

I. INSURANCE FRAUD OVERVIEW

Introduction to Insurance Fraud

Aside from tax fraud, insurance fraud is the most practiced fraud in the world. The insurance business, by its very nature, is susceptible to fraud. Insurance is a risk distribution system that requires the accumulation of liquid assets in the form of reserve funds that are, in turn, available to pay loss claims. Insurance companies generate a large, steady flow of cash through insurance premiums. Steady cash flow is an important economic resource that is attractive and easily diverted. Large accumulations of liquid assets make insurance companies attractive for *take over* and *loot* schemes. Insurance companies are under great pressure to maximize the return on investing the reserve funds, thus making them vulnerable to high yielding investment schemes.

What Is Insurance Fraud?

To conquer insurance fraud, one must first know what *insurance* is. In basic terms, it is a contract between an insurer and an insured. In a contract, the insurer indemnifies the insured against losses, damages, or liability from an unknown event. A preexisting condition must not exist for insurance to be valid. For example, obtaining automobile insurance after an accident is not insurance and does not indemnify the insured for any injuries suffered. Insurance fraud exists when individuals attempt to profit by failing to comply with the terms of the insurance agreement. Perpetrators of insurance fraud try to create losses or damage rather than joining others who have no losses but wish to keep themselves protected in case an unknown event should occur. Fraud can occur at any stage of an insurance transaction by any of the following:

- Individuals applying for insurance
- Policyholders
- Third-party claimants
- Professionals who provide services to claimants

Insurance fraud can come in two forms: (1) hard frauds and (2) soft frauds. A hard fraud occurs when an accident, injury, or theft is contrived or premeditated to obtain money from insurance companies. When a legitimate loss occurs, such as theft of a cell phone, and the insured adds an item to the claim (e.g., a phone accessory) to cover the deductible, it is considered a soft fraud. Soft fraud occurs when a legitimate claim is exaggerated.

Impact of Insurance Fraud

The cost of insurance to consumers continues to grow each year due to the huge losses that occur within the insurance industry. Most carriers can only estimate what they lose to claims that are discovered to be fraudulent. Insurance fraud usually does not come to light until the fraudsters get greedy and it becomes apparent that they are involved in an insurance fraud scheme.

Insurance fraud is not limited to one group, race, or gender. It is an equal opportunity crime that can be performed by an insurer or an insured. Insurance fraudsters are less likely to be turned over to the authorities because they are usually not equipped to handle or perform an adequate investigation due to lack of expertise in insurance. For insurance fraud to be proactively addressed, insurers must train their staff in identifying the red flags of insurance fraud schemes.

Insurance Fraud Schemes

There are numerous types of insurance fraud schemes. This section introduces some of the most common types of fraud involving the insurance industry:

- Agent and broker schemes
- Underwriting irregularities
- Vehicle insurance schemes
- Property schemes
- Life insurance schemes
- Liability schemes
- Health insurance schemes
- Worker's compensation schemes

Agent and Broker Fraud

CASH, LOAN, AND DIVIDEND CHECKS

A company employee without the knowledge of an insured or contract holder requests cash, a loan, or a dividend check, and deposits the check into either their bank account or a fictitious account. To minimize their chances of being detected committing a fraudulent act, the employee might change the company policyholder's address of record to either their address or a fictitious address. Once the check is issued, the address is then changed back to the previous address.

SETTLEMENT CHECKS

A company employee can misdirect settlement checks, such as for a matured endowment settlement, to the branch office, the employee's home, or a fictitious address. The employee can easily create a check defalcation by changing the address of record prior to the settlement check issue date, thus misdirecting the check in question. Also, an orphan contract holder might be transferred to the employee's agency periodically, affording the opportunity to improperly request the issuance of a settlement check.

An *orphan contract holder* is a policyholder or contract holder who has not been assigned to a servicing agent or the whereabouts of this individual is unknown. The servicing agent attempts to locate this family group and could influence them to purchase additional insurance.

PREMIUM FRAUD

The agent collects the premium, but doesn't remit the check to the insurance company. The insured has no coverage.

FICTITIOUS PAYEES

An agent or a clerk can change the beneficiary of record to a fictitious person and subsequently submit the necessary papers to authorize the issuance of a check.

FICTITIOUS DEATH CLAIMS

An agent or employee obtains a fictitious death certificate and requests that a death claim check be issued. The agent receives the check and cashes it.

The sales representative can also write a fictitious application and, after the contestable period (e.g., two years), submit a phony death claim form and obtain the proceeds. The agent, by investing a few thousand dollars, could receive \$50,000 or more in misappropriated claims.

Underwriting Irregularities**EQUITY FUNDING**

Equity funding is the process of using existing premium/policy values to finance new businesses. So long as the insured is aware of what is being done by the agent and fully understands the long-range method of payment on the new contract, there is no apparent underwriting irregularity.

Equity funding techniques, also known as *piggybacking*, usually do not produce quality business. Furthermore, the company increases the amount of life insurance on the books but receives little or no new funds while incurring increased sales and administrative expenses associated with the new business.

MISREPRESENTATION

Misrepresentation might occur if a sales representative makes a false statement with the intent to deceive the prospective insured in order to knowingly obtain an unlawful gain.

FALSE INFORMATION

A company employee might submit the following false information to obtain unlawful financial gain:

- Improper medical information to obtain a better insurable rate for the prospective policyholder
- Improper date of birth to obtain a cheaper premium on the new policy
- Improper home address to obtain a cheaper premium for home or automobile insurance
- Improper driving history prior to purchasing automobile insurance to reduce the annual premium or obtain insurance where normally the individual would have to apply through the risk pool

FICTITIOUS POLICIES

To keep their position, a salesperson submits fictitious policies to improve their writing record. Or, prior to an individual leaving the company, they write fictitious policies called *tombstone cases* to improve their commission pool so that their compensation will be greater. *Tombstone* means an agent literally takes names from tombstones in cemeteries and writes new policies.

SURETY AND PERFORMANCE BOND SCHEMES

Surety and performance bonds guarantee that certain events will or will not occur. An agent might issue worthless bonds to the insured for high-risk coverage in hopes that a claim is never made. If a claim is made, the agent might pay it off from agency funds, delay the payment, or skip town.

SLIDING

Sliding is the term used for including additional coverages in the insurance policy without the knowledge of the insured. The extra charges are hidden in the total premium and, since the insured is unaware of the coverage, few claims are ever filed. For example, motor club memberships, accidental death, and travel accident coverages can usually be slipped into the policy without the knowledge of the insured.

TWISTING

Twisting is the replacement, usually by high-pressure sales techniques, of existing policies for new ones. The primary reason, of course, is for the agent to profit, since first-year sales commissions are much higher than commissions for existing policies.

CHURNING

Churning occurs when agents falsely tell customers that they can buy additional insurance for no cost by using built-up value in their current policies. Nevertheless, the cost of the new policies frequently exceeds the value of the old ones.

Vehicle Insurance Schemes

DITCHING

Ditching, also known as owner *give-up*, is getting rid of a vehicle to cash in on an insurance policy or to settle an outstanding loan. The vehicle is normally expensive and purchased with a small down payment.

The vehicle is reported stolen, although in some cases, the owner just abandons the vehicle, hoping that it will be stolen, stripped for parts, or taken to an impound and destroyed. The scheme sometimes involves homeowner's insurance for the property that was "stolen" in the vehicle.

PAST POSTING

Past posting is a scheme in which a person becomes involved in an automobile accident, but doesn't have insurance. The person gets insurance, waits a little bit of time, reports the vehicle as being in an accident, and then collects for the damages.

VEHICLE REPAIR

This scheme involves the billing of new parts on a vehicle when used parts were replaced in the vehicle. Sometimes this involves collusion between the adjuster and the body repair shop.

VEHICLE SMUGGLING

This is a scheme that involves the purchase of a new vehicle with maximum financing. A counterfeit certificate of the vehicle's title is made showing that it is free and clear. The vehicle is insured to the maximum, with minimum deductible theft coverage. It is then shipped to a foreign port and reported stolen. The car is sold at its new location and insurance is also collected for the theft.

PHANTOM VEHICLES

The certificate of title is a document that shows the legal ownership of a vehicle. Even though it is not absolute proof that a vehicle exists, it is the basis for the issuance of insurance policies. Collecting on a phantom vehicle has been shown to be easy to do.

STAGED ACCIDENTS

Staged accidents are schemes in which an accident is predetermined to occur on a vehicle. The schemes are organized by rings and the culprits move from one area to another. They often use the same vehicle over and over, which is sometimes what causes their scheme to be uncovered.

INFLATED DAMAGES

The business environment and competition for work in the automobile repair industry have caused the development of a scheme in which some establishments inflate estimated costs to cover deductibles. The insured is advised by the repair shop that the shop will accept whatever the company authorizes.

VEHICLE IDENTIFICATION NUMBER (VIN) SWITCH

A VIN switch is a fraud scheme in which a wrecked vehicle is sold and reported as being repaired. The vehicle is not actually repaired; instead, the VIN plate is switched with that of a stolen vehicle of the same make and model.

RENTAL CAR FRAUD

A person doesn't need to own a vehicle to commit automobile fraud. There are several schemes that can be perpetrated using rental cars. The most prevalent involve property damage, bodily injury, and export fraud.

Property Schemes

Property schemes usually involve filing insurance claims for property that never existed or for inflated loss amounts.

INFLATED INVENTORY

Property that is lost through fire is claimed on an insurance form. However, property that doesn't exist also finds its way onto an inventory of the property claimed. Property claimed might have been previously sold or never owned by the claimant.

PHONY OR INFLATED THEFTS

A home or car that has been burglarized is the basis for filing a claim for recoveries of monies lost. However, as with items "destroyed" by fire above, the items never existed or were previously sold.

PAPER BOATS

A claim is filed for a boat that sank, but the boat never actually existed. It is not difficult to register a boat based on a bill of sale. After a period, a loss is claimed for the sinking of the boat. It is difficult to prove that the boat didn't exist or was sunk intentionally.

ARSON FOR PROFIT

Personal dwellings or commercial properties are destroyed by fire for the sole purpose of financial gain. Insureds sometimes act alone or in concert with agents or highly organized crime rings specializing in arson.

Life Insurance Schemes

FRAUDULENT DEATH CLAIMS

To obtain reimbursement for life insurance, a death certificate is required. However, phony death certificates are not that difficult to obtain. The person might be very much alive and missing or the person might be dead, and the death is past posted. With small settlements, death claims aren't closely scrutinized and are paid relatively easily.

MURDER FOR PROFIT

This scheme involves the killing (or arranging for the killing) of a person to collect insurance. The death might be made to look like it was an accident or a random killing.

Liability Schemes

In a liability scheme the claimant has claimed an injury that did not occur. The slip and fall scam is the most common, and involves a person claiming to fall as the result of negligence on behalf of the insured.

Health Insurance Schemes

Those practicing medicine should be bound by honesty and integrity, though this is not always the case. There have been cases where medical doctors were found guilty of insurance fraud scams. Examples include false billings in which services are exaggerated or no services were provided, preparing false trip-and-fall reports for a fee, or being an accomplice in staged accidents.

Workers' Compensation Schemes

Workers' compensation laws require employers or their insurance plans to reimburse employees (or on their behalf) for injuries that occurred on the job, regardless of who is at fault and without delay of legal proceedings to determine fault. The injury might be physical, such as a broken limb, or mental, such as stress.

Common Schemes

Schemes are generally broken into four categories: premium fraud, agent fraud, claimant fraud, and organized fraud schemes.

PREMIUM FRAUD

This entails misrepresenting information to the insurer by employers to lower the cost of workers' compensation premiums.

AGENT FRAUD

Agents issue certificates of coverage indicating the customer is insured, but never forward the premium to the insurance company. An agent might alter the application for coverage completed by the employer to be able to offer a lower premium to their client.

CLAIMANT FRAUD

Claimant fraud involves misrepresenting the circumstances of any injury or fabricating an injury.

ORGANIZED FRAUD

Organized fraud schemes are composed of the united efforts of a lawyer, a capper, a doctor, and the claimant. This scheme is used not only in workers' compensation cases, but also in other medical frauds, such as automobile injuries.

THE LAWYER

The lawyer is usually the organizer of the scheme and the one who will profit the most. The lawyer will entice the claimant into securing their services by promising a large settlement from the insurance company. The claimant might have to undergo medical tests, since the only requirement of the claimant is that they be insured. The lawyer will then refer the injured party to a doctor for “treatment.”

THE CAPPER

A *capper*, also known as a *runner*, is used to recruit patients for the scheme. They might be employed by either the attorney or the doctor, and is paid, either a percentage of the total take or per person, for bringing in patients.

THE DOCTOR

The doctor might be one of the organizers or a player in the scheme, but must be a part of it for it to work properly. The doctor is used to lend authenticity to the scheme, and they are well compensated for their efforts. The doctor bills for services that they may or may not render, as well as for unnecessary services. In addition, if the patient has regular health insurance, the doctor might double bill for the services. If the injury occurred as the result of an automobile accident while the patient was on the job, the doctor might bill all three insurance companies: the workers’ compensation carrier, the employee’s health insurance, and the automobile carrier.

Red Flags of Insurance Fraud

Red flags of insurance fraud might include any of the following:

- The claim is made a short time after inception of the policy, or after an increase or change in the coverage under which the claim is made. This could include the purchase of a scheduled property or jewelry floater policy, or more than one policy during the time before the loss.
- The insured has a history of many insurance claims and losses.
- Before the incident, the insured asked the insurance agent hypothetical questions about coverage in the event of a loss similar to the actual claim.
- The insured is very insistent about a fast settlement, and exhibits more than the usual amount of knowledge about insurance coverage and claims procedures, particularly if the claim is not well documented.
- In a burglary loss, the claim includes large, bulky property that is unusual for a burglary.
- In a theft or fire loss claim, the claim includes a lot of recently purchased, expensive property, or the insured insists that everything was the best or the most expensive model, especially if the insured cannot provide receipts, owner’s manuals, or other documentary proof of purchase.

- In a fire loss claim, property considered personal or sentimental to the insured and that someone would expect to see among the lost property (e.g., photographs, family heirlooms, or pets) is conspicuous by its absence.
- A large amount of the property was purchased at garage and yard sales and flea markets, or otherwise for cash, and there are no receipts. (The insured is unable to recall exactly where the sales took place or by whom.)
- The insured cannot remember, or does not know, where the claimed property was acquired, especially unusual items, or cannot provide adequate descriptions.
- The insured has receipts and other documentation, witnesses, and duplicate photographs for everything—the claim is too perfect.
- Documentation provided by the insured is irregular or questionable, such as:
 - Numbered receipts are from the same store and dated differently or sequentially.
 - Documents show signs of alteration in dates, descriptions, or amounts.
 - Photocopies of documents are provided, and the insured cannot produce the originals.
 - Handwriting or signatures are similar on different receipts, invoices, gift verifications, or appraisals.
 - The amount of tax is wrong, either for the price of the property or for the date appearing on the receipt.
 - Receipts, invoices, or shipping documents do not have “paid,” “received,” or other shipping stamps.
- In a theft or loss away from home, the insured waits an unusually long time before reporting the theft to the police.
- The insured can give the police a complete list of lost property on the day of the burglary or shortly after.
- The amount of the claim differs from the value given by the insured to the police.
- In a business inventory or income loss claim, the insured does not keep complete books, or the books do not follow accepted accounting principles.
- The physical evidence is inconsistent with the loss claimed by the insured.
- In a burglary loss, there is no physical evidence of breaking and entering, or a burglary could not have occurred unnoticed under the circumstances.
- In a fire loss:
 - The apparent cause and origin of the fire is inconsistent with an accidental cause and origin, or there is evidence of the use of an accelerant.
 - The remains of the property do not match the claimed property.
 - The premises do not show signs of having contained the claimed property, or the amount of property would not fit into the space where the insured says it was.
 - Physical damage to the insured’s car is inconsistent with its having been in a collision with an uninsured car.

- The insured has discarded the claimed damaged property before the adjuster can examine it.
- The cost of the claimed property, over the period it allegedly was acquired, seems to exceed the insured's financial ability to purchase it.
- The insured refuses or is unable to answer routine questions.
- The insured provides supporting evidence and documentation that cannot be corroborated.
- Information on a life insurance application is very vague or ambiguous as to the details of health history, such as dates, places of treatment, names of physicians or hospitals, or specific diagnoses.
- Applicant fails to sign and date the application.
- Pertinent questions on the application are not answered, such as income, other insurance carried, hazardous duties, or aviation or flying activity.
- The insured has "excess insurance," either shown at the time of application or developed through an underwriting report of database information.
- Earned income does not warrant the amount of insurance being applied for.
- The applicant's date of birth as shown on the application is much earlier than shown with other carriers or in previous applications or policies.
- The agent is putting on pressure to have the policy issued because of the large amount applied for, but is going over the underwriter's head to do so (working out of the system).
- The physician's report is very vague on details of past medical history and does not coincide with the information shown on the application.
- A death claim is presented in which the death has taken place outside of the country.
- The signature on the application for insurance does not appear to be the same signature as shown on an authorization at the time of the claim.
- A claimant or a claimant's attorney attempts to limit the type of information to be related by a signed authorization, which is a standard authorization used by the company.
- An attorney is immediately brought into a contestable death claim, attempting to interfere with the investigation and to withhold information required by the company.
- A contestable death claim is reported as an accidental death, but could possibly be a suicide (such as a fatal accident involving only one vehicle, a hunting accident, or an accidental shooting while cleaning or repairing a weapon).
- An autopsy report discloses a different height and weight than what is shown on the recent application (auto or house fire death). Dental records do not match the dental findings in the autopsy report.
- Records are missing on a patient who was confined to a hospital, or a patient's medical records are missing from the physician's office.
- The death claim package sent to the insurance company is too well packaged and complete in every detail with supportive documents. Documentation that was not initially asked for or required by the insurance company was voluntarily sent, such as newspaper reports, burial certificates, or shipment of the body from one country to another.

- The routine audit of a designated insured group shows a significant increase in employees whose names do not show up on the payroll.
- Gunshot wounds or stabbings were inflicted by the insured as the aggressor or were self-inflicted.
- Police accident reports were submitted by the claimant.
- The claimant pushes for the claim to be handled quickly; for example, they want to stop by the office to pick up their check “as we’re leaving for vacation in the morning.”
- Series of prescription numbers from the same drug store don’t coincide chronologically with the dates of the prescriptions.
- An automobile was destroyed by a fire in a remote rural area with no witnesses; the driver claims an electrical shortage in the engine compartment caused the fire.
- Preliminary information for a business or home fire loss indicates considerable financial difficulties and financial pressures being brought upon the owner, and the fire is suspicious in nature and origin.
- An employee within the claims operations of an insurance company is known to have a drinking or drug problem, financial pressures, serious marital difficulties, or an affair and irregularities start to appear.
- The investigator of burglary losses by a business, or especially a home, observes that the remaining contents at the scene are of much inferior quality than those reported stolen. There is no indication of indentation in the piling of the carpet where heavy items of furniture or equipment were to have been placed. There are no hooks or nails on the walls where valuable pictures might have been hung. Entrances or exits are too small to remove a large item without disassembling it.
- A claim contains false statements or it has been determined that there has been a deliberate cover-up.
- A disability income protection claim is filed, and it is determined that the claimant had recently purchased numerous expensive items on credit and had them covered by credit A&H insurance coverage.
- There are more passenger claims filed than there were passengers at the time of a public transportation accident.
- A witness to an accident or incident deliberately tries to hide from investigators rather than come forth and tell the truth.
- An official document of findings conflicts with the facts in the case, and there is no explanation for this conflict. Photographs or other documents do not substantiate the reported findings.

Summary

Insurance fraud has and continues to make an impact on society in a harmful way. There are many insurance fraud schemes that might involve either the insurer, insured, or third party. Some examples of insurance fraud schemes relate to life insurance, worker’s compensation, health care, and vehicles.

Fraud investigators should understand what insurance encompasses, including being familiar with the red flags of insurance fraud.

II. ESTABLISHING AND MEASURING A NEW SPECIAL INVESTIGATION UNIT

Introduction

One of the most pressing issues facing modern day insurance carriers is the identification and investigation of fraud. With estimates ranging from \$80 billion to \$110 billion a year, insurance fraud is a growing concern within the industry. Current estimates show that ten cents of every dollar earned is lost due to fraud.

Since the late 1980s, most insurance carriers have been mandated by state statutes to both form and maintain an in-house Special Investigative Unit (SIU), or to contract those services out. That mandate is still being addressed today. Some companies that have maintained an internal SIU are now converting to outsourcing, while others that previously outsourced that function are now bringing the SIU inside.

Since the growth of anti-fraud efforts began in earnest in the early 1990s, insurance companies have increasingly focused their efforts to determine the value that SIUs bring to a corporation. Through statistical measurement, insurers have sought to gauge the effectiveness of SIUs, calculate the returns on investments and determine whether SIUs should be expanded, reduced, taken in-house, or contracted out.

Until recently, all the individual efforts were largely unreported and certainly not in a central location. There was informal discussion, usually among executives, but nothing concrete that could be used as a benchmarking tool. SIUs were usually formed without the benefit of experience because SIUs were relatively new. There is now roughly twenty years of information from which to draw for the company that is revamping or newly instituting their Special Investigation Unit.

A company that is thinking about converting from an outsourced SIU function, or starting a new SIU from scratch, has many issues to consider. Among these issues are:

- Are they in compliance with state department of insurance mandates?
- Are they in compliance with state statutes governing the existence and operation of SIUs?
- How should they begin the planning and staffing process?
- What are the selection criteria for potential SIU candidates?
- Who measures the results of the SIU effort?
- What is the frequency of measurement?
- Who verifies or refutes the accuracy of the measurement?
- Should calculated savings be measured? If so, what method should be used?
- How are SIU expenses allocated?
- What are the parameters for SIU involvement and what specific areas will be charged with the responsibility to investigate?

- Should the SIU be a part of or separate from the Corporate Security Department?
- Who will the SIU directly report to?
- Which technology needs are currently available and which are not?

These are all questions that need to be addressed and decided upon before implementing the SIU. Once these questions are answered, the carrier can go about the staffing process.

In 2003, the Coalition Against Insurance Fraud conducted a study titled *Study on SIU Performance Measurement*. This study consisted of detailed information from 52 insurers on how they measured the performance of their SIU departments. Surprisingly, the study concluded that there is little consistency among insurers regarding the methods utilized in their performance systems. Among the findings were these five key elements:¹

- SIU management has the responsibility to conduct performance reviews in about three out of four companies with measurement systems in place. Senior management takes a role in overseeing measurement systems in approximately 42% of the companies.
- Most performance measurement is done annually (44%), although nearly one-third of the survey participants (29%) said they measure on a quarterly basis.
- The most popular method (29%) of calculating dollars not paid to detection efforts was taking the estimated or actual dollar amount of claims submitted. Nearly 22% of all respondents said they rely on the amount of reserves to calculate savings.
- The two most cited factors used in measurement systems are the number of referrals and quality and accuracy of the investigation. Others also consider the training services provided by SIU(s) to other departments in measuring the effectiveness of the SIU overall. Insurers use an average of five factors.
- There was an almost even split between whether insurers expensed SIU costs on an allocated or unallocated basis.

The results of this study closely mirror what has long been suspected within the industry—there is no actual benchmark or consistency in the way SIUs are established, measured, and maintained. Before discussing the unanswered questions from the survey, the following represents much of the compiled information. This information is critical knowledge, especially for the company just contemplating how to implement their SIU operation. It also provides a set of guidelines for many of the issues listed that need addressing.

1. www.insurancefraud.org/downloads/siu_study.pdf.

Measurement Systems in Place

Nearly 87% of insurers reported that they sponsor formal programs to measure the effectiveness of their SIUs. Of the minority that reported that they did not have a formal program, there was not a common reason why these measurement systems had not been developed.

One SIU for a large multi-line insurer wrote, “We believe that tracking the outcome (of investigations), or dollars denied due to fraud, creates the perception that SIU investigators are compensated for denying claims and at worst it creates actual bias by the SIU investigator.”

While some insurers might not have formal programs, they reported that they do compile statistics on anti-fraud activities for reporting requirements mandated by many states. Respondents for this study—which was fairly representative of the industry—who reported that they did not have measurement systems in place, included four medium-size companies, two small insurers, and one large company.

The results of this study show that most insurers think it is as important to measure the results of SIUs as it is with any other business unit.

Who Measures?

More than three-quarters of participants in the survey reported that the responsibility for implementing measurement programs rests with the SIU department itself. However, half of these respondents said that other departments—mostly senior management and claims executives—were also involved in reviewing or overseeing the measurement programs. Of the 45 respondents, 42% said senior management had a hand in measuring programs and 18% stated that the claims department was involved. To a much lesser degree, legal, compliance, finance, and audit departments were also involved in measuring SIU performance.

In reviewing whether the insurer’s size might affect which department measures performance, it was shown that small and large insurers tended to be measured by SIUs, whereas medium-size insurers relied more on the claims department and senior management to conduct measurement programs.

The following chart is a breakdown of the different areas responsible for SIU performance measurement.

Areas Responsible	Percentage
SIU management	76%
Senior management	42%
Claims management	18%
Legal department	7%
Compliance department	7%
Other (unspecified)	7%
Finance department	2%

How Often Are Measurements Taken?

