Financial Rights
LEGAL CENTRE

Guilty until proven innocent

Insurance investigations in Australia

MARCH 2016
FINANCIAL RIGHTS LEGAL CENTRE

About the Financial Rights Legal Centre

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers.

We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the Credit & Debt Hotline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took over 26,000 calls for advice or assistance during the 2014/2015 financial year.

Financial Rights also conducts research and collects data from our extensive contact with consumers and the legal consumer protection framework to lobby for changes to law and industry practice for the benefit of consumers. We also provide extensive web-based resources, other education resources, workshops, presentations and media comment.

This project was funded by over-collected fire services levies distributed in accordance with a process set up by the Victorian Fire Services Levy Monitor for projects benefitting consumers of insurance.

For Financial Rights Legal Centre submissions and publications go to

www.financialrights.org.au/submission or www.financialrights.org.au/publication

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Credit & Debt Hotline (NSW) 1800 007 007

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Monday – Friday 9.30am-4.30pm

Special thanks to Drew MacRae for his extensive research, drafting and overall commitment to this project.

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Executive Summary

Financial Rights Legal Centre ("Financial Rights") solicitors have long noted that a significant proportion of their work on the Insurance Law Service was devoted to providing advice to policyholders who found themselves subject to insurance investigations. It is accepted that insurers are entitled to investigate to ensure claims are genuine; however, there seems to be a lack of rules and consumer protections for consumers being investigated. There are no specific standards for the conduct of claims investigations in the General Insurance Code of Practice. There are no guidelines for the use of interpreters or independent support people, no right to have the interview held in a neutral location, no reminder or suggestion to seek legal advice and no interview time limits.

This Report takes a close look at investigations in general insurance – the investigation process, the lived experience of consumers subject to investigations and the matrix of consumer protections in place. It draws on a number of resources, including case studies of our clients, a survey of our callers, interviews with insurers and investigators, an analysis of Financial Ombudsman determinations and a range of information from academic research to government reports. Our research found that:

Close to one in four calls (22.6%) to the Insurance Law Service are from policyholders with concerns relating to insurance investigations.

The claims made by insurers that fraud costs the industry $2.1 billion annually are inflated - this figure being based on a 20 year old estimated percentage of claims insurers "believed to be fraudulent" rather than on any actual data of proven fraudulent claims.

In disputes that reached the Financial Ombudsman in 2015 where fraud was alleged, fraud was established on the balance of probabilities in only 17.7% of cases. Allegations of fraud were not positively established on the balance of probabilities by the insurer in 46.2% of disputes.

Consumers reported being subject to incredibly long interviews (sometimes over five hours in length) that are physically and mentally demanding, sometimes repeated over a series of interviews months apart. The average length of time faced by policyholders between the date of the event and/or claim first being made and the date of the final determination by the Financial Ombudsman was close to 18 months.

Consumers routinely feel bullied, harassed and intimidated by investigators. They often describe being "treated like a criminal" and that the investigator has prejudged their guilt with little or no basis, putting forward theories that bear scant resemblance to reality.

Consumers are grilled with repetitive and seemingly irrelevant questions about highly personal and sensitive issues like past relationships and medical conditions. Consumers report being threatened with the rejection of their claim and other serious repercussions (such as the reporting of relatives to immigration) if they do not act in the way the investigator demands. There is little transparency or consistency with "insurance reports."

Consumers from a Middle Eastern background have felt they have been racially profiled, others with poor English skills have not had access to appropriate translators, and consumers with mental health problems have been denied the use of a support person.

Consumers are provided with little or no explanation of the investigation process and no mention of any rights or standards. They are asked to sign documents that are not explained, asked to hand over personal and sensitive documents without warning and with no reasons given, and have had their neighbours, family, friends and business associates or clients questioned without the policyholder being notified.

The onerous demands placed on consumers by an investigation lead many to withdraw their claim, not due to any admission of fraudulent behaviour but simply because the process is too burdensome or invasive for many consumers to bear.

While Financial Rights found that some internal insurer standards governing investigations do exist, there is a lack of transparency since they are hidden from consumers and the public eye. Only IAG and Suncorp were willing to discuss their investigation processes with Financial Rights and no insurer provided documentation save for three paragraphs from IAG. Suncorp, has, subsequent to our discussions for this Report, decided to consider the development of a code of practice for its investigations.

The state of private investigator licensing in Australia is a mess with vast variability across jurisdictions offering few, if any, consumer protections.

This Report puts forward the following recommendations:

RECOMMENDATIONS

1. *That the industry establish a set of best practice standards for insurance investigations to be included in the General Insurance Code of Practice. In the event this does not occur the Federal Government should consider amending the Insurance Contracts Act 1984 (Cth) to codify consumer rights in relation to investigations*
2. *That the General Insurance Code of Practice include a statement on diversity and anti-discrimination*
3. *That the General Insurance Code of Practice include minimum standards in the use of interpreters*
4. *That a Memorandum of Understanding be developed between the Insurance Council of Australia and mental health stakeholders to improve the general insurance industry's treatment of Australians with a mental illness, during claims and investigations*
5. *That insurers ensure that all investigators receive ongoing diversity and anti-discrimination training*
6. *That the Financial Ombudsman Service Australia report on the number of fraud disputes and their outcome, and extend their collection of applicant demographic statistics to ethnicity or cultural identification and include this information in their Annual Review.*
7. *That the Code Governance Committee of the General Insurance Code of Practice provide detailed statistics relating to Code breaches, and investigations in their Annual Report*
8. *That the Financial Ombudsman Service Australia develop an Approach document or series of Approach documents with respect to disputes involving fraud allegations and investigations generally to drive better practice*

9. *That the Financial Ombudsman Service Australia update their Operating Guidelines to allow the use of support persons during interviews in disputes involving allegations of fraud*

10. *That the Insurance Council of Australia cease referring to inaccurate and unreliable fraud data and instead reference accurate and independently verified data*

11. *That Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct*

12. *That general insurers be subject to the unfair contract terms regime under the Australian Securities and Investments Commission Act 2001 (Cth)*

13. *That Federal and State Governments through the Council of Australian Governments develop uniform surveillance and listening devices laws that provide for strong consumer protections*

14. *That the Federal Government introduce insurance reporting regulations appropriate for consumer protection and privacy purposes*

1. Introduction

The Financial Rights Legal Centre ("Financial Rights") specialises in helping consumers understand and enforce their financial rights. We operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts. In running this line our solicitors recently noted that a significant proportion of their work was devoted to providing advice to policyholders who found themselves subject to insurance investigations.

> *A consumer has called the Insurance Law Service hotline, crying and in a distressed state.*
>
> *She is upset that her claim on her home, which was accidently burnt down, is taking so long. It has now been over ten months and she is living in temporary accommodation – a one bedroom apartment with her two children aged four and ten.*
>
> *The last she heard from her insurer was weeks ago. She reports that three months ago she and her eldest son were interviewed. They both found the whole experience traumatic and intrusive.*
>
> *They felt the interviewer was rude and aggressive, asked invasive personal questions and made snide comments about her personal situation.*
>
> *She tells the Insurance Law Service solicitor that she was made to feel like a criminal and that the investigator had presumed that she was guilty.*
>
> *She was asked to sign a whole series of documents that she can't recall and didn't understand at the time because she just wanted the guy out of her house.*
>
> *She felt incredibly uncomfortable and wanted to complain but was told by her case manager that she could not have another investigator and even if they could bring in a new investigator they would have to start the whole process again.*
>
> *She is at her wit's end. She can't afford her bills, she is going crazy in her one bedroom apartment with her kids and just wants it to end.*
>
> *She is willing to do anything. She asks is there anything, anything at all we can do for her?*

For Insurance Law Service solicitors calls like this are not uncommon. As this Report will detail, close to one in four issues raised with the Insurance Law Service relate to claim delays, non-transparent claims handling processes, requests for excessive information and allegations of fraud, that is the intentional misleading or deception of an insurer for the purpose of financial benefit where it would not otherwise be payable.

Investigations are undertaken by general insurers in a number of circumstances.[1]

Insurers may be looking to confirm the circumstances around a claim or check the accuracy of

1 This Report focusses on the general insurance industry rather than the life insurance industry, although many of the same issues apply across the sectors.

information provided when the policy was taken out or came up for renewal. Insurers are also on the lookout for evidence of fraud.

But what may seem ordinary or standard practice to an insurer is often extraordinary and foreign to a consumer. For most the experience of being investigated is a frightening and stressful one. They often feel powerless, have limited understanding of what is going on and are provided with little information on what to expect or how long the process will take.

Investigations also tend to concentrate on higher value claims including the loss of a house or a car. This means that a consumer can be left without accommodation or transport while waiting for an investigation that can take up to 12 months to complete. This can have obvious impacts on a consumer's life. Investigations can lead to significant financial hardship or worsen already existing financial difficulties. Delays can lead to frustration, stress, uncertainty and emotional suffering. Other consumers report feeling bullied, harassed and intimidated by investigators. Consumers often describe that they are being "treated like a criminal" and that the investigator has prejudged their guilt with little or no basis, putting forward theories that bear scant resemblance to reality.

Consumers are subject to incredibly long interviews (sometimes over five hours in length) that are physically and mentally demanding, sometimes repeated over a series of interviews at times months apart. They can be grilled with repetitive and seemingly irrelevant questions about highly personal and sensitive issues like past relationships and medical conditions. Consumers have reported being threatened with the rejection of their claim and other serious repercussions (such as the reporting of relatives to immigration) if they do not act in the way the investigator demands. Consumers from a Middle Eastern background have felt they have been racially profiled, others with poor English skills have not had access to appropriate translators, and consumers with mental health problems have been denied the use of a support person. Consumers are asked to sign documents that are not explained, asked to hand over personal and sensitive documents without warning and with no reasons given, and have had their neighbours, family friends and business associates or clients questioned.

All of which leaves the consumer feeling at different times violated, humiliated, and angry. And there can be significant long term impacts too. An accusation of fraud can mean the consumer is faced with higher insurance premiums or can't access insurance at all. It can also lead to significant financial hardship, a negative impact on their credit report and even their career.

Insurance fraud has long been claimed to cost the industry and policyholders $2.1 billion annually or 10% of all claims (ICA n.d., Smith 2014, p55). However this figure is over 20 years old[2] and based on an estimated percentage of claims insurers "believed to be fraudulent" (Baldock 1997, p3). Even a lower, more "conservative" calculation of insurance fraud of $832 million (IAG 2004) put forward by the industry includes both an estimate of the cost of cases that involved fraud and "cases where fraud is suspected but claims are nonetheless paid because of insufficient evidence" (IAG 2004 p12).[3] In other words the $2.1 billion annual cost of insurance fraud regularly quoted by the

2 The $2.1 billion figure is drawn from a 2004 study by IAG (IAG, 2004) which in turn relies on a 1994 Insurance Council of Australia report titled Insurance Fraud in Australia to base its calculations. The 2004 study states that "[i]n 1994 it is estimated that 10-15% of insurance claims exhibited elements of fraud." This 1994 report however is no longer available and the Insurance Council of Australia themselves were unable to locate a copy.

3 An even lower figure of $211 million being the "value of savings from the non-payment or reduced payment of claims" (IAG 2004 p12) could still be overstating the problem too as it potentially includes refused claims that were not in fact fraudulent but the policyholder accepted the non-payment of their claim because they were worn out by the process or did not take the matter to IDR or EDR.

industry includes genuinely fraudulent claims, claims suspected to be fraudulent but nonetheless paid because of insufficient evidence, as well as an even larger proportion of unidentified claims not even flagged as being suspected of fraud but that the insurer industry "believed to be fraudulent". The industry's willingness to overstate the cost of insurance fraud by including suspected yet wholly unproven cases of fraud in their statistical analyses belies a guilty until proven innocent approach that – given the lived experience of policyholders detailed in this Report – appears to feed into the investigation process itself.

Financial Rights accepts that undertaking an investigation is a legitimate and important process for insurers and for society. Insurers have a legal right to reasonably investigate all claims to make sure that a claim is genuine and falls within the scope of the policy. As a part of this process, insurers have every right to interview policyholders, ask for any information or records that are reasonable and relevant to a claim, and gather appropriate evidence.

However there is a significant gap – between a reasonable insurance investigation process and the everyday reality of investigations. This Report is a close examination of this gap and the lived experience of investigations. It draws on a number of resources to shine a light on the issues faced by consumers subject to an investigation. These include case studies drawn from Insurance Law Service clients, a survey of Insurance Law Service callers, interviews with insurers and investigators and a range of information including academic research and analysis of Financial Ombudsman Service Australia ("the Financial Ombudsman") determinations.

The Report begins with an overview of the insurance investigation process and the standard approach taken by insurers and how they are usually expected to proceed.

The Report then details the lived experience of over 40 consumers subject to investigations who have contacted the Insurance Law Service to seek advice and assistance with respect to their insurance claim. It provides an insight into the common problems faced by consumers during an investigation including inadequate communication and delays, poor investigator behaviour, unreasonable requests for information, the issues faced by vulnerable people and the pursuit of investigations with little or no evidence.

The Report scrutinises the matrix of protections currently in place and their failure to protect consumers from the excesses of the insurance investigation process. Finally the Report puts forward recommendations for reform including the development of a Good Practice Guideline for insurance investigations to assist both consumers and insurers in disputes involving allegations of insurance fraud.

2. The insurance investigation process

Insurers primarily initiate investigations to confirm the circumstances and details of a claim to ensure that there is an insurable event under the policy. Insurers sometimes seek to check the veracity of statements or accuracy of information provided to them at the time the policy was taken out or at the time of renewal. Insurers are also on the lookout for evidence of fraud.

The following section describes the standard investigation process as Financial Rights understands it. It is drawn from our casework experience, expected practices as outlined under the General Insurance Code of Practice (the "General Insurance Code") and information provided to us by insurers that we have spoken to for this Report. Specific details of the investigation procedure will obviously vary from company to company and case to case.

THE INITIAL CLAIM

A policyholder will have an event occur that leads them to make a claim on their policy. Within ten business days of receiving that claim (and all the information the insurer requires), the insurer will make a decision to accept or deny the claim (GICOP 2014, s. 3.1). Most claims are accepted or denied at this stage however a significant number of claims will be flagged for further investigation or assessment. This may be because all the necessary information was not provided in order for the insurer to process the claim. It may be because the insurer needs to investigate whether the event that occurred is an insurable event as conceived under the policy or whether there has been relevant non-disclosure on the part of the policyholder. Or it may be because the insurer has detected the possibility of fraud.

FRAUD DETECTION

There are a variety of ways insurers detect fraud. The most common way is what is known as a "red flag" system where suspicious indicators are identified either manually via a claims officer or through an automated process (Davidson 2000). Common "red flags" include the policyholder signing up for a policy a day or two before an accident, the vehicle is found burnt out, the policyholder is having financial/personal difficulties or the event occurred in a particular suburb.[4]

There are a number of other forms of data analysis and detection that insurers use to detect fraud including statement analysis, third party information from the police, mechanics, fire investigators, engineers, or informants, as well as more proactive risk assessment approaches where trends are gathered to avoid fraud in the first place (Davidson 2000).

Once detected, the claim may go through an additional internal triage process to examine whether the claim warrants further investigation or not.

4 Other common red flags include: there seems to be unnecessary costs for a minor accident; the policyholder holds multiple contracts with multiple insurance companies; there is incorrect and potentially misleading information provided (i.e. incorrect age or length of driving experience); the accident occurred in secluded non-urban areas between 11pm and 5am on a weekend; there is no police report; the policyholder is familiar with insurance "jargon"; the other driver is eager to accept blame for accident/theft; the vehicle was purchased with cash; the policyholder is aggressive; the accident or theft occurs late at night, usually on a Friday or Saturday (Lincoln 2003, p9).

INITIATING AN INVESTIGATION

Once the insurer makes a decision to investigate, a loss adjuster or investigator will be engaged.[5] These may be internal employees or third party service providers contracted on a service level agreement. Assuming that an external private investigator is appointed, they will usually be provided the full case file or at times a short letter outlining their brief. The insurer will then notify the policyholder within five business days of their appointment (GICOP 2014, s. 3.2.2). Notification of the policyholder that an investigation will take place will either be by a phone call or in writing via a standard letter. The policyholder will usually not be told explicitly that they are suspected of fraud. Rather, policyholders are told that their claim is simply being investigated. The phone call also provides an opportunity for the insurer to seek clarification around the claim and make sure there has been no miscommunication.

The policyholder is then informed of the name and details of the investigator and an interview is arranged, usually at the policyholder's home address. Some insurers provide other location options, if requested, including the local insurance office, a neutral location like a coffee shop or sometimes over the phone. The policyholder is sometimes informed how long the interview will take. Some investigators will gauge the standard of English of the policyholder and engage an interpreter if appropriate. The ability for the policyholder to have an independent support person present at the interview is not ordinarily offered but may be accepted if requested.

Some insurers will explain at this stage that they will be requesting documents to substantiate the claim or assist the investigation. They will either detail the exact list of documents they require or provide an overview of the type of documents that they may require such as phone and banking records. Investigators also initiate the gathering of other information and evidence to validate the claim.

THE INTERVIEW

On arrival investigators should identify themselves to the policyholder either with a business card or their professional licence. Before the interview takes place, the investigator will ask the policyholder to sign a consent form to conduct the interview. The policyholder will also be asked to sign an authority to record the interview. Interviews are generally recorded but this can be refused with the policyholder preferring to use a stenographer to have a typed record of interview. As a matter of course policyholders are not usually provided the recording or transcript but they are usually made aware that they can request a transcript.

While there are many approaches to interviewing the standard approach as Financial Rights understands it is to begin with asking the policyholder open-ended questions to "tell [the investigator] what happened." Once the basic story is outlined, the interview then enters a re-evaluation phase where the investigator goes over the information already provided with a more direct question and answer approach to further probe or clarify discrepancies or issues raised in the narrative. Some investigators automatically offer breaks during long interviews although for others breaks need to be requested.

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5 A loss assessor may be appointed by the policyholder but is less relevant for Financial Rights clients. This Report will refer to investigators only, for the sake of brevity.

The interview usually ends with a request to sign an authority to access records including criminal records, bank and phone records and any other documents relevant to the investigation. A lot of the time policyholders will offer to gather the required information themselves. This self-gathered material needs to be either originals or certified copies. Further interviews are often requested by investigators to seek clarification of details or additional information.

FURTHER EVIDENCE GATHERING

Upon receiving all the documentation the investigator will conduct fact-checking to confirm the policyholder's version of events and verify claim details. This may include contacting witnesses or third parties to confirm the information provided. Investigators will also gather and examine a whole range of evidence including insurance and criminal histories, social media communications, independent forensic reports, etc.

Investigators do not seek the permission of the policyholder to speak to and interview third party witnesses but sometimes do inform the policyholder that this may occur.

According to the General Insurance Code, insurers will conduct claims handling including investigations in a "fair, transparent and timely manner" and will only "ask for and take into account relevant information when deciding on your claim" (GICOP 2014, s. 3.5.1 & 2).

TIMELINES

Where an external expert has been engaged to provide a report they must do so in 12 weeks, however if they fail to do so, the insurer has the right to merely inform the policyholder that the report is not complete and keep the policyholder informed of its progress (GICOP 2014, s. 3.4.4).

The insurer should keep the policyholder informed of the progress of the claim every 20 business days and respond to routine requests for information within ten business days. The policyholder is usually provided the contact number of their claims handler to be able to contact the company and discuss their case at any time.

Insurers have the opportunity to negotiate an alternative time frame but if an agreement cannot be reached on this timeline the policyholder can access the insurer's internal dispute resolution (IDR) service. The right to complain to IDR is also available at any time if the policyholder wishes to complain although this is rarely explicitly made clear to a policyholder.

An investigation can last up to four months but if an allegation of fraud or any other exceptional circumstance is involved the insurer has up to 12 months to make a decision.

A report is ultimately provided by the investigator to the insurance company's claims manager and a decision is made as to the validity of the claim. The insurance company will then accept or deny the claim and notify the policyholder within ten days (GICOP 2014, s. 3.2.5). If the claim is denied the insurer will provide written reasons for the decision, inform the policyholder of his or her right to ask for copies of information that the insurer relied upon to assess the claim, inform the policyholder of the right to request a review of the decision, provide information about complaints handling and on request, provide copies of the reports from the investigator and experts within ten business days of the request (GICOP 2014, s. 3.5.5).

***

This investigation process is what Financial Rights understands to be, at least theoretically, the standard procedure. It is what is expected by the General Insurance Code and intended by insurers. However, investigations vary greatly due largely to the internal processes set by an insurer, the circumstances of each case, and the individual behaviour of each investigator.

The lived experiences of policyholders faced with investigations can, and do, diverge significantly from what has been described here. And at times policyholders are significantly impacted by the process.

3. Consumer experiences of insurance investigations

Financial Rights received over 8000 calls last year to the Insurance Law Service. Calls from policyholders with questions or concerns regarding claims investigations make up a significant portion of these. Financial Rights recently undertook a survey of callers to the Insurance Law Service to examine the number of calls that related to investigations. Over four weeks, close to one in four calls to the Insurance Law Service (or 22.6% of calls) involved questions or concerns regarding insurance investigations. For more information on this survey and analysis see the information box: Insurance Investigations Survey and call analysis, August 2015.

Insurance Investigations Survey and call analysis, August 2015

Financial Rights undertook a survey of callers to its Insurance Law Service (ILS) line between 29 July 2015 and 25 August 2015. Over the four week period (or 20 business days) the ILS provided advice to 465 callers (and emailers) with questions regarding their insurance. Of these, 42 callers were identified as being under investigation for fraud and seeking advice, and 37 of these were surveyed.

In addition to those surveyed, a further 37 callers were recorded as having claims that have been delayed; 20 callers were recorded with queries regarding excessive document requests; 12 were recorded as having a non-transparent claims process; 12 had their claim neither paid nor refused in writing and three were discouraged from lodging or pursuing a claim.

The total number of individual callers identified as having some problem with an insurance investigation amounted to 105 callers out of 465 or 22.6% of all calls to the ILS over the four week period.

The questions asked are at Appendix C.

The case studies that follow are drawn from both this survey period and the last few years of casework and calls to the Insurance Law Service. They are neither presented as a representative sample of insurance investigations nor are they statistically significant. They do however represent the lived experiences of over 40 consumers who have contacted the Insurance Law Service seeking advice and assistance with respect to their insurance claim. They are also generally reflective of the issues raised by callers to the Insurance Law Service.

This Report presents these experiences under five broad areas of concern:

A. *Communication and delay issues;*

B. *Poor investigator behaviour and investigation processes;*

C. *Unreasonable requests for information and/or documentation;*

D. *Unique issues faced by vulnerable people, and;*

E. *The pursuit of investigations with little or no evidence.*

A. COMMUNICATION AND DELAY

Financial Rights sees significant inconsistencies amongst insurers regarding the way they inform their policyholders that they are under investigation and what they are told when an investigation has been initiated. It is not uncommon for a policyholder to discover for the first time that they are being investigated for suspected fraud when they speak to an Insurance Law Service solicitor.

In these cases, insurers have provided the barest of information regarding an investigation into a claim - so bare that the investigation looks like a common bureaucratic exercise in claims handling rather than a serious allegation. For example, one insurer sent a letter titled "House Contents Claim" to a policyholder under investigation for fraud who made a claim on their home contents insurance. The letter included a reference number and stated the following:

> *"I refer to the above claim for your stolen contents during a house burglary on <date>.*
>
> *"To proceed further with your claim, please provide the following documentation and information ...*
>
> *Should we not receive this documentation from you by the <date>, we will assume you no longer wish to proceed with your claim.*

Other letters received by callers to the Insurance Law Service are however more explicit. One letter received by a caller from their insurer stated that:

> *"Due to the complexity of the claim circumstances <Insurance Company> have engaged an external representative ... to validate the circumstances of your claim."*

Another letter from a third party private investigator states that:

> *We have received conduct of an Insurance Claim Investigation from <Insurance company> that you have lodged in respect to a motor vehicle crash which occurred on the <date> 2015.*
>
> *<Your insurance company> have requested that we conduct a full Investigation in respect to the circumstances of the crash and they have also requested that you provide to us various documents to assist with our Investigation.*
>
> *A full factual Investigation entails a full digitally taped interview between yourself and I and also digitally taped interviews with any passengers, witnesses or third party persons involved. The scene will also be canvassed, Police Interviewed and the vehicle possibly examined by a Forensic expert to help ascertain the cause of the crash.*

The information provided in the letters seen by Financial Rights also varies wildly. Some letters explicitly detail the documents they wish to receive, others do not. Some letters include complaints handling details, others do not. No letter seen by Financial Rights includes information regarding the duty of utmost good faith[6] and the rights and obligations that this imposes. Some letters detail the

6 The duty of utmost good faith is one that is difficult to define but generally refers to concepts of fairness, fair conduct, reasonable standards of fair dealing, decency, reasonableness and decent behaviour (Tarr et al 2009). See further discussion in Chapter 4.

timeframe to which they will adhere to, others do not refer to any timelines at all. Insurance Law Service solicitors regularly need to inform callers that under the General Insurance Code, where an insurer suspects fraud or other exceptional circumstances[7], the insurer has a full 12 months to investigate a claim before making a decision to accept or deny a claim. This usually comes as a shock to a policyholder who has been significantly inconvenienced financially, logistically and at times emotionally by an event necessitating a claim on their insurance policy.

