

## Aviation Ground Safety Council

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## The training objectives

- Reduce the number of accidents in the workplace.
- Reduce the number of claims brought.
- Be in a better position to successfully defend any claims.
- Reduce financial costs (insured and uninsured losses – consequential down time).
- Explain the legal framework governing claims.

## Successful health and safety management

Organisations should ensure that:

- a Consultation is actively encouraged and supported.
- b Safety representatives are trained enabling informed contributions on health and safety issues.
- c Effective consultation bodies should be involved in planning, measuring and reviewing of performance.
- d Thorough investigations are undertaken following any accidents or incidents, ensuring the relevant aspect of health and safety is reviewed in the light of such incidents.

## Employee involvement

Employee involvement should, with a view to maximising employee buy-ins to health and safety schemes, ensure they :

- a Assist in helping setting performance standards.
- b Are involved in devising operating systems.
- c Contribute to devising procedures and instructions for risk control.
- d Help in monitoring and auditing.
- e Have input in respect of hazard reporting for example hazard reports to include recording of all incidents not just accidents.

The organisation should provide for a suggestion scheme, or safety circles to identify health and safety problems. Where disagreements arise as to the best way forward they should be resolved by having a procedure in place to resolve such issues that by way of recourse to specialist advice.

## Management involvement

The credibility of the health and safety policy can be underlined by visible behaviour, for example:

- i Management to lead by example.
- ii Management to undertake regular health and safety tours.
- iii The chairing of meetings by suitably senior people.
- iv Active involvement in investigations of accidents, incidents and ill health.

## The accident investigation

At a time of economic hardship or concern over the state of the economy, it is our experience that there is an increasing tendency for claims to be pursued following an accident, for those claims to be inflated or exaggerated, and furthermore for fraudulent claims to be pursued.

It is essential therefore, in order to combat such instances and reduce the overall expense that may be involved, for your strategy in respect of accident investigations to be as robust as

possible. Every accident circumstance is different. However consider collating the following evidence:

### *Documents*

- Accident book entry
- Riddor report
- First aid records
- Risk assessments
- Training documents
- Equipment operating documents
- Details of eye witnesses
- Statements
- Photographs
- Sketches
  
- Maintenance documents for machinery/operating docs
- First aid records
- Relevant health and safety minutes of any meetings
- Preserve equipment - where appropriate
- Record of conditions (esp if slip/trip) – was it wet/badly lit?
  
- Details of job rotation/system of work/speed of work (if WRULD)
- Video of the location or system if work operation may not continue.
- Production data
- Personnel file/OH file.

### *Statements*

Each set of circumstances is unique. Prepare for an interview by visiting the scene and gathering evidence first. It is important that you are aware of the issues to consider and which are relevant to each type of incident for example:

- a Slips/trips
- b Manual handling
- c Cuts/burns
- d Repetitive lifting
- e Occupational disease – WRULD
- f Accidents involving the use of work equipment.

### *Practical tips on obtaining witness evidence*

- Collect statements as soon as is possible/practical
- Establish the facts / avoid speculation ie 'what exactly did you see / hear'
- All interviews should be documented
- Ask the witness to review any notes or statement to agree the content.
- Ask the witness to sign and date the notes or statement

### *Conclusion of investigation*

- Consider accident root cause – this is not the immediate cause but the actual real cause based on the facts after you have fully investigated.
- Consider corrective action - if you think further action is necessary and say why
- Is refresher training necessary?
- Is a review of the risk assessment appropriate?
- Is there a relationship between the injured party and witness ie a motive?

# Appendix 1

## The claims timeline

Accident

### Pre action personal injury protocol

Letter of claim

Acknowledgement 21 days

Response 90 days

### Court proceedings

Claim form and particulars of claim

Acknowledgement of service 14 days

Defence 14 days plus 28

Allocation

Directions:

- Disclosure
- Exchange of witness statements
- Exchange of medical evidence
- Service of schedule of loss
- Service of counter schedule of loss
- Listing for trial
- Trial

# Appendix 2

## Putting the accident investigation in context

Health and safety policies

Risk assessments

Safe systems of work

Enforcement of safe systems

Inspections/monitoring

Health surveillance

Pro active maintenance systems

Job specific training

Documentation/record keeping

Managing vulnerable individuals

Affects legal liability

Accident investigation

Rehabilitation

Affects legal liability/value

# Appendix 3

## The pre-action protocol

The Civil Procedure Rules of 1998 introduced the pre-action protocol for personal injury claims. The personal injury protocol has been kept deliberately simple to promote ease of use and acceptability, which in itself promotes exchange of information and evidence at an early stage.

