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Cracking Down on Claims Fraud: The Evolving Penalties for Motor Insurance Scams

Motor insurance fraud has long been a feature of the UK claims landscape, but there is a growing appetite among insurers to pursue it through the courts and among courts to respond positively to cases presented before them. The recent jailing of a cyclist who exaggerated the severity of his injuries following a collision with a vehicle insured by Admiral serves as an example of an increasing will to hold fraudsters to account. However, the scale of the problem will require a sustained focus to drive a shift away from where the industry now stands and towards meaningful change.

The Scale of the Problem

The current landscape shows fraud as a considerable issue growing in magnitude, with the Association of British Insurers (ABI) highlighting that UK insurers detected a record £1.16 billion worth of fraudulent insurance claims in 2024, a 2% increase on the previous year. Insurers uncovered at least 98,400 fraud-related claims, a 12% rise from 88,100 in 2023, with motor insurance the biggest area with 51,700 fraudulent claims worth £576 million, 53% of all claims detected and a 5% increase from 2023.

According to analysis based on data from the ABI and Insurance Fraud Bureau (IFB), Motor insurance fraud is now so widespread that it impacts more than one in every five claims submitted. The cost of this deception adds an estimated £50 to £60 to every honest driver's annual premium, so fraud can be seen as a tax directly levied on honest policyholders by dishonest claimants.

Estimates suggest a similar amount of fraud goes undetected each year, which is why insurers invest at least £200 million annually in fraud identification. Even then, the gap between detected and actual fraud remains significant.

Evolving Tactics and Detection

The fundamental nature of motor fraud is shifting, and whilst exaggerated personal injury claims, particularly whiplash, remain the most common form, fraudsters are becoming more creative in their method and presentation. Admiral has reported a 71% rise in fraudulent motor, home and travel claims, with AI increasingly being used to tamper with photographs submitted in support of claims. The insurer found in a poll that 13% of people admitted inflating an insurance claim, with 25% confessing they had been tempted to do so. Despite exaggerating a claim carrying serious consequences, a significant proportion of people do not believe meaningful punishment will follow, and only 19% cited fear of criminal prosecution as their primary deterrent.

The legal framework for addressing fraudulent behaviour has progressed in recent years, with the 'fundamental dishonesty' provisions under section 57 of the Criminal Justice and Courts Act 2015 the most common tool used. This allows courts to dismiss personal injury claims in their entirety where serious dishonesty is established, even if elements of the claim are genuine. Committal for contempt, governed in England and Wales by Civil Procedure Rules Part 81, is a more severe and less frequently used measure, usually applied to only the most egregious and persistent deception.

Sending a Clear Signal

A recent case that attracted headlines involved Joshua Allen, who suffered a fractured kneecap in February 2016 when he was knocked off his bicycle by a car insured by Admiral. Medical advice at the time indicated he was expected to make a full recovery within three months, but what followed was a claim that had little resemblance to that prognosis.

Mr Allen claimed he had serious long-term symptoms, maintaining he was unable to work, could no longer cycle, and that he required ongoing care. The total of his claim was around £320,000, despite medical experts concluding that the injury should have healed well and that Mr Allen should have regained normal movement within a relatively short time. When examined, he adopted an unusual walking style which was described by one expert as inconsistent with his injury and more likely to worsen his condition than improve it.

Once available, surveillance evidence filmed six months after the accident showed Allen walking normally, riding a mountain bike, performing wheelies and later riding a motorcycle, all without any visible sign of the limitations he had described. A straightforward and unambiguous case of opportunistic exaggeration might have ended there, with the claim struck out and a costs order made. However, Mr Allen's next actions made his position significantly worse.

Rather than accepting the surveillance footage, Mr Allen denied he was the person shown and submitted witness statements from friends who fraudulently claimed that one of them was the cyclist captured on film. Another friend claimed they were not close to Mr Allen and had never visited his home, unaware that the footage clearly showed the cyclist riding directly into Mr Allen's driveway.

