THE LAW SOCIETY
OF NEW SOUTH WALES

Our Ref: ICC:GUml:1179615

13 July 2016

Committee Director
Standing Committee on Law & Justice
Parliament House
Macquarie Street
SYDNEY NSW 2000

By email: Law@parliament.nsw.gov.au

Dear Director,

First Review of the Compulsory Third Party insurance scheme

The Law Society of NSW appreciates the opportunity to provide evidence before the Standing Committee on Law and Justice on the First Review of the Compulsory Third Party insurance scheme.

Mr Tim Concannon, member of the Law Society's Injury Compensation Committee, appeared on behalf of the Law Society before the Standing Committee on 17 June 2016.

As requested, please find enclosed:

1. Corrected transcript; and
2. Answers to questions on notice taken during the hearing.

Once again, the Law Society thanks the Standing Committee for the opportunity to provide evidence at this review.

Yours faithfully,

Gary Ulman
President

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THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: ICC:GUml1179441

13 July 2016

Committee Director
Standing Committee on Law & Justice
Parliament House
Macquarie Street
SYDNEY NSW 2000

By email: Law@parliament.nsw.gov.au

Dear Director,

First Review of the Compulsory Third Party insurance scheme

Thank you for providing the Law Society of NSW with questions on notice after its appearance at the First Review of the Compulsory Third Party insurance scheme.

Mr Tim Concannon, member of the Law Society's Injury Compensation Committee, appeared on behalf of the Law Society before the Standing Committee on Law and Justice on 17 June 2016 for this review.

The Law Society sets out below its responses to the questions taken on notice.

"Mr David Shoebridge: You said there was a regulation in place, imperfectly worded, that made it unlawful to pay for a referred claim.

Mr Concannon: Yes.

Mr David Shoebridge: Do we just beef up that regulation to make it work and then that is what they audit?

The Hon. Lynda Voltz: I keep getting phone calls from somebody about car accidents and I hang up on them; it is now clear to me why they are ringing. They would obviously keep records that they had rung someone and they would get a payment. There would be some record of the fact that they had –

Mr Concannon: You would certainly hope so. I would thoroughly support it being audited by someone – whether that be the Legal Services Commissioner or SIRA, I don't think it much matters.

The Hon. Lynda Voltz: I have been wondering about the phone calls that I occasionally get.

The Chair: The telemarketers are doing the cold-calling, aggregating the data and then selling it to law firms.

The Hon. Lynda Voltz: But you would have a record of that transaction.

The Chair: If they buy it, that is correct.

Mr David Shoebridge: Perhaps you could also consider that question on notice and provide a response about whether it is SIRA or both SIRA and the Legal Services Commissioner.

Mr Concannon: Sure."

We understand the essence of this question is whether it is the State Insurance Regulatory Authority ("SIRA") or the Legal Services Commissioner who is responsible for the behaviour of law firms who accept referrals from telemarketers who are cold-calling injured persons and then aggregating the data and selling it to law firms.

The body responsible for investigating complaints, in the first instance, is the Legal Services Commissioner. The Commissioner then has the discretion of referring complaints for investigation by the Law Society of NSW or the NSW Bar Association.

The main provision applicable is cl 24 of the *Motor Accidents Compensation Regulation 2015*, which commenced on 1 April 2015. This clause provides that "a legal practitioner has a duty not to receive consideration for referring a claimant for the purposes of a service being provided in respect of the claimant's claim", or "to give consideration for the referral of a person in relation to a claim". It is not an offence to fail to comply with this provision, but such a failure may be considered as unsatisfactory professional conduct or professional misconduct.

Aside from any consideration of the concept of professional misconduct at common law,[1] ss 296 to 298 of the *Legal Profession Uniform Law* (NSW) ("*Uniform Law*") provide inclusive definitions of both professional misconduct and unsatisfactory professional conduct.

