

# Profile of a Household Insurance Fraudster

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# / INTRODUCTION

Insurance fraud is a major problem. Research by the Association of British Insurers (ABI) has found that every hour there are 15 fraudulent insurance claims detected and that in 2011 detected fraud amounted to £983 million. This represented 5.7% of all claims in 2011 and in total there were 138,814 fraudulent insurance claims that were discovered.<sup>1</sup> In addition to this there are the many fraudulent claims that slip through the insurers' counter fraud controls. The ABI has suggested this could amount to another £2billion. To put this in perspective, benefits fraud, which secures significant media and political attention, amounted to £1.2 billion in 2011.<sup>2</sup> Insurance fraud is therefore potentially double the size of benefits fraud.

There is also evidence to suggest that the general public are much more open to the idea of committing insurance fraud compared to other crimes and frauds. Research on the opinions of the general public has found:

- / **Making up an insurance claim** – 37% would not rule out committing in the future, 29% think it is acceptable or borderline and 2% admit to having done it.

- / **Exaggerating an insurance claim** - 47% would not rule out committing in the future, 40% think it is acceptable or borderline and 6% admit to having done it.
- / **Using someone else's credit card** - 26% would not rule out committing in the future, 6% think it is acceptable or borderline and 2% admit to having done it.<sup>3</sup>

Similar research by Karstedt and Farrall<sup>4</sup> has also found that 22% of those surveyed in England and Wales would consider padding an insurance claim.

Unfortunately, until now there has been little research on those who have submitted fraudulent insurance claims. This research is unique in the sense that it uses a large dataset of individuals who have submitted claims, which could be regarded as fraudulent. This report will utilise this unique dataset to outline some of the characteristics of household insurance fraudsters. Before we consider some of the findings it would be useful to briefly discuss some of the research, which has sought to profile fraudsters.

# / PROFILE OF A FRAUDSTER

There is much interest in the subject of offender profiling where the key characteristics of offenders are identified with the aim of enabling better prevention and detection of fraud. There have been a number of attempts to profile fraudsters, yet these have tended to focus upon internal/occupational fraud against organisations, although some also cover external fraudsters. The table below profiles the characteristics from KPMG,<sup>5</sup> ACFE<sup>6</sup> and Bussmann and Werle.<sup>7</sup> The latter also included external fraudsters in their analysis. The ACFE study is based upon global returns and KPMG from Europe, The Middle East and Africa. The ACFE research, which is broken down into regions, also shows substantial differences between them, which there is not the space to consider here.

/ Table 1. Comparing the Profiles of Occupational Fraudsters

	KPMG 2011	ACFE 2012	Bussmann and Werle 2006
Gender	Male – 87%	Male – 65%	Male – 87%
Age	36-55 – 76%	36-50 – 51%	31-50 – 71%
Employment	+6 Years – 50%	+6 Years – 52%	
Management/Top Management	82%	55%	18%

The picture of a fraudster these studies suggest is a male, middle aged, with 6 years plus service and from a managerial position. This is not surprising given that men tend to dominate managerial positions and that it is these that generally offer opportunities to commit fraud. As the research will shortly show, the profile of a household insurance fraudster is very different.

# / THE DATA

Since 2007 VFM Services Ltd (VFM) has processed thousands of household insurance claims through its New ERA process of conversation management. The researchers were given a database of 39,163 household contents claims (no personal information relating to names and addresses was supplied in order to maintain customer anonymity and client confidentiality). These were divided into the following categories:

- / Declined due to fraud: 268
- / Withdrawn not plausible: 32,921
- / Withdrawn no contact with customer: 1,936
- / Declined due to no policy cover: 3,010
- / Withdrawn plausible: 1,028

The conversation management process results in a risk assessment of the claim and a classification. Claims where plausibility becomes an issue which meet a threshold of doubt are classified as not plausible. A higher level of evidence of doubt results in a fraud classification. A caveat to the data must therefore be noted that some of the lower ranking 'withdrawn not plausible' may have been assessed as such due to a claimant not articulating their claim effectively rather than dishonesty per se. Nevertheless given the assessment process used, most of the claims assessed in this category are highly likely to involve an element of dishonesty.

It is debatable whether the 'withdrawn not plausible' cases would frequently meet the criminal standard of evidence under the 2006 Fraud Act under Section 2 of committing fraud by false representation, and some of the fraud category might not either. However, under the civil law for fraud, A will have committed the tort of deceit (or fraud) in relation to B, if:

- (1) He made a representation of the fact to B which was untrue; and
- (2) When he made that representation to B he did not honestly believe it was true; and
- (3) He intended, by making that representation to B, to induce B to act in a particular way; and
- (4) B was induced to act in that way by A's representation.<sup>8</sup>

These claims have failed, so have not met part 4, but it is likely that most of the claims in the first two categories 'declined due to fraud' and 'withdrawn not plausible' would meet the first three tests. As such this data should be considered as

the largest dataset of information on individuals who have submitted dishonest claims, which could in many cases be classed as fraud at least under the civil law if they had been successful.

