ANNUAL THEFT & FRAUD REPORT

2014/15

Compiled by the Department of Finance and Personnel

THEFT & FRAUD REPORT 2014-15

CONTENTS

SECTION 1

Introduction

Background

1.1 The Department of Finance and Personnel (DFP) is required to prepare an annual report on all actual, suspected and attempted frauds reported by departments involving public money. This requirement is set out in chapter 4 of Managing Public Money (NI) (MPMNI). The information contained within the report is collated by DFP through an annual exercise completed by departments in respect of their core department, agencies, Non Departmental Public Bodies (NDPBs) and other sponsored bodies.

1.2 The main purposes of the report are to:-

- identify trends in the cases reported;
- highlight to bodies how such cases have been perpetrated; and
- highlight what steps can be taken to prevent and detect them in future.

Defining fraud

1.3 While the 2006 Fraud Act provides a legal definition for the term "fraud", the annual fraud return exercise has been undertaken and this report written to provide a wider view of cases of fraud and irregularity perpetrated or attempted against the Northern Ireland public sector. Therefore cases of fraud referred to in this report including cases which commonly and historically may have been referred to as false accounting, bribery, corruption, conspiracy to defraud etc. The report and analysis also includes cases of theft.

Scope of report and analysis of cases

1.4 The report includes cases of theft and fraud reported by NICS departments in respect of their core departments and agencies, along with cases relating to departments' Non Departmental Public Bodies (NDPBs) and other sponsored bodies.

1.5 The returns provided to DFP do not include cases which may have arisen in the following bodies:-

- the NI Assembly ;
- the NI Audit Office ;
- the Office of the NI Assembly Ombudsman; or
- NI district councils.

1.6 Additionally specific types of fraud are not included in the main analysis sections. These include the areas of:-

- SSA – Benefit Fraud;
- NIEA – Environmental Crime;
- LPS – Benefit Fraud;
- NI Legal Services Commission – Legal Aid Fraud;
- NI Housing Executive – Tenancy Fraud; and
- NI Water – Water Connections.

There are however summary reports on these specific fraud risk areas included at Section 5 of this report.

1.7 Section 5 also contains a summary of the counter fraud work undertaken by Business Services Organisation (BSO) within the Health Sector. Health Sector cases are however included in the main analysis.

1.8 It is important that readers of the report understand that the report does not purport to be a complete/absolute record of all cases of theft and fraud perpetrated during the 2014/15 period. In this respect it is important to note that the cases reported include actual, suspected and attempted but prevented cases. Many of the cases reported are at an early stage of identification or investigations are ongoing at the time of reporting. Additionally it does not include suspected cases which were investigated but subsequently found to be unfounded during the course of the year.

1.9 That said it is considered that the annual fraud reporting exercise and production of this report is still a useful source of information for staff and management, who have responsibilities for preventing, detecting and investigating cases of fraud, across the NI public sector.

SECTION 2

General Fraud Issues Update

Comparisons with previous years

Number of cases reported annually

2.1 There was a considerable decrease in the number of actual, suspected and attempted cases reported by departments to DFP. In total 372 cases were reported as part of the 2014/15 exercise. This is a decrease of approximately 23% on the previous reported year (2013/14). In that year 483 cases were reported.

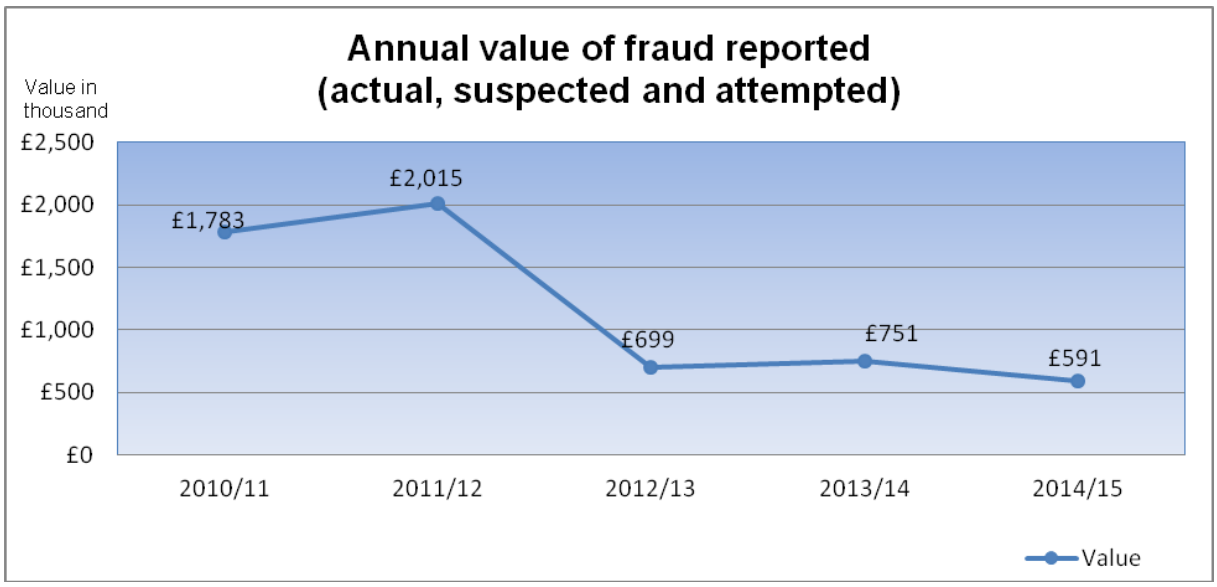
2.2 In looking at the cases reported to DFP the four main areas which have decreased considerably are in relation to theft of assets; payment process related; other cases; and pension fraud cases**.**

2.3 While there has been an overall reduction in the number of cases reported there were increases recorded in the categories of Health Service specific cases; travel and subsistence; and income related cases.

2.4 More detail on increases and decreases in numbers within these categories is provided at section 3.

Annual value of fraud reported (actual, suspected and attempted)

2.5 The total value of actual, suspected, and attempted but prevented cases reported in the 2014/15 return is approximately £591k. This is a decrease of over £160k from the value given in the 2013/14 report (i.e. £751k). In percentage terms this equates to a decrease of over 21% from the previous reported level in 2013/14.



2.6 The figure of £591k can be further broken down into those cases where respondents indicated that an actual value could be given (£313k – 129 cases) and those cases where an estimated only figure was provided (£277k – 77 cases). In a further 166 cases (45%) respondents advised that values could not be provided at the time of reporting.

2.7 Of the overall £591k value figure reported:-

- £217k relates to cases categorised as 'actual' cases;
- £293k relates to cases as only 'suspected' at the time of reporting; and
- £81k relates to cases categorised as 'attempted but prevented'.

National Fraud Initiative in Northern Ireland - data matching

2.8 One of the key mechanisms continuing to be used by NI public sector bodies to prevent and detect fraud is the National Fraud Initiative (NFI).

2.9 Over 100 Northern Ireland public sector bodies participate in data matching for the purposes of preventing and detecting fraud, as part of the NFI. The Comptroller and Auditor General NI (C&AG) acquired data matching powers in 2008 and all organisations whose accounts are audited by the C&AG or the local government auditor may be required to submit their data for matching. The NFI exercise is run every two years by the Cabinet Office.

2.10 In June 2014 the C&AG published his third report into the NFI in Northern Ireland. Outcomes so far in Northern Ireland are around £30 million, principally in the areas of pensions, rates and housing benefit.

