IDENTIFYING INSURANCE FRAUD IN TORT CLAIMS

By: Jim Tomlinson and Eric Katzman

Introduction

The 2011 Annual Report of the Office of the Auditor General of Ontario stated that:

> Industry estimates peg the value of auto insurance fraud in Ontario at between 10% and 15% of the value of 2010 premiums, or as much as $1.3 billion. Unlike many other provinces and American states, Ontario does not have significant measures in place to combat fraud.[1]

Although the 2013 Annual Report did acknowledge that progress had been made in the two years that separate the reports, at page 295 of the report it was admitted that this has yet to make a substantial impact on premiums. Due to the lack of significant institutional measures, it often falls to insurers and defence counsel to investigate instances of fraud on their own. An astute defence lawyer can identify trends in insurance fraud and become experienced in fraud detection through case work.

"Fraud", for the purposes of this paper, includes staged accidents, claims for accidents that have not occurred, falsified medical records, and false statements on applications or claims.

A defence lawyer's role is to be the nexus of the investigation against potential fraudsters in civil liability cases. Lawyers communicate directly with insurers, medical experts, plaintiff's counsel, the potential fraudster themselves,[2] and, in some cases, the police. This paper is a guide for defence lawyers and insurers as they confront insurance fraud in civil liability claims, including detecting, reacting to, and proving fraud. New trends in insurance fraud and some anecdotes from practicing defence lawyers will also be addressed.

Cause for Suspicion

It is important for a defence lawyer to recognize the "red flags" of a fraud case. These include the following:

1. **Location of the accident and other surrounding circumstances:** If two passenger vehicles collide on an industrial road in the middle of the night, an explanation as to what the drivers were doing there should be pursued. A similar example would be an accident occurring in a parking lot at a time when all surrounding businesses are closed. While these are obvious examples, similar logic should be used in analyzing potentially fraudulent claims in every case. A defence lawyer should consider what the parties were doing or where they were going at the time of the accident.

[1] At 47.
[2] This generally only occurs at examination for discovery.

2. **Vehicles claims search:** Searching a vehicle's claim history can be invaluable in the detection of fraud. If the previous damage sustained by a vehicle is similar or identical to the damage sustained in the current accident, further investigation is warranted. If a vehicle was listed as a write-off in a previous accident and miraculously resurfaces on the roadway only to be involved in another accident, this is more than suspicious.

3. **Black box data:** It is increasingly common for vehicles to be outfitted with devices which record "black box" data. This data can show what damage was sustained by the vehicle, whether a turn signal was used, and whether headlights were in use at the time of an accident. If this information conflicts with the narrative provided by the parties to an accident, this should alert a defence lawyer to the possibility of fraud. While it is important to obtain this information in all motor vehicle cases, it is imperative to download this data as early as possible in cases where fraud is suspected. Data may be lost when a vehicle is treated on a total-loss basis and is not preserved.

4. **Discrepancies in the documents:** Certain documents created on the date of loss may conflict with later documents submitted by a claimant. For example, a police motor vehicle report may list a certain number of people in a vehicle. If the number of injured claimants exceeds the number of occupants in a vehicle as listed in the police accident report, this may be a sign of fraud. Further, an officer may indicate the number of injured persons in a vehicle. Likewise, if this number increases, a defence lawyer should be wary. The complete police file is typically requested, which may resolve inconsistencies between the documents. Additionally, officers may mention witnesses in their reports who may be helpful in resolving, or proving, inconsistencies in a claimant's version of events.

5. **Inconsistencies in the property damage:** Sometimes the damage sustained by a vehicle does not match the sequence of events provided by the parties to an accident. For example, parties may claim that there was a single collision between two motor vehicles, whereas the crush patterns are more consistent with a series of strikes. Other signs may include a lack of paint transfer or damage sustained to a vehicle at an atypical height.

6. **Identical set of health care practitioners or identical injuries:** Sometimes, each of the occupants in a vehicle are treated by an identical set of health care practitioners, which is suspicious. It is even less likely that each of the occupants in a vehicle would sustain identical injuries, with identical complaints that lead to the same diagnoses from each health care practitioner. Such coincidences warrant further investigation.

Response

When a defence lawyer suspects that they are faced with a claim that may be fraudulent, the first step is always to inform the client, provide recommendations, and seek instructions. Depending on the circumstances of the case, recommendations to the client can include some or all of the following:

1. **Retain an expert:** A myriad of experts can assist defence counsel in addressing and investigating fraud. Accident reconstruction experts, bio-mechanical engineers, and physiatrists tend to be crucial assets.