The data on thousands of claims handled by VFM involves cases that have not been paid out by the insurers. VFM provides New ERA conversation management services to a range of insurers. Some insurers contract out all their claims of a certain peril to VFM, others forward all cases judged as high risk. What VFM claims investigators do, is over the telephone discuss with the claimant their claim in a detailed and structured way. This enables the claim to be risk assessed effectively. Legitimate claims are then processed quickly, whereas higher risk claims face further scrutiny. The greater detail required from the claimant, in cases where there is dishonesty, tends to expose flaws in their claim. Consider for example a case where a claimant is making a claim for a flat-screen television, which has fallen off the wall. The conversation will explore this incident in detail and will discuss the location of the wall, exactly how it fell, what happened when it fell etc. In one case of this type, which was recorded and played to the researchers, the claimant revealed when the television fell there was broken glass. The claims investigator looked up the model and make of television to discover there is no such glass in that model of television. This was then revealed to the claimant who clearly sounded very uncomfortable. The crux of the conversation management process is that it does not work up to a confrontation during which a bogus claim is unambiguously exposed. Instead the claimant is left with the opportunity to supply further evidence of their version of events such as evidence of the glass in the television, by a certain date. However, most claimants whose claims are assessed as high risk decide not to pursue their case any further. In effect they are given an honourable way out, as in this case where the claimant never supplied any further information. Such claims are classified by VFM as 'withdrawn not plausible'. Some examples of such claims are listed in figure 1.

/ Figure 1. Examples of claims from the data set

**/ Theft by seagull**

After accidentally washing her £1,000 gold watch in her jeans pocket, the customer left it outside to dry on the garden table. After about five hours, the customer went to get the watch, only to discover it had disappeared. When asked how this could have happened, she confirmed that it was not possible for someone to gain access to the garden from the house and that there were no signs of anyone climbing over the fences. However, she stated that they do have a problem with seagulls flying down into the garden, creating mischief. After asking for full validation and a police report, the customer rang back the next day to advise that she'd since found her watch in the shed, having forgotten she had tidied some things away and therefore the watch must have got mixed up amongst them.

**/ Unlucky laptop owner**

The customer went out cycling in the woods, carrying his laptop and smartphone with him in a backpack. He last saw both items at lunchtime, but then at around 5pm, he noticed that the zip of the backpack was undone and that both items were missing. When asked if he'd reported the Sim card missing, he replied, 'Yes.' However, when asked for further details, he said that in fact he hadn't and had just remembered he had actually removed the Sim card that very morning, because he knew the phone wouldn't work in the woods due to poor reception. He took the phone and laptop with him merely to take and edit photos. When asked about previous claims, the customer confirmed that this was the third time he'd lost a laptop and acknowledged himself that this was 'ridiculous'.

When the claims investigator raised concerns with the claim, especially with the fact that the customer hadn't noticed the weight of the backpack altering in any way after the loss, the customer displayed deceptive behaviours. Ten minutes after completing the claim, the customer rang back to withdraw his claim, advising that the laptop had been found and handed in to the police.

**/ Dangerous bubbles**

The customer went out leaving her teenage son at home watching TV. When she came home, her son explained he had been playing with a bottle of bubbles and the end had come off, subsequently spraying the soapy liquid over the

TV screen and wall. He had wiped the liquid off the screen, but the picture had partly gone off. The top third of the picture still worked yet the bottom third had no picture. An engineer's report was requested to determine the cause of the malfunction. The engineer said he had never come across anything like this before – there was no way of water getting into, or behind the screen, from the front and when further inspected by him, he confirmed there was no sign of water ingress anywhere. The bubbles therefore were not the cause of the damage, but wear and tear.

**/ TV wobbler**

The insured advised that she was trying to move her TV and stand forward out of the corner so she could clean behind it; she pulled too hard and fell backwards. The TV wobbled and fell in the opposite direction towards the wall. The right hand side of the TV slipped down to the floor, whilst the left hand side somehow stayed wedged up on the stand. This resulted in the picture on the TV disappearing, but not the sound. Concerns were then raised with regards to the final resting place of the TV, along with a previous claim for a TV, which was not pursued. When pressed on discrepancies in the claim, the customer admitted that the damage had occurred pre-inception. This case was closed as fraud and the policy voided.

**/ Laptop stolen on a train**

The customer had his laptop in a rucksack, which he placed at his feet during a 45-minute train journey first thing in the morning. When he stood up to get off the train, he noticed items falling out of his bag. Upon closer inspection he discovered the bag had been cut and his laptop taken. The claims investigator had concerns about the credibility of the claim and the fact that somebody had supposedly 'cut' the bag and taken the laptop without the customer noticing. In addition to this, the policy had been taken out only one month prior to the loss and there was no validation for the purchase on account of the fact that the laptop had been bought from a friend who had since left the country and could not be traced. The customer paid almost £2,000 cash for the second hand laptop, even though it didn't come with any accessories, not even a charger. Furthermore, the customer could not explain how he had been keeping the laptop charged, but instead stated that he hadn't used it since buying it. When the customer was

pressed to provide validation, an email arrived from a UK account in the name of the 'friend' from abroad, confirming its purchase. However, the email contained similar spelling and grammar mistakes to that of the 'Statement of Fact' given by the customer and contained two misspellings of the friend's name. The claim was repudiated on the grounds that the customer could not prove ownership of the item.

