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"Fraud" and fraudulent claims

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Abstract

In this paper we examine the meaning of the word "fraud" as it is applied in the context of fraudulent claims.[1] We consider whether the definition and the legal treatment of fraudulent claims are appropriate. We seek to argue that the law is too rigid and that some judicial discretion would be a worthwhile modification. We also suggest that the approach of the English and Scottish Law Commissions, in their December 2011 Joint Consultation Paper[2] demonstrates insufficient flexibility. The paper includes some reference to the position in Australia under s 56 of the Insurance Contracts Act 1984 (Cth), under which the law is, in certain circumstances, able to allow the punishment to fit the crime, a principle which in our view could be extended. We have no sympathy with fraudsters, and we do not underestimate the costs of fraud for the insurance industry and for honest claimants[3] but, for the reasons indicated in our paper, we are wary of absolute rules and we suggest that fears that a more generous approach might amount to a fraudster's charter are somewhat overstated."

The legal basis for the insurers' rights and remedies

As a prelude to our analysis, it is necessary initially to identify the underlying common law principle which allows insurers to refuse to pay fraudulent claims. Early statements, including the oft-quoted view of Mr. Justice Willes in *Britton v Royal Insurance Co*[4] that a fraudulent claims clause which states that the assured is to forfeit all benefit under the policy is "in accordance with legal principle and sound policy" entirely begs the question as to what "forfeit all benefit" actually means.[5] The traditional view is that the duty not to make a fraudulent claim is an element of the general duty of utmost good faith set out in s 17 of the Marine Insurance Act 1906. If that is right, then any breach of duty has the consequence of allowing the insurers to avoid the policy *ab initio*, i.e. from the beginning.[6]

The notion that there can be a pre-contractual remedy for a post-contractual infringement[7] has fallen out of favour,[8] and the balance of authority now supports the proposition that the duty not to make fraudulent claims is a contractual one which is independent of notions of utmost good faith and which accordingly attracts contractual remedies.[9] Those remedies allow the insurers to refuse to pay the fraudulent claim itself, and it is generally assumed that they also have the right to terminate the contract as from the date of the fraud.

This issue was discussed but not resolved in *Axa General Insurance v Gottlieb*[10] as the policy year in which the fraud occurred had naturally come to an end and the point did not arise for decision. There is, however, some support for the right to terminate in *Orakpo v*

Barclays Bank Insurance Services Co Ltd[11] on the basis that any fraud in making the claim amounts to a repudiation of the entire policy. It thereby confers an option on the insurers to accept the repudiation and bring the relationship to an end. If such a right exists and is exercised, it would mean that valid claims made prior to the fraud[12] remain payable and any payments actually made for previous claims in the policy year cannot be recouped.[13] There is no suggestion in the authorities that fraud has an automatic terminating effect.

Accordingly, if any part of a claim is fraudulent, the entire claim is lost. Quite why this should be so is, at least as a matter of legal doctrine, to some extent uncertain.[14] What is undoubted, however, is that severance of genuine from fraudulent loss is rarely possible.

It is of course open to insurers to specify their own contractual solutions where a fraudulent claim has been made, and these may[15] have more drastic consequences than the common law.[16] However, we will proceed on the assumption that the duty not to make a fraudulent claim derives from contract and gives rise to contractual rather than special remedies.

Dishonesty and fraud

The classic definition of fraud was provided by Lord Herschell in *Derry v Peek*:[17] "Fraud is proved when it is shown that a false representation has been made (i) knowingly (ii) without belief in its truth or (iii) recklessly, careless of whether it be true or false." *Derry v Peek* was a case involving fraudulent misrepresentation outside the context of insurance, although that definition has been applied in insurance decisions.[18] More recent cases introduced the concept of utmost good faith under s 17 of the Marine Insurance Act 1906 into the discussion of fraudulent claims – *The Litsion Pride*[19] and *The Captain Panagos*[20]. They gave rise to the argument that the insurers could avoid the policy by proving something less than fraud in the *Derry v Peek* sense.[21] However, with the demise of those cases it now appears that *Derry v Peek* remains the governing decision. That said, the application of *Derry v Peek* to insurance cases is not straightforward.

Insurance cases decided before *Derry v Peek* referred to fraud in terms of a statement which was "wilfully false in any substantial respect"[22] and to a fraudster as one who "knowingly preferred a claim he knew to be false or unjust"[23]. The statutory definition of fraud in the Fraud Act 2006 refers to a false representation which occurs where a person dishonestly makes a false representation and intends by making the representation to make a gain for himself or another, or to cause a loss to another or to expose another to a risk of loss.[24] *Twinsectra Ltd v Yardley*,[25] now the leading authority on knowing assistance for breach of fiduciary duty, sought to clarify the meaning of dishonesty. Lord Hutton stated in that case that "before there can be a finding of dishonesty it must be established that the defendant's conduct was dishonest by the ordinary standards of reasonable and honest people and that he himself realised that by those standards his conduct was dishonest". The modern gloss on the law accordingly recognises an objective and a subjective test. That definition was applied by Mr. Justice Eder in *Aviva Insurance Ltd v Brown*[26] to support the

view that for a misrepresentation to be fraudulent, the assured himself had to realise that his conduct was dishonest. Certainly there is authority for the proposition that even a grossly exaggerated claim is not necessarily fraudulent.[27]

Recklessness and fraud

Where does recklessness fit into this? It was noted above that, according to Lord Herschell, an assured who makes a statement recklessly can have no real belief in the truth of what he has said, and in this sense recklessness is an instance of type (ii) fraud. That is an extreme possibility. In other cases, recklessness could amount to nothing more than indifference by the assured as to the truth or falsity of his statement, perhaps in the belief that it does not much matter in the context of the claim, and that is not necessarily tantamount to dishonesty. One of the essential elements in deciding whether a claim is fraudulent is the intention to defraud and mislead the insurers and it is uncertain whether recklessness in any form, whether culpable or innocent recklessness, evidences such an intention. It is not obvious therefore, that recklessness satisfies the dishonesty test suggested in *Twinsectra*.

Nevertheless, the modern tendency is to treat recklessness as an aspect of fraud. The courts may, if not satisfied that the conduct is deliberate, refer to it as "at the least, reckless".[28] Lord Justice Mance (as he then was) explained in *Agapitos v Agnew* that "A fraudulent claim exists where the insured claims, knowing that he has suffered no loss, or only a lesser loss than that which he claims (or is reckless as to whether this is the case)". Lord Hobhouse in *The Star Sea*[29] referred to recklessness as a decision by the assured not to enquire into the true facts, fearing that the outcome would be unfavourable for him. He added, however, that that the position might be different if the assured did not enquire because he was too lazy or believed that there was nothing potentially amiss.[30] There may, therefore, be degrees of recklessness falling on either side of the dividing line between negligence[31] and fraud.