Any subsequent disciplinary proceedings, including the cautioning or reprimand of a legal practitioner, are undertaken by the relevant "designated local regulatory authority" (see Chapter 5 of the *Uniform Law)*. For complaints investigated by the Law Society of NSW, it is, generally speaking, the Council of the Law Society which is the responsible body. Serious conduct matters are normally referred to the NSW Civil and Administrative Tribunal. That Tribunal can make such order as it sees fit under s 302 of the *Uniform Law* except that, unlike the power it formerly held under s 562 of the *Legal Profession Act 2004* to remove a legal practitioner's name from the roll, it may only recommend to the Supreme Court that such removal take place (s 302(f)).

In addition to cl 24 of the *Motor Accidents Compensation Regulation 2015*, there are a number of provisions in the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015* which may be breached during the course of a cold call referral which is then sold on to a law firm. These include the following:

(a) Rule 12.1 states that a solicitor must not act for a client where there is a conflict between the duty to serve the best interests of a client and the interests of the solicitor. As part of this obligation, subrule 12.4.4 requires solicitors to inform clients when they pay referral fees.

[1] See *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750 per Lopes LJ – there is no common law definition of unsatisfactory professional conduct.

(b) Rule 9 provides that a solicitor is required to maintain the confidentiality of client information. Depending upon the information provided to the telemarketer as part of the referral arrangement, there could be a breach of this Rule. If the solicitor is responsible for the cold calling himself/herself, and refers the information onto another lawyer, then there may be a breach of the confidentiality provisions in this Rule.

(c) Rule 34.2 states that a solicitor must not seek instructions for the provision of legal services

> ... in a manner likely to oppress or harass a person who, by reason of some recent trauma or injury, or other circumstances, is, or might reasonably be expected to be, at a significant disadvantage in dealing with a solicitor at the time when the instructions are sought.

Rule 2.3 states that a breach of the Rules "is capable of constituting unsatisfactory professional conduct or professional misconduct, and may give rise to disciplinary action by the relevant regulatory authority".

"The Hon. Daniel Mookhey: In my first question as to whether or not you think claims harvesting is a legitimate business model, we would have to take a view on that?

Mr Concannon: Yes.

Mr David Shoebridge: It could be done pretty much straight away through regulation.

Mr Concannon: Yes, but you have to look at it from a philosophical standpoint: Do you want to demonise them and have these claims harvesters or CMCs, whatever you want to call them, out there doing these things in a dark cloak and dagger sort of way, or do you want to regulate them? I suppose as politicians you have to make that decision.

The Hon. Daniel Mookhey: Are you acquainted with the United Kingdom model of regulation on this?

Mr Concannon: To a certain extent. I have been involved with the fraud task force regulatory and legislation reform subgroup and there have been some proposals that emanated from that where that issue became the subject of focused attention, yes.

The Hon. Daniel Mookhey: It would be great if you could provide on notice any views you might have on the United Kingdom scheme as a regulatory model.

Mr Concannon: I do not have any direct views myself; I am only sending on information that I have got from others, I am happy to try to as best I can."

The body called the Claims Management Regulator in the United Kingdom is a unit of the Ministry of Justice and it regulates so-called claims management companies ("CMCs").

Any claims management company working in the personal injury sphere is required to be authorised by the Claims Management Regulator.[2]

It is an offence to provide referral services for a personal injury claim without being authorised unless the business is exempt.[3] Exempt businesses include organisations such as insurance brokers or insurance companies and solicitors and barristers.

The list of registered claims management companies is readily available on the website of the Regulator. There are set complaint procedures related to the conduct of claims management companies. As from 1 October 2014, all authorised CMCs must follow a Code of Conduct known as the *Conduct of Authorised Persons Rules 2014*.

By way of further assistance, we attach the following:

1. Slides from a workshop held on 31 May 2016 with a presentation by UK Insurance Fraud Expert (David Hertzell).

2. 'Think Piece' article by David Hertzell titled 'Insurance Fraud Task Force: The Problem and the Overall Conclusions', dated March 2016.

