IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: 85613/2017

SIGNATURE	DATE
.....	**08/09/2021**

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In the matter between:

DISCOVERY INSURE LIMITED **Plaintiff**

And

TSHAMUNWE MASINDI **Defendant**

DATE OF TRIAL: This matter was set down for trial on 10 to 11 February 2021 that was conducted virtually with oral evidence and argument submitted virtually.
DATE OF JUDGMENT: This judgment was handed down electronically by circulation to the parties' representatives by email. The date and time of hand-down is deemed to be 08 September 2021 at 10h00.

JUDGMENT

[1] In this action, the Plaintiff, Discovery Insure Limited ("Discovery"), is claiming from the Defendant, Mr Tshamuwe Masindi ("Masindi") one of its client, a repayment of benefits in the amount of R1 647 592.67, which the Plaintiff paid in settlement of a claim of a loss allegedly suffered by the Defendant. The Plaintiff alleges that the amount is recoverable as the Defendant's claim was tainted by fraud.

[2] The Plaintiff' is a registered long term Insurer under the Short Term Insurance Act 52 of 1998 (STI Act). Its claim is reliant on a written contract of insurance it concluded with the defendant on 23 March 2016 which comprised of a Policy Schedule and a Discovery Insure Guide Plan in terms of which the Plaintiff provided the Defendant with insurance cover for certain specified losses or /risks (insured risks). The Defendant in turn paid a monthly premium.

[3] One of the losses or risks insured was damage to the buildings located at No. [….], which is the Defendant's residence. The Defendant was also entitled to claim the costs of alternative accommodation if the insured building is rendered unsuitable to be lived in due to the occurrence of an insured event.

[4] The following clauses formed part of the material terms of the policy;-

> 5.5. Breach of conditions requiring your assistance;
>
> We reserve the right to cancel your Plan and claim repayment from you for any amounts we have paid in settlement of your claim if you breach or fail to comply with our claim procedure and the rules set out in this Plan Guide."
>
> 5.13 Fraud, misrepresentation and inaccurate information;
>
> All benefits in terms of this Plan in respect of <u>any claim</u> will be lost and this Plan may be voided or cancelled at our discretion:
>
> • Where there is a misrepresentation, non-disclosure, misdescription by you or anyone acting on your behalf; or
>
> • If false or incomplete information is supplied for any fact and/or circumstance in connection with an application for cover or in connection with a claim in terms of this Plan by you or anyone acting on your behalf; or
>
> • <u>If any claim or part thereof under this Plan</u> is in any way fraudulent, or if fraudulent means or devices are used by you or any acting on your behalf to get any benefit under this Plan, or if any insured event under this Plan is occasioned by your intentional conduct or any person acting on your behalf or with your involvement;
>
> • If any fraudulent information and/or document whether created by you or any other party is provided to us by you or anyone acting on your behalf or with your involvement in support of any claim under this Plan and whether or not the claim is itself fraudulent.

> • If the size of any claim is inflated by you or anyone acting on your behalf or with your involvement, for any reason whatsoever, and whether the claim itself is fraudulent.
>
> Where any benefit under this Plan is forfeited in circumstances set out in this section, we will have the right to cancel your Plan retrospective to the reported incident date or actual incident date, whichever is the earliest."
>
> 48. The term "forfeit" means: "Lose or give up (something) as a necessary consequence.

[5] On 16 December 2016 the Defendant lodged a claim with the Plaintiff under the building section of the policy following damages to the insured residence property due to a storm and flooding. The claim included a claim for emergency accommodation. Clause 10.3.2.1

[6] As a result of the claim the Plaintiff alleges in his particulars to have paid the Defendant a total amount of R972 592.67 that was claimed in respect of the repairs to the Defendant's residence and damage to household contents. In addition, to have paid an amount of R675 000.00 for costs for the Defendant's emergency accommodation after the Defendant had, on demand by the Plaintiff, provided what he purported to be tax invoices in respect of his accommodation at the Villa Africa Boutique Hotel during the period 20 November 2016 to 16 May 2017. The invoices are referred to as Annexures C1 to C6 ("the invoices").

[7] The Defendant had in fact not utilised the accommodation and therefore did not incur the expenses. The two invoices C1 and C2 were not invoiced to the Defendant for any services. C3 to C6 were made out to a 3rd party and the accommodation not utilised by the Defendant. The Defendant had fraudulently, alternatively misrepresented or alternatively provided inaccurate information when he submitted invoices for repayment and in support of his claims which according to the Plaintiff was in the sum of R675 000.

[8] Accordingly the Plaintiff alleges that due to the Defendant's fraud or misrepresentation or alternatively provision of inaccurate information during claim stage:

> [8.1] It is in terms of the policy entitled to claim back all the money paid to the Defendant,
>
> [8.2] The whole claim payment was made as constituted in the agreements of loss, signed and agreed to by the Defendant on each of the individual claims arising from the incident which equals R 1 646 892.67.

[9] The Plaintiff further pleads that a further accepted term in the agreement of loss, provides it with further and additional rights to recover all the payments. The clause reads:

> "Furthermore, you understand that if any part of this claim is fraudulent or if any fraudulent means or devices be used by me or anyone acting

> on my behalf with or without my knowledge to obtain a benefit, all benefits under the policy will be forfeited and Discovery Insure shall be entitled to recover all costs and expenses relating to this particular loss or claim."

