Reminder to insurers of the level of scrutiny that an allegation of fundamental dishonesty in high value claims will bring

INTRODUCTION

Section 57 of the Criminal Justice and Courts Act 2015 sought to address the spiralling numbers of exaggerated claims for injury that our courts were being asked to deal with. Until that point, there was little in the way of sanction to stop litigants (in many cases egged on by their representatives) from inflating their claims either by exaggerating the effect of the symptoms on their everyday life or by contending an inability to do something that they were capable of doing.

Section 57 directs a court to dismiss a claim in its entirety if the claimant is found, on the balance of probabilities, to have been fundamentally dishonest. The dismissal would include any element of the claim in respect of which the claimant has not been dishonest. The potential benefits to insurers are obvious.

As a result, insurers have been willing to challenge inflated claims and the courts have been willing to give effect to s.57, meaning savings on cases are potentially significant. It must be remembered, however, that an allegation of fundamental dishonesty ("FD") does not come without risk. The interplay between the often significant and long-lasting genuine injury has to be balanced against the potentially dishonest aspects of the claim to ensure that the test is made out.

In the case of Palmer v Mantas & Liverpool Victoria, in which judgment was handed down on 20 January 2022, the claimant faced an allegation of FD in relation to her claim for damages arising out of a serious road traffic accident which occurred on 15 June 2014.

Whilst the judgment leans towards the claimant, there are lessons for defendant insurers to learn

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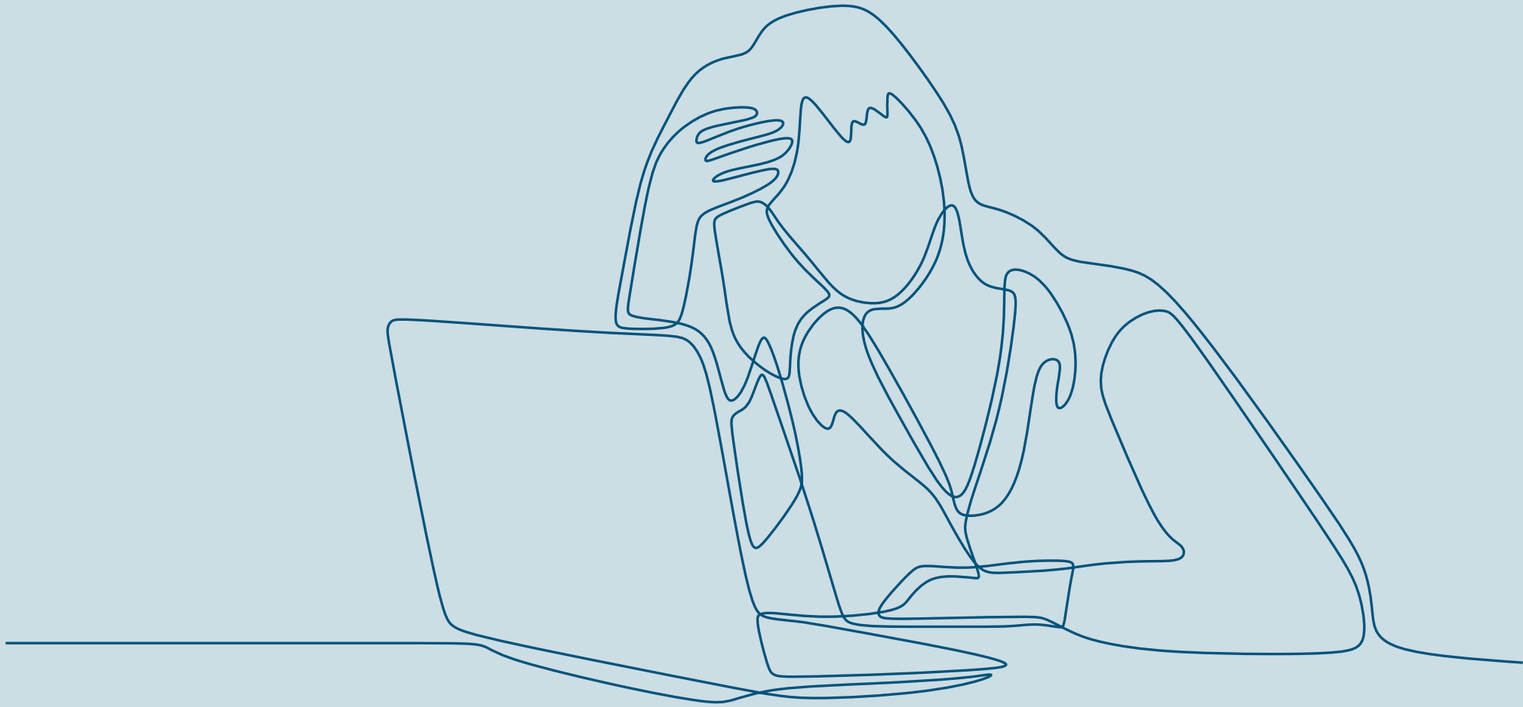
CENTRAL ISSUE - WORKING CAPACITY