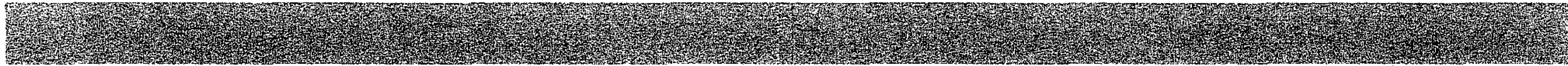
There is further information with regard to the work of the Insurance Fraud Task Force available on the website for the Task Force at www.gov.uk/government/groups/insurance-fraud-taskforce.

Thank you for the opportunity to provide the Standing Committee with responses to these questions on notice. Should you have any questions or require further information, please contact Meagan Lee, Policy Lawyer on or email.

Yours faithfully,

Gary Ulman
President

[2] UK Ministry of Justice, *Guidance: Claims management company regulations, guidance and legislation* (23 January 2015) <https://www.gov.uk/guidance/claims-management-company-regulations-guidance-and-legislation>.
[3] Ibid.



GOVERNMENT INSURANCE FRAUD TASK FORCE

2016

The size of the problem

- ABI estimate over £3bn per annum 2015.
- Educated guess – nobody knows.
- Over £200m spent on prevention (and rising).
- Other business cost – e.g. retailers.
- National cost – benefits, health service, emergency services, courts.
- Ultimately all paid for by honest policyholders and taxpayers – not by insurers!

Sponsorship

- Government (Treasury and Ministry of Justice) had three key concerns:-

1. Cost. Fraud adds to costs of all policyholders. Premiums increased to pay for claims and fraud prevention.

2. Fraud is socially corrosive. Undermines social cohesion. If society moves from “trust” to “verify” all lose.

3. Insurance fraud funds other crime.

Membership

- Core members were:- ABI, IFB, BIBA, FOS, CAB, FSCP + independent chair.

- Task force was assisted by a wide advisory group. Flexible membership from law, academia, insurance industry, regulators, police, loss adjusters and others.

- Task force established personal injury working group. Members were:- MASS, NAHL, APIL, Covea, Aviva, BLM law.

Timetable and Topics

- Established in January 2015.
- Interim report March 2015
- Concluded December 2015 - published Jan 2016.
- Personal Injury working group reported to task force July 2015.
- Task Force had limited time. Therefore focused on four broad topics covering both claims and application fraud:-

1. Types of fraud and fraudsters
2. Drivers of policyholder behaviour
3. Regulators, processes and deterrents
4. Data.

Working methods

- Regular discussions – minuted and available on web site.
- Regular minuted meetings with advisory group.
- Meetings with stakeholders. Very wide range to include insurers, regulators, claimant representatives, price comparison companies, service providers and others.
- Consultation. In addition to above, March 2015 interim report asked 28 questions.

Initial Findings

- Whilst there are arguments over exact statistics there is a clearly a significant problem.
- No simple profile of “fraudster” – people can move between categories.
- Broadly:-

1. Organised criminal activity
2. Opportunistic but pre-meditated
3. Opportunistic “spur of the moment”

- Then grey area of negotiation, error and misunderstanding.
- Intent is key.
- Different deterrents apply.