**/ Fragile laptop and memory loss**

The customer advised that he carried his laptop into the lounge with the lid open and placed it on the sofa with the back of the lid leaning against the left arm of the sofa. He then walked into the kitchen to get a drink, taking ice out of the freezer and filling his glass. He was in the kitchen for around two minutes when he then heard a bang. He walked back into the lounge to discover the laptop almost

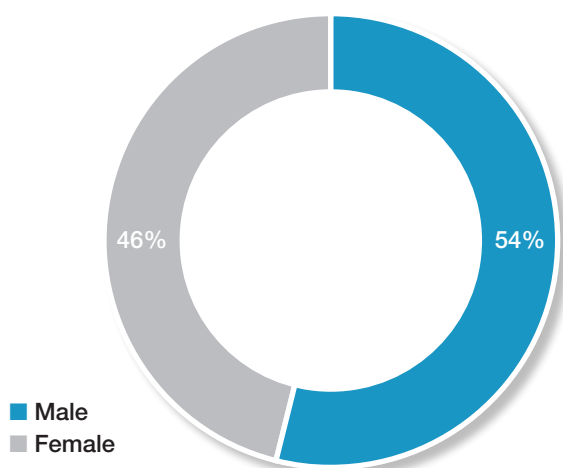
in two halves on the floor. He picked it up and found that whilst it was still working, the casing had cracked where the screen met with the keyboard. He then took the laptop to be repaired, but they laughed at him, telling him that there was a long list of issues and that its repair costs would be over £1000. During the assessment the Claims Investigator identified that the customer displayed a lot of deceptive behaviours regarding dates. When questioned further, he confirmed the date he had taken the laptop to the repairers, which turned out to be the same date as the initial call. Through a process of elimination and a series of critical questions, the customer confirmed that the accident happened in September. It was then pointed out to him that his policy was not incepted until the beginning of October. The customer finally admitted to knowing that he had no insurance in place for this event and the claim was repudiated.

# / THE PROFILE OF A HOUSEHOLD INSURANCE FRAUDSTER

## / Gender

One of the most striking findings from the research is the near equal gender balance of the dishonest claimants. Here 54% were male and 46% female. Previous profiles of occupational fraudsters have shown a dominance of men, which has been suggested is due to their dominance of positions of responsibility enabling them to secure the opportunities to commit fraud. This research shows that once opportunities arise the sexes will pursue them in a similar way. However, an alternative hypothesis might be that 'household' matters within traditional families may be regarded as 'the female domain'. That might also help explain a relatively high involvement of women. Both explanations would fit the criminological theory of 'Routine Activity Theory', which postulates that offending primarily occurs in the course of people's everyday life. It simply requires a motivated offender, a suitable target (the insurer may be seen as a weak and accessible target) and the perceived absence of guardians or other preventive measures. The existence of an insurance policy therefore may produce an easily available target for any motivated offender.<sup>9</sup> With opportunities equally open to men and women, the gender disparity often found in fraud research seems to disappear.

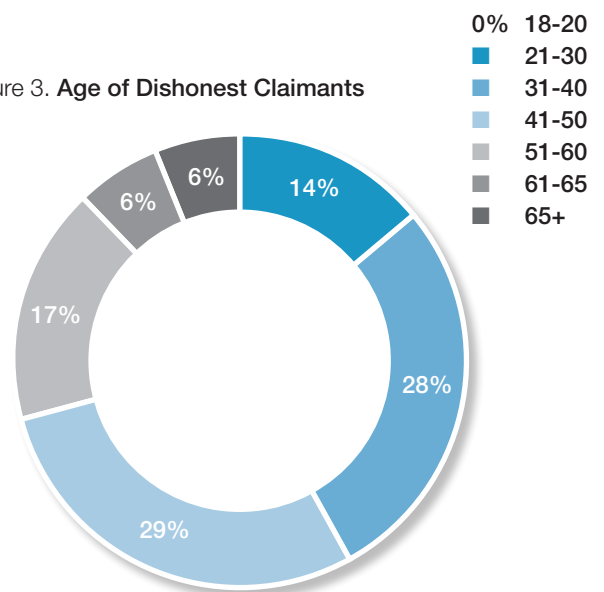
/ Figure 2. Gender of Dishonest Claimants



## / Age

Profiles of occupational fraudsters generally show a dominance of the 30-50 age group. The research for this report also shows the biggest group falling in the 31-50 age group representing 57% of the group. Those over 50 also accounted for a significant slice, representing 29%. The smallest group was the 18 to 29 group representing 14%. The mean age was 44, median 43 and mode 41 years old respectively. Given that most claims relate to insurance products that are more likely to be held by older persons this offers further insights upon Routine Activity Theory. This age group may simply be the most likely to hold household insurance policies. Furthermore, they may feel most able to competently report a fraudulent claim with a good chance of success and withstand what they might expect to be cursory scrutiny by the insurer. Making a fraudulent claim therefore would be part and parcel of everyday life where motivation and opportunity combine to produce this behaviour; perhaps the situation is as simple as to suggest that those most likely to hold policies are also most likely to make a dubious claim

/ Figure 3. Age of Dishonest Claimants



**/ Occupation**

Data was supplied by VFM on the occupations of those making a claim. The way VFM collect this data does not map across to the standard industrial classifications. The classifications VFM use allow for potential overlap, for example some of those recorded as self-employed might also be represented in other categories. The categories of civil servant and clerical might also overlap. It is likely, therefore, that data collected by VFM could not be compared to those standard industrial classification groups with confidence. The table below presents some of the largest groups identified from the occupations of dishonest claimants. There was only data on 8,723 of the claims, so percentages reflect the percentage of these known claims. Thus for the vast majority of dishonest claims there was no information on occupation.