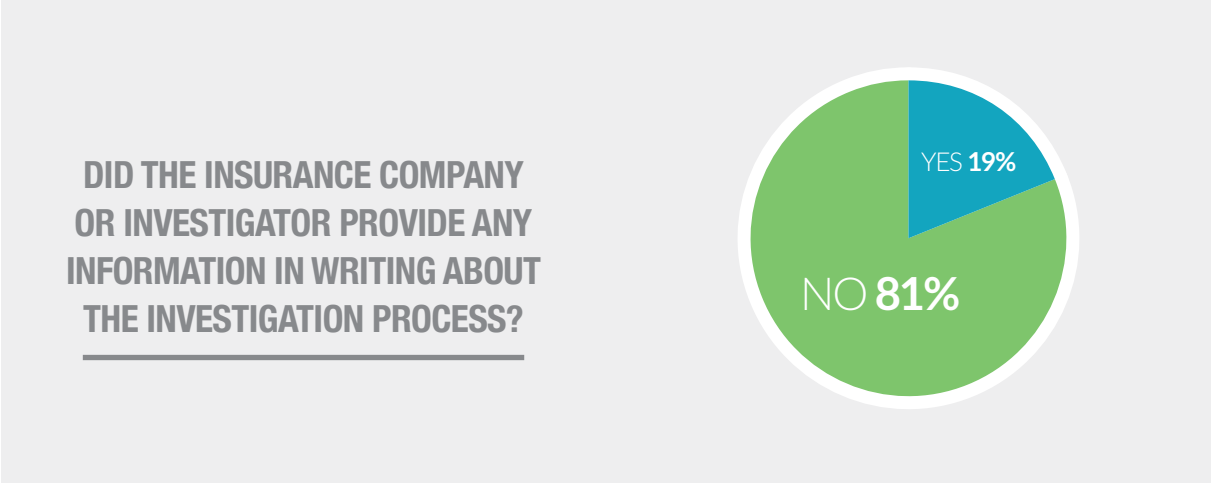
It is only in an interview or in the final decision letter that the word fraud is used in relation to the investigation of a claim. Financial Rights notes when considering a dispute, a Financial Ombudsman Service Ombudsman may discuss issues raised with the parties in order to "ensure the applicant is aware of the fraud allegations," suggesting that it is not uncommon for policyholders to be unaware that fraud is being alleged in their claim.

While many insurers have standard letters that they use, some don't send a letter at all, and others vary their practice and send a letter in some instances, and in other instances do not send a letter. Suncorp, for example, contacts the policyholder:

> *"via phone to inform them an investigation has commenced and to provide the name and direct contact information of the ... investigator. The investigator then reviews the claim information supplied... and contacts the customer via phone to schedule an initial interview to discuss details."*

A letter is then subsequently sent to confirm the details and request documents.

In Financial Rights' survey of 37 callers, we asked whether they received information in writing from their insurer informing them of the investigation. **A little over 80% of those surveyed (30 callers) stated that they were not provided with any written material describing the investigation process.**

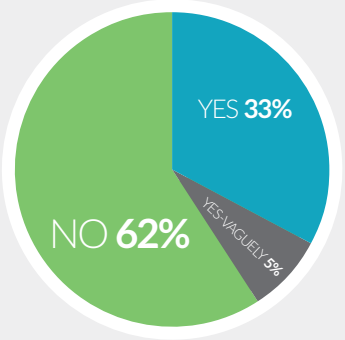


Being fully informed of the process of investigation over the phone is not common either. Sixty-two per cent (or 23 callers) stated that the insurance company or investigator had not explained the process of investigation at all either over the phone or otherwise. Thirty-three per cent (or

7 Such as a failure to respond to a reasonable request under the definition of "Exceptional Circumstances" under the General Insurance Code.

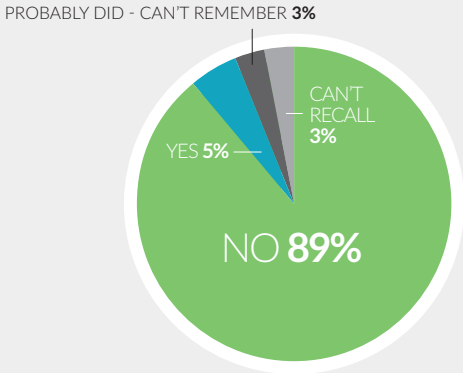
12 callers) answered "yes" and 5% (2 callers) answered "yes – vaguely". Indeed the reason many policyholders call the Insurance Law Service is because they do not know what is happening to their claim and seek information about what to do about it.

DID THE INSURANCE COMPANY OR INVESTIGATOR EXPLAIN THE PROCESS OF INVESTIGATION TO YOU?



When asked whether the insurance company or investigator at any time explained the policyholder's right to complain or query the process, 89% (33 of the 37 surveyed) said "no" they had not. Only 5% (two survey respondents) stated that "yes" the insurer had explained their right to complain while one respondent stated that they "probably did" but couldn't remember. This means that the vast majority of policyholders under investigation were not provided an essential piece of information – their right to complain or query the investigation.

DID THE INSURANCE COMPANY OR INVESTIGATOR AT ANY TIME EXPLAIN YOUR RIGHTS TO COMPLAIN ABOUT OR QUERY THAT PROCESS?



Under the General Insurance Code there are a series of timeframes to which insurers have committed to meet during the claims process ranging from ten business days to 12 month investigation times. The policyholders that Financial Rights work with are commonly subject to long delays and investigations can take up to and over 12 months. Delays can arise from the complexity of the case, the number of third party interviews required, the need to gather expert evidence, and subsequent fact finding.

Drawing on the Financial Ombudsman's online dispute database, Financial Rights analysed 130 disputes from the 2015 calendar year where the Financial Ombudsman made a determination that involved a denial of a claim on the basis of a fraud allegation. Financial Rights calculated the length of time between the date of the event and/or claim first being made and the date of the final determination.[8] This found that the average length of time policyholders had to face was 521 days or almost a year and a half. Seventy-four percent of the cases took over a year. For further information on this analysis see Allegations of fraud determined by the Financial Ombudsman, 2015, on page 58.

These delays can be personally and financially detrimental, sometimes seriously so. Policyholders in remote areas are forced to live without cars necessary for work or everyday activities like driving children to school or other errands. For example, in Rita's story (Case Study 15), the significant delays in her claim made life very difficult as she is a single mother with a three year old. Because of the delay, she has had to walk her child to pre-school and has had to borrow cars off family and friends for basic tasks.

Case Study 1 – Sharri's story[9]

At the request of her work, Sharri travelled to Tasmania to conduct business. She took her car with her to enjoy her time there on the weekends. She had an accident in her car when trying to avoid an echidna on the road. Sharri spoke to her insurer regarding repairs however the insurer began investigating the claim. Sharri was stuck in a rural Tasmanian hotel waiting for her insurer to instigate and approve the claim and organise repairs.

During this time Sharri was asked to send her driving history to her insurer who claimed never to receive either the PDFs or the scans she tried 15 times to send through. She then got a friend to scan each page individually to be faxed through to the insurer, and was told by the insurer it had not been received. Sharri was stressed as she did not know how long the process would take and she would have to leave Tasmania and return to her work at some point.

Other policyholders are faced with having to live in difficult and sometimes dangerous situations when their house is damaged. The policyholder in Fenella's story (Case Study 3) for example, a single parent of three had to live in a temporary residence with shared rooms after a fire destroyed her house. She faced significant year-long delays in processing her application. Delays can also cause further damage, wear and tear or deterioration to an insured property.

B. POOR INVESTIGATOR BEHAVIOUR AND INVESTIGATION PROCESSES

Insurance Law Service solicitors are regularly told by policyholders that they 'felt like a criminal' or the interviewer was rude, aggressive, bullying or intimidating. These common refrains also sometimes appear in applicant positions in determinations made by the Financial Ombudsman.+

8 Only two cases out of the 130 identified did not refer to a date of the original event and/or claim and were removed from the calculation.

9 Not her real name. All the names have been changed to maintain anonymity and protect their privacy. Case file numbers have been listed in the bibliography. Insurer names have been removed to focus on the issues involved rather than any particular company. The case studies do however involve a broad cross-section of general insurers.

Being subject to an insurance investigation is an intimidating, largely foreign experience to most people. It is inherently daunting with its own built-in adversarial power dynamic and quasi-criminal procedures. However a lot of the concerns raised by callers to the Insurance Law Service are specific and remarkable in nature and are more than simple misgivings or qualms. They include dauntingly lengthy interviews, issues with the location of the interview, aggressive conduct, and unethical behaviour

Overlong interviews

Interviews of any length are a stressful experience for a policyholder. However interviews that last over an hour or two can be physically and emotionally exhausting and at times traumatic.

Case Study 2 – Olivia's story

Olivia collided with two cars in November 2014. Olivia was at fault and admitted liability. Her insurer investigated the claim.

While being warned that the interview would be long, Olivia was ultimately subjected to a four hour long interview. The investigator asked extensive questions about Olivia's private life, including questions about her ex-husband, boyfriend, and children.

Olivia was asked to attend another interview and contacted the Insurance Law Service to ask whether she was obligated to attend the interview. Olivia was so traumatised by the length and invasive nature of the previous interview that she would have preferred not to take part in another interview despite wanting to do what she needed to do to resolve the matter.

Case Study 3 – Fenella's story

Fenella's house was broken into and set on fire while Fenella was inside. Fenella made a claim on her policy. The insurer rejected the claim suspecting fraud and breach of duty of utmost good faith.

The investigator explained to Fenella that her interview would be recorded, gave her an opportunity to object, and told her that she had the right to request a copy after the interview. No estimate was given regarding the length of the interviews conducted.

Three interviews were held with Fenella at her home, one of which ran for five hours. Fenella's Aunt had been present at one of the interviews. Two interviews were held with Fenella's mother, one of which lasted for two and a half hours. Two interviews were held with Fenella's aunt.

While no issues of intimidation were raised Fenella cried at the end of the five hour interview due to a combination of exhaustion and the fact that it was the fifth anniversary of the death of Fenella's grandmother – the original owner of the property.

The strain placed on a policyholder subject to a very long interview can lead to mistakes or misstatements based on tiredness and a lack of clarity rather than any intention to mislead or lie.

Sometimes long interviews can lead policyholders to answer questions in ways they believe will please the interviewer, shorten the length of the interview and 'get them off their back'. There has been extensive research into the effects of lengthy police interviews (for example, Drizin 2004, Kassin et al. 2010) particularly with respect to false confessions where resistance is worn down and the suspect is made to feel hopeless. While the cases eliciting false confessions are at times over six hours in length it is generally accepted that any interviews over two hours make excessive demands on subjects (Willis 1999).

Long interviews can be daunting simply through the sheer physical, intellectual and emotional strain placed upon the subject over such a period. This is particularly the case if the interview subject has not been made aware of the intended length of the interview beforehand, a circumstance commonly observed by Financial Rights:

Case Study 4 – Craig and Mary's story

Craig's motorbike was stolen and he subsequently made a claim on his comprehensive insurance. The insurer decided to investigate.

The investigator told Craig that he wanted to interview Craig and his wife Mary and that the interview with Mary would take two hours. Craig explained that his wife had to work but could spare 30 minutes. The investigator then said that he would be able to do the interview in 40 minutes to an hour. The investigator insisted that the interview take place in Craig and Mary's home.

Upon arrival to their home they were informed again that the interview with Mary would take two hours. However, the interviews with Craig and Mary took a total of five hours. Halfway into the interview Craig and Mary explained that they needed to go to work. In response, the interviewer told them that if they did leave then they would have to conduct the interview all over again "from scratch".

Craig and Mary stayed despite their work commitments. Mary felt pressured to answer despite a bad memory and at times made up answers simply to keep the investigator happy and have the interview be done.

When Mary expressed a dislike for the motorbike, she was asked whether she had stolen the bike herself. Mary responded that she was just not a bike person.

Case Study 5 – Uma's story

Uma and Ray had their house broken into by vandals, who stole jewellery, broke fixtures off the property and vandalised the house with paint.

Uma is a stay at home mother. She participated in three interviews with the investigator, totalling approximately 11 hours including one face-to-face interview for five hours.

She was not given an estimate as to how long the interviews would take.

In the survey that Financial Rights conducted, 65% of survey respondents (24 of the 37) were provided with an estimate as to how long their interview would take. However the estimates provided ranged from the vague "some time" and "a few minutes" to an hour or two hours. One caller was told that their interview would last between four and five hours. Of the 24 who were provided with an estimate, 13 were ultimately longer than what had been estimated, usually between half an hour to an hour longer than estimated.

The shortest interview to take place was 15 minutes (the interview had been expected to take an hour) and the longest was five and half hours, after an estimate of two hours. Other extreme examples from the survey include: a caller whose interview lasted five hours but was given no estimate; one caller who was provided with a one hour estimate but the interview took four hours; and a caller who had been interviewed three times for two and a half hours each.

In a July 2014 case where the Financial Ombudsman explicitly examined the conduct of an investigator, the Applicant had been interviewed for up to four and a half hours:

> *At the end of the Applicant's interview, the Applicant is asked whether he felt threatened and aggressive (sic). He responded "A little bit yeah". The Applicant has confirmed he felt intimidated. He made these comments to the [insurer] shortly after the interview. ... I do not believe the interview has been conducted in an appropriate or fair manner. ... It is quite clear that the Applicant had been given the impression that the interview would not last long and that he would be able to return to his duties as a teacher.*
>
> *The investigator seems to totally disregard the Applicant's work requirements placing the Applicant under significant pressure.*
>
> (FOS Case No. 324030)

In another Financial Ombudsman case the investigator interviewed the Applicant for up to five and a half hours. The Financial Ombudsman stated that

> *"I accept however that to interview a person for five and a half hours as alleged seems extraordinary given the nature of the claim. It is not clear why such a lengthy interview was necessary. ... While the interview was very long and the Applicant understandably frustrated, the interview was conducted professionally and politely. ... Other than the time taken for the interview, I find that the [insurer's] conduct in this matter has been reasonable."*
>
> (FOS Case No. 334585)

In speaking with one insurer and their external private investigator, they readily accepted that interviews can go on for periods of up to five hours, believing that this is necessary in complex cases.

The impact of a long interview can also be exacerbated by being subjected to multiple interviews over a period of days or weeks:

Case Study 6 – Louella's story

Louella's car was stolen in May 2015. Louella was told by the insurer that an investigator was coming to interview her. Louella spoke with the investigator and asked that she be interviewed over the phone. The investigator told her no, the interview had to take place face-to-face in her home. Louella has, to date, been interviewed three times for approximately two to two and a half hours each. Louella was asked for documents and further information at the end of each interview.

Case Study 7 – Salem's story

Salem's car was stolen in February 2014 and made a claim with his insurer. The claim was investigated and Salem was interviewed twice. He was informed that these interviews would take an hour but instead took three hours and one and a half hours. Salem felt as if the interview was an interrogation and complained to his case manager. Salem requested a different investigator but this was denied. The first interview was conducted at Salem's home at the investigator's insistence but after seeking advice from the Financial Rights website he asked for neutral location for the second interview. The second interview was held close to his workplace and despite being told the interview would take 45 minutes, Salem was forced to take an extra long lunch as it went for one and a half hours.

Interview location

Insisting that an interview be conducted at the home of the policyholder exacerbates the problem of overlong interviews. Conducting an interview at home disempowers the policyholder by not providing them with the option to walk away and leave in the same way a neutral location does. The policyholder is already in their own home and cannot leave. If a policyholder were to ask an interviewer to leave due to tiredness or other commitments, the request has the potential to be seen as uncooperative or obstructive, and could be a black mark against their duty of utmost good faith.

The investigative transaction is similar to that of the in-home sales process dynamic, which, while different, features many of the same complex set of interpersonal behaviours and pressures that arise when someone has 'invited' someone of authority into their home.

> *"To invite someone into your home requires a certain level of trust and is usually reserved for people in a personal relationship with you. ... The ramifications of this are that the salesperson may be treated as a friend or family member. For instance, the salesperson may be offered food or drink. The salesperson also becomes privy to a whole host of information about the consumer's private life that they might use to exert authority or*

> *enhance understanding, liking and similarity. These social elements act to enforce the prior commitment since people prefer to say yes to people they like, those they perceive as similar or individuals with authority. ...*
>
> *Aborting the transaction at any stage will mean huge psychological costs for the consumer who has committed to the visit... Asking someone to leave your house after you have invited him or her appears to be substantially more difficult than walking out of a retail store.... They must ask someone whom they may like (or their ego has told them they like, because (i) they have invited them into their home, and (ii) they perceive they will help them to solve a problem), trust or see as an authority figure, and whom they have entered into a personal transaction with, to leave after originally having invited them.*
>
> *Learned social conventions would generally consider it rude to revoke an invitation to the home (despite a rational awareness of the "real" reason for the visit),"*
>
> (Harrison et al 2010, pp23-4)

These pressures have been acknowledged in the courts too:

> *"The vulnerability of the consumer to the salesperson in her or his home arises from the difficulty in putting an end to the sales process once the salesperson in the home, especially after that person has spent time and undertaken persuasive effort in a sales process or "pitch". People can simply agree to things to put the situation at an end."*
>
> (ACCC v Lux Distributors [2013] FCAFC 90 at 10)

Again, in-home sales and the investigation process are very different however the behaviourial pressures and difficulties faced by consumers are remarkably similar.

Case Study 8 – Karl's story

Karl's Adelaide house was broken into. Karl had just moved from South Australia to Queensland for a job and had organised for his house to be rented out. Karl claimed on his insurance and provided proof of ownership of the stolen goods with receipts. An investigator interviewed Karl at his home after implying that if Karl did not hold the interview at his home, it would have a negative impact on his claim. Karl had preferred to have the interview conducted at a neutral place near where he worked. The investigator told Karl that the interview would take between two-three hours The interview lasted three and a quarters hours finishing at 10.30pm. The investigator took two cigarette breaks. The interview was only wound-up after Karl asked the investigator to leave because it was getting late and he had to get up for work the next morning at 5am. The investigator had not explained the interview process, clearly telling Karl that the interview would cover the list of items stolen. However Karl believes only about 30% of the interview touched on the list of items stolen; the rest involved questioning Karl on his personal life e.g. work and his separation from his wife. Karl felt misled as to the purpose of the interview and felt menaced and interrogated by the investigator. Karl also believes that the investigator asked too many irrelevant questions.

In other cases the fact that the investigator insists on an interview at the home of the policyholder can have a significantly negative impact on his or her business.

Case Study 9 – Robert's story

Robert had two work vehicles filled with building equipment stolen from his home, which is also his place of business. His claim was investigated. Robert was told that the interviews had to be in the home and no one was allowed to be present. Robert was forced to close his business for an entire day. The interview took five and a half hours, with additional interviews with his wife for two hours and his son for one hour. Robert called the Insurance Law Service to ask for advice as he had been requested to submit to another interview and Robert was concerned that he did not want to have to shut his business down again.

In the following case study the investigator did not insist that the policyholder submit to an interview in her own home but gave her the choice to rent a room at her own expense:

Case Study 10 – Zoe's story

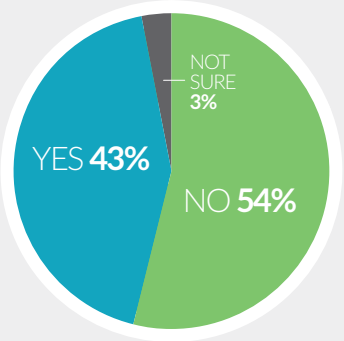
Zoe's house in central western NSW was damaged by a fire and completely destroyed. Zoe made a claim but was investigated by her insurer. The investigator sought to interview Zoe and requested that Zoe either hire a room for the interview or have the interview held at the local library. Zoe did not want to either hire a room or be interviewed at the library. In the end the interview was held in Zoe's car and lasted five hours. Zoe felt that the investigator kept making 'snarky' comments such as "that shouldn't have cost you that much – I'm sure you could have gotten it for much cheaper."

Case Study 11 – Dalton's story

Dalton had a motor vehicle accident in mid 2014 and was subsequently investigated. Dalton organised with the investigator to have the interview conducted at the local RSL. However the interview was eventually conducted on the side of the road in a remote location when the investigator asked Dalton to pull over. The interview lasted two hours after being told it would be one.

The survey of Insurance Law Service callers found that 43% of callers who had an interview arranged or already taken place reported that the investigator had insisted on the interview being conducted at their home.[10]

DID THE INVESTIGATOR INSIST ON THE INTERVIEW TO BE CONDUCTED AT YOUR HOME?

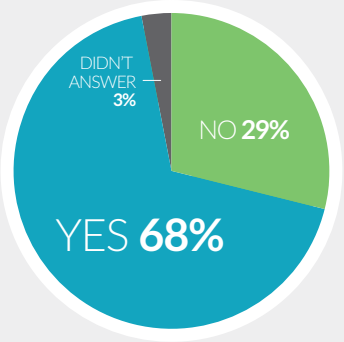


Aggressive interviewing behaviour and intimidating conduct

In addition to the length and location of interviews the behaviour and approach to questioning and communicating with a policyholder can also lead to feelings of intimidation. Policyholders subject to interviews regularly state that that they are "made to feel like a criminal", that the interviewer was aggressive and rude and that they felt like they were being made to trip over their words.

This was borne out in the survey of the Insurance Law Service callers. **Well over half of the callers or 68% reported feeling intimidated during the interview with the investigator.**[11]

DID YOU FEEL INTIMIDATED AT ALL DURING THE INTERVIEW?



10 Out of 37 callers surveyed, seven had yet to have their interview organised. The insurance company or investigator insisted on the interview taking place in the home of 13 of the 30 remaining callers surveyed or 43.3%. 16 callers reported that the insurer or investigator had not insisted on a home interview and one was not sure.

11 Out of the 37 callers surveyed nine had yet to have their interview take place. Of the 28 interviews that had taken place, 19 of the callers (68%) reported feeling intimidated during the interview with the investigator. Eight of the callers did not report feeling intimidated. One respondent did not answer.

The most common refrain mentioned five times variously was "I was treated like a criminal," or "I felt like a criminal." Another referred to the experience feeling like a "police interview." One caller complained that the investigator had lit a cigarette in her house without asking her.

Statements by survey respondents

"I was uncomfortable and judged immediately"

"I was treated like a criminal"

"I felt belittled and pressured into giving answers"

"I felt uncomfortable being left alone with a male investigator"

"He kept saying you do realise that if you lie, it is a crime and kept mentioning that it was being recorded"

"I felt like a criminal"

"It was an interrogation and he kept saying that we haven't given him all the information they need, I eventually had to kick him out. He was very aggressive and pushy."

"The investigator kept making snarky comments"

"There were intimidating questions, very invasive, repeated questions. He was asking for lots of documents and asking irrelevant questions from 20 years ago"

The process of interviewing can be inherently intimidating which can be further exacerbated by the physicality of the investigator. Many private investigators are drawn from the police and the military (in addition to the insurance industry); fields that value physical strength, authority, domination and aggression.

Heightened feelings of intimidation can also arise from the particular approach taken by the interviewer, the form of words they use, the type of questions being asked, the perceived attitude of the interviewer as well as the implied or explicit threats made. In some cases the investigator displays overtly aggressive behaviour.

Case study 12 – Violet's story

Violet's back shed was broken into and items worth over $20,000 were stolen. The items had been her son's and had only recently been moved into the shed from her caravan following her son's death from diabetes. The burglary was one of a series of break-ins on the same night, with her neighbour also having property stolen. The burglary was reported to the police and Violet made a claim on her contents insurance. Her insurer started an investigation.

Violet felt that the investigator engaged in intimidating behaviour and acted in an unpleasant manner. The investigator would not let Violet have her other son accompany her in the interview, which was conducted in her home. Violet was told by the investigator that she could not contact her insurer directly. When she did contact her insurer she received a call soon after from the investigator yelling and castigating her for contacting her insurer directly, reiterating that she was only allowed to speak to the investigator.

Violet was told by the investigator that it was his belief that she stole the items herself and that she was lying to him. Violet asserted that the investigator was calling a lot, verging on harassment and that the investigator asked her a number of questions that she felt were irrelevant - where was Violet going on the weekend and questions about her dead son. The investigator even stated to Violet "No wonder you don't have a husband." Financial Rights understands that the investigator was fired by the insurance company involved.