This was an interesting part of the study and clearly demonstrates the lack of consistency that still exists among insurers. When initially setting up an SIU, make sure to communicate the frequency of measurements to the SIU staff and other parties responsible for the overall management of the SIU. The newly formed and continuing unit should be aware of what they are being measured on and how often the measurement is to take place.

This study concluded that most of the time (44%) an annual performance review was conducted, while nearly one-third (29%) reported measuring SIU effectiveness on a quarterly basis. Fewer than 10% said they had no set period for measuring or that it was even done on an on-going basis. The larger and smaller carriers tended to conduct annual reviews, while medium-size insurers tended to hold quarterly reviews.

Calculating Savings

As discussed earlier, one concern that has been discussed in the insurance industry since the inception of SIUs is whether to measure or calculate the actual dollar savings as a business unit benefit, or as a return on investment. The concern has always been that there might be the perception that SIUs are encouraged to investigate claims to deny as many as possible, thus increasing the bottom line results for the carrier. It is apparent from this (the first concentrated survey addressing this particular issue) that the majority of carriers favor measuring results.

To avoid any misperception that SIU personnel are encouraged to suggest denials or mitigations of claims that are truly meritorious, the carrier might wish to consider hiring an outside SIU consultant to randomly review SIU files. The consultant can provide an objective and experienced review and at the same time spot any potential troublesome areas pertaining to SIU file handling or the training the unit

provides. These reviews are not intended to make SIU personnel “look over their shoulder,” but rather to provide an objective review for areas of performance improvement.

There are many ways to calculate the savings realized from using an SIU in file handling, but realistically it can never be an absolute figure. There are too many variables and intangibles that come into play. For example, how does one measure a claim that is withdrawn as soon as there is SIU involvement and before the investigation is even complete? When measuring this, the carrier should use caution if labeling this file as fraudulent simply because it contained red flags at the outset and was then withdrawn. Although that very well might be the case, if the investigation was not completed, the file cannot be assumed to have contained some element of fraud. Furthermore, the claim might later be resubmitted by the insured and the file reopened. If the file notes reflect that the claim was considered fraudulent, or if there is any indication the amount claimed was part of the SIU “savings” for that quarter, the insured has a reasonable argument that when the claim was reopened it was already predisposed to being fraudulent in the mind of the claims handler. This is but one of many examples that express the vagueness of the information regarding actual or attempted fraud in some claim files and the possible adverse impact these types of files can have if they are measured improperly.

The following methods are most often used for calculating savings or the perceived bottom line impact as a direct result of SIU efforts:

- Note the initial reserve(s) at the time the determination of suspected fraud or actual fraud is made; the “savings” then becomes the difference between what was paid and what was reserved, or the denial amount based upon the reserve itself.
- Evaluate the number of claimants, coverages, or files that are closed.
- Use any combination of the two listed above.
- Utilize the actual or estimated dollar amount of the claim submitted, with the initial reserve not considered.

All of these methods employ the idea of beginning with a stated dollar amount and then adjusting accordingly. However, what can’t be adequately determined by any of these methods is the impact other individuals involved with the file may have on the result. For instance, the initial claim handler’s observations and reactions to red flags or coverage issues, or the lack of same, most certainly affects the result and the amount of time in which the claim is resolved. Likewise, the person directly responsible for establishing and revising the reserves plays a huge role in whether the end figures are close to accurate. Over- or under-reserving directly affects the end results across the board.

Factors in Measuring Performance

When deciding how to evaluate current SIU performance or implement performance standards for a newly formed unit, several things must be kept in mind. Some measurement standards will be very concrete and easily tabulated. Other factors to be considered will be more nebulous and intangible, but both are extremely important in rating the SIU's overall effectiveness. Referring again to the 2003 study, for example, the average company used between five and six metrics, while some companies had as many as 15 and some didn't use any metrics at all.

Below are the factors most commonly used by insurance companies to rate SIU performance:

- Number of actual referrals received by the SIU (this involves a combination of direct referrals by claims handlers, fraud hotlines, outside agencies, and other carriers)
- Quality and accuracy of the investigation itself
- Total number of referrals as a percentage of total number of overall claims
- Total cost of maintaining the SIU versus dollars saved
- Number of files closed without payment
- Number of assists from the SIU
- Number of files that resulted in some type of criminal action
- Total dollar amount of restitution ordered or collected
- The cycle time or "claim life"
- Percentage of claims investigated
- File referral rate by different lines of business
- Number of files that resulted in some type of civil action
- Membership or leadership in anti-fraud organizations
- Average dollar amount paid on SIU claims
- Total dollar amount of recovered premiums
- The SIU's direct involvement in anti-fraud legislative activity

The measurement tools most often used are the number of actual referrals received by the SIU and the end quality and accuracy of the files they investigated. This information is the simplest to track and tabulate, and to a large degree provides a snapshot of how active the SIU is overall within the organization.

Additional Rating Factors

Most insurers also try to measure the intangible and indirect benefits that the SIU provides to the organization. These factors are many and vary widely because every insurer's SIU is setup to meet that organization's needs.

Some of these benefits may include:

- Anti-fraud training that the SIU provides for company personnel other than claim handlers, such as underwriting, loss control, internal audit, and HR
- Non-fraud-related activities performed by SIU personnel
- The deterrent value the SIU provides in helping to keep claimants honest

The anti-fraud training offered is by far the most direct nonclaim-specific benefit that the SIU brings to the organization. This is an invaluable asset that has a positive impact on the earnings for the company, but it is also the most difficult task to measure for effectiveness. There is never an effective way to measure what has been deterred, or not even reported, directly due to the training for claims handlers and other key company personnel. Most insurers, however, instinctively feel it is an effective tool even though it can't be measured.

Expensing SIU Costs

Understanding the different options for accounting for the cost of maintaining or outsourcing an SIU is important because those cost measurements are sometimes used in conjunction with SIU savings to determine whether anti-fraud activities truly add to the insurer's bottom line in a positive manner. One constant topic of discussion among most carriers regarding SIU costs is whether to allocate the expense to the claim file or to charge all SIU costs as an administrative expense. Realistically speaking, from an accounting perspective only, the larger the carrier, the simpler it is to make it an administrative expense. However, whatever determination is made is of little consequence to the SIU itself except as a manner of tracking its expenses overall.

Areas of SIU Responsibility

When measuring the effectiveness of the SIU, the first thing that must be considered is exactly what its stated areas of responsibility include. This varies with the lines of business of the carrier, whether it is separate from or a part of the corporate security function, and whether senior management wants it to be involved in anything other than claims investigations. The final determinant of the parameters for SIU involvement will largely depend on which business unit the SIU directly reports to.

One question that is often asked is whether the SIU should be a part, or a separate function, of the Corporate Security Department. The answer is—there is no right answer. Some insurance carriers' senior management feels that the SIU should be separate. The reason for this is because they want the SIU to be considered a part of the team that is there to assist other company personnel and to provide training and assistance as needed. They think that if the SIU is also charged with the added responsibility of investigating company personnel, then a natural mistrust may form. There might be some merit to

this logic, but it will not work well in all situations. The decision as to whether the SIU should be apart from or a part of corporate security rests with senior management. The decision should be made based on the company's long-term goals and objectives and decide on which way would best fit the company's need.

The 2003 study cited earlier asked respondents to give the types of cases investigated by the SIU in their companies. The following were the responses to that request (it should be noted the total percentages are more than 100% because of multiple answers):

- Automobile claims (80%)
- Homeowner claims (63%)
- Agent and broker investigations (53%)
- Commercial liability claims (51%)
- Internal investigations (company employees) (49%)
- Workers' compensation claims (41%)
- Disability claims (36%)
- Life claims (20%)
- Health claims (16%)
- Other (18%)

While industry experts agree this is a representative sampling and seems to reflect the perceived SIU function, investigators of health insurance fraud represented the smallest percentage of respondents for this specific study group.

SIU Personnel Selection

The criteria for selecting SIU personnel vary widely among carriers and largely depend upon the company's specific lines of business. Ideally, the decision regarding selection criteria should be made after the areas of responsibility have been decided. While this may seem obvious, it does not always happen that way. Some carriers have hired SIU personnel and then have established the areas of responsibility based upon the experience level or expertise of the SIU personnel. While this will show an immediate positive effect, and be initially perceived to have been the right decision, it turns out not to have been the best decision in the long run. Whenever a new SIU is established, there are automatically immediate success stories. Usually the new unit starts off with the "low-hanging fruit," as it should. These are the cases that require immediate attention and usually bring about a rather quick result. Although this is certainly positive, the immediate success reaffirms the decision that was made to just hire SIU candidates with a certain background. The assumption is that this trend of immediate successes will continue, which of course it can't.

Candidate selection should be based upon the long-term goals of the organization and the proposed structure of the SIU. The following questions should be answered before a candidate profile is formulated:

- What are the educational requirements for this position?
- Will SIU personnel be handling the files or will they serve in an advisory and assistance capacity only?
- If the organization has a formal succession plan, how will this role fit into that overall scheme?
- What particular expertise is required that is not currently in the organization or that needs to be augmented?
- Has a fact-finding project with other carriers that are willing to share information on SIU “lessons learned” been undertaken and thoroughly reviewed?

Many carriers hire ex-law enforcement and ex-fire officials to staff their SIU departments. The thinking is that ex-law enforcement officials have investigative expertise, which is a skill that is immediately transferable to the SIU position. Likewise, ex-fire officials bring fire suppression and investigation expertise, which can prove invaluable. Some insurers conduct their own origin and cause investigations and many fire officials are already Certified Fire Investigators.

To be sure, ex-law enforcement and fire officials bring immediate value to the company because of their expertise. Another asset they possess is their affiliation and familiarization with local, state, and federal governmental agencies. However, they most often lack insurance claim handling knowledge and corporate environment experience. As such, training needs to be provided in these areas.

Other carriers have taken seasoned claim handlers who have demonstrated a propensity for investigation and provided training to them specific to the SIU operation. They must learn investigative techniques and resources, and then apply those skills to the claims investigation to supplement their extensive claim handling experience. What these candidates most often lack, however, is that intangible “nose” that is only developed by conducting investigations for many years. Most often, these individuals have never dealt directly with hardened and intelligent criminals, so they are often ineffective in developing investigative strategies.

The consensus is that the best well-rounded SIU candidate is one that possesses insurance and law enforcement or fire investigation experience. Finding ideal candidates such as this may not be as unusual as one might first think. Many law enforcement and fire officials work as claim handlers as either a different profession after retirement or seek out this type of job when changing jobs. This blend of investigative expertise and claims experience makes the modern SIU investigator a formidable factor in the insurance industry’s fight against fraud.

Many insurers have developed the position of SIU analyst to augment the overall operation. This position(s) serves many roles and is rapidly becoming an integral part of the sophisticated SIU operation. The tasks charged to the SIU analyst include:

- Analyzing referral data to identify training needs and resource allocation
- Tracking SIU-related expenses to formulate a verifiable cost-benefit-analysis business unit report for senior management
- Using predictive modeling software to identify future fraud trends
- Tracking and capturing information for DOI compliance purposes and mandated state anti-fraud reporting
- Utilizing link analysis technology to correlate what seems to be unrelated data into useful investigative strategy information
- Providing statistical information to the major case and intelligence units regarding sustained efforts
- Providing data mining services to field personnel to control the gathering and disbursement of sensitive and often private personal information

Many insurers now armed with data mining tools and predictive modeling software are starting to form specialized units within their own SIU ranks. These might include major case and intelligence units that focus primarily on large or complex cases that typically involve organized ring activity and service provider fraud. Many companies also have public records and other information databases, along with support personnel, to provide background information to assist field investigators and support the claims operation.

Technology Requirements

The key to modern day success for an existing or newly formed SIU is the ability to evaluate anti-fraud technology and transform that data into knowledge. No longer dependent on manual processes, innovative companies are transforming data into knowledge.

The historical method of gaining referrals for most insurance companies was to train their claim handlers in the identification of suspicious indicators, commonly known as red flags. The claims adjuster would then refer the file to the SIU, if the company was fortunate enough to have an SIU. Some carriers went a step further and compared their questionable claims against various public record or information databases, but the manual and time-intensive process kept investigators from doing what they do best—managing street investigations.

Today, the entire process is being reengineered with automated solutions. The future of detecting and investigating insurance fraud is information intelligence. Leveraging internal and external data is the key to a successful program. A company's fraud program can be retooled with sophisticated fraud technology

solutions. A good insurance fraud program also requires a sound business strategy and a tactical business process integrated with the technology to be successful.

For a carrier looking to start a new SIU, or for those that are constantly reevaluating the current SIU function, an understanding of the many technological tools available, as well as their capabilities, is essential.

One advanced fraud detection solution on the front end of the claims process is data modeling and claims scoring. Claims scoring technology using predictive software can be used at the first notice of loss and throughout the life of the claim. There are generally two types of scoring models: one is predictive modeling and the other is a pure rules-based system, often referred to as an expert software system.

Rules-based systems typically use the traditional industry red flags of claim fraud. Data from a claim is run against a set of predetermined rules and then analyzed. One of the inherent problems with pure rules-based systems, however, is that some of the best red flags of claims fraud cannot be measured by data alone, which results in a system that is purely one-dimensional. Pure rules-based systems are assumption driven and do not necessarily respond to industry- or company-unique trends and patterns of fraud activity across claims. They simply automate what a claims adjuster should be able to manually recognize on a claim.

Insurance-related fraud today is more complex and sophisticated, requiring a much greater analytical and intelligent approach over hard-set rules.

Predictive models are much more intuitive than rules-based systems because they are built on data from a company's own historical claims and fraud investigation experience. Models can be built for various business lines, such as automobiles, property, and workers' compensation. Certain business lines may require more than one model, depending on the type of claim and data availability. The models are data driven, with the predictive attributes coming directly from a company's past claims and fraud experience.

The past can be a good predictor of the future. That maxim has held true many times when it comes to the process of hiring the right person for a job or evaluating job performance; the same holds true when it comes to identifying fraud.

Models produce statistical probabilities and other factors based on past claims with similar characteristics that resulted in successful fraud investigations. Data from newly reported or updated claims is run through the model's complex algorithm and can travel in many different paths until the claim is scored.

The higher the score, the greater the likelihood for potential fraud. A baseline score is established, and claims reaching that threshold are flagged for review and possible further investigation.

A hybrid claims fraud recognition solution can have both predictive attributes and hard-set rules. In this case, claims data is run through the model and scored. The information is also compared against a programmed set of red flags. The rules generally act independently of the predictive model, but sometimes the rules turn out to be the very same factors that the predictive model might be hitting upon. For example, the scoring model might spot a claim occurring soon after policy inception or cancellation, certain policy coverage changes shortly before the reported loss, or the claim is reported late. Predictive models are not assumption-driven like rules. The indicators of potential fraud might fly beneath the radar because they are too subtle or obscure to be recognized by common red flags. The relationship and combination of factors on a claim are the keys to identifying questionable claims.

Predictive models, like rules-based systems, are susceptible to producing false positives. Legitimate claims can produce a false positive when they meet the same or similar conditions of past suspicious claims. Keeping the number of false positives down involves some fine tuning and occasional model rebuilding. How many claims must be reviewed to identify one potentially fraudulent claim? This might be referred to as the “false positive ratio.” Pure rules-based systems can accurately measure whether certain conditions are present, but those conditions might not necessarily be the best predictor of fraud. The use of industry red flags alone is not an ideal predictor of fraud. Even claims that score high with predictive software or have many red flags, for example, will more times than not prove to be legitimate.

The potential benefit of predictive modeling is significant. With predictive modeling, the entire population of claims is segmented into a substantially smaller and more manageable group of claims. The refined or flagged group has a greater propensity for fraud than the rest of the population. This could be the difference between having to manually review 20,000 active claims per day for potential fraud and focusing closely on only 100 claims using automated fraud technology. This is a more accurate and consistent process than pure randomization or reliance on manual identification processes alone.

Data Mining and Link Analysis

One of the major problems in combating insurance fraud is the amount of meaningful data that remains trapped in a company’s disparate systems. Data mining is more commonly used on the back end for fraud investigation than it is for fraud detection. However, this doesn’t preclude data mining from being used proactively to identify potential fraud. Data visualization, or link analysis technology as it is more commonly called, joins and transforms seemingly unrelated pieces of data into meaningful information. Data can be pulled together from many different sources by creating a sort of defined data warehouse. Software is used to perform the analysis. Some data mining software applications can bring in data from

other sources without the need to create a data mart. Be cautious and even skeptical of assertions that some data mining tools do not require a structured data design, or can interact with any type of system or data source regardless of data quality or format.

Translating and transforming data into knowledge through visual analysis and visual data mining technology has many business benefits. Visual analysis software systems can be used to reveal patterns, trends, and relationships contained in complex data sets coming from a variety of sources. This is unlike statistical analysis, which deals mostly with aggregate results. Proactive and reactive analysis is done to explore trends, patterns, correlations, and relationships, both direct and indirect, in claims and claims-related data. These patterns and relationships emerge from the data and are presented in graphical representation. No data mining system would work if not for “similarity” or “fuzzy logic” search capabilities to match on pieces of information. This technology is typically embedded with the visual link analysis system. It identifies similarities in data to more accurately identify matches. For example, it helps to identify small variations of names and addresses that might very well be the same person or place.

Data mining technology is not an ideal tool for analyzing mainstream questionable claims of opportunity. Predictive modeling and claims scoring, on the other hand, work well for all business lines and most types of claims, including organized or opportunistic fraud. The primary goal of predictive software is to generate better quality referrals to the fraud investigations area, and to deliver them much sooner in the claims life cycle.

Integrated Business Processes

Anti-fraud technology has the potential to provide substantial benefits to a company’s fraud prevention program with the use of electronically enhanced detection and investigation tools. However, technology alone will not be effective without an integrated business process. Technology will certainly help to identify questionable claims, but there must be some follow-up after the claim has been flagged.

Anti-fraud technology alone cannot prove fraud. Proving insurance fraud still requires a thorough investigation and skilled, well-trained investigators. Quality investigations are essential in fighting fraud and no amount of technology can serve as a substitute for the knowledge and experience of a good investigator. One of the pitfalls of fraud technology is the belief that it can reduce the need for investigative and support resources. Human resource needs should be greater if the company’s fraud technology solution program is operating as intended. More questionable claims will be identified, requiring more time spent on actual investigations.

Anti-Fraud Personnel

To be successful in fighting insurance fraud, anti-fraud personnel must be capable and competent. This includes understanding the following:

- All insurance policy contracts used by the insurer
- Rules applied by the court for interpretation of contracts
- The Fair Claims Practices Act
- The regulations set by the Department of Insurance to enforce the Fair Claims Practices Act
- Contract law
- Torts
- Fraud
- Interview techniques
- Red flags of fraud schemes

Training personnel might include:

- Claims handlers
- Underwriters
- Agents
- Policy handlers
- Call center staff
- Legal staff

They must also understand insurance fraud schemes, such as staged accidents, the trip and fall that never occurred, and fraud related to premiums.

Summary

The value of claims referrals, either by adjusters or electronic means, to the SIU is found in three areas:

- Statutory compliance with mandated anti-fraud plans
- Reduction in loss payments
- Improved long-term profitability for the company

The benefits of compliance are realized by the creation of a process that documents the individual insurer's efforts to combat fraud. A successful referral process will show an immediate benefit by reducing the amount of loss payments paid by the insurer through the investigation of questionable claims. In the future, this will benefit the company by improving its overall financial performance as the overall loss adjustment expense (LAE) improves through reduced payments on suspicious or non-meritorious claims. This, in turn, positively affects the reserving requirements and the overall quality and look of the company. To achieve these goals, the insurer needs to understand the referral process and

develop a successful model for referrals that will establish effective protocols to ensure timely and accurate referrals of questionable claims for investigation by the SIU.

Most states require insurers licensed to do business within that state to file annual anti-fraud plans. Included in these plans is a statement to the effect that the insurer will try to control the adverse effects of insurance fraud by referring questionable claims to either an internal organization tasked with the deterrence of insurance fraud (such as an SIU), or to an external vendor that will perform the same functions by conducting investigations into questionable claims. Because of this, the claims department must establish a set of protocols to guide claims handlers in determining which claims need to be referred for further investigation. To accomplish this, the insurer needs to be aware of the present status of its claims screening process to determine its effectiveness and identify areas for further improvement.

III. THE POLICY: THE CONTRACT

A standard feature found in liability insurance policies is a provision contained in the policy conditions commonly known as the “cooperation clause.” The cooperation clause applies to both first- and third-party claims.

This discussion centers on some of the more commonly asked questions associated with:

- The purpose of the cooperation clause
- The types of breaches that relieve the insurer of its duty to provide coverage
- Applications to fraudulent claims
- The actions taken by an insurer that might prevent it from having to rely on the cooperation clause as a coverage defense

First-Party Claims and the Cooperation Clause

The cooperation clause in first-party coverage commonly requires:

- A notice provision requiring an insured to provide prompt notice of a loss and to complete a sworn proof of loss
- An insured to appear for an examination under oath and to produce supporting documents

Third-Party Claims and the Cooperation Clause

Depending on the jurisdiction, the legal basis of the cooperation clause is either contractual or statutory.

The purpose of the cooperation clause is to:

- Protect the ability to minimize an insured’s exposure in third-party cases.
- Allow the insurer to protect their own interests and prevent collusion.

The cooperation clause in third-party coverage commonly requires:

- An insured to provide prompt notice of a claim or lawsuit
- An insured to cooperate and assist by:
 - Securing and giving evidence
 - Responding to written discovery
 - Appearing for deposition
 - Attending trial

Prompt notice of an accident or claim provides an insurer with the opportunity to conduct a timely and thorough investigation. This helps protect against fraudulent claims and legitimate claims, which, because of liability issues, are not meritorious. Timely notice affords an insurer the opportunity to make

a timely and thorough investigation, which in turn provides a basis to enter into settlements in both a timely manner and for fair amounts. This protects the insured and the insurer.

Requiring the insured to assist in the defense of a third-party lawsuit serves the same function as the notice provision. It helps prevent fraudulent claims and ensures that claims and suits are settled or tried on the merits. For example, under the typical cooperation clause, the insured must cooperate in securing and giving evidence. This means the insured must provide a factually accurate version of the accident so that the insurer can render an objective evaluation of the claim's merits. This provides a means for the insurer to protect the interests of both the insured and the insurer.

Test When the Cooperation Clause Applies

BREACH AND PREJUDICE

The insurer may not deny coverage in a third-party case without a clear demonstration of prejudice.

Prejudice cases typically require the insurer to prove:

- The insurer has diligently sought the insured's cooperation by, for example, retention of a private investigator.
- Actual and substantial prejudices have resulted from the insured's failure to cooperate. If the breach of the cooperation clause is based on the insured's failure to initially report an accident to an insurer, coverage cannot be denied by the insurer without a showing of prejudice.

To prove prejudice, the insurer must show what the ultimate result in a claim would have been otherwise had the insured cooperated. For an insurer to establish prejudice and show that the ultimate outcome of a claim would have been otherwise, the insurer must prove there is a substantial likelihood that if the insured had not breached a cooperation or notice clause, the outcome of a trial or settlement would have been different. It is not enough to show that the insured failed to provide timely notice of an accident or attend a deposition. The insurer must also establish actual prejudice due to a breach. That an insurer is deprived of an opportunity to present a defense, which the court may reasonably have accepted, does not constitute substantial prejudice.

LATE NOTICE OF CLAIM OR ACCIDENT

In the case of a disputed liability, factors to consider include:

- Did the insured or insurer receive adequate representation of counsel?
- Were all reasonably potential witnesses interviewed?
- Were all reasonably possible defenses pursued?
- Was the testimony of all key witnesses preserved?
 - Was the insured or insurer provided with sufficient information from counsel to make an informed decision on whether to accept a reasonable offer of settlement?

QUESTIONABLE LIABILITY

If the insured willfully fails to appear for trial by failing to keep the insurer aware of where they may be contacted, substantial prejudice exists if:

- Liability is disputed.
- The plaintiff's and the defendant's versions of the accident are equally reasonable.

Even if the insured was deposed, this alone does not negate the finding of prejudice, especially where no reasonable excuse for the absence is offered to the jury and all questioning of the insured at the deposition was conducted by opposing counsel.

In most states, an insured's failure to attend the deposition or trial does not constitute actual and substantial prejudice because the absence of the insured does not affect the outcome of the insured's liability. In a few states, the failure of the insured to attend trial is, per se, evidence of prejudice and creates a questionable and arguable presumption of prejudice. A default judgment may be entered due to the insured's failure to forward the summons and complaint. However, this does not void coverage because cooperation by the insured would not have changed the outcome on liability. The insurer is still required to establish actual prejudice.

Willful and material misrepresentations by the insured regarding the circumstances of the actual loss constitute a breach of the cooperation clause.

Knowing the Policy and Its Language

It should go without saying that all those involved in the claims handling process should have a thorough knowledge of the policies upon which those claims are based. This knowledge allows the claims professional to make prompt, intelligent decisions about policy coverage while at the same time effectively explaining the basis for those decisions to insureds and claimants to ensure they are satisfied that they are being treated fairly.

