THE SUPREME COURT OF APPEAL
OF SOUTH AFRICA

Reportable

CASE NO: 01/2002

In the matter between :

S SCHOEMAN **Appellant**

and

CONSTANTIA INSURANCE CO LTD **Respondent**

Coram: **MARAIS, ZULMAN, STREICHER, CAMERON *et* LEWIS JJA**

Heard: **20 February 2003**

Delivered: **21 May 2003**

Insurance – burglary – claim allegedly partly fraudulent – no express forfeiture clause in policy – no such term implied *ex lege* or tacitly incorporated – when overvaluation of loss amounts to fraud – whether fraud proved.

J U D G M E N T

MARAIS JA/

MARAIS JA:

[1] I refer to the parties to this appeal as they were referred to in the court *a quo*. Appellant was the plaintiff and respondent was the defendant. The claim was under an insurance policy for indemnification for loss suffered as a consequence of a burglary. The question of liability was considered as a separate issue. Plaintiff was held to have forfeited her claim because she had fraudulently exaggerated her loss. With leave granted by the trial judge (Joffe J) she contests the finding.

[2] Unlike many policies of this kind this policy has no express term providing for a forfeiture in such circumstances. Joffe J upheld defendant's contention that a term to that effect was implied by law (as opposed to a tacit term derived from the supposed unexpressed consensus of the parties). As to the facts, he held that it had been established by defendant that plaintiff had fraudulently inflated her claim. The judgment is reported in 2002 (3) SA 417 (W). Whether those findings were correct were the two issues debated before us, one legal the other factual.

The legal issue

[3] Fraud in connection with insurance policies has many manifestations.[1] This case is not concerned with pre-contractual fraud. Nor is it an instance of post-contractual fraud such as that in which a claim is made when no loss at all

[1] They are conveniently summarized in Professor J P van Niekerk's article "Fraudulent Insurance Claims" in 2000 *SA Mercantile Law Journal*, vol 12 at pages 71-74.

was actually suffered, or the loss-causing event was not covered by the policy, or the loss was engineered by the insured. It is a case of alleged post-contractual fraud in which a claimant with a valid and legitimate claim to be indemnified for loss which had occurred and was covered by the policy, is alleged to have knowingly and falsely increased what she thought to be the true quantum of the claim by adding to it an arbitrary 10%.

[4] An implied term of the kind for which defendant contends would bring about, on proof of fraud, a forfeiture of plaintiff's entire claim including that part of it which would otherwise have been a valid and enforceable claim which defendant was contractually obliged to pay. That is no more than should be expected says defendant for, given the special nature of the contract of insurance and the vulnerability of insurers to fraud, the wages of fraud should be forfeiture of all claims, even legitimate ones. Not so, says plaintiff, who grants that the law prohibits anyone from profiting from fraud but argues that as long as such a claimant is restricted to recovering only the amount which is truly payable there is no infraction of that principle. To deny the claimant even that which is truly payable and for which a premium has been paid, is to impose a penalty upon the claimant – something quite disproportionate and against which our law by and large sets its face. Shorn of elaboration and references to the case law, text books and journals, those are the respective contentions of the parties.

[5] In the heads of argument filed by the plaintiff a concession was made that

fraud in the making of a claim resulted *ex lege* in forfeiture of the claim but it was suggested that a more precise formulation of the rule was required. At the hearing the plaintiff's counsel who had not drawn the plaintiff's heads of argument withdrew the concession as he was entitled to do, it being a matter of law. Oral argument ensued directed to establishing that no such term should be implied *ex lege* or be found to have been tacitly agreed upon by the parties. While the pros and cons of the respective stances of the parties were fully debated there was no more than passing reference to the writers on the Roman-Dutch law. We were handed some references supplied by Professor Thomas of the University of Pretoria and referred to Professor van Niekerk's published work on the topic but there it ended.

[6] The sole reference to any attempt to deal with this particular kind of problem in Roman-Dutch law was said to be an opinion given by Grotius in Hollandsche Consultatien.[2] He opined that an insured who had submitted an exorbitant (and suspected to be fraudulent) claim for expenses allegedly incurred to save the insured property should have his claim reduced to the expenses which would have been incurred by a reasonable person acting in good faith. In my view, it is not entirely clear that this was an example of fraud not resulting in forfeiture of the claim. There was only a suspicion of fraud and even in the absence of fraud the insured would not have been entitled to recover more than should reasonably have been expended. It is therefore dubious positive authority for the proposition that fraud in respect of part of an otherwise valid claim does not result in forfeiture of the entire claim.

[7] On the other hand, it seems reasonably clear that the sanctions against the presentation of a fraudulent claim in Roman-Dutch law were first, a refusal to allow an insured to profit (my emphasis) by the fraud, secondly, a rendering of the insured liable for any loss or expenditure caused by the fraudulent conduct, and thirdly, criminal sanctions entailing rigorous punishment.[2] Forfeiture of the

[2] Vol (2) cons 175, p471 (*Utrecht & Amsterdam* ed. 1745). A translation of this opinion will be found in D P de Bruyn, *The Opinions of Grotius*, p594

[2] See Grotius, *Inleidinge III*.24.2; Van der Keessel, *Praelectiones ad Inleidinge*, III.24.20; Van der Linden,

entire claim does not appear clearly as one of the available sanctions.