**/ Table 2. Top 20 Occupations for dishonest claimants**

Rank	Occupation Classification	Percentage of Dishonest Claims
1	Health and caring	9.6%
2	Management	7.7%
3	Unemployed	7.6%
4	Retired	7.3%
5	Clerical	5.6%
6	Housewife/husband	5.4%
7	Self employed	4.8%
8	Financial and legal	4.4%
9	Teaching	4.1%
10	Engineering	3.8%
11	Skilled labourer	3.8%
12	Sales and marketing	3.8%
13	Retail	3.5%
14	Labourer	3.5%
15	Civil servant	3.3%
16	Transport and logistics	3.3%
17	Hospitality and entertainment	2.0%
18	IT	1.9%
19	Student	0.9%
20	Armed forces	0.6%

Table 2 shows the top 20 occupations by percentage from the known data. It is important to note that this table does not mean that health and caring are the most dishonest occupations for this type of claim. To undertake that kind of analysis it would be necessary to have data on the occupations of all claimants for comparison. However, it was not possible to secure this data at this time. Another complicating factor is the data was collected over several years, when the labour statistics do vary. Despite this, the researchers did undertake a crude comparison of some of the occupations above against some labour market data, where there was a degree of comparison possible.

The results from this analysis are set out in table 3. They show selected occupations where some comparison was possible, their percentage of dishonest claimants and the ratio of dishonest claims to the percentage of the population over 16. As noted above, ideally there would be a comparison to actual policyholders by occupation, but this data was not available. Clearly there are some occupations that are more likely to have insurance than others. Students would be an example where the prevalence of dishonesty would be expected to be lower because there are fewer students with household insurance policies (and it is much lower). Setting this aside, however, some broad similarity could be expected for many occupations. The third column in table 3 shows the ratio. If the percentage of dishonest claims matches the percentage of the population over 16 the score would be 1. If it is less than one it would suggest that this group has less dishonest claims, if it is greater than one it shows it has more dishonest claims than would be expected in the population.

The data shows that students at 0.2, the retired at 0.36, sales and marketing at 0.79 and clerical at 0.86 have less dishonest claims than their size in the population would suggest. This does not necessarily mean these groups are more honest, because of the lack of data on actual holdings of insurance policies of this type amongst these groups. It is also likely that students are less likely to have household insurance policies, which could account for their under-representation. This could also account for the retired too, but with these it could also confirm evidence that the older generations are more honest [or could be reflective of the fact that insurers are reluctant to refer elderly customers into a fraud screening process]. For those occupations with a suggestion of a more dishonest profile, the most prominent was armed forces with a ratio of 1.7, i.e. they were over 1 and half times higher than what would be expected given their size in the population over 16. Health and caring had a ratio of 1.47, unemployed 1.46, teaching 1.41 and management 1.31. The breadth of the industrial classifications, which cover health and caring



and management and the way these are collected by VFM make us less confident of these figures. However, teaching, unemployed and armed forces are much clearer to classify. The unemployed could include many without household insurance, so this could make them an even bigger risk. All the other occupations are also likely to represent those who are householders who are likely to have household insurance. Therefore, with all these groups there could be a suggestion of greater dishonesty. This is, however, clearly an area that requires more research and better data collection related to standard industrial employment categories.

/ Table 3. Selected categories assessment for comparison to dishonest claimants<sup>10</sup>

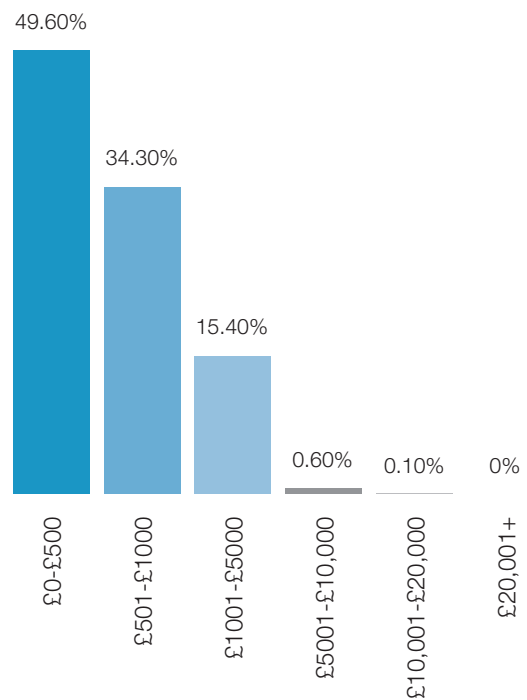
	% of Dishonest Claims	% of those over 16	% dishonest claims / % of population over 16
Retired	7.3%	20.2%	0.36
Unemployed	7.6%	5.2%	1.46
Students	0.9%	4.4%	0.20
Health and caring	9.6%	6.5%	1.47
Management	7.7%	5.9%	1.31
Armed forces	0.6%	0.35%	1.7
Clerical	5.6%	6.4%	0.88
Teaching	4.1%	2.9%	1.41
Sales and marketing	3.8%	4.8%	0.79

/ Value of claim made

VFM largely deal with claims under £10,000. Most of the claims related to items such as televisions, computers, jewellery etc, therefore it was unlikely to show a large number of dishonest claims of significant amounts. The median claim was for £500, mean £716 and mode £501. The distribution of claims showed 50% were £500 or less, 34% were £501 to £1000 and the rest were £1000 or more. Perhaps what is illuminating about these findings is that psychological experiments have shown that individuals are more likely to be dishonest with small amounts, than large amounts. Tests have been conducted on similar groups of individuals who are given opportunities to cheat and as the amount they can gain goes up, the level of dishonesty goes down slightly.<sup>11</sup>

Perhaps claimants therefore see £500 as a relatively small sum of money and worth the chance of securing, compared to putting in a claim for several thousand pounds.

/ Figure 4. Value of claim made by dishonest claimants



**Type of commodity claim made for**

Table 4 shows the most common commodities for dishonest claims. The top three were computers, televisions and mobile phones. These were then followed by multiple items, jewellery, home furnishings, other, bicycles, money and then audio systems.