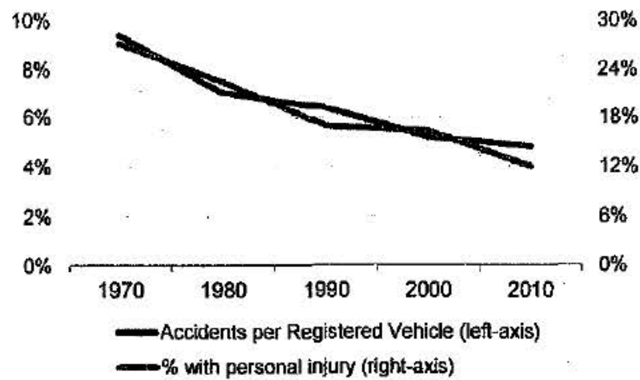
Initial Findings

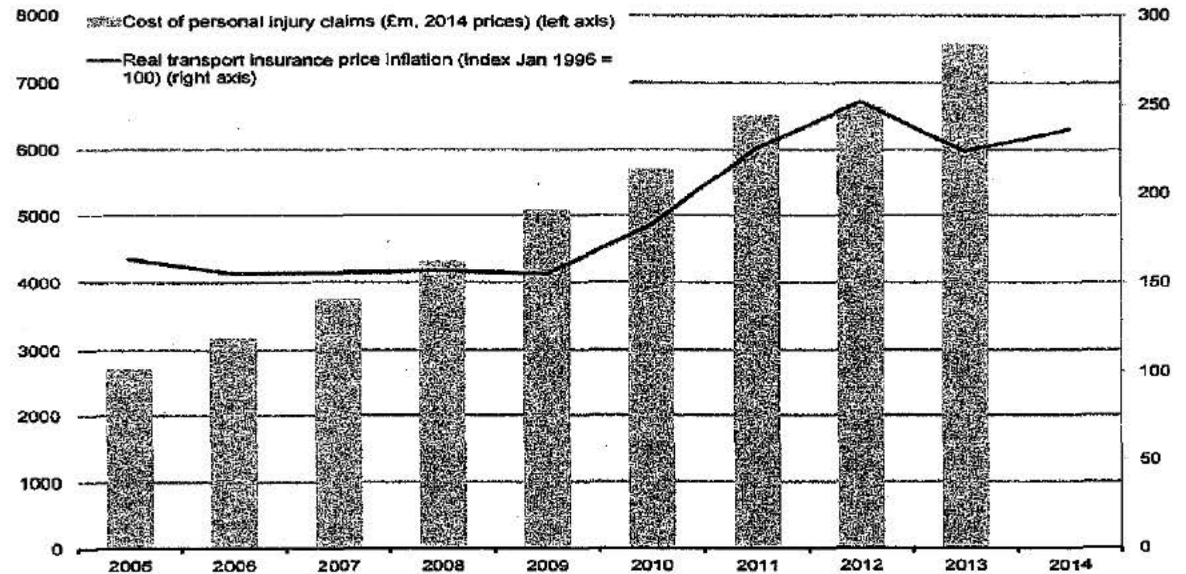
- Policyholder misunderstanding + perception a common and victimless crime + public disenchantment with business + industry has negative press = problem.
- IT – less human interaction.
- Exaggeration is acceptable – fine line negotiation/dishonesty. Applies both ways.
- Perception insurers will underpay or rely on “small print ” to avoid claim.
- Unlikely to be caught – “easy money”.
- No or low penalty – not really true.
- Encouragement of fraud by nuisance calls and professional enablers.

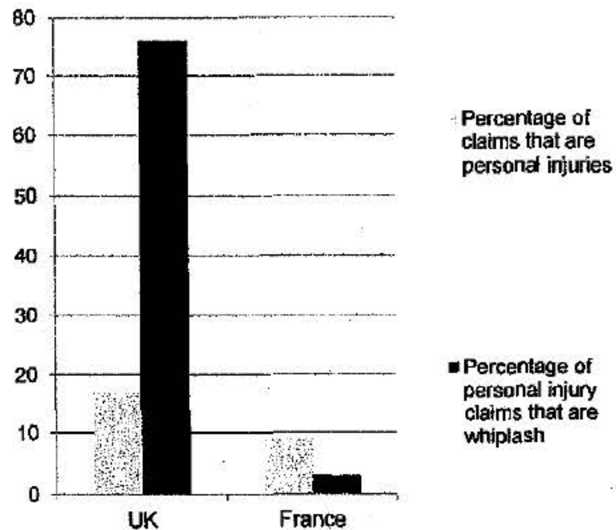
Personal Injury

- UK personal injury market is inconsistent with comparable jurisdictions for low value/higher frequency claims.
- Supplier market evolved – CMC's and "nuisance call" providers.
- Accident from "misfortune to business opportunity" – but importance of access to justice for honest policyholders.
- Challenges over regulation of lawyers and CMC's.
- Importance of this specialist area reason for separate working group.
- N.B. - Fraud is not confined to Personal Injury – includes arson, home, travel, health – and some commercial.