When dealing with suspicious claims, a thorough knowledge of the policy is extremely important. The decision to conduct a special investigation might subject the insured or claimant to intense scrutiny and might even lead to criminal charges. Either can expose the insurer to retaliation in the form of a civil action for bad faith and other wrongful acts. Decisions involving suspicious claims must be made carefully. Making these decisions requires knowledge of what coverages are provided by a given policy and what rights and duties the policy gives the parties to it.

The policy, whether property, liability, or workers' compensation, is a contract, and is thus subject to certain rules of contract law.

The Policy as a Contract

When dealing with any contract, one must read it carefully to fully understand the rights and liabilities of the parties entering into it. When reading an insurance contract, keep in mind that if a dispute over its terms results in a lawsuit, the terms and provisions of the contract will be interpreted by the court and the contract language will mean what the court decides it means.

In interpreting a contract, courts are required to follow certain guidelines. As a rule, insurance contracts must be interpreted to effectuate the intent of the parties at the time the contract was formed. Courts will read an insurance contract as a whole to determine what the parties reasonably intended by its terms.

The language of an insurance policy will normally be taken at face value. Only if an ambiguity exists will courts resort to “rules of construction” to interpret the policy. If the language of the policy is clear and unambiguous and the meaning of the contract can be discerned, a court will give effect to that meaning.

Whenever there is any question about the interpretation of a written contract, the court will seek to determine the intent of the parties when they entered into the contract by evaluating the language used. The best evidence of what the parties intended is the language used in the agreement itself.

As a rule, courts cannot disregard clear provisions that the insurer inserts into an insurance policy and an insured accepts. Thus, any clause that has been inserted in an insurance policy with the insured’s consent is valid if it is clear, unambiguous, and not in contravention of public policy.

A problem arises when a straight reading of the language in a policy reveals an ambiguity. The *parol evidence rule* generally precludes consideration of any prior oral or written agreements that contradict the meaning of an insurance contract. However, the parol evidence rule does not bar consideration of evidence about the meaning the parties intended to give to specific contract terms which are contained in the writing if a term in the policy language is ambiguous. If a court concludes that the language is ambiguous, it must look beyond the language of the policy to discern the intent of the parties in defining a contract term at the time the contract was made.

The key question thus becomes whether a provision is ambiguous. An ambiguity exists when a word or phrase is reasonably susceptible to more than one construction. Courts will find an ambiguity only where each of the competing interpretations is objectively reasonable:

A word or phrase is ambiguous when it is capable of more than a single meaning “when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated

agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade of business.

While ambiguities might exist, a court generally should not torture the language of the policy to create ambiguities. The rules of construction for insurance policies do not authorize a perversion of language or the exercise of inventive powers to create an ambiguity when none exists.

Upon finding an ambiguity, the court will consider extrinsic evidence regarding the intent of the parties in defining a contract term. Such evidence might include testimony as to the circumstances surrounding the making of the agreement so that the court can place itself in the same situation in which the parties found themselves at the time they entered into the contract. The court might also consider insurance industry literature, which might give an indication of what the drafters of a standard policy intended. Note, however, that at least one court has held that such evidence of the drafter's intent is inconclusive.

If the court is still unable to resolve an ambiguity by resorting to extrinsic evidence, the rules of construction may be applied. There are two primary rules of construction:

- The contra-insurer rule
- The reasonable expectations doctrine

Contra-Insurer Rule

The contra-insurer rule provides that when an insurance policy is constructed in such a way that allows room for two interpretations, the wording should be interpreted in such a way that is harsher toward the insurer. The insurer has the responsibility of making its intention clearly known in a contract, and if an insurer attempts to limit its liability by using ambiguous language that can be interpreted in more than one way, most courts will construe such an ambiguity strictly against the insurer.

The rationale for the contra-insurer rule is:

The policy, although of a standard form, was prepared by insurers, who are presumed to have had their own interests primarily in view; and hence, when the meaning is doubtful, it should be construed most favorably to the insured, who had nothing to do with the preparation thereof.

Contra-insurer rules are most strictly applied when there is an ambiguity in an exclusionary clause. Since exclusionary clauses limit the scope of the basic protections provided, an insurer has a duty to use precise language when describing these clauses.

While most courts only apply the contra-insurer rule where an ambiguity exists that cannot be resolved using extrinsic evidence, some courts have applied the rule in cases in which the policy language is unambiguous, holding that the policies should be interpreted liberally in the insureds' favor.

The contra-insurer rule was developed in response to the unequal bargaining power of the typical insured in relation to the insurer. Thus, the question has arisen as to whether this rule should be applied to business insurance policies, which are often drafted on behalf of the insured by sophisticated brokers or legal counsel. Several courts have held that in these circumstances the rule should not apply. The courts generally consider several factors when deciding when and if to apply the rule:

- The size of the business being insured
- Involvement of legal counsel on behalf of the insured
- Representation of the insured by an independent broker
- The use of a "manuscript" policy
- The insurance sophistication of the insured
- Whether the dispute is between two insurance companies
- Whether the parties possessed equal bargaining power

Reasonable Expectations Doctrine

The reasonable expectations doctrine is a variation of the contra-insurer rule. This doctrine provides that an insured's reasonable expectations regarding the nature, scope, and terms of the insurance coverage should be honored by the courts even though a strict reading of the policy language reveals a limitation or exclusion.

According to this doctrine, policy language is construed in accordance with the objectively reasonable expectations of the insured. Thus, the meaning of a word or phrase is not what the drafter of the policy provision intended, but rather what a reasonable person in the insured's position would have understood it to mean. A slight majority of states have recognized the reasonable expectations doctrine.

First- and Third-Party Policies

A contract is an agreement between two or more parties. Some contracts involve only two parties; others involve multiple parties. Some contracts are written for the benefit of individuals or entities that are not themselves parties to the contract, but for whose benefit the contract was created and who have certain rights that may be enforced under it. In handling suspicious claims, the rights of all interested parties must be taken into consideration.

Insurance contracts are first-party, third-party, or a combination of the two. So-called first-party policies involve the insurer and the insured (first party). They require indemnifying the insured upon the

occurrence of certain events. For example, a fire insurance policy is entered between an insurance company and an insured building owner. If a fire damages the building and assuming all other policy requirements are met, the insurer must indemnify the insured for the damage. With respect to suspicious claims, first-party policies are generally easier to deal with. The claimant is the insured, a party to the contract. According to the contract terms, the insured (claimant) must comply with certain conditions that allow the insurer to investigate the claim and satisfy itself as to the claim's validity prior to payment on the policy and without any legal involvement. However, when dealing with first-party policies, it is important to consider the rights of others in addition to the rights of the insured. There might be a mortgage, loss payee, or innocent coinsured to contend with. The rights of these parties are discussed in more detail later in this course. Other examples of first-party coverage are property policies of all types, automobile comprehensive and collision policies, medical payments, and automobile no-fault policies.

Third-party policies involve the insurer, the insured, and a claimant (third party) who has been injured or whose property has been damaged by the insured. The insurer is contractually obligated to defend and indemnify the insured against liability to the third party. While the insured has certain contractual obligations as well, the third party, typically not a party to the contract, has no such obligations and the insurer cannot compel the third party's cooperation in the investigation of the claim, suspicious or not. The PAP (Personal Auto Policy), BAP (Business Auto Policy), and CGL (Commercial General Liability) are examples of third-party policies.

Workers' compensation policies involve the insurer, the insured (employer), and the claimant (employee). While the claimant is technically a third party to the insurance contract, the semi-public nature of workers' compensation insurance creates a special relationship between the insurer and the claimant. Because of this relationship, the insurer's obligation toward the claimant might be greater than in a typical liability policy. For example, a valid policy defense against the insured (employer), even fraud, might not relieve the insurer of its duty to pay the injured employee's claim.

Innocent Coinsured

The insured named in a policy may be a single person, more than one person, or a business entity, such as a partnership or a corporation. In addition to the named insured, the policy can also define certain additional insureds who may also have enforceable contract rights. When dealing with suspicious claims, it sometimes happens that one insured is suspected of fraud while another insured on the policy is totally innocent of or unaware of the fraud. This problem frequently presents itself in property policies where more than one insured has an interest in the damaged property. It is difficult to decide who, if anyone, is entitled to be indemnified.

Husband and Wife

Spouses often jointly own property and when that property is real property, the ownership in most jurisdictions is determined by both spouses residing on the property. This means that each spouse owns an individual interest in the whole property and that the property may not be divested by either one alone. Upon the death of one spouse, the survivor becomes the entire owner of the property. If one spouse deliberately burns the jointly owned property, the question is whether that fraud is imputed to the innocent spouse. The question becomes even more complicated when there is a fire insurance policy on the property. Some courts have held that both spouses have a joint obligation to refrain from fraud because of their joint ownership and, therefore, there can be no recovery of fire insurance proceeds even by the innocent spouse.

On the other hand, many courts now separate the concept of property ownership from coverage under the insurance policy. They look to an analysis of the insurance policy language to determine the rights of the joint owners. If the language unambiguously refers to the fraud of “any insured,” then some courts have held that the innocent insured is also barred from insurance proceeds. If, however, the policy language does not clearly include both owners in its fraud exclusion, most courts will allow recovery by the innocent insured. These courts state that the fraud condition refers to the insured that is responsible for the fraud, thus barring their interest in the claim; but the interest of the innocent spouse is separate and a claim by that insured cannot be defeated by the defense of fraud. Some courts have decided that public policy prohibits punishment of the innocent insured in such cases.

Courts are also in disagreement with respect to the amount of the loss recoverable by the innocent coinsured. Some courts have restricted recovery by the owner of a one-half interest to one-half of the total damages, limited to one-half of the policy limits. Other courts, however, have permitted recovery of one-half the total damages limited only by the total policy limits.

The difference in approach can make a significant difference in the result. For example, if the damage amounts to \$150,000 and the policy limit is \$120,000, the narrower court rule would limit recovery to \$60,000, representing one-half of the policy limit. The more liberal approach would allow recovery of \$75,000, representing one-half of the total damages.

Joint Ownership Other Than Spouses

When the criterion for determining policy coverage is the nature of ownership of the property, it is generally held that the act of one joint owner to willfully cause or procure the destruction of the property will prevent recovery by an innocent co-owner. Similarly, if the interests are divisible or severable there would be some justification for allowing recovery by an innocent co-owner. But as the number of cases referred to above demonstrates, the courts are more frequently determining coverage strictly by interpretation of the policy contract and not giving as much consideration to the nature of the

ownership of the property. The same considerations may apply to property owned by a partnership or a joint venture.

Mortgages and Loss Payees

The section of the Standard Fire Insurance Policy that refers to mortgage interest and obligations typically states that “Other provisions relating to the interests and obligations of such mortgage may be added hereto by agreement in writing.” Pursuant to this permission, all forms designed to provide building insurance coverage contain a Standard Mortgage Clause. Even though this form may be used to insure property other than building(s), either alone or in conjunction with building insurance, or to insure building(s) not subject to a mortgage, the presence of this clause creates no complications. The clause states that it:

- Applies to building items only
- Is void unless the name of the mortgagee or trustee is inserted in the space provided on the first page of the policy

Thus, the presence of the clause in any form attached to the policy has no effect on losses that do not involve building coverage and does not protect the interest of anyone not named as the mortgagee or trustee on the face of the policy.

Aside from providing that any loss shall be payable to the named mortgagee (or trustee), the clause creates a contract between the insurer and the mortgagee that is entirely separate and severable from the contract between the insurer and the insured.

In a contract between the insurer and the mortgagee, coverage cannot be invalidated by any act or neglect, including fraud or arson, on the part of the mortgagor or owner, if the mortgagee did not concur in, and was not a party to, the insured’s acts. Likewise, it is not affected by foreclosure, notice of sale or change in the title or ownership of the property, or by the occupancy of the premises for purposes more hazardous than permitted by the policy. This makes the position of a named mortgagee superior to that of a mere loss payee, as the mortgagee’s right to recover cannot be defeated by anything the insured does or fails to do.

In exchange, the clause imposes certain obligations on the mortgagee. On demand, the mortgagee must pay any premium due in the event the mortgagor or owner fails to do so. The mortgagee must notify the insurer if the mortgagee becomes aware of any change in ownership or occupancy. If the change in occupancy results in an increased hazard, the mortgagee must pay the insurer any additional premiums called for by such increase in hazard on demand. Failure of the mortgagee to pay additional premiums on demand will void the contract between the insurer and the mortgagee. In this regard, the clause is

somewhat harsher on the mortgagee than on an insured. If any insured party fails to pay the premium when due, the insurer can only terminate coverage by canceling its policy in accordance with policy provisions. If a mortgagee fails to pay on demand any additional premiums due because of increased hazards, the policy will be void. Accepting the wording of the clause at face value, coverage could be terminated without the necessity of policy cancellation.

If the insured fails to file proof of loss, the mortgagee is entitled to be notified of this fact by the insurer. The mortgagee then typically has sixty days after the receipt of such notice to file proof of loss on their own behalf. Thereafter, the mortgagee has the same rights and duties that the insured would have as to appraisal, time of payment, and time within which suit on the policy must be filed.

If transfer of ownership has been made to the mortgagee prior to the loss, a number of courts have held that the mortgagee is entitled to the insurance proceeds at least to the extent of any deficiency because there has merely been an increase in the mortgagee's interest rather than a change of ownership.

The clause reserves the right of the insurer to cancel both the policy and the mortgage clause by giving the mortgagee ten days' notice regarding such a cancellation. The clause protects the insurer in the event it is required to make payment to the mortgagee when it claims no liability to the owner or mortgagor. If the amount due from the insurer to the mortgagee is less than the amount of the mortgagee's interest, the insurer is entitled to be subrogated to the rights of the mortgage against the mortgagor and the property, as well as any other security held by the mortgagee as collateral to the mortgage, to the extent of its payment. At the option of the insurer, it may pay the whole principal of the mortgage debt, with interest to the date of payment, to the mortgagee. Upon such payment, the insurer becomes entitled not only to the assignment of the mortgage but also to any other security held by the mortgagee as collateral for the mortgage, as well as any bond or note for which the mortgage may be security.

Loss Payees

When an insured procures a policy with a loss payable clause in favor of another, the insured is, in effect, giving permission for the insurer to pay any sums that may become due under the policy to the party named as the loss payee. Under a loss payable clause, the loss payee acquires no rights under the policy except the right to have the proceeds of any adjustment paid to them rather than to the named insured. As the loss payee is only entitled to receive money that may become due to the insured, the loss payee is bound by any acts or failures to act on the part of the insured. If the insured has breached any of the conditions or warranties of the policy or has failed to do any of the things required in the event of a loss, this will serve to defeat the claim of the loss payee just as it would have defeated the claim of the insured had the legal payable clause not been made a part of the policy.

A loss payee is in no sense an insured. They do not have the right to submit a claim to the insurer if the insured fails to do so. There are no rights regarding appraisal. There is no right to participate in adjustment negotiations. There is no right to reject an adjustment to which the insured has agreed. The loss payee's only right is to receive the proceeds of any adjustment that might be agreed upon between the insured and the insurer.

Most loss payable clauses are drawn up to provide that losses shall be payable to the insured and the loss payee as their respective interests dictate. To avoid becoming involved in a debate as to how much of the proceeds of an adjustment belong to a loss payee and how much belong to the insured, insurers commonly issue a single settlement draft naming both as payees, leaving it up to them to work out a proper allocation of the funds.

Most courts distinguish between a mortgagee and a loss payee. They discern that a mortgagee who is typically protected by a standard mortgagee clause in the policy has greater rights than the insured and a loss payee. They also determined that a loss payee who is merely an appointee who receives insurance proceeds to the extent of its interest has no greater rights than the insured. When the insured commits fraud, therefore, the mortgagee is protected and the loss payee is not.

The SIU investigator must always remember that the policy language in effect at the time of the loss is the final determinant that is most often used by the courts. The policy is in every way a literal contract between the insured and the company, which includes its employees, such as an SIU. The skilled and experienced investigator will thoroughly know the policy and its limitations before embarking on an investigation.

IV. CONDUCTING THE EXAMINATION UNDER OATH

Following the submission of a notice of claim, insureds must take, or refrain from taking, certain actions to preserve their right to coverage under the policy. Liability insurance policies generally contain a requirement that the insured cooperate with the insurance company in its investigation, defense, settlement, or other handling of a claim against the insured. Cooperation with the insurance company, therefore, is one of the conditions to obtaining coverage under a liability policy.

Such clauses generally provide the following:

- The insured shall cooperate with the company and, upon the company's request, assist in making settlements, in the administration of lawsuits, and in enforcing any right of contribution or indemnity against any person or organization that may be liable to the insured because of bodily injury, property damage, or loss with respect to which insurance is afforded under the policy.
- The insured shall attend hearings and trials, assist in the securing and giving of evidence, and assist in discovering witnesses to testify.
- The insured shall not, except at their own expense, voluntarily make any payment, assume any obligation, or incur any expense, other than for immediate medical and surgical relief for others that might be imperative at the time of the accident.

Courts rarely allow an insurer to deny coverage based on the insured's failure to cooperate. Violations of the cooperation requirement must be substantial and material to affect coverage.

Additionally, to avoid coverage on the grounds of lack of cooperation, the insurer must:

- Demonstrate that it acted diligently in seeking to bring about the insured's cooperation.
- Show that its efforts were reasonably calculated to obtain the insured's cooperation.
- Show that the attitude of the insured, after their cooperation was sought, was one of "willful and avowed obstruction."

Thus, the courts have interpreted a "due diligence" requirement on the part of the insurer into the cooperation clause, refusing to allow forfeiture of coverage unless the insurer can show that it made reasonable efforts to obtain the cooperation of the insured.

The noncooperation defense is often further limited in claims involving compulsory liability insurance (e.g., automobile liability insurance required by a state financial responsibility statute). Many courts have held that in light of the statute mandating coverage for the benefit of third-party claimants, the insurer may not avoid its obligation to the intended beneficiaries of the law merely because its own insured failed to cooperate. This, of course, presumes there has been no collusion between the insured and the third party. If the insurer can prove collusion, it should be relieved of its duty to defend and indemnify.

Duties After Loss

The insurance policy specifically states in the section titled “Your Duties After Loss” that the insured must: *“Submit to an examination under oath, while not in the presence of any other insured, and sign the same.”*

This allows the insurer to separately take sworn testimony from each spouse or any other insured on the policy separately. All examinations under oath regarding the loss should be scheduled for the same day (if possible) with a short break in between. This prohibits one insured from “pumping” the other to see what they said about the loss itself.

SECTION I—CONDITIONS

1. *Insurable interest and limit of liability—Even if more than one person has an insurable interest in the property covered, we will not be liable in any one loss:*
 - a. To the insured for more than the amount of the insured’s interest at the time of loss; or
 - b. For more than the applicable limit of liability.
2. *Your duties after loss—In case of a loss to covered property, you must see that the following are done:*
 - a. Give prompt notice to us or our agent.
 - b. Notify the police in case of loss by theft.
 - c. Notify the credit card or fund transfer card company in case of loss under credit card or fund transfer card coverage.
 - d. Protect the property from further damage; If repairs to the property are required, you must:
 - * Make reasonable and necessary repairs to protect the property.
 - * Keep an accurate record of repair expenses.
 - e. Prepare an inventory of damaged personal property showing the quantity, description, actual cash value, and amount of loss. Attach all bills, receipts, and related documents that justify the figures in the inventory;
 - f. As often as we reasonably require:
 - * Show the damaged property.
 - * Provide us with records and documents we request and permit us to make copies.
 - * Submit to examination under oath, while not in the presence of any other insured, and sign the same.
 - g. Send to us, within sixty days after our request, your signed, sworn proof of loss, which sets forth, to the best of your knowledge and belief:
 - * The time and cause of loss;
 - * The interest of the insured and all others in the property involved and all liens on the property;
 - * The other insurance that may cover the loss;
 - * Changes in title or occupancy of the property during the term of the policy;
 - * Specifications of damaged buildings and detailed repair estimates;

- * The inventory of damaged personal property described previously in 2e;
 - * Receipts for additional living expenses incurred and records that support the fair rental value loss;
 - * Evidence or affidavit that supports a claim under the credit card, fund transfer card, forgery and counterfeit money coverage, stating the amount and cause of loss.
- h. Cooperate with us in the investigation of settlement of the claim.

SECTIONS I AND II—CONDITIONS

Concealment or fraud is deleted and replaced by the following:

1. Concealment or fraud

- a. Under SECTION I—PROPERTY COVERAGES, with respect to all insureds covered under this policy, we provide no coverage for loss under SECTION I—PROPERTY COVERAGES if, whether before or after a loss, one or more insureds have:
- * Intentionally concealed or misrepresented any material fact or circumstance;
 - * Engaged in fraudulent conduct; or
 - * Made false statements relating to this insurance.
- b. Under SECTION II—LIABILITY COVERAGES, we do not provide coverage to one or more insureds who, whether before or after a loss have:
- * Intentionally concealed or misrepresented any material fact or circumstance;
 - * Engaged in fraudulent conduct; or
 - * Made false statements relating to this insurance.

Components of an Effective Examination Under Oath

Many commentators and court opinions have observed that the Examination Under Oath (EUO) is perhaps one of the most useful and powerful tools in the war against insurance fraud. Used properly, an EUO can provide a limitless amount of information and documents, and can generally be an extremely useful mechanism for a thorough and complete investigation into losses claimed under various insurance policies. On the other hand, used improperly, an EUO can be an expensive waste of time, and in the worst cases can create numerous problems for the insurance carrier that can lead to an incomplete investigation, claims of bad faith, and the potential inability to deny a claim that should otherwise be denied.

WHERE DID IT COME FROM?

- References to the EUO process in case law regarding insurance disputes go back to the 1800s.
- Some simple language policies require “Statements Under Oath.”

WHAT IS THE PURPOSE OF THE EXAMINATION UNDER OATH?

The EUO provision gives the company the ability and the right to determine whether a claim is fraudulent. The U.S. Supreme Court explained the EUO over a century ago in *Clafflin v. Commonwealth Insurance Co.*, stating:

The object of the provisions in the policies of insurance, requiring the assured to submit himself to an examination under oath, to be reduced in writing, was to enable the company to possess itself of all knowledge, and all information as to other sources and means of knowledge, in regard to the facts, material to their rights, to enable them to decide upon their obligations, and to protect them against false claims...

WHAT IS IT?

- Contractual requirement
- Similar, but not identical to a deposition:
 - Sworn testimony
 - Q-and-A format (oral interrogation)
 - Court reporter is present to transcribe

Effective Use of the Examination Under Oath

At the outset, it is important to note that for policy defenses of concealment, fraud, or misrepresentation, it is *not* necessary for the insured's statements to be made under oath. Therefore, any material misrepresentation or concealment made by an insured at any point in the claim process, either verbal or written, might still give rise to the defense provided that the misrepresentation is carefully detailed in the company's claim files.

However, the most effective way to establish a coverage defense based on fraud or misrepresentation is through the EUO. The EUO procedure and the insured's testimony that is offered at the EUO provide the most powerful tools in establishing the fraud defense. It also provides legal counsel with the most persuasive and damaging weapon for challenging the insured's credibility and disproving the veracity of the insured's claim.

To properly investigate fire, theft, or other first property homeowner claims, the following constitute typical areas of inquiry:

- Does the named insured have an insurable interest in the protected property (real or personal)?
- Do the insured's finances support the dollar amount(s) claimed?
- Does this specific insured have a financial motive to stage or cause the subject loss?
- Where did the insured reside at the time of loss?

- Where was the insured at the time of loss?
- What proof of alibi does the insured have?
- What were the insured's debts, assets, and income on the date of loss?
- What was lost?
- Does the loss detail and analysis of supporting documents support the claim?
- Has the insured had prior insurance claims?
 - When?
 - With whom?
 - Was there a claim disposition?
 - Were there first-party lawsuits?
 - Were there case captions?

To properly investigate a fire or theft claim, any competent carrier would require answers to these basic questions. The traditionally accepted method for procuring answers to these questions is the scheduling and taking of the insured's EUO by independent, outside counsel. This ensures objectivity and allows a carrier to make a fully informed claim decision, which is required by law.

Before a claim is put in suit, an insurance company has no subpoena, police, or grand jury power. An insurance company is a private concern, and a major protection against fraudulent or questionable coverage claims is the EUO procedures authorized by its policies.

The Role of Counsel

The remaining issue regarding representation of an insured by counsel at an EUO is the question of what, if anything, the proper role of counsel is during the EUO. Once again, there are relatively few cases that have spoken directly to this point; however, COUCH ON INSURANCE has spoken on the subject in 13 COUCH ON INSURANCE § 196:10 (3d ed.), stating that:

An insured may have an attorney present at the time of the Examination Under Oath, but such attorney cannot take part.

Observation: The attorney's inability to participate during an Examination Under Oath does not, however, mean that the attorney cannot take actions to protect the insured's interests (i.e., objecting to the taking of separate examinations.)

It is this writer's experience that leads to the following suggestions regarding the role of counsel during an EUO:

- The attorney should be allowed to attend the EUO.

