased forgot that her sister had actually died the year before her own alleged death occurred.

Conclusions

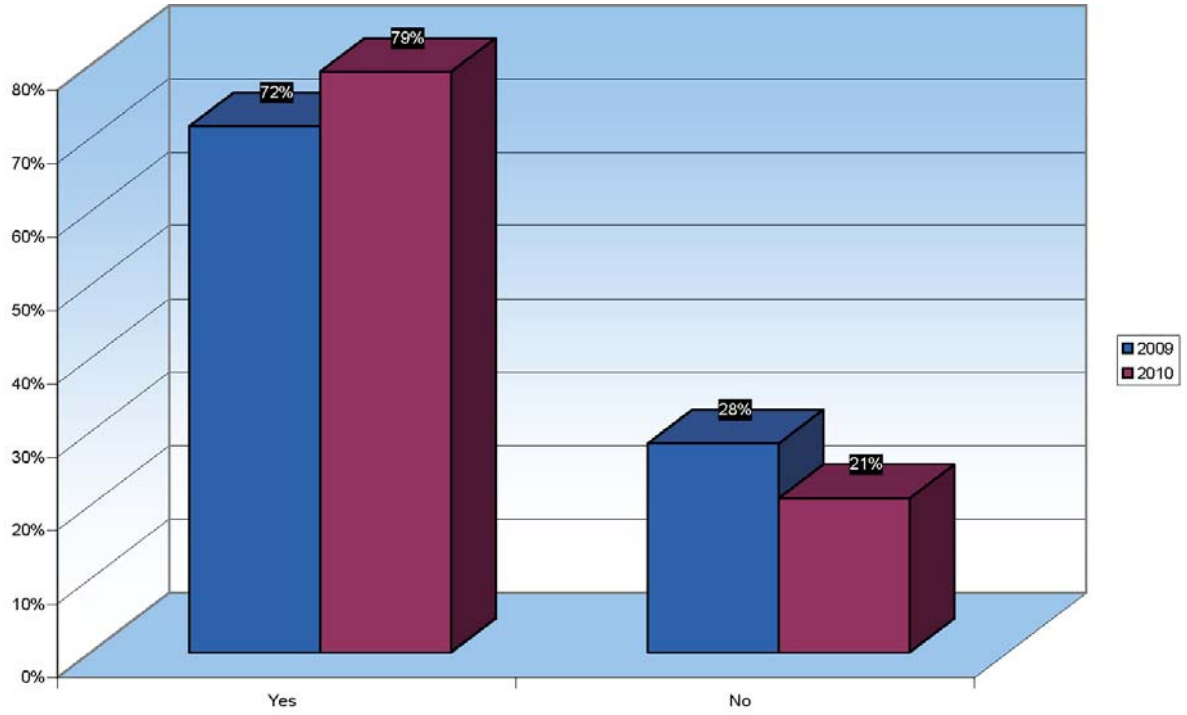
- Whilst the majority (over three-quarters) of IFIs have seen an increase in insurance fraud, organisations are also investing in more staff and fraud detection systems to counter the increase. However, over 40% expect resources will be a concern in the next 12 months.
- Geography is extensively used by IFIs to help highlight hot spots or patterns of fraud, detection at the claims stage and to help validate customer information. Just under half of those using geography are now using it to build up evidential cases for prosecution; benefiting from the visualisation/story telling that maps provide and indicating that the industry are taking more cases to prosecution stage.
- The current economic environment is clearly high on the agenda of IFIs, with two-thirds expecting to have concerns about coping with an increase in fraud over the next 12 months, fuelled by the recession. Ministry of Justice (MoJ) reforms are also a growing concern from way down the agenda last year.
- Internal policy or culture or data protection issues was stated as the main barrier to data sharing between suppliers, third parties or industry peers. In addition, there is a need to improve trust across the sector and also a uniform understanding of the DPA as this also causes a barrier to data sharing, as just over 50% of respondents stated.
- Some 90% of people said fraud had stayed the same or risen up their organisation's agenda, and two thirds (64%) said that their organisations had invested in anti-fraud as a result – with the majority investing in more staff or fraud detection systems.
- The 10% increase of commercial property claims, compared to last year, could be a reflection of the property market and the recession.
- Aggregators/brokers need to do more – stringent checks, information sharing, identity checks, when signing up customers, to prevent fraud at policy inception.

A Data analysis

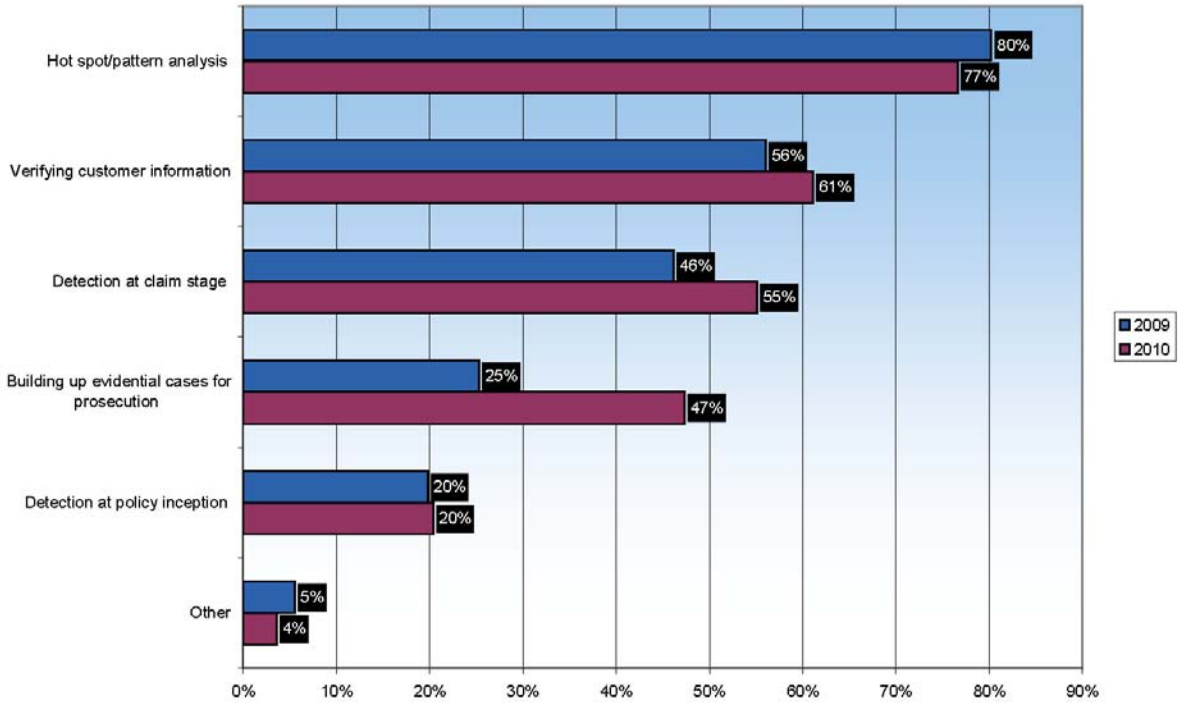
Question 1 – What areas of fraud do you look at from an organisational point of view?