[8] In *Videtsky v Liberty Life Insurance Association of Africa Ltd*[3] the insured had a legitimate claim but sought to reinforce it by fraudulently forging a signature on a physiotherapist's report. The court (Flemming J) declined to accept the proposition that forfeiture of the claim was the consequence because of the existence of a term to that effect arising *ex lege*. He concluded that no such term existed or should be held to exist in our law.

[9] There are thus two conflicting judgments in the High Courts and despite my reluctance to do so in the circumstances in which the issue was argued, I am persuaded that it is in the public interest that the conflict be resolved. As the English cases featured so strongly in the argument of the defendant's counsel, I shall commence there.

The English law

[10] Understandably, defendant relied heavily upon cases decided in England. They undoubtedly provide support for the general thrust of the proposition for which defendant contends but it does not necessarily follow that South African law is or should be the same. That is not to say that there is no value in looking at the way in which English law deals with this kind of problem. Apart from the fact that our courts have done so for generations in the field of insurance law and that in some provinces the English law of insurance was specifically made applicable by statute,[4] it would be parochial indeed to treat with disdain decisions of the courts in a highly developed and sophisticated mercantile nation

Koopmanshandboek, IV.6.10. The view of the jurists as to the effect of fraud is given and discussed by Professor J P van Niekerk in his work, *The Development of the Principles of Insurance Law in the Netherlands from 1500 to 1800*, Vol II, pp. 993-1012.

3 1990 (1) SA 386 (W).

4 See generally *Gordon and Getz on the South African Law of Insurance*, 4 ed (D M Davis) at 1-7; 12 LAWSA 16-20.

with a vast storehouse of such decisions accumulated over centuries. That accumulated wisdom merits the fullest consideration but one must guard against being mesmerized by it.

[11] A fully comprehensive review of the English cases and journals is not possible if this judgment is to be kept within the bounds of reasonable length. Instead, I shall summarise what I understand the existing state of English law to be concerning the kind of problem which this case raises. I confine myself to the case where there is no express forfeiture clause in the policy.

[12] 'Even when the policy does not contain such a clause, there is a rule that the assured is penalised (emphasis supplied) for fraud in the making of a claim.'[5] 'What is clear is that the assured who is detected in dishonestly making a false statement as to part of his claim automatically forfeits the entire claim.'[6] The penalty is that the claim is forfeited even although it was in all other respects a valid claim which, but for the fraudulent conduct, would have had to be paid. The penalty may extend even further and entail the termination or avoidance of the policy with prospective effect by the insurer. Whether the rule rests upon the fraud amounting to a breach of a continuing duty to observe the utmost good faith which characterises the entry into a contract of insurance in English law, or whether it rests simply upon considerations of public policy and a special need to provide a robust, if draconian, sanction to deter insurance fraud may still

5 *MacGillivray on Insurance Law*, 10 ed, paras 19-54

6 *MacGillivray, ibid,* paras 19-56, 19-60

remain a question. However, there is no doubt that the rule of law exists. The most recent decision in the House of Lords affirms it.[7]

[13] There are powerful and persuasive reasons given by the English judges for the existence of this admittedly penal rule. A selection: 'It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed. And if there is wilful falsehood and fraud in the claim, the insured forfeits all claim whatever upon the policy.'[8] 'The logic is simple. The fraudulent assured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.'[9] 'Just as the nature of the risk will usually be within the peculiar knowledge of the insured, so will circumstances of the casualty. It will rarely be within the knowledge of the insurance company. I think that the insurance company should be able to trust the assured to put forward a claim in good faith. Any fraud in making the claim goes to the root of the contract and entitles the insurer to be discharged.'[10] '(T)here is … an incentive to honesty if the insured knows that, if he is fraudulent, at least to a substantial extent, he will recover nothing, even if his claim is in part good.'[11] 'The making of dishonest insurance claims has become all too common. There seems to be a widespread belief that insurance companies are fair game, and that

7 *Manifest Shipping Co Ltd v Uni-Polaris Co Ltd, The Star Sea* [2001] 1 All E.R. 743, 764 para 62.
8 Willes J in *Britton v Royal Insurance Company* (1866) 4 F & F 905, 909.
9 Lord Hobhouse in *The Star Sea, supra,* 764 j-765 a.
10 Hoffmann LJ in *Orakpo v Barclays Insurance Services and Another* [1995] LRLR 443 (CA) 451.
11 Sir Roger Parker in *Orakpo v Barclays Insurance Services and Another, supra,* 452.

defrauding them is not morally reprehensible. The rule … may appear to some to be harsh, but it is in my opinion a necessary and salutary rule which deserves to be better known by the public. I for my part would be most unwilling to dilute it in any way.'[12] '(I)t is well accepted that the law has a disciplinary element in order to discourage the making of false and fraudulent claims.'[13]