The claimant, who at the time of the accident worked in marketing, was able to return to work shortly after the incident and continued to work for over three years post accident until November 2017. The defendant alleged that the claimant's ability to work was at odds with her description of her symptoms, although the claimant demonstrated that she had been afforded flexibility by her employers and was allowed to leave work early if she was struck down by a migraine.



SOCIAL MEDIA EVIDENCE

The claimant, who was 26 at the time of the trial, posted extensively on social media (as is the norm). Those posts showed the claimant travelling on holidays and to events. They were generally upbeat posts that the defendant alleged showed the claimants true condition, alleging that the posts painted a very different picture to the one advanced to the medical experts.

The claimant maintained that the posts were (again as is the norm) intended to put 'a positive gloss on how she was doing'.

She pointed out that there were examples of her posting about her injuries and her attempts to deal with her restrictions.

Undoubtedly there were huge discrepancies between the claimant's social media posts and her account to the experts, sufficient to form the basis of an allegation of dishonesty.

The question, as with all cases involving s.57, was whether the identified inconsistencies were enough, taken in the round, to undermine the claimant's claim.

SURVEILLANCE EVIDENCE

Unusually in a case of this nature the defendant had obtained surveillance footage of the claimant but decided not to deploy it when launching the allegation of FD. Their reasoning was that the footage was 'neutral'. In reality, there is no such thing a 'neutral' surveillance footage. The footage will either show the claimant engaged in activities they say they are incapable of or will not. If the latter, then the claimant would be entitled to say the footage is consistent with their presented case.

Here, the footage, which was obtained on 17 days between 2017 and 2019, was not disclosed until an express request by the claimant for all unused material capable of undermining the defendant's case. The footage showed the claimant driving between her and her parent's home and that she was usually accompanied when she made those trips. She was filmed attending three medico-legal appointments although there was no footage from the following days, which the claimant submitted supported her case that she needed to rest after each examination.

MEDICAL EVIDENCE

The trial judge invited the parties to provide their respective experts' views on whether they considered the claimant to have been engaging in conscious or unconscious exaggeration, either at the time of their examinations or subsequently, when presented with the evidence of alleged dishonesty.

Of the experts who gave live evidence at trial, only one was prepared to say that his opinion was that the claimant had a dishonest presentation.

The high mark for the remaining experts was that there was a mix of conscious and unconscious exaggeration.

The majority of the experts expressed a view that the claimant presented with 'no obvious [signs of] exaggeration', was 'sincere and genuine' and was 'honest, transparent and cooperative'.

THE JUDGMENT

The judge classified the relatively minor inconsistencies in reporting to the experts as supportive of her claim, saying that it would have been more suspicious for her to have given identical accounts. He also bore in mind, and accepted, that the claimant was not one to 'over volunteer'.

The claimant was not criticised for failing to initially identify all of her alleged symptoms – she was believed that she had focused on the more significant problems in the first instance. Her first statement was held to have been, in effect, draft only and only fell into the defendant's hands because it had been sent to one of the claimant's experts, thereby making it disclosable.

Much of the defence was grounded in an allegation that the claimant had been dishonest by omission. The judge rejected that, saying:

> *"I note in conclusion on this issue that a substantial part of the second defendant's case is essentially that the claimant was dishonest by omission, i.e., chose only to answer questions asked by the medical legal experts and omitted to disclose her true level of function. I have already set out why I do not consider that as a fair approach to expect of the claimant when being asked about the history and symptoms by all the medical legal experts. I am fortified in my view that that is a particularly difficult submission for the second defendant given that I was not provided with any reported authorities where a finding of fundamental dishonesty has been made in a personal injury claim because a claimant had failed to volunteer information not asked of her during a medical legal assessment."*

COMMENTARY

Of course, the judgment sets no particular precedent. Imagine a scenario where a claimant has completed a series of triathlons yet fails to volunteer that to the medical experts, whilst maintaining that they have physical restrictions resultant from an RTA. That sort of omission would certainly be enough to ground an allegation of FD and likely secure a dismissal. It would likely be of no assistance to that claimant to say that he had never been asked about triathlons. The courts must be able to assess the intention behind each claimant's words and any omissions in the context of the particular facts of their claim.