Materiality and inducement

For an insurer to refuse payment of a fraudulent claim, the relevant fraud needs to be material. The concept of materiality in the context of fraudulent claims is not the same as its equivalent in the pre-contract utmost good faith context.[32] It can rather be considered as a "substantiality" requirement. English law is clear that there is a quantitative element to fraud,[33] but it is less certain whether substantiality relates to the quality of the assured's conduct. That may be a live issue where the alleged fraud does not constitute overvaluation, but rather some act or statement designed to induce payment by the insurers. Lord Justice Millett suggested in *Galloway v Guardian Royal Exchange (UK) Ltd*[34] that fraud is substantial if, "taken in isolation, the making of that claim by the insured is sufficiently serious to justify stigmatising it as a breach of his duty of good faith so as to avoid the policy"[35]. This can presumably be dismissed, given that fraudulent claims and good faith are now recognised as separate concepts.

That aside, what is apparent from the cases is that fraud may be substantial even though it has no financial value and does not cause loss to the insurers, and it was said in *Agapitos v Agnew*[36] that a lie would be substantial if it would objectively yield a not insignificant improvement in the assured's prospects of obtaining settlement or winning a trial. It is irrelevant that the lie cannot as a matter of fact be relevant to the claim.[37] Two examples suffice. In *Aviva Insurance v Brown*[38] the assured's property had suffered damage flowing from an insured peril and he had to look for alternative accommodation. In a letter that he sent to the insurers, he informed them of accommodation that he thought suitable, but he did not disclose that he was its owner. In the event he chose not to occupy it. The representations were held to amount to substantial fraud[39] even though they did not affect, and could not have affected, the handling of the claim. Similarly in *Sharon's Bakery (Europe) Ltd v Axa Insurance plc*[40] the assured, needing to prove title to damaged machinery but unable to do so, presented a fraudulent invoice to the insurers in order to substantiate an otherwise valid claim. The lie of the assured was held to be substantial and the claim was forfeit although again there was no real significance in use of that fraudulent device.

As far as inducement is concerned, in contradistinction to the pre-contractual position, a statement which is fraudulent retains that quality even though it actually had no inducing effect upon the insurers in deciding whether or not to pay a claim.[41] If the assured rightly or wrongly believed that his statement could not have an inducing effect then he has not been fraudulent in the first place, but if he believed that it could have such effect then his conduct would be classified as fraudulent even if he was wrong and the insurers actually knew the truth or regarded the misstated fact as irrelevant to their decision. That in turn means that *Danepoint Ltd v Underwriting Insurance Ltd*[42] is[32] incorrectly decided. In that case, following a fire at the assured's block of flats, exaggerated claims for repair costs were submitted. The claim was held not to be fraudulent because the insurers, through adjusters, had themselves examined the premises and made their own assessment of the costs and had thereby rejected that of the assured.

The principle that no inducement is required leads to the further proposition that fraud cannot be retracted. That was specifically stated to be the case by Mance LJ in *Agapitos v Agnew*,[43] a point confirmed by him speaking for the Privy Council in *Stemson v AMP General (NZ) Ltd*,[44] a case in which the assured sought to withdraw a fraudulently exaggerated claim after the insurers had discovered the fraud.

Classes of fraud

One of the central themes of our argument is that the all or nothing rule does not adequately distinguish between the various classes of fraud conveniently classified by Mance LJ in *Agapitos v Agnew*.[45] Our argument is that each merits discrete treatment.

The first class arises where the assured has not suffered a fortuity giving rise to loss: either there is no loss at all, or the loss is the result of the deliberate act of the assured.[46] Plainly the assured should recover nothing in either situation because there is no loss.

The second class consists of exaggerated claims, where the assured has suffered some loss but not as much as the amount he is seeking to recover. That may involve the overvaluation of lost property, or the embellishment of what has been lost by the addition of other property. This is the paradigm situation in which the all or nothing rule hits home. But not every overvaluation is fraudulent. The *Twinsectra* test requires that the assured appreciates his own dishonesty, and many assureds are rightly or wrongly of the view that they will not be offered the full amount of their loss and so some creative claiming is necessary. The courts have recognised this possibility and there is now a body of authority accepting that some degree of overvaluation is not fraud.[47] The greater the exaggeration, the greater the prospect there is of a finding of fraud.[48] Ultimately the judicial approach has become to "consider the fraudulent claim as if it were the only claim and then to consider whether, taken in isolation, the making of that claim by the insured is sufficiently serious to justify stigmatising it as fraud."[49] *De minimis* (i.e. insignificant) fraud is thus to be disregarded.[50]

The bar on severance applies even where the losses are different in nature. It was held in *Danepoint v Allied Underwriting*[51] that there was a single claim following a fire, and it was irrelevant that there were two heads of damage, repair costs and lost rent: fraud in relation to the former tainted the claim in respect of the latter. Similarly in *Direct Line v Khan*[52] the assured under a home and contents insurance policy made a fraudulent claim for lost rent following a fire, and that was held to taint his claim for reinstatement of the buildings and replacement of the contents arising from the same event. In *Yeganeh v Zurich Plc*[53] a combined property and contents insurance was at issue, and it was assumed that a claim under this insurance was a single claim. The assured made a genuine claim for fire damage to his house, costing £270,000 to reinstate, but lost the entire sum because a small part of a contents claim worth in total £12,465 was fraudulent. It is uncertain just how far this goes: if fraud can travel across different sections of the same policy, can it also travel across different policies with the same or indeed a number of insurers?

Mance LJ's third class arises where the assured, having apparently sustained a loss, subsequently discovers that there is no loss at all, or a loss of a smaller amount, but continues to press his claim. This class may, for present purposes, be regarded as indistinguishable from the second class.

The fourth class encompasses that of an assured who makes a claim against his insurers knowing that they have a defence to the claim under the policy. This overlaps with the fifth class, discussed in the next paragraph, but it may be thought not to be an absolute principle. Plainly if the assured has carried out welding operations in breach of policy provisions, and that welding has given rise to the loss, suppression of the welding ought to give the insurers a defence.[54] But is it really the case that an assured has to draw to the insurers' attention a defence which they could easily have discovered for themselves based upon the facts known to them?