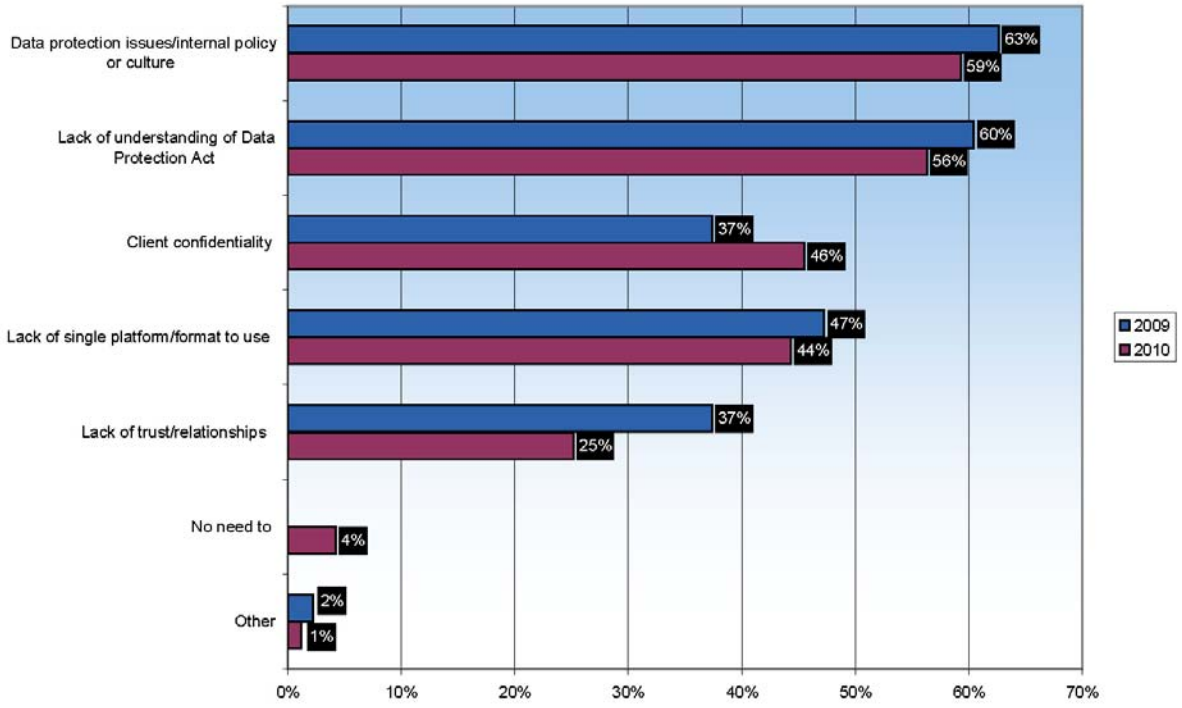
Question 2 – Do you use geography in your current role/function?



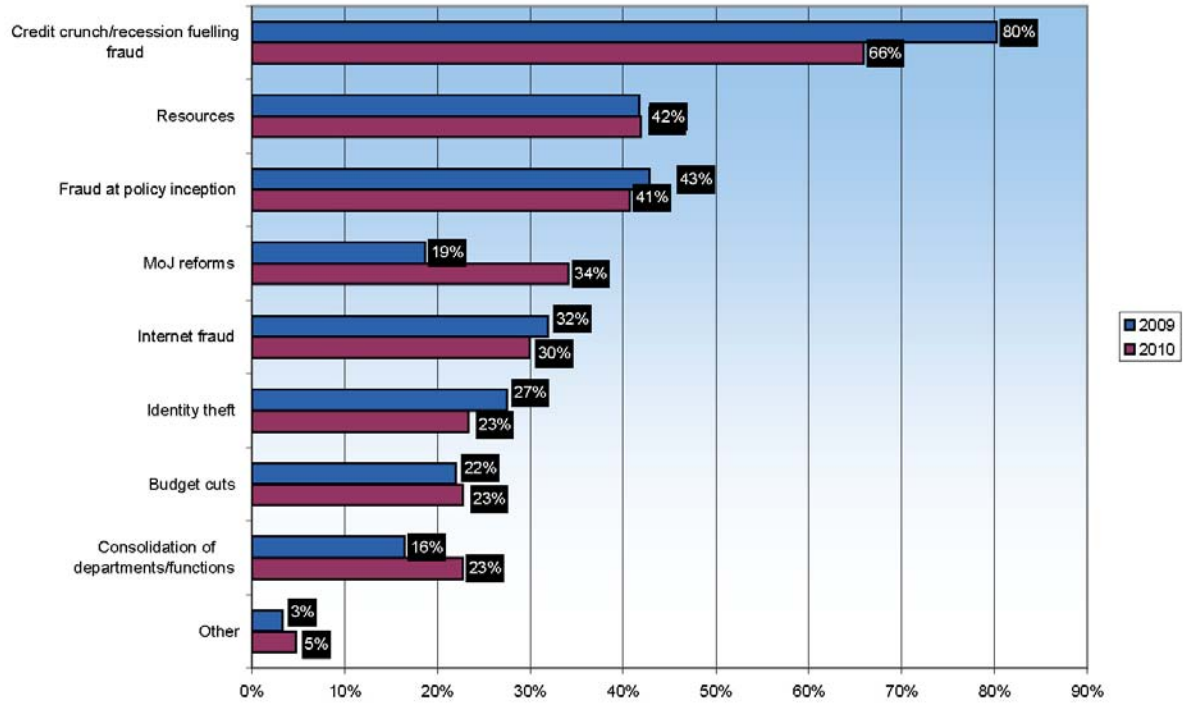
Question 3 – How do you or how could you use geography in your current role?



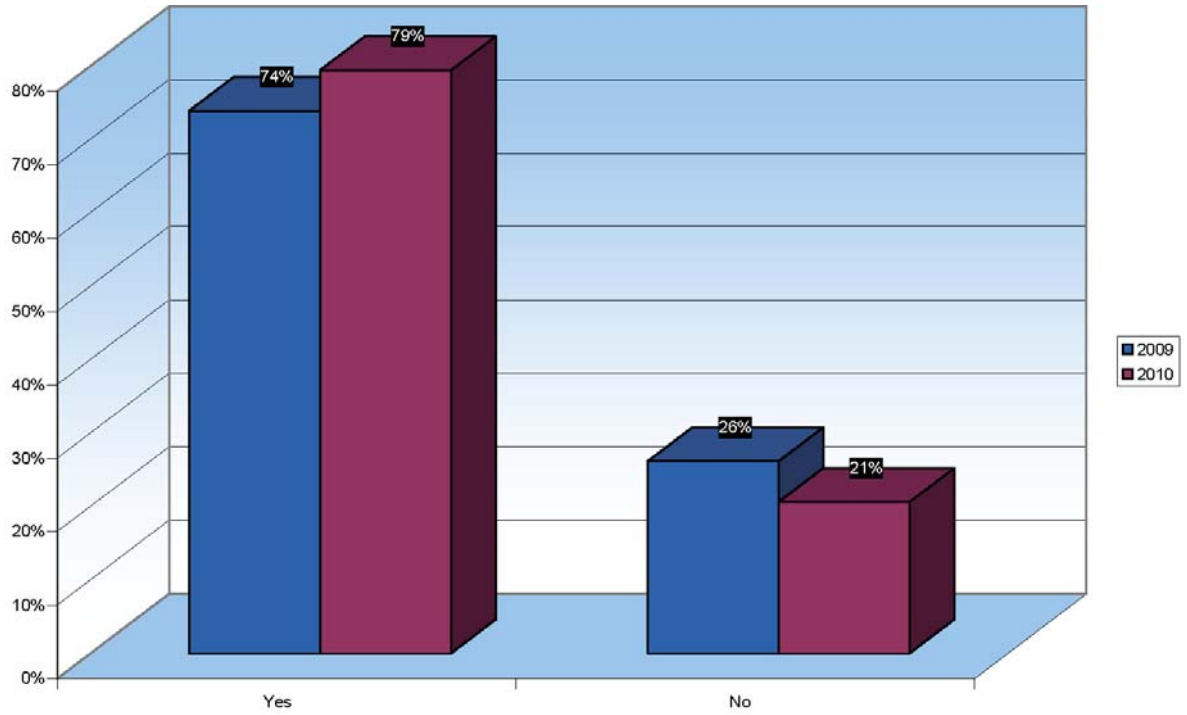
Question 4 – What are the main barriers to data sharing between suppliers, third parties or industry peers?