[14] The potential harshness of the rule was remarked upon by Lord Phillimore[14] over 75 years ago and English courts appear to have felt constrained to ameliorate the rigour of the rule by a resort to qualifications the boundaries of which are not easily determinable. Thus, the rule does not apply to 'anything … so unsubstantial as to make the maxim *de minimis* applicable'.[15] 'One should naturally not readily infer fraud from the fact that the insured has made a doubtful or even exaggerated claim. In cases where nothing is misrepresented or concealed and the loss adjuster is in as good a position to form a view of the validity or value of the claim as the insured it will be a legitimate reason that the assured was merely putting forward a starting figure for negotiation.'[16]

[15] 'If a claim is fraudulently inflated so that the claim is made in an amount which the plaintiff clearly knows he has not suffered, that will amount to a fraudulent claim and will have the same effect. . . . However, it is important

[12] Millet LJ in *Galloway v Guardian Royal Exchange (UK) Ltd, [1999] Lloyd's Rep I.R. 209 (CA) 214.*

[13] Longmore LJ in *K/S Merc-Scandia XXXXII v Certain Lloyd's Underwriters:* The "*Mercardian Continent*", [2001] 2 Lloyd's LR 563 (CA) 575.

[14] *Lek v Mathews* (1927) L.C.L.R. 141 (HL) 164.

[15] Lord Sumner in *Lek v Mathews, supra*, 145.

[16] Lord Hoffmann in *Orakpo v Barclays Insurance Services and Another, supra*, 451.

to stress that in connection with this way of putting the claim it is my view that very clear evidence of fraud would be required because one has to accept as a matter of commercial reality that people will often put forward a claim that is more than they believe that they will recover. That is because they expect to engage in some form of "horse trading" or other negotiation. It would not generally in those circumstances be right to conclude readily that someone had behaved fraudulently merely because he put forward an amount greater than that which he reasonably believed he would recover. He would have to put forward a claim that was so far exaggerated that he knew that in respect of a material part of it, there was no basis whatsoever for the claim.'[17]

[16] However there is a lone voice raised in dissent. In the case of *Orakpo v Barclays Insurance Services and Another*[18] Staughton LJ had this to say in a minority judgment on this aspect of the case:

'Of course, some people put forward inflated claims for the purposes of negotiation knowing that they will be cut down by an adjuster. If one examined a sample of insurance claims on household contents, I doubt if one would find many which stated the loss with absolute truth. From time to time claims are patently exaggerated; for example, by claiming the replacement cost of chattels, when only the depreciated value is insured. In such a case it may perhaps be said that there is in truth no false representation, since the falsity of what is stated is readily apparent. I would not condone falsehood of any kind in an insurance claim. But in any event I consider that the gross exaggeration in this case went beyond what

17 Thomas J in *Nsubuga v Commercial Union* [1998] 2 Lloyd's LR 682 (QB) 686.

18 *Supra*, 450-451.

can be condoned or overlooked. Nor was it so obviously false on its face as not to amount to a misrepresentation. . . . . There is, however, one aspect of this second defence [fraud in the making of the claim] which gives me pause. For a long time it has been very common for insurance policies to state expressly that, if any claim is made which is false or fraudulent, all benefit under the policy will be forfeited. There is no such provision in the insurance contract in this case. . . . . Why did the draftsman omit the provision which had previously been so common? . . . . . I do not know of any other corner of the law where the plaintiff who has made a fraudulent claim is deprived even of that which he is lawfully entitled to, be it a large or small amount. I certainly would not imply such a term in order to give business efficacy to the contract, or because it is so obvious it goes without saying. But Mr Phillips says that it is to be implied as a matter of law; in other words, it is a term which the law imposes unless the parties contract out of it.

The argument is that a contract of insurance is one of the utmost good faith. So it is in the formation of the contract. The customer must disclose every material circumstance in his knowledge, even if, or rather especially if it increases the risk. If he does not do so the insurer may avoid the contract. It is said that the same duty of good faith applies in making claims, and that the same consequence follows if it is not observed. I can readily accept that there is a duty not to make fraudulent claims; but I have doubts about the suggested punishment for breach of that duty. [After referring to cases and the text books which support the doctrine of forfeiture, Staughton LJ continued.] But we were not told of any authority which binds us to reach that conclusion. I would hesitate to do so, so I am not convinced that a claim which is knowingly exaggerated in some degree should, as a matter of law, disqualify the insured from any recovery. If the contract says so, well and good – subject always to the Unfair Contract Terms Act. But I would not lend the authority of this Court to the doctrine that such a term is imposed by law'.

The United States of America

[17] In at least two states the courts refuse to acknowledge the existence of a forfeiture rule unless an express term to the same effect has been incorporated in the policy.[19]

The South African law

[18] The use in insurance policies of express terms which provide for a forfeiture of the entire claim even if only a part of it is fraudulent is of course common. It has never been suggested either here or in England that such a provision is entirely unenforceable[20] because of its penal nature but it does not follow that where such a term has not been expressly agreed upon by the parties, it should be regarded as either having been tacitly incorporated in the policy by the parties or as having been so incorporated by operation of law.