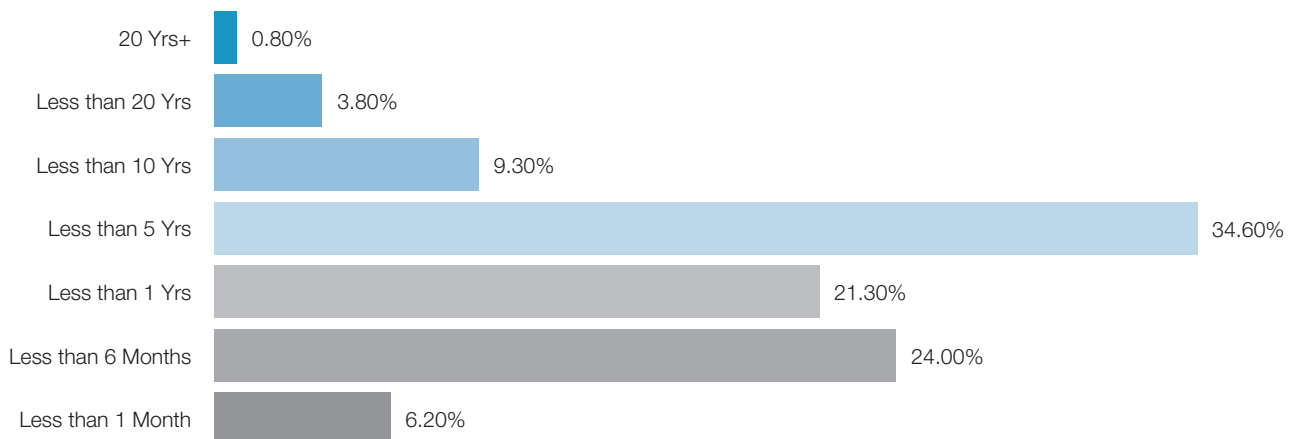
Table 4. Top 10 commodities for dishonest claimants

Rank	Commodity	Percentage
1	Computers	25.7%
2	Television	17.8%
3	Mobile Phones	14.1%
4	Multiple Items	11.1%
5	Jewellery	11.0%
6	Home Furnishings	8.2%
7	Other	2.7%
8	Bicycles	2.5%
9	Money	0.8%
10	Audio Systems	0.7%

**Length of time from opening policy to claim**

Figure 5 shows just over 50% of claimants had submitted a claim within one year of opening the policy, with just over 30% within 6 months. This would suggest claims made on a policy within a year of opening would seem to be at higher risk for fraud. However, it is also important to note that with the emergence of price comparison websites, customers changing insurance providers has become much more common, so this might just be a feature of the more common changes that occur.

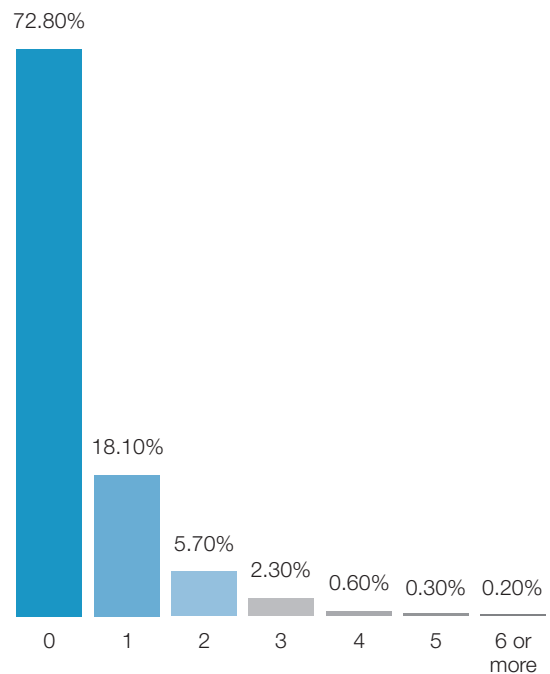
Figure 5. Period of time before dishonest claim made



**Number of previous claims made**

Another interesting finding was the significant number of 'virgin' claimants. When gaps in information were screened out, just under three-quarters had never made a claim before and when those who had made one previous claim were added, it rose to 90%. It highlights the fact that VFM deal with customers who haven't made previous claims. See figure 6.

Figure 6. Number of previous claims made



**/ The non-plausible scenario [Peril]**

Fabricating an insurance claim involves inventing an event that is covered or adapting and embellishing one that has occurred. By far the most common choice of scenario was found to be some form of accident. Here 85% of claims were in this category, followed by 12% through theft. This is also the least risky because fabricating a crime involves reporting it to the police, which increases the risk of getting caught as well as committing another crime with potentially more severe consequences ('wasting police time', 'perverting the course of justice'). This perhaps also offers further evidence to support 'Routine Activity Theory' in that most are choosing scenarios with the least perceived risk.