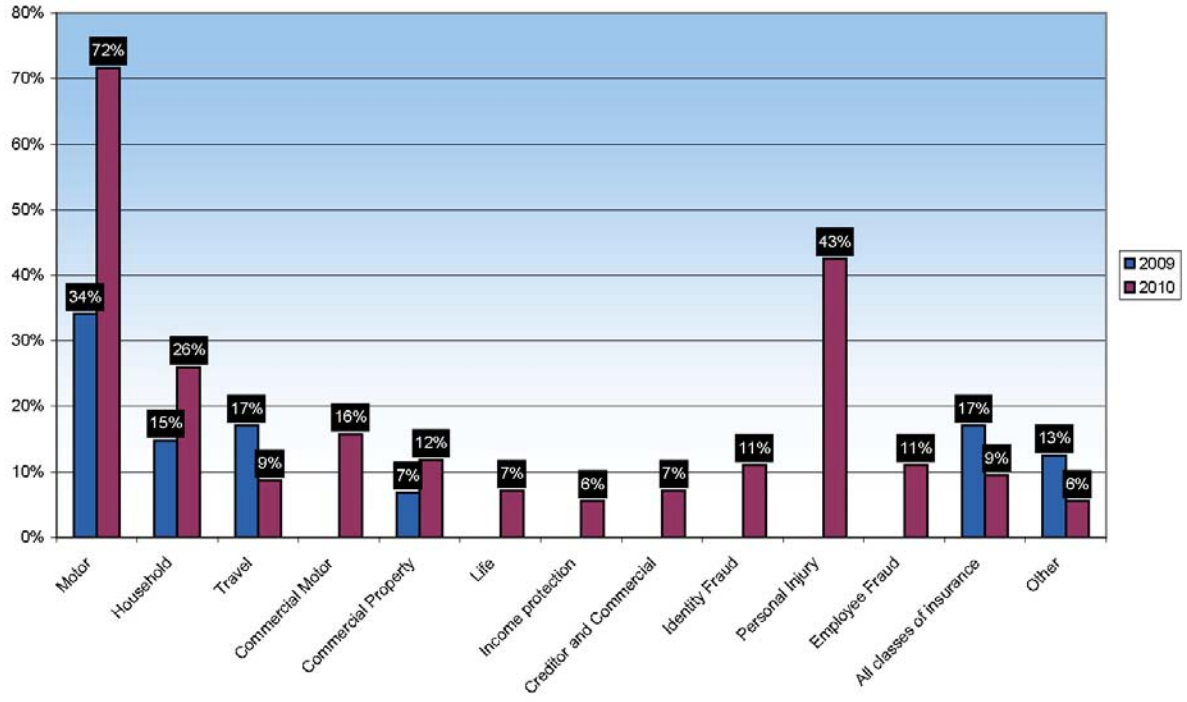
Question 5 – What do you envisage being the top three key issues directly affecting you and your role over the next 12 months?



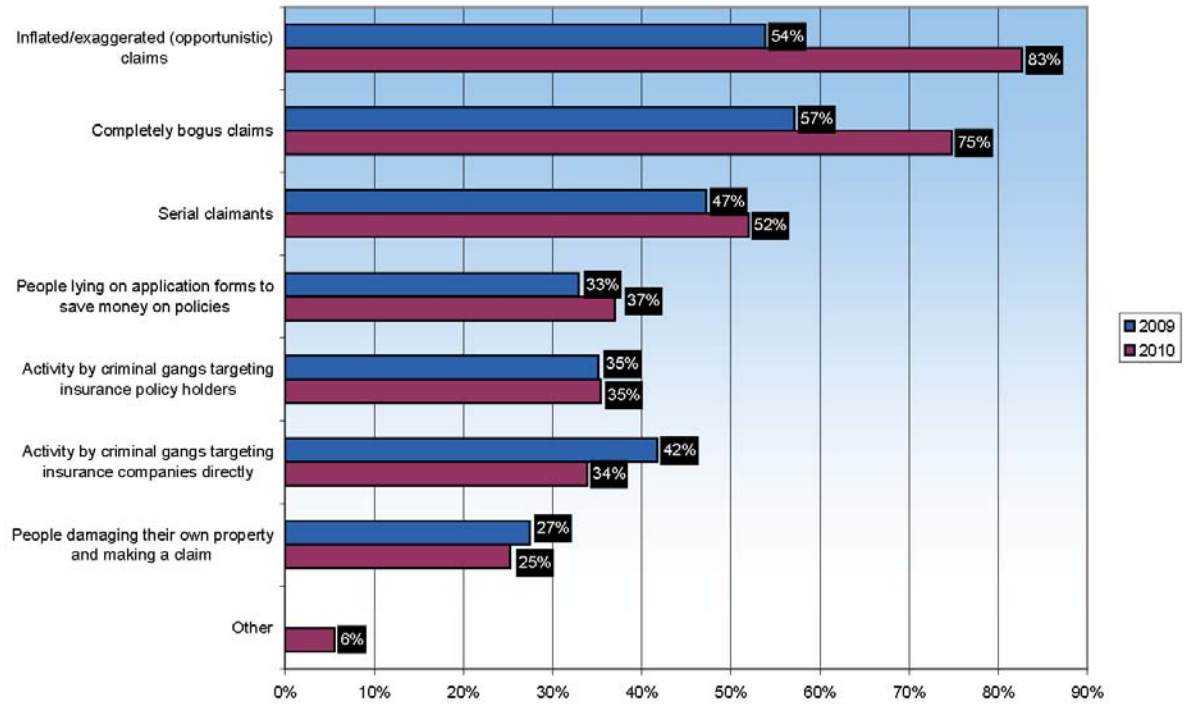
Question 6 – Have you seen an increase in fraudulent claims since the beginning of year?



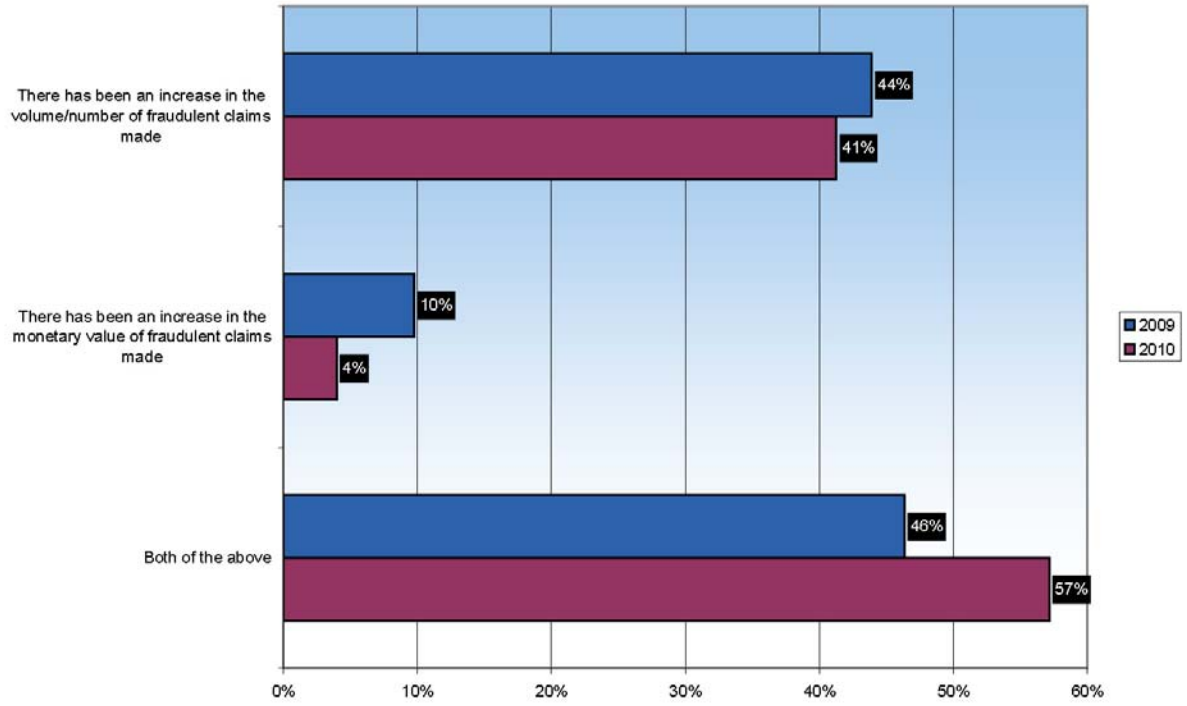
Question 7 – Are you seeing an increase in any of the following?