- The attorney should be instructed that in the event they have an objection, they may state that they have an objection, and if they want to confer with their client during the taking of the EUO, at that point they are welcome to do so. However, no speaking objections or arguments concerning the objections should be allowed to occur at that time.
- The attorney should be instructed that there will be no on-the-record dialog or other participation.
- The attorney should be instructed that the EUO is not a deposition and is not being conducted under the rules of procedure for the jurisdiction in which the EUO is being taken.
- In the event that the insured's attorney becomes overbearing or in any manner begins to make efforts to take charge of the EUO or in any way interferes with the complete and thorough examination of the witness, the attorney should be told that they must cease and desist from such behavior and that failure to do so will result in a temporary termination of the EUO and further that the insured will be jeopardizing their rights under the policy for failure to cooperate and for failing to participate and answer proper questions posed during the EUO. A full record should be made of this warning to the attorney to make certain that the insured understands the ramifications of such continued behavior on the part of the attorney.

The Uses of an Examination Under Oath

The purpose of an Examination Under Oath (EUO) is to:

- Detect fraud (arson, phony theft, claim inflation).
- Clarify or determine insurable interests.
- Resolve damage disputes.
- Present claims.
- Clarify or determine other potential policy defenses (e.g., increase of hazard).

Submitting to an EUO is essentially a condition precedent to the filing of a lawsuit by the insured against the insurer. The failure by an insured to submit to an EUO can result in a dismissal of the action.

At What Point in the Claims Process Is the Examination Taken?

- After an examination report of loss has been made and a sufficient preliminary investigation has been conducted to determine that an examination is warranted (i.e., the presence of arson or fraud indicators, identification of complex or confusing facts warranting additional investigation, or sworn testimony to clarify)
- Within 60 days of the insured's submission of a properly executed "Sworn Statement in Proof of Loss" (or 30 days if the policy so requires)
- The effects of conducting the examination before properly executed proof is solicited and obtained:
 - How late in the claim process can one take an exam?

- Open-ended if by agreement and other rights are protected (i.e., one-year suit limitation period). But as soon as the insurer is past the 60-day period for proof submission, they are in uncharted water.
- The insured's submission to the preliminary interview while not under oath and subsequent refusal to provide further information does not satisfy EUO requirements.

How to Put the Insured on Notice of the Company's Intention to Conduct an Examination

- Notice must be in writing by certified mail, return receipt requested, and regular post.
- Notice should state:
 - The insurance company
 - The policy and claim numbers
 - The date of loss
 - The names of insureds
 - The names of those to be examined
 - The identity of the examiner
 - The time and place of the examination
 - The time and place for document production
 - The documents to be produced

How the Examination Under Oath Is Conducted

- The insured is sworn in by the court reporter.
- The insurance company's outside attorney asks questions of the insured while the insured is under oath and on the record.
- Issues with conducting the examination over the telephone:
 - Identification problems (for the examiner and the court reporter)
 - Unable to confront witnesses and observe their demeanors
 - Drastic limitation of effective cross-examination
 - Possibly limited evidentiary impeachment value at trial
- What about the insured requesting submission of written questions to be answered in writing?
 - "Appear and submit" to exam at specific time and place is consistent with an interpretation that written questions and answers are sufficient.

Who Must Submit?

- Any (and all, if appropriate) named insureds:
 - Homeowner or renter's policy: husband and wife
 - Commercial policy: business owner or manager, corporate officers, and directors
- Anyone else coming within the expanded definition of an "insured" under the policy

- Corporate insured's officers' actions or statements can be basis for denial
- The mortgage or contract seller

Where May the Examination Be Conducted?

Reasonable locations include:

- The insured's county of residence
- The county where the insured works
- The county in which the property that is the subject of the insurance policy is located
- The place where the loss occurred

Who Conducts the Examination?

The policy language might state that the examination may be conducted by "any person named by this company," but usually the examiner is outside legal counsel or a company representative, employee, or attorney.

Who May Be Present?

- Insured's counsel
- Public adjuster
- Additional company representatives who are not licensed to practice law; usually allowed to sit in on the EUO for damage questions only. Even though represented by a public adjuster, the insured's duties to cooperate and establish damages are not diminished.
- Other insureds
- Minor children (if their testimony will *not* be required; company discretion)

Can the Company Require Separate and Private Examinations of Multiple Insureds?

- The company's interests are best served by conducting examinations of each of the insureds outside of the presence of the others.
- This is the best method for investigators to maximize their chances of discerning truthful testimony from fabrication; minimizes possibility of collusion.
- If the insureds are fabricating their testimony, it is almost impossible to keep all the minute details identical to the testimony given by each one.
- Current ISO forms require insureds to submit to an EUO "while not in the presence of any other insured."

What Is the Scope or Areas of Questioning?

Generally, questioning is tailored to specific facts of each case; however, each examination will probably cover:

- General identifying information

- Background information, such as marital and family history, residential history, military and criminal records, and job history
- Identification and verification of all information contained in any documents or records that are produced
- Circumstances surrounding the execution of the policy and any changes, endorsements, or increased coverage or limits made to the policy
- Information necessary to do a financial reconstruction of the insured's debts and assets for the period leading up to and including the date of the loss
- Verification of loss and damages, to include the description of items claimed and the facts and circumstances surrounding their acquisition
- Identification of any documentary verification (i.e., photos, receipts, or cancelled checks)
- Facts and circumstances surrounding the loss
- Specific areas of inquiry uncovered by the company's SIU personnel or outside investigator

What About the Insured's Fifth Amendment and Privacy Rights?

- The policy's language is indicative of the fact that the insured has contracted away certain privacy rights (e.g., see the EUO requirement, document production language, and the insured's duties in event of loss language).
- Constitutional immunity is irrelevant to a private EUO arising from a contractual relationship; it is only relevant under public process.
- In California, insureds are always given a transcript to sign and another opportunity to clarify or correct testimony. This allows the company additional time to investigate.
- The insured cannot use the Fifth Amendment privilege as both a shield and a sword.
- The Fifth Amendment privilege does not excuse the insured from responding to material questions at EUO.
- The insured could not file an action against the insurer and claim Fifth Amendment privileges during their deposition to avoid presenting crucial facts that could be used against them in a pending indictment.

What the Adjuster Should Do to Prepare the Claim File for the Examination Under Oath

- Verify coverage.
- Examine the policy for coverage dates and amounts, and policy exclusions, limitations, and deductibles.
- Obtain the underwriting file and examine the application and any change requests or endorsements.
- Obtain a non-waiver or send a "Reservation of Rights."
- Inspect the loss location.
- Verify insurable interest.

- Order a title search—Check the title holder, identity, and the number of mortgages and existence of other liens on property (i.e., foreclosure, demolition, health of building department, mechanics liens, or money judgments).
- Take the insured's statement, preferably handwritten and signed.
- Ascertain prior claim history.
- Obtain police, fire, or other investigative reports.
- Interview responding officers and investigating detectives. (Official reports are often silent regarding the investigator's opinions or feelings about a case; these can provide the company with valuable investigative leads—any delay here can be fatal.)
- Solicit a proof of loss and detailed loss inventory from the insured.
- Attempt to verify purchases with the retailers of the larger items.
- Determine the insured's financial condition.
- Solicit input from the outside counsel who is to take the examination.
- Refer file materials to outside counsel in a timely manner to assist them in conducting the examination.
- Don't wait until the last minute; referring the complete copy of the file to the attorney prior to receipt of the proof of loss is appropriate and very helpful when it is obvious that an examination will be required.
- Send original photos, receipts, etc.

Practice Points and Practical Considerations

- Conduct a thorough analysis of facts and circumstances.
- Close partnership between the SIU investigator and the attorney.
- Insist on getting what is asked for—production of documents.
- Follow up.

Once the EUO is complete, a prompt and thorough follow-up should be conducted to contact all witnesses whose names have come up during the EUO and to follow up on leads that might indicate the innocence of the insured in the matter under investigation. In short, follow the rabbit trails until there are no more.

Strategic Issues—Timing of an EUO

The SIU investigator must always determine the correct and strategic time for conducting an EUO. In many instances, EUOs can be most beneficial when conducted at the very early stages of an investigation; however, under other factual scenarios, quite the opposite might be true.

The best mechanism for determining the proper timing of an EUO is for the SIU investigator and the attorney (if appropriate) to determine exactly what goals and objectives are to be accomplished during

the EUO. In some instances, the simple investigative goal might be to obtain a complete statement of all the facts known to the insured to fill in as many factual gaps as possible.

Additionally, if the insured has already given a recorded or verbal statement not under oath to a claims adjuster or to the SIU investigator, the goal of the EUO might simply be to see whether the insured tells the same story while under oath as was told at an earlier time. It might also be appropriate for the investigator to determine whether the insured is being investigated by law enforcement agencies and whether there is any potential for criminal charges to be brought against the insured.

While it is important for the investigator to cooperate with law enforcement officials in the conduct of an investigation, it is also important for the investigator to maintain a substantial degree of separation and independence from any law enforcement activities or investigations.

It is particularly important that insurance carriers conduct prompt, thorough, and timely investigations and reach conclusions regarding insurance coverage as required by the various Unfair Claims Settlement Practices Acts. In this regard, the interests of the insurer in promptly and properly resolving claims will, in most instances, win out over any necessary regard for the insured's Fifth Amendment rights.

The Interplay of the Arson and Fraud Defenses in a Fire Claim

The investigation of an arson claim has two facets. First, the insurer conducts a thorough investigation to establish, by a preponderance of the evidence, the three elements of the arson defense: incendiary origin, motive, and opportunity. Second, and regardless of the relative strength or weakness of any one of the elements of the arson defense, the insurer should conduct a thorough investigation to determine whether the insured has engaged in any fraudulent conduct or made any material misrepresentations that would void coverage.

Generally, when an insured is willing to commit arson for economic gain, they are also willing to engage in a pattern of material misrepresentations and concealments to ensure that the gain is realized.

Therefore, the typical arson claim presents fertile ground for an insurer to investigate and expose material misrepresentations made by an insured upon which an additional, and independent, basis for denying and defending a claim may be predicated. Unfortunately, however, there has traditionally been a tendency by insurers, SIU investigators, and defense counsel to develop tunnel vision about the arson defense itself. Too often, the insurer's investigation and subsequent defense efforts at trial tend to emphasize evidence establishing the arson defense and the insured's link to the ignition of the fire while de-emphasizing oftentimes powerful, if not devastating, evidence establishing that the insured breached the policy by engaging in a pattern of material misrepresentation or concealment. When this occurs, a jury will naturally place greater emphasis on the issue of whether an insured was or was not responsible

for intentionally causing the fire and will often decide a case exclusively upon that issue. In other words, when the insurer emphasizes the arson defense to the exclusion of defenses based on fraud and false swearing or misrepresentation, a jury will ultimately hinge its decision solely upon the issue of whether it was convinced that the insured caused the fire.

Typically, an insurer, at least initially, will interpose two affirmative defenses to litigation instituted by an insured following the denial of an arson claim. First, the insurer will assert an affirmative defense based on the intentional act exclusion contained in the policy. Second, the insurer will interpose an affirmative defense based upon the concealment or fraud provision contained in the policy. As previously noted, however, insurers and defense counsel typically view the two defenses as being intertwined, and therefore, fail to clearly delineate, through both evidence and argument, the fact that the two defenses are not dependent upon each other but rather that an insurer may prevail based upon carrying the burden of proof on both or either.

The importance of pursuing the fraud defense vigorously and independently of the intentional conduct defense cannot be overemphasized, especially where any one of the elements of the arson defense (i.e., incendiary origin, motive, or opportunity) is weak.

The Fraud Defense

Current ISO forms generally used throughout the United States contain a concealment or fraud provision, which typically provides as follows.

CONCEALMENT OR FRAUD

The entire policy will be void if, whether before or after a loss, an insured has:

- Intentionally concealed or misrepresented any material fact or circumstance;
- Engaged in fraudulent conduct; or
- Made false statements relating to this insurance.

An insurer's right to protect itself from fraudulent claims and to strictly enforce the concealment and fraud provisions contained in the property policies has long been recognized and sanctioned by courts throughout the United States. The United States Supreme Court stated as follows:

A false answer as to any matter of fact material to the inquiry, knowingly and willfully made, with intent to deceive the insurer, would be fraudulent. If it accomplished its result, it would be fraud affected; if it failed, it would be fraud attempted. And if the matter were material and the statement false, to the knowledge of the party making it, and willfully made, the intention to deceive the insurer would be necessarily implied, for the law presumes every man to intend the natural consequences of his acts. No one can be permitted to say, with respect to his own statements upon a material matter, that he did not expect

to be believed; and if they are knowingly false, and willfully made, the fact that they are material is proof of an attempted fraud, and because of the materiality, in the eye of the law, exists in their tendency to influence the conduct of the party with interest in them, and to whom they are addressed.

What Is a Misrepresentation?

The elements of misrepresentation in the context of an insurance claim are distinct from those required to establish the common law tort of misrepresentation or common law fraud. In the context of an insurance claim, the insurer must generally establish three elements:

- The statements/submissions were false
- Were willfully made
- Material to the insurer's investigation

What Is Willful Misrepresentation?

Courts have generally held that a misrepresentation will be deemed willful when the statements are untrue and known by the insured to be untrue. There is typically not a requirement that an insurer prove intent to deceive, or that the insured's intent in making the false statement was to enhance their chances of recovery under the policy or to perpetrate fraud. The insured's motive for lying is irrelevant.

Forfeiture does not depend on proof that an insured harbored an attempt to recover proceeds to which they were not entitled. An insurer may refuse payment if an insured willfully misrepresents material facts after a loss, even if the insured did not harbor such intent.

It is only where the insured's misrepresentations were unknowing, inadvertent, or the result of an honest mistake that the policy will not be voided.

What Is Material Misrepresentation?

No issue has generated more case law in the context of the fraud defense than what is and what is not deemed a material misrepresentation. Fortunately, most jurisdictions in the United States have adopted a very broad definition of materiality in the context of an insurer's right to thoroughly and completely investigate a claim.

The law is clear that the materiality of false statements during an insurance company's investigation is not to be judged by what the facts later turn out to have been. Thus, the materiality requirement is satisfied if the false statement concerns a subject relevant and appropriate to the insurer's investigation as it was proceeding at the time.

Courts have properly noted that materiality comprises what is relevant and appropriate to an insurance company's investigation as it is then proceeding. In other words, when an insurer poses an inquiry to an

insured to which it is entitled to receive a truthful answer, and when that answer might ultimately change the course of the investigation to be pursued, the matter will be deemed material. Second, and even where the item misrepresented or concealed is ultimately not dispositive of the insurer's claim decision, it may still be deemed material if the insurer had a reasonable basis for investigating the issue.

Who Determines What Is and Is Not Material?

Most jurisdictions hold that both the issue of whether a misrepresentation has occurred and whether that misrepresentation is material are generally deemed questions of fact to be determined by a jury. Most jurisdictions, however, recognize an exception in circumstances where the evidence produced by the insurer is so convincing that the insured's misrepresentation cannot be seen as innocent. Under these circumstances, whether a statement is false and whether it is material are deemed questions of law to be determined by the trial judge. This issue is important in that it allows an insurer, in appropriate cases, to seek disposition of a case by means of a motion for summary judgment or directed verdict.

What Is Material Concealment?

Most property policies contain provisions that void coverage where the insured has either potentially misrepresented or concealed a fact material to the insurer's investigation. Generally, courts have applied the same definition of materiality to concealment as they have to misrepresentation. Furthermore, courts have realized that there are at least two additional aspects to concealment. First, concealment can occur where an insured specifically and unequivocally answers questions posed to them in such a way as to conceal information relevant to the insurer's investigation. Second and more importantly, the courts have deemed an insured's concealment material when the insured fails to voluntarily offer documents or information that the insured knows to be relevant to the insurer's investigation, even when no inquiries are made by the insurer on the issue.

The Divisibility Doctrine

For years, courts have struggled with the issue of whether a material misrepresentation made by an insured regarding only one facet of a claim will void coverage for the entire claim. For example, when an insured's home is destroyed in a fire that would otherwise be covered by the policy, will the insured's subsequent fraudulent inflation of their personal-property claim void coverage for the entire claim or only for the claim for personal property? This issue is known as the divisibility doctrine. Fortunately, most U.S. jurisdictions do not recognize the divisibility doctrine and consistently hold that a material misrepresentation for fraudulent conduct on one part of the claim will void coverage for the entire loss.

Summary

The EUO remains a powerful tool in the war on insurance fraud. As with any weapon, it must be used wisely and with great regard for the "rules of engagement." The EUO affords a great opportunity for

skilled and experienced SIU investigators to work closely with legal counsel to achieve high-quality results stemming from thorough and effective investigations of complex insurance claims.

V. THE INSURANCE INTERVIEW PROCESS

The Preliminary Statement of the Insured or Claimant

Perhaps the first step in investigating a suspicious claim—or any claim for that matter—is to obtain the preliminary statement of the insured or third-party claimant. The purpose of this statement is to get a brief sketch of the facts and circumstances surrounding the loss. The insured or claimant should be asked for the basic facts about how the loss occurred. Background questions should also be asked, as well as basic questions about the insured’s financial condition where appropriate. To avoid lapses in memory, the statement should be conducted as soon as possible after notification of the loss is provided by the insured.

A witness’s credibility depends not only on how they appear and present themselves, but also on how well they can stick to their story. When dealing with insureds, witnesses, and claimants, it is preferable to get their story committed as soon as possible. The sooner they are committed to their story, the less the likelihood they can successfully change their story at trial. Recorded statements are usually taken at the earliest possible opportunity. Keep in mind, however, that in many states, including Texas, all recorded statements are discoverable, including recorded statements by the insured defendant. Insurers should keep this in mind when deciding who to take a recorded statement from and whether to take a recorded statement from their own insured.

The preliminary statement of the insured is not designed as a substitute for the EUO. This fact should be made clear to the insured at the time of the statement. If the insured doesn’t know what the EUO is, it should be explained to them. It should also be explained to the insured that participating in the EUO is a condition of the policy. According to most court decisions, a voluntary statement given by the insured will not relieve them of their obligation to later submit to an EUO as required by the policy.

Taking an effective recorded statement is the most effective weapon in the fraud investigator’s arsenal. The recorded statement is often the first, and sometimes only, opportunity for the fraud investigator to interact in depth with the claimant or insured being interviewed. The information gathered during the interview not only details the factual background of a claim, but might uncover leads that will enable the fraud investigator to exonerate an insured suspect of fraud or confirm suspicions about a questionable loss. While most homeowners and personal automobile insurance policies contain a requirement that an insured submit to an EUO, there is normally no requirement in the policy stating that an insured must submit to a recorded statement. However, when taking a recorded statement, investigators should be aware that there have been instances in which insureds have brought charges of *bad faith* against an insurer when the insured(s) have submitted to one or more recorded statements by the insurer and is later required to submit to an EUO. One such case that addressed the issue of whether submission to multiple recorded statements constitutes “substantial compliance” with a policy’s EUO requirement was

decided by the Washington Court of Appeals. The court held that a recorded statement is “fundamentally different” from an EUO because:

- A recorded statement is unsworn when it is made.
- Insurers, in practice, do not intend for recorded statements to substitute for EUOs.

The fact that the recorded statement is unsworn allows the investigator or claims professional to dig deeper to elicit responses that will enable them to conduct a more focused and detailed investigation into the information gathered in the recorded statement. Also, if the matter proceeds to trial, the insured’s or claimant’s credibility may be impeached with a transcript of the recorded statement, although it was not given under oath.

Therefore, the adjuster or investigator should not be concerned with obtaining every minute detail and piece of information during the insured’s preliminary statement, particularly since the statement is taken at the earliest stage of the investigation. Remember that a more detailed and thorough EUO will likely follow later in the investigation. Indeed, asking every conceivable question during the preliminary statement, and then repeating the same questions at the insured’s EUO, may later be construed as evidence of harassment or bad faith.

Perhaps the most elementary aspect of an investigation is the taking of statements. The question and answer format is probably the simplest method of obtaining and documenting information. Types of statements can range from the informal conversation, which is completely unrecorded (not recommended), to the EUO, which is typically conducted before a professional court reporter.

A good rule of thumb to remember when initially contacting someone to schedule an interview is that roughly 70% of people contacted by phone or mail will not readily agree to an initial interview.

Conversely, that number falls to roughly 30% if the individual is contacted in person first. The preferred method is to contact them in person and begin taking the statement as soon as it is practical to do so. However, the insured should be given notice and allowed a chance for a mutually agreeable time to be established. Once done, the investigator should document the file via a letter to the insured indicating the agreed upon time and place for the interview.

Taking an effective recorded statement is a challenging and often difficult task. In a face-to-face interview situation, complex social factors are at play. For the interviewer to succeed in obtaining the recorded statement, they must feel both confident and competent.

Recorded statements can be the most interesting part of the fraud investigator’s job. This comes from the face-to-face interaction between an insured or claimant who might or might not be committing

fraud and a determined professional who is committed to objectively investigating the claim and exposing any potential fraud. Taking recorded statements, and mastering that task, is an art that can only be sharpened through time and experience. Each statement taken is another opportunity to incorporate the skills the investigator already possesses and apply them to the facts at hand, which results in an effective and thorough statement. A good statement will save time and money in further investigation of the claim because the issues and areas of controversy will be more clearly defined than they would be in a stiff, “by the numbers” interview. An effective interview must adapt to the information volunteered by the insured or claimant and the interviewer must be willing to explore those avenues that might deviate from the “game plan.” In this fashion, the fraud investigator can use the insured’s or claimant’s statement to paint a more complete picture of the claim and streamline its future handling.

Statement Methods

The method of taking a statement really has two meanings—how the statement is documented and the way in which the questions are asked. Preferably, all statements should be recorded in some fashion, whether they are handwritten and signed by the witness or tape-recorded. In this way, there will be no question later as to what the witness stated. Moreover, statements are frequently taken long before the witness must testify in court. If the statement is recorded and later transcribed, the statement transcript can be shown to the witness to refresh their recollection of events that might have occurred years ago. Recording a statement or taking it in writing also avoids paraphrasing or construing the statement in an improper fashion. Instead, the answers are in the witness’s own words.

The way in which questions are asked can also be important. Since the investigation of a suspicious claim is supposed to be fair and objective, the questions should be open-ended, unlike in a deposition or at trial, where cross-examination might be appropriate. Cross-examination is the phrasing of questions in a leading manner as to suggest the answer to the question. For example, an open-ended question might be: “What color was the light when you crossed through the intersection?” In cross-examination, however, the question would probably be phrased: “The light was red when you crossed through the intersection, wasn’t it?” By asking open-ended questions, which do not suggest answers, the adjuster or investigator can avoid allegations that the statement was designed to elicit information which would support a denial of the claim—an assertion sometimes raised in support of bad faith claims.

As with every aspect of the investigation, statements should be conducted in a polite, professional, and business-like manner. However, particularly when taking the insured’s statement, the adjuster or investigator should keep in mind that the purpose of the statement is to ask questions, not answer them.

Most insurers have detailed scripts for adjusters and investigators to use in taking recorded statements. Most are quite good. The one problem with these scripts is that it is often very easy for the investigator

to read through the questions without ever stopping to listen to the answers. This is a problem that plagues many lawyers as well. The most effective recorded statements not only cover the essentials, but also gain explanations into answers that are initially left vague or unclear.

The fraud investigator must:

- Prepare well in advance of the statement.
- Listen carefully to the interviewee, while at the same time watching for nonverbal behavior that is inconsistent with the interviewee's words.
- Control the statement parameters and the surroundings.

Preparation

Proper planning beforehand greatly enhances the likelihood of a successful interview:

The following are suggested steps for taking the statement and things to bear in mind before speaking with the insured(s), claimants, or witnesses.

Investigators should remember that these statements are usually not sworn and that very few policies have a compliance clause that requires the insured(s) to provide a statement per se. This is especially important to remember with reluctant or combative insureds or claimants. Do not tell the insured or claimant that they must provide a recorded statement, because they don't have to. If the claim is legitimate, it is usually in their best interest to provide a statement to expedite the claims investigation process. This is especially important to remember when dealing with states that recognize the separate standing of innocent coinsureds. As is often the case, especially seen in arson or property theft cases, a spouse might have no knowledge of the crime and assume that their spouse doesn't either. Conversely, the spouse that committed the crime knows the innocent spouse either suspects or knows something about the act and will want to be present at the interview of the other. If this can be avoided, do so. If the investigator suspects this might be the case, it might be advisable to proceed directly to the EUO.

By thoroughly reviewing all of the file documentation beforehand, the interviewer already has answers to many of their questions. This allows the interviewer to focus on obtaining necessary information they do not already have and to confirm or refute any information already received.

If the information has not been verified before the interview, it is imperative that the interviewer determines the *standing* of the interviewee in regard to the policy. This is a critical piece of the interview. The interviewer must determine the interviewee's standing, or lack of it, in regard to the policy language to properly frame their questions. The interviewee may be any of the following:

- An insured
- An ex-insured

- An additional insured
- A coinsured
- A loss payee
- A mortgagee
- A contract beneficiary
- An unnamed beneficiary
- A partner or joint venture participant
- An estate holder
- A lien holder

Each of these parties has a different interest in the loss and their standing is determined by the policy language and the applicable laws of the state in which the claim is held.