[19] Even in a case (*Lehmbecker's Earthmoving & Excavators (Pty) Ltd v Incorporated General Insurances Ltd*[21]) in which such a term had been expressly incorporated this court declined to give it its wide literal meaning because of the "grossly and intolerably disproportionate" penal effect which doing so could have.[22] That was a case in which a valid claim had arisen under a policy but before it was paid a further claim was made in respect of another incident. The

[19] *Phoenix Insurance Co v Moog* (1884) 78 Ala 284; *Tempelis v Aetna Casualty & Surety Co* (1991, App) 164 Wis 2d 17.

[20] It has been suggested that such a provision may be governed by the Conventional Penalties Act 15 of 1962 and that s 59 of the Long-term Insurance Act 52 of 1998 and s 53 of the Short-term Insurance Act 53 of 1998 may be applicable. See J P van Niekerk, *2002 SA Mercantile L J* 575, 578, 584. I express no opinion on these matters.

[21] 1984 (3) SA 513 (A).

[22] At 522 E-F.

latter claim was fraudulent. Relying upon a clause in the policy which provided that if a claim was fraudulently made "all benefit under this policy shall be forfeited", the insurer terminated the policy and refused to pay either of the claims. There was no connection between the claims. The insured sued to recover only the first claim. The claim was upheld. The court was not prepared to interpret the admittedly wide language of the provision as extending to a previously accrued valid claim which was not tainted by fraud.

[20] The implications of that judgment upon a case where there is only one incident giving rise to a claim and that claim is partly, but not wholly, fraudulent are not entirely clear. By parity of reasoning it can be argued that the right to claim the indemnity accrued before the making of the partly fraudulent claim and that the subsequent fraud cannot preclude the insured from claiming what was truly due under the policy. Such an argument could not succeed in the face of an express clause such as there was in *Lehmbecker's* case[23] for it would render the clause entirely nugatory. But where there is no such clause it is difficult to see why the reasoning based upon the accrual of the liability to indemnify prior to the fraud should not lead to the same conclusion.

[21] Our common civil law is basically anti-penal.[24] Until statutory intervention took place[25] penalty provisions in contracts (with the exception of a

23 Supra.

24 *Pearl Assurance Co v Union Government* 1934 AD 560 (PC).

25 Conventional Penalties Act 15 of 1962.

forfeiture clause accompanying a *lex commissoria* in a contract of sale[26] sanctioned in *Voet* 18.3.3) were unenforceable. In the law of delict punitive damages are not claimable. Fraudulent attempts to exact greater payment under other kinds of contract, even though they all also require good faith, do not result in the innocent party being relieved of the obligation to pay even that which is in fact due. Lies told by a plaintiff when giving evidence in support of a claim will not debar the plaintiff from obtaining a judgment for that which is otherwise satisfactorily proved to be owing. There would therefore have to be either a clearly recognised doctrine of forfeiture in our law or a compelling present need for its adoption before this court would be justified in lending its *imprimatur* to such a fundamentally penal doctrine.

[22] As to judicial precedent or the authority of the jurists who wrote on the Roman-Dutch law, as we have seen, there is little to be found concerning the narrow question of what effect upon a claim fraud has when it is confined to only a part of an otherwise legitimate claim or when it relates only to the proof of what is in fact found to be a legitimate claim. I have already alluded to the conflict which exists between the decision in the case of *Videtsky*[27] and the decision in the present case.

[23] It appears that there is no authority in the Roman-Dutch law for the implication *ex lege* of what is in essence a penal term. Nor, in my opinion, is

26 *Baines Motors v Piek* 1955 (1) SA 534 (AD).

27 Supra.

there a compelling social need for the adoption of such a doctrine as an incident of the common law. That its adoption would serve the ends identified in the English cases is of course so but if the cost of doing so would be that cases would arise in which great inequity would be the consequence, that is good reason to hesitate.

[24] When there is added to that the fact that insurance companies are masters of their own policies in the sense that they are free to unilaterally devise them, the insured has no say in the process, and that it is a simple matter to include an appropriate clause to protect the insurer against fraudulent claims by providing for forfeiture, there does not appear to be any pressing need for the law to provide such protection.

[25] There is also the consideration that the onus of proof of loss and value burdens the insured. Where fraud is shown to be present in the making of a claim the insured is likely to experience problems first, in having his or her evidence regarding even the ostensibly valid parts of the claim accepted and secondly, in satisfying the court that the tainted aspect of the claim can and should be separated from the untainted aspects of the claim. If he or she fails to satisfy the court on that score the entire claim will of course fail.

[26] There are also other sanctions which are available: prosecution for fraud, the potential inability to obtain insurance cover in future, punitive costs orders made by the court, and delictual liability for expense incurred in investigation by

the insurer. It is not as if there is nothing else in an insurer's arsenal which can be used to deter insurance fraud.

