

## Legal update

**Stuart Smith considers the forthcoming Ministry of Justice Reforms of the Road Traffic Accident Claims process, whether they will encourage fraudulent claims and the factors Insurers should bear in mind when looking at their response.**

The latest publication by the MOJ regards the Road Traffic Accident claims reforms was published in October 2009 – click on the following to see the full paper.

<http://www.justice.gov.uk/publications/docs/personal-injury-claims-road.pdf>

### The Process

The new process, which is due to be implemented for road traffic accidents occurring on or after 6<sup>th</sup> April 2010, is designed to streamline low value claims for personal injury (£1,000 – £10,000) and provide fixed costs to claimants solicitors at various stages.

The new process will involve 3 stages as follows:

- Stage 1 – Providing early notification of claims to defendants and insurers

This will involve full details of a particular claim being presented to the insurer. The insurer will have 15 working days in which to respond with a decision on liability. For MIB claims (under the Uninsured Drivers' Agreement) this is extended to 30 days. In the event liability is conceded then the case will proceed to Stage 2.

Fixed costs of £400 are payable at this point (subject to a 12.5% Success Fee which is payable at the end of stage 2 where the claim is successful and where a conditional fee agreement is in place)

- Stage 2 – Medical Evidence, offers to settle and negotiation

Once the defendant's insurer admits liability the claimant solicitor will take steps to obtain a medical report. There is no fixed timetable within which the claimant solicitor has to obtain the report. Once a report is obtained this is checked for accuracy. Within 15 working days of the report being confirmed as factually correct, the claimant solicitor will complete a stage 2 settlement pack. This will be submitted electronically to the insurer to consider. The insurer will have 15 working days in which to consider the report and either accept the offer or make a counter offer to settle the claim. If the offer is not accepted or a counter offer is not made within 15

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days the matter will fall out of the process. Where a counter offer is made there will be a further 20 working days for consideration and negotiation.

Where agreement on quantum is not reached by the end of the negotiation period the matter will proceed to Stage 3.

The defendant's insurer (where settlement cannot be agreed) will pay by way of an interim payment the full amount of their offer (minus CRU liability) to the claimant together with Stage 2 fixed recoverable costs of £800. Where the case settles at stage 2, fixed recoverable costs of £800 will apply (plus 12.5% success fee where a conditional fee agreement is in place).

- Stage 3 – Where Quantum cannot be agreed

The claimant will send a stage 3 settlement pack detailing the offers of the parties to the insurer.

After 10 working days from the date the settlement pack has been sent to the insurer, the claimant's solicitor may make an application to the Court for damages to be determined. If the claimant solicitor fails to send a stage 3 settlement pack within the prescribed timescales the insurer may take steps to do so and then make an application to the court for quantum to be determined. The settlement pack will set out both parties' final offer and lodged in a sealed envelope only to be seen after the Judge has made his decision. There will be a paper hearing unless either party requests an oral hearing.

Assuming the claimant is successful in beating any offers made there will be further costs payable by the insurer of £250 for paper hearings and £500 for oral hearings (plus success fee of 100%). Defendants costs for Stage 3 will be identical.

## The Advantages

The proposals aim to provide a very quick way of presenting and settling claims. There is scope given the tight time lines for fraudulent claims not being detected. However, with any new process we must build in safeguards for fraud detection and evaluation. The reforms have borne in mind the threat of fraud to insurers and there are a number of features that will help insurers detect fraudulent claims. Of particular interest are:

- Full particulars of the claim, together with complete personal details of the claimant will be mandatory at the outset giving Insurers a full picture, rather than the present common occurrence of a 'drip feed' of information.
- Details of all passengers in the vehicle will be required at the outset.
- It is requested that the claimants' solicitors disclose the source of their work. Although this is not a mandatory requirement. This will help identify those accident management companies that are under suspicion. Failure to answer this question may give insurers cause for suspicion in any event. Much depends on how co-operative the claimant community is with this provision.
- During Stage 2 the medical report is to be checked for factual accuracy before it is sent to the defendant. Where an inaccuracy in the report is noted and the report amended the defendant is to be informed as to the reason for the delay. There will be no further opportunity for the claimant to challenge the factual accuracy of the medical report once it has been disclosed giving certainty to insurers who at present often face unconvincing explanations of inconsistencies long after the medical report has been submitted.

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## **Suspicious Claims and leaving the process**

Whilst the process will provide for swift resolution of claims and provision of comprehensive and accurate information, there will be many cases where a suspicion of fraud arises. Accordingly insurers should consider the ways in which a claim can leave the process.

At paragraph 3.2.15 it states that “where fraud is uncovered at any point during the process the claim will leave the process. The insurer will notify the claimant solicitor that the claim will not continue in the process due to an allegation of fraud.”

However, in many cases there will not be sufficient evidence with which to justify an allegation of fraud and accordingly Insurers should be aware of other ways in which a claim may leave the process and ensure that these are utilised effectively. The other ways of leaving the process are:-

- Liability is not admitted in the first stage (or an allegation of contributory negligence is raised)
- A denial of causation during Stage 2.
- By neither accepting the claimants offer to settle or making a counter offer during Stage 2.

Based on the proposals to date effective use of these provisions may help Insurers in avoiding payment where there is a reasonable suspicion of fraud but no conclusive evidence with which to justify a formal allegation.

## **The future**

The new reforms look set to provide a simple and straightforward way of dealing with honest claims arising out of genuine accidents.

However, for those attempting to defraud insurers the proposals provide a quicker and easier way of processing the claims before suspicion arises. Accordingly insurers should review their fraud detection procedures to ensure where possible suspect claims are identified at the outset and handled proactively from an early stage.

There is a clear danger that Insurers will see an increase in the numbers of and cost of fraudulent claims. Accordingly it is ever more important that Insurers have an effective deterrent policy so that those involved in the presentation of fraudulent claims are effectively brought to book.

If insurers respond by maintaining effective detection, case handling and deterrent policies then fraudsters should remain on the back foot.

## **Weightmans Consultancy**

We have a team dedicated to the MOJ reforms. These reforms challenge existing processes as well as management information. We at Weightmans are fully alive to the challenges but also the solutions that need to be put in place to ensure compliance but not at the expense of leakage.

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We can assist you in overcoming these challenges and ensure you are MOJ compliant. Our services range from providing advice on your processes, fraud to tracking behaviours. We will provide a solution which ensures that you maximise the benefits of these reforms.

Insurers and compensators who require advice regards the new reforms and their response to them should contact:

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## **Weightmans LLP December 2009**

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