Case study 13 – Haresh's story

Haresh lives on a farm with his mother and works in a mine. Haresh had a car accident where he lost control and the car went off the road. The car is a write-off. Haresh made a claim with his insurer in August 2014. An investigator held an interview in September 2014 at Haresh's home for one to two hours. Haresh claims that the investigator was rude, implied that Haresh had a criminal history (he did not) and threatened to interfere with the immigration of his fiancé if Haresh was lying. The claim was ultimately paid out 12 months later.

Case study 14 –Wesley's story

Wesley's vehicle had broken down and he could not afford to have it towed. The vehicle was subsequently stolen and burnt out. He claimed on his insurance but was investigated. Wesley, who is a war veteran suffering from PTSD, has an acquired brain injury and extreme injury to his leg and spine, was advised by his insurer that he had to cancel a hospital stay to meet with an investigator. Wesley advised that he felt bullied by the investigators who told him words to the following effect after the recording had been turned off 'that he was lying and would be arrested by a detective.' He was given very abrupt responses by his claims officer and was not provided with updates as required under the General Insurance Code. He felt as though the claims handling process was not clear.

Wesley took his matter to the Financial Ombudsman and obtained a successful determination. However despite the determination outlining payment of interest, representatives of the insurer told him they would not pay the claim.

Case study 15 – Rita's story

Rita's car was stolen and she lodged a claim with her insurer. Rita found the interview process very difficult, and the investigator suggested that he had her under surveillance. The investigation process was not explained to her and she was not given the option to have the interview held anywhere other than her home. Rita was also told that she couldn't have anyone else present during the interview. The questions asked were in her view aggressive, with the investigator questioning Rita's memory, even asking Rita what clothes she was wearing on the day, three months prior.

Her insurer rejected the claim three months later on the basis that Rita had failed to provide documents that were in her ex-partner's name, despite considerable effort to do so. Rita's car was found later in the year by police following the execution of a search warrant in the backyard of a person that is unrelated to Rita.

Rita was advised by her insurer that until the police concluded their investigation concerning the theft, her insurer would be unable to pay out the benefit. Rita does not know the person currently being investigated for the theft and has never met them. In speaking to the investigator she was asked "How do we know that he's not your friend?"

The way investigators approach interviews, conduct themselves and ask questions can vary widely (Roberts 2012) from a basic question and answer approach[12] or interrogative approach[13] to persuasive[14] or ethical approaches to interviewing.[15] There have been many developments in

12 where the interviewer asks a series of questions around matters of interest without any attempt to build rapport (Roberts 2012, p4)

13 where the interviewer dominates the conversation and may include implied threats and coercion (Roberts 2012, p4)

14 where the interviewer does seek to build rapport and a supportive environment to encourage information out of the subject (Roberts 2012 pp4-6)

15 Ethical approaches involve treating interview subjects with respect and as equals with rights to dignity, self-determination and choices (Roberts 2012, pp6-7) These interview techniques include the model used in the UK known as PEACE, cognitive interviewing and a practice known as conversation management.

interview technique over the last century. Trends have shifted from a majority of leading or closed questions to more open-ended questions and the 5WH (Who, What, Where, When, Why, How) formulation (Roberts 2012, p11). Small changes in tone, wording or even the environment and the time of day can have profound impact on the interview subject and the outcomes achieved from the interview.

While researching this subject, Financial Rights spoke to one investigator working in the Australian industry who indicated a number of techniques are used in the same interview. The interviews conducted usually began with open-ended questions which then moved into a review phase where the information gathered is further interrogated where inconsistencies arise or there is a lack of detail.

A common reason why interview subjects are "made to feel like a criminal" is that **they feel that the interviewer and insurer have come to the table with a preconception that the policyholder is guilty.** This impression arises when the interviewer puts forward their own or alterative versions of what occurred and persistently seeks information and evidence of this scenario however minor or circumstantial.

The personal opinions and biases of the investigator can also seep into the report provided. In 2004, Alternative Referee and Adjudicator Ron Beazley of the then Insurance Ombudsman Service discussed this matter in his Referee's Report of that year:

> *The issue of perceived bias is a more vexed problem in respect of general investigator's reports. It is acknowledged that contracted investigators work within a highly competitive environment and it is understandable that an investigator may sometimes exceed the bounds of enthusiastic enquiry in the course of a record of interview or in the preparational interview.*
>
> *Generalisations can be odious and unhelpful, but it is important ... to note that there persists [in 2004] among some investigators adherence to a strongly adversary method of interviewing claimants and their witnesses.*
>
> *The use of phrases that refer to the interviewee's body language, apparent nervousness, sweating and shifty eyes brings little value to the report. On the contrary, an insurer in receipt of such a report has a more difficult task in preparing a measured and objective statement of the factual matters that are relied on, in arguing it has reasonable grounds for believing the claim may be fraudulent.*
>
> *The old adage 'drop the epithets and personal comments' will assist an investigator in the production of a measured and objective report.*
>
> (IECL 2004)

The following example demonstrates that a simple opinion-laced comment by an interviewer can raise in the mind of the policyholder that they are preconceived to be a criminal or guilty of fraud, tainting the perception of the rest of the interview.

Case Study 16 – Peter's story

Peter's car and trailer were stolen. The trailer was insured with one insurer, the car with another. The trailer's insurer investigated and quickly paid the claim. The car's insurer however undertook a lengthier investigation. They conducted four telephone interviews with Peter. Peter felt that the investigator took an aggressive and accusatory approach.

For example, when questioning the twentysomething Peter about an amount of money his father had provided to him for a deposit on a house, the interviewer asked "Why would anyone do that?"

Further, when Peter was asked about friends of his visiting from Canberra the week after the car was stolen, Peter was interviewed extensively on the purpose of their trip, how many there were and other questions that Peter felt were invasive and irrelevant to the matter.

When Peter told the interviewer that the trailer's insurer had accepted his claim the investigator responded that he would "be speaking with [the trailer's] insurer." When the investigator asked questions Peter felt drilled about every minor detail of the week in which the car was stolen. The interviewer would ask a question and then ask "and then what, and then what, and then what" repeatedly.

Aggressive interview behaviour can range from a display of confirmation bias (that is, seeking answers to support preconceived views of the investigator) to implied or explicit threats. In Karl's story (Case Study 8) detailed above, the interviewer implied that if the claimant did not hold the interview at his own home then that would have a negative impact on his claim. Gaby's story (Case Study 27) below includes the threat that if information held by the policyholder's ex-partner wasn't provided by the policyholder then the insurer would reject the claim, even though both the policyholder and the insurer themselves had asked for and were denied the information from the recalcitrant ex-partner. Adam's story (Case Study 28) involves the threat that the claim would be denied despite the telephone provider advising that there were no records to supply.

A policyholder's duty of utmost good faith means that an investigator can request cooperation and particular conduct. This can however go too far, as the following case demonstrates:

Case study 17 – John's story

John held comprehensive car insurance when his car was stolen. The car was recovered by the police with damage to the windows and the panel under the steering was ripped. John made a claim and his insurer asked to conduct an interview. John went to his insurer's branch and participated in the interview.

A few days after the interview the investigator turned up at John's property unannounced demanding entry to the property. John was not home but his partner was. The investigator had not arranged to speak to John to conduct an additional interview. The investigator knocked on the door and asked to come inside. John's partner was home alone with her children and not comfortable letting a strange and unannounced man in her home so she said 'no.' The investigator then said to John's partner that "I can do what I want, when I want. I want to come and look." He presented no ID nor did he wear an identifying uniform. John's partner continued to deny the investigator entry as she thought at first he was a salesperson and didn't know what the house call was about. The investigator told John's partner that he had a right to enter the property and would not leave, eventually sneaking around the back of the house without permission.

John's partner called the insurer to complain about the behaviour of the investigator and was told "don't be silly, [investigator's name] would never do that" and insisted that the investigator was wearing a uniform and had an ID. John also complained and was told by the investigator that "Your wife is a f***ing liar".

John found the whole experience so stressful that he chose not to pursue the claim any further.

Apart from the overt intimidating behaviour of the investigator, the above example raises the issue of gender. For many, the simple act of a man interviewing a woman can make some women feel uncomfortable and vulnerable, particularly when there is perceived aggressive or intimidating interviewing behaviour. This is exacerbated when cultural or ethnic elements arise – for example, the interviewing of a Muslim woman by a man, alone or without the presence of her husband.

The following case involves intense questioning of a woman on highly personal details that bear no relevance to her claim.

Case Study 18 – Nina's story

Nina is a single parent with two children on Centrelink.

Nina's car was stolen and she lodged a claim on her insurance policy.

Nina had informed the investigator that she had no criminal history but she had had dealings with the police. Earlier that year, Nina had given birth to a baby, which was the result of a rape. The offender was never brought to justice as she could not identify her attacker.

During the interview, the investigator stopped the recording to ask Nina questions about the rape itself. The investigator asked "Can you remember what the guy looked like? What happened to you during the incident?" "Why did you decide to keep the baby afterwards?"

Nina felt very pressured and uncomfortable answering all these personal irrelevant questions as part of her claim. After all the personal questions, the investigator then resumed the recording and carried on with more standard claim questioning about the actual car.

Nina complained to her insurer about the investigator's inappropriate conduct asking about her rape and asserted that the rape had nothing to do with her theft claim. The insurer responded that it was all relevant to the claim.

The tactics described above and in the following section are not only abusive and unnecessary they don't always benefit the investigation and the insurer's case – unless the policyholder gives up and withdraws their claim. This raises the question as to whether the goal of many investigations is an objective gathering of the facts or withdrawal by intimidation and exhaustion.

Unethical behaviour

Financial Rights has learnt of interviewer behaviour that ranges from overtly aggressive and implicitly threatening to other conduct, while not aggressive, is certainly unethical. In some cases the unethical behaviour arises when the investigator tries to gain an advantage. This case involves asking a policyholder to sign a blank authority:

Case Study 4 – Craig and Mary's story continued

As detailed above, Craig's motorbike was stolen. He subsequently made a claim on his comprehensive insurance and was investigated. Craig and Mary were interviewed for five hours.

In seeking documents at the end of the interview, the investigator asked Craig and Mary to sign a blank authority form. Craig looked at the form and asked the investigator to fill in the details of who the investigator would like documents from, as he felt very uncomfortable giving the investigator carte blanche with the unfilled in form. The investigator then filled the form in to seek information from the police only.

In the following case the behaviour involves altering an authority after it was signed.

Case study 8 – Karl's story continued

As described above Karl's Adelaide house was broken into in August 2014 and he made a claim. He was subsequently interviewed for three and a quarter hours.

During the interview Karl was provided a List of Authority to Release Information form allowing the investigator to gather documents from a variety of sources all listed on the form. Karl signed the form. Karl took a photo of what he agreed to on the form. Karl discovered later that the investigator had added items to the form after Karl had signed it without his knowledge or permission.

In January 2015, Karl was informed by his insurer that the investigator had been suspended and they needed to interview Karl again. Karl was not told what the interview would involve, and he was frustrated there was still no outcome on his claim. Karl's claim was finally paid out fully in September 2015.

The following two cases involve inappropriate encouragement by the investigator to have the policyholder potentially breach the terms and conditions of online accounts:[16]

Case Study 6 – Louella's story continued

As described above, Louella's car was stolen in mid-2015 and she was interviewed three times for approximately two hours each with requests made for a large amount of documents.

With respect to her phone account information, Louella first provided an excel document.

This was not enough according to the investigator. Louella then provided it as a PDF. This was still not satisfactory. The investigator then requested that Louella open an online account and give the investigator the password so he can access her account and she can change her password later.

16 Most online accounts include terms that prohibit telling a third person pins or passcodes. Commbank, for example, states in its electronic bank terms and conditions, "never tell or let anyone find out a PIN, password or other code – not even family or friends." (Commonwealth Bank n.d.) Virgin Mobile terms and conditions state: "You must keep confidential any password, code or personal identification number (or PIN) that you choose or we give you to use in connection with the service." (Virgin Mobile 2011)

Case Study 19 – Sarah's story

Sarah's car was hit whilst parked outside her sister's home.

Sarah made a claim on her insurance. Her insurer began an investigation. Despite an estimate of 45 minutes, Sarah was interviewed for more than three hours over two sessions.

The interviews were conducted at Sarah's home at the investigator's request. She was asked to sign a number of forms relating to accessing her credit rating and other information. These forms were explained but Sarah was heavily pregnant and overwhelmed by the experience and did not understand much of what she was told. A list of documents requested was provided to Sarah at the end of the interview. Sarah was at first advised by the interviewer that they were not needed but later Sarah was followed up by the investigation team requesting that she provide these documents, without any explanation as to their relevance to the investigation. These included phone records for her ex-partner, her sister and her ex-partner's bank statements.

Sarah was told that her insurer would interview her ex-partner, with whom Sarah was going through a divorce at the time.

The investigator explained that despite the car and the policy being in her name Sarah was obliged to ensure her ex-partner be made available to interview because he was entitled to 50% of the payout once the claim was accepted. This was distressing to Sarah since the circumstances surrounding the divorce were difficult.

Sarah was again asked to provide her ex-partner's bank account records. She provided screen shots of her ex's bank records but not the actual statements as she has a joint account which she can view but not access. A representative of her insurer advised Sarah to obtain her ex-partner's internet banking password, go online and download his account statements.

The final two cases involve the demand of a fee for work being undertaken.

Case study 15 – Rita's story continued

As described above, Rita's car was stolen in February 2014 and after a long and difficult investigation process and rejection of her claim, her car was found by police. Rita sought information regarding her claim and the insurer demanded a $165 service fee to provide information and a $20 service fee for each call recording.

Case study 20 –Samuel's story

Samuel had comprehensive motorcycle insurance when his motorbike was stolen at a train station. Samuel reported the theft to the police and lodged a claim. The bike was recovered heavily damaged and was being held in a holding yard. A private investigator was appointed and during his interview he threatened that Samuel will be responsible for the private investigator's fees if his claim turns out to be unsuccessful as well as the holding yard fees.

Financial Rights has learnt that the demand of investigation fees is an actual policy of at least one insurer. The RAA includes the following statement on its comprehensive car insurance:

> *"If your claim has been investigated and you withdraw your claim or we refuse to accept it, you may have to pay any costs incurred for the investigation of your claim."*
>
> (RAA 2014, p22)

Racial Profiling

Racial profiling can involve policyholders being chosen for investigation on the basis of stereotypes held about race, ethnicity, religion or ancestry. Racial profiling can also arise in the way investigations are conducted. Profiling arises when any action taken by an investigator to evaluate the veracity of a claim is based on stereotypes rather than on a reasonable suspicion, singling out an individual for greater scrutiny or different treatment.

Anecdotally the charge of racial profiling is regularly made by policyholders to Insurance Law Service solicitors. Whether there is truth to any of the claims is hard to say when providing basic advice over the phone. However Financial Rights is concerned with the over-representation of those from a non Anglo-Celtic background in the calls we receive on the Insurance Law Service phone line with respect to investigations.

In a recent training session on fraud, the Financial Ombudsman also raised a concern that there had been a significant number of applications in their fraud section involving claimants from a middle-eastern background.

In our survey 19 of the 37 callers were of an ethnicity that was non-Anglo-Celtic. The 19 callers identified variously as Middle Eastern (6), Serbian (3), Maltese (2), Indian (2), Thai (2), Macedonian (1), African (1), Nepali (1) and Aboriginal and Torres Strait Islander (1). While pinning down the exact ancestral make-up of the Australian population is difficult and fraught,[17] it is generally understood that Anglo-Celtic percentage ranges between two thirds of the population (ABS 1995) to 70% (ABS & Hugo 2001) to three quarters of the population (Babacan 2010, p16). Thus non-Anglo-Celtic Australians make up roughly between 25 and 33% of the population.

17 This arises from difficulties in the concept of ancestry, self-identification (particularly with the concept of identifying as "Australian"), cultural identification practices and the complexities of identification for second and third generation Australians with parents with different ancestry.

The results of this admittedly small survey suggest that there is an over-representation of policyholders (51%) from a non-Anglo background proportionate to their population size. A longer and more extensive survey of policyholders under investigation would be required to explore the issue further, however the survey results do at least match up with the subjective impressions of solicitors who work on the Insurance Law Service that Australians with non-Anglo-Celtic backgrounds are disproportionately represented in calls to the Insurance Law Service regarding insurance investigations.

These findings, while only preliminary indications of patterns of racial bias, do support the anecdotal evidence collected by Financial Rights solicitors:

Case study 21 – Verddah's story

Verddah, a woman of Middle Eastern background, was involved in a collision with another vehicle where the other party, a man who was also of Middle Eastern background, admitted fault.

After making a claim on her insurance her insurer investigated and asserted that the claim was fraudulent and that Verddah had staged the accident with the help of her brother. The insurer's evidence of this fraud was that Verddah telephoned her brother several times around the time of the accident, that two witnesses saw a man of middle eastern appearance running from the collision and that the other party's son was employed by a smash repairer that was previously used by Verddah following an accident seven years previously.

In examining the allegations the Financial Ombudsman accepted that the phone calls made to her brother were to simply inform her family of the accident and that the person of middle eastern appearance was never identified and no meaningful conclusion could be drawn from the evidence. The Financial Ombudsman also rejected any connection between the other party's son and Verddah and her family. While the other party's son had worked at the repairer two years previously, he was only eleven years old when the earlier accident occurred and was not associated with the repairer at the time. No link was ever established between Verddah's brothers and the other party.

No financial motive was substantiated given Verddah was a bank manager, had a healthy wage and had a large amount of accrued savings.

Case study 22 – Joel's story

In early August 2014, Joel's car was stolen and Joel made a claim on his comprehensive insurance.

His insurer claimed that some incidents didn't match up and insisted on carrying out a fraud investigation. A private investigator was sent to interview Joel and his wife. He explained who he was, what the process was and that Joel didn't have to answer any questions he didn't want to answer.

Consent forms were provided and explained and the interview was recorded. The interviewer was friendly but did state that he "was happy to talk to some 'normal' people as opposed to the 'Lebanese people' he is always sent to who have usually committed fraud."

Case study 23 – Berhat's story

Berhat's is a young student of Iranian background with her first language being Farsi. Her car was stolen and Berhat claimed on her comprehensive insurance. She was subsequently investigated by the insurer. During the interview the investigator asked Berhat for a witness's phone number, who is a friend of hers. The investigator asked Berhat if this friend was also from her country. Berhat replied and said yes, all my friends are from my country. The investigator responded by laughing.

C. UNREASONABLE REQUESTS FOR INFORMATION AND/OR DOCUMENTS

Information such as phone records, bank and other financial records, driving history and the like are documents commonly sought by insurers when investigating a claim. They are, generally speaking, relevant to a claims decision[18] and go to establishing "crucial factual matters."[19]

However Insurance Law Service solicitors are regularly contacted by policyholders with concerns over document requests. Many feel that their privacy may be breached with requests for particularly sensitive documents. Others do not see the documents' relevance to the facts at issue since this relevance has not been spelled out to them by the insurer. A number of policyholders that Financial Rights speak to are overwhelmed by the extent of documents requested and overcome by the process of obtaining the documents. And most policyholders that Financial Rights speak to are not

18 Under the General Insurance Code of Practice (2014, cl. 7.3) insurers "will only ask for and rely on information relevant to our decision when deciding on your claim."

19 In a 2009 determination the Financial Ombudsman Service explained that: "Bank and financial documents clarify the existence of a possible motive and phone records can help clarify the movements of the insured and any relevant contacts. A criminal history check is also commonly requested to ensure that an insured does not have a history of behaviour consistent with the concerns identified in the claim." (FOS Case No. 203931, para. 19) A 2012 Financial Ombudsman Service determination extrapolated further on the scope of relevant documents arguing that investigating a policyholder's financial position is a viable line of enquiry: "A financial motive is a viable precursor to the commission of a fraudulent act. This is not in any way to suggest that the Applicants have committed any such act in relation to either of the lodged claims in this instance. In a general context, a policyholder who is in a parlous financial state may have sufficient motive to commit a fraudulent act in an attempt to induce an insurer to pay a claim. This makes the investigation of a policyholder's financial position a viable line of enquiry in claims involving theft. An established financial motive alone may not be enough for an insurer to deny a claim, although I am satisfied that such a possibility is a reasonable reason for investigation to consider the merits of a claim." (FOS Case No. 260992, paras. 22-24)

provided with any assurances that their information will be stored and dealt with in accordance with the National Privacy Principles.

With respect to privacy concerns callers can feel a genuine sense of violation when insurers seek certain documents and want to know whether they can refuse access to particularly sensitive material, such as material on relationship breakdowns, prior unrelated minor criminal histories or information about third parties such as their names, phone numbers and addresses. Financial Rights advises policyholders that insurers do have a right to determine the veracity of a claim and if they are able to, they should work with insurers and share their information. However if sharing something makes them particularly uncomfortable they should contact the insurer and ask for an explanation in writing why that particular piece of information is relevant to the investigation.[20]

When genuine issues of privacy arise, Financial Rights works with policyholders to ensure that they cooperate as much as possible and that their privacy concerns are addressed. For example, a common issue that arises is that of concerns relating to third parties learning of an insurance investigation taking place. This can have a perceived negative impact - or in some cases cause an actual negative impact on a person's reputation, particularly in a professional context:

Case Study 24 – Ian's story

Ian's car was stolen and he made a claim with his insurer. Ian was concerned about the documents his insurer requested including three months of bank records, two weeks of phone records and a criminal history check. After a month, his insurer contacted Ian with a list of 20 phone numbers they took from his phone records and requested that he provide the names and details (i.e. how they are related to him) for each number.

Ian cooperated fully but was concerned about the privacy of his work clients listed on the phone record. Financial Rights advised that in order to protect his privacy he should write on the list: "Please do not contact these people without my explicit permission, they are work related. It would be damaging to my professional reputation if you contact these people. If you feel that you need to contact them, please give me your reasons in writing why that is relevant to this investigation."

20 The Financial Ombudsman Service addresses the competing needs of privacy and the need to investigate a claim in a 2012 determination: "Unfortunately, an insurer's entitlement to investigate a claim may result in delays and inconveniences, and may sometimes come into conflict with a person's right to privacy. In such instances, I acknowledge that a policyholder may have well founded concerns and may very well be acting within his or her rights to refuse provision of such information. However, delays and inconveniences are unavoidable consequences if an insurer is to be permitted to fairly exercise its right to conduct enquiries with respect to a claim. Accordingly, I am of the opinion that it is unreasonable to deny an insurer an opportunity to conduct enquiries simply because it will result in delays and inconveniences. In other words, whilst a policyholder may be entitled to refuse provision of information he or she believes to be private, an insurer may still be entitled to refuse payment of a claim if the lack of such information places it in a position where it is unable to conclude its investigations, or for that matter, determine the veracity and extent of the claim it is called upon to meet." (FOS Case No. 216410, paras. 21-23)

Case Study 7 – Salem's story continued

As described above, Salem's car was stolen and his insurer began investigating. The investigator requested interviews with Salem's mother and sister which was agreed. The investigator also questioned and interviewed Salem's neighbours without his permission. Salem only learnt of their involvement when the neighbours came to Salem afterwards to ask if everything was OK.

Case Study 11 – Dalton's story continued

As described above, Dalton had a motor vehicle accident in mid-2014 and was subsequently investigated and interviewed on the side of the road in a remote location. The investigator requested a number of documents from Dalton. Amongst the documents requested were a number relating to his partner. Given she was not a joint owner of the car nor the insurance, nor was she driving with him, he didn't understand why these needed to be provided. The investigator also requested Dalton's work phone records but his employer did not want to get involved in the matter even refusing to provide a letter to that effect.

Insurers are entitled to determine the veracity and extent of any claim made by a policy holder in a fair and reasonable manner. The following cases however involve requests for documentation that stretch the concept of relevancy to breaking point:

Case study 25 – Melissa's story

Melissa's car was stolen in early January 2015. The insurer began an investigation where both Melissa and her husband were interviewed. Her insurer's investigator requested Melissa provide both her and her husband's entire Facebook history as part of the investigations. The investigator sent Melissa a document with instructions setting out the steps she had to take to download this document, the contents of which include all of her private emails and messages going back for six years. Melissa was unable to print the volume of data involved, and was told to hand over this information on a USB drive which she did. She was subsequently asked for six months of SMS records, three months before and three months after the car was stolen.

The extent of the information and documentation requested in this example and the following case study brings up serious privacy concerns and is also suggestive of a fishing exercise for any material that may be used against a claimant.

Case Study 26 – Anton's story

Anton's motorcycle was heavily vandalised in July 2015 and Anton made a claim on his comprehensive insurance. The insurer appointed investigator conducted a face to face to interview for over three hours. Anton mentioned that one of his Facebook friends posted a picture of Anton's motorcycle before it was vandalised. The investigator requested that Anton "friend" the investigator on Facebook to confirm the photo and post.

Accepting a Facebook friend request from an investigator enables that investigator to access a policyholder's entire Facebook history and network, rather than simply confirming one post. Like the previous example it provides the investigator the ability to undertake a fishing exercise.