[27] As for implying a tacit forfeiture term, the traditional test to be applied cannot, in my opinion, be satisfied. I am not confident that if the question had been raised both parties would have agreed that forfeiture of even a valid claim should occur. Indeed, one may ask, if such a tacit term is to be implied in an insurance contract, why not in other contracts? All contracts require good faith in our law.

[28] I conclude therefore that the court *a quo* erred in recognising the implied term which it did. That conclusion might be thought to render it unnecessary to consider whether the plaintiff's claim was partly fraudulent but in as much as she was found to have acted fraudulently and the trial will now have to continue it is necessary to deal with that finding.

The factual issue

[29] In October 1997 the relevant policy was issued. The cover provided for the loss of household contents was R250 000. That sum had been arrived at by the plaintiff, her personal assistant, Mrs Graham, and an experienced insurance broker, Mr Roedman, systematically completing a written inventory of the contents of the household room by room and assigning values to the contents of each room. Included in the list of items in the main bedroom were "clothing & footwear – R120 000".

[30] On 9 May 1998 while the plaintiff was away for the weekend her house was burgled. She returned on Sunday 10 May to find that numerous articles had been stolen. On Monday 11 May, and with the assistance of Mr Roedman and Mrs Graham, the plaintiff completed a claim form supplied by the insurer. It was tabular in form and consisted of six columns headed from left to right: number; description of property; date acquired; from whom purchased or acquired; deduction for wear and tear or depreciation or value of salvage; amount claimed.

[31] The manner in which it was completed is of considerable significance. There were 38 entries in all. In 25 instances the number of items, a description of the items, from whom they were purchased or acquired (in some instances only the city was given), and the amount claimed were reflected. In 12 instances it was not stated from whom (or where) they were purchased or acquired. In four instances no amount claimed was entered. In none of the instances was the date acquired given or any deduction made for wear and tear or depreciation or value of salvage. In all of the instances where an amount was claimed a round sum in rands was entered. In one instance the entries were simply:

"Various" (under number), "Various other items of clothing" (under description of property), and "R20 000" (under amount claimed).

The amounts claimed were totalled and came to R107 230 of which R62 630 represented clothing and footwear. Included in the amount of R62 630 was the

R20 000 claimed for “various other items of clothing”.

[32] What is patently clear is that this was no more than a provisional estimate of the plaintiff’s loss and a partial and incomplete furnishing of information which would be relevant to a consideration of the claim. The warranty printed on the claim form which recites inter alia that the amount claimed represents the plaintiff’s loss cannot derogate from that intractable fact.

[33] It is not surprising that the claim was made in that tentative and provisional manner. As is graphically illustrated by the photographs taken when Mr Koekemoer, an insurance assessor appointed by the insurer, visited the plaintiff’s house to assess the loss, the burglars had not confined their activities to any one room and the plaintiff’s dressing room in the main bedroom in which there were 25 capacious open shelves for clothing and also provision for the hanging of clothes had been stripped virtually bare. To expect from the plaintiff instant and perfect recall of everything that had been in those rooms and of every item of clothing which had been in the dressing room and elsewhere shortly after having been exposed to the trauma of learning of a criminal intrusion into her home would be unreasonable.

[34] The fraud which the defendant sought to attribute to the plaintiff was evidenced, so the argument ran, by what the plaintiff herself said in two facsimiles sent to the defendant after she had undergone a polygraph test at the defendant’s instance. In that of 10 July 1998 she referred to “the honest mistake,

if such a thing exists" of building in "a slightly inflated figure" "because (Mr Roedman had said) it was standard practice for the insurance company to lower the settlement amount". In that of 29 July 1998 she said:

'(I)f they do not accept my explanation for the 10% inflation on the claim they need to do a prompt investigation to satisfy themselves that this is a bona fide claim. Equigen [the broker] has not even bothered to contact Mrs Wendy Graham of Production Partners who was at the meeting with the broker when he suggested the adjustment on the claim to try and limit the inevitable loss by his client. And as he predicted and tried to mitigate against with 10% recommendation, I have in the course of the last three months discovered a number of other valuable items which I was not aware of at the time and therefore were not included in my claim. If I had been settled promptly in full and final settlement as SA Eagle have done with the business claim (Production Partners), I would have had to carry the loss of additional missing items uncovered over time, i.e. binoculars, clothing, etc. I considered my broker's advice to have been prudent, and followed it accordingly as a contingency measure rather than fraud.'

[35] It was fundamentally these two facsimiles upon which the trial judge's finding that the plaintiff had been guilty of fraud in the making of the claim rested. He considered that they raised an inference of fraud which was not neutralised by the evidence given by the plaintiff and on her behalf.

[36] The onus of proving that the claim was fraudulent was of course upon the defendant. It had to be discharged upon a balance of probability but in considering the probabilities a court's point of departure is that fraud is not to be imputed lightly to anyone. Before considering the evidence in greater detail

some preliminary observations are necessary.