**/ Figure 7. Claimants' excuses**

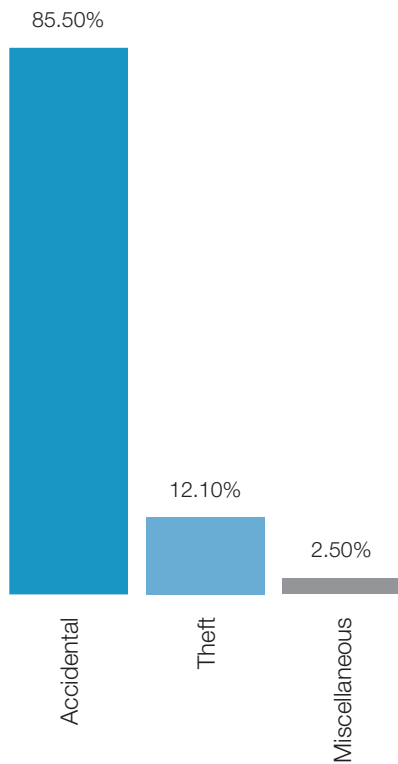


Figure 8 shows when the excuses are examined by commodity, again the overwhelming numbers are accidental. However, for jewellery and mobile phones theft, although small, accounts for a significantly larger number of excuses compared to the others, at around 10%. Clearly this is yet another area which requires research against the insurers whole book of work.

Figure 8. Claimants' excuses by commodity

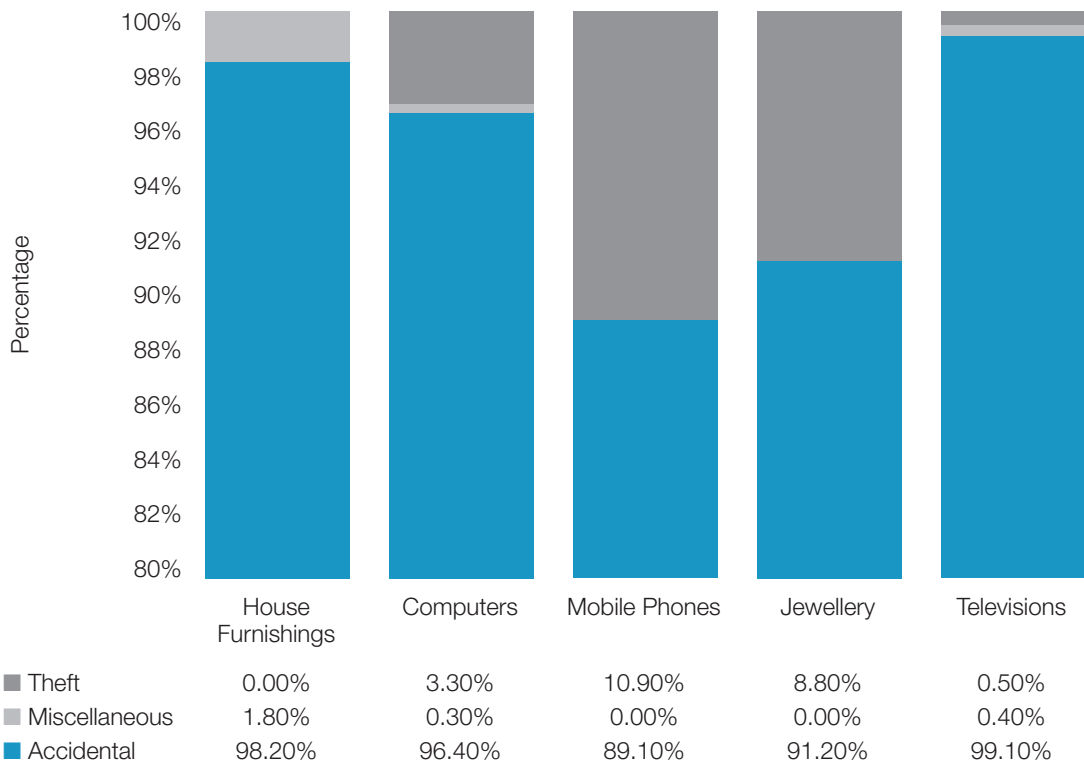
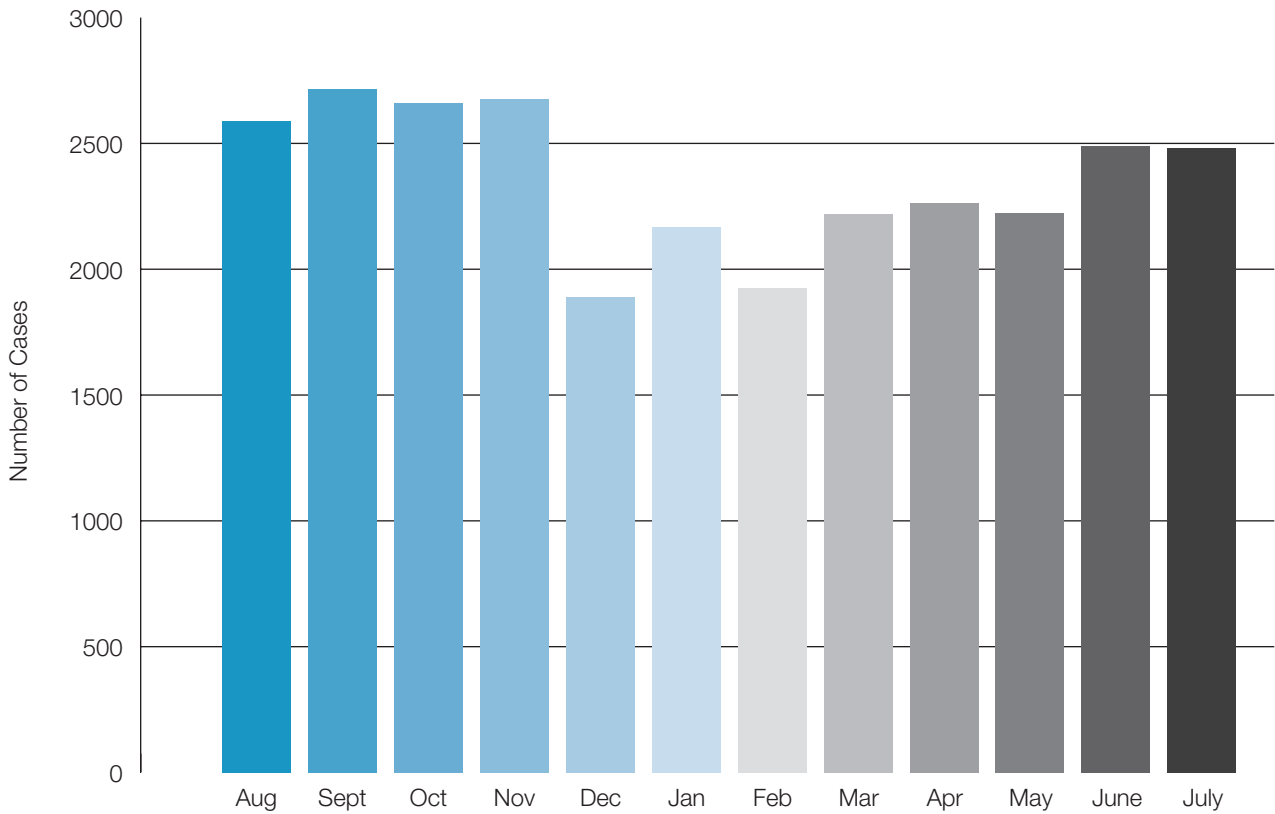