2. **Research the claimant:** Google searches, background checks, and skip traces can be of assistance in identifying a suspect claimant's propensity for and history of insurance fraud.

Positive findings can be useful in confirming the need to take further steps. In some cases, an independent investigator may be required.

3. **Order surveillance:** The use of surveillance has become a popular method for collecting the information that defence lawyers need to support allegations of fraud. Surveillance, and surveillance reports, fall under the ambit of rule 30.03(1) of the Rules of Civil Procedure. This rule states that:

    > A party to an action shall serve on every other party an affidavit of documents (Form 30A or 30B) disclosing to the full extent of the party's knowledge, information and belief all documents relevant to any matter in issue in the action that are or have been in the party's possession, control or power.

    There is contention in the case law with regards to the need to disclose surveillance that a defendant does not intend to rely on. The recently decided case of Chatham-Kent Children's Services v. T.(R).[3] stands for the proposition that if surveillance yields negative results or is not intended to be relied on, this material is irrelevant and need not be disclosed. However, on appeal,[4] the court held that an opposing party is entitled to the particulars of a surveillance report at examinations for discovery even if they are not entitled to the report itself. Further, the Ontario Superior Court released its decision in *Arsenault-Armstrong v. Burke et al*[5] on October 25, 2013. In this case, the Court required the defendant to produce particulars of surveillance even if they did not intend to rely on that evidence at trial, as it would assist the plaintiff in evaluating the strength of her case prior to trial. Regardless, if positive results are found or an insurer intends to rely on the surveillance and an affidavit of documents has not been served, an entry indicating that surveillance or an investigation has been conducted must be listed in Schedule "B" of an affidavit of documents with a claim of litigation privilege. However, if an affidavit of documents has already been served, there is no duty to update Schedule "B" if litigation privilege is being asserted over the surveillance and reports.[6] In order to be called at trial, the surveillance evidence must be disclosed at least 60 days before trial with the investigator listed as a witness. Normally on examination for discovery, plaintiff's counsel will demand particulars of the surveillance and a copy of any reports.

4. **Inform plaintiff's counsel:** Many plaintiff lawyers have little interest in pursuing a fraudulent claim and will promptly take steps to remove themselves from the record. Arguably, the following *Rules of Professional Conduct* encourages a defence lawyer to be forthright with plaintiff counsel in such matters.

    > 6.03 (1) A lawyer shall be courteous, civil, and act in good faith with all persons with whom the lawyer has dealings in the course of his or her practice.

    Arguably, subsection (1) requires defence counsel to disclose reasonable suspicions of fraud. However, defence counsel should keep in mind their duty to protect their

[3] 2013 ONCJ 550 at 18.
[4] 2014 ONSC 789.
[5] 2013 ONSC 116 OR (3d).
[6] *McDonald v. Standard Life Assurance Company*, 2006 CanLII 4507 (ON SC) at 13.

own client's interests. Defence counsel should also consider the Rules of Civil Procedure regarding the treatment of documents that are the subject of litigation privilege.

5. **Involve the police:** In some circumstances, it may be advisable to contact the police as they may pursue criminal charges against fraudsters. However, the police will often not pursue an investigation against a claimant unless the investigation is largely completed by the insurer. If the police are successful in obtaining a conviction against the claimant, this will be helpful in the resolution of the tort claim. Further, the police will use their resources to collect additional evidence against the claimant, from which the insurer client will benefit. Finally, the pressure of criminal charges tends to deflate the resolve of fraudsters, such that they may walk away from their civil actions.

   Police involvement has the potential to combat fraud in a way that extends beyond the confines of a single action. If the fraudster is a member of a larger, organized criminal operation, the police may be able to pursue charges up the ring's chain of command.

   Care should be exercised before presenting evidence to the police, especially when dealing with an insured. If the court finds that involving the police was done in bad faith, an insurer may be exposed to aggravated and punitive damages.[7]

6. **Initiate a Counterclaim:** Depending on the stage of a proceeding, if the insurer has collected substantial evidence of fraud, it may be able to recover monies already paid by way of counterclaim. This often applies to accident benefits cases. Again, care should be exercised before this avenue is chosen due to the potential exposure to aggravated and punitive damages.

7. **Do Nothing:** While a lawyer may have suspicions of fraud, it may be impossible to prove. The circumstantial evidence may be too light, or the witness statements may rely too much on hearsay. In such cases, a defence lawyer should proceed as though the case is not fraudulent. In *Whiten v. Pilot Insurance Company*,[8] an insurer denied coverage for a house fire based on an allegation of fraud. The Supreme Court of Canada held that the insurer breached the duty of good faith owed to their insured and was held liable for $1 million in punitive damages, alone. In the more recent case of *Branco v. American Home Assurance Company*,[9] the Saskatchewan Court of the Queen's Bench ordered one insurer to pay $1.5 million and another to pay $3 million in punitive damages alone for their abusive treatment of an insured. Beyond punitive and aggravated damages, an improper allegation of fraud can result in increased legal costs to an insurer by extending the life of a claim and exposure to a costs award from the court. Therefore, if fraud cannot be proven, it has no place in a legal analysis.