Mr Allen's legal team subsequently withdrew, and his injury claim was struck out. However, Admiral then applied for his committal to prison for contempt of court. The judge rejected Mr Allen's evidence in its entirety, describing him as an unreliable witness and his explanations as "*ridiculous*", before sentencing him to ten months' imprisonment. In ruling, the judge treated Mr Allen's response to the surveillance evidence, together with his attempt to support a fraudulent case with false witness testimony, as particularly serious.

In articulating Admiral's position, the Head of Technical Claims, Stuart Cook, said, "*Not only did Mr Allen lie to us, he lied to the court and then compounded those lies by persuading others to support them. Justice demanded that he be held to account, and we hope this outcome sends a clear message that Admiral will not tolerate dishonesty and will use all available tools to deal decisively with fraud.*"

The case is significant for the custodial sentence itself, but also because it sends a clear message that exaggeration, especially when accompanied by persistent dishonesty, will attract consequences that extend well beyond claim rejection.

In another incident, Admiral and Horwich Farrelly secured a significant civil judgment against mother and son Inderjit and Simerjit Singh, who conspired to exaggerate the mother's injuries following a minor accident. The claim was valued at £9,500, but the total value of her claim exceeded £2 million, stating she had suffered significant cognitive impairment and needed round-the-clock care. Her son submitted fraudulent witness statements and a fabricated schedule of care in support of the claim.

Surveillance and investigation revealed she was walking unaided and driving, with the pair ordered by the courts to pay costs and damages exceeding £200,000. The case serves as a reminder that claimants who dishonestly exaggerate their otherwise genuine claims should be wary of the power the court has to dismiss claims and that those who assist in such deception face their own punishments.

A recent case, this time exploiting the claims supply chain rather than directly targeting an insurer, involved Kamlesh Vadukul and Raju Patel. Together, they ran Tyre Boys Ltd, a Walsall repair shop, as a front for 'crash for cash' fraud and between 2015 and 2016 they staged or invented road traffic collisions using stolen or borrowed identities to claim against insurers. The pair obtained a credit agreement with Accident Credit Group, gaining access to short-term finance across 39 cases totalling more than £275,000.

Both defendants pleaded guilty to conspiracy to commit fraud by false representation and to transferring criminal property, with Mr Vadukul sentenced to a total of more than 6 years' imprisonment and Mr Patel sentenced to seven years and six months.

The Industry Response

Insurers are investing heavily in the tools and processes needed to detect and respond to fraud. Aviva prevented over 6,000 fraudulent claims in the first half of 2025 alone, avoiding more than £60 million in losses, whilst Allianz UK detected £92.6 million in fraudulent activity during the same period, a 34% increase year-on-year. The Insurance Fraud Bureau has also launched a five-year anti-fraud strategy called 'Connected to Protect' to strengthen industry collaboration and public awareness.

The Economic Crime and Corporate Transparency Act 2023 has also introduced a corporate criminal offence of failure to prevent fraud, which requires insurers to amplify existing anti-fraud controls and processes and ensure any changes are reflected in existing compliance frameworks.

Between 2019 and 2023, whilst general inflation rose by 21%, motor insurance claims costs increased by 34%, a trend that shows no sign of declining and one that further reinforces the urgency of the issue. This level of fraud, operating alongside legitimate inflationary pressures, makes the gap wider and increasingly harder to close.

For legal professionals operating in this area, stricter proportionality rules and heavy penalties for fundamental dishonesty have changed the landscape, and courts are more willing to impose custodial sentences in cases where the actions of the claimant are particularly blatant. In addition to the investments insurers are making in surveillance capability and cross-industry data sharing, cases are being pursued to act as a deterrent for potential fraudsters, and not just to defend a claim. In doing so, insurers are sending a clear message that, when detected, fraud will be punished to the fullest extent of the law.

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