Figure 9. Dishonest claims by month

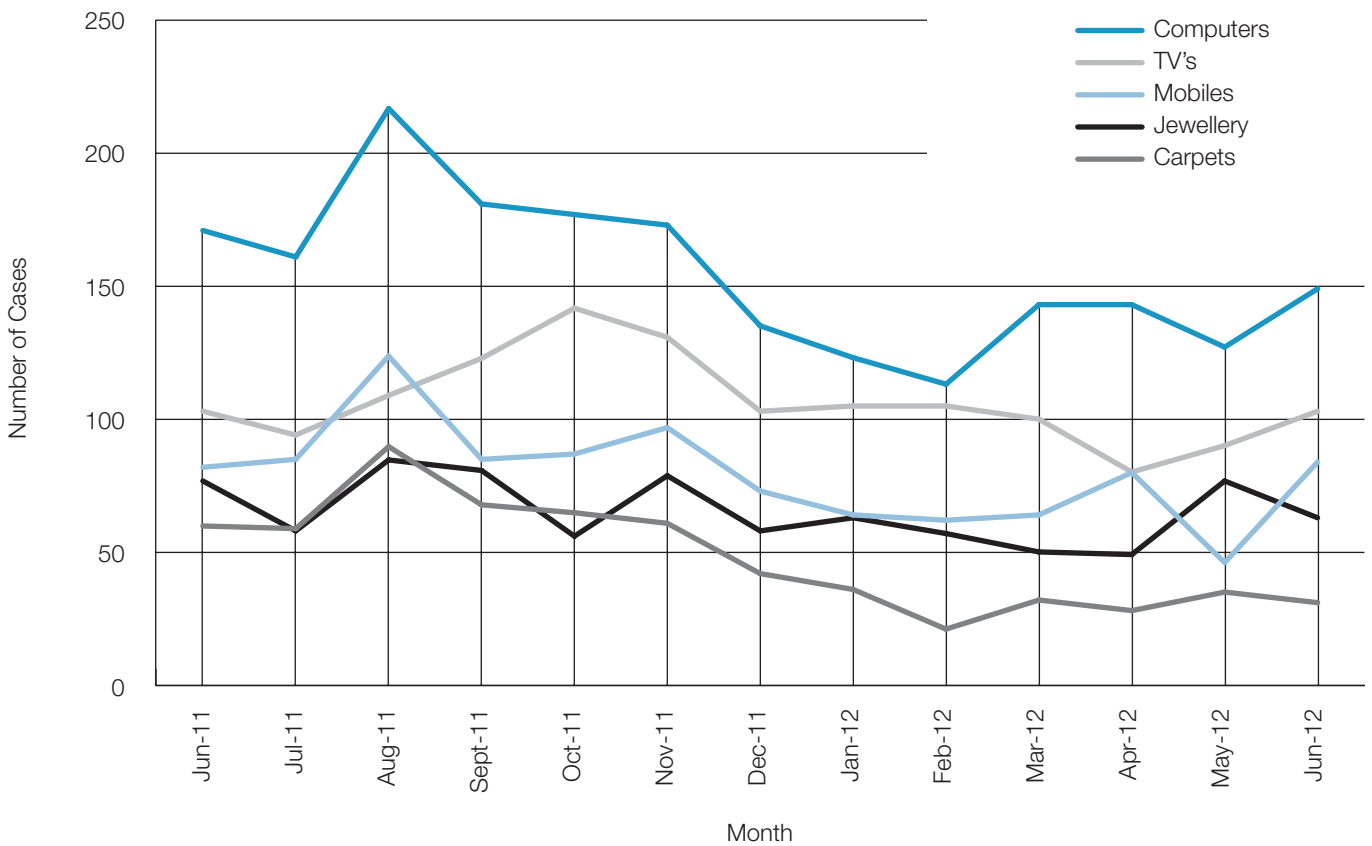


**Time of claim**

The researchers were able to undertake analysis of when the claim was made. The data only distinguished by commodity item from June 2011 onwards. However, it was possible to assess all claims by the month they were submitted to see if there is a particular time of the year where people are more likely to submit a dishonest claim. We can see that the months from August to September see more claims forwarded to VFM than the rest of the year. Here we cannot discern an increase in claims either in the build-up to Christmas or in the run up to the summer holidays. See figure 9.