Some insurers also rely on statements in PDS's which state that the policyholder must provide information where requested. However, according to the Financial Ombudsman, "this does not extend to all information but information which is relevant to a claim and would assist the [insurer] in its investigation of a claim." (FOS Case No. 259196, paras. 33-34)

In an August 2012 determination regarding the theft and subsequent burning out of a vehicle, the Financial Ombudsman addressed the issue of overreach in the seeking of extensive telephone records, explaining that it can go directly to the approach and prejudicial mindset of the insurer:

> *An entitlement to investigate a claim is not a blanket authorisation to seek everything however relevant, nor is to (sic) be used to simplistically override the privacy laws that apply to this country; especially the privacy of parties who were not parties to the insurance contract…*
>
> *Although insurers are entitled to investigate claims, it is inappropriate insurance practice (and inconsistent with an obligation to act with utmost good faith) to adopt a mindset of assuming or suspecting claims to be fraudulent at first instance (in the absence of a reasonable basis) and thereafter, look for evidence to either confirm or dispel that assumption or suspicion. There is no presumption that a person is guilty of wrongdoing until proven otherwise in our society.*
>
> (FOS Case No. 262825, paras 27, 30, cf. FOS Case No. 275937, paras 25-29)

Financial Rights is concerned that this presumption of guilt prejudices a great number of investigations.

Case Study 6 – Louella's story continued

As described above, Louella's car was stolen and she has been interviewed three times for approximately two to two and a half hours each interview.

After the first interview the investigator had requested a number of financial documents. At the end of the second interview the investigator requested Louella's pay slips. Louella was concerned given she works in child care and that she would be disclosing names of the families and children that she works with.

Louella declined to provide the information, believing the investigator already had wages information from her bank records and explained her concerns regarding privacy to the investigator. The investigator responded that her claim may be rejected for not providing the information. The investigator told Louella that she needed to provide the information to "prove me wrong".

The investigator has requested documents related to where Louella studies, stating hours, her courses etc.

After the most recent interview, the investigator has now requested two years worth of tax returns and has requested Louella provide the number of children she looks after, asserting that she could not be paid what she does for childcare, the relevance of which is unclear.

Requests for the policyholder to obtain documents from third parties are also common. In the May 2012 determination the insurer requested the policyholder's son's records. The determination states that:

> *"the son is not a policy holder and thus I accept that the Applicant cannot be made to provide the son's telephone records. However I do not consider it unreasonable for the [Insurer] to ask for those records or for the [Insurer] to expect to the Applicant to reply and to advise as to why the records are not to be provided."*
>
> (FOS Case no. 259196, para. 21)

Financial Rights has seen a number of cases where this approach has not been accepted by the investigator. For example, in Sarah's story (Case Study 19) the investigator did not accept the policyholder's explanation that she could not access her ex-partner's account and suggested she obtain his password and gain access to the documents requested. The following two cases involve a policyholder unable to obtain third party information, which has subsequently been used as leverage against a policyholder to assert a lack of cooperation and therefore a potential breach of the policyholder's duty of utmost good faith:

Case Study 27 – Gaby's story

Gaby's car was broken into and she made a claim on her insurance. Her insurer began investigating the claim. Gaby had originally bought the car off her ex-partner, who had bought the car previously at an auction. Gaby was told by the investigator that if she did not provide records regarding the purchase of the car, her claim would be rejected. Gaby asked her ex-partner for the records, but he had not kept them. Her insurer rang her ex-partner directly and was told the same. Her insurer subsequently told Gaby that if she does not provide the documents that they will reject claim and cancel the policy.

Case Study 28 – Adam's story

Adam's motor vehicle was stolen in late 2014 and he immediately lodged a claim under his comprehensive insurance policy. The police later discovered the car burnt out.

The investigator requested numerous documents including Adam's bank and income statements, car registration details, phone records and criminal history checks. Apart from the criminal history checks, Adam had to bear the costs in obtaining these documents. The investigation also requested phone call records covering the five day period around the date of the car being stolen. Adam was unable to obtain these records since he owned a pre-paid mobile phone. After extensive delays, his mobile phone provider advised Adam that it was unable to supply the records simply because there were no inbound and outbound phone calls on the mobile phone during the period requested. Adam requested a written explanation from the provider but after repeated requests, the provider refused to do this. His insurer threatened that they would deny the claim if Adam was unable to obtain the phone records for the relevant period.

Ultimately there is significant inconsistency in the approach insurers take to requests for documentation. Some insurers ask that policyholders sign broad open-ended authorities to gather documents. Other insurer's authorities are more limited and specific in nature. Further still, some insurers require policyholders to gather the information themselves - sometimes at their own cost, at other times they were reimbursed. The following case involves a policyholder with limited capacity to gather material, having their claim rejected on the basis that the documents were not gathered (despite this not being the case) and the insurer making no attempt to gather the material themselves by obtaining an authority.

Case Study 29 – Carrie's story

Carrie and her partner live in regional NSW with their three children, including two with autism. Carrie's partner is on a disability support pension for bipolar disorder. Carrie is their carer.

In mid-2013 Carrie and her partner reported her car stolen, and lodged a claim with their insurer. The car was recovered burnt out a few days later. The insurer investigated. The claim was rejected in early 2014 on the basis that the insurer claimed Carrie had not provided the telephone records for mid-2013. They did not allege any fraud, only non-cooperation. The phone records were initially supplied in excel format but rejected as they may be "tampered with". Carrie took further steps, and emailed the insurer the records in late 2013.

It was clear that the investigator had undertaken a cursory examination of the material and had not clicked on the correct link provided in the material to obtain the information required. At no point in the six month investigation had the investigator obtained an authority to obtain the records directly from the telecommunications providers on Carrie's behalf, a reasonable approach given Carrie's difficult circumstances and a supposed risk of tampering as suggested by the insurer.

D. UNIQUE ISSUES AND CIRCUMSTANCES OF VULNERABLE PERSONS

When investigating insurance claims, investigators are likely to encounter policyholders who could be broadly deemed "vulnerable". This term captures a large array of people that have distinctive needs or require special consideration when they are contacted or interviewed, during the process of a claim. They include those with a mental illness or mental health issues, people with a developmental disability, people from a non-English speaking background (NESB), Aboriginal and Torres Strait Islanders, and those with a physical disability. This Report examines the issues raised in investigating two of these vulnerable groups: those with a mental health issue and people from a non-English speaking background.

Mental health

There are a number of issues faced by policyholders with mental health problems including the discrimination they face in obtaining insurance in the first place, increased premiums, excessive restrictions on their policies and rejection of their claims when a history of mental illness is disclosed. In addition to these issues, Financial Rights receives calls from policyholders with mental health problems who are under investigation and have significant concerns – either that the investigation process may impact negatively upon their mental illness, or that their mental illness will impact on their claim and the investigation in a negative way. Financial Rights also hears from policyholders who do not want to be interviewed, wish to be interviewed in a particular way or wish to have a support person present because of their mental health condition.

Case Study 9 – Robert's story continued

As detailed above, Robert had two work vehicles stolen from his home and was forced to close his business for a five and a half hour interview. Robert has a condition impacting his memory; a condition for which he has documented proof from his doctor. Given this Robert found that during the five and half hour long interview he could not remember things properly and the investigator gave him a very hard time about giving consistent answers. Robert felt so harassed over the five and half hour interview that he became "really upset and aggressive" and told the investigator to "get the hell out." The claim was ultimately paid.

Other callers are concerned that the information provided in their interview was not clear enough because of an issue related to their mental illness or the medication that they were taking. Financial Rights understands that at least some investigators do ask whether the interview participant is on any medication (or any other substances) that would impair their ability to take part in the interview. **Policyholders with a mental illness are concerned whether the simple fact that they have mental illness will impact negatively upon their claim.**

Financial Rights advises callers to cooperate with any investigation, provide medical evidence where it is being requested (reassuring the caller that the health information should be destroyed under the Privacy Act 1988 (Cth) once the investigation is closed) and provide any information relating to the medication that they take if requested.

Financial Rights notes that one investigator we spoke to stated that while their company trained their investigators in-house to deal with those affected by mental issues, alcohol and drugs, they were not trained psychologists. Nor does there seem to be any accreditation or requirements for working with people who are affected by mental issues, alcohol and drugs. This lack of understanding can have an impact on investigator's interpretation of answers provided by the policyholder.

Case Study 30 – Paolo's story

Paolo parked in an inner suburb with the intention of an evening out in the city. However Paolo's car was destroyed by fire. Paolo made a claim on his comprehensive insurance policy, which was subsequently refused six months later.

The insurer alleged inconsistencies in Paolo's statements. Rather than being deliberate, dishonest or capricious, the inconsistencies arose from Paolo's suffering from mental illness (including bipolar disorder, schizoaffective disorder and substance abuse disorder). The inconsistences were also irrelevant to the case, easily explained and did not reduce the insurer's liability under the contract.

Another issue that arises frequently is the situation where a third party's mental health becomes the central focus of an insurer's investigation and is relied upon in an attempt to defeat a claim. Both of the following case studies demonstrate a propensity to draw unfounded inferences when a third

party close to the insured has had a history of mental illness. The investigator then undertakes a fishing exercise to seek any and all evidence to support this assertion.

Case Study 31 – Yolande's story

A fire occurred at the property of Yolande. A forensic fire investigation was conducted and a separate insurer investigation was initiated on the suspicion that Yolande's son set fire to the property for financial gain. It was unclear whether the son would financially gain from an insurance claim despite being part owner of the house.

The private investigators insisted on interviewing Yolande's son despite his having had a mental breakdown. Yolande asked the private investigators not to contact her son but she said the investigator yelled at her over the phone. When Yolande complained of this behaviour to her insurer the claims person was rude, raised her voice and insisted that Yolande and her son cooperate with the investigator or the claim would be refused. Yolande's son was subsequently contacted by the investigator after hours, upsetting the son. The investigator insisted he allow himself to be interviewed or the claim would be cancelled. The investigator stated that a medical certificate will need to be produced to prove his inability to be interviewed or again the claim will be cancelled.

Yolande requested that she be allowed to act as a support person to her son and to record the interview, held at the insurer's local branch. The investigator agreed but asked that she sign an "Observers Guidelines" document agreeing to not say anything during the interview process, a request that Yolande refused. Yolande asserted that she is a support person, not an observer and was provided no warning that she would have to sign the form. The investigators again threatened to cancel the claim but continued with the interview anyway. Yolande asserted that the interview with her son was conducted in an aggressive and intimidating manner. The investigators told Yolande's son that they believed he was mentally unstable, accused him of starting the fire for financial gain and attempted to catch him out with leading questions. Yolande was forced to intervene several times to tell the investigators to stop the leading and aggressive questions.

Case Study 32 – Aileen's story

Aileen's house was burned down by arson. Her adult son Jack was home alone at the time of the fire and he told the police that two strangers came onto the property, attacked him, pushed a bookcase on top of him and left him in the house unconscious. When he woke up, the house was engulfed in flames. He crawled out from under the bookcase and ran next door to call the fire department. Jack was taken to the hospital and treated for injuries to his shoulder and smoke inhalation. Aileen's home, where she had lived for 25 years and raised her children as a single mother, was completely destroyed.

Immediately after the fire Aileen made a claim on her home building and contents insurance policy. The insurer immediately appointed an investigator to ascertain whether Jack had intentionally started the fire. Jack was also investigated by the police as a suspect for the arson. Jack was interviewed, forensic evidence was collected and DNA samples were analysed. After nine months it was clear that there was not enough evidence linking Jack to the arson, nor was there any viable motive for him to have started the fire. He was not a beneficiary under either insurance policy, and his mother was underinsured anyway. Jack was officially eliminated as a suspect by the police, but the insurer continued to insist that he was to blame for the fire.

Jack and his mother were both aggressively interviewed by private investigators for six hours split across two interview sessions with long, complex, contradictory questions repeated multiple times despite having been answered. They were also asked very personal, intimate and seemingly irrelevant questions including about Jack's personal relationships. Jack was even forced to hand over all of his medical records which included his history of battling mental illness, all of which was completely irrelevant to the arson and upsetting for him to share. It was discovered at the end of the Financial Ombudsman dispute that the insurer had already obtained copies of some of his medical records months before while still claiming that Aileen had failed to cooperate by not handing them over herself.

After a long dispute the Ombudsman agreed with Aileen that the insurer had failed to prove Jack had started the fire or that our client had made any fraudulent statements and the claim must be paid.

Non English Speaking Background and Interpreters

It goes without saying that consumers from a non-English speaking background are at a significant disadvantage compared to native English speakers with respect to effectively participating in the insurance process, including obtaining and claiming on their insurance and especially when a dispute or investigation occurs.

Financial Rights understands that at least some insurers do, where appropriate, engage interpreters to assist in investigations. An external investigator for IAG, for example, usually engages a claimant in a conversation over the phone to gauge their standard of English and fluency and make a call based on this whether to engage an interpreter. At times when an interview proceeds and it is clear an interpreter is required, the interview is stopped and an interpreter is engaged.

However Financial Rights receives calls from distressed NESB policyholders who have variously engaged in claims negotiations over the telephone without access to or offer of an interpreter, been interviewed by investigators without the assistance of an interpreter or dealt with investigators who lack the capacity and training to fairly interview an NESB consumer with an interpreter.

Case Study 33 – Rosa's story

Rosa made a claim on her home and contents insurance policy. She had dropped her phone in the toilet at home and had lost her engagement ring. Rosa was interviewed in her house on the investigator's insistence. After the interview, the investigator took pictures of Rosa's apartment and the clothes she was wearing the day she dropped her phone in the toilet. Rosa's first language is Portuguese and she did not understand some of the things the investigator was asking her. Rosa was not provided with a translator, and when she answered with uncertainty, was reprimanded by the investigator for not knowing the answer.

In 2008 the Financial Ombudsman's predecessor, the Insurance Ombudsman Service, noted in its Referee's Report two "simple, but not uncommon examples" of an insurer not offering the use of an interpreter to a consumer where it is clearly a need. The Referee stated that:

> *"I find it disappointing that an investigator would not offer the services of an appropriately qualified interpreter when it becomes obvious that person has difficulty in comprehending the matters which are being put to them. I find this particularly disturbing when these statements are subsequently relied upon and the inconsistencies highlighted as part of an allegation of fraudulent conduct."*
>
> (IOS 2008, p 11)

The Referee discussed the matter with investigators at the time and most advised him that it was their view that when an interpreter was required they would "suspend the interview and arrange a new interview with an interpreter after seeking instructions from the insurance company client." It was therefore of some concern to the Referee to note that he had dealt with a number of matters of fraud allegation where interpreters had not been used where they should have been.

> *This has not been isolated to these two I have referred to, and has occurred in other matters throughout the year but perhaps in less dramatic circumstances. Those insurers I have spoken to advise me they have a process that requires an investigator to notify them immediately the investigator believes an interpreter is required. Again a sound practice but given my experience clearly there has been a breakdown in that practice*
>
> (IOS 2008, p 12)

In the following year, Financial Rights provided a number of examples to the Review of the General Insurance Code on the lack of sound interpreter practices (see case studies 22 & 60 in ILS 2009, pp70-1) including one case involving the claim that the Burundi refugee policyholder had admitted liability despite barely speaking English. This breakdown in sound investigation practice with respect to the use of interpreters however continues to this day:

Case Study 34 – Irfan's story

Irfan's car was stolen in mid-2014 and eventually found three to four weeks later but in a heavily damaged state. His insurer subsequently wrote the car off. The insurer accused Irfan and his friend of fraud relying on the fact that their version of events did not match up. The insurer rejected the claim, informing VicRoads of this rejection whereby preventing Irfan from having any car registered. During the investigation the insurer had interviewed Irfan's friend. Irfan's friend however does not speak English well. The insurer offered an interpreter, but the interpreter provided spoke Fijian Hindi as opposed to Indian Hindi, specifically Gujarati. Irfan's friend felt that he could not appropriately communicate with the interviewer and interpreter.

Case Study 35 –Bao's story

Bao's property burnt down in early-2014. He was unemployed, does not speak or understand any English and was looking after his three year old son while his wife was in China unable to obtain a visa. After the fire, he and his son were living in the back of a restaurant as he could not afford alternative accommodation.

Bao's insurance claim was rejected on the basis that the property burnt down in suspicious circumstances and that Bao had given a number of inconsistent statements to the investigators. However on a number of occasions Bao was either interviewed without a translator or a translator that could not understand him and simply "made up" the answers. In late 2014, Financial Rights assisted Bao in convincing his insurer to pay out his claim. His claim was paid, including alternative accommodation expenses so he and his son no longer needed to live in a restaurant.

Financial Rights also notes a number of recent cases determined by the Financial Ombudsman where interpreters were not used. Financial Rights details three examples:

Case Study 36 - Financial Ombudsman Service Case #375295, 10 February 2015

The Applicant lodged a claim with the Insurer following the theft of the insured motor vehicle.

The insurer investigated the claim and refused liability on the basis the claim was fraudulent and the Applicant had failed to act in the utmost good faith. In part, the insurer relied on inconsistencies between the statements of the Applicant and his friend AS.

However, the Applicant understood very little English and no interpreter was provided. The Ombudsman noted from the statement that the Applicant was asked by the investigator "Do you understand English?" The Applicant answered "Not that much actually, yeah". He was then advised by the investigator that he would get an interpreter. No explanation was given as to why the interview continued or why no interpreter was obtained. It was clear from the transcript that there was a lot of confusion in the statements provided by AS and in the absence of the interview being conducted with the assistance of an interpreter, little value could be placed on the allegations made.

Case Study 37 - Financial Ombudsman Service Case #285180, 9 April 2013

The Applicant was involved in a traffic accident with the Applicant's vehicle deemed a total loss. The claim was investigated and the claim denied on the grounds that the Applicant had not been truthful.

However the interview conducted by the investigator was not conducted with the assistance of an interpreter. Approximately halfway through the investigator's formal interview with the Applicant, the investigator asked "do you speak English, okay?" The Ombudsman was satisfied that this question and the confusion over a number of questions and answers confirmed that the investigator should have obtained the assistance of an interpreter and the absence of an interpreter "raises counts as to reliability of the questions and answers contained within the formal interview."

This was significant because the insurer relied upon a number of alleged inconsistences in statements made in the interview.

Case Study 38 - Financial Ombudsman Service Case #292716, 8 July 2013

The Applicant was a Pakistani national who immigrated to Australia and became an Australian citizen in 2003.

His native language is Urdu and speaks limited English with little understanding of written English.

His insured vehicle was destroyed by fire after a mechanical breakdown and he made a claim under his comprehensive motor vehicle insurance policy which was refused.

The insurer's investigator interviewed the Applicant and the Applicant informed him that his English was poor. However the interview proceeded without the aid of an interpreter. It is evident from the transcript of the interview between the investigator and the Applicant that the Applicant spoke in "broken English," had difficulty explaining himself and difficulty understanding some of the questions asked.

A related point that Financial Rights solicitors have observed is that some people of varying cultural backgrounds have a tendency to simply agree or say yes to a statement put to them. Generally speaking, when interacting with people across cultures and languages, a lot of people have a tendency to say yes when asked whether they have a understood a question or have been presented with a yes or no proposition. This is particularly the case with people from certain cultural backgrounds, eg Indian culture.[21]

E. INSUFFICIENT EVIDENCE

Financial Rights has assisted a number of Insurance Law Service callers who have had their claims denied on the basis of fraud with very little evidence to back this assertion. These cases usually involve insurers relying solely on unfounded and incorrect reports made by investigators with little corroborating evidence and/or misrepresentation of third party investigation report findings.

Although the onus of proof in a fraud determination is the same in the Financial Ombudsman Service as in a court of law,[22] the evidentiary rules in an insurance matter in the Financial Ombudsman Service vary significantly to those before a court of law. While the Financial Ombudsman Service is not bound by any legal rule of evidence (FOS 2015a, s. 8.1) the evidence provided should not be inexact proofs, indirect testimony or speculation. Cases based on evidence that is purely circumstantial or hearsay are fundamentally weak and lead to the significant chance of error, flawed reasoning and confirmation bias. It is incumbent on insurers and investigators to ensure that the evidence is "well considered and persuasive" (Price 2005, p22).

Financial Rights analysed 130 disputes where the Financial Ombudsman made a determination in 2015 that involved a denial of a claim on the basis of a fraud allegation. For more information on the conduct of this analysis see the information box: Allegations of fraud determined by the

21 Health Queensland (n.d.) for example, provides a guide to medical practitioners to deal with this issue when speaking to patients.

22 That is a policyholder must prove on the balance of probabilities that an event or loss has occurred and then an insurer must establish that a dishonest act or an admission with an intention to deceive in order to gain a material advantage has occurred on the balance of probabilities (Price 2005, p22)

Financial Ombudsman Service, 2015. We found that, in those cases where fraud had been alleged, fraud was established on the balance of probabilities in only 23 (or 17.7%) cases. The Financial Ombudsman found that the allegation of fraud had not been established on the balance of probabilities by the insurer in 60 cases (or 46.2% of determinations). In other words, there was little or no evidence to support a claims denial on the basis of fraud in close to half the cases determined by the Financial Ombudsman, where an allegation of fraud was involved. No determination was made on the allegation of fraud in 47 cases (36.2%).

Looking more broadly at the results, the Financial Ombudsman found in favour of the policyholder in 45 out of 130 determinations or 35% of cases. The remainder (65% or 85 determinations) were found in favour of the insurer on the grounds of either the 23 determinations of fraud or that an insured event was not established on the balance of probabilities.

Allegations of fraud determined by the Financial Ombudsman Service, 2015

A search was conducted on 4 February 2016 on the FOS Decisions Online Database for disputes limited to between 1 January 2015 and 31 December 2015 and selecting for Product Line: General Insurance, Product Category: Domestic Insurance and Issue: Denial of claim – Fraudulent claim. This produced 135 disputes. Financial Rights found that a determination was made in 130 cases out of 135. A conclusion was not able to be reached by the Financial Ombudsman in the remaining five disputes.

Focussing on these 130 disputes Financial Rights analysed their results for the following information:

- *whether fraud was established on the balance of probabilities by the Financial Service Provider (or insurer);*
- *whether an insured event had been established on the balance of probabilities by the Applicant (or policyholder);*
- *whether a determination was made in favour of the insurer or the policyholder*
- *whether a determination was made regarding expunging the policyholders records of any allegation or finding of fraud*
- *whether costs (financial or non-financial) were awarded and*
- *what the length of time was between the date of the event and/or claim first being made and the date of the final determination.*

It is difficult to generalise as to the reasons why particular matters are pursued by insurers and investigators when there is a clear lack of cogent evidence, however Financial Rights points to one possibility: that preconceptions of guilt shape the investigation. If an investigator starts from the position that there is something suspicious, this will colour the approach and subsequent information gathered. Or to put it even more simply, **investigators can be subject to confirmation bias that presumes policyholders to be guilty and requiring them to prove their innocence.** Preconceptions can arise in a variety of ways:

- *cultural bias: for example an investigator might not appreciate that some cultures have a tendency towards agreeing to statements whether or not that is their view;*
- *racial stereotyping: assuming because all the parties involved in an accident are of middle eastern background from a particular suburb that they know each other and are colluding;*
- *misreading observations: eg, assuming an interview subject is sweating and nervous because they are lying as opposed to stress from the unusual situation, exhaustion, or they are a naturally sweaty individual;*
- *lack of understanding of human nature: for example that people are generally less consistent in their recounting of events because of the vagaries of memory*
- *a lack of understanding of individual characteristics: including illnesses and mental conditions*
- *an inability to distinguish between unusual and usual events – that is, the fact that an event is unusual is not sufficient to establish fraud*
- *the inherent financial incentive in claims assessment: examining a suspicious element to a claim and unreasonably extrapolating in order to increase the number of claims denials.*

Accusations should never be made lightly. The Financial Ombudsman has stated that alleging fraud without the written approval of the insurance company is inappropriate.[23] **An accusation or finding of fraud is a serious matter and can impact a consumer's ability to gain insurance and finance in the future.** It is also an incredibly stressful, emotional, time-draining and difficult process to go through. As mentioned above, Financial Rights found that, when examining 130 disputes from 2015 where the Financial Ombudsman made a determination on a dispute involving a denial of a claim on the basis of a fraud allegation, the average length of time policyholders had to face was 521 days or a little under a year and a half. Examining those disputes where the Financial Ombudsman actually found in favour of the policyholder, the average was slightly less at 503 days. Financial Rights suspects that there is a significantly larger pool of policyholders who withdrew their claim or failed to pursue action in IDR or EDR due to the lengthy, frustrating and burdensome process.

Financial Rights has had to support a number of policyholders subject to allegations of fraud where the insurer patently did not have the evidence to back the claim.