The fifth class, which in our view raises the most difficult questions, is the use of fraudulent means or devices by the assured in presenting his claim. What is contemplated here is a loss which is perfectly genuine and which the insurers are liable to pay, but the

assured – through impatience with non-settlement, or perhaps through embarrassment of the circumstances in which the loss has occurred[55] – has misstated[56] facts about his own conduct before or after the loss. The decisions in *Sharon's Bakery* and *Aviva v Brown*, discussed above, demonstrate that policyholders who have done no more than attempt to secure payment which was undoubtedly due to them and in a manner which cannot affect the insurers' interests may lose their claim by virtue of deliberate misstatement.

The consequences of fraud

Few would argue with the need to deter fraud through the removal of all possible incentives for an assured to put forward a fraudulent claim. However, the loss of the entire claim is not necessarily the only means to achieve that end, as is demonstrated by a comparison with the treatment of other forms of fraud in the insurance context. What is apparent is that discretions – even in the case of fraud – are far from unknown in the law.

Where a tort claim is in part valid and in part fraudulent – as where the degree of personal injuries suffered by a person, or indeed the number of victims of a motor vehicle collision – are exaggerated, the law required only the valid part of the claim to be paid. The principle that the entire claim is lost is one unique to insurance frauds. That does not of course mean that a fraudulent claimant will actually walk away from the court with pockets bulging. In *Fairclough Homes Ltd v Summers*,[57] the Supreme Court denied the possibility of the court giving judgment striking out the claim as a whole, other than in exceptional circumstances. It noted, however, that costs could be awarded against the claimant on an indemnity basis and interest could be refused. Any attempt to prove the amount of the valid part of the claim would be looked upon with scepticism, and permission to launch contempt proceedings could be granted by the judge. These devices, coupled with the ability of the judge to refer the matter to the criminal prosecution authorities, mean that a claimant is likely to be substantially worse off as the result of any attempted fraud.

It is also clear that fraud following the commencement of legal proceedings is not to be regarded as any part of the claim but rather is a matter for the court to resolve by the application of its own contempt rules. So if the assured submits false or exaggerated invoices, or misstates the circumstances of the loss, in court proceedings,[58] the insurers cannot deny liability or indeed exercise any other contractual right but are in the hands of the court. Quite what a court would do is uncertain, but it is obvious that it would reach a proportionate decision utilising some or all of the remedies detailed in *Fairclough Homes*. Again, the fraudulent claims rules cannot be relied upon before the assured has made a claim against the insurers, as where circumstances which may give rise to a claim against the assured are notified to the insurers under a professional indemnity policy and there are fraudulent misrepresentations in the notification,[59] or where there is fraud (eg, the submission of forged invoices for payment of the agreed sum) after the claim has been

settled.[60] Each of these possibilities may give rise to the very problems caused by fraudulent claims but the remedies are quite different. In the former case the insurers may well incur substantial expenditure ascertaining the true position and preparing a defence on behalf of the assured which is entirely unnecessary, and their remedy is damages for their loss. In the latter case there is presumably no sanction at all other than that the assured has failed to establish that he has incurred the relevant expenditure and so cannot claim reimbursement.

Some reference may also be made to the law of illegality. An assured who has committed a criminal offence as a result of which he has suffered an insurance loss does not automatically lose his claim. The principle that illegality bars a claim necessarily applies where the assured is seeking an indemnity against a fine or other punishment, but the rule is less rigid where the criminality is simply the backdrop against which the assured has suffered loss, eg, speeding or transporting drugs: he will lose his claim only if his criminality has a close causal connection to the loss and the criminality is of a type which would cause a court to refuse to lend its assistance to the claim.[61] An extreme illustration of the same principle is found in the Forfeiture Act 1982, which removes the right of a beneficiary to derive any benefit from homicide but nevertheless confers upon the court a discretion to allow the claim in full or in part other than in cases of murder.[62]

So it could be argued that loss of the entirety of an insurance claim where part of it is fraudulent is simply one means to achieve the aim of deterrence, and one which is not available in a number of important situations. Proportional remedies are plainly inappropriate where the assured has deliberately caused his own loss. There is room for debate as to whether proportionality should be applied to exaggerated claims, a position which can in any event be reached by treating fraud as *de minimis* and thus to be ignored. However, our point is that the "all or nothing" treatment extends not just to the paradigm cases of manufactured or exaggerated loss, but also affects the rather less heinous use of fraudulent means or devices where it may be thought that a different and less rigid approach is appropriate.

Third party fraud

Where two or more policyholders are insured under the same policy and only one of them acts fraudulently, it is important to have clear rules as to whether and how the innocent policyholders are affected. The law adopts a distinction founded on the nature of the parties' interests rather than on the description of the policy.[63] Where the policyholders have a joint single and indivisible interest over the same subject-matter there can only be one claim and accordingly the fraud of one policyholder is fatal to them all. Where, however, the co-assureds have different and severable interests over the subject-matter insured but are insured by a single document, the policy is composite and each policyholder has a separate claim against the insurers.[64] That said, an innocent composite

assured might lose the claim if the fraudster is regarded as having acted as agent, which was the somewhat inexplicable assumption of the Court of Appeal in *Direct Line Insurance v Khan*[65]. In that case the husband made a fraudulent claim in respect of lost rent and his fraud was held to bar any claim by his wife, not because the policy was joint (which was almost certainly the case) but because the husband was acting as agent for his wife.

Classifying spouses as joint assureds, or one spouse as agent for the other, is scarcely an enlightened approach to relationships, and the balance of recent authority from other common law jurisdictions has rejected it. In *Maulder v National Insurance Company of New Zealand Ltd*[66] the High Court of New Zealand expressed the view that categorising property as "joint" was meaningless and that if an insurer wished to prevent an innocent party from recovering due to fraud by a co-assured, the policy had to state it clearly and unambiguously.[67] That does not of course mean that the innocent co-assured will actually benefit: in cases of deliberate destruction by one co-assured the insurers will, having indemnified the innocent co-assured, possess subrogation rights against the fraudster which, if exercised, will strip the couple of any recovery. But that does not affect fraud of different types, where no subrogation rights will exist.

The innocent may suffer independently of co-insurance principles. If the controller of a company deliberately sets fire to the company's property, the doctrine of attribution[68] will treat the acts of the controller as if they were the acts of the company, thereby depriving other shareholders of the benefits of the policy.[69]

The position in Australia:[70] the remedy for fraud

The Insurance Contracts Act 1984 (Cth), s 56, based upon the recommendations of the Australian Law Reform Commission in its seminal Report No 20, 1982,[71] ("ALRC 20") partially addresses some of the problems identified above. The requirement of the assured to observe utmost good faith is maintained by s 13, but the full consequences of breach of that duty at common law are removed. Section 56(1) accordingly states that if the assured makes a fraudulent claim the insurers may not avoid the policy *ab initio* although they may refuse payment of the claim.[72] This more or less represents the position reached by the common law since the passing of the 1984 Act and also the codification proposals of the English and Scottish Law Commissions. There is no definition of "fraud" in the legislation, and the authorities have accepted the forms of fraud recognised by the common law fall within s 56(1).