Comparisons







Source: CEA, 2004

Source: Frontier analysis of Datamonitor data for the claims (deflated to 2014 prices) and Eurostat for transport insurance price inflation data

Data

- Consultees regard effective use of data as key in combatting application and claims fraud.
- General view that data is available but not used as effectively as possible.
- Fragmentation of data bases/commercial interests.
- Not all potential users contribute or pay.
- Extend access – and on what terms?
- Incentives? E.g. price comparison knowledge.
- Not just insurance fraud – outside interest e.g. banks, government.
- Privacy and data protection. More clarity would help.

Industry challenges

- Data and fraud prevention – common good or competitive advantage? Silos.
- Data protection issues and understanding – internal and external.
- Consumer education – language and style.
- Data management – arson?
- Personal injury interests – ABS's.
- Accounting.
- Service provider fee arrangements – incentives?
- Liaison with other financial service sectors.
- Resources and time – senior management commitment.

Recommendations

- **Group 1**. Series of recommendations to improve consumer understanding of insurance (e.g. promote CII Made Simple). Include better promotion of good practice by ABI.
- ABI, IFED, IFB communication strategy to improve consumer understanding of insurance fraud and consequences including increased promotion of IFB "Cheatline". N.B. external channels effective. Funding?
- ABI/CII to commission research into consumer behaviour.
- ABI to promote counter fraud best practice.
- In line with FCA financial crime requirements fraud should be board level responsibility.

Recommendations

- **Group 2** Data issues including:
- Standard definition of fraud.
- Better participation in ABI annual fraud survey.
- Ensure data is accurate – proper checking and appeal procedures in place for consumers.
- Increasing membership of central schemes e.g. MyLicence, CUE.
- ICO guidance on data sharing (n.b. new EU regs).
- IFB to have access to claims portal data.
- IFB to develop into central data hub and data coordinator.
- Clarify weak data (arson) and plan for emerging risks.
- Aggregator/Insurer data sharing to improve – regulation?

Recommendations

- **Group 3** Regulators
- ICO guidance on data sharing and consumer education on "consent".
- Improved liaison amongst diverse group – IFB role.
- Increase some powers e.g. SRA.
- SRA to work with CMR to enforce referral fee ban.
- Professional enablers – senior level overview e.g. IFB/SRA.
- CMC's – Taskforce recommends stronger regime and lists concerns but no specific recommendations as separate review.

Recommendations

- **Group 4.** Personal Injury
- ABI should discourage inappropriate pre-med offers.
- Government (MoJ) to consider how to discourage late claims.
- Government to consult on mandatory statement of referral source on CNF's.
- Claimant and defendant representatives to agree standard insurer letter to confirm claimant instructions.
- ABI/IFB to clarify what direct contact with represented claimant is appropriate.
- Government develop strategy to tackle nuisance calls.
- Government (MoJ) to consider improved process for NIHL claims including fixed recoverable costs (CJC).

- Government to establish a legacy vehicle to oversee progress on recommendations through annual reports.

- Probably the most important recommendation of all!