2.11 The fourth NFI exercise in Northern Ireland is underway and participating organisations are currently reviewing and investigating their data matches in line with their own fraud risk assessments. The C&AG will report on the current exercise in June 2016.

Organised Crime Task Force

2.12 The 2015 Organised Crime Task Force Annual Report and Threat Assessment can be obtained at: *OCTF Annual report 2015*.

2.13 DFP continue to be represented on the OCTF's Criminal Finance Sub Group. Through attendance on the Sub Group relevant developments are fed back to departments through the NICS Fraud Forum.

NICS Fraud Forum

2.14 The NICS Fraud Forum consists of representatives from all NI departments. Representatives from the Northern Ireland Audit Office have also been long standing members of the Forum. The Forum also includes representatives from the Public Prosecution Service, the Police Service of Northern Ireland, Business Services Organisation (which represents the health sector) and the NI Housing Executive.

2.15 The forum is a best practice advisory group and during 2014/15 two meetings of the Forum were held. Through these meetings members:-

- liaised with the Centre of Applied Learning on the development of an e-learning fraud awareness package;
- considered progress reports on the National Fraud Initiative from the NIAO;
- considered lessons learned from Public Accounts Committee hearings into whistleblowing cases;

- considered the NIAO's Good Practice Guide on Whistleblowing;
- liaised with DFP on the establishment of the Group Fraud Investigation Service within the NICS;
- streamed the annual fraud reporting process for respondents; and
- quality assured the 2013/14 Annual Theft and Fraud Report.

2.16 During the period 2014/15 DFP, with the assistance of the NICS Fraud Forum, issued the following guidance:-

- FD(DFP)07/14 – Fraud Alert – Spam Email; and
- DAO(DFP) 02/15 – Whistleblowing Guidance. This included circulation of the NIAO's Whistleblowing in the Public Sector: A Good Practice Guide for Workers and Employers. This DAO also highlighted some good practice recommendations arising from NIAO reports and PAC reports and hearings.

SECTION 3

An analysis of actual, suspected and attempted fraud as reported to DFP through the 2014/15 Annual Fraud Return exercise[1].

Number of cases reported

3.1 The total number of cases reported for the 2014/15 annual fraud exercise was 372, a decrease of 23% on the previous reporting year (483 cases in 2013/14).

3.2 The four main areas which recorded a notable decrease were:

- theft of assets (181 cases in 2013/14; 101 cases in 2014/15) - a reduction of 80 cases;
- payment process related (56 cases in 2013/14; 27 cases in 2014/15) - a reduction of 29 cases;
- other cases (36 cases in 2013/14; 12 cases in 2014/15) - a reduction of 24 cases; and
- pension fraud (19 cases in 2013/14; 4 cases in 2014/15) – a reduction of 15 cases.

3.3 Increases in cases reported were however noted in:-

- Health Service specific cases (78 cases in 2013/14; 117 cases in 2014/15) – an increase of 39 cases;
- travel and subsistence (3 cases in 2013/14; 13 cases in 2014/15) – an increase of 10 cases; and
- income related (8 cases in 2013/14; 17 cases in 2014/15) – an increase of 9 cases.

3.4 Overall the Health Service specific category recorded the highest number of cases reported for 2014/15 – 117 cases, 31% of the total number of cases reported. Theft of assets accounted for 101 cases, 27% of the total number of

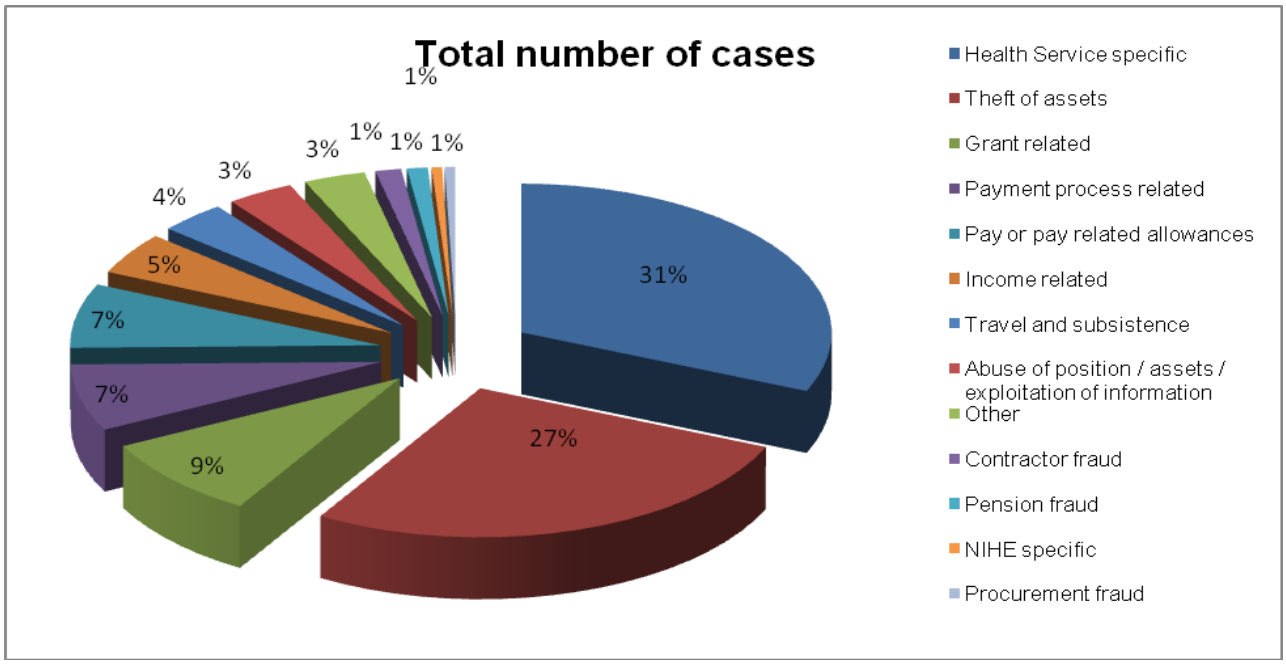
[1] The analysis contained in this section is based on information provided by departments and their sponsored bodies. It does not include the areas covered by SSA, NIEA and Legal Services Commission, LPS and NI Water in their summary reports as set out at Section 5.

cases. Grant related cases was the third highest category reported with 33 cases reported, 9% of the total number of cases reported.

3.5 Of the total cases 210 were categorised as actual cases, while 124 cases were suspected and the remaining 38 cases were attempted but prevented cases.

Number of frauds reported by category					
			Categorisation of case reported		
Category of fraud	**Total number of cases**	**Percentage of frauds reported**	**Actual**	**Attempted but prevented**	**Suspected**
Health Service specific	117	31%	59	11	47
Theft of assets	101	27%	94	0	7
Grant related	33	9%	9	6	18
Payment process related	27	7%	13	11	3
Pay or pay related allowances	26	7%	10	2	14
Income related	17	5%	9	0	8
Travel and subsistence	13	4%	4	1	8
Abuse of position/ assets/exploitation of information	13	3%	3	1	9
Other	12	3%	4	5	3
Contractor fraud	5	1%	0	0	5
Pension fraud	4	1%	4	0	0
NIHE specific	2	1%	1	1	0
Procurement fraud	2	1%	0	0	2
Total	**372**	**100%**	**210**	**38**	**124**

There may be a slight discrepancy in the exact percentages due to the rounding of figures.