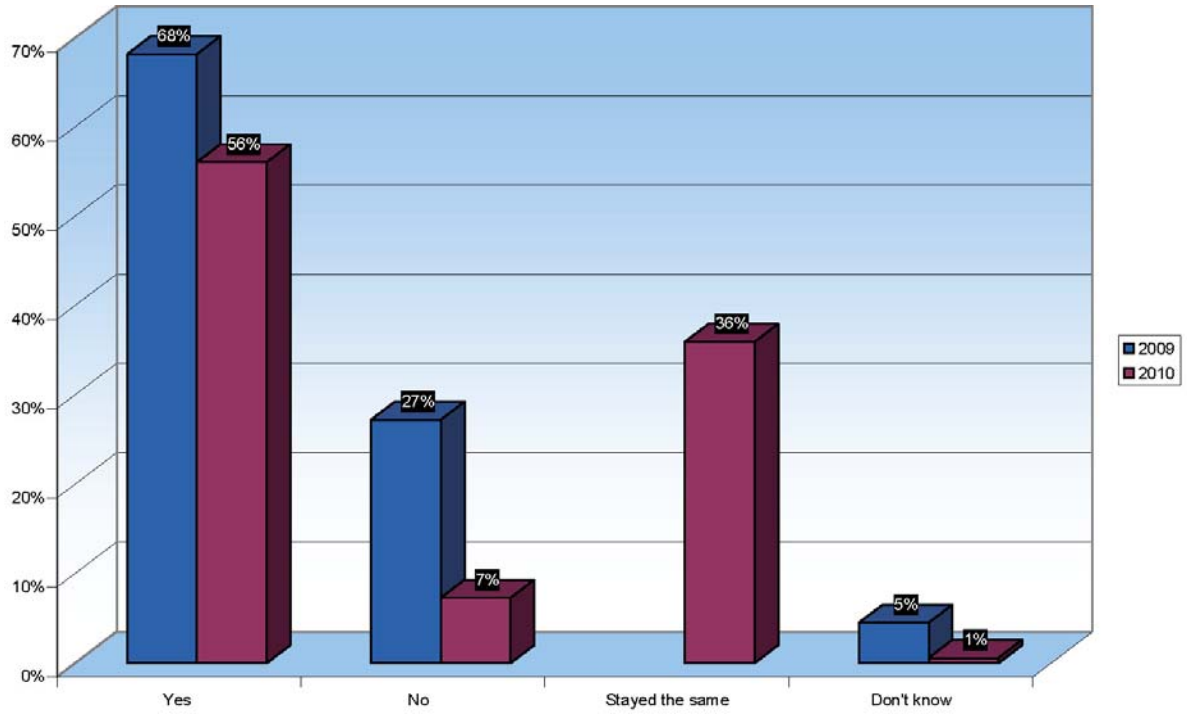
Question 8 – What types area are you seeing an increase?



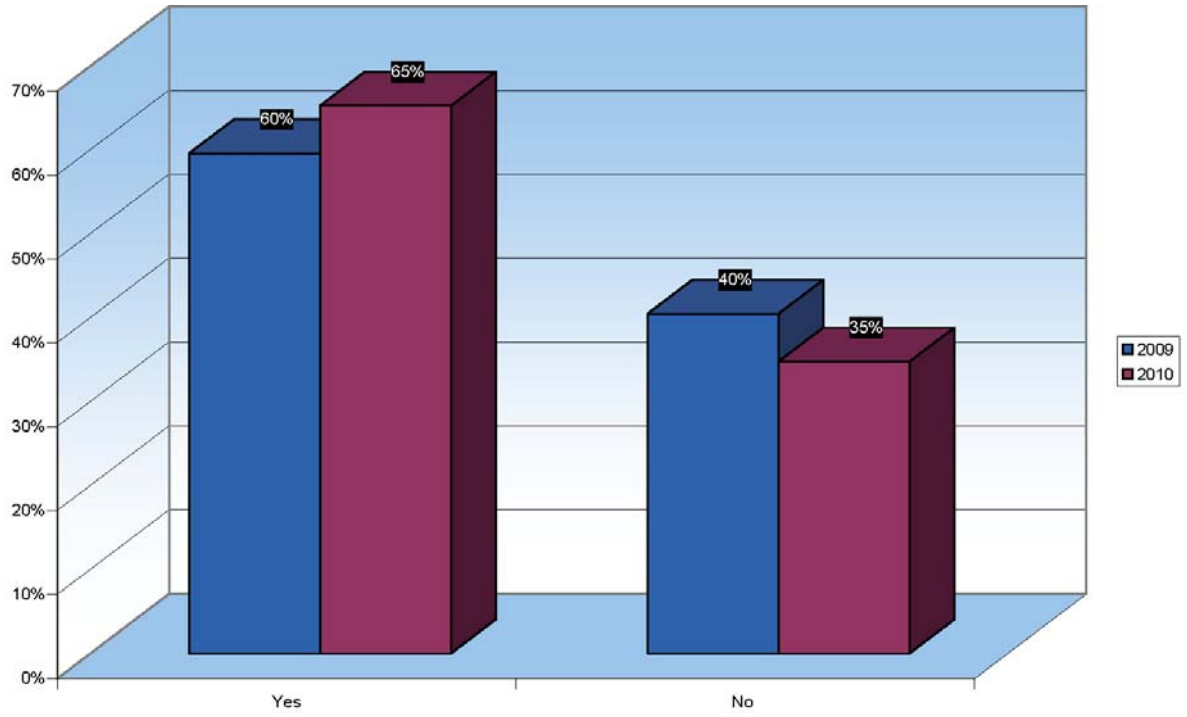
Question 9 – Which of the following statements best describes the increase in fraudulent activity?



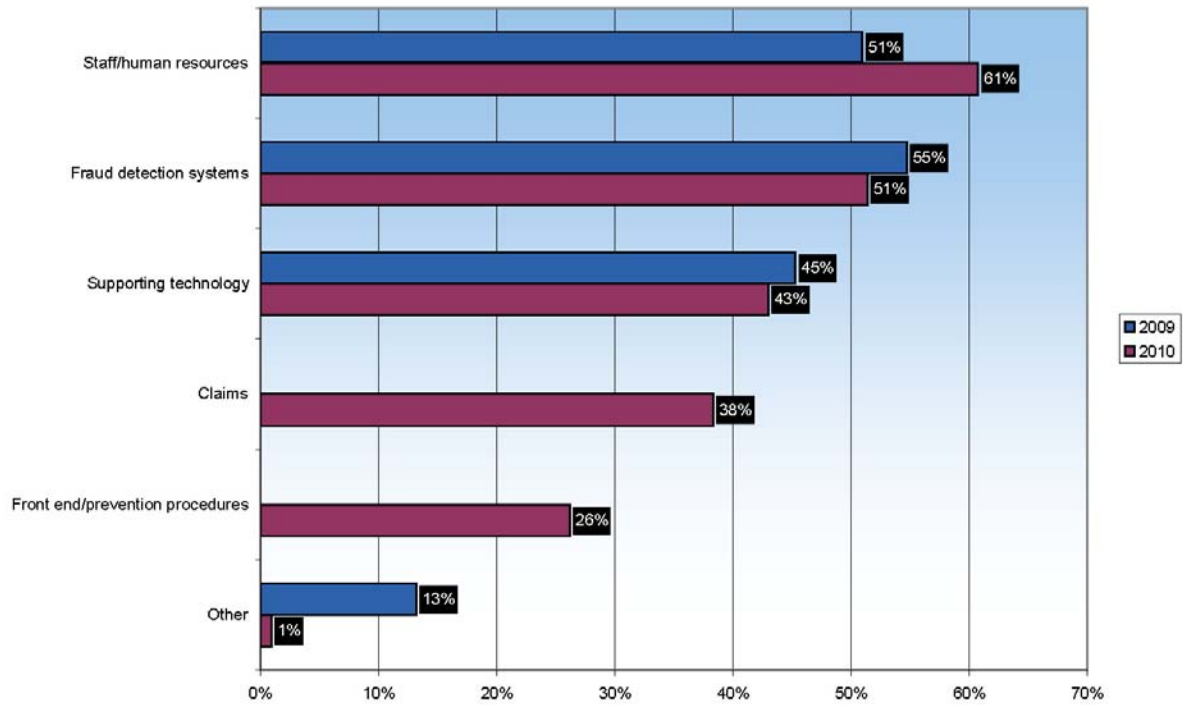
Question 10 – Has fraudulent activity moved up your organisation's agenda?