Glossary

- ABI – Association of British Insurers
- APIL – Association of Personal Injury Lawyers (claimant lawyers)
- BIBA – British Insurance Brokers Association
- CAB – Citizens Advice Bureau
- CJC – Civil Justice Council
- CMC – Claims Management Company
- CNF – Claim Notification Form
- CUE – Claims Underwriting Exchange (claims database)
- FOS – Financial Ombudsman Service
- FSCP – Financial Services Consumer Panel
- GMC – General Medical Council
- ICO – Information Commissioner's Office
- IFB – Insurance Fraud Bureau
- IFED – Insurance Fraud Enforcement Department (police department)
- IFR – Insurance Fraud Bureau
- MASS – Motor Accident Solicitors Society (claimant lawyers)
- MID – Motor Insurance Database
- NAHL – National Accident Helpline (claimant lawyers)
- NIHL – Noise induced hearing loss
- Ofcom – Office of Communications (telecoms regulator)
- SAFO – Specified Anti Fraud Organisations (data sharing with public sector)
- SRA – Solicitors Regulation Authority

Thinkpiece

CII

Number 123 March 2016

INDEPENDENTLY PROMOTING DEBATE AND FRESH THINKING IN THE FINANCIAL SERVICES INDUSTRY

Insurance Fraud Task Force: the problem and the overall conclusions

David Hertzell
Chair, Insurance Fraud Task Force

- Insurance fraud is a costly phenomenon: in 2015 the ABI estimated it cost the sector about £3bn a year, and given the highly competitive market, insurers also spend an estimated £200m a year combating it.
- The Government established the Insurance Fraud Taskforce in January 2015 on the basis of three major concerns: the cost for honest policyholders, the erosion of social cohesion and trust if fraud becomes widespread, and the diversion of the proceeds of fraud to other criminal activity.
- The Taskforce made a total of 26 recommendations and a series of advisory comments, all across four broad topics: policyholder understanding and education, the use and reliability of data, the role of regulators and some specific personal injury issues.
- There is no simple profile of a fraudster. However fraudsters normally fall into two broad categories, organised criminals and opportunistic chancers. There is also a grey area of negotiation, error and misunderstanding which may not be fraudulent but shows many similar characteristics.
- We have an evolved privatised supplier market with specialist law firms, claims management companies and medical experts. An accident, as one consultee described it, has gone from being a misfortune to a business opportunity.
- The Taskforce recognised the importance of ensuring access to justice and that in order to achieve this claimant organisation must earn a reasonable profit in the absence of legal aid.

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CII Introduction: with an estimated cost of £3 billion per year, plus another estimated £200 million per year spent combating it, fraud has been the bane of the general insurance sector. In this Thinkpiece, former Law Commissioner and now Chair of the CII Professional Standards Board David Hertzell returns to the Thinkpiece series to describe his recent work as Chair of the Insurance Fraud Task Force, which has been tasked by the Government to develop concrete proposals on how insurance fraud could be tackled.

Fraud may be as old as insurance itself. However in the early days the discipline of mutuality and personal contact probably discouraged dishonesty. Now most insurance transactions are automated and depersonalised. It is much easier to steal from a computer than from a person.

However there is no firm evidence as to the overall amount of insurance fraud or whether the position is improving or deteriorating. That is probably inevitable as the purpose of fraud is to obtain money by deception without detection. In 2015 the ABI estimated the total amount of fraud at £3bn per annum. That is no more than an educated guess. In a highly competitive market insurers spend money on fraud prevention and detection, possibly as much as £200m per annum – another educated guess. Whether the real figure is half of these numbers or twice as much it is still a lot of money. Some associated costs such as benefit fraud, unnecessary NHS costs and court costs fall outside insurance and are paid for by the taxpayer. Other businesses such as utility companies and retailers have experienced similar patterns of fraud from road traffic claims and bear similar costs. These costs are all ultimately paid for by honest policyholders, customers and taxpayers.

The Insurance Fraud Task Force

The Government established the Insurance Fraud Taskforce in January 2015 on the basis of three major concerns: the cost for honest policyholders, the erosion of social cohesion and trust if fraud becomes widespread and the diversion of the proceeds of fraud to other criminal activity. There may have been a fourth. It is difficult for insurers to deal with the problem alone as many of those involved in the wider picture such as telecom companies or professional regulators would not perceive insurance fraud as a particular issue for them.