Value of Cases Reported

3.6 The total value of cases reported for 2014/15 has decreased by 21.5% from £751k in 2013/14 to £591k in 2014/15. In value terms this is an overall decrease of £160k.

3.7 The overall value given for cases can be broken down further into those cases where:-

- an actual value could be given/recorded;
- only an estimated value could be provided at the time of reporting; or
- no value could be given/estimated.

3.8 In 129 cases a total value of £313k was recorded as the actual value of cases. This accounted for 53% of the total value.

3.9 An estimated figure of £278k was given in 77 cases and was 47% of the total value.

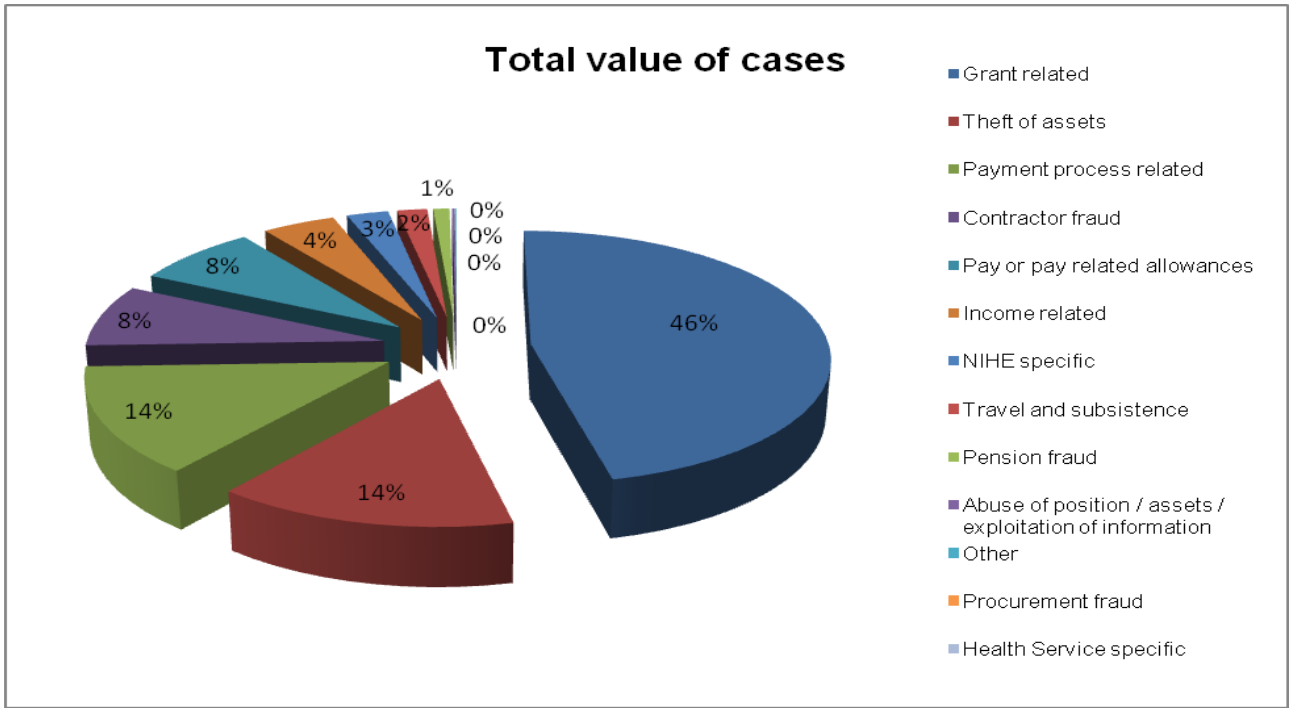
3.10 There were 166 cases which stated that a value could not be provided at the time of reporting. Just over 70% of the 166 cases with no value relates to the 117 Health Service specific cases reported in 2014/15.

3.11 The category with the highest value noted for 2014/15 was grant related cases which had a total value of £274k, 46% of the overall total. Further analysis shows that out of the cases recorded in this category there were a number of high value cases.

3.12 The theft of assets category recorded the second highest value at £85k which equates to 14% of the overall value.

3.13 Payment process came third with a value of £81k, which was just under 14% of the total value.

Value of cases reported by category							
Category of fraud	**Total**	**Number of cases where a value was recorded**	**Number of cases where a value could not be estimated**	**Actual value**	**Estimated value**	**Total value**	**Percentage of total value of cases reported**
Grant related	33	30	3	£126,870.88	£147,257.00	£274,127.88	46%
Theft of assets	101	94	7	£45,201.27	£39,508.10	£84,709.37	14%
Payment process related	27	20	7	£80,702.20	£0.00	£80,702.20	14%
Contractor fraud	5	2	3	£16,600.50	£30,000.00	£46,600.50	8%
Pay or pay related allowances	26	16	10	£24,967.40	£19,936.26	£44,903.66	8%
Income related	17	15	2	£8,151.05	£18,172.00	£26,323.05	4%
NIHE specific	2	2	0	£0.00	£15,000.00	£15,000.00	3%
Travel and subsistence	13	12	1	£3,203.55	£7,611.00	£10,814.55	2%
Pension fraud	4	4	0	£5,826.32	£0.00	£5,826.32	1%
Abuse of position/ assets/exploitation of information	13	7	6	£776.73	£180.00	£956.73	0%
Other	12	4	8	£491.00	£0.00	£491.00	0%
Procurement fraud	2	0	2	£0.00	£0.00	£0.00	0%
Health Service specific	117	0	117	£0.00	£0.00	£0.00	0%
Total	**372**	**206**	**166**	**£312,790.90**	**£277,664.36**	**£590,455.26**	**100%**

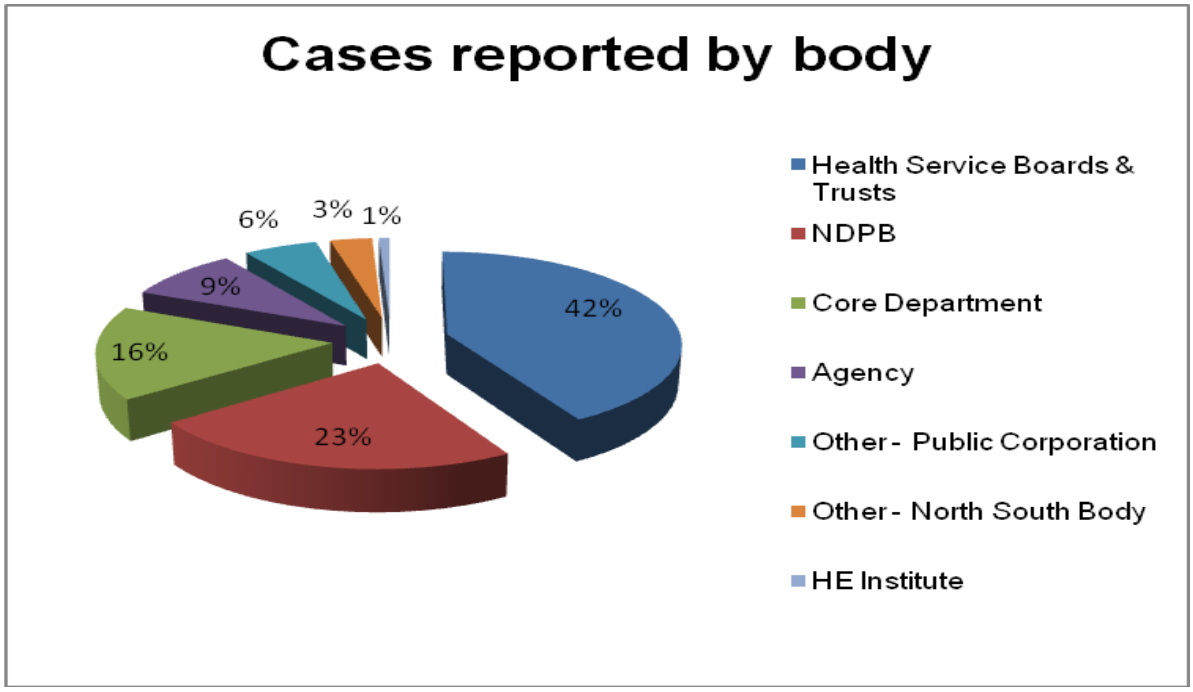


Bodies Reporting Cases

3.14 For the second year Health Service Boards and Trusts recorded the highest number of cases. This was for 155 cases equating to 42% of the overall total number of reported cases.