[37] In cases where estimates of value have been made by the insured the mere fact that an estimate has been found to have been exaggerated is not proof of fraud. It must appear at least that it was knowingly exaggerated which implies that it was not made in good faith. Furthermore, even where there has been some conscious exaggeration of a claim, if it appears that the amount claimed was recognisably put forward as an opening gambit in what was intended to be a debate with the insurer as to the true value of the claim, and that the insured did not intend or expect the amount stated to be taken at face value, there can be no finding of fraud. Both the necessary intention to deceive and the necessary intention to defraud would be lacking.[28]

[38] In Ewer v National Employers' Mutual General Insurance Association, Ltd[30] the court refused to stamp as fraudulent a "preposterously extravagant" claim because it was so manifest that the prices which had been inserted in the claim form by the plaintiff were the prices of new things. He was only entitled to the second-hand value of the lost goods. Nonetheless, MacKinnon J said: "The plaintiff here has put down the cost price of new things. I do not think he was doing that as in any way a fraudulent claim, but as a possible figure to start off with, as a bargaining figure. The plaintiff knew the claim would be discussed, and probably drastically criticised by

[28] As to the distinction between these two concepts, see *S v Bell* 1963 (2) SA 335 (N) 337 c; *S v Isaacs* 1969 (2) SA 187 (D&CL) 191H-192A.

[30] [1937] 2 All ER 193 (KB). See too *Nafte v Atlas Assurance Co Ltd* WLD 339, 241-2; *Papas v The General Accident, Fire & Life Assurance Corporation, Ltd* 1916 CPD 619, 635-7.

the assessors, he had been asked for invoices, and he started the bargaining with them by putting down the cost price of these articles as if they were new. Though I admit the resulting figure is preposterously extravagant, I do not think there was any fraud in putting it forward."

In my opinion, for the reasons which follow, the facts of the present case lead to the same conclusion.

[39] In this case the insurer's burden of proof is not lightened by the fact that the loss adjuster (Mr Koekemoer) appointed by it to investigate the claim and assess the loss ultimately assessed it as being R139 353,84 of which R68 790,84 was in respect of clothing and footwear. It will be recalled that the plaintiff's provisional claim was for R107 203 of which R62 630 (which included the R20 000 for "various other items of clothing") was for "clothing and footwear". Moreover, he testified that a revised claim form which he assisted the insured to complete on 21 May 1998, and in which the total claim was R117 578 (of which R62 630 was for clothing and footwear), was intended to supersede the earlier claim.

[40] After he had made further enquiries regarding the value of the items for which claims had been made, he not only increased some of the amounts

claimed because they had been grossly understated by the plaintiff but ultimately made no downward adjustment of those increased claims. For example (I give first the sum claimed by the plaintiff, secondly, the sum substituted by Mr Koekemoer, and thirdly, the difference between them):

	Claim	Substituted Claim	Amount Underclaimed
Samsonite 3 piece suitcase set	R10 000	R10 140	R 140
Choker pearl necklace	R 3 600	R17 000	R13 400
Bear graphite golf clubs	R 3 500	R 6 270	R 2 770
Silver Christoffle cutlery set	R 3 100	R14 012	R10 912
Limoge fruit cutlery set	R 2 500	R 4 900	R 2 400
Theo Fennell gold earring	R 1 000	R 2 000	R 1 000
Clothing and footwear	R62 630	R68 790,84	R 6 160,84

These items amount collectively to an underclaiming by the plaintiff of R35 882,84 if Mr Koekemoer's assessment was correct. However, whether or not his assessment was in fact correct is not the point; the point is that he was plainly bona fide in his valuation and, by comparison, the modesty of the plaintiff's original provisional claims simply does not chime with any intention of defrauding the insurer.

[41] The revised claims totalled R152 875,84 in all and after Mr Koekemoer had adjusted some of the claims downwards he recommended a payment of R139 353,84 of which R68 790,84 (which included R20 000 claimed for "various other items of clothing") was for clothing and footwear. Both those amounts were of course far higher than the total amount of R107 230 and the amount of R62 630 for clothing and footwear which the plaintiff had originally claimed in the claim form which the insurer alleges was fraudulent.

[42] The relevance of this evidence of Mr Koekemoer is simply that an independent third party with professional experience of assessing loss and value, after investigation, and acting in good faith, assessed the plaintiff's loss as being far higher than the plaintiff had said she estimated it to be when making her first and provisional claim. The estimates which the plaintiff made were thus certainly estimates which could have been made in the honest belief that her loss was at least what she claimed it to be at that stage. The large discrepancy which

exists between her estimate of the value of the items I have listed in para [40] and that of Mr Koekemoer is difficult to reconcile with the plaintiff having been intent upon defrauding the insurer.

[43] That the plaintiff had no such honest belief and that she did intend to defraud the insurer is evidenced by the facsimiles the plaintiff sent to the insurer and the inadequate explanations given by her and her witnesses of what she meant by saying that the claim had been "inflated". So ran the argument for the insurer. I turn to those explanations.