The core members of the Taskforce were the ABI, the IFB, BIBA, the FOS, the CAB and the Financial Services Consumer Panel (FSCP). The members broadly balanced insurer and consumer interests. The Taskforce was assisted by a wider advisory group with a membership including regulators, loss adjusters, lawyers, the police, academics as well as insurers and brokers. The Taskforce established a personal injury working group whose members balanced claimant and defendant interests. The Taskforce published an interim report in March 2015 and a final report in January 2016. The personal injury group produced a report to the Taskforce in July 2015. Over the course of 2015 members of the Taskforce met a wide range of consultees and attended many meetings and conferences. The Taskforce made a total of 26 recommendations and a series of advisory comments. The report and minutes of meetings are available on the Taskforce website: www.gov.uk/government/groups/insurance-fraud-taskforce. The problem of insurance fraud will not be solved in a year but the Taskforce drew together a wide range of interested parties and views.

The criminals and the chancers

The Taskforce was able to identify some general themes. There is no simple profile of a fraudster. However fraudsters normally fall into two broad categories; organised criminals and opportunistic chancers. There is also a grey area of negotiation, error and misunderstanding which may not be fraudulent but shows many similar characteristics. It was recognised that different deterrents apply to the different types of fraudster and that fraud can occur either at the application or claims stage. Indeed there is often a link between the two.

Many opportunistic fraudsters were "getting their retaliation in first" or claiming to seek compensation from an unfair system. The problem is not helped by a generally poor understanding of insurance and policy terms.

A great deal of opportunistic fraud takes place in a difficult climate for business and for financial services.

Consumers are disenchanted with business following the financial crash and media stories about price obfuscation, executive excess and tax avoidance. Financial services generally are not highly regarded and there is a perception that insurers will "rely on the small print" to avoid paying claims. However unfair this might be academic research shows that many opportunistic fraudsters were "getting their retaliation in first" or claiming to seek compensation from an unfair system. The problem is not helped by a generally poor understanding of insurance and policy terms.

Research reveals that a major cause of dispute with policyholders was that the consumer bought the wrong product or did not understand the terms of their policy. In addition some opportunistic fraudsters thought they were unlikely to be caught or that if they were nothing much would happen.

Much reported fraud in the UK involves personal injury and in particular road traffic claims. The personal injury market in the UK is unlike that in other European countries especially for high frequency low value claims. We have an evolved and developed privatised supplier market with specialist law firms, claims management companies and medical experts. An accident, as one consultee described it, has gone from being a misfortune to a business opportunity.

The Taskforce recognised the importance of ensuring access to justice and that in order to achieve this, claimant organisations must earn a reasonable profit in the absence of legal aid. Nonetheless the Taskforce was made aware of difficulties in the regulation of law firms and claims management companies (CMCs), the problems of cold calling and claims farming. The Taskforce did not consider that its terms of reference, the members' expertise or the composition of the consultees were an appropriate basis to recommend changes to the English legal system particularly as changes would affect honest and dishonest alike. However fraud, especially organised fraud, took place within the framework of the existing system and therefore the Taskforce commented on those areas the government may need to address.

Main themes of recommendations

Following discussion with consultees and taking into account the time available the Taskforce divided its work and recommendations into four broad topics: policyholder understanding and education, the use and reliability of data, the role of regulators and some specific personal injury issues.

Policyholder understanding and education

A key observation was that improving consumer understanding of insurance is a very long term project. However some useful initiatives have already been noted:

- the CII *Made Simple* project and other efforts to improve the presentation of information to consumers. These should remain a priority: not only do they improve the reputation of insurance but they also counter the victim mentality that fuels some opportunistic fraud;
- the IFB *Cheatline* can make honest policyholders aware that they might be subsidising the dishonest;
- there exists research showing that the design and content of document or on-line material can incentivise or discourage policyholder honesty.