Thus the subsection applies to deliberate destruction, as in *Preseed Pty Ltd v Colonial Mutual General Insurance Co Ltd*,[73] exaggerated claims, as in *Entwells Pty Ltd v National and General Insurance Co Ltd*[74] (falsified stock sheets) and also to the use of fraudulent means or devices as in *Tiep Thi To v Australian Associated Motor Insurers Ltd*[75] (misstatement as to the circumstances of the loss). The section also maintains the principle that the fraud need not be material, but it does not enlarge that definition but merely removes the harsh

consequences of the avoidance remedy.[76] Consistently with the common law, a claim is not fraudulent within s 56(1) if made in the course of judicial proceedings on the policy.[77] Section 56(1) does not affect the rules on joint and composite assureds, so an innocent composite assured is able to recover irrespective of the fraud of the other in the absence of agency[78] and one joint assured is barred by the fraud of another.[79] The section leaves untouched the doctrine of imputation, which may preclude a company from recovering where the fraud is that of its controlling mind and will.[80]

As to the continuing relationship between the assured and the insurers, ALRC 20 favoured the position that the insurers should be entitled to cancel both the policy under which a fraudulent claim was made and also any other existing policies to which the assured is party, on the basis that the insurers could not be expected to continue to be in a contractual relationship with a fraudster.[81] These proposals were implemented by s 60(1)(e). This allows the insurers to cancel any existing policy where the assured has made a fraudulent claim,[82] including a claim against some other insurer. The subsection goes much further than the common law, which has yet to recognise a right to terminate any other policy.

There is one further variation, but in favour of the assured. Under s 50(2A)(a)(i) termination takes effect fourteen days after notice of cancellation is tendered, whereas the common law does not impose any notification requirement and termination becomes effective from the date of the fraud. That leaves open the questions whether a genuine claim made between the fraudulent claim and termination becoming effective has to be paid, and whether cancellation removes claims for independent genuine losses occurring prior to the making of fraudulent claim.[83] What is clear is that if the right to cancel is not exercised, the policy remains valid and enforceable, and later claims have to be paid.[84]

The position in Australia: proportional recovery

Section 56(2) states as follows:

> In any proceedings in relation to such a claim, the court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, order the insurer to pay, in relation to the claim, such amount (if any) as is just and equitable in the circumstances.

The court may, therefore, apply a proportional remedy.[85] In doing so the court must, under s 56(3) "have regard to the need to deter the fraudulent conduct and to any other relevant matter." In assessing the impact of these provisions, two questions must be posed: to what classes of fraud do they apply; and do they lay down principles which would not otherwise be reached by the English courts?

Turning to the first of these matters, it is apparent from both ALRC 20 and from the wording of s 56(2) that the targeted fraud is exaggerated claims. The use of fraudulent means and devices was not under consideration, and there was indeed authority for the proposition that if the assured had a valid claim then later fraud could not affect it.[86] Although ALRC 20 was expressed in the general terms that the courts should have discretion to order the insurer to pay a just and equitable amount "in cases where the total loss of the insured's claim would be seriously disproportionate to the harm which the insured's conduct has or might have caused",[87] the section is not drafted in those terms. ALRC 20 gave an example of when its proposals might bite, namely, a claim for contents worth A$3000 coupled with a claim for a non-existent computer allegedly worth A$200.

The Explanatory Memorandum to the 1984 Act gave a further illustration of a claim for lost contents worth A$100,000 along with a claim of A$50 for a non-existent watch. The implementing words of s 56(2), "non-payment of the remainder would be harsh and unfair" presume that the claim is divisible into a fraudulent part, which is minor, and the remainder, which is substantial. It follows that if the fraud taints the entirety of a claim and not just a divisible component of it, the subsection cannot apply. That is the case with the use of a fraudulent mean or device, consisting of a misstatement in the claims process[88] or with a quantum claim which is expressed not in financial terms but by way of comparison with the value of other equivalent property.[89] On the same basis it is unlikely that s 56(2) could be prayed in aid to benefit an innocent joint assured.

However, the divisibility requirement has not always been adhered to in practice, and indivisible fraud which is minor has been regarded as capable of being disregarded. In *Rego v Fai General Insurance Company Ltd*[90] the assured when completing an insurance proposal form, in response to a question about prior losses, suppressed a prior burglary claim he had made against another insurer in respect of the same premises. The assured suffered a further loss and, when he completed the claim form, he falsely answered the same question because he did not want to delay the handling of the claim. It was held that the only part of the claim which was fraudulent was the answer to the question about previous claims, and that this was minimal and could be disregarded under s 56(2) because denial of the claim would be harsh and unfair. It is difficult to see how this can fall within s 56(2) if the indivisibility principle is applied, because the fraud affected the entire claim and there was no issue as the payment of any "remainder". In the same way, the Insurance Ombudsman Service, the forerunner of the present Financial Ombudsman Service, has ruled that a fraudulent statement of the circumstances of the loss is to be disregarded if it is retracted before fraud has been alleged or the claim denied.

Turning to the second of these matters, the Australian courts have been reluctant to exercise their power under s 56(2) to apportion a claim based upon the degree of fraud, and it might be thought that there is little difference in practice between the s 56(2) power of apportionment and the common law *de minimis* principle.[91] Gerald Swaby[92] has

helpfully collated the English and Australian case law, and has noted that the test of substantiality is both relative and absolute, assessed by way of percentage and the figure sought. He also notes that the outcomes in each of the jurisdictions are more or less comparable, although the limited evidence shows that the Australian cases are marginally more generous. In his words, and based on the English cases: "although 2% in itself can appear to be a relatively small *quantitative* amount, anything greater than 2% is capable of being substantial, with 0.3% or below considered to be *de minimis*".[93] As far as Australia is concerned, in *Allianz Australia Insurance Ltd v Douralis*[94] the Supreme Court of Victoria was of the view that a false statement by the assured in the course of the litigation, alleging that anxiety and stress had been suffered would have justified invoking s 56(2), because the amount claimed was minimal and insignificant[95]. In *Entwells Pty Ltd v National & General Insurance Co Ltd*[96] the court's view was that, had the claimant not been a party to the fraudulent setting of the fire, a claim totalling A$520,000, including a genuine stock claim of A$100,000 and a fraudulent stock claim of A$27,000, would have been dealt with under s 56(2) by depriving the assured of the entirety of the A$100,000 stock claim but allowing the remainder. This indicates that fraud of between 5%-12% could trigger the section. By contrast, a claim exaggerated by at least 33% (the fraud being worth at least A$15,000) has been held to be incapable of condonation under s 56(2).[97]

Reforming English law

We have in this paper highlighted the problems which are inherent in the common law all or nothing approach. We have also analysed the Australian reforms and we have concluded that, despite the best of intentions, they achieve relatively little, not the least because some of the issues which have recently come to the fore – and in particular the strict application of the law to fraudulent means and devices – were not in contemplation when they were drafted.