Occasionally, the interviewer will be interviewing someone who thinks they have standing, but in reality, they do not. For example, a couple who was once married jointly bought property together that later is deemed a total loss. They were married at the time the property was purchased, but later divorced. As decreed by the divorce agreement, one of them waived their rights and interest to the property, but they now think that because it's a total loss they are entitled to half of the proceeds.

Proper planning is crucial prior to the taking of a recorded statement. This planning should include a thorough review of the claim file, new loss reports and diary notes, and background information, such as traffic records, driver's license records, and prior loss history, if available. It is only when the fraud investigator has a thorough working knowledge of the background information surrounding the claim that they are ready to begin identifying specific areas of inquiry or specific questions to address those areas of background or claim information that are inconsistent, incomplete, or unclear.

When specific questions are prepared, it is a good idea to list them in a logical sequence. However, the goal of preparation is to anticipate problem areas in the information already at hand and to flesh out the details of the claim to establish a starting point for a more thorough investigation of the claim.

Investigators should always avoid backing themselves into a corner by becoming too committed to a narrow series of questions for the insured or claimant. The investigator should anticipate that the recorded statement will almost invariably deviate from the outline prepared beforehand, sometimes rendering the most carefully drafted questions virtually useless. However, the outline keeps the investigator on track and reminds them of necessary information needed to be gathered from the statement.

When preparing questions to ask the insured or claimant during the recorded statement, the investigator or claims professional should word the questions in the most open-ended manner possible. The open-ended approach to interviewing will help the interviewer avoid answering their own questions because it requires questions to be asked in such a way that does not lead the interviewee toward an anticipated, specific response. The open-ended approach to questioning will also give the claimant or insured an opportunity to talk at length about their injuries, property damage, loss, etc. Most people like to talk about themselves, and the use of open-ended questions provides the insured or claimant the opportunity to do just that. In addition, a claimant might reveal information in their responses that they otherwise would not, had the scope of the interviewer's questions been too narrow.

This point is illustrated in the following questions, which can be posed during a recorded statement. They both concern the same incident, but the practical effect differs substantially:

"Where exactly were you when the fire started?"

"Please describe your activities on the day of the fire for the entire day."

The benefits of the open-ended approach are obvious in that it encourages the insured or claimant to go into greater detail to describe exactly how, when, and where the alleged injury took place or how any type of loss might have occurred. It also might inadvertently provide the interviewer with witnesses that can be contacted to verify time frames and alibis.

Another crucial aspect of the recorded statement is timing. A statement taken weeks, or even months, after the incident in question might be filled with speculation and inaccurate information as the claimant tries to recall what happened weeks or months ago.

In the case of a very complicated claim in which there is a complex set of information to be gathered, the detailed statement is crucial. If the investigator is extremely detailed in their questions regarding the property at the loss site prior to the loss, or income verification in the event of a business income loss, they have already roughly scoped the damages in many instances. If the claim is legitimate, this will speed up the investigation and aid in resolving the claim for the insured or claimant. If the claim is not meritorious, it can provide valuable information later for a denial of the claim or possible prosecution.

As a rule, the sooner a statement is taken from a claimant, the more accurate and reliable the information obtained will be. In addition, if a statement is taken prior to a claimant retaining an attorney, the investigator can avoid problems stemming from a wary and, inevitably, coached claimant or insured and the real possibility of running into dead ends during the interview.

Remember, however, if the insured or claimant has an attorney, the attorney has the right to be present at the time of the statement. Do not, however, allow the attorney to control the statement-taking process or to attempt to stonewall the investigation process. If the attorney cannot be adequately controlled, halt the statement process and consider conducting an examination under oath.

Listening

Since information given by the insured or claimant might deviate from the “list” or outline prepared by the interviewer prior to the recorded statement, it is essential that the interviewer listen carefully to everything the insured or claimant says in response to their questions. Without this ability, the recorded statement becomes little more than a race to the finish and not the invaluable source of additional information that will assist the claims professional or investigator in conducting a thorough investigation of a claim that it should be. Often, it is necessary to deviate from the outline prepared in advance to pursue avenues of inquiry started by the subject during the course of the recorded statement. Careful listening also allows the interviewer to catch subtle or not-so-subtle inconsistencies in the insured’s or claimant’s answers. Note-taking during the recorded statement is very important in that it allows the interviewer to focus on these inconsistencies and to ask for clarification. As noted earlier, the use of open-ended questions will go a long way in eliciting information from a claimant or insured when compared to narrow, “single answer” questions. Interviewers should try to use expressions during the interview such as:

Explain. Describe. How? How often? How much? How far? Who? What? Where? When? Why?

Each of these expressions helps the interviewer gather as much detail as possible during the statement. The details gathered from the interviewee help the interviewer complete a “puzzle” out of each of the pieces gathered from the interviewee. However, it is important that the interviewer does not try to construct the entire puzzle by making assumptions during the statement. Each piece of information fits into the puzzle somehow, but it is not possible to complete the puzzle until all of the pieces have been gathered.

Control

Prior to beginning the interview, interviewers should shake hands, introduce themselves, and provide a brief overview of the plan for the interview. During the statement, remove physical barriers and never impede the entrance or exit of the claimant or insured. The last thing an interviewer wants is for the interviewee to feel intimidated and then claim that their statements were coerced and against their will.

The investigator conducting the recorded statement must feel in control of the situation to be able to ignore any distractions generated by the surroundings and focus instead upon the information provided by the interview subject. Control is crucial in potentially “hostile” environments, such as the claimant’s

attorney's office or the insured's or claimant's home. One technique that can be employed to gain control in a situation in which the interviewer is at a disadvantage (e.g., the interviewer is alone with both the claimant and their attorney in the attorney's office), is where the interviewer requests that the person in "power" of the given situation (the attorney) perform a task for them. This could involve anything from getting a glass of water or a pad of paper before starting the recorded statement. This seemingly slight exercise of control over an unfamiliar and sometimes unfriendly situation could go a long way toward bolstering the interviewer's confidence and establishing a degree of dominance in a situation.

The statement location should be as neutral as possible. However, this is not always possible in cases with an insured who is at home or at their place of business. Although a statement needs to be taken as soon as possible from the date of loss, one shouldn't sacrifice obtaining necessary information just for the sake of expediency. Remember, the information is needed to conduct a timely and thorough investigation as required by the policy (contract). It will only extend the investigation and cause unnecessary delays for the insured if the investigator must keep getting follow-up statements and is gathering their information by piece-meal. Investigators should explain the importance of conducting a timely and thorough investigation to the insured, claimant, or witness so that they can understand the need for a controlled environment.

As the interview begins, do not set a specific timetable for the interview to end. Do not allow the interviewee to set the time frame for the interview. If the interviewer does set a time frame, they will not be able to explore areas that require further questioning and answers. Also, if the interviewee is being deceptive and having difficulty answering, they can stall and "wait out" the interview.

The interviewer should make sure to refer to their outline. These are questions they deemed important to have answers to before the interview commenced, so they should make sure they are answered. Listen to and hear the answers to the questions. If it seems as if the question is being answered but it really isn't, ask it again until an answer is given. Be firm but polite, and indicate that the question has not been answered or that clarification is needed of what was said.

An insurance investigator should make sure that they obtain more information than they provide during the statement taking process. Their job is to thoroughly investigate the claim and to provide assistance to the insured to resolve their claim in a reasonable amount of time. This is where knowing the standing of the individual being spoken with is critical. Avoid bad faith claims by not providing any information about the claim that someone is not legally entitled to know.

Interviewers must make a conscious effort to explore their own interviewing "weaknesses" beforehand. Some examples might include:

- Is the interviewer truly a good listener?
- Does the interviewer assume they already know the answer before they ask the question and hears the answer?
- Are they a seeker of truth or a seeker of deception?
- Does the interviewer consciously avoid becoming an extension of law enforcement?

Nonverbal Language

Listen to and observe the nonverbal behavior. This can help determine the truthfulness of a person. When no physical evidence exists, the fraud investigator must be subjective in their questioning and look for behaviors in body language that could be a sign that the interviewee is deceptive. Examples of behaviors to look for in an interviewee when interviewing include:

- Exhibits signs of dry mouth
- Fidgets
- Sweats in an air-conditioned room
- Plays with hair
- Constantly swallows
- Does not make direct eye contact

This behavior is just as telling, if not more so, as verbal behavior. As the interview progresses, the interviewer will observe what is normal and predictive nonverbal behavior and what is not. The interviewer can use this as an advantage to pursue areas in which the interviewee is not as comfortable. Again, bear in mind that one should not assume they already know the answer to any question or that the interviewee is being deceptive. They might not be practicing deception—they simply might not know the answer or are confused as to what is being asked of them.

When referring to their outline, interviewers should make sure to begin with open-ended questions and complete that line of questioning with specific, close-ended questions. Later, at an examination under oath (EUO), interviewers can ask follow-up questions, but it is important to get the interviewee to commit to some type of answer on the vital questions. If they are practicing deception, the statement may be used later to impeach their credibility.

If, during the interview, the interviewee makes statement(s) that the interviewer is certain are false, don't confront the interviewee right away. Allow them to continue talking and maybe compound the falsehood by making other false statements. The interviewer might not want to confront the false statements at all at that time, but choose to address them later at the EUO. If they do confront the subject with the apparent falsehood, they should start out by directly quoting back to them the response they believe to be false. After doing so, ask the interviewee if the statement was indeed heard correctly

and if this is what they said. This technique locks them into their statement and will negate a later allegation that the interviewer misunderstood or wrongly interpreted their answer.

Remember the following issues concerning material misrepresentations. A misrepresentation is material if:

- It is reasonably relevant to the insurer's investigation.
- It might have affected the attitude and subsequent actions of the insurer.
- The statement(s) were made to intentionally discourage, mislead, or deflect the company's investigation.
- The overall outcome, regardless of the true facts at the time, is not the issue, but rather the materiality at the time is the overriding issue.

Regarding *concealment*, the issues are somewhat different and can be characterized as the following in regard to the investigation and its subsequent outcome:

- The concealment must have been of material fact.
- The concealment may void the policy.
- The undisclosed facts were material to the risk.
- The insureds have a duty to disclose the pertinent and material information, whether or not they deem it to be material.

Witness Statements

Obtaining thorough and objective witness statements is critical in helping to determine whether a claim is meritorious or contains some element of fraud. Independent witnesses can corroborate or refute statements made by the insured(s) and the timeline of events, assist in determining the actual value of the property, help to locate additional witnesses, and provide background information regarding the insured(s) and their associates. Sometimes they are even able to provide tangible real evidence that can become crucial later on, such as photographs, contracts, receipts, and invoices.

In most investigations, witnesses who are not a party to the insurance claim will have relevant information. As with the insured, it is advantageous to record this information, whether in writing or by tape recording, through a witness statement. When taking such statements, however, care should be taken to avoid making pejorative or opinionated statements regarding the insured. Such conduct can give rise to claims for defamation, slander, and bad faith.

The insurance investigator should have a signed copy of their particular carrier's version of an "Authorization to Investigate" when speaking to witnesses. This needs to be signed by all affected

insureds and should be dated and legibly signed. This is particularly critical when seeking financial or employer information as the investigator will not likely be given this type of information without it. Pretext interviews are those that employ subterfuge to secure the confidence of a witness who might not otherwise agree to be interviewed. The Connecticut Insurance Information and Privacy Protection Act, Conn. Gen. Stat. Ann. § 38a-976(v), defines a pretext interview as follows:

Pretext interview means an interview where a person, in an attempt to obtain information about an individual, performs one or more of the following acts: (1) Pretends to be someone he is not, (2) pretends to represent a person he is not in fact representing, (3) misrepresents the true purpose of the interview, or (4) refuses to identify himself upon request.

Care should be taken to avoid unreasonable conduct when employing this tactic. While such interviews are not always permissible, they can be particularly sensitive and require extreme care to avoid the appearance of impropriety. Using pretext in any form is not recommended when interviewing a perspective witness because later at court, it could damage the insurance carrier's case. The jury might see the investigator as resorting to "trickery," thereby damaging their credibility. If the witness later tries to recant their earlier version of events, the use of pretext could bolster that assertion in the eyes of the jurors. It is recommended that investigators identify themselves up front to the witnesses as employees (or agents) of the insurance carrier and indicate that they are simply following up on facts surrounding the alleged loss.

Some possible witnesses to contact during an investigation include, but are not limited to:

- All witnesses identified by the insured(s)
- Family members
- Ex-spouses and other former members of the family
- Coworkers, both current and former
- Neighbors, both current and former
- Bankers, loan officers, loss payees, mortgagees, lien holders, etc.
- Business partners or ex-partners
- Insurance agents

It is imperative that the investigator contact and interview all witnesses identified by the insured. This is done for several reasons, including:

- The insured has identified these individual(s) as potential witnesses and as part of a good faith investigation they should be interviewed as soon as possible.
- The investigator and defense counsel need to know exactly what the witnesses are going to say and get them "locked in" regarding their statements.

- The face-to-face interview allows the investigator to “size up” the witnesses in terms of credibility, appearance, and how articulate they are. This is important to know later when determining how they might be viewed by potential jurors.
- If they end up refuting the allegations of the insured(s), their witness impact is very favorable. This is because the witness was provided by the insured, thus negating any allegations that the investigator was “out digging up witnesses” to undermine the insured(s) version of circumstances surrounding the alleged loss.

Family members should be spoken with as soon as possible to avoid them “getting their stories straight” if the loss is indeed fraudulent. The investigator should not assume that family members will automatically cover for the insured or claimant if the claim has an element of fraud. Often, just the opposite is the case. Some family members become fed up with what they perceive as scheming by the insured or claimant and are quite willing to talk to investigators. However, the investigator must exercise extreme caution during the interview and not say or imply anything that can be construed as disparaging about the insured(s), the claimant, or the claim itself. Remember the old saying, “Blood is thicker than water.” When it comes time later for a possible policy denial or a criminal trial, what once seemed a reliable witness might turn into an angry and willing adversary. The investigator should take whatever information they get from a family member and verify and independently corroborate the information or refute it as soon as possible.

Ex-spouses and former family members can often be excellent sources of information as witnesses. They might be able to provide detailed information about the insured’s or claimant’s background and prior schemes that are unknown to the investigator. They might have heard the insured or claimant hypothesize about the claim long before it took place and might be able to provide information regarding past or current associates that the investigator wasn’t aware existed.

Care must be taken not to coax ex-spouses or former family members if the investigator feels there is some underlying animosity toward the insured or claimant. There might well be animosity, but that doesn’t mean the information they provide isn’t true and accurate. Remaining objective and not “egging on” the ex-spouse or family member helps avoid any later allegations that might be made that the investigator was trying hard to “get the goods” on the insured or claimant. Conversely, any alleged antagonism by the ex-spouse or former family member toward the investigator might be contrived. This might be done merely to get the investigator to reveal information about the claim investigation thus far or to say something derogatory about the insured or claimant. Investigators must remain objective and neutral and assume that anything they say will be repeated to the insured or claimant.

Coworkers and neighbors, both current and past, should be interviewed regarding the claim, but only if there is a reasonable tie to the claim that can later be articulated by the investigator. The investigator

cannot go on a “fishing expedition” and interview anybody that might have ever known or associated with the insured or claimant. However, if the claimant has an alleged injury and there is reason to believe they might have been injured at work during the same time frame, then it is reasonable to seek out that information. On property claims, if the insured states they regularly used or purchased the item they now claim was stolen from someone at work, it is reasonable to explore that possibility.

All financial information needs to be followed up on and verified. There are many motives that induce someone to commit insurance fraud, but far and away, financial gain is the most often identified motive. As such, the investigator must show a financial hardship relief or monetary gain as the reason the insured(s) fabricated or exaggerated the loss.

When interviewing financial personnel, the investigator should seek to determine the following information:

- Was the insured current on payments?
 - Was there a second or third mortgage on the property? When was it taken out? (Get supporting documentation.)
 - Was the insured ever turned down for a loan request? If so, find out when and get a copy of the application.
 - Were there any foreclosures?
 - Have any credit cards been revoked or maxed out?
 - Have there been any instances of repossession?
 - Are the insureds cosigners for any other loans?
 - Any bankruptcies? (This should be known from running credit reports.)
 - Has any insured spoken to anyone at the financial institution regarding the alleged loss? If so, when?
- Interview each person independently.

Interview any current or ex-business partners as soon as possible. They, like ex-spouses or former family members, might have useful information. They will generally have an opinion regarding the character of the insured or claimant and might have had conversations themselves regarding the claim.

Caution should be exercised if the current business partner is eligible to make a claim but is represented by another carrier, which might be adverse. The investigator must make sure not to provide details that might later preclude subrogation or worse yet prejudice the current investigation.

The insured’s insurance agent is one who most definitely needs to be interviewed. The insured’s agent will be able to provide specific details regarding the coverage, notice of loss, and any recent changes to the policy at the behest of the insured. Often, the agent lives in the same area as the insured and might in fact be very familiar with them. However, caution must be exercised when interviewing the agent.

Remember, the insured is the customer of the agent. As such, the agent will want to discover as much information as possible regarding the claim. Do not share with the agent any information they are not entitled to receive.

As the agent is the product supplier and not an employee of the carrier, they are not entitled to the specifics of the investigation. Also, agents do not always know they are subject to becoming a witness and therefore subject to deposition and subpoena for trial.

When interviewing the agent or CSR at the agency, try to ascertain the following information:

- Specifics on how they received the first notice of loss
- If payments are made through the agency, was the insured current?
- When was the last time any endorsements or changes were made to the policy? What were they? Who requested the changes?
- Prior to the loss, had the insured requested a copy of the policy or asked questions regarding coverage?
- Obtain a copy of the application and specifically interview whoever took the application regarding specific answers to the questions.

As with any interview, any information received by the insured, claimant, or other witnesses needs to be verified, corroborated, or refuted. The statement is a powerful tool to be used if the claim eventually ends up containing at least some element of fraud.

VI. INFORMATION GATHERING AND LEGAL ISSUES OF SHARING

There are many legal rights and responsibilities that arise when a company's investigation coincides with a governmental investigation. There are several types of informational exchanges that take place during an investigation, including:

- Informal exchange of information between insurers and law enforcement
- Formal exchange of information between insurers and law enforcement pursuant to immunity laws
- Inter-company exchange of information
- Access to the loss site
- How the state's investigation can help or hinder the company's investigation

Immunity Reporting Acts

What Are Immunity Reporting Acts?

Immunity reporting acts vary from state to state, but in general they provide for two things. First, they require the insurer, upon request from a designated agency or official, to turn over reports, records, and other items produced during, or pertaining to, the investigation of a loss in which the insurer suspects fraud. Second, they provide some form of immunity for the insurer from prosecution and civil liability for releasing such records. Immunity can be a powerful weapon to defend against civil suits brought by insureds for claims such as libel, slander, and malicious prosecution.

What Is the Scope of the Immunity?

In one case, the insureds accused the insurer of having “instigated and assisted a criminal prosecution” against the insureds for arson. The insureds filed an action for malicious prosecution against the insurer. The court noted that state laws vary on this issue, but under Virginia law, when a defendant swears out an arrest warrant, the defendant’s “participation” is a requisite element for a malicious prosecution action to go forward. When the defendant does not take an active role in the prosecution, but merely cooperates with the investigation, the defendant’s actions are not sufficient to constitute actionable participation.

The insureds alleged the insurer “conducted a biased, result-oriented investigation; turned over the results of the investigation to law enforcement officials; eagerly supported and encouraged the prosecution of the charges; and then testified about the misleading results of their investigation at [the insured’s] criminal trial.” The Virginia court found these allegations were sufficient for a charge of malicious prosecution to go forward.

The insurer contended that Virginia's Arson Reporting Immunity Act rendered the insurer immune from the malicious prosecution action. The court noted that the state had requested a copy of the adjuster's report by letter. The court found that the immunity Act did not protect any communications before that date. Also, because the state only requested the adjuster's report, the immunity afforded by the Act extended no further than to that report. Finally, the court found that the Act did not provide immunity for a release of information made with "actual malice," and the court gave the insured leave to amend his complaint to allege actual malice. Virginia is not alone in exempting the release of information made with "actual malice" from the general grant of immunity. If the governing state has no limitations, then the immunity afforded by the statute may completely absolve insurers from malicious prosecution claims.

The immunity granted by the Virginia Act did not extend to all communications between the insurer and the state; rather, only those communications made after the state's request and those specifically responsive to the state's request were protected. In many states, the Act authorizes and protects disclosures made on the initiative of the insurer.

Note that because a statute provides immunity to insurers only to the extent that they act in good faith does not mean that an insured can automatically maintain a suit for malicious prosecution. For example, Maryland's reporting statute provides for immunity from civil liability for insurance fraud where the person reporting the fraud acted in good faith. In one case, the insurer suspected that the insured made a fraudulent injury claim and reported its suspicions to the Maryland Insurance Administration. The Administration ultimately declined to prosecute the insured, and the insurer took its suspicions to the police. The insured was indicted, but the trial judge granted his motion for acquittal. Undaunted, the insurer took the evidence it collected regarding the insured's fraud to the state's attorney, and apparently contacted the insured's employer, who in turn fired the insured. Another grand jury indicted the insured, but again the court granted a motion for acquittal. The insured sued the insurer for, among other things, malicious prosecution. The trial court granted the insurer's motion for summary judgment on the malicious prosecution claim, concluding that the evidence proffered by the insured did not "show the lack of good faith necessary to maintain the action."

The appellate court noted that the declination of the state insurance administration to press charges did not constitute a conclusion that there was no fraud. The court also noted that the state's attorney concluded there was sufficient evidence of fraud to present the case to the grand jury. Finding "no evidence of 'a dishonest purpose or some moral obliquity,'" the appellate court affirmed the summary judgment.

Do Immunity Acts Make Insurers an Agent of the State?

THE FIFTH AMENDMENT

Because a criminal investigation and an insurer's investigation are often simultaneous, an insured might want to claim the Fifth Amendment privilege against self-incrimination at an examination under oath (EUO). However, most courts will not permit the insured to both invoke the privilege at an EUO and seek to recover insurance benefits without fulfilling the obligation to submit to questioning under oath.

The amendment provides in part that "no person... shall be compelled in any criminal case to be a witness against himself." This is true even though generally one who invokes the privilege cannot be penalized for that invocation, as such a penalty would create an impermissible compulsion to testify. The most common reason for this distinction offered by the courts is that the state is not compelling the testimony, but rather the insured's own contractual obligation.

State laws that require an insurer to disclose to the state what it learns during its investigation add a new layer to this line of cases. If the insured invokes the Fifth Amendment during their EUO, the insurer may assert a lack-of-cooperation defense. Depending upon the jurisdiction, this might or might not hold as a *breach of policy*.

The underlying issue is whether the insurer is a conduit for a governmental agency to proceed with a criminal investigation based upon the information the insurer obtains at the EUO.

THE FOURTH AMENDMENT

Along these same lines, an insured might argue that the entry of private insurance investigators onto their property, without a warrant and without the insured's consent, might violate the insured's Fourth Amendment rights. In a Connecticut case that addressed this specific issue, the trial court held that the insurer's investigators were agents of the state and therefore violated the insured's rights. In support of its ruling, the trial court noted that the policy of turning over insurance reports to the state was required by Connecticut's Immunity Reporting Act; that the state police would sensibly want to see the reports; and that the state fire marshal typically requested fire scene investigation reports from insurance companies, incorporated those reports into the marshal's file, and then provided them to the prosecutor's office.

The state argued that the trial court found that the insurer was an agent of the state by Connecticut's Immunity Reporting Act. The appellate court found that the Act did not require insurance investigators to act for the state or to investigate in any specific way. The court noted further that the statute did not require insurers to investigate every fire, nor did the statute indicate that insurers have accepted such an endeavor. Finally, the statute did not provide that the state exercised any degree of control over insurers in conducting cause and origin investigations. Accordingly, the court concluded that the Immunity

Reporting Act did not create an agency relationship between the insurer and the state by operation of law. Because the Act did not create an agency relationship as a matter of law, the court turned its attention to whether the facts of the case supported an agency relationship. There is no bright line test for determining whether a private citizen or other entity is acting as an agent of the state.

Some factors used to determine if a private citizen or other entity is acting as an agent of the state include whether the action was initiated by the private citizen or entity, who decides whether “the fruit of the action” is given to the state, who determines the way in which the action was conducted, and whether the private citizen or entity receives an inducement from the state.

The court found no evidence in this case that the state coerced, suggested, or initiated the insurer’s investigation. Instead, the court found that the investigators acted at the behest of the private insurers. The court also found that there was no evidence that the state maintained any control over the insurer’s investigation, noting that while the Immunity Reporting Act required the insurer to turn over its investigative reports, the Act did not require any investigation at all. Finally, the court found that while the trial court’s factual findings were largely correct, they did not equate to a finding of agency.

CIVIL RIGHTS CLAIMS UNDER 42 U.S.C. § 1983

Section 1983 of Title 42, United States Code, allows individuals to bring a claim against state actors, acting under color of state or local law, alleging a deprivation of civil rights guaranteed by the U.S. Constitution or federal law. To state a claim under section 1983, a plaintiff must allege: (1) that they have been denied a right guaranteed by the Constitution and the laws of the United States, and (2) that the defendant(s) deprived them of that right while acting under the color of state law.