Mrs Graham

[44] She identified the problems they encountered in completing the first claim form. Some missing items had been bought overseas and their value could not be established then and there. There was an "enormous amount" of clothing that was missing but it was not possible to recall each and every item that had been in the dressing room but was no longer there. Where they could identify a particular item as having been taken they estimated a value as best they could. They then "lumped a sum" meaning "an estimated value of the items we thought had gone missing". She made it clear that she could not recall exactly how they arrived at R 20 000 but it was a figure which represented what had been in the dressing room but was no longer there. What had been there could be recollected in a general sense but the precise details of what had been taken could not be recollected. For example, they knew track suits had been taken but could not

remember how many there had been. The same applied to things like t-shirts, jerseys, socks, underwear, scarves, stockings, gloves and "all the rest that were in the wardrobe". They could not itemise these things and they simply reflected them "generically" in the claim form as "various other items of clothing" and estimated them globularly as having a value of R20 000.

[45] She was cross-examined with a view to extracting from her an admission that the claim was inflated, in the sense of being deliberately pitched at a higher amount than they believed to be the real value of the loss, to guard against the danger of the defendant "lowering the amount of her claim". A fair reading of her evidence fails, in my opinion, to yield any such admission. It is quite clear that what she regarded as the antidote to the insurer lowering the claim was an estimate of loss which was as realistic as the difficult circumstances allowed and which did not err on the side of understatement and thereby play into the hands of an insurer intent upon beating the claim down. She was often subjected to questions the nuances of which she had difficulty in understanding but she steadfastly refused to acknowledge that after their estimates had been arrived at they arbitrarily and for no legitimate reason inflated their estimates to a yet higher amount.

[46] When she was asked whether Mr Roedman had said at the time that it was not inappropriate to build in a slightly inflated figure because it was standard practice for the insurer to lower the settlement amount she said that he had.

When asked whether they had acted on that advice she said they had "on the contingency of the R20 000". She understood building in a slightly inflated figure to mean that "you increase the amount of the figure that you put onto the claim form". On being asked if that meant increasing the amount that would otherwise have been claimed she replied in the affirmative. However, further questions showed that what she regarded as the slight inflation of the claim was their decision, when attempting to place a value on the stolen "various other items of clothing", to allow for the fact that they could not "readily identify" everything that had been stolen from the dressing room and that they knew that more had been taken than they were able then to identify. Built into the R20 000 which they estimated to be the value of the "various other items of (stolen) clothing" was an amount to cater for that contingency.

[47] Mr Roedman

He explained that he assisted the plaintiff and Mrs Graham in the completion of the initial claim form. It was completed by him and signed by the plaintiff. He said that the R20 000 claimed for various other items of clothing was an allowance for items that were stolen but could not be identified at the time. He said "At the time of the loss it was obvious that a large portion of her clothing was stolen and she didn't claim for the whole lot item by item. What I advised her is to, we came to a figure to allow for items that we couldn't identify at the time as being stolen but that were obviously gone and that's what that R20 000

is".

[48] He said that he told them that the sum would be reflected in the claim form but that a loss adjuster would be appointed and that he would probably adjust the claim down as insurers generally did so because they can source various items at a cheaper price than the general public can. He denied that he had advised that the claim be inflated but said "I would advise them not to underclaim so if they can't identify all the items that are stolen at the time item by item I would say put a general sum in for an amount not claimed for but she will ultimately have to prove that amount to the loss adjuster". He also said in answer to a suggestion that one way of inflating a claim would be to add 10% to it: "Okay in this case it wasn't inflating the claim; it was trying to get the correct claim, amount claimed". He denied that the claim was inflated in any way.

[49] He explained that they knew from the inventory that had been taken at the inception of the policy that the plaintiff had clothing and footwear to the value of R120 000. They could identify specifically certain items of clothing and footwear which were missing and they could put a value to those items. (The value given to those items was R42 630.) The plaintiff then had to try and place a fair value on the rest of the contents of the dressing room without being able to itemise each and every item which had been there but knowing that a dressing room which had been fully stocked with clothing was virtually bare. She

provided the estimate of R20 000. He regarded it as a fair estimate but told her that the amount "would be adjusted by the loss adjuster because the onus is on the insured to prove the claim". He said it was obvious to anyone that it was a "generic claim, not properly specified" relating to "miscellaneous clothing".

[50] He was asked again whether he had or would have advised anybody to inflate a claim to provide for the danger that the insurer might lower the amount claimed. He said he would not but that he would advise the client to put an amount in for items they could not identify at the time. On being confronted with what the plaintiff had said in the facsimiles referred to earlier, he denied having advised her to inflate the claim and said that she could have misunderstood what he had said to her.

The plaintiff

[51] She said that the dressing room was a particular problem. It was obvious that it had been ransacked. All the shelves and the hanging rails had been full of clothes. Certain items of clothing stolen she was able to describe and list individually. She was also aware in a general sense of what had been in the dressing room but could not possibly recall everything item by item. Amongst other things there were scarves, gloves, stockings, t-shirts, sporting gear, tennis kit, golf kit, tracksuits, jerseys, nightwear, pyjamas and belts. She did her best to place a value on the particular items which she could recollect but for the rest of what had been in the dressing room she had to find some way of estimating their

value without being able to list what had been there item by item.