Where, then, should the law go from here? The English and Scottish Law Commissions, in their December 2011 Joint Consultation Paper, felt that only minor tweaking of the common law was necessary and that there was no place for the Australian modifications. The Law Commissions confirmed the current principles that fraud should be an all or nothing defence, that insurers should be permitted to terminate but without prejudice to pre-fraud valid claims and that there should be no right of avoidance *ab initio*. The Law Commissions also recommended that policies should not be allowed to confer greater rights against consumers although express clauses should be enforceable in business policies. The Law Commissions were unconvinced that a case had been made out to reform the law on joint and composite insurance. In our view, however, pulling together the various strands discussed above, the law is unsatisfactory. Our case is based upon the uncertainties of the law and upon the fine distinctions that presently have to be drawn. We would point to the following specific issues and we suggest possible reforms.

First, the definition of fraud is of itself uncertain. There is some protection for an assured who has made a false statement, in that the court may undertake a close examination of the assured's motives for making an uncorroborated statement and conclude that the conduct should be classified as merely lazy or negligent. Dishonesty may also be negatived by the assured's belief as to the effects of his statement. In *Aviva Insurance Ltd v Brown*[98] Mr. Justice Eder held a deliberate false statement by the assured in making a claim for renting alternative accommodation when the premises in question were under his indirect control was dishonest by objective standards. It did not amount to fraud, on the other hand, because of his subjective but incorrect belief that the insurers knew the true position. In other words an assured who believes that the insurers will not be fooled by his falsity is to be regarded as not dishonest. However, given the absence of any need for proof of inducement, the position of the insurers in law may well be better if they have not been fooled than it is when they have, because the focus is on the assured and not on the insurers.

This leads to the second point, which is that the insurers' own conduct is to be left out of account. *Aviva v Brown* is an extreme example of the point. The assured's house suffered subsidence damage in 1989. The insurers did not admit liability, and maintained their stance despite an award in the assured's favour by the Financial Ombudsman Service. It was not until 2008 that repair works were commenced. Eder J held that none of this delay in any way mitigated the assured's intended (but not implemented) fraud to claim rental costs for premises he actually owned. Less extreme scenarios can be imagined, as where an insurer offers to settle for an amount less than the sum insured but without apparent justification or where the insurers unreasonably insist upon proofs of loss.[99] We have already noted that "bargaining claims" which either anticipate or respond to that possibility are not fraud if the additional sum sought is *de minimis*. Reforming the law on payment of claims, requiring payment to be within a reasonable time,[100] may remove some frauds of the *Brown* type, but it may be said that poor claims-handling may well provide a trigger for the very fraud which justifies complete refusal of the claim. Even as the law stands such poor claims-handling will generally be a breach of the insurer's duty to "handle claims promptly and fairly" under Rule 8.1.1R of the Financial Services Authority's Insurance Conduct of Business Sourcebook.

Thirdly, it is not obvious why the all or nothing approach should extend beyond the precise fraudulent claims and to other claims which arise from the same event but falling under different policy sections. Can it be said that that principle gives a proportional remedy, particularly where – as in *Yeganeh* – the innocent element dwarfs the fraudulent element? The fraud entitles the insurers to terminate their relationship with the assured as from its date, so they are under no further risk of fraudulent claims. Does that not suffice? The English and Scottish Law Commissions felt that this matter should be left to the courts. The Australian approach in *Entwells Pty Ltd v National & General Insurance Co Ltd*[101] evidences a proportional approach to this situation.

Fourthly, insufficient attention has been given to the distinctions between the different types of fraud. If the claim is exaggerated, then the loss of the entire claim is a settled – although, as we have argued, not a necessary – principle of English law. But we would suggest that the situation in which a perfectly genuine claim becomes tainted by the use of fraudulent means and devices is quite different. It is one thing for an assured to manufacture documents to boost the value of the lost subject matter,[102] but it is quite another for the assured to resort to such conduct in order to establish to the satisfaction of insurers title to property which he already owns.[103] It is here of interest to compare the generous approach of the Western Australian District Court to the interpretation of s 56(2) of the Insurance Contracts Act 1984 (Cth) in *Rego v Fai General Insurance Company Ltd*[104] with the hard common law line of the English courts in both *Aviva v Brown* and *Sharon's Bakery*.

The attitude of the Financial Ombudsman Service in the UK is also instructive. FOS has drawn a distinction between false or exaggerated claims and the use of fraudulent means or devices, so that "fraud which does not prejudice the insurer's liability to pay the claim should, in effect, be disregarded … … where the fraudulent act or omission makes no difference to the insurer's ultimate liability under the terms of the policy, it should not entitle the insurer to 'forfeit' the policy or reject the claim. In the example … of the forged receipt, the claim should be paid. Indeed, it was the insurer's unreasonable insistence on strict proof that caused the policyholder to act dishonestly in the first place."[105] FOS has indeed ordered an insurer to pay a self-employed plumber who suffered a genuine loss of tools by theft but forged purchase receipts in order to establish his undoubted title to them.

Fifthly, the rules which deny a co-assured any recovery if the fraudster has deliberately destroyed the subject matter or submitted a claim which is exaggerated or tainted by fraudulent means or devices are outmoded. The English and Scottish Law Commissions chose not to make any recommendation on the point, as they did not regard it as of sufficient significance to justify law reform and could find no way of ensuring that the guilty party did not benefit.[106] The notions that a wife should be denied recovery either because she is a joint assured or because her husband acted as her agent are outmoded, subrogation will ensure that the guilty husband receives no benefit in the case of deliberate destruction. Similarly the corporate attribution rules reinforce artificiality and it is surely possible to find a mechanism, which could be subrogation in destruction cases, for confining payments to the innocent. Alternative approaches might be either to reduce the claim to the extent to which the fraudster himself would benefit[107] or alternatively to allow the claim in full but with insurers having a right of subrogation against the wrongdoer.