WHO IS POTENTIALLY LIABLE?

Corporate defendants are generally not vicariously liable under section 1983 for the acts of their employees. Rather, corporate defendants are liable only where the plaintiff shows that their employees acted pursuant to corporate policy or custom. It is not enough to show that an insurance investigator acted pursuant to an insurer’s policies or customs in investigating a fire; rather, the inquiry is whether the alleged unconstitutional acts were performed pursuant to such policies or customs. The upshot of this is that an insurer will generally not be liable under Section 1983 for its investigator’s actions. However, an investigator could be so liable under certain circumstances.

One court held that where the insured alleged the insurance investigator acted in concert with state law enforcement officers to maliciously prosecute them, the insured presented a jury question on whether the investigator and the officer conspired to maliciously prosecute the insured. If the jury so found, the investigator was considered a state actor for section 1983 purposes.

WHETHER IMMUNITY ACTS CREATE STATE ACTORS FOR PURPOSES OF SECTION 1983

In one Wyoming case, the insured argued that the insurer “promoted” the arson prosecution of the insured and therefore violated the insured’s civil rights. The insureds argued that the insurer “secretly provided” portions of their investigative findings to the state and withheld exculpatory evidence. In support of their argument that the insurer acted under color of state law, the insureds cited the Wyoming Arson Reporting Immunity Act. The Supreme Court of Wyoming found that the “supplying of information concerning suspected arson to state authorities, standing alone, is not enough to amount to ‘joint activity.’” The court cited the “two-part approach” to determine whether a given action was done under color of state law. First, the deprivation must be caused by the exercise of some right or privilege created by the state or by a rule of conduct imposed by the state. Second, the party charged with the deprivation must be a person who may be fairly said to be a state actor. The court found that the insurer’s conduct did not satisfy either aspect of this test. The insurer was not exercising a right or privilege created by the state, but was rather complying with a requirement of the state. Second, the insured did not allege that the insurer acted together with or received aid from state officials. Accordingly, the court affirmed the trial court’s grant of summary judgment for the insurer on the insureds’ section 1983 claim.

The elements of a section 1983 malicious prosecution claim have been defined as follows:

- The defendant commenced a criminal proceeding against plaintiffs.
- The proceedings terminated in plaintiff’s favor.
- There was no probable cause for the criminal proceeding.
- The criminal proceeding was initiated due to actual malice.

Although an insurance company is not generally considered to be a “state actor,” the court held that an insurance investigator may be considered a state actor if they “joined as a willful participant in a joint activity with the state.”

COMMON LAW FRAUD

The elements of common law fraud are straightforward. They include:

- A misrepresentation by the insurer
- Which the insurer knows to be false
- Which the insured justifiably relies upon to their detriment

Remember, each jurisdiction is different and the investigator must remain abreast of the latest rulings in their state.

Public Records Laws

Many states have very broad public record laws. Florida is a prime example; all public records in Florida are open for personal inspection by any person. Fla. Stat. § 119.01 (2003). Florida's public records law "excludes any judicially created privilege of confidentiality and exempts from public disclosure only those public records that are provided by statutory law to be confidential or which are expressly exempted by general or special law." In other words, unless the Florida statutes expressly exempt a given public record from disclosure, it must be disclosed.

"Public record" is broadly defined in most states as "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software or other material, regardless of the physical form, characteristics or means of transmission made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency."

Suspected arson cases are often the catalyst for requests that do not necessarily involve only public records. The state fire marshal or any law enforcement officer who might be investigating a loss caused by fire may request any insurance company or its agent, adjuster, employee, or attorney investigating a claim under an insurance policy or contract with respect to a fire to release any information whatsoever in the possession of the insurance company or its agent, adjuster, employee, or attorney relative to a loss from that fire. When this happens, the insurer is normally obligated to release the available information to and cooperate with any official authorized to request such information pursuant to the cited state section. The information normally falling within the scope of this section includes, but is not limited to:

- The policy
- The premium payment records
- Records of previous claims
- Material gathered during the investigation, including witness statements and proof of loss
- Memoranda, notes, and correspondence pertaining to the investigation of the loss in the possession of the insurance company or its agents, adjusters, employees, or attorneys

Basically, a public record includes anything "received" by an agency "pursuant to law or ordinance or in connection with the transaction of official business by any agency." Upon its request, the state fire marshal or other state agent receives, pursuant to law or in connection with the transaction of official business, all documentation of an insurer's investigation, including confidential memoranda authored by its lawyers. Thus, the information the state fire marshal receives from an insurer during a fire investigation is a public record. As such, it must be disclosed to anyone who requests it, *often including the insured*, unless a statute exempts it from disclosure.

Florida, for example, has statutes that provide for a limited exemption to the public records law for this information. Fla. Stat. § 633.111 (2003). Specifically, the records are exempt from the public records law

“until the investigation is completed or ceases to be active.” An investigation is “active” so long as it is being conducted by the department with a reasonable, good faith belief that it might lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department is proceeding with reasonable dispatch, and there is a good faith belief that action might be initiated by the department or other administrative or law enforcement agency.

Conversely, if an investigation is no longer active, the items received are no longer exempt from the public records law. While most of the material insurers disclose to the state fire marshal is subject to civil discovery in most states anyway, some items, such as memoranda reflecting the insurer’s mental impressions, letters from the insurer to counsel seeking legal advice, or reports prepared in anticipation of litigation, would ordinarily not be discoverable. Understandably, insurers do not want insureds in an adversarial posture to have these items.

Some states have found that the work-product doctrine and the attorney-client privilege are not exceptions to the public records law. An insurer could argue that the statutory provision preserving all privileges must mean something and allowing an insured to receive otherwise privileged documents as public record would effectively nullify that provision. In response, an insured could argue that a client generally waives a document’s privilege by disclosing the document to an individual who is outside of the attorney-client relationship.

It is important to note that insurers that simply refuse to cooperate with the state fire marshal’s or authorized law enforcement agency’s request for information do so in violation of law. Moreover, some courts have held that failure to comply with Immunity Reporting Acts may be considered evidence of an insurer’s bad faith.

Other insurers ask the state fire marshal for the documents back when the investigation is complete, and the state fire marshal agrees to do so in many cases. This is also precarious by nature. The state fire marshal is supposed to keep a record of all fires investigated and all facts and evidence concerning those fires. Simply turning over public records back to the insurer violates the storage and disposal provisions of some states’ public records law.

In some states, this may subject the state fire marshal to fines, possible criminal prosecution, attorney’s fees, and suspension or removal from office. Moreover, someone could simply demand the record from the insurer to whom the record was returned. In Florida, for example, the insurer must turn over the records to the state fire marshal within ten days of the demand or be subject to fines and criminal prosecution. Fla. Stat. § 119.10. Other insurers have filed lawsuits to enjoin the state fire marshal from disclosing confidential materials. Insurers have had some success in getting the state fire marshal to

agree to the entry of an injunction. These injunctions might not have any legal force at all, as courts cannot create exemptions to the public records law.

The injunction route is effective (so long, at least, as nobody challenges it), but somewhat cumbersome and expensive. When the insurer receives a request from the state fire marshal for investigative records, the requests are often quite broad. An insurer with a good relationship with the state fire marshal should contact the investigator's office and ask what they really need and convey the insurer's concerns over sensitive documents. These discussions are usually considered confidential. Often, the insurer can convince the state fire marshal to narrow the request and can come up with acceptable ways to provide the state fire marshal with the information it needs and protect confidential records at the same time.

Reciprocal Information Exchange

While all state immunity reporting laws provide that an insurer must respond to a request for information from the state, some states provide for a reciprocal exchange by which the state must also share information with the insurer.

Disclosure

Insurance companies are understandably concerned about extra-contractual liability. While contract damages are usually limited to a defined amount, extra-contractual damages are often measured in the millions of dollars.

When dealing with SIUs and police interaction, several issues are pivotal, including the following.

Bad Faith

Many states have enacted bad faith statutes. Still others have recognized a common law tort of bad faith. "Bad faith" on the part of an insurer is any frivolous or unfounded refusal to pay the proceeds of a policy; it is not necessary that such a refusal be fraudulent. For the purposes of bringing action against an insurer for failing to pay a claim, such conduct involves a dishonest purpose and means a breach of a known duty (i.e., good faith and fair dealing) through some motive of self-interest or ill will. Mere negligence or bad judgment does not constitute bad faith.

Malicious Prosecution

Most states recognize a common law tort of malicious prosecution. The most commonly cited elements of malicious prosecution are:

- Criminal charges are initiated or procured by the insurer.
- The criminal prosecution is resolved in a manner that is favorable to the insured.

- No probable cause existed for the initiation of the criminal proceedings. Probable cause is defined in some jurisdictions as a reasonable ground of suspicion supported by circumstances sufficient to warrant an ordinary, prudent person in the same situation in believing that the party is guilty of an offense. Probable cause does not depend upon proof beyond a reasonable doubt, but upon the honest and reasonable belief of the party alleging criminal conduct.
- The insurance company initiated proceedings with malice.

Section 1983

As stated above, to prevail in a claim under section 1983, the plaintiff must prove two critical issues:

- That they have been denied a right guaranteed by the Constitution and the laws of the United States
- That the defendants deprived them of the right while acting under color of state law or authority

Common Law Fraud

There are three elements of common law fraud:

- A misrepresentation by the insurer
- That the insurer knows to be false
- That the insured justifiably relies upon to their detriment

This is straightforward. If an insurer or its agent made a misrepresentation to the insured knowing it to be false and the insured acted upon that misrepresentation resulting in their detriment, the insurer is liable. This is the essence of bad faith. When sharing information with law enforcement or other carriers, the investigator must ensure that the information they are sharing is true to the best of their knowledge and belief.

When sharing information with other carriers, the rule is simple. Make sure that the state in which the loss occurred provides, by statute, for such a transfer of information. Use a form that is expressly for that purpose and make sure that the person receiving the information is authorized to receive it.

CONDUCT GIVING RISE TO LIABILITY

In support of their extra-contractual claims, plaintiffs have utilized a variety of different allegations of conduct. The following examples of conduct might give rise to extra-contractual liability:

- SIU personnel conduct an interview jointly with police. The interviewee later claims to have only given the statement under duress by both the SIU agent and police officers.
- SIU personnel recommend unreasonably delaying payment of the claim until something “pops up” from queries with other sources where information is being exchanged.

WORK PRODUCT

The work-product privilege relates to information known or prepared by a party or attorney in anticipation of litigation. Work product can include references to the mental impressions, conclusions, opinions, notes, summaries, legal research, or strategies of the party or its attorney. The scope of protection afforded by the work-product privilege varies between federal and state law. Work product is constantly being challenged in the various courts—the investigator must stay abreast of recent developments.

In state court actions, the preparation of a document in anticipation of litigation will not automatically defend against disclosure. However, discovery cannot include mental impressions, conclusions, or opinions regarding the value or merit of a claim, nor should it include references to the strategy or tactics to be used by the party during litigation.

In federal court, discovery of trial preparation materials is governed by Federal Rule 26(b)(3). Under this rule, trial preparation documents may be disclosed only upon a showing that the party seeking the discovery has “substantial need” of the materials and that prejudice will occur without disclosure. The rule further provides that the court must make every effort to protect against disclosure of mental impressions, opinions, conclusions, and strategies of an attorney or other representative of the party involved in the litigation.

Generally, courts have held that investigative reports of an insurance adjuster or investigator are discoverable. Therefore, those reports must remain objective, based on fact, and not include the investigator’s personal bias in any form.

ARSON AND FRAUD REPORTING STATUTES—IMMUNITY

Many states have enacted legislation that requires insurance companies to notify law enforcement agencies where there is evidence of arson or insurance fraud.

Several of these acts provide immunity to an insurance company that complies with the provisions of the act. However, care must be taken to comply with all of the requirements of the act. For example, Pennsylvania’s Arson Reporting Immunity Act requires that information be requested in writing and that the insured be notified within certain time parameters following disclosure of information. When the mandates of the law are followed, the insurance company is generally immune from any bad faith claims based upon such disclosure to the proper authorities.

Generally, failure to comply with notice requirements found in an arson reporting statute will void any immunity granted by the statute.

Recommended Procedures for Disclosure

It is recommended that the following procedures be utilized whenever information is requested by law enforcement from the insurer:

- An effort should be made to ensure that all materials regarding the file are gathered together at one location. If there is an adjuster's file, underwriting file, or agent's file maintained apart from the SIU file, all original documents should be gathered together and maintained at one location.
- The preparation of disclosures and responses should not be entrusted solely to administrative personnel. The final product should be prepared or reviewed by management and legal counsel.
- The compilation of records should be reviewed to ascertain if any documents are privileged under the attorney-client privilege or work-product doctrine.
- At no time should proprietary information, such as manuals, operating procedures, checklists, or instruction forms, be disclosed voluntarily. Management or legal counsel should be consulted before a response is made to any such request.
- Once privileged or otherwise protected information is removed from the documentation to be disclosed, the remaining information should be copied twice. One copy should be forwarded to the law enforcement agency and a second copy should be retained so that the insurer knows in the future what specifically was disclosed.
- A cover letter should be sent to the law enforcement agency along with the documentation. A general statement that certain items were withheld should be included within this letter; it should also state specifically what was withheld.
- If an insurer is requested to give an opinion or recommendation to law enforcement, they should decline to make such a recommendation.

Immunity Reporting Acts keep the lines of communication open between public and private claims investigators. The specific language of the Acts at issue will determine the extent of the insurer's immunity. Careful practice dictates that an insurer should assume that only those disclosures made in good faith will be immune from potential suits. Compliance with immunity acts in itself does not appear to convert an insurer's actions into state action. This is crucial because the law constrains many aspects of state activity but does not infringe upon private actors undertaking the same activity. The best rule to remember is that if the investigator is unsure as to whether to release information—*don't*. Once they have released the information, the Act cannot be rescinded. Seek advice first from legal counsel, other SIU personnel and claims professionals, or the prosecutor's office. Investigators should not put themselves and their companies at risk just to be accommodating to others. Exploring all the options and consequences beforehand will help investigators make an informed, not impulsive, decision.

Ethics and Insurance Fraud

Ethical behavior is required of both the insurer and insured. It is by applying good faith that both parties can maintain a system that works. *Ethics* is the process of continuously applying and using concepts of right and wrong behavior. Ethical values within an organization impact the success of the organization. When ethical behavior is displayed by all within the same department and organization, any attempts to conduct fraudulent acts is reduced. Demonstrating high ethical and moral standards is needed for insurance companies to survive. Along with the insurers, the insureds must also display ethical behavior to help their insurers maintain success. This can help ensure that there is a win-win for both parties. Some states have attempted to reduce insurance fraud on the part of the insurer by enforcing the Fair Claims Practices statute under the state's insurance code. For example, California Insurance Code §790.03 lists several acts that the legislature considers unethical and an unfair claims practice.

Information Gathering

Fifteen years ago, insurance investigations were conducted a little differently than they are today. Investigators performed the usual field investigations but relied heavily on expensive subscription databases to obtain background information about the subject of their investigations. While subscription databases are still being used, their role has slightly diminished. The commercialization of the Internet has not only affected the how insurance investigations are conducted, but their cost as well.

Investigators cannot rely on the Internet as their sole source of information, but it is another valuable tool in the fraud fighter's toolbox. In fact, many life and health insurance carriers are effectively using the Internet, in conjunction with more traditional information-gathering techniques, to obtain background information, confirm representations made by insured individuals, and investigate potential cases of insurance fraud.

However, simply logging on to the Internet does not guarantee success for an investigation. Insurance investigators must possess a strong working knowledge of the Internet and use superior research, information-gathering, and investigation techniques. Skilled Internet investigators navigate freely through the Web's inner passages, often finding the information they are after. Thorough Internet investigations might uncover the information necessary to deny a false claim, close a fraudulent claim, or refer a claim to the state department of insurance under mandatory fraud-reporting requirements. Information obtained from the Web has been accepted by prosecutors' offices in criminal cases, and with proper evidence-gathering techniques, might be sufficient to establish the probability cause necessary to initiate further law enforcement investigation.

Claims analysts and investigators are effectively using the Internet to obtain information about businesses, work activity, physical activity, and hobbies that might contradict an insured's representations

or stated limitations and restrictions. Additionally, analysts have found it to be a helpful tool when reverse-searching telephone numbers that an insured or anonymous tipster calls from.

The following are a few useful tips for conducting effective Internet research:

- The investigator should think about what they are searching for before doing it.
- Use a well-established search engine.
- Use more than one search engine.
- Be comfortable using the search engine.
- Review the results.

Think About the Search Before Doing It

Preparation is the key. Before surfing the Internet, think about the information that is available and the words, phrases, or names that most accurately describe what is being looked for. Does the subject belong to any professional trade associations? Do they have professional licenses? What hobbies do they participate in? What are their interests? How common is the name being searched? When name searching, would it be beneficial to use a full name?

Once a search strategy has been formulated, decide whether it is important to use search engine features that limit responses to the search. If so, what words, symbols, or phrases would be most effective?

Use a Well-Established Search Engine

Once the pre-search analysis is complete and the investigator has a strategy, it's time to search. One of the most important keys for success is using a well-established search engine. According to Cynthia Hetherington, principal of Hetherington Information Services, a New Jersey-based Competitive Intelligence and Business Research consultancy: "Five years ago, there were over 800 million indexable web pages on the Internet. While the number of indexable web pages has steadily increased over time, investigators should use the search engine containing the largest database with full text imaging, not just meta tag indexing." For more information about which search engines to use for Internet investigations, Hetherington recommends www.searchenginewatch.com, which contain useful information about search engine rankings and features.

Use More Than One Search Engine

We all use our favorite search engine regularly, but relying on one search engine isn't the most effective investigative technique because each indexes its information differently. Consider that one is looking at a claim file with numerous red flags suggesting that an insured is operating a business. They call the city business-licensing department and finds no business licenses under the claimant's name. They also conduct an initial Internet search using Google without success. Instead of discontinuing the investigation, the investigator expands their search using additional search engines.

While querying the ninth search engine, they find documentation confirming the red flag, which then uncovers government records referencing the insured's business. This is not uncommon. Routinely using more than one search engine to conduct Internet research dramatically increases the chances of being successful and finding useful information. Google is one of the most popular Internet search engines, but Hetherington says, "using more than one search engine is necessary because Google only captures 1% of the Internet, including the deep Web."

When conducting research, also consider using an Internet search portal such as www.crimetime.com or www.searchsystems.net.

Know the Search Engine

It is important to know how the search engine works because they are all different. Hetherington suggests reading the search engine's advanced instructions for search tips. To narrow down the information retrieved by the query, use the search engine's limit features, symbols, and more than one phrase in the search. Routinely use quotes around search phrases to ensure that only the exact phrase that the investigator is interested in will be returned.

Review the Summaries

Internet searching can be time-consuming, tedious, and frustrating, often leading investigators down the wrong path. Rather than clicking on each hit to determine whether it pertains to the requested subject, reviewing the summaries associated with the results is an excellent way to quickly and efficiently evaluate them.

Use Alternate Search Strategies

Investigators using basic Internet research techniques often give up when they fail to produce results. This is the time to expand the search. There are many alternate search strategies that are effective and likely to produce results as well. The following are some other useful suggestions for finding information about the subject of an investigation:

- Name variations
- Physical addresses
- Email addresses
- Phone numbers
- Names of persons associated with the claimant

TRY NAME VARIATIONS

Search all variations of the claimant's name. For example, if the claimant is named Robert, search all derivations of that name: Robert, Bob, Rob, Robby, Bobby, etc. Search nicknames as well. A person named John might use the name Jack. Checking all name derivations is an effective investigative

technique and greatly expands the search capability. When searching common last names, consider adding extra words or phrases to narrow down the results returned. Searching “John Smith” returns more name possibilities than an investigator can reasonably review. So, add a descriptive word about the individual and search again. Search “John Smith” San Francisco or “John Smith” and San Francisco to further narrow down the results. If the investigator still has too many results, they should narrow it down even further by adding another phrase. Try “John Smith” and San Francisco and Architect or “John Smith” San Francisco Architect.

If the subject’s name has been typed into the search engine with no results, try adding a middle initial, for example “John Q. Public.” If that doesn’t work, switch it around. Enter the subject’s last name, then the first name with a space between. Put the name in quotes, “Smith John.” Hetherington says, “Most search engines respect the space, so no comma or period is necessary between names or after initials as long as there is a quote around the entire word or phrase.”

SEARCH PHYSICAL ADDRESSES

The investigator should check all physical addresses that they have access to. They might find results under a subject’s home address and not their name. They might also find information under old addresses that were later developed. Try all derivations and abbreviations of the street address.

SEARCH EMAIL ADDRESSES

Check all known email addresses. This is valuable in case the subject is computer literate and is corresponding over the Internet or involved in any usenet or newsgroups. Newsgroups contain electronic messages that are posted to a central server by users with common interests. There are thousands of newsgroups on the Internet to which the subject might subscribe.

If email searching reveals that the subject has subscribed to newsgroups, search their postings for background information about them. The subject’s postings might reveal quite a bit about their daily activities and how active they are. Information contained in newsgroup postings has also been instrumental in determining what dates are the most conducive for conducting surveillance.

SEARCH PHONE NUMBERS

Check all known phone numbers. Investigators can enter telephone numbers without enclosing the area code in brackets just as they do not need to use commas in their searches. Enter the telephone number with spaces: “503 555 1212.”

CHECK NAMES OF PERSON ASSOCIATED WITH THE CLAIMANT

If searching under the subject’s name is unproductive, try searching under the name of a person associated with the subject, such as spouses, family members, or business associates. This is important

because subjects might establish businesses under spouses or family members' names to avoid detection by the insurance company. Using this technique is also valuable to the investigator because it might periodically find photos of subjects and their spouses on the Internet vacationing in some exotic location or performing activities they claim they are unable to do.

Besides trying to get additional information about the subject and their daily activities, background searching might yield valuable information about their business activities. This is often material if the insured is working or operating a business and the disability policy requires them to declare all sources of income.

Domain Name Searching

If the investigator's research uncovers that the subject might have a website, check the website's domain name registration to obtain the name of the individual who registered it, the registration date, and the registrant's contact information, if available. While there are many different domain registrars, a simple "who is" search at www.networksolutions.com is a good starting point. Domain name registration information is significant and compelling evidence. It might also be useful in determining whether an insured's business activity rises to the level of material misrepresentation or material omission, which could be important in a disability claim.

Historical Website Information

If the investigator finds that the insured has a website and is interested in determining how it has looked historically, they can visit archive.org/web and enter the website address into the WayBack Machine, which will produce a listing of dates the insured's website was captured by the Internet archive.

They can click on each of the historical dates and see exactly how the site looked on that date. This is particularly valuable in cases where the insured claims to never have had an active role in the business or was not involved with the business until recently.

Secretary of State Records

Most states have their corporation records available online. Investigators should get what they can online from the states that make those records available for free and revert to their subscription databases to check the ones that do not.

City and County Business Licensing

Larger cities and counties are more likely to have their business licensing or assumed business name information available online. This writer's experience suggests that it is not worthwhile to try to get this information online from smaller cities, except to get the correct telephone number to call for the information. Smaller cities usually require a manual search.

Newspaper Searches

Online newspaper sites are a great resource for investigators. Insureds have been interviewed about their activities, hobbies, and new business ventures, and now this might be what the lead investigators are looking for to continue their investigation. Investigators should find a newspaper portal they enjoy and become familiar with it.

Professional Licensing

Investigators can go directly to a state's website to look for the information they are after, but if they're unaware of where to find it, using a portal such as www.searchsystems.net might be helpful.

UCC Filings

This is a real gold mine. Most states have their UCC filings available online, and searching these records is often very effective in certain types of life and health investigations. Why would an insured who is claiming to be disabled have a UCC filing that indicates they financed the kitchen equipment necessary to open a restaurant? While not all UCC filings indicate an insured is operating a business, they might be indicative of increased physical activity. For example, an insured claiming a disabling back condition was recently found in UCC filings to have financed a 30-foot horse trailer. While online UCC records might contain some of the information an investigator needs, a follow-up phone call to the creditor often results in additional information about the transaction that was not available online.

Treat All Information Obtained as a Lead

Things aren't always what they appear to be, and information found on the Internet is no different. Because this information is potentially misleading, it is imperative to confirm all information obtained from Internet research through official public record sources or additional investigation.

Summary

No matter what Internet research and investigation techniques the investigator uses, planning and persistence are imperative. Investigators should keep digging until they find what they're looking for. Once they find it, they should document it. It's easy to get lost while searching the Internet. There is an overwhelming amount of information available, and it is not uncommon for one to find what they're looking for but forget how they got there. If investigators are convinced there is information online that might be valuable to their investigation, but they can't find it, they should consider using the services of an outside research company.

VII. CONDUCTING SURVEILLANCE

Surveillance is a tool that insurance investigators use for a variety of purposes. There are different types of surveillance and different instances in which they are used. Some of the reasons for using surveillance include:

- Determining the extent of a claimant's alleged injuries
- Locating property allegedly stolen or destroyed
- Locating witnesses
- Determining claimant identification where previously unknown
- Locating a health care provider to verify treatment

Each one of these types of surveillance has its own unique applications. Depending on what information needs to be obtained, one or a combination of these may be used.