Further research should be undertaken by the ABI and CII into these areas as well as behavioural economics. As a matter of good practice the Taskforce considered that fraud should be a senior management or board issue in order to ensure that effort and resources are devoted to prevention over the longer term.

The use and reliability of data

The effective use of data is key to combatting both application and claims fraud. However although it was recognised that much data was of high quality, there was a concern that it was not used effectively and that some data was inaccurate. Even where data is available, take up was sometimes low and it was not always shared effectively especially with those outside insurance such as the government or banks. A number of recommendations were posed to improve the take up and sharing of data, particularly suggesting proper systems to check and appeal data. This is especially pertinent given the public suspicion of "big data".

Take-up of critical schemes such as *MyLicence* or CUE should be increased and some thought should be given as to how that could be expanded beyond insurers, on what basis should access be given and how the cost should be funded. The Taskforce thought that the IFB could develop a role as a central data coordinator and that weak data sources such as that for arson should be improved. In order to facilitate data sharing the Taskforce considered the Information Commissioner's Office (ICO) could issue some clear and tailored guidance on data sharing for the insurance sector.

The role of regulators

Several regulators across different sectors have a relevance to insurance fraud even though this may be outside their core concerns. That ranges from telecom regulators and nuisance calls to professional bodies such as solicitors and doctors and commercial concerns such as CMCs. There should be better coordination amongst regulators on fraud facilitated by the IFB and a greater emphasis on fraud prevention amongst professional regulators again with information and actions coordinated at a senior level by the IFB. In some cases, that may also require enhancement of the regulator's powers. Whilst it was appreciated that only a very small minority of professionals facilitated insurance fraud, their capacity for widespread harm is considerable. Their involvement also caused significant reputational damage to the profession concerned.

Specific personal injury issues

No recommendations were made about the current English and Welsh legal system. However the Taskforce made a number of suggestions within the existing framework. The ABI should discourage the use of inappropriate "pre-med" offers. Whilst a quick claims settlement might provide a short term benefit in the long run over use encourages the perception of "easy money" from insurers. The government should consider how to discourage late claims for minor injuries as whilst such claims could be genuine many seem to be the product of claims farming. The government should also consult on a mandatory statement of referral source on Claim Notification Forms and should consider how to implement an improved process for noise induced hearing loss claims where costs have risen steeply in relation to compensation recovered.

It was surprising to learn that some claims seem to be progressed without any proper authority from the alleged claimant to their representatives.

Surprisingly some claims seem to be progressed without any proper authority from the alleged claimant to their representatives. It was recommended that a standard letter should be agreed by claimant and defendant organisations allowing insurers to contact a represented claimant direct to confirm that instructions have actually been given to bring a claim.

The Taskforce recommendations were based on widespread consultation and the Taskforce is optimistic that some positive steps will be taken by all concerned to counter what is a long term problem. However the Taskforce is also aware that many of those involved work outside insurance and that the pressures and exigencies of everyday business life mean that fraud even for insurers may fall down the priority agenda. In order to ensure that positive activity is sustained perhaps the most important recommendation made by the Taskforce is that a legacy body should be established to oversee progress and report to the government.

Fraud is socially corrosive and costs honest policyholders a lot of money. Fraud can be effectively combatted but only if effort and resources continue to be devoted to detection and prevention over the long term.

David Hertzell was a Law Commissioner for Commercial and Common Law in the period 2007-2015 and was a leading force on the implementation of both consumer and commercial insurance contract reform. He is now at law firm BLM and insurance consultants Mactavish where he is helping to inform educate and prepare the firms' customers in advance of the implementation of the Insurance Act. David is currently the President of the British Insurance Law Association, Chair of the CII Professional Standards Board and a member of the AIRMIC Board. He is a pension fund trustee and sat as the independent member on the audit and risk committee of the Judicial Appointments Committee. He was awarded at the British Insurance Awards 2015 for making a major contribution to the development and reputation of general insurance claims in the UK.