Finally, as regards the rule that a fraudulent claim cannot be retracted, a case can be made out for a different outcome where the assured voluntarily retracts his fraud before it has

been discovered and before the insurers have acted to their prejudice as a result of it. It is a well established principle in the general law of contract that a party who repents of illegality performance is entitled to restitution of sums paid by him under the contract, but a repenting fraudster has no rights whatsoever.

Endnotes

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1 See: Anthony Tarr, "Dishonest Insurance Claims" (1998) 1 Ins LJ 42; Julie-Anne Tarr, "Fraudulent Insurance Claims: Recent Legal Developments" [2008] JBL 139.

2 *Post Contract Duties and Other Issues*, LCCP 201/SLCDP 152, Chapter 2, building on *The Insured's Post-Contract Duty of Good Faith*, Issues Paper No 7, July 2010.

3 The sum is estimated to exceed £2 billion per annum, although that encompasses not just claims *by* assureds, but also claims *against* assureds by those feigning or exaggerating injury or loss. The latter is a growing phenomenon. The reader is referred to the website of the Insurance Fraud Bureau for full details.

4 (1866) 4 F & F 905, 909.

5 Noted by the Court of Session in *Fargnoli v GA Bonus plc* [1997] Re LR 374.

6 That would not be the sole remedy: insofar as fraud takes the form of misrepresentation, the insurers are perfectly free to claim damages in deceit as an alternative, or in addition, to avoiding the policy. For this reason the suggested rule (see *London Assurance v Clare* (1937) 57 Ll LR 254) that insurers cannot claim damages for the costs of investigating a claim is almost certainly incorrect, and it may be noted that in *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm) it was common ground that the insurers' non-fixed costs incurred in investigating the claim were held to be recoverable as damages.

7 First suggested in *Black King Shipping Corp v Massie, The Litsion Pride* [1985] 1 Lloyd's Rep 437 and followed in *Continental Illinois National Bank & Trust Co of Chicago v Alliance Assurance Co Ltd, The Captain Panagos DP* [1986] 2 Lloyd's Rep 470.

8 As well as Canada (*Gore Mutual Insurance Co v Bifford* 45 DLR (4^{th}) 763 (1987), Scotland (*Fargnoli v GA Bonus plc* [1997] Re LR 374) and Australia (Insurance Contracts Act 1984 (Cth), s 56(1)). However, the duty is still classified as one based on good faith in New Zealand: *Blanshard v National Mutual Life Association of Australasia Ltd* (2004) 13 ANZ Insurance Cases 61-621; *Vero Insurance NZ Ltd v Posa* (2009) 15 ANZ Insurance Cases 61-791; *Fussell & McNamara v Broadbase Christchurch Ltd* (2011) 16 ANZ Insurance Cases 61-913.

9 The story begins with the judgment of Lord Hobhouse in *Manifest Shipping Co Ltd v Uni-Polaris Shipping Co Ltd, The Star Sea* [2001] Lloyd's Rep IR 247, and the process was perfected by Longmore LJ in *K/S Merc-Skandia XXXXII v Lloyd's Underwriters* [2001] Lloyd's Rep IR 802 and Lord Mance in *Agapitos v Agnew, The Aegeon* [2002] Lloyd's Rep IR 573 and *Axa General Insurance v Gottleib* [2005] Lloyd's Rep IR 369. For confirmation, see *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV* [2005] Lloyd's Rep IR 396. The matter is analysed at length by the Law Commissions, *Post Contract Duties and Other Issues*, Chapter 2, Part 6.

[10] [2005] EWCA Civ 112, para 21.

[11] [1995] LRLR 443, 451 per Hoffman LJ, referring to the direction to the jury by Willes J in *Britton v Royal Insurance Co* (1866) 4 F & F 905.

[12] That almost certainly means that if claim A occurs, followed by claim B, and then the assured commits fraud in respect of claim A, claim B has accrued and remains unaffected.

[13] The Law Commission Consultation Paper No 201 and the Scottish Law Commission Discussion Paper No 152, para 6.53.

[14] See the vacillation of the Court of Appeal in *Orakpo v Barclays Insurance Services* [1995] LRLR 433 on this point.

[15] In consumer cases validity has to be tested against the reasonableness requirements laid down in the Unfair Terms in Consumer Contracts Regulations 1999. The Regulations were prayed in aid in *Direct Line Insurance plc v Fox* [2009] EWHC 386 (QB), but the clause was held to replicate the common law and thus not unreasonable.

[16] See, eg: the Institute Hull Clauses 2003, which create a condition precedent to recovery that the assured does not mislead or attempt to mislead the insurers; *Joseph Fielding Properties (Blackpool) Ltd v Aviva Insurance Ltd* [2010] EWHC 2192 (QB), where the clause operated with retroactive effect.

[17] [1889] 14 App CAS 337, 376.

[18] In *Lek v Mathews* (1927-28) 29 Ll LR 141, 145 Viscount Sumner stated that a claim is false not only because it is deliberately invented, but also if it is made recklessly not caring whether it is true or false, with the sole intention to succeed in the claim.

[19] [1985] 1 Lloyd's Rep 437

[20] [1986] 2 Lloyd's Rep 470

[21] *Hussain v Brown (No 2)* 1996, unreported; *Parker & Heard Ltd v Assicurazioni Generali SpA* 1998, unreported; *Bucks Printing Press Ltd v Prudential Assurance Co* [2000] CLY 880.

[22] *Goulstone v The Royal Insurance Company* (1858) 1 F & F 276, at 278.

[23] *Chapman v Pole* (1870) 22 LT 306, at 307.

[24] Fraud Act 2006 s 2(1).

[25] [2002] 2 AC 164.

[26] [2011] EWHC 362 (QB). See also: *Dawson v Monarch Insurance Co of NZ Ltd* [1977] 1 NZLR 372; *Insurance Manufacturers of Australia Pty Ltd v Heron* [2005] VSC 482.

[27] [1937] 2 A11 ER 193.

[28] As in *Tyndall Life Insurance Co Ltd v Chimsol* [1999] SASC 445.

[29] [2003] 1 AC 469.

[30] In *Vero Insurance NZ Limited v Posa* (2009) 15 ANZ Insurance Cases 61-791, the High Court of New Zealand confirmed the finding of the primary judge that a failure by the assured to enquire into the truth was a consequence of his belief that the issue was not important, so that he could not be said to be fraudulent. Cf *Australian Casualty and Life Ltd v Hall* (1999) 151 FLR

360 (a disclosure case in which the same distinction was drawn).