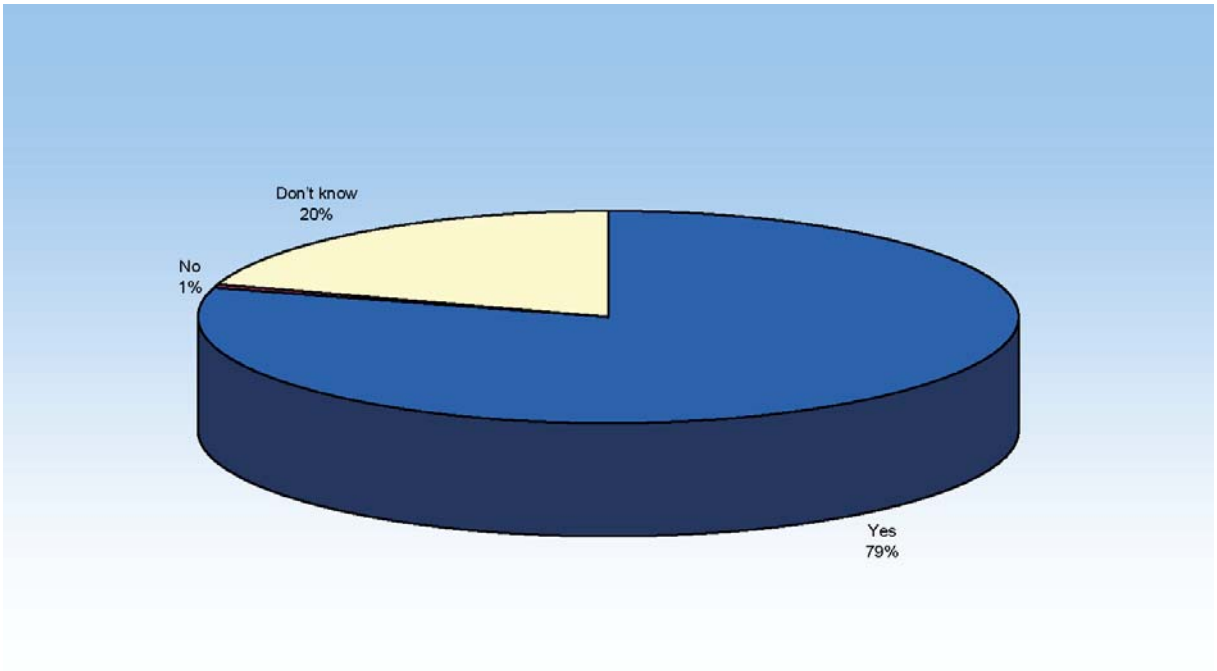
Question 11 – Have you seen increased investment in fraud detection in your organisation?



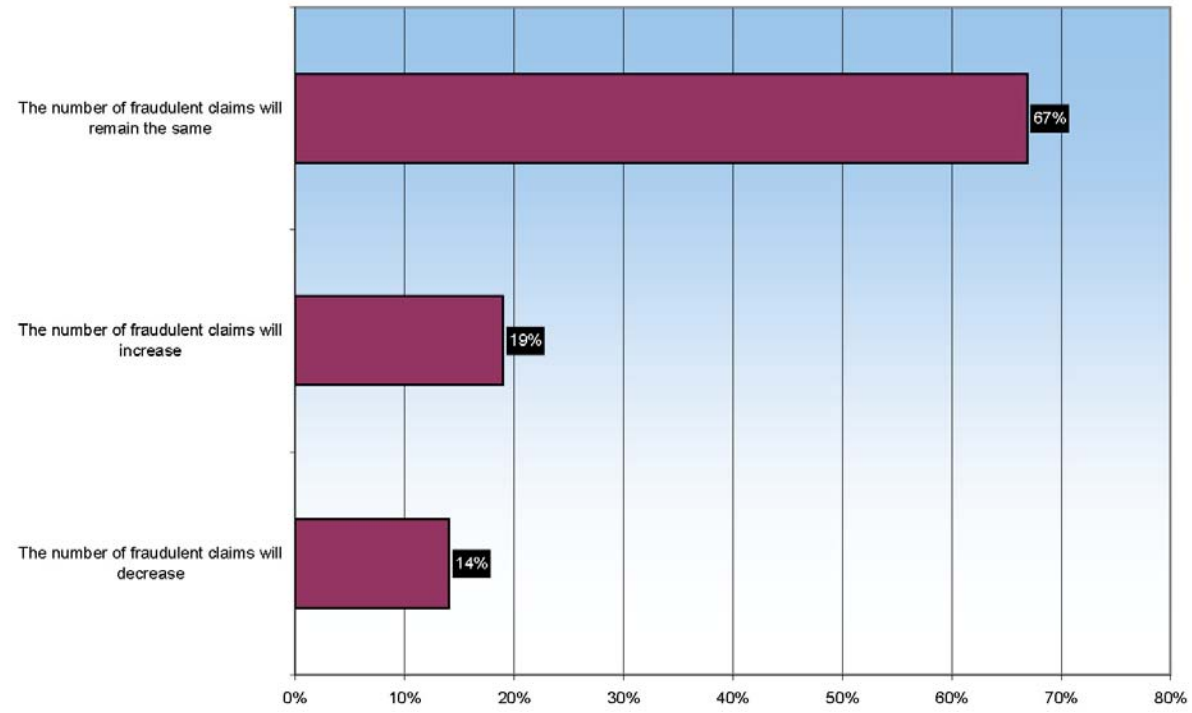
Question 12 – If yes, where have you seen investment made?