As with anything that may be considered by the courts to have the propensity to be intrusive by nature, there are several issues to consider. They include, but are not limited to:

- Is there a justifiable reason for conducting the surveillance?
- Who will be conducting the surveillance: in-house employees or vendors?
- Has the state in which the surveillance is occurring enacted "stalking laws?"
- Will access to the results be limited to only a few key individuals?
- Is the risk in this case worth the potential gain?
- Does the requesting insurance company have a policy for conducting surveillance, either by in-house personnel or by vendors?
- Is there a plan for what needs to be accomplished as opposed to a blind surveillance effort?
- Is there an alternative investigation strategy that could accomplish the same thing as surveillance without incurring the risk?

Surveillance is the planned observation of people, places, or objects. It is normally concerned with people. Places and objects being observed are usually incidental to the primary interest of gathering information about certain people.

There are laws governing surreptitious audio and video recordings. In some jurisdictions, it is unlawful to make an audio recording or to listen in on a conversation unless one of the individuals involved in the recording is a party to that conversation. In other jurisdictions, it is lawful to record any conversation if one party to the conversation consents.

Recording conversations with eavesdropping devices (supersensitive microphones that listen from behind closed doors, for example) is usually illegal. People behind closed doors have a reasonable

expectation of privacy. Videotaping or photographing someone in a public place is legal, if the person does not have a reasonable expectation of privacy in such a place. For instance, a restroom or locker room might be a public place, but people have a reasonable expectation of privacy and that they will not be photographed in such a place. If operatives or witnesses are used to record telephone or other conversations, written consent should be obtained.

As just mentioned, it is generally not a crime to videotape a person in public if the tape is not to be used for commercial purposes (i.e., the tape will not be sold). However, if any part of the person's conversation or words are picked up on the videotape, then the taping is subject to all the laws and rules regarding the recording of conversations (i.e., it is the same idea as recording the person on the telephone; the investigator may be prohibited from recording the conversation if they are not a party to the conversation or they do not have the person's consent).

Surveillance can be used to locate residences, businesses, other places of interest to the investigation, and places where criminal activity is conducted. It also can produce important evidence concerning the scope and nature of a person's activities. Surveillance activities must be carefully recorded. Detailed notes and logs, films and video (often with special lenses and light sources), and tape recordings must be used appropriately.

Methods of Surveillance

During *loose surveillance*, targets do not need to be kept under constant observation. This type of surveillance should be discontinued if the person becomes suspicious. In *close surveillance*, subjects are kept under continuous observation even if they appear to become suspicious.

Circumstances might require a change from a loose to a close surveillance. Planning helps, but the investigator must observe and interpret the act or circumstances to decide what tactics to employ. If the plan calls for loose surveillance until the completion of a specified act, or until a meeting with another person after which the subject is to be put under close surveillance, the observer must determine when the specific incident has taken place.

Preparation

The observer's attire should fit in with the area and group. Dress should be conservative, unless conservative dress is not appropriate for the area. Attire should not be loud or flashy so that if the subject notes the observer, they will be less likely to form a lasting impression of the observer. Minor changes in outer clothing or hand-carried items might alter the overall impression and help to prevent recognition by the subject.

Two or more observers working together on surveillance need complete agreement about the surveillance techniques and schedule. Discreet signals will help each observer understand any given situation. Planning is essential, but the observer's adaptability and ingenuity are vital. Observers should be chosen for both aptitude and resourcefulness. They must have poise, patience, and endurance. Prior to engaging in surveillance, the observer should prepare and document a cover story that will stand up under scrutiny. This cover story should provide the observer with a reasonable excuse for being in the area and for doing what must be done there.

Basic Precautions

An observer should refrain from making abrupt, unnatural moves that could attract attention. Disguises such as false beards are impractical, hard to maintain, and easily detectable. The observer should not look directly into the subject's eyes.

Inexperienced observers must overcome the tendency to believe that they have been "made" (identified) because the subject glances at them several times. The geography of the area where surveillance is to take place should be studied carefully. The observer should know the locations of cul-de-sacs or dead-end streets or alleys to avoid being trapped or discovered. A subject who becomes suspicious might suddenly reverse course and enter a dead-end street, board or jump into alternate modes of transportation (i.e., taxi or bus), or engage in a variety of other evasive actions. The observer can counter these strategies by following approved surveillance techniques.

Techniques of Foot Surveillance

One-Person Surveillance

One-person surveillance is best for a fixed surveillance. If a moving one-person surveillance must be used, the observer should follow the subject on the same side of the street and keep close. Crowd and street conditions will dictate the appropriate distance. When the subject turns a corner in an under-crowded area, the observer should continue crossing the intersecting street. By glancing up the street in the subject's direction, the subject's position and actions can be noted.

In a crowded area, surveillance distances might be decreased. Unless the subject is standing just around the corner, surveillance can be continued from the same side of the street. Do not turn a corner immediately behind the subject. When operating across the street from the subject, circumstances will dictate whether to operate forward, to the rear, or abreast of the target. The observer should be abreast of the target when they turn a corner to observe any contact with individuals or entry into a building.

Two-Person Surveillance

In the “A-B” surveillance technique, the observer directly behind the target is known as the A observer. A follows the target and B follows A, either from across or on the same side of the street. When both observers operate on the same side of the street and the subject turns a corner, A continues in the original direction and crosses the intersection. From a vantage point, A then signals the correct moves to B. When B is operating across the street and the subject turns a corner to the right, B will cross the street behind the subject and take up the A position. This move should be pre-arranged. No signals should be necessary. All visual signals should be discreet and consistent with the environment. Should the subject turn to the left and cross the street toward B, B should drop back to avoid meeting the subject. B should keep A in sight to observe signals indicating their next move.

In another variation of this technique, both A and B might continue in the original direction and cross the street. A signals C to take up the A position. B then recrosses the street and assumes their former B position. A assumes the C position. In the third situation, when C notices that the subject is about to turn a corner, C signals to both A and B which positions to assume.

Other Techniques

There are other ways to lessen the chance of an observer being made. First, by either pre-arrangement or signal, the two or more observers can change places with each other. This is commonly referred to as the “leap-frog” method.

Progressive surveillance is used when extreme caution is necessary. With this technique, the subject is followed at a certain distance and after a certain length of time the surveillance is discontinued and the time noted. The next day another observer picks up the surveillance of the subject at the time and place where the surveillance was previously discontinued, and again follows the subject for a short distance. This continues day after day until the surveillance is completed.

Techniques of Vehicle Surveillance

Vehicle surveillance demands additional preparations. A dependable vehicle similar to types commonly found in the area where the surveillance is to take place must be used. This can be a panel truck, an automobile, or a large truck or trailer. The license on the vehicle should be of the state and country where the surveillance will be taking place. If more than one vehicle is to be used, two-way radio or cellular telephone conversation is usually necessary. Consideration should be given to gasoline, water, first aid equipment, and road map requirements.

Whenever possible, combining foot and vehicular surveillance is an advantage. The observers will likely remain more alert. When the subject parks their vehicle and remains in it, an observer on foot can better monitor the subject's actions and those of individuals passing by.

As with foot surveillance, vehicular surveillance requires inconspicuous actions. Observers should generally stay in the same lane as the target to avoid having to make turns from the wrong lane. If the situation allows, observers should change direction, perhaps going around a block to break continuity before the suspect becomes suspicious. One of the disadvantages of vehicular surveillance is that it is difficult at night to be sure the investigator is following the right vehicle. The target's car can be kept in sight better if it is distinctive. The dome light of the observer's car should be disconnected so that the light will not show when a door is opened. Headlights and license plate lights can be wired to allow them to be turned on or off.

One-Vehicle Surveillance

When one vehicle is used in surveillance, it must remain close enough to allow the observers to monitor the subject's actions, but far enough behind to avoid detection. When a subject's car stops, one observer should follow their actions on foot. The subject normally will not expect to be tailed by a person on foot while they are using their car. When the subject turns a corner, the remaining observer can make one of two possible moves. They can continue in the original direction, cross the intersecting street, and make a U-turn; the subject will take little interest in a car turning into the street behind them coming from the opposite direction. An alternative would be to continue in the original direction, cross the intersecting street, and continue around the block.

Two-Vehicle Surveillance

This technique uses two vehicles to follow the subject at different distances on the same street, as in the "A-B" method of foot surveillance. This technique can be varied by having one vehicle going in the same direction as the subject on a parallel street while receiving radio-transmitted directions from the observers directly behind the subject. This technique is more flexible because the two vehicles can exchange places from time to time.

Fixed Surveillance

In a fixed surveillance, or stakeout, the subject remains stationary. The observer can move around for closer observation. When one observer is detailed to watch a place with more than one exit, they might have to move about considerably. When preparing for a stakeout, the base of operations should be well planned. It might be a store, apartment, house, automobile, or truck. A thorough but cautious area reconnaissance should be conducted. Necessary equipment should be readily available, such as binoculars, electronic investigative aids, and cameras.

Satellite Surveillance

Although insurance investigators will rarely need it, satellite data is now available. For a relatively small amount, an investigator can buy detailed images from nearly anywhere in the world.

Plant security lends itself to satellite imagery. In addition to providing much of the same information as conventional satellite photographs, multispectral imagery can detect muddy ground, paths taken by people and vehicles, and other information that might help identify potential security problems.

Satellite imagery can be useful in surveillance if it is combined with more traditional types of photographic intelligence. This is especially true for large estates or industrial sites where aerial photography is prohibited. It can also be beneficial in a covert operation.

Satellite imagery can help to determine ways to penetrate a site, develop a map of the grounds, and identify important areas. In addition, satellite imagery can be used to investigate areas that are too remote, too expensive, or too dangerous to send operatives into.

Buying satellite imagery is simple if the latitude and longitude of the target is known. The products range from photographic prints of the image to magnetic tapes of geographically corrected data. Prints, not much different from the enlargements from a film processor, are usually the cheapest. While they don't allow sophisticated enhancement, they only require a magnifying glass to examine.

The next most expensive product is a transparency or a negative. This allows the investigator to make prints and is convenient for exhibiting the image with an overhead projector. Stereograms are pairs of images that show the same object from slightly different positions and provide a three-dimensional view when viewed through stereoscopic glasses. They are available as either prints or transparencies. Magnetic tape is the digitized version of the images. A particularly sophisticated analysis of the target is possible with magnetic tape.

Night Surveillance Equipment

Basically, there are two types of night viewing devices: *active* and *passive*.

Active

The active type of night viewing devices puts out its own light source, an infrared beam, which is visible to the user through the infrared scope that is part of the unit. The advantage of active types is that the user can see in total darkness. Disadvantages of this type are the limited range in which they are effective and the fact that the infrared beam is visible to anyone looking through an infrared scope or through a passive night viewing device.

Passive

The passive type of night viewing device electronically amplifies whatever existing light is in the environment, such as moonlight or sky glow. Therefore, such units are sometimes referred to as “starlight scopes.” Night viewing devices have been in use since 1969. Their primary purpose is to allow the observation of events occurring more than one block away during the night. A night viewing device, with an adapter, can be attached to the front of a camera to obtain evidence that will stand up in court. Television videotapes, movies, and still photos can all be obtained using night viewing devices.

Vendor Management

Insurance investigators must understand and relay to any surveillance vendors that they might be using that the individuals conducting the surveillance in no way have the same legal rights as a duly sworn law enforcement officer. As such, during surveillance for an insurance case, nothing should be done or utilized that could be considered intrusive or out of the boundaries of the investigator. This should include the use of any manual or electronic device that is used to record audio conversations or that intrudes upon the person or property of the intended target, such as attached GPS trackers or reflective tape on the target’s automobile or clothing.

Conducting surveillance for an insurance claim is for a very specific reason. As such, the investigator, the claim handler, the attorney involved if there is one and the independent medical provider should all have a clear understanding of what to expect from the surveillance.

The investigator should not set up a surveillance plan with the intent of catching the insured or claimant performing activities that they say they cannot perform. Rather, the sole purpose of surveillance should be to covertly observe the activities of the insured or claimant during their daily activities. One of the misconceptions made by new investigators is the feeling that if they don’t “catch” the insured or claimant doing something, then they have in essence helped the insured prove their case by showing that they are incapable of performing strenuous activity. Of course, that is not the case.

The investigator should certainly be creative and plan for the likelihood of the surveillance being successful, but there will be times when there will be no activity on the part of the insured. This might be for a variety of reasons, including the weather just isn’t conducive to activity, the claimant is not very active and might be a couch potato by nature, or there is just no need during the particular time frame that the investigator is there for the claimant to involve themselves in activity. As such, the investigator should note the level of activity.

The investigator should thoroughly review any video obtained, and be prepared to discuss the implications. Often, either the claims handler or the attorney for the carrier think only a smoking gun in

the obtained video is worth viewing and eventually using in court. This is where the investigator must know the significance of what they have filmed. For example, while the video might only show the claimant “puttering around” in the garage, this might be significant. If the claimant has alleged to the treating physician that they can’t stand erect or bend without pain, showing the claimant doing just that for an extended period on a concrete floor might have a positive impact on the case. Another example, using the same scenario, is if the claimant reaches up to place something on or to remove something from a shelf. On the face of it, that seems mundane enough. However, if the claimant has alleged to the treating physician that they are unable to stretch without severe pain or have a limited range of motion that prevents them from lifting their arms above their shoulders, this video footage would be significant in refuting that claim.

Another situation that seldom occurs, but that can result in a significant adverse award if it does, is when the investigator is unaware that the case has been settled and continues surveillance after it should have been terminated. Sometimes the investigator is asked to conduct surveillance a few days before or on the day that the case goes to trial. Often, these cases are “settled on the courthouse steps,” or in previous negotiations with the claims handler in which an agreement is reached. At the point that an agreement has been reached, there is no legal right for the investigator to continue surveillance; however, due to poor communication between the investigator and the claims handler or the defense attorney, surveillance may continue. For this reason, it is imperative that the investigator makes it clear that they need to be notified immediately of any agreed upon settlement. Although it may be a reasonable defense that the continued surveillance was only monitoring activity that was carried out in public, the adverse stance could argue that, regardless of that assertion, privacy was violated and stalking laws were then applicable. All of these potential problems can be effectively alleviated or mitigated if there is a good avenue of communication established at the outset of the surveillance between all interested parties.

Sometimes, the claimant or insured becomes aware or senses they are being watched. If this occurs, the investigator should keep filming if they are in a place where they are concealed. If the claim is meritorious, the surveillance documentation is helpful in concluding the claim. If the claimant is malingering or exaggerating the extent of their injuries, they might tend to “overdo it” when they think they are being filmed. Oftentimes, this is more obvious than the claimant intended. Many jury trials have ended with the plaintiff getting no award at all because the jury was convinced that the claimant was “faking it.”

The claims handler or attorney often has just enough time to look at a couple of minutes of tape. By doing so, they might underestimate or not fully recognize the importance of sustained activity or no activity on the video, as mundane and unimportant as it might initially seem. The investigator must be prepared to educate the carrier as to what the video documentation contains. The investigator should be objective, and not try to sell the carrier on the fact that the claimant might be exaggerating their injuries,

but rather try to get them to objectively evaluate the information and take the time to thoroughly review the tapes and photos.

On the other hand, the claimant might have sustained a legitimate injury. Thus, the investigator must objectively report their findings and not be disappointed if the claimant appears injured. This is critical for the carrier to know. That way, they can more adequately value the true extent of the claimant's injuries and go about making a fair settlement offer. By documenting the claimant's limitations, it allows the claims handler to expedite the claims process and keeps the claimant from having to endure a longer than necessary claims process.

Most insurance carriers outsource the surveillance function to outside vendors. This is usually done for cost control purposes. However, the insurance carrier must understand that they cannot completely exclude themselves from the inappropriate or possibly illegal actions of the vendor working on their behalf and at their behest. As such, certain guidelines should be used to retain and monitor the vendor's actions, credentials, and eventual work product.

Many companies that provide surveillance as a vendor service might not be prepared to answer many of the questions posed by the carrier right away. However, the trend within the insurance industry is to qualify all vendors, so give them a reasonable amount of time to provide the information, but don't give them the option of not providing it. If the investigator allows some vendors to operate without submitting the proper qualifications, but requires others to do so, they have placed the carrier at risk.

The carrier should send each potential vendor a request for information response. This should be accompanied by a confidentiality agreement signed by both parties that has been approved by general counsel for the insurance carrier.

The following four areas should be the focus of the request for information from the prospective vendor:

- Functionality
- Costs
- Viability
- Technical

Functionality refers to the criteria used for determining what products or services best meet the business needs of the carrier.

Costs refer to the exact fee schedule from the vendor to be charged to the carrier for specific services. This may be negotiated later, but the cost needs to be stated up front so that the carrier can compare it with other vendors.

Viability pertains to the criteria for determining the stability of the vendor and the chances of them becoming a long-term business partner. Although some vendors might feel this information is proprietary in nature, the use of the confidentiality agreement should ease their concerns.

Technical refers to the technical capabilities of the vendor and whether they are compatible with the needs and technical resources of the carrier.

The following information should be gathered about the potential vendor.

Functional Requirements

- Company name, including any fictitious names used
- Account representative or direct contact person
- Physical address of company, not a post office box
- Mailing address, if different than the physical location of the business
- National representative's name and contact information
- Regional representative's name and contact information
- Names and curriculum vitae of all investigators who will be working for the carrier, including the principal of the company
- Investigative guidelines for its investigators
- Information on how the company identifies and complies with any relevant statutes and regulations in the states in which they operate
- Processes used to screen new or potential investigators
- Background checks for potential investigators
- Information about the drug-screening program
- Information about company-provided vehicles or investigators' own vehicles used for surveillance
- Proof of insurance
- Driving records of potential, new, and long-term employees
- Information about company employees who carry weapons of any type during work
- Information about any company subcontractors
- Information about the type and frequency of training the company provides their investigators
- The type of video equipment investigators use
- Information regarding indoor surveillance equipment
- Information about nighttime surveillance equipment
- Information about the in-house capability of tape, CD, or DVD dubbing and photograph copying

- How the chain of evidence is maintained if outsourced
- Copies of the internal protocols for the collection and preservation of evidence including, but not limited to, maintenance and chain of custody policies
- Information on the approach to addressing admissibility concerns as it relates to digitally recorded evidence
- A sample copy(s) of the reports the company's investigators are required to submit along with any written guidelines regarding such reports
- States and other countries in which the company provides investigative services
- A list of all of the office locations and contact information
- Protocols for how investigators are supervised during their various assignments
- Documentation regarding any lawsuits, criminal complaints, and nongovernmental complaints.
- Information about the quality assurance program
- The approach used to monitor customer satisfaction and how customer service issues or problems are addressed
- Information about service level agreements
- Any other information the company feels is pertinent regarding the functionality of its firm and the service it provides to its clients

Costs

Please describe in detail the professional service(s) and other costs associated with the services, including discounts, options, or other related information. Be specific and account for all services and their projected costs. Provide detailed information on assignment costs that require one or more investigators or special equipment needs.

Viability

- Is the firm publicly or privately held? Describe the type of corporation structure (e.g., LLC, sole proprietor, or S Corporation).
- If the company is a publicly held corporation, please provide an annual report and current Dun & Bradstreet statement.
- If the company is privately held, please provide an audited financial statement or comparable document.
- Please provide the number of employees in the organization and their general job duties and descriptions.
- How many years has the firm been in business?
- Please provide the total number (not names) of new clients that have been added within the past three years.
- How many clients have been lost in the same three-year time frame?

- Estimate the percentage of the market the firm currently services in the areas in which it operates. What does it base this estimated information on?
- What strategic partnerships does the company have with other products and service vendors? Please list them and describe the nature of the relationship.
- Describe the current mission statement and the firm's future vision.
- What plans does the company have for growing and improving while enhancing its business reputation?
- Please provide a description of three large-scale or significant investigations the firm has performed within the past two years. Do not provide references to any client, rather just the engagement or investigation details. What was the eventual resolution or disposition of each?

Technical

Please provide a detailed list of the firm's technical proficiencies and how they might be compatible with the technology currently in use with the company requesting the information. For example, when describing word processing documents and spreadsheets used in investigative reports, describe the software used, such as Microsoft Word, Word Perfect, or Excel. Please be sure to list the software version the company currently uses. Other examples of technical compatibility might be the type of media used, such as VHS tapes, video CD, or DVD, and the types of cassette tapes used for recording statements. Describe how reports, invoices, and other documents will be submitted (i.e., paper copy or electronic email attachments). Include the type of electronic equipment used in investigations and the steps taken to ensure security for the information gathered, such as firewalls, password protections, and internal control protocols.

Summary

By maintaining a tightly controlled vendor management process, the investigator reduces the risk of the vendor's representative engaging in unacceptable, illegal, or potentially file-damaging behavior. The relative inconvenience caused to the vendor by complying with supplying this information is offset by the decreased risk of a bad faith allegation made by an insured or claimant. The overall goal for any surveillance operation should be to covertly and objectively ascertain answers to questions surrounding an investigation. If the claimant's injuries are verified or refuted, or if stolen or concealed property is located by surveillance information that is ethically and legally obtained, the outcome should be considered a success.

VIII. EXPERT SELECTION PROCESS

In most insurance companies, it is the responsibility of the claims department personnel and the SIUs who use experts to ensure that the right expert is assigned to the right situation. Many companies maintain a list of experts that they use and have developed a comfort level with certain experts, due primarily to long standing business relationships. Insurance carriers might fall short, however, by failing to determine their own standards. Insurers sometimes fail to recognize the critical need to update their lists and to consistently and annually verify the credentials and expertise of the experts.

Based upon the rigid legal requirements for the admission of “expert testimony” in the courts, the following guideline will help the insurance carrier evaluate and enhance its current expert selection process.

The following is a suggested guideline for using resources already found within the insurer’s own ranks. These personnel resources should at least include the following:

- Defense counsel
- Subrogation specialists
- Property specialists
- SIU personnel

There are many different types of experts used every day by insurers because there are so many different types of claims. The following is a *partial list* of commonly used experts, though the list *excludes* cause and origin fire- or explosion-related experts. As fires and explosions are where most experts are used, and the exposure is normally relatively high, they will be discussed in detail later in this course.

- Mechanical engineers
- Accident reconstructionists
- Forensic accountants
- Doctors and other health care professionals
- Computer data retrieval specialists
- Handwriting experts
- Ignition system specialists

Selection Process Steps

The following is a list of steps insurers should take in the selection of experts:

- Advise, in writing, all current and potential experts of the company’s intention to institute a quality review program.

- Explain that the process is not optional, and that it is mandatory for each applicant in the firm, not just the principals.
- Specifically address what is to be submitted, such as:
 - Curriculum vitae
 - Licenses (for each applicable state)
 - Liability insurance coverage (errors and omissions)
 - Proof of workers' compensation coverage
 - Court transcripts (again, for each applicant)
 - Verifiable training records
 - Business references
- The next step is to carefully review and then verify the credentials.
- The team then interviews and assesses each candidate in the firm.
- Establish a database list of qualified candidates. In writing, notify both successful and rejected candidates.
- Establish a quality control audit procedure in field offices to ensure that only accepted candidates are being used and that they are being assigned to the right exposure level and type.
- Annually review cases for work-product efficiency, then reaffirm selections.
- Annually send surveys to field office claims handlers and defense counsel to evaluate each expert—not just the whole firm.
- Annually review regional legislation regarding “expert” testimony and qualifying experience in various locales.

Besides being more efficient and accessible, there are several reasons to maintain this information in a database, such as:

- Easily accessible to field and home office personnel
- Easily revised and updated
- Retrieval speed and ease of use
- Immediate transfer of information to defense counsel

The database should have only one administrator who can make changes. All other users should have “read only” capabilities and should not be able to print information from the database. Preventing printing limits the risk of paper copies being disseminated to unauthorized persons and eliminates individuals being added or removed from the list that have not gone through the entire approval process.

There will be those who do not wish to comply with the process of instituting a quality review program for a variety of reasons. There are also administrative pitfalls that might negate the effectiveness of the process. Some of those might include the following aspects.

Old-Timer Experts Refusing to Participate

These might include experts who have been used for years by the same company and think it's beneath them to have to qualify. Many of these experts might also refuse to allow anyone in their company to participate because they think it's a waste of time.

Verification Process Tapers Off After Initial Phase

This can happen because either the person(s) who is responsible for verifying training and credentials is no longer involved, or the verification process has become a "secondary" task. This task must remain a priority.

Claims Personnel Not in Compliance

This can and will occur when claims handlers want to use a specific person but do not want to go through the approval process. They will circumvent the procedure. It is for this reason that companies should develop a quality control process up front.

Selected Experts Fail to Annually Update Their File Information

After a while, some of the candidates might fail to provide the company with information regarding their latest training, insurance information, educational requirements, and license updates. Do not allow this to occur—it places the company at considerable risk.

The role of an expert witness in fire litigation cases has been greatly emphasized in recent years. At the same time, the challenges to the admissibility of expert testimony have come under greater scrutiny. Hiring a competent expert to work on a case is only half the battle. Successfully presenting the findings of that expert to convince a jury of the expert's conclusions is the real challenge. Unless the findings of an expert can be successfully presented in court, the case will be lost.