3.15 87 cases (23%) were reported by NDPBs and 61 cases (16%) by core departments.

Cases reported by body		
Body where case occurred	**Number of cases**	**Percentage of cases reported**
Health Service Boards & Trusts	155	42%
NDPBs	87	23%
Core Department	61	16%
Agency	33	9%
Other - Public Corporation	21	6%
Other - North South Body	12	3%
HE Institute	3	1%
Total	**372**	**100%**

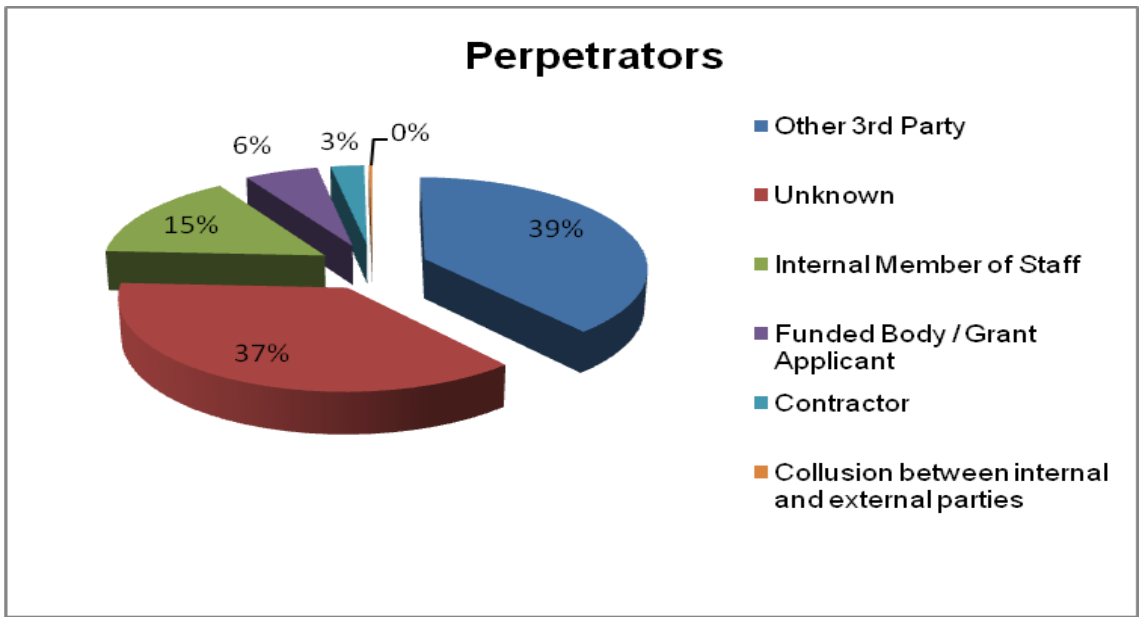


Perpetrators

3.16 Frauds committed by other third parties accounted for 144 cases (39%). The majority of these cases relate to Health Service specific cases i.e. persons obtaining health services dishonestly.

3.17 Unknown perpetrators were recorded for 138 cases (37%). In many cases this category of perpetrator was recorded against the theft of asset cases.

Reported by perpetrators		
Perpetrators	**Number of cases**	**Percentage of cases reported**
Other Third Party	144	39%
Unknown	138	37%
Internal Member of Staff	57	15%
Funded Body / Grant Applicant	22	6%
Contractor	10	3%
Collusion between Internal and External Parties	1	0%
Total	**372**	**100%**

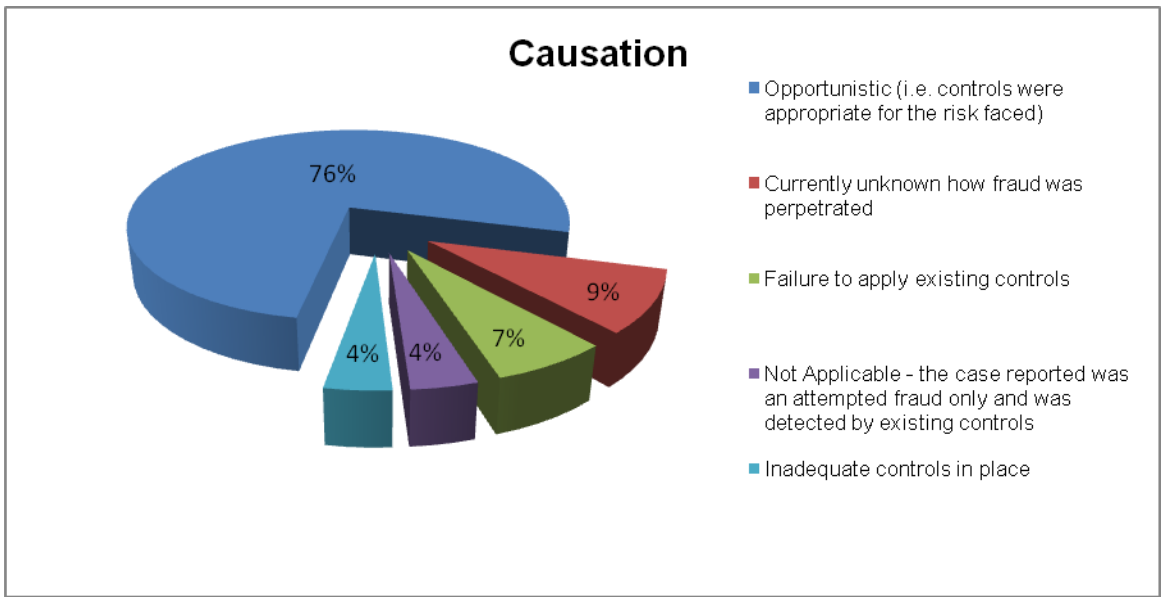


Causation

3.18 76% of all reported cases (284 cases) reported that the causation of the theft/fraud was opportunistic in nature.