CONCLUSION

Nothing in this judgment detracts from the forceful effect s.57 can have on the right case – no-one could sensibly argue that fraud and exaggeration are not widespread in insurance litigation. Insurers cannot, however, lose sight of the scrutiny that an allegation of FD will come under. Ensuring that all of the evidence is objectively considered will guard against the risk of too much weight being placed on one particular point.

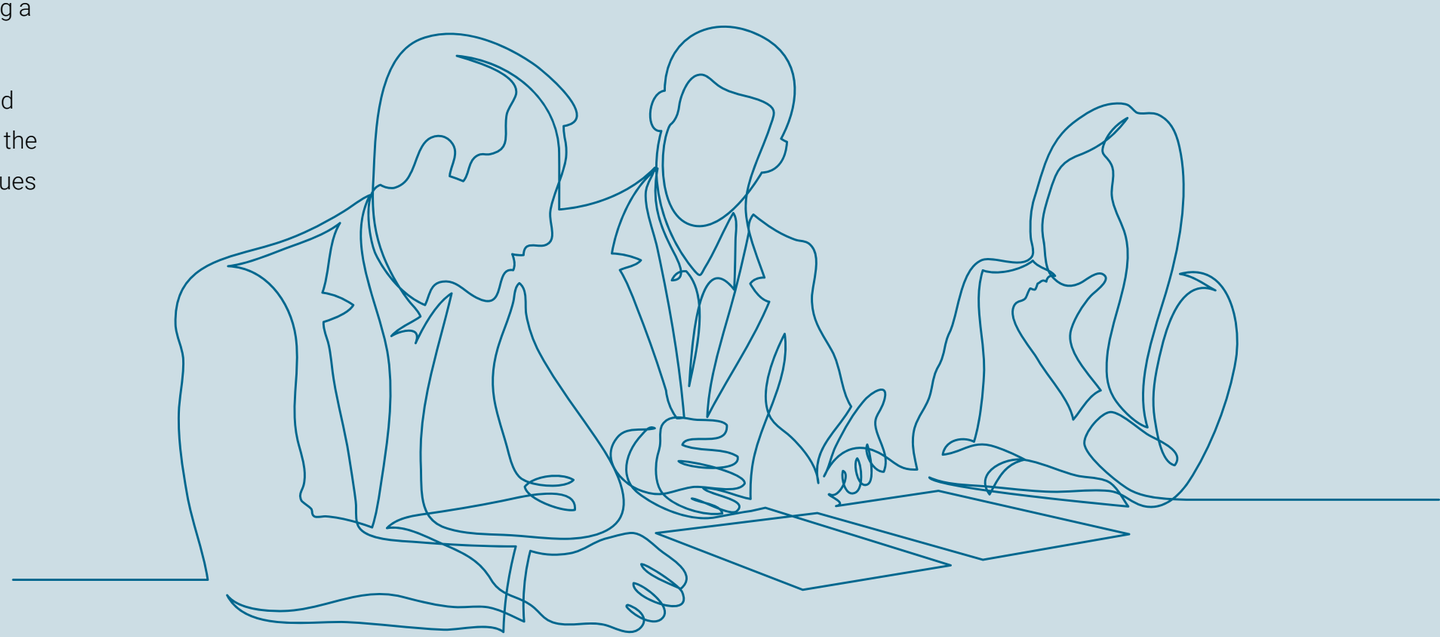
Fraud investigations must be conducted in tandem with the more traditional elements of a lawyer's role in high value cases, to ensure a balanced decision is reached on the merits of pursuing an allegation of FD.

Justice will often dictate that a claimant's claim fails under s.57 and here at Horwich Farrelly we have recorded significant savings for insurers in high value claims.

Our expertise across counter-fraud and large loss litigation gives insurers a unique 'full picture' service allowing clients to objectively assess the merits of a case from all angles before pursuing a finding of FD.

Our dedicated team of large loss fraud lawyers have particular experience in the intricacies of these cases and the issues that arise.

This approach has led to savings for insurers in excess of £15 million and counting.



If you would like to discuss any of the information contained within this document, please do not hesitate to get in touch.

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