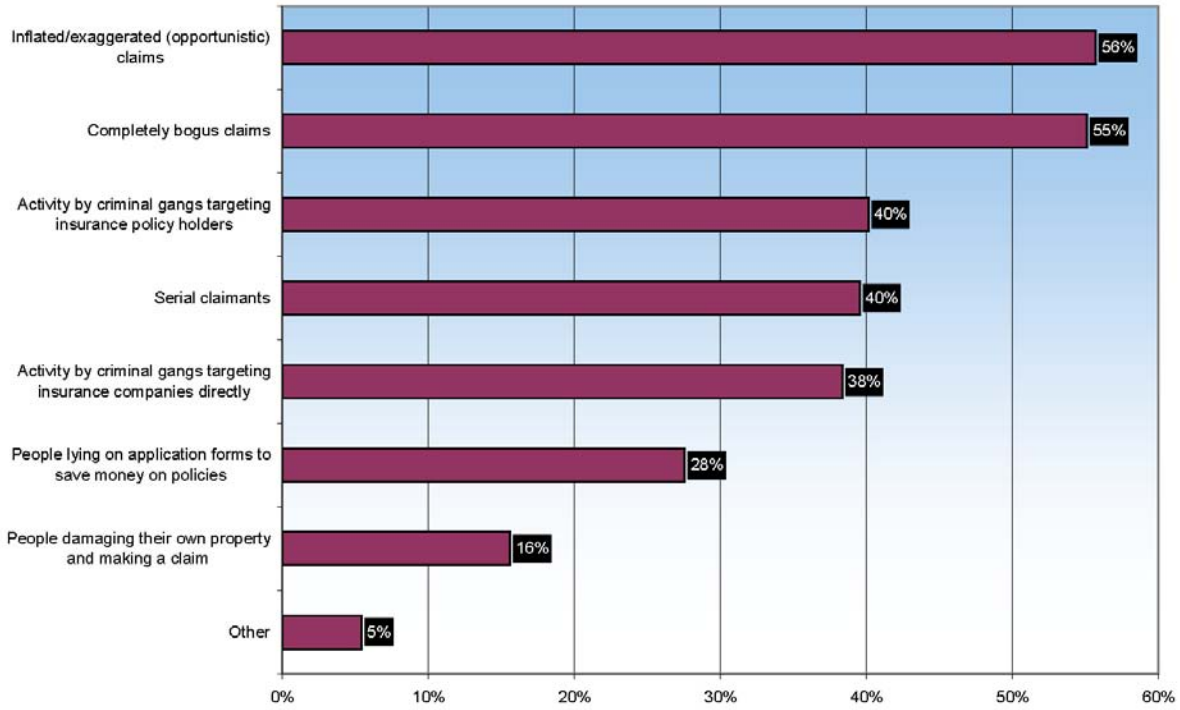
Question 13 – Should aggregators/brokers be taking more of an active role/responsibility to prevent fraud?



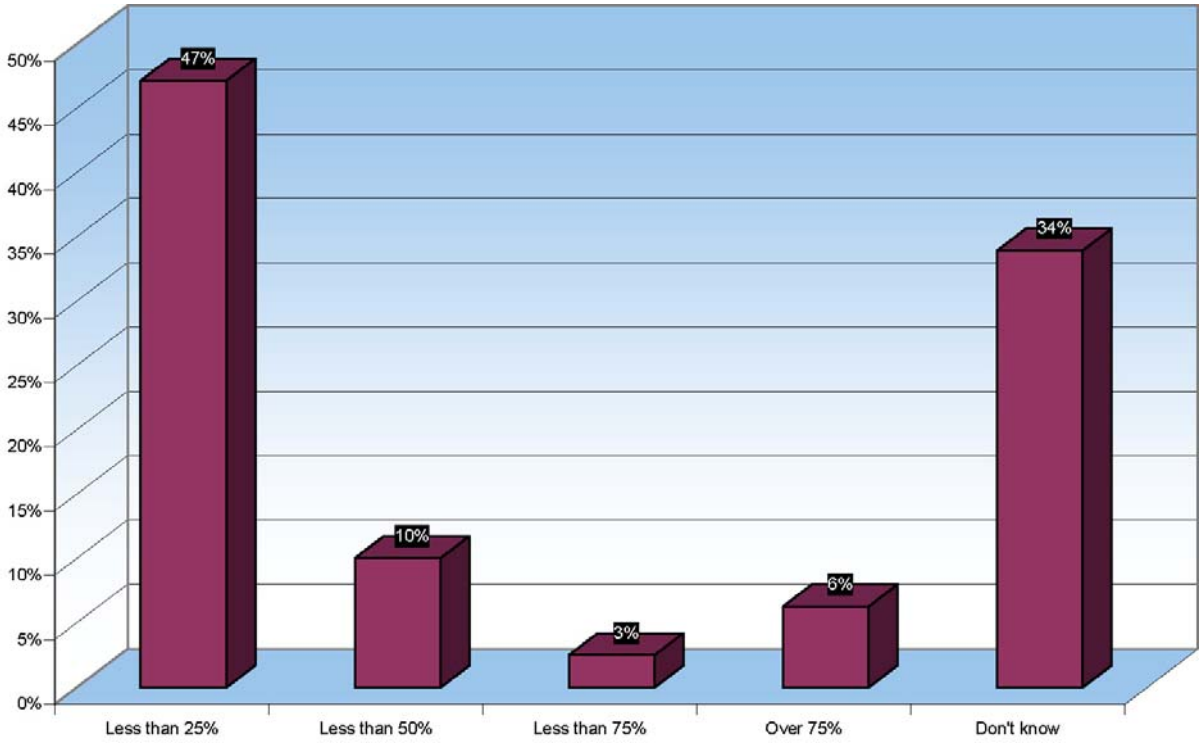
Question 14 – What impact do you think the Jackson review will have on insurance fraud?



Question 15 – Where are you most concerned about fraud occurring?



Question 16 – What % of your company's resources is spent on tackling fraud?



Respondents' comments

What can aggregators/brokers do to prevent fraud?

Aggregators proactively working with insurers to prevent fraud.

We don't use aggregate sites.

Developing a central database of fraud, trigger questions to detect inconsistencies in customer's responses.

By sites providing all information changes (prior to completion) to the Insurance companies free of charge.

Don't have any involvement with aggregate sites.

Communicating suspicions to the fraud department. Awareness training.

By using further identity checks and using better communication.

Sharing intelligence with other validation offices; meetings with claims assessors to share intelligence.

A single prevention database tool whereby aggregators must share information on claims and so on.

Data mine the information supplied to support the application.

Credit checking upon application.

Checks should be made on data for physical address, for example electoral role, credit checks.

Better front end profiling.

Training and awareness.

By sharing information.

By verifying more information which is provided.

Technology to quickly identify common data, for example email addresses, credit cards.

Improved fraud detection software being used by the aggregators.

Harsher penalties for confirmed fraud, rather than them being free to do it again.

By them allowing us to request search history under DPA to ascertain matches.

Increased awareness/training.

Smarter tools to identify abusers.

Better vetting methods.

Better detection at an early stage and more fraud awareness training.

More mandatory questions, better bank card checks.

Not in a position to comment on this issue.

Closer assurance testing and ownership.

Data sharing.

Block internet upon discovery.

Know your customer checks.

Insurers sharing data.

Due diligent customer checks, or once sale made then ID checks to be made.

More thorough checks at the inception stage.

Better monitoring.

Validation of policyholder: track IP addresses/phone numbers.

Enhanced training in fraud detection at inception and first notice of loss (FNOL) stage.

Enhanced validation processes.

More cross-checking of information given.

Better understanding and more validation checks on information.

Not my area of expertise.

Checking of policyholders' history against CUE and tracking of changes to declarations at quote and buy.

Supporting ID documents should be sent in addition to application.

Education of staff. Publicised enforcement. Directed intelligence led action.

More pro-active approach from insurer, that is, telephone interviews or fact-find calls.

More verification at policy inception stage, information validation visits.

Link to CUE.

Aggregators need to highlight quote rigging and make data more easily available to their insurer clients.

Clever use of the identification systems for credit checking, CUE, licence checking and so on.

Profiling and history checks.

No experience in this area of work.

More fraud awareness and the possible consequences.

Verifying information submitted. Insisting on proof of identity, proof of NCD.

Intelligent monitoring of activity.

Analysis – red flagging of input data changes. (Flagging customer experimentation).

It cannot be prevented without compromising the attractions of aggregate sites to genuine customers.

Vigilance.

The sharing of information allows you to look for a similar hit or pattern on your database.

Verification of policyholder on an ad hoc basis to check details provided as being correct.

Perhaps put a block on personal details so that only the third party involved can see those details.

Difficult. Profit sharing scheme with the brokers? Provide an Inducement to self-policing?