3.19 In a further 9% of cases (35 cases) it was deemed currently to be unknown how the fraud was perpetrated.

Causation		
Causation	**Number of cases**	**Percentage of cases reported**
Opportunistic (i.e. controls were appropriate for the risk faced)	284	76%
Currently unknown how fraud was perpetrated	35	9%
Failure to apply existing controls	25	7%
Not Applicable - the case reported was an attempted fraud only and was detected by existing controls	14	4%
Inadequate controls in place	14	4%
Total	**372**	**100%**

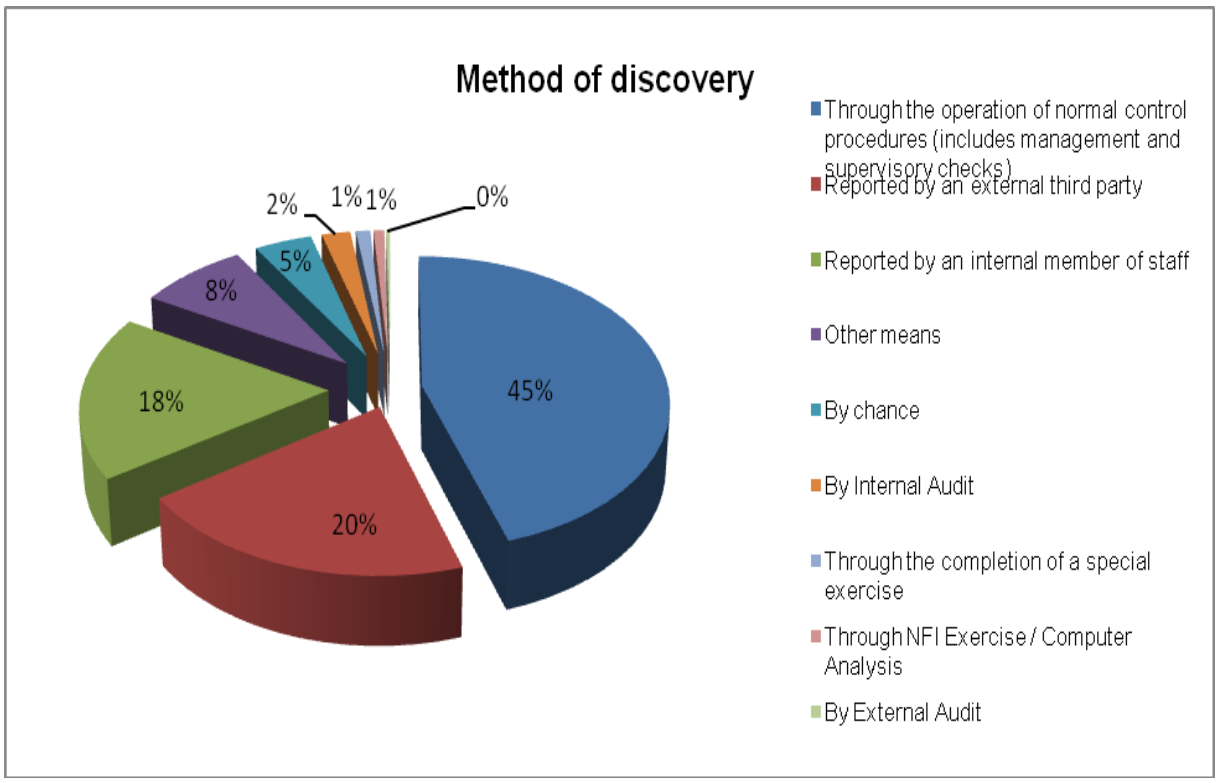


Method of Discovery

3.20 168 cases were discovered through the operation of normal control procedures (45% of total cases). Frauds reported by an external third party made up a further 20% of the total - 75 cases were reported in this way. Frauds discovered by an internal member of staff was the third highest category with 67 cases (18% of total cases).

3.21 'Other means' of discovery included cases notified through whistleblowers; hotlines; and cases discovered as part of PSNI or HR investigations. Such methods accounted for 8% of all cases reported (30 cases).

Method of Discovery		
Description of discovery	**Number of frauds reported**	**Percentage of frauds reported**
Through the operation of normal control procedures (includes management and supervisory checks)	168	45%
Reported by an external third party	75	20%
Reported by an internal member of staff	67	18%
Other means	30	8%
By chance	16	5%
By Internal Audit	8	2%
Through the completion of a special exercise	4	1%
Through NFI Exercise/computer analysis	3	1%
By External Audit	1	0%
Total	**372**	**100%**



Whistleblowing

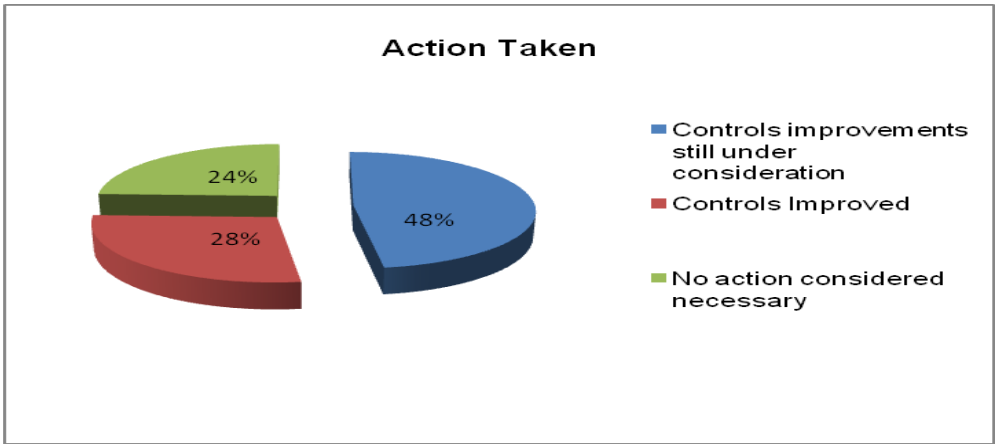
3.22 The number of cases reported through established whistleblowing policies was 74. This equates to 20% of the total amount of cases reported.

3.23 Further analysis shows that of the 74 cases reported through whistleblowing channels, 14 are considered to be 'actual' cases, 3 'attempted but prevented' and 57 were classified as 'suspected' cases at the time of reporting.

Actions taken to improve controls

3.24 In 103 cases it was noted that action was taken to improve controls (28%), while in 48% of frauds it was reported that control improvements were still under consideration (178 cases).

Action Taken		
Action Taken	**Number of cases**	**Percentage of cases**
Controls improvements still under consideration	178	48%
Controls Improved	103	28%
No action considered necessary	91	24%
Total	**372**	**100%**



SECTION 4

An analysis of the main categories of cases reported.

Health Service specific

4.1 Health Service specific cases was the most common category in 2014/15. This category accounted for 31% of the total number of cases being reported, recording a total of 117 cases.

4.2 This was an increase of 39 cases from the number recorded in 2013/14 (78 cases). The value for the category was recorded as zero. This is due to the fact that cases in this category include where individuals are suspected of accessing free health care services by using a false address in Northern Ireland or attempting to obtain prescription medication fraudulently. BSO have advised that in a large percentage of these cases the individuals do not reside in this jurisdiction but are suspected of providing incorrect/false details to obtain free healthcare in Northern Ireland. However as the individual is often not resident in NI it is difficult for BSO to pursue criminal and/or civil proceedings in these cases. The only sanction available is removal from the NI GP registration lists so preventing any further access to healthcare in NI, which can result in potential savings to the heath care budget.

4.3 The other type of Health Service Specific case is fraudulent medication reports (FMRs) where individuals seek to obtain medicines to which they are not entitled. These are normally pursued via the criminal prosecution route. All successful prosecutions are publicised by BSO Counter Fraud.

4.4 More detail on the counter fraud activity undertaken by BSO within the health sector is outlined at section 5.

Theft of assets

4.5 The theft of assets category recorded a decrease in the number of cases reported to DFP compared to the previous year's total of 181 cases. 101

cases of theft were reported in 2014/15. This is a decrease of 44%.

4.6 The value for the theft of assets category also showed a decrease of approximately £130k. In the previous year the value was £215k in this category. The 2014/15 value of £85k reported equates to a 60% reduction in value.