The claimant is under an obligation to send a letter of claim to the proposed defendant. The court can impose sanctions for non compliance with the protocol. In the light of the circumstances in which the defendant may have no financial interest, the court requires a copy of the letter of claim to be passed to the Insurer as soon as possible.

The letter of claim has to contain certain information. It must contain a clear summary of the facts on which the claim is based together with an indication of the nature of any injuries and any financial loss suffered. Sufficient information should be given in order to enable an investigation to be undertaken and a broad valuation on the risk to be assessed.

The defendant should reply within 21 calendar dates of the date of posting of the letter, identifying the Insurer if any. Often, the defendant will simply pass the letter of claim to the Insurer and the Insurer will acknowledge receipt of the letter of claim within that 21 day period. The defendant's Insurers have three months from the date of acknowledge of the claim to investigate the matter.

The claimant's solicitors are making use of a procedure in respect of a failure on the part of a defendant or its Insurers, to comply with this timetable by virtue of applying to the court for an order for pre-action disclosure of documents. These applications are very standard, but if justifiable, result in a costs order against the defendant and therefore an incurrence of costs which could otherwise have been avoided. It may be possible to raise arguments as to whether the application is justifiable, for instance, in circumstances where:

- a The claimant, him or herself, should have the documents, perhaps following the provision of a service such as installation of double glazing.
- b The letter of claim has been addressed to the incorrect defendant but has nevertheless reached the correct Insurers and may give rise to a technical argument that the pre-action protocol has not actually begun.
- c The request for documents is reasonable and too wide in the context of the documents sought. The letter of claim contains insufficient information to enable a proper investigation to be undertaken.

The obligations to undertake a search for documents, in accordance with the pre-action protocol, is important because if proceedings are commenced, there will still be a requirement to provide a disclosure of documents by way of a list and adverse consequences may be drawn if relevant documents are not disclosed at the time of the pre-action protocol response or in accordance with any pre-action protocol order, or if provisional documents of gravity are subsequently disclosed.

Such adverse inferences may result in an adverse costs order being made for instance, indemnity costs for a period of the litigation.

### Minimising the expense of disclosure

Documents which may be available for disclosure can be quite voluminous. An early search for relevant documents and preservation of documents will assist in first, complying with the pre-action protocol period, and will also assist in minimising costs. It will also assist in the context of whether the issue of primary liability should be retained or not, or whether there should be an

early decision to admit liability. Economics and proportionality *ie* that the matter should be conducted in a manner which is proportionate to its value, are important considerations in lower value cases.

The standard disclosure of documents which should be retained in an attempt to minimise the expense of disclosure include:

- a The accident book entry.
- b The first aid work surgery record.
- c The foreman/supervisors report.
- d The safety representatives report.
- e The minutes of the health and safety committee meetings where the event may have been considered.
- f Statutory report to the health and safety executive or to the local authority.
- g Other communications between the defendant and the health and safety executive or local authority.
- h The report to the DWP, form BI76.
- i Details of any previous events alleged by the claimant as prove of negligence (this must be considered carefully).
- j Earnings information (the standard practice is to provide earnings information for 13 weeks before the accident, both gross and net and details of any payments whilst absent from work).
- k Pre and post accident risk assessments in relation to the system of work connected to the happening of the accident.
- l The accident investigation report.
- m Information provided to employees.
- n Health and safety training documents.

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Information is correct at the time of release.

## Identifying potential exposures for fraud in EI and disease claims

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## Identifying potential exposures for fraud in EL and disease claims

EL and disease claims differ from other areas where fraud has historically been identified such as motor and PL. These areas are a breeding ground for exaggeration claims which are said to account for 40% of all identified fraudulent claims. Fraud in these areas is more difficult to spot however as the fraud indicators are less obvious. There are no hard and fast rules and causation plays an important role.

BLM has a specialist EL team dedicated to dealing with such cases and a specialist disease unit dedicated to handling all types of industrial diseases including asbestos, deafness, asthma, HAVs, cumulative back, WRULDs and dermatitis claims.

Given the complexities involved in handling disease claims in particular and the potential for fraud in these areas our team are trained to spot any claims where there may be cause for concern and to liaise with the BLM fraud unit internally for back up and assistance where necessary thereby providing a seamless service to the client.

## Fraud indicators

Below is an initial list of potential indicators and concerns/comments in EL and disease claims.

### EL

- The staged accident at work on an obvious defect.
- A failure to report the accident even though it allegedly occurred during trading hours.
- Witnesses who come forward are friend or relatives.
- Injuries caused are more compatible with other causes.
- Limited information available from the claimant in respect of accident circumstances, witnesses etc.
- Medical records show a history of claims.
- The description of the accident in the medical records is inconsistent with the claimants statement/witness statement/what he has told the experts.
- The claimant or witnesses do not reside at the address given.
- The claim is old.
- The insured's premises are about to close/redundancies have or will be made.