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23 "Despite the absence of evidence of fraud on the part of the applicant, the participating company's service provider suggested to the applicant that he had acted fraudulently and that he might be investigated for fraud. There was no evidence available to the service provider to suggest that the applicant had acted fraudulently in any way. Even if any facts had been established to indicate a prima facie suspicion of fraudulent non-disclosure, it would still have been inappropriate to assert fraud, without first giving the applicant the opportunity to put forward his version of relevant events … Instructing the service provider that it is not authorised to allege fraud against a policyholder, under any circumstances, in the absence of written approval from the participating company." (FOS 2010, p14)

Case Study 39 – Sharon's Story

Sharon went to the local cinema to see a film, after which she discovered her car had been stolen. When she was interviewed by her insurer's investigator, Sharon felt that the investigator was rude and accused her of committing fraud. Her claim was eventually rejected by her insurer on the basis that she provided false and misleading information and that her claim was fraudulent.

Sharon disputed this allegation and escalated the matter to the Financial Ombudsman Service. The Ombudsman found no evidence of motive, no evidence undermining Sharon's character and credibility and no evidence to dispute Sharon's account of her activities that evening. Furthermore, the insurer put forward no forensic evidence relating to the car or its security system to support their claim. The insurer had spoken to a forensics expert but the insurer provided no explanation as to why no report was produced and delivered to the Ombudsman. The insurer largely relied on interviews with a cinema employee 30 days after the event that contradicted Sharon's story. No contemporaneous notes of these discussions were made or provided. No evidence was put forward to support the assertions made by the witness, many of which were at best vague recollections.

The Financial Ombudsman found in favour of Sharon and stated that "the information relied upon by the [insurer] [was] not sufficient for the [Insurer] to justify its refusal of the claim" and that as a result Sharon had "suffered an unusual degree of inconvenience in the time taken to resolve her claim and loss of enjoyment of life." Sharon claim was paid and she was awarded $1500 by way of non-financial loss.

Case Study 30 – Paolo's story continued

As described above Paolo's car was destroyed by fire while Paolo was out for the evening.

To back their allegation of fraud the insurer claimed a witness had indicated that the last person seen near the vehicle was Paolo. This was supported by a further statement by the insurer that the police believed that Paolo was this person. Neither allegation was supported by the evidence. There was no witness statement attesting to this and only a purely speculative statement by the police officer.

The insurer also sought to draw inferences against Paolo due to his inability to recall his complete movements the night of the fire, despite the fact that during the relevant time period, evidence was found to fundamentally contradict the insurer's asserted scenario. That is, credit card evidence gathered during the investigation that clearly demonstrated Paolo's presence over 20 minutes away from the car at the time that it was claimed he had lit the fire.

As described above the insurer alleged inconsistencies in Paolo's statements but rather than deliberate, dishonest or capricious, the inconsistencies arose from Paolo's suffering from mental illness.

Finally the insurer misrepresented the findings of the investigator and pharmacologist, directly contradicting statements found in these documents, in their letter of refusal. The insurer ultimately settled and paid the claim before the Financial Ombudsman decided the dispute.

Case Study 40 – Edwina's story

Edwina was involved in a motor vehicle accident and made a claim but three months later it was rejected. The insurer claimed she had engaged in fraud and breached her duty of utmost good faith and that the accident didn't happen in the way she claimed. The insurer relied on inconsistencies between an interview with Edwina's husband, which was conducted via an interpreter, and a Forensic Collision Investigation Report.

Edwina applied to the Financial Ombudsman for a determination arguing that (a) the insurer misrepresented what the internal investigators had found in its refusal letter and (b) the Forensic Collision Investigation Report was seriously flawed as it was based on a version of events that was not consistent with the version Edwina described during her interview.

With respect to the assertions made in the refusal letter, every assertion made by the insurer was contradicted by the investigator report and easily explained. For example, the refusal letter stated that Edwina didn't tell her husband where the accident happened, however the interview clearly stated that "she told me and I knew straight away where it was."

The Forensic Collision Investigation Report relied on by the insurer was also seriously flawed with basic factual errors clearly contradicted by the evidence and the interview with Edwina. For example the report stated that the car had been turning left from one street to the other when it was the other way round. The Report also concluded that the vehicle had been stationary at the time and claimed that this contradicted the version of events provided by Edwina. However the interview transcript clearly indicates that she said she had been stationary or close to stationary at the time of the accident.

The insurer ultimately paid the claim before the FOS dispute was decided.

Case Study 3 – Fenella's story continued

Fenella's house was broken into and set on fire while Fenella was inside. Fenella made a claim on her policy. The insurer rejected the claim suspecting fraud and breach of duty of utmost good faith. Fenella had inherited the house from her grandmother and had made significant renovations in the preceding years.

A number of elements were put forward as evidence by the insurer. These were as follows:

- *Fire accelerants may have been used.*
- *The neighbour saw a lighter fall out of Fenella's pocket shortly after the fire. Fenella was however a smoker.*
- *Fenella's mother gave conflicting information about which of them had placed a fuel container for the mower back on top of a cupboard, after the yard was tidied up the weekend earlier. The insurer claimed that the yard hadn't been worked on but photos taken by journalists after the fire contradicted this claim.*
- *The insurer thought the timing of the fire was wrong based on phone records, but phone records were using a different time zone.*
- *The home was insured for more than it was worth, but Fenella was told by the insurer that she could not lower this when the policy was taken out. The insurer did not provide a copy of the phone recording backing this claim.*

Ultimately the insurer agreed to accept the claim before it was brought before the Financial Ombudsman.

4. Insurance investigations and consumer protections

> *"It is an established principle that insurers are entitled to determine the veracity and extent of any claim that it may be called upon to meet. In doing so, they are entitled to decide how they wish to conduct their enquiries. A policyholder is neither in a position to dictate whether or not such enquiries should be conducted, nor dictate how or in what manner it should be carried out.*
>
> (FOS Case No. 216410, paras 19-20)

While there are a range of broad rules in place to regulate the insurance process and behaviour there is a dearth of consumer protections that explicitly seek to regulate the investigation process itself and the excesses described in the previous chapter. This chapter briefly details the matrix of general consumer protections in place including the duty of utmost good faith, those found under the Insurance Contracts Act 1984 (Cth) and other statutes, the fairness standards under the self-regulated General Insurance Code, the external dispute resolution regime available through the Financial Ombudsman, and the laws in place regulating the private investigator industry.

A. THE DUTY OF UTMOST GOOD FAITH

The highest level of protection for consumers arises from the common law "duty of utmost good faith" now codified under section 13 of the Insurance Contracts Act 1984 (Cth).[24] **The duty of utmost good faith is one that is difficult to define but generally refers to concepts of fairness, fair conduct, reasonable standards of fair dealing, decency, reasonableness and decent behaviour** (Tarr et al 2009). Importantly, the duty of utmost good faith is reciprocal, applying to both the insured and the insurer. The consumer therefore has broad obligations with respect to their insurer but similarly the insurer has duties and obligations to the consumer.

Under the duty of utmost good faith, the consumer must be upfront and honest with the insurance company, act fairly, reasonably and in good faith, and must cooperate with the insurance company's investigations by making reasonable efforts to provide any reasonable and relevant information or documents the insurance company asks of them. An insurer can reject a claim if a consumer breaches any of these as their failure to cooperate can deny the insurer a fair opportunity to assess and decide a claim.

The insurer however is conversely required to act fairly, reasonably and in good faith towards the insured. The insurer must have due regard for the interests of claimants and a duty to act reasonably in considering and determining the assessment of a claim. This obligation extends to anyone the insurance company appoints to act on their behalf including investigators.

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24 A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

These duties are in part expanded upon and detailed in the Insurance Contracts Act 1984 (Cth) and the General Insurance Code.

B. THE INSURANCE CONTRACTS ACT 1984 AND OTHER STATUTORY PROTECTIONS

The Insurance Contracts Act 1984 (Cth) codifies the duty of utmost good faith and provides a series of consumer protections some of which are general, some more applicable to the investigation process. These include limiting reliance by an insurer on unusual and 'non-standard' clauses (ICA 1984, ss. 35 & 37), safeguards relating to the reliance by an insurer on non-disclosure and misrepresentation (ICA 1984, ss. 21, 21A, 26 and 28), and preventing the insurer from relying on fraud if the fraud was minor and it would be unfair to reject the entire claim (ICA 1984, s. 56). [25]

As holders of Australian Financial Services Licences, insurers are also subject to the Corporations Act 2001 (Cth) including the general obligation to ensure that the services that they provide are done so efficiently, honestly and fairly (CA 2001, s. 912A(1)). The Corporations Act 2001 (Cth) also requires that terms and conditions of a general insurance policy be presented in a "clear, concise and effective manner" (CA 2001, s. 715A). The Corporations Act 2001 (Cth), the ASIC Act 2001 (Cth) and the Australian Consumer Law prohibit misleading and deceptive conduct or unconscionable conduct (s. ASIC Act 2001, CA 2001 s1041H; ACL s 18).

Insurers and their service providers are also subject to various commonwealth and state acts and regulations including the Racial Discrimination Act 1975 (Cth), the Disability Discrimination Act 1992 (Cth) and the Privacy Act 1988 (Cth). They are also subject to trespass, property access, harassment and nuisance laws, privacy law and the use of surveillance devices. It is this last aspect for consumers that, while less common, is of significant concern.

Surveillance device laws theoretically provide a level of protection against the unwarranted, intrusive or inappropriate surveillance of Australians, including insurance claimants. While laws are in place in each state and territory to regulate the use of surveillance devices, their complexity, inconsistency and failure to keep up with technological progress provide irregular protection and little comfort to parties subject to intrusive and unwarranted surveillance: see Table 1. The level of consumer protection is therefore highly contingent upon where the surveillance occurs.[26]

25 Other protections include preventing insurers from relying on exclusions regarding some categories of pre-existing conditions (ss 46-7), voiding provisions in contracts that allow insurers to vary terms to the prejudice of anyone but themselves (s. 53) and preventing the insurer from relying on an act or failure to act, or statement or misstatement on your part, if your words or conduct did not contribute to the loss or prejudice the insurer's interests (s 54).

26 For example, mobile phones can be deemed a tracking device for the purpose of the Act in NSW but not necessarily in Victoria. In Victoria, surveillance of a person in their own backyard is not an offence but in NSW optical surveillance is an offence only when it has involved installation, use or maintenance of the device that required entry onto a premises or interference with an object such as a car. With respect to listening devices, some states provide an exception if the surveillance has the consent of all parties to a conversation (NSW, ACT, Tas, WA), others if one party provides consent (Qld, Vic, NSW). Some jurisdictions provide for a public interest exception (NT, WA).

Table 1: State surveillance legislation coverage

STATE	ACTS	OPTICAL DEVICES	LISTENING DEVICES	DATA DEVICES	TRACKING DEVICES
ACT	Listening Devices Act 1992	No	Yes	No	No
NSW	Surveillance Devices Act 2007	Yes	Yes	Yes	Yes[27]
NT	Surveillance Devices Act	Yes	Yes	Yes[28]	Yes[29]
QLD	Invasion of Privacy Act 1971	No	Yes	No	No
SA	Listening and Surveillance Devices Act 1972	No	Yes	No	No
TAS	Listening Devices Act 1991	No	Yes	No	No
VIC	Surveillance Devices Act 1999	Yes	Yes	Yes[30]	Yes[631]
WA	Surveillance Devices Act 1998	Yes	Yes	No	No

* The Surveillance Devices Act 2004 (Cth) only applies to federal law enforcement officers and not to the general public.

Insurers are bound by the National Privacy Principles (NPP) set out in the Privacy Act 1988 (Cth) which sets out standards on how the private sector collect and handle personal information. Insurers can develop and institute their own privacy code as an alternative as long as the standards are no less than those required under the NPP. The General Insurance Code includes clauses on abiding by the principles of the Privacy Act 1988 (Cth).

As a final point, insurers are not subject to the consumer protections afforded by the unfair contract terms (UCT) regime under the ASIC Act 2001 (Cth).[32] The UCT laws apply to most if not all other contracts that consumers enter.

C. THE GENERAL INSURANCE CODE OF PRACTICE

Introduced in 1994, the self-regulatory General Insurance Code commits insurers to uphold minimum standards when providing services (GICOP 2014) and is "the general insurance industry's promise to be open, fair and honest in the way it deals with customers" (ICA 2010, p7).

27 Includes those devices "capable of being used to determine or monitor" the geographical location of a person or object ie includes mobile phones.

28 Only covers acts by law enforcement officers.

29 Includes those devices that "may be used to determine" the geographical location of a person or object ie includes mobile phones.

30 Only covers acts by law enforcement officers.

31 Only includes those devices whose "primary purpose of which is to determine" the geographical location of a person or object ie does not include mobile phones.

32 This is via a carve-out from the unfair contract terms regime under s. 15 of the Insurance Contract Act 1984 (Cth). In 2013 legislation was drafted to extend the regime to general insurance products (but not life insurance products). Under the draft bill, a term in an insurance contract would be considered unfair if it were to cause a significant imbalance in the parties' rights and obligations under the contract; cause detriment to a party if relied on; and is not reasonably necessary to protect the legitimate interests of the party advantaged by the term. This legislation has however has yet to pass.

Following an Independent Review in 2010, the Code was altered to highlight the fundamental duty of utmost good faith (GICOP 2014, s. 2.2).[33] With respect to the claims process under which most investigations take place, the General Insurance Code commits insurers to "conduct claims in an honest, fair, transparent and timely manner" (GICOP 2014, s. 7.2). The protections found in the General Insurance Code are both broad and at points open to interpretation.

The General Insurance Code compels insurers to only rely on information relevant to their decision when deciding and "all relevant facts" on a claim (GICOP 2014, ss. 7.3 & 7.11). Importantly the General Insurance Code sets out a number of time limits for the claims and investigation process.[34] The reasonable suspicion of fraud is deemed an exceptional circumstance entitling the insurer to an extended time limit to investigate further (GICOP 2014, ss. 7.8 & 7.19). There is however no requirement under the General Insurance Code to tell the insured that the insurer holds this "reasonable suspicion."

Service suppliers, including private investigators, are also subject to the General Insurance Code and must "provide services … in an honest, efficient, fair and transparent manner" (GICOP 2014, s. 6.2). The General Insurance Code commits insurers to appoint investigators who are qualified, competent and professional including holding a membership of a professional body, and hold a current licence, but only if required by law,[35] which, as will be seen below is not necessarily the case. Investigators must inform a claimant that they have been authorised to provide the service on the insurer's behalf (GICOP 2014, ss. 6.3 & 6.6).

The General Insurance Code outlines minimum standards relating to complaints and disputes (GICOP 2014, s. 10) and ensures that insurers will supply complainants with the information the insurer relied on in their claims assessment (GICOP 2014, s. 14).

The General Insurance Code does not however contain any specific standards for the conduct of claims investigations. There are no guidelines for the use of interpreters or independent support people, no right to have the interview held in a neutral location, no reminder or suggestion to seek legal advice, no interview time limits, and no explicit guideline for interviewing or investigating. Financial Rights with a coalition of consumer groups made a series of recommendations during the previous General Insurance Code of Practice Independent Review that the Code set standards and processes for fraud investigations and investigations generally.[36] These recommendations and the issues raised were not mentioned in the independent review's final report (Enright 2013).

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33 "The objectives of this Code will be pursued having regard to the law, and acknowledging that a contract of insurance is a contract based on the utmost good faith."

34 Including ten business days to handle a claim when all relevant information is provided (GICOP 2014, ss. 7.9-7.10), keeping a consumer informed every 20 days if the further information or assessment is required (GICOP 2014, s. 7.13) and a limit of four months to conduct an investigation (GICOP 2014, s. 7.17) or 12 months if exceptional circumstances apply (GICOP 2014, s. 7.18).

35 "reasonably satisfy us at the time of appointment that they are, and their employees are, qualified by education, training or experience to provide the required service competently and to deal with you professionally (including but not limited to whether they hold membership with any relevant professional body); and hold a current licence, if required by law" (GICOP 2014, s. 6.3 (a)).

36 Recommendations included that: 1. Duration of interview, number of interviews and conduct of interviews, who can be present, place of interview, breaks etc.; 2. Code Participants must only make reasonable requests for documents and information; 3. Providing information on the process to the insured and their rights whether that be in the form of a factsheet or otherwise about the investigation process. This can form part of the documents discussed above about providing claimants with full information about what they can expect from the claims, complaints/IDR process and EDR process. 4. Clarifying that third parties have no compulsion to participate or provide information 5. Identifying people at a special disadvantage (e.g. NESB, mental illness) and referring for support/advice (ILS 2012).

Nor is there a statement on diversity and anti-discrimination encouraging consideration of the diverse needs and circumstances of consumers despite this being recommended by the Australian Law Reform Commission (ALRC 2013). There is also no statement with respect to appropriately engaging with vulnerable people with special needs, particularly those with mental health issues and no reference to complying with all relevant privacy laws.[37]

D. INTERNAL AND EXTERNAL DISPUTE RESOLUTION

Consumers are able to access their insurer's complaints processes, which vary from insurer to insurer (ASIC 2015). Lodging a complaint is required before a consumer can access the external dispute resolution scheme required and approved by ASIC for the general insurance industry – the Financial Ombudsman.

The Financial Ombudsman expedites all general insurance disputes in which the insurer alleges fraud to an Ombudsman to make a determination without first making a recommendation (FOS 2012). Determinations made by the Financial Ombudsman are binding upon all financial service providers (GICOP 2014, s. 10.23, FOS 2015a, cl. 1.3), while a consumer still has the right to take action against an insurer under the common law.

While consumers regularly raise issues with the investigation process, they are rarely directly addressed in the Financial Ombudsman dispute determinations. While the Financial Ombudsman does provide compensation for non-financial loss (FOS 2015a, cl. 9.3) with respect to particularly egregious examples of poor investigator behaviour, this type of additional compensation is awarded conservatively (FOS Case No. 201242) and sometimes the Financial Ombudsman take no action at all to address accepted poor behaviour. For example, Wesley's story (Case Study 14) the Financial Ombudsman found for the applicant and that the insurer should pay the claim. In addressing the accusations of bullying where the investigator accused Wesley of lying and that he would be arrested, the Financial Ombudsman stated that:

> *"Whilst I accept the Applicant [Wesley] may have experienced inconvenience in the investigation of this matter, I am satisfied that the [Insurer] was entitled to investigate the matter and given the anomalies revealed, entitled to seek further information before determining the claim. In my view, whilst the dispute handling may not have been ideal, I am not satisfied that an award of compensation is required. I am satisfied that the payment of the claim in this matter is sufficient."*
>
> (FOS Case No. 398385 p6, cf. FOS Case No. 324030)

Financial Rights notes that in examining the 2015 Financial Ombudsman determinations involving allegations of fraud, only two cases out of 130 involved a costs finding additional to the provision of interest. One case involved the insurer paying half the legal costs of the policyholder, the other involved a finding of non-financial loss calculated at $7500.

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37 This can be contrasted to the highly regulated nature of the duties, rights and obligations found in an investigation and interview by police. Before a police interview starts, a police investigator must warn an interview subject of a number of things usually strictly outlined in statute such as cautioning that they are not under arrest. The caution must be in a language that they understand and interpreters may be used when necessary. The interviewer is required to advise the interview subject that they have a right to remain silent and that they don't have to answer their questions. Other requirements include advising the interview subject of the right to a support person and lawyer, recording the caution and the interview and the interview subject's right to a free copy of the interview tape within a week or two. These rights are found in most Australian jurisdictions but as an example they are provided in Queensland under the Police Powers and Responsibilities Act 2012 (Qld), Police Powers and Responsibilities Regulation 2012 (Cth) and the Sch. 9 Police Powers and Responsibilities Code (Qld).

Poor investigator behaviour, delays and other issues brought up in this Report are potential breaches of the General Insurance Code and its requirements to handle claims in an honest, fair transparent and timely manner. Code compliance is managed by the Code Governance Committee (CGC) who monitor and enforce insurers' compliance with the General Insurance Code. Under the Code policyholders can report alleged breaches of the Code to the CGC (GICOP 2014 s. 13.1). Insurers are required to report significant breaches of the General Insurance Code (GICOP 2014 s. 13.3). The Financial Ombudsman too "may report possible Code breaches to the CGC" as they arise out of determinations (GICOP 2014, c. 13.17). It is however less than clear when and under what circumstances the Financial Ombudsman would report a possible breach of the Code to the CGC. This creates the potential for inconsistencies in the Financial Ombudsman's approach to reporting possible breaches.

The CGC produce an Annual Report that details statistics on types and frequency of breaches. It reports that they worked with insurers to resolve and close 430 breaches in 2014-15, up from 267 breaches the previous year. The Report currently does not detail how many complaints or allegations of possible breaches were made although "future annual reports will … include information as to the number of reports of Code breach allegations and investigated Code breach allegations" (GICGC 2015, p22). The Report does not provide any information on the source of the complaints, be they from direct policyholder complaints, insurer subscribers to the General Insurance Code, or Financial Ombudsman referrals. Nor is there a database of determinations relating to Code breaches like the database of Financial Ombudsman determinations. All that is currently available are five case studies included in the 2014-15 Annual Report. It is therefore is not particularly clear whether the CGC has considered any of the systemic issues with respect to investigations detailed in this Report.

The Financial Ombudsman produces a guidance tool known as the Financial Ombudsman Approach that outlines the way Financial Ombudsman deals with different types of disputes. The aim is to provide practical information and explain the service's approach to substantive issues. There is however no Approach guideline for those cases involving an allegation of fraud.

E. REGULATION OF PRIVATE INVESTIGATORS

> *"Actually, [private investigators] have no more powers than you or me. They are not privileged to any information not legally obtainable by the public. Neither are they required to undertake professional development or show any real evidence of their competency. In fact, for around $1000 you could become a licensed private investigator in a couple of days. Simply complete a short course, take your certificate to the state police and receive your licence."*
>
> Ricky French, "Eyes on the spies: how far can private investigators go?"
> The Weekend Australian, 16 August 2014

The face of the investigation is regularly an externally engaged private investigator, who is charged with establishing whether the facts as stated by the consumer are true and correct. Private investigators abide by and are subject to the General Insurance Code as a service provider to

insurance companies. They are also licensed in most states and territories (except for the ACT) and are subject to their own set of regulations and codes of practices.

There is however significant variability and inconsistency across Australia with respect to private investigator licence schemes, which are at least theoretically designed to protect the public from unscrupulous agents (Prenzler 2001, p28).

For example, there is little agreement as to what a private investigator is or does.

Table 2. State Investigator Legislation

STATE	ACT	INVESTIGATOR TERMS AND FUNCTIONS
ACT	-	-
NSW	*Commercial Agents and Private Inquiry Agents Act 2004;* *Commercial Agents and Private Inquiry Agents Regulation 2006*	Private Inquiry Agent (s.4) is the holder of a master licence or operator licence with respect to one or more private inquiry agent activities including investigation of persons or surveillance of persons.
NT	*Commercial and Private Agents Licensing Act 1979;* *Commercial and Private Agents Licensing Regulations*	Inquiry Agents (s.4) perform any of the following functions: • *obtaining or providing information as to the personal character or actions of any person, or as to the business or occupation of any person;* • *obtaining evidence for the purposed of any legal proceedings;* • *searching for missing persons on behalf of any other person.*
QLD	*Security Providers Act 1993;* *Security Providers Regulation 2008*	Private Investigator (s.6)is a person who, for reward • *obtains and gives private information about another person, without the other person's express consent; or* • *carries out surveillance for obtaining private information about another person, without the other person's express consent; or* • *investigates the disappearance of a missing person.*

Table 2. State Investigator Legislation		
SA	*Security and Investigations Agents Act 1995;* *Security and Investigation Industry Regulations 2011*	Investigation agents (s. 3) functions include • *Ascertaining the whereabouts of or repossessing goods that are subject to a security interest;* • *Collecting or requesting the payment of debts;* • *Executing legal process for the enforcement of a judgement or order of a court;* • *Executing distress for the recovery of rates, taxes or money;* • *Obtaining or providing (without the written consent of a person) information as to the personal character or actions of the person or as to the business or occupation of the person;* • *Searching for missing persons;* • **Obtaining evidence for the purpose of legal proceedings (whether the proceedings have been commenced or are prospective).*
TAS	*Security and Investigation Agents Act 2002* *Security and Investigation Agents Regulations 2005*	Inquiry Agents (s. 3) obtain or provide information on behalf of another person about: • *the personal character or action of any person* • *the business or occupation of any person* • *getting evidence for the purpose of legal proceedings* • *searching for missing persons*
VIC	*Private Security Act 2004;* *Private Security Regulations 2005*	Investigators (s.3) are people who on behalf of any other person, is employed or retained: • *to obtain and furnish information as to the personal character or actions of any person or as to the character or nature of the business or occupation of any person; or* • *to search for missing persons.*
WA	*Security and Related Activities Act 1996; Security and Related Activities Regulations 1997*	Investigators (s. 28) are defined as a person who for remuneration conducts: • investigations into the conduct of individuals or bodies corporate or the character of individuals; • surveillance work; or • investigations concerning missing persons • *Inquiry Agent* (s. 27) is a person who supplies the services of investigators

In some states (NSW, WA, Vic) the administering authority is the police force, in others the authority is the local department of fair trading and/or consumer affairs (NT, Qld, SA, Tas). The threshold requirements to become a private investigator vary greatly from state to state[38] as do the training and competency standards.[39] The greatest variability however is found in the offences that attract penalties. Most jurisdictions make it an offence not to display credentials, place restrictions on advertising, or require investigators identify themselves to others. There is a variety of offences that apply in one or two jurisdictions only, including intoxication (Tas, Vic), failing a medical exam (WA), breaching the code of conduct (WA) not purporting to have powers outside the licence (SA, NT), and harassment (NSW, NT, Tas, Vic).[40]

Only one state, WA, has an enforceable Code of Conduct (WA Govt n.d.) outlining the responsibilities of licensees including promoting the public interest, acting with integrity and avoiding conflicts of interest. The SA legislation enables regulations to be developed to require "investigation agents" to comply with a code of conduct but there is no regulation or a code of conduct in place. In Queensland there is no code of conduct in the legislation but licensed private investigators must adhere to their industry associations' Code of Conduct (Qld 2015). This however is confusing and unclear because there are a multitude of approved and unapproved associations operating in Queensland each maintaining their own separate code of conduct, code of practice or code of ethics: see the National and State Investigator Professional Associations table below.