Proving Insurance Fraud: Examination for Discovery

An insurer has a right to examine a claimant in advance of trial at examinations for discovery. It is at this stage that a defence lawyer can put the claimant's inconsistencies on the record. Sometimes, the fraudulent nature of a claim can be revealed at this stage. For example, in one

[7] *Whiten v. Pilot Insurance Company*, 2002 SCC 18.
[8] *Ibid [Whiten].*
[9] Saskatchewan Court of the Queen's Bench, 2013 CarswellSask 176.

case, a defence counsel was able to get a plaintiff to admit that they were not in the motor vehicle at the time of the accident and that their case was fraudulent.

If fraud is suspected, it is advantageous to conduct examinations for discovery before obtaining engineering or surveillance reports. Defence counsel can hold off on obtaining a written expert report until after the examination for discoveries. If an expert report is obtained and disclosed prior to the examination for discovery of the claimant, it enables the claimant to take into account some of the conclusions in the expert report and tailor their testimony accordingly. In addition, defence counsel could be asked at examinations for discovery for the key conclusions contained within the expert report.

Proving Insurance Fraud: Modern Solutions

New technology can assist defence counsel in collecting information pertaining to fraud. First and foremost, experts have access to new products and techniques that can assist in disproving a claimant's version of events. New accident modeling and reconstruction software can be used to depict what the position and condition of vehicles should be after an accident, according to the claimant's version of events. An expert can use this technology in support of an allegation of fraud when there is a discrepancy between the product of the modeling software and the actual result of the accident as it may well mean that the accident did not occur as the claimant asserts. The black box data discussed in the previous section of this paper is another new source of information which has only recently been made available to experts.

Facebook, LinkedIn, Twitter, online dating sites, and other forms of social media assist defence lawyers in proving fraud. For example, an alleged occupant of a vehicle may be tagged in a photo on Facebook showing them in another province on the date of the accident. Alternatively, a claimant may post a complaint about their job on Twitter, despite claiming a total incapacity to maintain employment. When investigating a larger ring of insurance fraud, social media is useful in detailing interpersonal connections between members of the illegal operation. Quite often, conspirators are Facebook friends.

New Trends

While the traditional forms of insurance fraud, such as the classic wrench-to-the-car-door routine have by no means been eliminated, modern fraudsters are often substantially more creative in their endeavours.

One of the most recent, popular, and pervasive examples of modern insurance fraud is the accident benefits fraud ring allegedly involving over 300 clinics in Ontario.[10] This operation

---

[10] Henry, Michele, The Toronto Star, *Shady clinics bilk $1.3 billiion in bogus car insurance claims scam,* July 13, 2011, http://www.thestar.com/news/gta/2011/07/13/shady_clinics_bilk_13_billion_in_bogus_car_insurance_claims_scam.html; Henry, Michele, The Toronto Star, *Charges laid in fraudulent auto injury claims investigation* January 17, 2013, http://www.thestar.com/news/canada/2013/01/18/charges_laid_in_fraudulent_auto_injury_claims_investigation.html; Insurance Bureau of Canada, Insurers Allege Clinics Stole Signatures to Bill, April 21, 2011 http://www.ibc.ca/en/Media_Centre/Articles_of_Interest/2011/04-21-2011.asp;

allegedly began with tow truck drivers, who would direct insureds involved in accidents to rehabilitation clinics and paralegals. The clinics would use stolen signatures of medical practitioners to advance bogus claims for rehabilitation services on behalf of insureds. The insureds were often unaware of the status or progress of their claims, including the fact that money was being provided for clinic services. In addition to the charges laid, three civil actions have been launched by insurers seeking to recoup the losses alleged to have been sustained at the hands of the clinics in question.

In August of 2012, police began prosecuting events from 2009 and 2010 around Vaughan, Ontario, where they alleged that a fraud ring staged nine separate crashes in a three kilometre radius. Forty-three suspects were arrested, on charges including fraud, conspiracy to commit an indictable offence, and obstruction of justice.[11] Twenty-two other arrest warrants were issued. The police allege that vehicles previously involved in accidents were purchased and used to stage accidents. The occupants of the vehicles would pursue low value, soft tissue claims for damages against insurers. Chiropractor and physiotherapy signatures were stolen, and costs for services which were never rendered were claimed.