[31] *Tonkin v UK Insurance Ltd* [2007] Lloyd's Rep IR 283; *US Trading Ltd v Axa Insurance Co Ltd* [2010] Lloyd's Rep IR 505; *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

[32] Where the misstatement needs to affect objectively the decision of an insurer to take on the risk.

[33] The relevant cases are discussed below.

[34] [1999] LRLR 209.

[35] *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] LRLR 209, 214.

[36] *Agapitos v Agnew (No 1) (The Aegeon)* [2002] EWCA Civ 247.

[37] Materiality in the wider sense has similarly been rejected by the New Zealand courts. Materiality was originally held to be an element of fraud (*Vermeulen v SIMU Mutual Insurance Association* (1987) 4 ANZ Ins Cas 60-812, *Kinred v State Insurance General Manager* (1990) 5 ANZ Ins Cas 60-923) but that view no longer holds sway (*State Insurance Office v Bern* (1991) 6 ANZ Ins Cas 61-085).

[38] [2011] EWHC 362 (QB).

[39] At para 96.

[40] *Sharon's Bakery (Europe) Ltd v Axa Insurance plc* [2011] EWHC 210 (Comm).

[41] *Interpart Comerciao e Gestao SA v Lexington Insurance Co* [2004] Lloyd's Rep IR 690; *Stemson v AMP General Insurance (NZ) Ltd* [2006] Lloyd's Rep IR 852.

[42] *Danepoint Ltd v Underwriting Insurance Ltd* [2006] Lloyd's Rep IR 429.

[43] 2002] Lloyd's Rep. I.R. 173.

[44] [2006] Lloyd's Rep. I.R. 852. See also *Direct Line Insurance Plc v Fox* [2010] Lloyd's Rep IR 324.

[45] *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

[46] For burden of proof issues, see Johanna Hjalmarsson, "The standard of proof in civil cases; an insurance fraud perspective" [2013] JBL (forthcoming); *Moustakos v Federation Insurance Ltd* (1984) 3 ANZ Insurance Cases 60-587; *West End Aeronautical plc v QBE Insurance (Aust) Ltd* [2009] NSWDC 18; *AMI Insurance Ltd v Devich* (2011) 16 ANZ Insurance Cases 61-895.

[47] *Norton v Royal life Assurance Co* (1885) 1 TLR 460; *Ewer v National Employers Mutual General Insurance Association* [1937] 2 All ER 193; *London Assurance v Clare* (1937) 57 Ll LR 254; *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682.

[48] Of the many authorities, it is necessary to cite only the most recent, which include *Orakpo v Barclays Insurance Services Ltd* [1995] LRLR 443 and *Danepoint Ltd v Underwriting Insurance Ltd* [2005] EWHC 2318 (TCC).

[49] *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] LRLR 209; *Engel v South British Insurance Co Ltd* (1983) 2 ANZ Insurance Cases 77-938.

[50] As in *Tonkin v UK Insurance Ltd* [2007] Lloyd's Rep IR 283, where fraud in the sum of £2000 amounted to only 0.3 per cent of the total loss.

[51] [2005] EWHC 2318 (TCC)

[52] [2002] Lloyd's Rep IR 364

[53] [2010] EWHC 1185 (QB)

[54] *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

[55] *Thompson v Hopper* (1856) 6 E & E 172; *Shoot v Hill* (1936) 55 Ll LR 29; *Bucks Printing Press Ltd v Prudential Assurance Co* [2000] CLY 880.

[56] The law does not recognise a duty of disclosure, only a duty not to misstate: *Aviva Insurance Ltd v Brown* [2011] EWHC 362 (QB), dismissing the doubts expressed in *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV* [2005] Lloyd's Rep IR 396. But contrast the New Zealand decision in *Blanshard v National Mutual Life Association of Australasia Ltd* (2004) 13 ANZ Insurance Cases 61-621, based on the classification of a fraudulent claim as part of the continuing duty of utmost good faith.

[57] [2012] UKSC 26.

[58] *The Star Sea* [2001] Lloyd's Rep IR 247 laid down this principle for the continuing duty of utmost good faith, and it was extended to fraudulent claims by *Agapitos v Agnew* [2002] Lloyd's Rep IR 573.

[59] *K/S Merc Skandia XXXXII v Certain Lloyd's Underwriters* [2001] 1 Lloyd's Rep 802.

[60] *Direct Line Insurance Plc v Fox* [2010] Lloyd's Rep IR 324. But contrast *PT Buana Samudra Pratama v Maritime Mutual Insurance Association* [2011] EWHC 2413 (Comm), where it was held to be arguable that post-settlement fraud amounted to a fraudulent claim, although *Fox* was not cited.

[61] *Gray v Thames Trains Ltd* [2009] UKHL 33, applied in *Safeway Stores Ltd v Twigger* [2010] EWCA Civ 1472. For a recent example of an assured committing a crime but not being denied a claim as a matter of common law, see *Delaney v Pickett* [2011] EWCA Civ 1532 (although the victim lost on other grounds).

[62] Forfeiture Act 1982, s 2, applied in *Re S (Deceased)* [1996] 1 WLR 235.

[63] *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm), where a policy on property described the fraudster as a "joint policyholder", but the policy was nevertheless held to be composite.

[64] *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm). Although the parties were here married, that had occurred after the policy was taken out and it was not clear that the fraudster had any interest in the property at all; at best the policy was composite.

[65] [2002] Lloyd's Rep. I.R. 364.

[66] [1993] 2 NZLR 351, and cf *Gate v Sun Alliance Insurance* [1995] LRLR 385, although contrast the opposite view taken shortly beforehand in *Royal Insurance Fire & General (NZ) Ltd* v *Renata* 1990, unreported, Whangerai High Court and *McQuade* v *Sun Alliance Insurance Co* (1992) 7 ANZ Ins Cas 61-136. See also *Holmes v GRE Insurance Ltd* (1988) Tas R 147.

[67] See generally, Lisa Cunningham, "The Right of An Innocent Co-Assured Spouse to Recover under "Joint" Insurance Policy" (1994) 8 *Otago Law Review* 170.

[68] For the principle, see *Meridian Global Funds Management Asia Ltd v Securities Commission* [1995] 3 NZLR 7.

[69] *Americano's Ltd v State Insurance Ltd* (1999) 10 ANZ Insurance Cases 61-455.