4.7 The items reported stolen included both large and small items such as a tractor; laptops; batteries; mobile phones; ipads and cash etc.

4.8 There was a reduction in the theft of fuel/heating oil and lead/metal. There were 23 cases of fuel/heating oil theft in 2014/15 compared to 30 cases in 2013/14. Lead/metal thefts accounted for only 5 cases this year compared to 16 cases in 2013/14. Reductions in the theft of fuel and metal are trends which has been recognised across the province, following increases in these areas in previous years.

4.9 As in previous years the controls which can be put in place to try and prevent cases in this category centre around physical security measures such as locks; key pads; perimeter fencing; and safe storage of valuable and attractive items.

Grant related

4.10 Grant related cases accounted for 46% of the total value reported in the 2014/15 year (£274k). The number of cases reported (33 cases) was similar to the number reported in 2013/14 (29 cases). However, there is a considerable increase in the value of cases reported, £77k in 2013/14 to £274k in 2014/15.

4.11 The increase in value can be attributed to a number of reported high value cases in this category. However it should be recognised that at the date of report in many instances the cases were suspected only and it was unclear whether the sums involved were related to the full grant amount, or only a proportion of the granted sum.

4.12 Cases reported included where grant had been paid to the funded body but the necessary payments may not have been made to HMRC; groups and individuals supplying false information to obtain funding to which they may otherwise not have been entitled; and providing false documentation in respect of claims made to support grant drawdown.

4.13 Such cases emphasis the need for robust pre award checks and letters of offer and the need for regular risk based checking and verification of claims made.

Payment process related

4.14 27 cases were recorded in this category for 2014/15. This equates to 7% of the total number of frauds. This was a 52% reduction in the number from last year when 56 cases were reported. However although the number of frauds was lower, this category recorded the third highest value at £81k.

4.15 The highest value case for payment process related fraud was £37k and was in relation to an unrecognised supplier payment set up on an on-line banking system. Fortunately in this instance a member of staff noticed the unrecognised supplier and thanks to their diligence no loss to the organisation concerned occurred.

4.16 The second highest value case within this category recorded a value of £14k and was classified as cheque encashment fraud. Fortunately again this was an attempted but prevented fraud and therefore there was no loss to the organisation. Other cases in this category included cheque fraud and counterfeit notes.

4.17 All these cases highlight the need for staff training and vigilance and for organisations to carry out regular bank reconciliations.

Pay or pay related allowances

4.18 The pay or pay related category showed a decrease of 10 cases for this reporting period bringing the total number of cases to 26. The value for the category remained fairly consistent with a value of £45k compared to £50k

reported in 2013/14.

4.19 Cases in this category include where employees continued to be paid after leaving employment; staff working elsewhere on behalf of an agency while on sick leave; and staff claiming for hours not actually worked.

4.20 The importance of having sound policies and procedures in place which cover these issues and the need for managers to be vigilant in their sign off/approval of claims is highlighted by these cases.

Income related

4.21 Both the total number of cases and the total value of cases within this category increased in 2014/15. The number of cases more than doubled from 8 in 2013/14 to 17 cases in 2014/15. The value had a significant increase from £1.5k in 2013/14 to £26k in 2014/15.

4.22 Much of the increase in value can be attributed to one reported case submitted which was valued at £18k. The case related to monies being collected by an employee but not paid over to the organisation. At the time of reporting both an internal investigation and a PSNI investigation were underway.

4.23 This type of case highlights the need to have appropriate segregation of duties in place and to carry out reconciliations of monies received back to source documentation.

Travel and subsistence related

4.24 13 cases were reported in this category with a total value of just under £11k (4% of the total number of cases and 2% of the overall value reported). The number of cases and the value both showed an increase compared to last year's figures when there were only 3 cases reported with a value of around £6k.

4.25 The 2014/15 cases included incidents where mileage was claimed for journeys actually taken on public transport; claiming false refreshment and parking fees; and misuse of a taxi account.

4.26 Again the cases reported demonstrate the need for clear policies and procedures, and for managers to be sufficiently vigilant when approving claims.

Abuse of position / assets / exploitation of information

4.27 There were 13 cases recorded in this category for 2014/15 showing a decrease on the figure for last year of 22 cases. The value recorded was just under £1k for 2014/15. The cases recorded included instances of attempted bribery; an employee using a contract for personal use; and a member of staff using his position to gain sensitive information for his private business.

Other

4.28 This category showed a reduction in the number of cases and in value being reported for 2014/15 year, falling from 36 cases in 2013/14 to 12 cases. The 12 cases recorded had a reported value of £0.5k.

4.29 The cases included misuse of blue badges for parking; the alleged issue of fraudulent vehicle test certificates; and false injury and repair claims.

4.30 Due to the variety of types of cases which fall under this category each individual organisation needs to consider the particular circumstances of the case to determine lessons learned and additional controls which may be useful to implement.

Contractor fraud

4.31 Contractor related cases related to 5 cases with a total value of under £47k. This is a decrease in the total number of cases but an increase in the total value recorded compared to the 2013/14 report. All 5 cases were suspected cases and were not concluded at the date of reporting.

4.32 The cases related to where contractors are suspected of charging for services not provided to the required standard or for good/services they have not provided. Such examples highlight the need for terms and conditions to be clearly set and for staff approving payments to ensure that work done or goods/services charged for, have been provided as billed for.

Pension fraud

4.33 There were only 4 cases of pension fraud reported this year, a significant reduction in the number from 2013/14 when 19 cases were recorded. This can be part explained by the cyclical nature of NFI matches and investigations over a two year period.

4.34 The value of the cases of pension fraud in 2014/15 also reduced to just under £6k. Failure to notify the death of a pensioner resulting in an overpayment of pension was the reason for all the cases reported.

4.35 Three of the cases were discovered through the NFI exercise which reiterates the importance of participation for those organisations that are responsible for pension payments.

Procurement fraud

4.36 The number of frauds reported under this category was 2 cases. Both cases were classified as suspected cases and at the time of reporting the responding bodies advised that values could not be estimated. Investigations into both were ongoing at that time.

4.37 While there were no clear lessons identified from these 2 cases, issues around procurement irregularities in general highlight the need for procurement policies and practices to be followed; staff to be aware of their duties and responsibilities, including the need for actual or perceived conflicts of interest to be identified and managed; and for tender processes to be run in an open and fair manner.

NIHE related fraud

4.38 There were 2 cases of NIHE related frauds reported this year with a total value of £15k. Only one of the cases gave a value and was in relation to a landlord who contrived a number of tenancies in order to fraudulently obtain Housing Benefit payments. The other related to a potentially fraudulent claim for homelessness being made.

SECTION 5

Summary reports from the relevant organisations are included in this section from:-

- SSA – Benefit Fraud
- NIEA – Environmental Crime
- LPS – Benefit Fraud
- NI Legal Services Commission – Legal Aid Fraud
- NI Housing Executive – Tenancy Fraud
- NI Water – Water Connections
- Health Sector – Counter Fraud Services

Social Security Agency (SSA) – Benefit Fraud

5.1 The SSA is responsible for social security benefit expenditure of approximately £5.0 billion each year. The Agency has a robust strategy for tackling fraud and error when it occurs in the social security system. The strategy focuses on the prevention, detection, investigation, sanctioning of benefit offenders, and instigating legal proceedings against offenders when appropriate. The Agency considers it important that any losses associated with benefit crime are rigorously pursued.