This confusing state of professional associations for investigators extends nationally. Financial Rights has identified at least eleven state and national associations across Australia.

Table 3 - National and State Investigator Professional Associations

Professional Association	Website	Code	Approved in Qld
Australia Institute of Private Detectives (AIPD)	www.aipd.com.au	National Code of Practice for Investigators and Mercantile Agents and a Code of Ethics	-
Australian Institute of Professional Investigators (AIPI)	www.aipi.asn.au	Code of Ethics	-
Association of Investigators & Security Professionals (AISP)	www.aisp.asn.au	Code of Ethics	-

38 Most require an applicant to be over 18, hold appropriate training qualifications and be a fit and proper person but add a variety of random yet specific requirements that are different from state to state and mutually exclusive including that the applicant can't be bankrupt (NSW, NT), must not be a member of a declared organisation (NSW), must be an Australian citizen (NSW), must demonstrate that they will be actively involved in the activities authorised (Tas) and must pass a medical exam (WA).

39 Most states require licensees to meet the same training and competency standards found in the Certificate III in Investigative Services. Some however vary in what electives need to be taken and Tasmania identifies an additional unit outside of Certificate III that needs to be taken namely CPPSEC3002A: Managing conflict through negotiation. The Northern Territory currently does not require private investigators to be trained.

40 Many states also list a variety of prescribed offences relating to state and commonwealth criminal codes or privacy laws that disqualify the licensee from holding a licence but this too is far from uniform.

Table 3 - National and State Investigator Professional Associations			
Australian Security Industry Association Ltd (ASIAL)	www.asial.com.au	Code of Conduct	Yes
Institute of Mercantile Agents Limited (incorporating the Australian Investigators Association and Australian Mercantile Agents Association) (IMAL)	imal.com.au/	Code of Ethics and Code of Conduct according to the IMAL website they are developing best practice guides for different aspects of the industry, although so far none relating to the conduct of investigations	Yes
National Security Association of Australia (Qld) Inc (NSAA)	www.nsaaqld.com.au/	Code of Conduct	-
Security Agents Institute of Western Australia (SAIWA)	www.saiwa.asn.au	WA State code	-
Security and Traffic Control Executive Association Qld Inc (STCEAQ)	richard671.wix.com/steaq	Code of Conduct	Yes
Security Institute of South Australia (SISA)	www.sisa.biz	-	-
Security Providers Association of Australia Limited (SPAAL)	www.spaal.com.au	National Code of Practice and Code of Ethics as well as a specific Queensland Security Firm Code of Conduct	Yes
Victoria Security Institute Inc (VSI)	www.vsi.org.au	Code of Ethics	-

According to one private investigator that Financial Rights spoke with, some of these have as few as twenty members and largely do not cater to the interests of investigators, rather are largely controlled by the interests of the security industry and locksmiths. Many of these associations maintain a code of conduct, code of practice or code of ethics or a combination of all three. There is vast variability in their approach and content. The largest code (Australian Institute for Private Detectives) reaches 73 pages minus appendices, the shortest 140 words (Australian Institute for Professional Investigators): see Table 3 above. The codes seek to ensure minimum standards of conduct with respect to either a member's duty to their client or their duty to the association itself.[41] Few address any duties owed to the consumers that they are investigating or to the public

41 In relation to the duty to a client, the codes cover the need for confidentiality and privacy and acting with honesty, integrity and credibility. Some codes (usually one or two) ensure that fees are explained to clients, counsel against client illegal conduct, ensure that success fees are not used or inducements for work not accepted, avoid conflict of interest or ensure good business practices. The key issues of concern in relation to members' duty to the association and one another centre on maintaining the professional reputation of the association and its individual members. Some codes include procedural matters (such as expulsion processes) in their codes.

more generally. When there is reference to a duty to the public it is usually a statement relating to the some variation on a requirement of "integrity, reliability and honesty" and a statement ensuring cooperation with the law. Only one code (ASIAL) refers explicitly to the need to respect and promote the public interest. No industry code touches upon any of the problematic procedural issues experienced by clients of Financial Rights and outlined in this Report.[42]

The Victorian WorkCover Authority Code of Practice for Private Investigators (VWA 2014) comes the closest to promoting best practice standards for investigations however it only applies to WorkCover investigations in Victoria, not insurance investigations. However this code addresses many of the issues that have been raised in this Report including a prohibition on threats, promises and inducements; providing a choice of interview venue other than one's home; reasonable restrictions on interviews: including timeliness; a prohibition on contacting neighbours, and; guidelines for working with those with mental health issues.

While a few of the associations have outlined disciplinary procedures in their codes, only a handful of associations include clear information relating to the raising of complaints on their websites (VWA 2014). A particularly noteworthy example is the process of the Institute of Mercantile Agents who provide significant details of their complaints procedure on their website (IMA n.d.) which includes a lodgement fee of $220.00 (incl. GST) for each complaint, payable by the complainant at the time the complaint is lodged.

It should finally be noted that there is significant ambiguity over whether private investigators working for insurance companies are actually required to be licensed under their state regulations at all. The General Insurance Code requires third party investigators to hold a current licence but only "if required by law" (GICOP 2014, s. 3(b)). However all state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator.[43] If private investigators working on insurance investigations are exempt from the protections provided by the state regulations and codes, this would be of significant concern to Financial Rights. It would mean that private investigators working for insurers would not be subject to any limitation or constraints on their powers outside of those voluntarily entered into through membership of an association, any internal investigation procedures, processes or policies developed and maintained by insurance companies, or the minimal guidance provided by section 6 of the General Insurance Code. It would mean that for particularly egregious breaches of expected investigator conduct there would be little recourse for a consumer against the private investigator.

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42 Outside of this there is great variability in what is included. References to advertising restrictions and the duty to display their licence is mentioned in a couple of codes (SPAALQ and SPAALN), not engaging in false, misleading or deceptive conduct (ASIAL), avoiding being political or sectarian (AIPI, VSI, SPAALN, AIPD) and not purporting greater powers (ASIAL, IMA, SPAALQ, SPAALN). Granted, many of these issues may already be covered by the regulations in place in the state, but there is no clear pattern or uniformity amongst the breadth of the ten codes examined.

43 Tasmania requires the loss adjuster to be a member of the Australian Institute of Chartered Loss Adjusters. Significantly South Australia exempts "a person employed under a contract of service by a [loss adjuster] while acting in the ordinary course of that business." This has the potential of including private investigators solely working in the fraud investigation field for loss adjusters under a contract of service. In its Code of Conduct the Australian Institute of Private Detectives refers to this potential ambiguity when it states: "it is contestable in the majority of the State based licensing regimes in relation to Commercial Investigations, as to whether a person requires a license at all in order to conduct investigations when engaged by insurance companies or authorised deposit taking institutions (ADI's) under the Commonwealth Banking Act 1959." (AIPD 2008,

> *"Private detectives can be distinguished from other enforcement bodies on the basis that they are not accountable to the government or the community, or any accountability body such as an ombudsman who can investigate complaints and award compensation, in the same way that law enforcement agencies are.*
>
> Office of the Privacy Commissioner (ALRC 2008, para 44.75)

F. INTERNAL RULES AND PROCEDURES OF INSURERS

A final protection against consumer exploitation and abuse in investigations lies with the insurance companies themselves. Financial Rights assumes (rightly or wrongly) that most if not all insurers have procedures, policies, protocols, internal codes, or rules in place that govern their individual organisation's approach to investigations. These could include simple procedure manuals, training guides or service contracts but could also potentially include guidelines on everything from how to avoid racial profiling, and treat vulnerable persons including those with mental illness or people from non-English speaking backgrounds, to how interviews should be conducted and evidentiary and documentation requirements. **Assuming they exist, these documents are not available to policyholders or the public in general.**

As a part of this Report, Financial Rights contacted 21 general insurance companies asking whether they would be willing to meet with us to discuss their approach to investigations. Financial Rights specifically asked each insurer whether their company:

- *has a set of procedures in place when a consumer is suspected of fraud;*
- *what, if any information you provide to claimants when they are under investigation;*
- *what standards of practice private investigators are held to when they are acting on your behalf; and*
- *whether you require the private investigators to be licensed under the appropriate state licensing regime.*

Most insurers were unwilling to speak with Financial Rights due to reasons of commercial-in-confidence, business competition, intellectual property or the insurer felt that they had limited market influence. One insurer confirmed that they had a set of procedures but were only willing to speak about them off the record, which Financial Rights did. Another confirmed they had a set of protocols but then told us there were in fact no documents that they could provide. Other insurers simply declined to be involved at all and many never responded to multiple contact attempts.

Financial Rights however did speak with representatives of two major insurers, IAG and Suncorp, who were willing to meet, be interviewed and provide a written response to assist with this Report. Both insurers committed significant time and resources in assisting Financial Rights to learn more of their approach to investigations. These interviews and documents confirmed that both insurers do have a set of procedures, be it expressed contractually in a service agreement, in a procedures manual or in the training undertaken.

While Financial Rights was given a broad overview of their processes, we were not provided with any of the actual procedure documents. IAG however did provide three short extracts of their service level agreement instructions. These related to expected investigator behaviour with respect to misrepresentations, threats and deceptions. IAG also confirmed in writing that the investigation services that they engage need to be licenced, are required to undertake training, must ensure timely service, and must demonstrate honesty and integrity as well as be professional and diligent. Furthermore IAG also confirmed that policyholders were able to have a support person attend an interview, interpreters are used when appropriate, particular care is taken when interviewing those with mental health issues or who have an intellectual disability, are aged or infirm and significantly have 'strict guidelines' in place with respect to interview location, length breaks and recordings. These guidelines were however not provided to Financial Rights. It is understood from speaking with one of IAG's investigators that interviews up to and beyond five hours are not uncommon. Both IAG and Suncorp made it clear that they have strict performance management processes in place to regularly and, on an ad hoc basis, ensure that their investigators are meeting the standards expected.

Ultimately no insurer was willing to provide to Financial Rights specific documentation as to the procedures, guidelines or any other safeguard with respect to investigations, beyond the three paragraph extract, mentioned above.

Subsequent to speaking with us for this Report, Financial Rights understands that Suncorp are examining the way they engage investigation firms and are currently considering the development of a code of practice similar to that of the Victorian WorkCover Authority. While this may take some time to progress, Financial Rights commends Suncorp for taking this important step towards greater procedural fairness. This is, as Financial Rights understands it, in addition to Suncorp taking steps to streamline their fraud identification and investigation triage system.

Notwithstanding this positive development, Financial Rights remains concerned with the general lack of transparency that has been shown by the general insurance industry with regards to their investigations processes. Financial Rights is not confident that policyholders are protected by the internal insurer processes and standards in place when these processes and standards are not available to either ourselves or policyholders to read, nor are policyholders even informed that they exist at all.

Financial Rights notes that the General Insurance Code requires insurers to conduct claims handling in a transparent manner. It is Financial Rights view that by not making available to policyholders under investigation what standards, procedures and guidelines are in place for that investigation, there remains a significant failure by insurers in being fully transparent when it comes to those investigations. Financial Rights is also concerned about the lack of a consistent approach to investigations and basic expectations and protections afforded to policyholders subject to them.

G. INSURANCE REPORTS

The general insurance industry has a process of sharing information about the claims history of every consumer that has purchased insurance. The database is managed and supported by Veda Advantage on behalf of Insurance Reference Services Ltd – a member organisation owned by Australian insurers. The database contains the following information on consumers in Australia:

- *Name, date of birth, driver's license, gender and residential address*
- *Applications made for insurance*
- *Enquiries made by agents of insurance companies - such as loss assessors, insurance investigators and recovery agents*
- *Claims made under insurance policies*
- *Details of fraud investigations*

A consumer can only obtain a copy of their insurance report or "insurance passport" at **www.myinsurancepassport.com.au** for $29.95. There is no free access available to an insurance report for a consumer.

Insurers regularly check insurance reports when a claim has been made. The consumer purchasing insurance is told about the possibility of reporting to an "insurance reference bureau" (or similar) in the Product Disclosure Statement, often close to the end of the PDS. There does however seem to be inconsistency in obtaining consent to provide this information.

The selling point of insurance passport put forward by Veda is that:

> *"It's a good idea to obtain a copy of your insurance passport before shopping for insurance online or obtaining quotes from the your insurance company so that you are aware of the minimum claims information that you must disclose to insurers in order to purchase a valid policy." (Veda n.d.)*

A consumer being able to access a central database of claims information that assists in answering disclosure questions holds some potential value but we are unaware to what extent consumers have taken up the opportunity. Insurers tracking consumers who make fraudulent or excessive claims to reduce the instance of fraud and calculate premiums also has potential value but there are many opportunities for misreporting and abuse without adequate rules and oversight.

However in speaking to insurers, the reports are haphazard, inconsistent and largely unreliable so that the current report provides minimal benefit to insurers or consumers.

It was also clear in meeting with insurers for this Report that insurers may use the database inconsistently, and are not aware of what the information contained on the report may mean. This could lead to a consumer being disadvantaged in unfair premiums, rejections for non disclosure and inconsistent treatment. The utility and value for a consumer in having the report at the cost of $29.95 is therefore undermined if the information it records is not consistent, accurate or up to date.

Financial Rights has several additional concerns about the 'Insurance Passport'. First, very few consumers know that insurance reports exist, their purpose and when their information is recorded.

Secondly, if information on a consumer's insurance history is collected and shared amongst insurers, access to this report should be free. Consumers need to be able to access information held by insurers about them to ensure that that information is accurate.

Finally, Financial Rights is concerned that there are no specific regulations covering insurance reports stipulating the permitted contents of the report, the type and the meaning of listings and the length of time the information is retained on a report.[44] The information held in an insurance report has the potential to be very prejudicial to a consumer in obtaining insurance or in making a claim. The lack of specific regulation in insurance reporting is in stark contrast with credit reports where there is extensive regulation about what information can be held, how consumers can get access and correction procedures.[45] Fraud is a serious allegation and the reporting of fraud on an insurance report is potentially defamatory and needs to be tightly regulated.

Under s. 4.8 of the General Insurance Code (2014) insurers have committed to giving reasons why they cannot provide insurance and supplying consumers with the information they have relied on, if requested. In Financial Rights' experience these reasons are often vague and rarely have information regarding an insurance report. This means consumers are not even aware of the problem on their insurance report.

Of additional concern is that it appears that Veda Advantage uses the claims history information used in the insurance report in a related product called My Car History at www.carhistory.com.au. It does not appear that any consumer has received disclosure of this use and further, that there was no intention of insurers to provide the information for this use.

44 According to Veda Advantage insurance enquiries are held for five years and claims for ten years, calculated on the date the information was added to the file and are based on the time limits provided in the Privacy Act 1988.

45 Part IIIA of the Privacy Act 1988 (Cth) regulates consumer credit reporting in Australia and is supported by the Privacy Regulation 2013 (Cth) and the Privacy (Credit Reporting) Code 2014 (Cth).

6. Discussion and recommendations

This Report has provided an overview of the insurance investigation process and presented a series of case studies that detail the most common concerns raised by consumers to the Insurance Law Service. The case studies have not been presented as a representative sample of insurance investigations nor are they statistically significant. Rather they represent the lived experiences of over 30 consumers who have contacted the Insurance Law Service seeking advice and assistance with respect to their insurance claim.

The case studies present a wide range of issues faced by consumers subject to investigation. They include intimidating, threatening and bullying behaviour, unreasonable requests for information and documentation, a lack of consideration of their personal circumstances and the persistence of investigations where insufficient evidence exists.

On a personal level, consumers subjected to an insurance investigation face significant anxiety and stress. This distress is further exacerbated by the impact investigations can have on the finances of already in-need consumers, be it through delays or the uncertainty borne of the process. Investigations have significant negative impacts upon a person's relationships with family, friends and peers as well as on their employment and ability to earn a living.

The onerous demands placed on consumers by an investigation lead many to withdraw their claim, not due to any admission of fraudulent behaviour but simply because the process is too burdensome or invasive for many consumers to bear. This was certainly the case for John in Case Study 13 and many other consumers who contact Financial Rights for advice. This withdrawal rate is also heavily weighted towards those consumers in more vulnerable positions for financial, health or other reasons as they simply do not have the resources to cope with the long and arduous process demanded in an investigation.

This Report makes several recommendations directed at both industry and Government to lift investigation practice standards and improve outcomes for both consumers and the insurance industry alike.

1. *That the industry establish a set of best practice standards for insurance investigations to be included in the General Insurance Code of Practice. In the event this does not occur the Federal Government should consider amending the Insurance Contracts Act 1984 (Cth) to codify consumer rights in relation to investigations*

This Report details a series of case studies that demonstrate a wide range of poor investigation practices and procedures. While Financial Rights has found that internal insurer standards policing investigations do exist, they are hidden from consumers and the public eye largely for commercial-in-confidence reasons. This has led to a lack of confidence in the process and healthy suspicion of insurance investigators. There is also a clear lack of effective regulation with respect to investigator behaviour.

Financial Rights notes concerns expressed by some insurers that they do not want to tip off potentially fraudulent policyholders on internal processes that would make it potentially easier to perpetrate a fraudulent claim. Furthermore Financial Rights acknowledges that insurers are protective of their intellectual property with respect to their contracts, training, manuals and other documents that could potentially be deemed commercial-in-confidence.

Financial Rights is not seeking to have the procedure manuals of insurers to be made available to policyholders and competitors. Nor are we seeking access to the processes and insights used by insurers in detecting potential fraud. Financial Rights is solely interested in ensuring that policyholders are made aware of:

A. *what to expect in an insurance investigation; and*

B. *their rights and obligations during an investigation*

and further, that there are minimum standards of conduct and behaviour that insurers (individually and collectively) expect investigators to meet and that these are made publicly available.

Financial Rights does not believe this to be either controversial or difficult and making policyholders aware of this information would contribute greatly to improved procedural fairness in the insurance industry.

Financial Rights notes that internationally Finland has developed Good Practice Guidelines for Insurance Investigation (FFFS 2014) detailing the principles governing insurance industry investigations.[46] Furthermore, the Victorian WorkCover Authority has developed a Code of Practice for Private Investigators that touches on many of the issues outlined in this Report including allowing for alternative interview venues and working with policyholders with a mental health issue (VWA 2014).

As mentioned above, Suncorp have informed Financial Rights that they are examining the way they engage investigation firms and are currently considering the development of a code of practice similar to that of the Victorian WorkCover Authority. While this may take some time to develop, Financial Rights commends Suncorp for taking this important step towards greater procedural fairness.

Financial Rights recommends the development of a similar set of best practice standards to apply to the entire general insurance industry to guide the distinct approaches taken by different insurance companies. This document should set standards of practice with respect to a range of issues.

A set of best practice standards should ensure standard, clear and thorough communication practices to policyholders subject to investigation. As a minimum policyholders should be informed both verbally and in writing of their rights and obligations under the reciprocal duty of utmost good faith, the name and contact details of the investigator, the precise reason for the investigation, the standards of behaviour expected of the investigator, the timeframes that they will be working to and the internal and external complaints processes.

46 The UK Association of Insurers have a set of Guidelines on the instruction and use of Private Investigators, Sept 2014, however these are directed at the relationship between the insurer and the private investigator, that is assisting insurers appointing and instructing PIs who operate within the law, rather than a set of standards for which policyholders can expect and rely upon (ABI 2014).

A set of best practice standards should detail standards and behaviours expected to be upheld in organising and conducting interviews including providing a choice of venue, limits on both the duration of an interview and the number of interviews, the right to request breaks, shorter interviews to help consumers meet family and employment responsibilities, and the right to be accompanied by an independent support person.

Furthermore a set of best practice standards should outline how investigators and insurers handle document requests, including providing clear reasoning as to the relevance of the documents requested.

A specific guide for interviewing vulnerable persons

Financial Rights believes that a set of best practice standards should also include a separate section focussing on the needs of vulnerable persons. Police forces across Australia recognise and acknowledge the need to identify and institute appropriate procedures when interviewing vulnerable persons. While Financial Rights acknowledges the differences between insurance investigation and police investigations, the process falls within a similar procedural context raising similar issues. It is Financial Rights' view that it is appropriate for insurers to take into account the needs of vulnerable persons when interviewing.

The Financial Ombudsman recognises and acknowledges the needs of vulnerable people through its Financial Ombudsman Service Accessibility Guideline and "is committed to being accessible to all people and to meeting any particular needs people using our service may have" (FOS n.d.). This guideline explicitly details some of the factors that affect access to the service including: language barriers, physical impairments, medical conditions, literacy barriers, mental health issues and social and economic barriers. The Financial Ombudsman collects statistics on those vulnerable people who use the service. In 2014-15, 817 requests were made for special assistance up from 808 in 2013-14 (FOS 2015c, FOS 2014). Mental Health issues made up 45% of this figure at 366 applicants. 590 applicants requested assistance of a translator, up from 573 from the previous year (FOS 2015c, FOS 2014). These figures demonstrate the extant and increasing need in the community for assistance as well as the need for a flexible and constructive approach in engaging with vulnerable people.

Financial Rights strongly supports this approach and is of the view that vulnerable people are routinely treated poorly by a system that fails to acknowledge the needs of particular sections of the community.

Comply with key privacy, discrimination and other relevant laws

The Victorian WorkCover Authority Code currently includes an explicit reference to the need for providers to comply with all related State and Commonwealth law and lists these (VWA 2014, s. 4.1). While it is true to say that all insurers must comply with the law no matter what, the inclusion of a statement identifying the key laws and provisions applying to insurance investigators would act as a significant reminder to all providers of the obligations that they must meet in the execution of their work.

This Report recommends that a similar statement be included in the proposed best practice standards outlining all relevant State and Commonwealth laws including: ***Privacy Act 1988 (Cth); Racial Discrimination Act 1975 (Cth); Disability Discrimination Act 1992 (Cth); all relevant state Crime Codes; all relevant state Private Investigator regulations; all relevant equal opportunity acts; and all relevant state surveillance and privacy laws.***

Code Compliance

A set of best practice standards should ideally be enforceable. They should be a term of the contract between the insurer and the consumer as well as the insurer and the investigator, and governed under the auspices of the General Insurance Code. Financial Rights notes that the Code Governance Committee Charter provides the committee with the power to provide guidance on compliance with the Code to Code Subscribers and other interested persons (GICGC n.d., s. 1.1(l)). Financial Rights recommends that the Code Governance Committee consider developing such a document. Alternatively, a set of best practice standards could be a standalone document agreed to by insurers and supported by the representative body of the insurance industry, the Insurance Council of Australia.

Financial Rights has developed a draft set of best practice standards for insurance investigations for consideration at **Appendix A.**

In the event this does not occur the Federal Government should consider amending the Insurance Contracts Act 1984 (Cth) to codify consumer rights in relation to investigations

Financial Rights notes that the Financial Services Council is currently consulting on the introduction of a code of practice for the life insurance industry similar to the General Insurance Code of Practice. While this Report has focussed on the general insurance industry many of the issues raised apply equally to investigations in the life insurance industry. Financial Rights therefore believes that the Financial Services Council should similarly establish a set of best practice standards applying to life insurance investigations and incorporate this into its Life Insurance Code of Practice.

2. *That the General Insurance Code of Practice include a statement on diversity and anti-discrimination*

Financial Rights notes that in its 2013 report Access All Ages – Older Workers and Commonwealth Laws (ALRC 2013), the Australian Law Reform Commission recommended that the General Insurance Code include a general statement on diversity and anti-discrimination encouraging insurers to consider the needs and circumstances of a diverse range of consumers, including mature age persons.