It was also possible to assess the smaller dataset related to specific types of commodities. This analysis is presented in figure 10. Here we find that for computers, mobile phones, jewellery and carpets the peak month is that of August. For televisions however, the busiest month for dishonest claims is October. We may assume that if fraudulent claims occur further to the claimants' everyday activities this may be the case for these commodities as well. It is well established that TV viewing figures are highest in winter and lowest in the summer. October may be the start of increased usage of the television when the evenings draw in and people spend more time inside. The peak in TV claims may coincide with the steepest seasonal increase in TV watching. This could also be related to the school holidays: parents who take time off work to look after the children may find themselves with more time to make a claim; a return from a expensive family holiday may also provide the motive for embellishing or fabricating a claim to settle the credit card bills.

Figure 10. Dishonest claims by commodity by month



# / CONCLUSION

Two main conclusions can be drawn from this analysis. The first is that dishonest household insurance claimants differ in their demographics from occupational fraudsters and they also present a very different picture from regular offenders, which tend to be in majority male and in their teens or early twenties. From that we may infer that household insurance fraud may come about through a different set of dynamics than regular crime and other types of fraud.

We suggest that 'Routine Activity Theory' emphasising the connection between crime and the everyday life and circumstances of offenders, is a useful lens through which these results can be examined. What is claimed by who and when is probably frequently connected to aspects of their everyday life, such as ownership of goods. Professionals are more likely to claim for certain luxury items than others, e.g. the elderly. The seasonality of claims may also reflect seasonal variations in usage of certain items and hence patterns in claimant behaviour.

In addition, the work of Ariely et al. on dishonesty in everyday life suggests that many people are prepared to be 'a little dishonest' in life. A bogus household insurance claim may well be that perceived 'little dishonesty' that mostly honest people allow themselves to engage in. That may explain why the bulk of the claims are under £500 and that few claimants appear in these figures more than once. Finally we note, however, that dishonest claims are relatively often made soon after an insurance policy has been taken out. That may be a factor to be taken into account when assessing risk.

Clearly there also needs to be more research on this subject and the authors have further research planned on the geographical location and consumer classifications. More research also needs to be conducted on occupations and prevalence of fraud. For this purpose it will also be beneficial for insurers to collect more data when claims are made and to do so against standard classifications. This research is hopefully the start of many by these and other authors to start to truly understand the problem of insurance fraud.

## / End Notes

- <sup>1</sup> Association of British Insurers (2012) *No Hiding Place: Insurance Fraud Exposed*. London: Association of British Insurers.
- <sup>2</sup> National Fraud Authority (2012) *Annual Fraud Indicator*. London: NFA
- <sup>3</sup> ABI (2003). *What is Dishonest?* Retrieved 26 November 2007 from <http://www.abi.org.uk/Publications/24810.pdf>
- <sup>4</sup> Karstedt, S. and Farrall, S. (2006) The Moral Economy of Everyday Life. *British Journal of Criminology*, 46 (6): 1011-1036.
- <sup>5</sup> KPMG (2011) *Who is the Typical Fraudster*. London: KPMG.
- <sup>6</sup> ACFE (2012) *Report to the Nations on Fraud and Occupational Abuse*. Austin: USA.
- <sup>7</sup> Bussmann, K., D. and Werle, M., M. (2006) Addressing Crime in Companies First Findings from a Global Survey of Economic Crime. *British Journal of Criminology*, 46, 1128-1144.
- <sup>8</sup> McBride, N., J. and Bagshaw, R. (2005) *Tort Law*. London: Longman. P435.
- <sup>9</sup> Felson, M. (2002) *Crime and Everyday Life: Insights and Implications for Society*. Thousand Oaks, UK: Pine.
- <sup>10</sup> Labour market data sourced from: Office for National Statistics (2012) Labour Market statistics, June 2012. Retrieved on 16 November 2012 from [http://www.ons.gov.uk/ons/dcp171778\\_265818.pdf](http://www.ons.gov.uk/ons/dcp171778_265818.pdf) and All In Employment By Status, Occupation & Sex. (Apr – Jun 2012). Retrieved from Office for National Statistics website: <http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-21588>. Statistics on size of the armed forces from <http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121025/text/121025w0001.htm>
- <sup>11</sup> See Mazar, N., Amir, O. and Ariely, D. (n.d.) The Dishonesty of Honest People: A theory of Self-Concept Maintenance; Mazar, N. and Ariely, D. (2006) Dishonesty in Everyday Life and Its Policy Implications. *Journal of Public Policy and Marketing*, 25, 1-21.

# / ABOUT THE CENTRE FOR COUNTER FRAUD STUDIES

The Centre for Counter Fraud Studies is a specialist research and knowledge services centre focussed upon counter fraud and is part of the Institute of Criminal Justice Studies, University of Portsmouth. It provides research, consultancy, academic courses, specialist training courses and accreditation services to the public, private and voluntary sectors to enhance their resilience to fraud.

The Centre also hosts the Fraud Hub, which is an online repository of research and publications on fraud open to those registered with the Centre. The Centre also hosts in partnership with the Portsmouth Business School Accounting Group the annual counter fraud and forensic accounting conference. The Centre is also linked through the provision of Secretariat functions to the Counter Fraud Professional Accreditation Board.

## / For more information

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