Project Whiplash is a police operation which led to the arrest of thirty-seven people in February of 2012.[12] Police believed that seventy-seven collisions were primarily organized by ten people from Markham, Ontario. These ten individuals recruited twenty seven others to assist in staging the accidents. This operation was described as well organized and involved choreographed collisions, allowing paralegals involved in the scam to submit claims for accident benefits.[13] Again, the signatures of medical professionals were stolen as part of the claims process.

These recent cases indicate that insurance fraud has become far more complicated, coordinated, and costly than ever before. Further, they demonstrate the need to break up fraud rings earlier, as they are able to launch dozens of fraudulent claims in a matter of months.

Future Care:

Future care is often the largest part of a tort award. Housekeeping and home maintenance are one component of future care. This is an area ripe for fraud. Furthermore, tort insurers are liable for housekeeping and home maintenance expenses that may exceed the limits established by the AB portion of a policy. Another component of future care is medical/rehabilitation costs, which

---

Economical v. Fairview, 2011 ONSC 7535; The Dominion of Canada General Insurance Company v. MD Consult Inc. (Toronto Regional Medical Assessment Centre), 2013 ONSC 1347; *Allstate Insurance Company v. Fairview Assessment Centre*, 2013 ONSC 544; and *Economical Insurance Co. v. Fariview Assessment Centre*, 2013 ONSC 4037.

[11] *Coutts, Matthew, The Toronto Star, Ontario police bust intricate auto insurance fraud scheme*, August 9, 2012, http://toronto.ctvnews.ca/ontario-police-bust-intricate-auto-insurance-fraud-scheme-1.908977.

[12] Gillis, Wendy and Josh Tapper, The Toronto Star, *Car insurance scam: 37 arrested in Project Whiplash raids*, February 23, 2012, http://www.thestar.com/news/crime/2012/02/23/car_insurance_scam_37_arrested_in_project_whiplash_raids.html.

[13] Tapper, Josh and Wendy Gillis, The Toronto Star, *Project Whiplash: Anatomy of a car insurance scam*, http://www.thestar.com/news/gta/2012/02/23/project_whiplash_anatomy_of_a_car_insurance_scam.html.

involves various types of therapy. This area is also subject to fraud, as fabricated clinic information can impact a claim for future therapy needs.

The following anecdotes on insurance fraud were provided by lawyers from McCague Borlack LLP from closed files:

In an alleged collision, engineering evidence established that while the two vehicles claimed to be involved had collision damage, the vehicle heights, paint transfer, and damaged areas did not match. Furthermore, in staging the accident, the fraudsters failed to plant debris and fluid leakage.

In a housekeeping fraud case, the claimant and his wife, who were both injured, submitted claims for identical services, resulting in double payment. At FSCO arbitration, arbitrator Alev Fadel found that:

> The applicant testified that he and his wife shared equally in all of the domestic chores except he did not assist with laundry. Not only is this inconsistent with what he told Mr. Tran in January 2008, but the number of hours that he testified he and his wife each completed, being 46 to 51 hours per week per person, seems excessive and lends to the suggestion that the applicant is falsely inflating the numbers to support his claim for the benefit.[14]

In a file containing a claim for caregiving benefits, the insurer requested documentation from the caregiver to support that these expenses were in fact incurred and the caregiver submitted fraudulent documentation to the applicant. She used a letter from a company that she was not employed by and had it signed by a person who did not work for the company and who allegedly held a position within the organization that did not exist. The fraud was discovered when the adjuster called the caregiver's alleged employer.

Finally, in another case, an applicant stated that she worked for her husband's company. The husband submitted documentation in support of her employment. After further investigation, it became clear that the applicant never worked for her husband and that the documentation provided was fraudulent.

Conclusion

The 2011 and 2013 reports of the Auditor General of Ontario, the recent scandals involving large criminal rings, and the experiences of the defence bar all indicate that insurance fraud is prevalent in Ontario. In confronting this problem, defence lawyers must be sensitive to the signs of insurance fraud and work with insurers to respond with a modern approach and a critical eye. As has been demonstrated by Project Whiplash and the other police operations, law enforcement has been more willing to involve themselves in these matters and to break up fraud rings in recent years. Hopefully, with the combined efforts of the defence bar, insurers, and law enforcement, the prevalence of fraud can be reduced. However, civil fraud proceedings remain

[14] *Thayalan v Wawanesa*, 2011 FSCO A10-003528.

an important component in fighting fraud in Ontario. Therefore, defence lawyers must be well-equipped to confront fraud using modern techniques and the best experts.

.