Today, a true "expert" witness possesses more than just the technical skills to do the job. An effective "expert" witness knows how to present their findings in a courtroom so that their testimony will be both admissible and persuasive. Making a persuasive presentation in court requires the expert to show that the investigation was properly conducted, thoroughly analyzed, and a sound conclusion reached. The jury will likely evaluate the methodologies utilized by the investigator and the validity of their opinions. Was it a methodical investigation? Was it a comprehensive investigation? Were all possibilities considered in reaching the conclusion?

This can only be done when the investigator employs a systematic approach that utilizes an accepted methodology. The investigator must show that they followed an established protocol for conducting the investigation and that this method is utilized when conducting all investigations.

While every investigation will have unique aspects that might require a specific approach to a particular issue, the overall investigation must be conducted within an established framework.

Consistency is the watchword for conducting a proper investigation. Documentation of the investigation cannot be overemphasized. The investigator must carefully document every aspect of the investigation to show the jury what was done and why it was done.

Fire and Explosions

As previously discussed, there are as many potential experts as there are types of claims. In the insurance business, most investigators are most familiar with fire origin and cause experts and explosion-related experts. This is due to the large number of fires in the industry each year, and the potential risk exposure each represents. As such, the following information is related to fire and explosion investigations. This applies to the SIU investigator who assists or supervises the scene, is assigned the case after the scene has been cleared, or who is the cause-and-origin expert. Even if they are not the expert, each investigator should know what is reasonably expected of the assigned expert.

Photographs, videos, and diagrams document the activities of the investigator at the scene. Physical evidence from the scene is not only important to the investigation (such as fire debris that is sent for laboratory analysis); but it also becomes an important part of the expert's presentation at trial. Tangible physical evidence in the courtroom has strong persuasive value with a jury. An expert can tell a jury about significant physical evidence from a fire scene, but their testimony alone will never be as persuasive as showing the jury the physical evidence itself. Thus, proper documentation of a fire scene must include the recovery of physical evidence to be presented at trial.

While an expert witness must ultimately persuade the jury of their conclusions, they must first persuade the judge of the relevance and reliability of their findings and methodologies. Under the *Daubert* standard, which is now employed in all federal courts and in a growing number of state jurisdictions, the trial judge acts as a "gatekeeper" in determining that the investigative methodologies employed and the conclusions reached in the case are both relevant and reliable. To determine reliability, the court must confirm that the investigation was conducted in a scientifically valid and verifiable manner, with the results of the analysis being scientifically valid and verifiable as well. The expert must be prepared to demonstrate this in a convincing and coherent fashion at trial.

The potency of a potential ignition source and the ignition temperature of a suspected first fuel are examples of issues the expert witness will consider and validate during their investigation. The conditions or circumstances that brought the two items together will often form the basis of the expert's cause determination. The relationship between the potency of an ignition source and the ignitability of

the item first suspected of being ignited is an important factor when substantiating an ignition hypothesis (i.e., cause determination). This “relationship” should be validated by an expert witness, who uses scientific and engineering principles in combination with data derived from laboratory testing.

Examples of laboratory tests frequently used to characterize the ignitability of materials include ASTM E 162 Surface Flammability, ASTM E 648 Critical Radiant Flux, and ASTM E 1321 Material Ignition and Flame Spread. By conducting this type of testing on an item suspected of being ignited, first the material’s susceptibility to ignition from impinging radiant heat fluxes can be assessed in terms of heat-energy densities required to achieve combustion. This data can then be related to *real-world* sources of such heat fluxes (i.e., ignition sources, such as open-controlled flames, hot surfaces, and hot airflows) through applying scientific and engineering principles or data generated by additional laboratory testing. After conducting this analysis of relating material ignitability to an ignition source, the cause determination can be validated.

The concept of forming investigative hypotheses based on information gathered during the investigation and validating those hypotheses through the application of theory (science and engineering) and practice (laboratory testing) can also be employed in other areas of fire investigations, such as analyzing heat and combustion products generation. Commonly referenced laboratory tests for analyzing such material behavior include ASTM E 1354 Cone Calorimeter and ASTM E 662 Smoke Chamber. Using these laboratory tests in conjunction with theoretical principles, hypotheses can be evaluated regarding fire growth and the spread of combustion products. Preparation is another important component of every investigator’s success in determining the origin, cause, and responsibility of a fire.

Preparation begins with the establishment of a planned and systematic approach to every phase of the investigative process and concludes with a powerful presentation in the courtroom. The scene investigation is not the only time that a “systematic approach” is necessary. The selection of a properly qualified expert is not something that should be done without a system or protocol. The case might be won or lost at the time the expert is selected. It takes an “informed consumer” to make the right choice, and to understand the value and the consequences of that selection.

Many state-of-the-art laboratories retain a highly skilled and respected staff of scientists and engineers that will provide their experience, scientific knowledge, and laboratory capabilities to bring an investigation to a successful conclusion. Many of these labs are prepared to respond to an incident scene and work with the investigative team to provide a complete and thorough scientific analysis upon which informed decisions can be made.

State-of-the-art facilities should staff or partner with experienced professionals to assist with the following:

- Assembly and management of an appropriate team of experts and resources
- Liaison with other investigative entities
- Recognition and mitigation of critical investigative issues
- Development of protocols dealing with the identification, collection, and storage of physical evidence

True state-of-the-art facilities should also have an experienced team of engineers and scientists to provide scientific/technical assistance with:

- Investigation of the fire/explosion incident
- Identification, collection, examination, and testing of the physical evidence
- Interpretation of test results
- Expert testimony and second opinions
- State-of-the-art laboratories for the scientific validation of hypothesis
- Fires involving solids, liquids, or gases
- Explosions involving dust, vapor, or gas atmospheres
- Flammability of materials
- Spontaneous combustion, thermal instability, and chemical reactivity
- Transport and storage of dangerous goods
- Electrostatic discharges

From Theory to the Courtroom

The ability to prove an investigator's theory or opinion is what determines a successful investigative effort. Investigating a major fire or explosion incident is a challenge that requires specialized knowledge as well as established procedures for collecting the evidence and documenting the findings to satisfy the legal standard of proof. The time to establish a plan is well before an incident occurs. Having a protocol that addresses critical decisions that must be made throughout the investigation is essential.

The first step in the plan is to evaluate the unique aspects of the scene investigation and to begin assembling a pre-approved team of experts. The plan should include staffing requirements, notification procedures, logistical details, and a complete response agenda.

The initial response at the scene might require only one team member, or several based upon the size and complexity of the scene. The initial responder (team) must address a number of critical issues that can affect the success or failure of the entire investigation. The scene must be treated with care to preserve all forms of physical evidence that need to be documented and collected.

Communication and effective interaction with the first responders at the scene and government investigators coordinating their needs and intentions with the investigators must be a priority. Public safety officials might need to maintain control of a major fire or explosion scene for days or even weeks. It is during this critical time that the second phase of the protocol should become operational: notification and briefing of team members with the skills required for the task at hand.

Team members might include:

- Origin and cause expert
- Electrical engineer
- Chemical engineer
- Fire protection engineer
- HVAC expert
- Videographer/photographer
- Toxicologist
- Code expert
- Interviewers
- Process engineer
- Environmental engineer
- Administrative assistant
- Evidence technician
- Testing laboratory
- Metallurgist
- Surveyor

Complex fire and explosion scenes often require written protocols addressing such issues as:

- Who will collect evidence?
- Who will control access to the scene and evidence?
- Where will evidence be stored?
- When will scientific testing of evidence be performed and by whom?

The written protocols should be drafted before a major investigation occurs, and they should be utilized by all involved parties to move the investigation forward.

Communication is the most important component of the scene manager's duties and responsibilities. Frequent communication with the insured, legal counsel, team members, other interested party representatives, and government officials is essential. Note, however, communication with the insured should be limited only to determining the scope of damages. At no time should the insured or their representatives be involved in a discussion regarding any segment of the investigation. Make sure all

parties are briefed so as not to inadvertently discuss the case within earshot of the insured or others. Regular meetings and briefings should be scheduled for all relevant issues to be discussed and resolved. Proving an investigative theory or hypothesis is the goal of every investigative endeavor. Finding the data necessary to prove an investigator's theory requires that an established protocol be in place before a major incident occurs. There is only one opportunity to conduct a proper scene investigation. Having a system and established scene investigation protocol in place will help the scene manager control the investigative effort and the individual tasks that need to be completed.

The pre-approved team of experts assembled to conduct individual aspects of the investigation should be well-informed, competent, and focused on applying their skills and knowledge to complete their assigned responsibilities. The burden to prove the theory about the cause of a fire or explosion is accomplished by proper protection, identification, and documentation of all forms of evidence and information. A well-prepared plan that addresses as many of the conceivable issues that will confront the investigative team as possible will provide a roadmap toward successfully completing the investigation.

Proactive efforts to provide a well thought-out comprehensive response to a major fire or explosion scene will significantly contribute to the investigator's ability to progress from theory to proof.

Spoliation—NFPA 921—*Daubert*—Systematic Approach

Fire causes billions of dollars in damage and indirect economic consequences each year in the United States. To successfully investigate the origin, cause, and responsibility of a fire or explosion, public and private entities must employ a consistent and carefully constructed strategy. In recent years, the methodologies and procedures employed by the fire investigation community have been challenged as never before. New information, technologies, and scientific applications have been developed to improve the quality and effectiveness of fire investigations. A reliance on scientific and engineering experts to verify the theories and opinions of origin and cause investigators has become the rule, not only in cases involving major fire losses, but in all cases.

The reliability of the data considered by fire investigators will undergo constant challenges from the beginning of the investigation through the litigation phase of the case. Untested hypotheses and opinions derived from unreliable methodologies employed during the investigation process will be readily exposed in testing those theories under the admissibility standards of the legal system.

Over the last decade the National Fire Protection Association (NFPA) has released four editions of its *Guide for Fire and Explosion Investigations, NFPA 921*. This “consensus” and “peer reviewed” document

recommends that a systematic approach be employed by those involved in the process of determining a fire's origin, cause, and responsibility.

NFPA 921 advocates the scientific method as the process for conducting a proper investigation. Although no fire scene is completely reproducible in a laboratory setting, many aspects of the fire's ignition, development, and responsibility can be analyzed under scientific standards. Successful investigators must consider alternative theories that might be used to challenge the hypotheses and opinions formulated during the investigation. Each alternative theory must be tested utilizing every available analytical resource, which can range from the application of a basic cognitive process to a full-scale laboratory analysis, until only one valid theory remains.

Every investigation should be a coordinated effort for identifying any potential causal factors and then utilizing a systematic method of testing and challenging each hypothesis developed. The testing of an investigative hypothesis might be as simple as the application of an open flame to the vapors rising from a small pool of gasoline, or as complex as the creation of a computer model to test the theory of a fire's growth and development. Any inquiry into a fire's cause or condition requires a systematic methodology.

If the investigator suspects that an ignitable vapor or gas might have caused an explosion, they should consider the best way to prove or disprove that theory, including:

- What method, procedure, or technical expertise can be applied to test that theory and eliminate any alternative theories until only one proven theory remains?
- Is the scientific data utilized in the investigative process acceptable in the scientific community?
- Does any aspect of the investigation require a second opinion?
- Can the theory be tested so that alternative theories can be eliminated?

A successful investigation will consider all of these factors and utilize every tool available to prove and protect the conclusions and opinions developed through this process.

The modern fire investigator will be confronted with a host of issues that came about in the 1990s. NFPA 921 has become a benchmark document in the industry, used to measure an investigator's procedures and conclusions. Several court decisions affecting expert witness testimony (e.g., *Daubert*, *Benefield*, and *Kumho*) have challenged not only an expert's credentials, but also the methodologies of the investigation, to determine the legal qualifications of the witness to give expert testimony.

Spoliation related to the evidence collected at fire scenes has become another concern for origin-and-cause investigators when the cause results in litigation. Jurors have become much more sophisticated, due in no small part to the presence of courtroom dramas in their own living rooms. Some recent high-

profile cases have led to today's jurors expecting forensic science and high-powered expert witnesses in almost every trial.

Today's investigator should focus on the courtroom and anticipate the challenges that must be met by an expert witness to be successful. When an expert takes the witness stand, proving what did *not* cause a fire or explosion is often as important as proving the actual cause. The use of specialist experts has always been a powerful strategy in a successful investigative effort. Today, those experts not only include the chemist that tests debris samples, but a long list of specialized experts that possess the necessary ingredients for success.

The time to begin thinking about the use of demonstrative evidence in support of expert theories and opinions is during the scene examination. The composition of today's jury is much more sophisticated than the jury of just ten years ago. Their high expectations of the expert's ability to explain and prove their opinion are in part based on the availability of police, forensic, and courtroom drama on television and the widescreen. They have an insatiable appetite to help solve the case in an hour or two from the comfort of their homes using every modern application of science and technology.

Jurors expect and deserve a level of sophistication from an expert witness, which should include every possible demonstrative tool available when offering expert opinion in the courtroom. Real evidence will always rule the case but success or failure in the courtroom will often be determined by how effective the expert's message is presented. The strength and effectiveness of demonstrative evidence is to educate, convince, and help prove the case. This type of evidence is not a luxury in the courtroom; it is a necessity. The expert's mission in the courtroom must be to offer a clear and convincing presentation of the facts and circumstances that led them to their opinion.

The use of demonstrative evidence will greatly enhance the probability that the testimony will be understood and retained by the audience. During testimony, the expert will have an opportunity to bring the jury back to the fire or explosion scene and have them utilize as many of their senses as possible to comprehend their testimony. Verbal communication alone might not provide sufficient details to allow the expert's message to be understood. A picture is still worth a thousand words, but a blown-up photograph complemented by an architectural model and a timeline of events is worth thousands of words to both the witness and the jury.

Determining the origin, cause, and responsibility of a fire or explosion is only part of an expert's duty. Presenting a quantified, clear, and convincing opinion during a legal proceeding is a true measure of ability. Some forms of demonstrative evidence can be costly, such as architectural scale models, computer reconstruction, or animation and fire modeling. Others cost only the time that the expert gave to appreciate and visualize the effectiveness of a demonstrative aid during testimony.

For example, the next time the investigator secures a sample from a tongue and groove wood floor, they should consider removing a three-foot by three-foot section of the floor to use as an instructional aid during the expert opinion presentation. With the section of flooring affixed to an easel or angled on a table in front of the jury, it can explain why a sample was secured from that section of flooring, how irregularly shaped patterns may be formed, characteristics of ignitable liquids on tongue and groove flooring, and a score of other issues relevant to the investigation and opinion.

Another effective demonstrative powerhouse in the courtroom is a blown-up aerial photograph depicting the incident scene and several blocks surrounding the scene. It can be used by numerous witnesses to enhance their communication to the jury as to how they interacted with the incident scene. Emergency responders can explain their route of travel and observations upon arrival. Eyewitnesses to actions and events can describe their location when certain observations were made. Occupants, employees, experts, and others can utilize the same demonstrative aid to pinpoint the location of evidence, the dynamics of fire growth and movement, or the significance of exposure buildings and firefighting tactics. In fact, it is not unusual to have every witness during a trial utilize a single aerial photograph to paint a mosaic of their interaction with the scene.

Photographs and video utilized to capture technical and scientific tests conducted to determine the validity of hypotheses and opinions are powerful demonstrative tools in the courtroom. These tests can be as simple as a series of photographs capturing an ignition scenario, to a video of a compartment burn, to flashover complete with a running clock and superimposed thermocouple and infrared readings.

Origin and cause investigators utilize items that have been affected by the heat of a fire to help them develop a hypothesis. These items can be photographically documented and included in a report and diagram; however, the best evidence is the evidence itself. Investigators should consider collecting one or more of these items from the scene to utilize them as an aid during testimony. Some examples would include distended light bulbs, melted plastic bottles, furniture legs, or any item that displays a significant and relevant effect from its presence in the path of a fire that will contribute to a witness's effectiveness in communicating to the jury.

Whether it's high-tech computer animation, video of a scientific test or experiment, or an aerial photograph, an expert witness should consider utilizing any form of demonstrative evidence that will aid the jury in understanding relevant issues. The expert only has one opportunity to present their opinion and to make a positive and lasting impression on the jury. The expert's use of demonstrative evidence will help jurors understand the expert's messages early and remember them long for a long time.

Planning for the role as an expert witness should begin while examining the fire or explosion scene, and should include any visual demonstrative aid that will make the expert's message clear, concise, and easily understood.

Validation of Expert Opinions

Expert opinions regarding the origin and cause of a fire or explosion have no value in a courtroom unless the opinion or hypothesis offered by an expert witness can be properly validated. In 1993, the United States Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), defined the legal criteria for the admissibility of expert testimony in federal court cases. Under *Daubert*, the admission of expert opinion testimony is authorized if (1) the testimony is based upon sufficient facts or data; (2) the testimony is the product of reliable principles and methods; and (3) the witness has applied these principles and methods reliably to the facts of the case. Many state courts have adopted the criteria from this case as well.

Since the *Daubert* decision, many federal and state courts have examined the issue of "expert opinions" based upon the "reliability and relevance" of the opinions under the *Daubert* standard. A 2004 decision by the U.S. Court of Appeals for the Tenth Circuit underscored the importance of this process in *Truck Insurance Exchange v. Magnetek, Inc.*, 360 F.3d 1206 (10th Cir. 2004). The decision rejected an opinion that was not based on scientifically validated facts. The expert's opinion in the *Magnetek* case hypothesized that an allegedly failed ballast in a ceiling-mounted fluorescent light fixture ignited wood surrounding the fixture. The theory was that the heat caused by the failed ballast caused the wood to form pyrophoric carbon, thus lowering the wood's ignition temperature. This allowed the failed ballast, which would not normally generate sufficient temperatures to ignite the wood, to become a competent ignition source and the cause of the fire.

On the surface, the opinion seemed to satisfy the necessary *Daubert* criteria when weighing the competency of an ignition scenario. However, when each component of the opinion was examined, the opinion failed to meet the *Daubert* challenge. The opinion identified an ignition source, but failed to produce scientific validation on its competency to ignite wood. It identified the first fuel ignited (wood) but failed to produce scientific validation of the actual ignition temperature of pyrolyzed wood. Absent scientific proof of both the ignition source's competency and the fuel's reduced ignition temperature, the opinion failed to quantify its reliability and failed to satisfy the requirements under *Daubert*. Ignition of pyrolyzed wood has long been considered and debated by some of the most respected experts in the fire investigation field. Unfortunately, in the *Magnetek* case, it was shown that no reliable testing data exists to support the theory. Three articles were introduced as evidence on the issue of the ignition of pyrolyzed wood. However, the articles showed no scientifically validated facts in support of the theory.

The articles failed to substantiate the theory due to one or more of the following criteria:

- The theory had not been sufficiently tested.
- The opinion was not supported by published and peer reviewed data.
- The data introduced did not conform to any standard methodology or establish any known rate of error.
- The theory had not been accepted in the scientific community.

Before an investigator makes difficult decisions regarding the origin, cause, and responsibility of a fire, they should challenge each component of the ignition scenario. They should also ensure that the theory has been tested and scientifically validated. Decision makers must recognize and understand the standards imposed in both federal and state courts regarding the admissibility of an expert's opinion.

Whether the opinion of a fire's origin and cause is the investigator's own, that of someone they supervise, or of an expert retained by the investigator's company, that expert should be able to answer the following questions:

- What was the ignition source?
- What was the first fuel ignited?
- How did they come together?
- How can this opinion be proven?
- Were all reasonable accidental causes eliminated?
- How were they eliminated?

Testing a theory might be as simple as measuring the surface temperature of a high-intensity light bulb to measure its competency as an ignition source. It might also be as complex as conducting a test of a material over a prolonged period and under specific conditions to determine its capacity to self-heat.

The forensic engineer or scientist has become an increasingly integral component in all phases of the investigative process. They can provide invaluable impetus during the scene investigation, as well as develop, conduct, and evaluate the testing of materials, devices, or scenarios in the laboratory.

The team approach utilized to investigate the origin and cause of a fire or explosion has proven very effective.

Every team should include a scientific or engineering component capable of providing the validation required to satisfy any challenge in the courtroom.

Scientific Testing: What Can a Laboratory Contribute to the Case?

This section will focus on discussing several standardized fire test methods used to generate specific pieces of fire-related “data” and the application of that data towards various investigation and litigation options. Literally hundreds of standard fire test methods exist to quantify the ignitability, flame spread, and heat and smoke generation characteristics of materials. Thus, the applicable fire test method for a given scenario should be discussed among the investigative team. Many tests might appear to be similar in terms of equipment and procedure; however, slight disparities between methods could affect the derived data, along with the resulting case outcome. Standardized methods should be utilized whenever possible; however, when the availability of representative test methods is limited, testing should be conducted based on standardized methods that have been modified (i.e., customized) using sound engineering judgment to accurately represent the scenario under examination (e.g., ignition, spread, or heat/smoke generation scenario).

Frequently in a fire investigator’s career, questions surface regarding how easily a material ignites and how rapidly it burns after igniting. Several standard test methods exist to assist investigative teams in answering these two questions. For example, ASTM E 1321 (Standard Test Method for Determining Material Ignition and Flame Spread Properties) is a standard “bench scale” laboratory test to quantify ignition sensitivity and flame spread of materials oriented vertically, while ASTM E 648 (Standard Test Method for Critical Radiant Flux of Floor-Covering Systems Using a Radiant Heat Energy Source) provides similar information for horizontally mounted materials. Additionally, ASTM E 162 (Standard Test Method for Surface Flammability of Materials Using a Radiant Heat Energy Source) can be utilized to evaluate material flammability (i.e., a combination of ignitability and flame spread) during instances where flame spread down a vertically mounted material is under question.

Another question commonly asked of investigative teams is, “how thick is the smoke generated by the material in question relative to other materials.” For the quantification of smoke thickness produced from a burning surface (i.e., smoke density), ASTM E 662 (Standard Test Method for Specific Optical Density of Smoke Generated by Solid Materials) should be employed. A second method available for answering this question is ASTM E 1354 (Standard Test Method for Heat and Visible Smoke Release Rates for Materials and Products Using an Oxygen Consumption Calorimeter), which also quantifies a second parameter, “how much heat is produced from this burning material.” Often, data generated by ASTM E 1354 is utilized in engineering analysis to model the spread and accumulation of hot combustion gases and smoke within a structure during a fire.

Additionally, test methods are available for assessing the fire behavior characteristics of specific types of consumer products, including upholstery, draperies, wall coverings, plastics, foams, mattresses, furniture, sleeping bags, insulation, and floor coverings, just to name a few. These test methods were often

developed with the intent of classifying or comparing consumer products in the same grouping (e.g., clothing for infants or children) under prescribed fire conditions.

For example, several test procedures are available to determine the flammability of mattresses and box springs. In fact, since January 1, 2005, the state of California requires manufacturers to conduct CAL TB 603 (Resistance of a Mattress/Box Spring Set to a Large Open-Flame) as well as a smolder resistance test mandated by the CPSC. Plastics are another material that might have a significant effect on the ignition, development, and spread of a fire. ASTM D 2863 is a test utilized to measure the minimum oxygen concentration required to support candle-like combustion of plastics. This test, also known as an oxygen index test, is designed to determine the minimum level of oxygen required to sustain flaming combustion.

As previously stated, hundreds of laboratory tests are available to provide investigators with the scientific validation their case might require. Whether the case requires the testing of upholstery, draperies, wall coverings, plastic or foam materials, mattresses, furniture, sleeping bags, insulation, and floor coverings, or literally dozens of other products, there is likely a test available to supply the investigator with the vital information they will need to make proper decisions in their case.

Investigators' needs might require tests that address building and fire codes and whether any violations of applicable codes occurred. Whatever the need, investigators should always consider consulting with an engineer, scientist, or forensic testing professional, who might give them the guidance and scientific interaction their case might require.

As an insurance investigator or claims handler, always remember the expert is retained because of their particular expertise. Their job is to objectively evaluate the scene and its evidence, and to render a professional opinion. If there is something that the investigator does not understand or if they question the reasonableness of a stated opinion, *it should be clarified immediately*. Ultimately the claims handler, based largely on the results of the investigator's findings, will have to make the decision to pay or to deny the claim, so they should fully understand the evidence at hand. If it doesn't "feel right" to the investigator, it most likely won't "feel right" to a jury either. A complete understanding of the expert's findings and evaluating the overall claim will help make the appropriate decision regarding the claim when the time comes.

Summary

The expert selection process might seem tedious, but it is important to the success of an investigation. Selecting the investigator could make or break a case. It is important to remember the reasons that the selection process might not go as intended. One reason is due to "old timers" not wanting to change the

current process because they are used to the ways things have always been done. Or there might have been a verification process initially used that is now obsolete. Claims personnel might not comply, and experts selected might fail to update their files annually.

Literally hundreds of standard fire test methods exist to quantify the ignitability, flame spread, and heat and smoke generation characteristics of materials. Thus, the applicable fire test method for a given scenario should be discussed among the investigative team. The ability to prove an investigator's theory or opinion is what determines a successful investigative effort. Investigating a major fire or explosion incident is a challenge that requires specialized knowledge, as well as established procedures for collecting the evidence and documenting the findings to satisfy the legal standard of proof.