The 2012 Independent Review of the General Insurance Code briefly examined the issue of discrimination and while stating it was “terribly important” suggested that it was not possible in the timeframe to examine it more thoroughly.

Financial Rights recommends that the next Independent Review consider introducing diversity and anti-discrimination clauses to the General Insurance Code that address the needs of mature age people, people from non-English speaking backgrounds, those with a disability or with a mental illness. Such a clause should apply to third party service providers and to all stages of the insurance process including investigations.

3. *That the General Insurance Code of Practice include minimum standards in the use of interpreters*

Financial Rights recommends that explicit inclusion of minimum standards in the use of interpreters in the General Insurance Code is warranted, given the practices described in this Report.

Financial Rights notes that in the Financial Ombudsman Service 2008 Referee Report the Referee concluded that insurers needed to review and bolster their guidelines to promote better practice.[47] However it is unclear whether this has occurred or has led to any perceivable changes in industry practice. Given the case studies above the issue remains a significant one.

Financial Rights further notes that the Commonwealth Ombudsman recently examined the use of interpreters in government agencies including the Federal Police. While not examining investigation practices exclusively, the Ombudsman developed a set of eight Best Practice Principles for the Use of Interpreters. They include amongst others: promoting access to interpreter services; providing fair; accessible and responsive services; specifying who can be used as an interpreter (i.e. an independent interpreter should be used not a family member or friend); staff should be appropriately trained and good records should be maintained (CO 2009a & 2009b). These principles would be a sound starting point for the development of minimum standards in the use of interpreters for inclusion in the General Insurance Code.

Again Financial Rights notes that the Code Governance Committee Charter provides the committee with the power to provide guidance on compliance with the Code (GICGC n.d., s. 1.1(l)). Financial Rights recommends that the Code Governance Committee consider developing a guidance on interviewing policyholders. Alternatively, a Good Practice Guideline could be standalone document agreed to by insurers and supported by the representative body of the insurance industry, the ICA.

4. *That a Memorandum of Understanding be developed between the Insurance Council of Australia and mental health stakeholders to improve the general insurance industry's treatment of Australians with a mental illness, during claims and investigations.*

Much work has been undertaken by the mental health sector and the life insurance industry in tackling these issues including the development of a memorandum of understanding between life insurers and a coalition of mental health sector stakeholders.[48] However it seems less work has taken place in the General Insurance context.

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47 "I would strongly recommend to all insurers that they audit their guidelines for the use of interpreters, in particular where statements taken by investigators are to be used to highlight inconsistencies and form the basis of an allegation of fraudulent conduct. Ensuring they have a robust process for determining the use of interpreters should help resolve a number of 'inconsistencies' to the benefit of all parties" (IOS 2008, p11).

48 In 2003, the then Investment and Financial Services Association (IFSA) (now the Financial Services Council) representing life insurers developed this MOU with the coalition of mental health sector stakeholders (MHSS) in recognition of the issues faced by people with a mental health disorder. The MHSS included the Mental Health Council of Australia, Beyond Blue the Australian Psychological Society and five other representative organisations. The aim of the memorandum was to "improve the industry's understanding of mental health conditions, their risk management practices and ultimately the life insurance outcomes for Australians with mental health conditions." The memorandum has led to a number of significant developments including new guidelines for underwriting and claims treatment, a mechanism to address complaints, consumer facts sheets detailing the process, information sheets to assist the community to understanding the implications of applying for insurance products and the importance of making accurate statements about their health, annual data collection and the introduction of the Financial Services Council's Standard No. 21 Mental Health Education Program and Training.

Following the lead of the Financial Services Council, Financial Rights recommends that Insurance Council of Australia work with mental health stakeholders to develop a Memorandum of Understanding to improve the general insurance industry's consideration of mental health conditions, their risk management practices and outcomes for Australians with mental health conditions. A memorandum should encourage collaboration to work on the collection of data, guidelines to support the appropriate treatment of those with mental illness during investigations and education and training standards for those in the industry that work directly with people a mental illness.

The Financial Services Council's Standard No. 21 regarding Mental Health Education Program and Training (FSC 2013) for example requires that life insurance members of the FSC must implement a Mental Health Education Program for its representatives which:

- *Increases their general awareness and understanding of the causes, signs and symptoms of common mental health conditions in the community*
- *Increases their understanding of what it's like to have a mental health concern*
- *Helps them to develop communication skills for interacting with consumers who may have mental health concerns.*

Financial Rights believes similar program should be implemented in the General Insurance industry. In addition, employees who have regular, direct contact with insured persons or applicants should have specific training in relation to:

- *Communicating the process and outcome of insurance applications that involve the disclosure of a mental health concern; and*
- *Managing a policyholder's claim with mental health conditions/concerns.*

There is extensive and growing literature on communicating with people who suffer from a mental illness that has fed into police interviewing techniques, legal aid interviewing clients and interviewing people with a mental illness in other contexts. Financial Rights believes that general insurers and investigators should be appropriately trained to interviewing and communicating with people with a mental health issue.

5. *That insurers ensure that all investigators receive ongoing diversity and anti-discrimination training*

This Report has detailed concerns with respect to racial profiling and the preponderance of non-Anglo-Celtic Australians amongst those policyholders being investigated. This is supported by consistent anecdotal evidence.

There is little evidence that insurance investigators receive formal ongoing training with respect to cultural diversity and anti-discrimination. Financial Rights understands that Certificate III in Investigative Services includes a Unit on conducting interviews and taking statements. This unit touches upon issues relating to conducting interviews with sensitivity to individual and cultural experiences as well as relating to people from a range of social, cultural and ethnic backgrounds and of varying physical and mental abilities. It also deals with procedures for the use of interpreters.

Financial Rights believes that it is incumbent upon insurers to provide specific diversity and anti-discrimination training to all new employees or contractors as well as regular refresher training to ensure boost industry competency in this area.

6. *That the Financial Ombudsman Service Australia report on the number of fraud disputes and their outcome, and extend their collection of applicant demographic statistics to ethnicity or cultural identification and include this information in their Annual Review.*

The Financial Ombudsman expedites all general insurance disputes in which the insurer alleges fraud to an Ombudsman to make a determination without first making a recommendation (FOS 2012). The service however does not report on the numbers of these disputes expedited in its Annual Review. Financial Rights has undertaken its own analysis of determinations made by the Financial Ombudsman involving the denial of a claim on the basis of a fraud allegation: see the information box: Allegations of fraud determined by the Financial Ombudsman Service, 2015 on page 58 of this Report. This analysis found that insurers had not established fraud on the balance of probabilities in 46% of the cases and that the average length of time these claims took through the claims process, internal dispute resolution and external dispute resolution process was close to 18 months. Financial Rights believes that these figures should be calculated, analysed and reported on an annual basis by the Financial Ombudsman in order to shine an ongoing light on the extent of the problem and trends in this area.

The Financial Ombudsman currently collects extensive statistics relating to over 31,000 applicants to the service.[49] These statistics are reported in their Annual Review and include applicant's geographic distribution, gender, age, language barriers, hearing speech, vision and other physical impairments, medical conditions, literacy barriers, mental health issues, social and economic barriers and the use of translators. The Financial Ombudsman also collects the indigenous status of applicants on the online dispute form. The Financial Ombudsman does not report on the specific numbers of disputes involving allegations of fraud.

Financial Rights recommends that the Financial Ombudsman extends this collection of data to capturing the ethnicity or cultural identification of applicants to their service generally and in particular those involved in fraud disputes. This information should subsequently be reported in their published Annual Review. The Financial Ombudsman is the central clearinghouse for most general insurance disputes involving investigations and allegations of fraud. Outside of individual insurer data, it is the only organisation that could identify whether there is an overrepresentation of Australians of a non-Anglo-Celtic background in cases involving fraud allegations. Under the National Privacy Principles an organisation can't require somebody to provide the information, but an organisation can collect "sensitive information" including race/and or ethnicity with the consent of the individual pursuant to s.10.

49 The Financial Ombudsman Service received 31,895 disputes in 2014-15 of which 6,780 of these were accepted as general insurance disputes.

7. *That the Code Governance Committee of the General Insurance Code of Practice provide detailed statistics relating to Code breaches, and investigations in their Annual Report.*

The Code Governance Committee currently does not detail how many complaints or allegations of possible breaches were made although "future annual reports will … include information as to the number of reports of Code breach allegations and investigated Code breach allegations" (GICGC 2015, p22).

In addition to the recommendation that the Financial Ombudsman report statistics on fraud disputes and demographics of those who use the service, Financial Rights recommends that the Code Governance Committee report on:

- *the number of Code breach allegations;*
- *the number of investigated Code breach allegations;*
- *the cumulative results of these investigated Code breach allegations;*
- *the source of both the allegations and the investigated Code breach allegations be they from direct policyholder complaints, insurer subscribers to the General Insurance Code, or Financial Ombudsman referrals*

The role of the Code Governance Committee should be to closely monitor compliance of the Code by insurers, investigate breaches where appropriate and publicly publish breaches and outcomes, identifying all relevant insurers. This requires transparency through the publishing of extensive data to better inform consumers, government and policymakers.

The Code Governance Committee should also publish claims handling and complaints reporting per insurer, per industry on a quarterly and annual basis. These reports should include cases of natural disasters or catastrophes where relevant for that reporting period and should cover the:

- *number of claims accepted;*
- *number of claims rejected;*
- *number of claims withdrawn;*
- *number of claims investigated;*
- *average length of time for assessment;*
- *number of complaints to IDR; and*
- *number complaints to EDR.*

8. *That the Financial Ombudsman Service Australia develop an Approach document or series of Approach documents with respect to disputes involving fraud allegations and investigations generally to drive better practice*

The Financial Ombudsman creates Approach documents to help consumers and financial services providers better understand the way the Financial Ombudsman deal with different types of disputes and how it reaches decisions on key issues. The aim is to provide practical information and explain the service's approach to substantive issues.

The Financial Ombudsman held a seminar on the issue of fraud for consumer advocates including NSW Legal Aid, the Financial Right Legal Centre and Wesley Community Legal Centre on 14 August 2015. In the past, we understand the Financial Ombudsman has been reluctant to publish an Approach document on a topic as broad as 'fraud'. This view was maintained at the recent seminar. However, Financial Rights believes that some guidance is warranted particularly in the light of the investigation practices outlined and detailed in this Report. A Financial Ombudsman Service Approach document focussed on disputes where an insurer has refused to pay because of a suspicion of fraud would assist both consumers and insurers to better understand how the Financial Ombudsman generally considers common issues that arise, which in turn has the potential to lead to improvements in claims assessment and investigation procedures.

Financial Rights believes that an Approach document that details evidentiary standards and expectations would help address a number of the issues faced by policyholders faced with investigations with insufficient or non-existent evidence. It would make explicit the onus of proof and high standard of evidence required to substantiate an allegation of fraud

Financial Rights notes that the Financial Ombudsman has already made a number of consistent public statements in various determinations, seminars and other documents (FOS Case nos. 202858, 203598, 203931, 262825, FOS 2000, pp21-22, FOS 2015b, O'Halloran & Bennett 2012, Price 2011, 2015). An Approach could consolidate this thinking into a central source document to make it easier for interested parties to understand the principles and issues at play in determining disputes involving allegations of fraud.

An Approach document could:

- *address how the Financial Ombudsman applies the General Insurance Code to disputes involving allegations of fraud*
- *outline the special procedures established by the Financial Ombudsman to conduct determinations in fraud disputes with a detailed step by step guide*
- *detail the relevant laws and their application relating to the onus of proof of the policyholder to establish a claim and the onus of proof on the insurer to establish fraud, paying specific regard to tests set down by the High Court (Briginshaw 1938, Neat Holdings 1992)*
- *spell out what guides the Financial Ombudsman in making a determination including the common types of documents and records and other forms of evidence they examine, and*
- *clarify the principles that Financial Ombudsman takes into consideration when determining a dispute.*

Financial Right notes too that the UK Financial Ombudsman Service has published a similar Approach on fraud in 2002 (FOSUK 2002).

9. *That the Financial Ombudsman Service Australia update their Operating Guidelines to allow the use of support persons during interviews in disputes involving allegations of fraud*

The current operating guidelines state that:

> *The Financial Ombudsman Service permits an Applicant to bring another party to an interview, for assistance or support, except where the Dispute involves allegations of fraud. In these Disputes, an Applicant will not be allowed to bring another party to the interview. (FOS 2015a)*

Financial Rights recommends that the Financial Ombudsman permit the use of a support person where appropriate for assistance or support. This would align with statements made by the Financial Ombudsman at its recent seminar and in its process statement (FOS 2012)[50] that they do in fact allow the use of support people in fraud interviews.

10. *That the Insurance Council of Australia cease referring to inaccurate and unreliable fraud data and instead reference accurate and independently verified data*

Insurance fraud has long been claimed to cost the industry and policyholders $2.1 billion annually or 10% of all claims (ICA n.d., Smith 2014, p55). However this figure is over 20 years old[51] and based on an estimated percentage of claims insurers "believed to be fraudulent" (Baldock 1997, p3). Even a lower, more "conservative" calculation of insurance fraud of $832 million (IAG 2004) put forward by the industry includes both an estimate of the cost of cases that involved fraud and "cases where fraud is suspected but claims are nonetheless paid because of insufficient evidence" (IAG 2004 p12).[52] In other words the $2.1 billion annual cost of insurance fraud regularly quoted by the industry includes genuinely fraudulent claims, claims suspected to be fraudulent but nonetheless paid because of insufficient evidence, as well as an even larger proportion of unidentified claims not even flagged as being suspected of fraud but that the insurer industry "believed to be fraudulent." The industry's willingness to overstate the cost of insurance fraud by including suspected yet wholly unproven cases of fraud in their statistical analyses belies a guilty until proven innocent approach that – given the lived experience of policyholders detailed in this Report – appears to feed into the investigation process itself.

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50 "Whilst the applicant can have a person attend the interview with them, legal representation at the interview is not permitted unless there are exceptional circumstances."

51 The $2.1 billion figure is drawn from a 2004 study by IAG (IAG, 2004) which in turn relies on a 1994 Insurance Council of Australia report titled Insurance Fraud in Australia to base its calculations. The 2004 study states that "[i]n 1994 it is estimated that 10-15% of insurance claims exhibited elements of fraud." This 1994 report however is no longer available and the Insurance Council of Australia themselves were unable to locate a copy.

52 An even lower figure of $211 million being the "value of savings from the non-payment or reduced payment of claims" (IAG 2004 p12) could still be overstating the problem too as it potentially includes refused claims that were not in fact fraudulent but the policyholder accepted the non-payment of their claim because they were worn out by the process or did not take the matter to IDR or EDR.

Financial Rights asserts that these figures are inaccurate, out-of-date and misleading. Financial Rights recommends that the Insurance Council of Australia and others cease to refer to these statistics and instead reference accurate and independently verified data.

11. *That Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct*

The state of private investigator licensing in Australia is a mess. There is vast variability across jurisdictions in the content and coverage of licensing schemes, training methods and quality control, and a multiplicity of associations and self regulatory codes. This is confusing to consumers. It is not clear there is any uniform competency and accountability of private investigators across Australia. This mess is at least in part acknowledged by the industry itself (ALRC 2008, para. 44.76). One private investigator told Financial Rights that they are a member of an Australian association only because he had to be and would not be a member otherwise. He and his colleagues have chosen to be a member of the US based Association of Fraud Examiners which has Sydney and Melbourne chapters. This association provides significant training and certification standards unavailable in Australia.

Financial Rights also notes the substantial ambiguity with respect to whether insurance investigators need to be licensed. As noted above, all state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator. The General Insurance Code requires third party investigators to hold a current licence but only "if required by law" (GICOP 2014, s. 6.3(b)). Some insurance companies do however require their external investigators to be licenced. Ultimately this means that some of the investigators working in insurance investigations will be licenced and others will not. Not that this ultimately means much to a policyholder given the variability of regulations, dearth of standards and lack of clear avenues of redress applying to their conduct.

The ALRC recommended in its 2008 Report on Privacy Law and Practice that the Federal Governments through the Council of Australian Governments consider developing uniform private investigator regulations. As apart of this there should be a uniform enforceable code of conduct that supersedes the mess of ineffective and unsubstantial self-regulatory codes that currently exists.

12. *That general insurers be subject to the unfair contract terms regime under the Australian Securities and Investments Commission Act 2001 (Cth)*

Unfair contract terms protections currently apply to every other contract an Australian consumer is ever likely to enter and it has always been the view of consumer advocates that there is no sound reason to exempt the insurance industry. National unfair contract terms (UCT) laws apply to most contracts of financial products and financial services under Subdivision BA of Division 2 of Part 2 of the ASIC Act 2001 (Cth). The laws were introduced as part of the Australian Consumer Law reforms on 1 July 2010 to protect consumers from unfair terms in standard form consumer contracts. The UCT laws apply to all sectors of the economy, and to all businesses operating in those sectors in Australia which use standard form contracts in their dealings with consumers. However, the

UCT laws for financial products do not currently apply to contracts of insurance regulated by the Insurance Contracts Act 1984 (Cth).

The former government announced in 2012 that the existing protections from unfair contract terms available for consumer contracts of other financial products and services would be extended to general insurance contract with a Bill drafted. The Bill never entered into law.

Financial Rights believes that subjecting general insurance contracts to the unfair contract terms regime would allow remedies for consumers who have suffered detriment because an insurer relied on an unfair term. It would also create an incentive for insurers to draft their contracts with an eye to fairness and review their existing contracts and remove terms which may be unfair, rather than face enforcement action later.

Specifically it would prevent insurers relying on unfair terms to instigate investigations and void a claim. It would also ensure that other terms, for example those terms requiring the provision of any and all documents or the cost of an investigation to be borne by the consumer would be removed.

13. *That Federal and State Governments through the Council of Australian Governments develop uniform surveillance and listening devices laws that provide for strong consumer protections*

The ALRC Report recommended that surveillance device laws should be uniform across Australia, a recommendation supported by the majority of submissions. Financial Rights supports this recommendation as well. Such legislation should: provide stricter protections for members of the public; provide greater certainty to consumers and businesses; be technologically neutral to ensure that all (known and developing) forms of surveillance be captured; and should remove "participant monitoring" exceptions (found in Qld, Vic, and NT), that is outlaw the recording by one party to a private conversation or activity without the consent of other parties.

14. *That the Federal Government introduce insurance reporting regulations appropriate for consumer protection and privacy purposes*

Insurance reports drawn from the database owned by Insurance Reference Services Ltd managed by Veda Advantage are haphazard, inconsistent and largely unreliable providing minimal benefit to both consumers and insurers. Very few consumers know that insurance reports exist. Access to a consumer's own information is not free. There are no specific regulations defining and limiting the permitted contents of the report, the time information stays on the report, and no systems in place to ensure that incorrect, prejudicial and potentially defamatory information can be removed.

Similar to the regulation in place already for consumer credit reporting, Financial Rights recommends that the Federal Government, working with the Office of the Australian Information Commissioner and the insurance industry, overhaul the insurance reporting system through regulation. Central to any regulations should be rules to address issues of accuracy, timing, consistency of information, dispute resolution and the application of natural justice. The management of the database should also be put out to tender and principles of competition applied. Consumers should also have free access to the information held on them.

Appendix A: Proposed best practice standards for insurance investigations

THE PURPOSE OF INSURANCE INVESTIGATIONS

Insurance fraud and other financial crimes cause significant losses to the insurance industry and policyholders.

Insurance investigations are critical to detecting and reducing opportunities for fraud. Policyholders must be able to rely on insurers working to detect and prevent fraud in an efficient and ethical manner, limiting costs to policyholders incurred as a result of such abuse.

This document has been developed to establish good practice in insurance investigations to ensure that no policyholder is suspected of fraud without reason nor unreasonably or disproportionately impacted by an insurance investigation.

The objective of an insurance investigation is to fundamentally find out what occurred. All circumstances detected in the investigation, whether positive or negative for the parties involved, should be taken into account with equal weight.

Policyholders are entitled to the presumption of innocence under any investigation.

The methods used for the investigation, including information gathering, shall be in reasonable proportion to both the nature and the extent of the case at hand.

Parties to an insurance contract are not opponents of each other.

No investigation may unduly weaken the position of the party entitled to compensation or benefit. Sometimes insurance investigation may result in a finding that there is no reason to suspect any party of fraud or of any other improper action. At other times investigation may reveal that no compensable damage or loss or injury has occurred or that the occurrence has not been proved but there are not sufficient grounds to file an investigation request to the police. In such cases, insurers shall deny the claim without undue delay, specifying the reasons for the denial. No investigation may unduly delay the processing of the underlying claim by an insurer.

INVESTIGATORS

All insurance investigators, be they in-house employees of insurers or third party service providers, must:

- *hold a current security industry license under the appropriate state regulations at all times;*
- *hold appropriate investigations qualifications including education, training and experience;*
- *receive competency training to enable them to conduct investigations in accordance with this document;*
- *hold membership of the relevant professional body;*
- *not act in an intimidating, rude or inappropriate manner;*

- *not behave in a manner that will impact negatively on the reputation of the insurance industry and insurance investigators;*
- *not make any threat or promise, or offer any inducement to any person when conducting an investigation.*

CONDUCT OF INVESTIGATIONS

Insurance investigators acquire, analyse and document information on the circumstances surrounding an insurance contract and the circumstances surrounding the occurrence of an insured event.

In doing so, investigators will take into account the policyholder's situation and circumstances such as health, age, experience and education, language skills and other personal qualities which may have an impact on the person's chances of influencing the processing of the case.

Insurers and investigators will not discriminate against anyone on the basis of gender, age, ethnic or national origin, nationality, language, religion, conviction, opinion, health, disability, sexual orientation, or any other personal characteristic.

Investigators will not conduct any pretext activity in the course of an investigation. This includes any conduct or communication that conceals the true reason for that activity.

INFORMING THE POLICYHOLDER OF AN INVESTIGATION

Insurers will inform policyholders that an investigation is being conducted into their claim as soon as possible. If the investigation is being conducted on the basis of suspected fraud this will be explicitly stated to the policyholder both verbally and in writing.

The statements from the insurer will:

- *detail who will be contacting the policyholder;*
- *inform the policyholder the exact reason for conducting the investigation;*
- *explain what the policyholder can expect to occur during the investigation including the conduct of interviews and the requesting of documents;*
- *explain the reciprocal duty of utmost good faith and the policyholder's rights and obligations during an investigation, as well as the rights and obligations of the insurer and investigator;*
- *inform the policyholder of the insurer's Internal Dispute Resolution process and the policyholder's right to access an External Dispute Resolution service;*
- *provide details of how a policyholder can make a complaint if they have a problem with an investigator;*
- *specify the standards of behaviour to which the investigator is expected to meet;*
- *assure the policyholder that all information obtained in the investigation will be dealt with in accordance with the National Privacy Principles; and*
- *set forth the timeframes to which the investigation is working.*

INTERVIEWING THE POLICYHOLDER

The investigator will fully identify themselves and provide the policyholder with their license details and business card. If the investigator is a third party service provider they will explain that while they are not a direct employee of the insurer, they are acting on the insurer's behalf.

If a policyholder does not wish to be interviewed at their home, their workplace or the insurer's office, the policyholder will be provided with the opportunity to be interviewed in a neutral location at no cost to the policyholder.

If an investigator is required to attend the policyholder's home for the purposes of investigating the claim, this will be explained to the policyholder and arranged separately if the interview is held elsewhere.

The investigator will prepare all relevant information prior to commencing the interview, in order to minimise the time required for the interview.

At the start of an interview, the investigator will clearly outline the policyholder's rights and advise them that:

- *the policyholder has the right to terminate or reschedule the interview, at any time;*
- *the policyholder has the right to suspend the interview to have a break at any time;*
- *the policyholder has the right not to answer a question that is put to them;*
- *the investigator is not responsible for making decisions related to their claim;*
- *the investigator has a responsibility to ask a wide range of relevant questions in order to enable the insurer to assess their claim.*

The duration of the interview will be outlined beforehand and not exceeded without agreement. Interviews will take no longer than two (2) hours at a time. If after two (2) hours the interview is incomplete, the investigator may extend the time for no longer than thirty (30) minutes to enable the subject to read through and sign any statement or document, if the policyholder agrees. If an interview is expected to take longer than two (2) hours, a further interview will be arranged. The investigator will conduct no more than two (2) interviews in total.

Policyholders have the right to request and arrange a shorter interview, without prejudice, if circumstances require such as employment, family or other responsibilities.

The insurer will advise the policyholders of their right to be accompanied by an independent support person during the interview and encourage the policyholder to exercise this right. An independent support person is somebody who is not a material witness to the events surrounding a claim. If the policyholder requests a support person, the investigator will not commence the interview until the support person is present. A support person is, for example, entitled to participate in the interview by asking the investigator to rephrase or explain the relevance of questions, and encourage the interview to exercise their right to not answer or end the interview.

An investigator will not record an interview without the permission of the interviewee.