Greater controls at the registration stage. Designated SPOC in police to liaise with insurance companies.

Greater and more robust checks.

Remove anonymous applications.

By imbedding real-time links to fraud data bases which validate data entered on internet.

Store answers of the ‘variables’ and share with other aggregators to prevent fake policy information.

Improved data and intelligence sharing across the industry to enhance fraud risk profiling.

Identity checks.

More direct contact with customers/personnel involved.

With difficulty, as you have no proof of who you are dealing with.

Incorporate validation of the prospective customer prior to the point of sale, realistically real-time.

They should be viewing photographic ID of people taking out policies.

Work closer with the insurers to prevent selling to repeat offenders.

Vetting properly.

Not an area that I know very well so not able to comment.

Varying factors apply to different sites.

Being more vigilant with regard to information submitted.

Better procedures are implemented to prevent fraud.

On the latest systems:

Screening for fraud, claims history and identity at point of application.

Recently forged a relationship with an investigations supplier and assessing the benefits of interactive telephone interviews which seem to be providing good results.

Equifax Call Credit GeoFraud.

CRIFF.

Currently investigating the market.

C-MAX, C-Link, LexisNexis.

Detica.

Data mining.

Red flags linked to staff training.

Intelligence system based around i2 products, plus bespoke Prospect data mining system.

Facebook and other social networking sites.

SIRA.

IFIG, HUNTER, CIFAS.

Staff with the experience required to investigate properly.

currently using Sira, considering Ibase.

Voter's Roll Experian Credit Data other ad hoc searches as required.

Digilog.

i2 and similar.

Hunter, CIFAS.

Theft reports derived from an analytical method of identifying potentially fraudulent theft claims. Specific key factors are identified, which, on their own may be insignificant, but when they occur in certain sequences indicate a strong probability of fraudulent claims.

Unsure, as there are several considerations to be taken into account.

i2.

Various.

Using the SIRA system designed and run by Synectics Solutions Ltd.

PI Cue, 192.com, internet, google maps.

Tracesmart, Experian, Hunter 2, MDM.

Intergration of i2 into network database. In house cross-referencing software.

SIRA and various data matching arrangements.

ibase, CUE, MIAFTR.

Ibase, IFIG.

CUE at policy inception stage.

IFIG Alerts Access to DVLA keeper details access to HPI register applying to access IFB information.

ID verification, DVLA data, address verification, credit history all on the SIRA platform.

IIL at quote or point of sale.

We're probably behind the ‘times’ but we're looking at getting Experian.

Use of geographic analysis to proactively identify the clustering of activities/nominals, cleansing of fraud database.

Profiling and claims history checks at proposal stage.

Using SIRA but insufficient resource (headcount) available to make fullest use of its capabilities and output.

Interviewing techniques, recorded interviewing and data mining of own records.

Emphasis on developing front-end prevention due to alarming rise in internet/policy fraud.

Vehicle history and duplicate car hire checks.

CIFAS.

Bespoke claims management system being installed.

New telephone system being installed to allow recording of calls dealt with by conversation management claim handling.

Person-to-person interviews.

SIRA.

Using Ordnance Survey mapping at the moment.

Hunter, open sources information, Cifas FIND, Equifax, Voters.

Profiling conversation management surveillance cognitive interviewing.

Hunter II, CUE.

Hunter.

upgrading i2 database and analytical tools.

WitKit intelligence databases crash data recorders.

CUE.

None at present.

We investigate fraud reported to us – police organisation.

A greater cooperation between other agencies and the sharing of information.

None at present.

MapInfo additional i2 software.

Identity verification tool.

SIRA.

I use the banking/financial institutions to acquire information relevant to my investigations.

We are currently using and plan to develop further, our i2 system to assist in trend analysis, hotspot anaylsis and so on. We are also considering mapping software.

No new systems being used to detect fraud, just more fraud awareness training being carried out for front-line staff to pick up fraud cases better.

On memorable/unusual claimants:

A customer who claimed they had fallen onto some railings whilst travelling and claimed for some corrective surgery. The customer could not recall the circumstances/respond to basic questions about the scenario. Investigations revealed that the customer had had surgery but it was for liposuction and not related to any fall.

Injury claim, pleaded at in excess of £500 000, for back injury/chronic pain/psychiatric injuries involving an Australian claimant (who had subsequently returned to Oz) where liability admitted fully in protocol period, but where we were always suspicious of the claimed value. Offer of £3000 made for the genuine back injury initially but nothing for the chronic pain aspect. Claimant provided the GP's records himself, but when we rang up his GP in Oz to clarify a couple of the entries (GP's writing is obviously the same the world over!) it was clear we were looking at altered entries from those in the original notes. We obtained an order for the GP to provide the original records to us, and shortly before trial the claimant filed a statement trying to explain why he had altered the copy of the GP's notes on his home computer using Photoshop software, apparently due to his depression, rather than any desire to hit the damages jackpot. He was eventually awarded £900 damages at trial in UK and ordered to pay our costs.

A lorry driver who claimed his handset had been stolen from the cab of his lorry whilst sleeping. The offender was disturbed by the police who detained the suspect, who hid the phone from the police by inserting the phone up his rectum, which was later recovered by the police and had to be destroyed as a health hazard. The handset was actually given away to a female friend and then he made this very elaborate claim.

A personal injury claim, whereby the claimants had somehow got hold of our insured’s phone statement and written on it that she accepted liability, and this was not in her hand writing.

Woman claimed for having lost half her leg after being knocked down by a car. She was only suffering from sciatica.

Two keys submitted for an Audi didn't match. He had joined the ‘fraudulent’ key to the correct blade – beautifully done but didn't fool Audi.

Some years ago, in the earlier days of tracking systems – a claimant thought they had disabled the security system that enabled the tracking of a HGV and its load. The transmitter aerial was covered by tin foil, blocking its signal. The vehicle, with the policyholder's involvement, then went off-route to drop off the trailer with a high value cargo of mobile phones, and then the tractor unit returned to its route. The complicit employee/driver was bound and gagged, and the foil removed to suggest it had been hijacked on-route to throw police and Insurers off the trail. Unknown to the policyholder, whilst the signal was interrupted for the period the aerial was covered by the tin foil, the system still collected the data and was merely waiting for the signal to be re-established before transmitting the stored data, leading police to discount the drivers story, implicate him and, via admission, the policyholder, and backtrack to recover the load from its hiding place.

Phantom passengers – as we are a bus company there are many of these and I believe many which are undetected.

To be honest, they are all remembered for very different reasons, but perhaps when I have obtained a confession and that person has thanked me for relieving them of the stress/burden and usually, they are 'innocent' victims, people who have a financial problem, who are targeted by accident management companies to become involved in the fraud, when ordinarily, they wouldn't.

Claimant reporting the theft of a vehicle at the same time as it had been found on fire 32 miles away.

A claim for bogus/ghost passengers in the policyholder's own vehicle.

Road traffic claim where the policyholder lived at the same address as the accident management company utilised by the third party, although the policyholder could not be traced, save for sending an admission of liability to his insurers. The accident management company insisted that they had not spotted that the policyholder had provided their address when they were instructed by the third party, and they then provided the third party with a hire vehicle. The link between the parties was noted and the claim defended to trial, with fraud being alleged by our client (the insurer). The third party insisted that he had been referred to the accident management company by the policyholder and that the accident was genuine, and could not understand why fraud was alleged. The accident management company director gave evidence to the effect that the third party had walked into his offices 'off the street'. At Trial, the third party was alleged to have made death threats to the director of the accident management company during the lunch break, and examination of their mobile phones (at the request of the Judge) confirmed that they had spoken, at a time when the accident management company director had been under oath and so not permitted to discuss the case with any other affected party. The Judge found that the claim was fraudulent and ordered the accident management company to pay our client's costs of £25 000. It is my suspicion that the policyholder deliberately caused an accident so that he could refer the third party to the accident management company, with whom the policyholder was in league – this was never proven, however.