### Disease

- There are other claims at the same company for the same condition (*ie* diffuse WRULD).
- The medical report/notes indicate that the claimant has a history of the condition prior to exposure and the claim is not one for an exacerbation/exaggeration.
- There is evidence the claimant did not work in the exposing area.
- Breach on a line/particular area has already been admitted (watch for floodgates which could bring with them false and/or exaggeration claims).
- Lack of reporting of symptoms at the material time.
- Injury and pain is subjective and WRULD claims and back injury claims are areas where fraud and in particular substantial exaggeration is rife. Always consider surveillance and always get your own medical evidence.
- Upon consideration of the claimants work history and/or hobbies it transpires that the condition could have been caused by other factors (other than the current employment).
- The condition is grave and the claimant cannot work again allegedly.
- In the case of WRULD claims the symptoms arise after a period of time away from the alleges source of the problem (i.e. the claimant carries out the job complained of then ceases this work and thereafter symptom start to manifest) - this is unusual as there should be a short temporal relationship between breach and onset.

- Symptoms worsen once the claimant is away from the source (in short tail claims). Again this is unusual as symptoms should stabilise or improve once the claimant is away from the source.
- The claimant has brought previous claims.
- The claimant alleges use of tools which were not in fact used.
- The claimant substantially exaggerates use of tools which have a greater vibration level than the lower level of vibration or non-vibrating tools used throughout a working day (HAVs).
- The claimant over exaggerates the actual time (anger time) using the tools whilst they are emitting vibration (HAVs).
- Alleging longer working hours than is true (HAVs).
- Alleging more overtime than was actually carried out.
- Not mentioning exposure to vibration in other employment/home (HAVs).
- The claimant appears briefed or coached and uses terminology such as 'blanching' when examined/in his statement.
- Issues arise over medical examination such as inconsistent accounts of vascular symptoms/over exaggeration of sensorineural symptoms (HAVs).
- Symptoms develop or deteriorate more than two years after exposure to vibration has ceased (HAVs).
- Very rapid onset of symptoms or onset after exposure for a short period.
- Limitation fraud (saying that symptoms developed later than they did/saying they didn't consider the injuries to be significant/omitting to mention attendances at hospital/GP).
- Problems occur on the audiogram - no clear signs of occupational deafness. A history of noise exposure without clear confirmation from the audiogram is not enough. (NIHL).
- Audiogram show other problems rather than NIHL such as presbycusis (NIHL).
- Tinnitus in the absence of NIHL (NIHL).
- Exaggeration of value i.e. a claim for hearing aids when not required. The average loss at which a claimant would start to require a hearing aid is 45Db (NIHL).
- Exaggeration of exposure i.e. period, level, duration, frequency, proximity and/or source (NIHL).
- Substantial exaggeration of special damages claim (care/gardening/DIY).

## Combating fraud

There are many tactics which can be used to combat fraud within an organisation. A potential starting point is to identify individuals with a high level of knowledge and experience in the relevant fields with an investigatory nature and a keen eye to spot fraud. Given that it's rare to see direct evidence of fraud such as an admission, fraud has to be teased out of a case and the handler needs to be fully aware of the potential indicators and how to deal with cases where fraud (including substantial exaggeration) may be a factor.

## Tactics

Which tactics to use will very much depend on the individual circumstances of the case. Listed below are some examples.

- Utilising specialist fraud experts (such as the BLM dedicated fraud unit).
- Early investigations.
- Requesting early disclosure of the claimants evidence and signed statements in support.
- Consideration of available data bases (including those within BLM).
- Surveillance.
- Part 35 questions and the correct use of experts.
- Part 18 requests.
- Notices to admit facts.
- Reconstructions expert.

- Detailed file consideration (look for inconsistencies in evidence).
- Consideration of all notes and records including inland revenue, DWP, occupational health and personnel records.
- A robust approach.

## Going forward

Just because there are several indicators this *does not* mean that the claim is fraudulent. Spotting and dealing with fraud in EL and disease claims is complex and becomes easier over time once handlers are properly trained in what to look for and how to combat fraud in these fields.

Consideration needs to be given in respect of identifying trends, insureds and/or areas where fraud may be more prevalent and how to train claims handlers in these areas so that they become more confident in dealing with such claims when it is considered that fraud may be present.

Benefits are not only financial in that costs and damages can be saved on the claim but success in fraudulent workplace claims undoubtedly sends a message via the policy holder to the workforce and can ultimately lead to a reduction in spurious claims.

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