If the interview is recorded, a digital copy and/or transcript of the interview will be provided to the policyholder within five business days of the interview at no cost to the policyholder. The policyholder may tape the interview.

INTERVIEWING VULNERABLE PERSONS

An investigator will take steps to determine if a policyholder that they plan to interview is a vulnerable person. A vulnerable person includes:

- *someone from a non-English speaking background, who is unable to communicate in English, has a limited understanding of English, or is more comfortable communicating in their own language*
- *someone who is deaf, hearing impaired or speaking impaired;*
- *someone who has impaired intellectual capacity or functioning;*
- *someone who suffers from a mental illness or mental health condition;*
- *someone from cultural and linguistically diverse background (including Aboriginal or Torres Strait Islanders) subject to cultural, ethnic or religious factors that lead them to be vulnerable in an interview.*

Once identified, the investigator will take steps to ensure that any additional requirements including the use of an independent interpreter or a support person are provided and the length, location or approach to the interview is appropriately altered.

An investigator will offer the use of an independent interpreter where required. That is, the interview subject speaks English as a second language and either requests an interpreter or it is evident that the person is struggling to understand or answer the questions. Similarly, the policyholder may request the use of an interpreter, if English is their second language or they feel more comfortable communicating in a language other than English.

Just because someone can speak English to do everyday tasks does not mean that they can cope with the stress of an investigative interview. If in doubt, an interpreter will be engaged.

If using an interpreter an investigator will explain how the interview will be conducted, seat the interpreter to one side, maintain eye contact with the interview subject, speak in the first person and speak slowly.

The investigator will at all times consider the demeanour and apparent mental state of the policyholder and determine if it is appropriate to commence or continue the interview at that time, and if necessary, terminate the interview.

Where a policyholder under investigation is identified as having a mental illness or mental disability an investigator with a minimum five years relevant experience and who has completed appropriate mental health training will be appointed.

The insurer will offer the policyholder the option of being interviewed by an investigator of the same sex.

INVESTIGATION TIMEFRAMES

Insurers will inform policyholders of the maximum timeframes for claims assessment, investigation and decision making according to both the General Insurance Code and, if different, any internal procedures.

The decision to investigate a policyholder will be made within ten (10) business days of receiving the claim.

If an investigator is appointed, the policyholder will be informed within five (5) business days of the appointment, and will be told the name, license information and company of the investigator. At this time the policyholder will also be provided an initial estimate of the timetable and process for making a decision on their claim.

Insurers will keep the policyholder informed about the progress of their claim at least every 20 business days.

Investigations will not take more than twelve (12) weeks unless exceptional circumstances apply or the policyholder has not reasonably cooperated with the investigation.

If exceptional circumstances cause the investigation to take longer than twelve (12) weeks, the policyholder will be given an estimated alternative timeline and details of how to complain via internal dispute resolution and external dispute resolution.

No claim investigated for insurance fraud will take longer than six (6) months to be accepted or rejected.

DOCUMENT REQUESTS

Investigators will only ask for and rely on information and documents relevant to a decision when deciding on a policyholder's claim. It is normal to request personal information such as financial records including bank statements, credit card statements, loan statements and loan documents; telephone records; driving history and criminal history, where they are relevant.

Investigators will provide clear reasons why they are asking for information or documentation, at the time of the request.

Investigators will request all documents required of a policyholder as early as possible and not subject policyholders to excessive, unwarranted follow-up requests over an extended period.

Insurers will provide policyholders with the option to obtain the documents requested themselves or have the insurer obtain the documents with a signed authority.

Insurers will pay the costs of a policyholder obtaining documents that the insurer requires. Policyholders have the right to reclaim any costs they directly incur in obtaining documents that an investigator requires as part of an investigation. Where a consumer is in financial difficulty, the insurer will pay these costs directly.

Policyholders will be provided with a consent authority to sign for the investigator to obtain requested documents. Authorities given to consumers to sign will be specific, limited and reasonable in scope.

Policyholders can be asked to seek third party records but cannot be forced to seek and provide such documents.

All documents collection will be dealt with by the investigator and the insurer in accordance with the National Privacy Principles.

PRIVACY

The conduct of insurance investigation is an activity that poses a potential risk to a person's legitimate expectation of privacy.

All investigators must be aware of and comply with the obligations imposed by the Privacy Act 1988 (Cth) and all other state and commonwealth privacy related legislation.

Clear written information will be provided to policyholders on how the investigator and insurers will collect, use, retain and share information and documents obtained in the course of an investigation, as well as detailing the policyholder's rights and obligations under the National Privacy Principle and other privacy legislation.

Investigators will inform a policyholder of their right to interview third parties and inform them of their intent to contact a third party (friend, neighbour, business contact) Investigators will discuss any privacy concerns that the policyholder may have. Investigators will make every effort to ensure that any privacy concerns are considered in their contact with third parties.

COMPLIANCE

Investigators must comply with this document and all state and commonwealth laws including: Privacy Act 1988 (Cth); Racial Discrimination Act 1975 (Cth); Disability Discrimination Act 1992 (Cth); all state Criminal codes, Private Investigator regulations, Equal Opportunity acts and Surveillance and Privacy laws.

CLAIM DECISIONS

If a claim is rejected on the basis of fraud, the insurer will give the policyholder full reasons for its decision, in writing and inform the policyholder of their right to ask for the information that was relied on in assessing the claim, including the investigator's report. This information will be supplied with the decision.

At this time, the insurer will again provide details of its internal dispute resolution process and the external dispute resolution process.

The insurer will not charge the policyholder the insurer's investigation costs.

Appendix B: Proposed consumer factsheet on insurance investigations

FACT SHEET

Your insurer has begun an investigation to determine the circumstances surrounding your claim. The letter that you have received should detail your insurer's reasons for conducting an investigation, contact details for your case manager and investigator (if appointed) and what you can expect to occur during the investigation, including the standards of behaviour that your investigator will meet.

This factsheet has been provided to assist you in understanding your rights and obligations during the claims investigation process.

ESTABLISHING AN INSURED EVENT

When making a claim on your insurance policy it has to be established that an insured event has taken place. Your Product Disclosure Statement (PDS) (your contract of insurance) will list the events and occurrences that will trigger the insurance covering you for certain defined losses after particular events. It will also list a series of exclusions where your insurer will not be obliged to cover the loss.

THE DUTY OF UTMOST GOOD FAITH

Under insurance law, both you and your insurer are subject to the duty of utmost good faith. This means that your insurer and their employees will act in a fair, honest, transparent and timely manner towards you, paying due regard to your interests and acting reasonably in considering and determining your claim. It also means that you will need to be open, honest and transparent with your insurer and cooperate with your insurer's requests for relevant information to support your claim. This can include participating in interviews, supplying receipts, phone records, criminal histories, financial records including bank statements, or other forms of evidence relevant to the claim.

COMPLAINTS

You are entitled to make a complaint at any time about your insurer regarding any aspect of your relationship including the handling of this investigation. Details on how to make a complaint are available on your insurer's website.

If your complaint to your insurer's Internal Dispute Resolution Department has been rejected or delayed beyond 45 days, you can raise a dispute with the free and independent Financial Ombudsman Service. To lodge a claim call FOS on **1800 367 287 (1800 FOS AUS)** or visit their website **www.fos.org.au** to obtain the relevant forms.

PRIVACY

Your insurer must abide by the Privacy Act 1988 (Cth) when they collect, store, use and disclose personal information about you. You will have access to information about you that your insurer has relied on in assessing your claim including reports from service suppliers or external experts, upon request. However note that your insurer may decline to provide access to this information during an investigation.

TIMELINESS

When an investigation has begun your insurer should keep you informed of your claim at least every 20 business days. They will respond to routine requests for information about your claim within ten business days. Once your insurer has all relevant information and completed their enquiries, your insurer will notify you of their decision to accept or deny the claim within ten business days. Their decision can take up to 12 months from receiving the claim where exceptional circumstances apply including where the insurer holds a reasonable suspicion of fraud or there is a failure by you to respond to reasonable inquiries or requests for documents or information concerning your claim.[53]

If your claim is denied, your insurer will give you reasons for their decision in writing and inform you of your right to ask for information about you (including external expert or investigator reports) that your insurer relied on in assessing your claim and supply that information within ten business days if you request it. Your insurer will also provide details of their complaints process

53 Twelve months is the current timeframe as permitted under GICOP 7.18, although Financial Rights believes that this length should be shortened.

For further information on your rights you can read the General Insurance Code of Practice at **codeofpractice.com.au** which the general insurance industry's commitment to you to uphold minimum standards of practice.

Appendix C: Financial Rights Insurance Investigations survey, August 2015

INVESTIGATION SURVEY CLSIS# _____

DATE _____

ETHNICITY _____

1. *Did the insurance company or investigator explain the process of investigation to you?* Yes ☐ No ☐

→ ***If yes,***

- *Who were you told by? (Insurer/Investigator/Other_____*
- *How were you told? (Over the phone/In person)*
- *What were you told?*

2. *Did the insurance company or investigator provide any information in writing about the investigation process?* Yes ☐ No ☐

→ ***If yes,***

- *Ask for a copy to be sent to us*

3. *Did the insurance company or investigator at any time explain your rights to complain about or query that process?* Yes ☐ No ☐

→ ***If yes,***

- *What were you told?*

4. *Were you given an estimate of how long the interview would be?* Yes ☐ No ☐

→ ***If yes,***

- *how long?*

5. *How long was the interview?*

6. *Did the investigator insist on the interview to be conducted at your home?* Yes ☐ No ☐

7. *Did you feel intimidated at all during the interview?* Yes ☐ No ☐

→ ***If yes***

- *Why? (Provide specifics, if possible)*

Bibliography

SOURCES

Association of British Insurers (ABI), (2014). Guidelines on the instruction and use of Private Investigators, https://www.abi.org.uk/~/media/Files/Documents/Publications/Public/2014/Fraud/Private%20Investigators%20Guidance.pdf

Australian Bureau of Statistics (ABS), (1995). Ethnic and Cultural Diversity in Australia, Year Book Australia, 1995, http://www.abs.gov.au/Ausstats/abs@.nsf/Previousproducts/1301.0Feature%20Article41995?opendocument&tabname=Summary&prodno=1301.0&issue=1995&num=&view=

Australian Bureau of Statistics (ABS), Hugo, Prof. G, (2001). A Century of Population Change in Australia, Year Book Australia, 2001, http://www.abs.gov.auAusstats/abs@.nsf/94713ad445ff1425ca25682000192af2/ 0b82c2f2654c3694ca2569de002139d9!OpenDocument

Australian Institute of Private Detectives (AIPD), (2008). National Code of Practice for Investigators and Mercantile Agents, http://www.aipd.com.au/pdf/COP_Adopted220908.pdf

Australian Securities and Investment Commission (ASIC), (2015). RG 165 Licensing: Internal and external dispute resolution, http://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-165-licensing-internal-and-external-dispute-resolution/

Australian Law Reform Commission (ALRC), (2008). For Your Information Only: Australian Privacy Law and Practice, ALRC Report No. 108, http://www.alrc.gov.au/publications/44.%20New%20Exemptions%20or%20Exceptions/private-investigators

Australia Law Reform Commission, (2013). Access All Ages – Older Workers and Commonwealth Laws – Final Report, http://www.alrc.gov.au/sites/default/files/pdfs/publications/whole_final_report_120_.pdf

Baldock, Tony (1997). Insurance Fraud: Trends and Issues in Criminal Justice No. 66, Australian Institute of Criminology, http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi066.pdf

Babacan, A, Singh, S, (2010). Migration, Belonging and the Nation State, Cambridge Scholars Pub. Sample viewed on 20 January 2016, http://www.cambridgescholars.com/download/sample/59611

Commonwealth Bank (n.d.). Electronic Banking Terms and Conditions, viewed on 20 January 2016, https://www.commbank.com.au/personal/netbank/terms-and-conditions/terms-and-conditions.html

Commonwealth Ombudsman (CO), McMillan, Prof. J. (2009a). Use of Interpreters, Report No 3, http://www.ombudsman.gov.au/files/investigation_2009_03.pdf

Commonwealth Ombudsman (CO), (2009b). Fact Sheet 4: Use of Interpreters, http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet4-interpreters.pdf

Davidson, J, NRMA, (2000). The Insurance Role in Vehicle Theft Prevention, at the Reducing Car Theft: How low can we go? Conference, 2000 hosted by The Australian Institute of Criminology, in conjunction with the National Motor Vehicle Theft Reduction Council http://www.aic.gov.au/media_library/conferences/cartheft/davidson.pdf

Drizin, S., & Leo, R. A. (2004). The problem of false confessions in the post-DNA world. North Carolina Law Review, 82, 891-1004, http://web.williams.edu/Psychology/Faculty/Kassin/files/drizenl.leo.04.pdf .

Enright, I, (2013). General Insurance Code of Practice, Independent Review 2012-13, Final Report, http://www.insurancecouncil.com.au/assets/report/GI%20COP%20Independent%20Review%20Final%20Report%202012-13.pdf

Federation of Finnish Financial Services (FFFS), (2014). Good Practice Guidelines for Insurance Investigation, https://www.fkl.fi/en/material/publications/Publications/Good_practice_guidelines_for_insurance_investigation.pdf

Financial Ombudsman Service (FOS), (n.d.). Accessibility Guideline, viewed on 20 January 2014http://fos.org.au/about-us/accessibility/

Financial Ombudsman Service (FOS), (2000). General Insurance: Process for Disputes involving Fraud Allegations in Circular, Issue 4, December 2000, https://www.fos.org.au/the-circular-4-home/gi-fraud-disputes/

Financial Ombudsman Service (FOS), (2010). General Insurance Code of Practice – Overview of the Year 2009 – 2010 http://www.fos.org.au/public/download/?id=14819&sstat=285859

Financial Ombudsman Service (FOS), (2012). General Insurance: Process for Disputes involving Fraud Allegations https://www.fos.org.au/the-circular-4-home/gi-fraud-disputes/

Financial Ombudsman Service (FOS), (2014). Annual Review 2013-2014, http://www.fos.org.au/custom/files/docs/20132014-annual-review.pdf

Financial Ombudsman Service (FOS), (2015a). Terms of Reference 1 January 2010 (as amended 1 January 2015) http://www.fos.org.au/custom/files/docs/fos-terms-of-reference-1-january-2010-as-amended-1-january-2015.pdf

Financial Ombudsman Service (FOS), (2015b). Operating Guidelines to the Terms of Reference, 1 January 2015, http://www.fos.org.au/custom/files/docs/operational-guidelines-as-at-1-january-2015.pdf

Financial Ombudsman Service (FOS), (2015c). Annual Review 2014-2015, https://www.fos.org.au/custom/files/docs/20142015-fos-annual-review.pdff

Financial Ombudsman Service, UK (FOSUK). (2002). Insurance Fraud, Ombudsman News October 2002 Issue 21 http://www.financial-ombudsman.org.uk/publications/ombudsman-news/21/insurance-fraud.htm

Financial Services Council (FSC), (2013). Standard No. 21 Mental Health Education Program and Training. http://www.fsc.org.au/downloads/file/FSCStandards/21SMentalHealthEducationProgramandTrainingStandardFINAL22August2013.pdf

French, R, (2014). "Eyes on the spies: how far can private investigators go?" The Weekend Australian, 16 August 2014, http://www.theaustralian.com.au/news/features/eyes-on-the-spies-how-far-can-private-investigators-go/story-e6frg8h6-1227024080022

General Insurance Code Governance Committee (GICGC), (n.d.). Code Governance Committee Charter, http://codeofpractice.com.au/assets/The%20Code%20Governance%20Committee%20Charter.pdf

General Insurance Code Governance Committee (GICGC), (2015). General Insurance Code of Practice Annual Report 2014-2015, http://codeofpractice.com.au/assets/GICGC%20Annual%20Report%202014-15.pdf

Harrison, P, Massi, M, Chalmers K and CALC, Shutting the Gates: An analysis of the psychology of in-home sales of educational software, A joint research project by Deakin University and Consumer Action Law Centre, March 2010 http://consumeraction.org.au/wp-content/uploads/2012/04/Shutting-the-Gates.pdf

Health Queensland, (n.d.). Indian Ethnicity and Background, viewed 20 January 2016, https://www.health.qld.gov.au/multicultural/health_workers/Indian-preg-prof.pdf

Institute of Mercantile Agents Limited (IMA), (n.d.). Complaints, viewed 20 January 2016 http://www.imal.com.au/index.php?option=com_content&view=article&id=40:complaints&catid=13:general&Itemid=51

Insurance Australia Group (IAG), (2004). Hidden costs: Insurance fraud in Australia, written in cooperation with the Economist Intelligence Unit.

Insurance Council of Australia (ICA), (n.d.). Insurance Fraud, viewed 20 January 2016, http://understandinsurance.com.au/insurance-fraud?download=friendly, http://www.ifba.org.au/

Insurance Council of Australia (ICA), (2010) Submission to Treasury re: Unfair Terms in Insurance Contracts: Options Paper, icareview.treasury.gov.au/content/_download/submissions_options_paper/Insurance_Council_of_Australia.pdf

Insurance Council of Australia (ICA), (2014). General Insurance Code of Practice, http://codeofpractice.com.au/

Insurance Enquiries and Complaints Limited (IECL), (2004). The General Insurance and Complaints Scheme 2004 Annual Review,

https://web.archive.org/web/20050615172633/http://www.insuranceombudsman.com.au/review/AR2004.pdf

Insurance Law Service (ILS), (2009). Submission to the Review of the General Insurance Code of Practice, file://cclcnswts/redirected/drewm/Downloads/sub054%20attach%203%20(1).pdf

Insurance Law Service (ILS), (2012). Joint Consumer Submission to the General Insurance Code of Practice Independent Review 2012 Issues Paper, http://www.humanservices.gov.au/spw/corporate/publications-and-resources/centrepay-review/resources/submission-29-cclc.pdf

Insurance Ombudsman Service (IOS), (2008). 1 July 2007 – 30 June 2008 Annual Review, http://www.fos.org.au/custom/files/docs/annual_report_0708_general_insurance.pdf

Kassin, S. M., Drizin, S. A., Gr isso, T., Gudjonsson, G. H., Leo, R. A., & Redlich, A. P. (2010). "Police-induced Confessions: Risk Factors and Recommendations: Looking ahead. Law and Human Behavior, 34, 49–52 http://web.williams.edu/Psychology/Faculty/Kassin/files/White%20Paper%20-%20LHB%20(2010).pdf

Lincoln, R, H. Wells and W. Petherick (2003). An Exploration of Automobile Insurance Fraud. Centre for Applied Psychology and Criminology, Bond University, Gold Coast. http://epublications.bond.edu.au/cgi/viewcontent.cgi?article=1064&context=hss_pubs

O'Halloran, D, Bennett, Dr D, (2012). Behaviour Analysis: Fraud Key Indicators presented at the 2012 National Conference for Members, http://fos.org.au/custom/files/docs/conference_2012_presentation_behaviour_analysis_key_indicators_of_fraud.pdf

Prenzler, T, (2001). Private Investigators in Australia: Work. Law Ethics and Regulation http://crg.aic.gov.au/reports/prenzler.pdf

Price, J, (2005). Referee's Report 2005 in Insurance Ombudsman Service (IOS), (2005). Annual Review http://www.fos.org.au/custom/files/docs/ios_annual_report_2005.pdf

Price, J, (2011). Motor Vehicle Insurance: Clearly Informed theft or fraud presented at the 2011 National Conference for Members https://www.fos.org.au/custom/files/docs/nc2011_motor_vehicle_insurance_handoutpdf.pdf

Price J, (2015). Fraud Presentation to Legal Aid NSW, Financial Rights Legal Centre, Wesley Community Legal Centre, 14 August 2015

Queensland Government, (2015). Join an approved security industry association, viewed on 20 January 2016, https://www.qld.gov.au/law/laws-regulated-industries-and-accountability/queensland-laws-and-regulations/regulated-industries-and-licensing/regulated-industries-licensing-and-legislation/security-industry-regulation/legal-requirements-for-the-security-industry/join-an-approved-security-industry-association/

RAA, (2014). Comprehensive Car Insurance, Product Disclosure Statement http://www.raa.com.au/documents/comprehensive-car-insurance-pdsapr15

Roberts, Dr K, (2012). Police Interviewing of Criminal Suspects: Historical Perspective, Internet Journal of Criminology, http://www.internetjournalofcriminology.com/roberts_police_interview_criminal_suspects_ijc_dec_2012.pdf

Smith, RG, Jorna, P, Sweeney, J & Fuller G, (2014). Counting the costs of crime in Australia: A 2011 estimate, AIC reports. Public policy series 129, http://www.aic.gov.au/media_library/publications/rpp/129/rpp129.pdf

Tarr JA, Tarr A & Clarke, M, (2009). Insurance: The Laws of Australia, Thomson Reuters UK Association of Insurers, (2014). Guidelines on the instruction and use of Private Investigators, https://www.abi.org.uk/~/media/Files/Documents/Publications/Public/2014/Fraud/Private%20Investigators%20Guidance.pdf

Veda, (n.d.). myinsurancepassport.com.au FAQs, viewed on 20 January 2016, http://www.myinsurancepassport.com.au/faq/

Victorian WorkCover Authority (VWA), (2014). Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

Virgin Mobile (2011). General Terms, https://www.virginmobile.com.au/global/virgin-mobile/static/pdfs/terms-and-conditions/General%20Terms%20-%2017%20November%202011%20034SA.doc

Western Australian Government, (n.d.). WA Security Industry Code of Conduct, viewed on 20 January 2016 https://www.police.wa.gov.au/~/media/Files/Police/About-us/Our-agency/Security/Code-of-conduct/WA-Security-Industry-Code-of-Conduct.pdf?la=en

Willis, GB, (1999). Cognitive Interviewing – A "How to" Guide, Research Triangle Institute, http://www.hkr.se/pagefiles/35002/gordonwillis.pdf

FINANCIAL OMBUDSMAN SERVICE DETERMINATIONS

#201242 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/201242.pdf

#202858 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/202858.pdf

#203598 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/203598.pdf

#203931 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/203931.pdf

#216410 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/216410.pdf

#259196 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/259196.pdf

#260992 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/260992.pdf

#262825 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/262825.pdf

#275937 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/275937.pdf

#285180 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/285180.pdf

#292716 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/292716.pdf

#324030 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/324030.pdf

#375295 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/375295.pdf

#389487 https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/389487.pdf

#398385, unavailable online as of 20 January 2016.

2015 CASES INVOLVING AN ALLEGATION OF FRAUD DRAWN FROM THE FINANCIAL OMBUDSMAN SERVICE DECISIONS DATABASE:

http://www.fos.org.au/resolving-disputes/decisions/

#326622, #333842, #337510, #338032, #339306, #340928, #342648, #345325, #346681, #353383, #353607, #353668, #353715, #354416, #355001, #355148, #355219, #355649, #356035, #356041, #356624, #357802, #358045, #359202, #360631, #361054, #361421,

#362242, #362312, #362908, #363103, #363560, #363901, #364193, #364225, #364278, #364371, #364961, #365165, #365423, #365559, #365873, #365926, #366295, #366304, #366339, #366518, #367295, #367405, #367889, #368276, #368805, #368896, #369001, #369623, #369838, #370869, #371002, #371259, #371351, #371396, #371724, #371900, #371946, #372152, #372759, #374039, #374394, #374530, #374587, #374642, #374747, #375295, #375579, #375649, #375922, #375938, #376138, #376157, #376631, #377100, #377480, #377665, #377798, #377886, #378292, #378336, #378862, #379578, #380063, #380506, #380847, #381306, #381602, #381643, #381674, #383464, #383501, #383713, #383803, #383909, #384477, #384652, #384894, #385097, #385166, #385175, #385207, #385633, #385766, #385795, #386045, #386486, #387032, #387162, #387453, #387455, #387782, #387928, #388649, #388847, #389177, #389487, #389937, #391518, #391729, #391979, #393487, #393521, #393959, #394221, #394503, #396358, #397671, #400025

LEGISLATION

ASIC Act 2001 (Cth) viewed on 20 January 2016

http://www.austlii.edu.au/au/legis/cth/consol_act/asaica2001529/

The Australian Consumer Law (ACL) (Cth) viewed on 20 January 2016

http://www.austlii.edu.au/au/legis/cth/consol_act/caca2010265/sch2.html

Corporations Act 2001 (Cth) viewed on 20 January 2016

http://www.austlii.edu.au/au/legis/cth/consol_act/ca2001172/

Insurance Contracts Act 1984 (Cth) viewed on 20 January 2016

http://www.austlii.edu.au/au/legis/cth/consol_act/ica1984220/

CASELAW

ACCC v Lux Distributors [2013] FCAFC 90 http://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/full/2013/2013fcafc0090

Briginshaw v Briginshaw [1938] 60 CLR 336 http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1938/34.html?stem=0&synonyms=0&query=briginshaw

Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd [1992] 110 ALR 449

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