A recording artist arranging for the theft of his performance vehicle to fund a new recording suite at his home.

Claimants, all asylum seekers, presented a claim for personal injury against our insured who allegedly collided with the rear of the claimant vehicle. The claimant was claiming a total loss value for a Porsche 911 along with credit hire in addition. A claim form was sent to the insured and returned completed however we did not accept this was a genuine claim and/or that our client actually existed. Investigators were sent to the address in Coventry which was a kebab shop. On the initial visit, the shop worker at the time assisted with the enquiry and advised there was no living quarters at the shop and that the upstairs was a storeroom. We refused to deal with the claim but the claim was not withdrawn. Almost 18 months following the collision, we contacted the owner of the shop who was kind enough to help us with our enquiries. He produced a copy of the shop rental agreement covering the period of the accident and the person renting the shop at the time was in fact the claimant.

Loss of a pedigree dog, which prior to it going missing, allegedly attacked someone which also brought about a personal injury claim. A claim ensued for the loss of the dog and a personal injury claim was also pursued. Following an investigation it was ascertained that the dog did not exist, and following interview, (granted by claimant's lawyers) the claimant admitted the same. Both claims were repudiated following interview with the dog owner and the claimant. Value £13 000.

A staged bus crash on Merseyside. The focus before then was on 'bogus passengers' in Liverpool bus accidents however all 50 occupants of the (usually deserted) bus knew the accident was going to happen.

Travel claim following the bush fires in Greece (circa 2007). Family of four evacuated into the sea as fire threatening hotel. All had iPods, mobile phones and cameras with them and parents rings ‘floated off’ in the water!! Unable to disprove during face-to face interview in claimants own home, as claimants had photographic evidence and receipts for the goods included in the claim.

Company approached to supply a coach for a day trip to Alton Towers, coach passengers would have been supplied via an accident management company and a car and driver briefed to collide with the coach on route.

My involvement relates to misrepresentation and non-disclosure rather than fraud during the claim for inflated costs, unless related. The main claims in this category relate to eastern European drivers now within the EU declaring full UK driving licence and residency since birth via internet or aggregator sites.

A claimant claimed she was on one of our vehicles when it was hit in the rear. The vehicles CCTV proved that she was still standing in the bus stop when the incident happened. She was duly prosecuted and convicted but she didn't receive a custodial sentence due to the fact she was a single mother with nine children.

A motorcyclist travelling in a group came off his bike at high speed and sustained very serious injuries. About 12 months later, our insured motorcyclist alleged that he had struck the injured party and caused the crash. Expert engineering evidence failed to convince the High Court that the incident could not have happened as described. We then managed to trace two key independent witnesses who had stopped at the scene and were able to provide evidence proving that our insured motorcyclist was not present at the scene at all. The court ultimately ruled that the injured motorcyclist had colluded with our insured to fabricate their version of events and they had deliberately 'airbrushed' other key witnesses out of their account.

Staged bus 'accident' which resulted in over 40 whiplash claims being attempted.

An individual making a claim for personal injury resulting from a road traffic accident that they were not involved in or near!!

There are so many! Perhaps the case of the ‘fake sheikh’. This persistent and confident third-party claimant pretended to be a wealthy Arab sheikh, set up a bogus policy with us, invented an accident to enable him to get his hands on a replacement hire Aston Martin DBS which he intended to ship abroad. Luckily, our supplier hire company and a previous IFIG alert prevented a vehicle ever being supplied to him.

A serial claimant who alleged the theft of property in the policyholder's possession and allegedly on their premises. The contents of the property were allegedly of the value to £80 000. There was no record of work done or record of money paid in cash up to £10 000. The claimant was well studied and found all excuses why the claim needed to be paid and had studied in depth the exemptions that would have applied to this claim.

Someone trying to claim for Italian bed linen valued at £000's but when I checked and saw pictures of items, these looked as though someone’s granny had crocheted them really badly. The claim was eventually thrown out.

Induced road traffic accident involving a 'decoy' vehicle that was witnessed by an off-duty fireman who, one month earlier, had been the 'negligent' party involved in a similar induced RTA, at the same exit on the same roundabout, at approximately the same time of the day. In his accident, the fireman pursued and caught the driver of the 'decoy' vehicle. That person just happened to be the driver of the 'innocent' third party vehicle involved in our accident/the accident witnessed by the fireman. Although this chap tried to deny he was one and the same person, as the fireman said, he ‘never forgets a face’.....

Most memorable is a series of car accidents, believed staged, most of which occur late at night around the back of the accident management company, and many of the cars involved have at one time been owned by a convicted drug dealer.

A case where there were more claimants than there were seats in the third-party vehicle.

Small Nissan Micra collided with the rear of a crane. Crane company suggested the hook at the front of the crane had swung like a pendulum and cracked the windscreen of the crane. Claim for loss of revenue for lost use of crane and cracked window screen. Basic physics demonstrated that this was not physically possible.

Claimant at scene of road traffic accident fabricating injury and insisting they can't get out of vehicle (owing to injury). Fire service has to cut roof off of vehicle rendering same a write-off. Scenario adds to validity of injury claim.

Most memorable outcome was a genuine motor accident where the third party deliberately pleaded a fictitious loss of contract, head of claim in conspiracy with a professional accountant, which resulted in successful criminal prosecution and custodial sentences for both the third party and the accountant.

Claimant suffered a genuine groin injury and claimed in his psychological report he'd lost confidence/libido and couldn't maintain a relationship and so on. He also claimed he'd not worked since the accident. On his Facebook page, however, he'd posted post-accident photos of himself at parties with various girls and, later, details of his new girlfriend and comments between the two and details of his various jobs and the companies he'd set up. Claim eventually settled for a fraction of the amount claimed.

Investigating a suspicious death in India where the deceased was still alive and purporting to be a sister. Unfortunately the deceased forgot that her sister had actually died the year before her own alleged death occurred.

£500 000 overseas death claim – which once notified to the police, became in excess of £10 million – ranging from life fraud, motor, household plus other criminal activity.

Fraud ring involving 100 claimants.

A serial fraudster made repeated surrender requests to obtain funds from a number of high profile investment firms. Some of the policyholders had just died and the fraudster had to impersonate these dead people and submit forged documents in order to obtain the funds held by the investment companies.

A vehicle damage claim, where after investigations it turned out that all three witnesses were related, and had lived at the address at the same time, despite their witness evidence to the contrary.

Serial claimant for household claims, who used several alias names and addresses to take out policies and make claims, when paid by cheque he would call and advise the cheque had not arrived and then ask for payment to be made direct to a bank account. If items claimed were replaced, he would get them delivered to his work address. This person was eventually caught out and admitted making over 20 fraudulent claims, he was reported to the police and received a 12-month prison sentence.

A quote from a claimant solicitor on his client after I caught him out: 'well they all try it on don't they', yes – and obviously the solicitors as well, in supporting and pursuing the claim. A total acceptance from a member of the 'legal' profession that it seemed quite normal for fraudulent claims to be made.

Having declined a commercial property claim for lack of security precautions, and having many lengthy, quite adversarial conversations trying to explain the basis of the exclusions, what might be considered adequate and what was not, the Insured subsequently had a second claim which met the policy security requirements to the letter. Whilst I suspect it was fraudulent, it could never be proved.

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If you are interested in joining IFIG, visit **www.ifig.org**

INVESTOR IN PEOPLE

www.ordnancesurvey.co.uk
customerservices@ordnancesurvey.co.uk

General enquiries: +44 (0)8456 05 05 05
Dedicated Welsh Language HelpLine: 08456 05 05 04
Textphone (deaf and hard of hearing users only please): +44 (0)23 8079 2906

Customer Service Centre, Ordnance Survey, Romsey Road, SOUTHAMPTON, United Kingdom, SO16 4GU.

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