5.2 Reducing fraud and error remains a key priority for the Agency. Wide ranging powers combined with an improved IT support system means that the Agency operates effectively within wider criminal justice frameworks. These include information gathering powers, investigatory powers, surveillance powers, powers of entry, effective sanctions and the authority to recover assets derived through crime. The Agency also measures the extent of fraud and error annually to help direct its focus to areas of greatest risk.

5.3 The Agency introduced its new Single Investigation Service in April 2013. Fraud investigation, customer compliance and case intervention functions are now integrated within this new Service, effectively managing all customer behaviour by organising customer fraud and error activity within one cohesive structure. This new organisation provides greater flexibility with the capability

to assess risk quickly and effectively and ensure cases are dealt with efficiently.

5.4 A range of further initiatives to help modernise the Agency's counter fraud and error capabilities are being taken forward by a dedicated project team within the Agency. The focus is the mitigation of any potential future risks and to create an infrastructure necessary to deal promptly and effectively with fraud and error.

5.5 Principally these initiatives are:

- Joined up working – closer liaison and joint working with Her Majesty's Revenue and Customs and the NI Housing Executive with the aim of carrying out joint prosecutions for those customers who abuse both the tax credit and benefit systems.

- Targeting – continued development, alongside Department for Work and Pensions (DWP), of the use of new data sources including Real Time Information (RTI), to enhance future fraud prevention and detection capability – with particular focus at the gateway i.e. the point of entry to a benefit claim.

- Deterrence – legislative proposals contained within the Welfare Reform Bill to prevent and deter those intent on committing fraud including increased penalties and loss of benefit.

- Communication – continuing to remind staff and the wider public of the need to remain vigilant and to report suspected fraud.

5.6 The 2014 estimates calculate benefit fraud loss at £25.2 million, or 0.5% of expenditure: a slight increase from the previous year.

Investigations, Penalties and Convictions

5.7 The Single Investigation Service focus remains the prevention, detection and investigation of benefit fraud and error. In 2014/15 counter fraud activity led to a total of 743 penalties and convictions being imposed.

Financial Recoveries

5.8 Financial Investigation Unit continues to pursue assets of those convicted of serious benefit fraud using powers in the Proceeds of Crime Act 2002. During the 2014/15 year the Unit's intervention brought about the recovery of £495,161 of assets criminally obtained. This figure included 20 confiscation orders to the value of £356k and 8 voluntary payments to the value of £140k.

Customer Compliance

5.9 The SSA's Customer Compliance activity transferred to the newly formed Single Investigation Service (SIS) from 1 April 2013. During 2014/15 3,464 cases have been completed resulting in 1,157 changes to benefit entitlement and monetary value of adjustment of £4.0 million. This equates to a 33% hit rate for the period.

Organised Crime

5.10 During 2014/15 the Organised Fraud Unit investigated 150 potentially serious and complex fraud allegations and raised overpayments totalling £140k.

Data sharing and international co-operation

5.11 The Agency continues to work closely with the DWP and Department of Social Protection through the Cross Border Forum and the higher level Memorandum of Understanding Committee. During 2014/15 the Agency investigated a total of 13 cases with an element of cross border fraud, uncovering overpayments amounting to £96k.

5.12 The Agency pursues cross jurisdictional counter-fraud measures through participation in Memoranda of Understanding with the Republic of Ireland, Netherlands, Spain, Australia, Belgium, Malta, Norway Sweden, Poland, Germany, the USA, and Denmark. Additionally, the Agency's liaison with DWP allows the Department to participate in the development of international agreements and is doing so with a number of other countries, including France, Switzerland, Italy, and Cyprus.

Northern Ireland Environment Agency (NIEA) – Environmental Crime

5.13 NIEA's Environmental Crime Unit (ECU) was established to deter and disrupt the serious and organised criminality that surrounds the waste management industry in Northern Ireland. It oversees frequently complex and intensive investigations and prosecutions under the Waste and Contaminated Land (Northern Ireland) Order 1997.

5.14 During the 2014/15 financial year, ECU has continued to develop its partnership arrangements with a range of other law enforcement agencies and more broadly also with others who assist in enabling the deterrence, disruption and detection of serious and organised waste crime. For example, ECU remains an active participant in the Organised Crime Task Force Criminal Finance Group and Cross Border Fuel Fraud Enforcement Group.

5.15 Also, during the year, ECU's criminal investigators secured 23 convictions for waste offending, from illegal landfill at unlicensed sites through to the unauthorised treatment of end of life vehicles. These cases generated £41,745 in fines.

5.16 In the same period, under the Proceeds of Crime Act 2002 (POCA), ECU's financial investigators secured four confiscation orders to the value of £543,940. POCA clearly remains an effective tool in depriving waste offenders of the proceeds of their criminal conduct. This approach serves also to ensure that, as far as possible, such offenders are deprived of the means to further offend. In addition, it adheres to the important environmental principle that 'the polluter pays'.

Land and Property Services (LPS) – Benefit Fraud

5.17 LPS administer Housing Benefit for rates support for owner occupiers. The Housing Benefit scheme is a means tested benefit that provides assistance for rates to approximately 60,000 ratepayers at a total cost of approximately £40 million per year. The benefit is given to claimants by means of a non-cash credit which is applied against their rate debt – no actual money is paid out.

5.18 LPS take a zero tolerance approach to fraud and will report instances of fraud to the PSNI if necessary. LPS also participates fully in NFI by investigating matches in relation to payroll, pension, trade creditors, rates and housing benefit data. The data matching involves comparing sets of data which allows potentially fraudulent claims and payments to be identified. Where no match is found, the data matching will have no material impact on those concerned. Where a match is found it indicates that there may be an inconsistency that requires further investigation. The department has a designated team to action the 10,000 cases identified by the NFI, mainly where housing benefit has been paid by both NIHE and LPS, or where there is an income strand that LPS was not aware of.

5.19 A quarterly Standard Assurance Unit (SAU) report on housing benefit fraud and error is a standing item at the LPS Audit Risk Committee. For the year ended 31 December 2014, SAU detected suspected fraud on 3.2% of the cases monitored.

Northern Ireland Legal Services Commission – Legal Aid Fraud

5.20 During 2014/15 responsibility for the administration of Legal Aid fell to the Northern Ireland Legal Services Commission (referred to as the 'Commission') - however from 1 April 2015 this function now falls to the Legal Services Agency Northern Ireland.

5.21 In 2014/15 the Commission was responsible for legal aid expenditure of approximately £100 million. The Commission had in place a counter fraud and

error strategy which focused on the prevention, detection and investigation of persons who defrauded or attempted to defraud the Legal Aid Fund. The Commission considered it important that any suspected or reported cases of legal aid fraud were rigorously pursued.

Investigations and Sanctions

5.22 The Commission's Counter Fraud Unit undertook the investigation of all suspected fraud against the Legal Aid Fund. Frauds perpetrated included both applicant and supplier fraud. Applicants are members of the public who applied for legal aid whilst suppliers are members of the legal profession – solicitors and barristers. Primary sanctions used by the Commission included the revocation of an applicant's Legal Aid Certificate or seeking to withdraw Legal Aid assistance, which may leave the applicant responsible for payment of legal fees. In other instances cases were referred to the PSNI and, in these circumstances, an evidential package was prepared for the PSNI. Members of the legal profession could also be referred to their respective regulatory bodies.