[70] Mann, *Annotated Insurance Contracts Act*, 5th ed 2012, para 56.10; Greg Pynt, Australian Insurance Law, A First Reference, 2nd ed 2011, chapter 21; Kenneth Sutton, *Insurance Law in Australia* 3rd ed 1999, paras 15.70 to 15.97.

[71] Para 243.

[72] It has been held that, where the duty is enshrined not to act fraudulently is contained in the policy itself, the position is governed by s 56(1) and not by the causation rules for breach of contract set out in s 54 of the 1984 Act: *Entwells Pty Ltd v National and General Insurance Co Ltd* (1991) 6 WAR 68; *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104; *Tiep Thi To v AAMI Ltd* (2001) 161 FLR 61; *Walton v The Colonial Mutual Life Assurance Society Ltd* [2004] NSWSC 616.

[73] 1992, unreported (NSWSC).

[74] (1991) 6 ANZ Insurance Cases 61-059. See also *Moxia Pty Ltd v AMP General Insurance Ltd* 1992, unreported (VSC).

[75] [2001] VSCA 48. See also *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104 (misstating a breath test reading).

[76] *Tiep Thi To v Australian Associated Motor Insurers Ltd* [2001] VSCA 48, per Callaway JA at para 7

[77] *Brescia Furniture Pty Ltd v QBE Insurance (Australia) Ltd* (2007) 14 ANZ Ins Cas 61-740; *Allianz Australia Insurance Ltd v Douralis* (2008) 15 ANZ Ins Cas 61-763.

[78] *VL Credits Pty Ltd v Switzerland Insurance Co* [1990] VR 938; *MMI (Workers Compensation) Ltd v AMEV Finance Ltd* (1988) 5 ANZ Ins Cas 60-855.

[79] *MMI General Insurance Ltd v Baktoo* (2000) 11 ANZ Ins Cas 61-446.

[80] *Entwells Pty Ltd v National and General Insurance Co Ltd* (1991) 6 ANZ Insurance Cases 61-059.

[81] Para 251.

[82] There is no right to avoid the policy as of the date of the fraud: *Walton v The Colonial Mutual Life Assurance Society Ltd* [2004] NSWSC 616.

[83] See *CIC Insurance Ltd v Bankstown Football Club Limited* (1997) 187 CLR 384, although there the issue was whether the policy had terminated before the second loss.

[84] *Barroora Pty Ltd v Provincial Insurance (Australia) Ltd* (1992) 7 ANZ Ins Cas 61-103; *C E Heath Casualty and General Insurance Ltd v Grey* (1993) 32 NSWLR 25.

[85] See Michael Kirby, "Australian Insurance Contracts Law: Local Reform with a Global Relevance" [2011] JBL 300, the Hugh Rowell Memorial Lecture 2010.

[86] *GRE v Ormsby* (1982) ANZ Ins Cas 60-472, although this is plainly unsupportable in the light of later authority. See, in addition to the English authorities and the post-1986 Australian authorities: *New Zealand Insurance Co Ltd v Forbes* (1988) 5 ANZ Insurance Cases 60-871; *Vermeulen v SIMU Mutual Insurance Association* (1987) 4 ANZ Insurance Cases 60-812; *Back v National Insurance Co of New Zealand Ltd* [1996] 3 NZLR 363.

[87] Para 243.

[88] *Gugliotti v Commercial Union Assurance Co of Australia* (1992) 7 ANZ Ins Cas 61-104; *Marriott v Australian Associated Motor Insurers Ltd* [2010] NTMC 53. Section 56(2) has not featured in fraudulent means or devices claims:; *Naomi Marble & Granite Pty Ltd v FAI General Insurance Co Ltd* [1999] 1 Qd R 507; *Rego v FAI General Insurance Co Ltd* [2001] WADC 98; *Denes v NRMA Insurance Ltd (General)* [2002] NSWCTTT 327; *Ceper v NRMA Insurance Ltd (General)* [2003] NSWCTTT 474; *Mourad v NRMA Insurance Ltd* (2003) 12 ANZ Ins Cas 61-560; *Nasser v AAMI Insurance P/L (General)* [2005] NSWCTTT 478; *Insurance Manufacturers of Australia Pty Ltd v Heron* [2005] VSC 482; *Marshall v AAMI Insurance Ltd (General)* [2008] NSWCTTT 1243; *Younan v GIO General Ltd* [2012] NSWDC 67. The contrary view was assumed in *Titley v Tower Life Australia Ltd* [1997] SADC 3646, but the matter did not proceed to trial.

[89] *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

[90] [2001] WADC 98.

[91] Indeed, the common law may be more beneficial to the assured, because a *de minimis* finding means no fraud at all, whereas the Australian approach is condonation of a proven fraud. That means that, for future applications, the latter approach may require disclosure whereas the former approach does not.

[92] "The Price of a Lie: Discretionary Flexibility in Insurance Fraud" [2013] JBL (forthcoming).

[93] *Insurance Corporation of the Channel Islands v Royal Hotel* [1997] LRLR 94 (frauds ranging between 32% and 84%); *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyds IR 209 (11%); *Direct Line v Khan* [2002] Lloyd's Rep IR 364 (10.5%); *Axa Insurance v Gottleib* [2005] Lloyd's Rep IR 369 (33%); *Micro Design Group Ltd v Norwich Union Insurance Ltd* [2006] Lloyd's Rep IR 235 (2%). But contrast *Tonkin v UK Insurance* [2007] Lloyd's Rep IR 283 (0.3%).

[94] [2008] VSCA 72.

[95] This was "*obiter*", i.e. an incidental remark and not part of the decision itself.

[96] (1991) 6 WAR 68. Contrast *Tsorotes v RACV Insurance Pty Ltd* 1993, unreported, Supreme Court of Victoria.

[97] *Ricciardi v Suncorp Metway Insurance Ltd* [2001] QCA 190.

[98] [2011] EWHC 362 (QB).

[99] Albeit that they are under a common law duty not to do so: *Parker v National Farmers Union Mutual Insurance Society Ltd* [2012] EWHC 2156 (Comm).

[100] As recommended by the Law Commissions' December 2011 Consultation Document.

[101] (1991) 6 WAR 68.

[102] *Eagle Star Insurance Co Ltd v Games Video Co (GVC) SA (The Game Boy)* [2004] Lloyd's Rep IR 867.

[103] *Sharon's Bakery Ltd v Axa Insurance* [2011] EWHC 210.

[104] [2001] WADC 98.

[105] *Ombudsman News*, November 2004.

[106] Paras 9.10 to 9.12.

[107] See, for such a suggestion in the context of illegality, *Moore Stephens v Stone & Rolls Ltd* [2009] UKHL 39.