[52] What she said she did was this. She knew that she had had approximately 20 shirts which she valued at R6 000. She estimated the contents of the shelves each of which had been full (the photograph shows them to be very capacious) as having a value of approximately R500 to R600. In arriving at that average value she was conscious of the fact that her inability to identify then precisely what had been taken could result in her estimate of R500 to R600 a shelf being too low so she rounded the final figure up to R20 000 to cater for that contingency.

[53] She was cross-examined at length on her *modus operandi* and her arithmetic. It is quite evident from a perusal of the record that the questioner and the plaintiff were often at cross purposes in dealing with particular topics. It is also obvious that the plaintiff was having difficulty recalling the details of how the exercise which resulted in the claim for R20 000 was done. She was testifying nearly 2½ years after the exercise was done. Thus, she said in evidence that there were “probably about 20” shelves in the dressing room. In fact, as appears plainly from the photograph, there were 25. No one corrected her and it was not surprising that ensuing calculations put to her in the course of questioning failed to square with the “inflation” factor of 10% that she alluded to in one of the facsimiles. As a fact, 25 shelves of clothing at an average value of R500 per shelf yield an amount of R12 500. If 10% be added to that a figure

of R13 750 results. If shirts at a value of R6 000 be added the resultant figure is R19 750 which, if rounded up to the nearest thousand, gives a total figure of R20 000 which was what the plaintiff's estimate was.

[54] The plaintiff's state of mind when these estimates were made is of course critical to the defendant's case. There is no good reason to doubt the truthfulness of the following excerpt from her evidence relating to the problem of the contents of the dressing room.

"Mr Roedeman was at pains to point out to me that the final figure would be the insurance company's figure, they would be appointing a loss adjuster who would come and take a full inventory and work out what that final figure was. So my figure, even if it was a guesstimate and even if that guesstimate was slightly more or less, it didn't really matter because theirs would be the final figure, they weren't going to pay out on what was on my claim form."

[55] It is reasonably clear that the plaintiff did not attach to the word "inflate" the pejorative meaning which it might ordinarily convey. She accepted that it meant to make bigger but denied that it meant claiming more than what she thought to be her loss. With reference to one of her facsimiles she was asked: "This is the explanation Equigen must rely upon finally, namely that you built in a slightly inflated figure, a figure greater than it should have been, do you agree? . . . . A figure greater than it should have been given the what, the knowledge that I had <u>with certainty</u> (my emphasis) of what was missing."

[56] Her evidence is replete with repeated and consistent explanations that what she meant by the slight inflation of the claim was the rounding up to R20 000 of her estimate to cater for the likelihood of underestimation of the value of what was in the dressing room due to her inability to remember everything that had been taken. That is the contingency to which she referred. She had been made aware by Mr Roedman that the inability to specify item by item what was in the dressing room would probably result in the reduction of her claim and that, if that were going to happen, she would be unwise to leave out of account altogether the likelihood that in the days ahead she would become aware of yet further items which had been stolen from the dressing room. Catering for that contingency would also "guard against" the lowering of her claim by the insurer. Indeed, that is what happened. Months later when the plaintiff was about to go skiing she discovered that two Eles ski suits and her ski boots, a camel cashmere coat, a Lorden Muntel coat, and a pair of binoculars had also been taken.

[57] No credibility findings as such were made by the learned judge in the court *a quo*. It may be inferred that he did not accept plaintiff's explanation of what she meant by "inflating" the claim but no reasons were given for reaching that conclusion. This court is therefore at large to make its own assessment of the evidence. The onus of proving fraud rests upon defendant and it must therefore satisfy this court that the evidence of plaintiff and her witnesses should be rejected.

[58] When the facsimiles are considered in the context of what had happened, the nature of the problem which confronted the plaintiff in ascertaining and quantifying her loss, the manifestly provisional nature of the first claim form, the plaintiff's candour throughout her dealings with both her own broker, the defendant's loss adjuster and the defendant's staff, and the gross understatement of many claims which were assessed as being very much higher by the insurer's own loss adjuster, I find it to be most improbable that there was any fraudulent intent on the plaintiff's part. There was nothing in the evidence given by the witnesses called by the defendant which detracts from that conclusion. When all was said and done the defendant's case was built upon a particular interpretation of the facsimiles, namely, that they were confessions (or at least conclusive evidence) of fraud. Once they are found not to bear that meaning there is really nothing left which would justify a finding of fraud.

[59] It follows that the plaintiff's claim should not have been dismissed and that the trial should have continued to enable the plaintiff to prove her loss and the sum for which judgment should be given.

It is hereby ordered that:

1. the appeal is upheld with costs including the costs of senior counsel;
2. the order of the court *a quo* dismissing the claim with costs is set aside and substituted by the following order: The defendant is declared to be liable to indemnify the plaintiff for the loss sustained by her as a

consequence of the burglary at the insured premises on 9 May 1998 and is ordered to pay the costs of the hearing on the question of liability.

3. the case is remitted to the court *a quo* for further hearing.

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R M MARAIS
JUDGE OF APPEAL

LEWIS JA) CONCURS