5.23 Between 1 April 2014 and 31 March 2015 the Legal Aid Counter Fraud Unit received 524 allegations of fraud of which, following assessment, 191 were registered for further investigation. In the same period the Unit revoked the Legal Aid certificates of 23 applicants and sought the withdrawal of Legal Aid assistance in 27 other cases.

Counter Fraud Strategy

5.24 Reducing fraud and error was a key priority for the Commission. The Commission used the investigative and legislative powers it had at its disposal to fully investigate those cases that might be fraudulent. The Counter Fraud Unit regularly conducted risk assessments of all operational areas and measured the extent of fraud and error annually, to help direct the focus into those areas considered to be of greatest risk of abuse. A range of initiatives overseen by the Counter Fraud Strategy Group were also undertaken within

the Commission to help identify suspected fraud cases and/or error to further enhance well established procedures in these areas.

Data sharing and co-operation

5.25 The Commission worked closely with a number of government departments including the Legal Aid Assessment Office of SSA which assesses the financial eligibility of each applicant for legal aid. The Commission also had a Memorandum of Understanding for the referral of cases with PSNI which has been in place for 11 years.

5.26 With the establishment of the Legal Services Agency Northern Ireland (as stated above) the counter fraud activities in the area of Legal Aid will be taken forward from 1 April 2015 by Legal Services Agency.

NI Housing Executive - Tenancy Fraud

5.27 The Tenancy Fraud Unit of the NIHE is a sub unit of the Counter Fraud and Security Unit under the control of the Counter Fraud and Security Advisor. The Tenancy Fraud Unit began operating on the 1 August 2014 following a NIAO report titled 'Tackling Social Housing Tenancy Fraud in Northern Ireland'. Prior to this there was no dedicated Tenancy Fraud Unit, and any tenancy fraud was investigated within the Counter Fraud and Security Unit.

5.28 Tenancy fraud is classified as:- abandonment with associated housing benefit; sub-letting; false succession; giving false information in a housing application; and fraudulent right to buy applications.

5.29 The recovery of social housing for re-allocation within the community, and the prosecution of those who criminally abuse the system for their own benefit, is a priority for the NIHE. Since the development of a dedicated Tenancy Fraud Unit a total of 96 cases were registered as tenancy fraud during the period April 2014 to March 2015. These include tenancy fraud cases transferred prior to the commencement of the Tenancy Fraud Unit on the 1 August 2014.

5.30 Thirty one cases were as a result of whistle-blowing within the community, the remaining 65 were as the result of departmental control procedures.

5.31 Of the total of 96 cases, 78 were in respect of non-occupation, of which 28 were being sub-let for profit. Almost all had a housing benefit fraud associated with the non-occupation, with appropriate undue benefits being recovered. Eight were false succession claims, with the remaining 10 giving false information within their housing application or within supporting documentation.

5.32 Two housing applications were withdrawn and a further three succession claims were denied following the unit's investigations. This ensured that eligible families in need were properly housed in the available accommodation.

5.33 Twenty six properties were also recovered for re-allocation which equated to a 'recovered property benefit' of £208k.

5.34 The success of the Unit, the recovery of properties for re-allocation and the benefit to the local communities should bring about greater community cohesion and cooperation in future years.

NI Water - Water Connections

5.35 Forty four cases of water fraud were reported during 2014/15 representing a significant increase on similar cases reported in previous years. The increase is partly due to greater awareness around this type of fraud, resulting in more cases being reported by the public. However, NI Water has also improved its controls to detect this type of fraud.

5.36 Water fraud includes illegal network connections for commercial premises, bypassing or tampering with water meters and the use of illegal standpipes to connect with the water supply network.

5.37 In the majority of water fraud cases it is very difficult to assess the value of lost revenue. It is not, therefore, possible to provide a meaningful indication of the cumulative financial loss incurred by NI Water as result of this type of fraud. However, it is likely to be significantly less than 1% of the circa £37m in non-domestic water charges recovered by NI Water in 2014/15.

5.38 Dealing with water related fraud is a standard business practice for any water company and NI Water has adopted a proactive and integrated approach to the identification and management of this type of fraud. The company handles investigations into water fraud on a case by case basis and in compliance with its own and the Department for Regional Development's Anti-Fraud Policy and Fraud Response Plan. The measures it employs to tackle these cases normally involve collaboration with water network colleagues, meter readers, customer metering and billing through to the issue of caution letters and, in cases where a customer refuses to co-operate, the issue of a court summons.

5.39 The effectiveness of these measures has resulted in a number of successful outcomes, including amicable resolution with customers repaying outstanding debts and a recent prosecution under the Water and Sewerage Services Order 2006 for metering tampering offences.

5.40 NI Water continues to tackle this type of fraud through its established arrangements and will pursue prosecutions, if required.

Health Sector – Business Services Organisation Counter Fraud Activity
Counter Fraud and Probity Services (CFPS)

5.41 Counter Fraud Services provide a range of specialist counter fraud services to Health and Social Care (HSC) organisations and the Department of Health, Social Services and Public Safety (DHSSPS). The unit focuses on three strands of operation: fraud prevention, investigation and detection.

Fraud prevention

5.42 The Fraud Prevention team have responsibility for a number of functions including counter fraud policy development; stakeholder and client engagement; managing the regional HSC fraud reporting database; and working in conjunction with organisations to increase the level of fraud awareness among HSC staff and patients.

5.43 During 2014/15 the fraud prevention team:-

- undertook 86 presentations to 2,550 staff;
- launched social media platforms publicising fraud news which resulted in 33,369 views across the online platforms;
- issued 16 fraud alerts highlighting a range of scams;
- participated in a range of activities in support of International Fraud Awareness Week;
- engaged with HSC staff at road-shows held at six key sites; and
- processed 257 fraud reports.

5.44 The prevention team also lead in the development of Memorandum of Understanding and Data Sharing Agreements with external HSC organisations such as HMRC and the Department of Social Protection (DoSP), Republic of Ireland.

Fraud investigation

5.45 CFPS provide a specialist fraud investigation service through the employment of a team of specially trained investigators. In 2014/15 a total of 285 referrals were dealt with by CFPS investigators.

5.46 There were 52 sanctions applied to individuals as a result of the work undertaken by the investigators. This involved court administered fines, community service orders, custodial sentences, financial recoveries and removals from GP registration lists.

Fraud detection

5.47 Access to Health and Social Care:-

- the team carried out a number of proactive projects in 2014/15 to detect potentially fraudulent activity - this led to the removal of 379 patients from GP registration lists resulting in potential annual savings of £799k;
- processes have been developed for piloting across secondary and social care to identify chargeable patients or those not entitled to access services; and
- the team provide a specialist advice and guidance service to HSC and successfully resolved some 160 complex queries.

5.48 Forensic Data Analytics (FDA) - a new FDA service was launched in February 2015 which makes use of the latest innovations in data mining and analysis, amongst other tools, to identify potential fraudulent activity and loss within HSC. This has facilitated a range of proactive exercises to be undertaken that will assist with the prevention, detection and investigation of fraud.

5.49 Patient Exemption Claims to Ophthalmic and Dental Charges - the Probity Team carry out a range of both random and targeted checks where exemption from Health Service dental and/or ophthalmic charges has been claimed. Where patients have falsely claimed exemption from charges, the sums are required to be repaid and, where applicable fixed penalty and surcharges are applied.

5.50 Patient Claims - A total of 29,428 dental and ophthalmic claims were selected for verification this year, resulting in 6,094 cases requiring further examination. Some £50K has been recovered directly by CFPS with a further £4k recovered via civil action.