[10] The Plaintiff therefore pleads that if any claim was fraudulent, the Plaintiff was entitled to cancel the contract with retrospective effect to the date of the incident (11 November 2016) and to reclaim all payments made to the defendant, irrespective of which claim a payment was made. Every single payment made, subsequent to 11 November 2016 to be repaid.

[11] Subsequent the fraud, the Plaintiff, sent a letter dated 8 June 2017, duly cancelling the contract of insurance with retrospective effect to the date of the incident (11 November 2016). In addition, the letter demanded repayment of all amounts paid under the cancelled contract.

[12] Notwithstanding what was pleaded in the Defendant's Plea, when the matter came before court, there was no dispute on the merits regarding the fraud in respect of the mentioned claim, therefore all facts in that regard were common cause to the parties.

[13] The Defendant disputed the claim on the basis that there is no express provision in the policy that determines that on the retrospective termination of the policy the Defendant becomes liable for the repayment of any/all benefits paid by the plaintiff before termination, including benefits in respect of claims not tainted by fraud, challenging each of the provisions.

[14] The Defendant further disputes that the Plaintiff paid to him all the amounts alleged to have been purportedly claimed. The total amount that was paid to the Defendant by the Plaintiff was therefore also in dispute and the Plaintiff put to the proof thereof.

Issues to be determined

[15] On the date of the trial the parties had therefore narrowed the issues on both questions of law and fact, it being common cause that the benefits paid in relation to the insured building for emergency accommodation were fraudulently gotten.

Legal issue

{16] It is the proposition of the Defendant that fraud in respect of part of an otherwise valid claim does not result in forfeiture of the entire claim, whilst the plaintiff proposes otherwise, saying that it results in forfeiture of all claims retrospective to the date of the incident not to the date of breach specifically if it is an express term of the contract.

[17] The issue to be decided is therefore whether on cancellation of the policy as per terms of the contract, the Plaintiff is entitled (legally) to claim repayment of all the amounts paid on all the claims that arose, retrospect to the date of termination, that is from the date of the insured incident as per clause 15.3. and agreement of loss, irrespective of their validity, or of only the payments made on the fraudulent claim. It is therefore whether what is repayable is all the amounts that were paid on the claim or only the ill- gotten amounts.

Legal framework

[18] Many policies of this kind has no express term providing for a forfeiture in such circumstances, like in the matter of *Schoeman v Constantia Insurance Co Ltd* (1) (001/2002) [2003] ZASCA 48; [2003] 2 All SA 642 (SCA) (21 May 2003) referred to by both parties in support of their respective arguments. It is however of significance to note that in *Schoeman*, the SCA noted that:

> "**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. (my emphasis)"

[19] The court in *Schoeman* was however mainly dealing with a different proposition altogether from the one advanced by the parties in casu. It having been settled that in the absence of an express term on forfeiture in the insurance policy, fraud confined to only part of a claim by an insured against an insurer not in the whole claim being forfeited. On the implications of a contract that has an express term on forfeiture, in (*Lehmbecker's Earthmoving & Excavators (Pty) Ltd v Incorporated General Insurances Ltd*[21] 1984 (3) SA 513 (A) at 522 E-F) in which such a term had been expressly incorporated as referred to in Southern, the SCA on the facts of that matter, declined to give the forfeiture clause its wide literal meaning because of the "grossly and intolerably disproportionate" penal effect doing so could have.

[20] In the instance of *Lehmbecker* too, the court was dealing with a different set of facts, there being two claims arising from two total different insured risk events. There was no connection between the claims. The insured sued to recover loss only on the first untainted claim whose liability arose prior to the incident in respect of which the tainted claim was made. The claim was upheld. The court was not prepared to interpret the admittedly wide language of the forfeiture provision as extending to a previously accrued valid claim which was not tainted by fraud, having concluded that it would result in a gross and intolerable disproportionate penal effect.

[21] In this matter the claims arose from one and the same risk incident although for different insured risk /benefits with an express term of cancellation and specified date of forfeiture stated in the contract. On what might be the implication of the *Lehmbecker* decision thereon, the following statement by the court in *Schoeman* is significant, that:

> "[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 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**. (my emphasis)

[22] The cardinal question to be considered is what are the circumstances where there is an express forfeiture clause, in case of one risk incident giving rise to a claim that partly, not entirely was fraudulent. In *Lehmbecker* the cardinal question considered was whether such termination had the effect of rendering unenforceable a valid claim under the policy submitted prior to the making of the fraudulent claim and prior to termination of the policy, *Lehmbecker o*n para 14. Also being mindful of the fact that cancellation and the wide forfeiture implications thereof are an express term in the contract. Millar JA in Southern conceded that the situation would be different.

[23] The Defendant in casu has argued like the Respondent in the *Lehmbecker* matter, that. because the aim was to combat fraud, very wide terms were used in the policy, and that if proper effect were given to such wide terms, the termination of the policy on the ground of the making of a fraudulent claim would affect any and all claims even if they had accrued to the appellant in terms of the policy, prior to its termination, which is indeed what the Plaintiff is advocating (however retrospective to the date of the incident) invalidation of all liability that has accrued from the risk incident. The Plaintiff referred to the decisions in *Papagapiou v Santam Ltd* (58/2005) [2005] ZASCA 140 (30 November 2005) and *Harikasun v New National Assurance Company Limited* (190/2008) [2013] ZAKZDHC 67 (12 December 2013).

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[24] The court in *Lehmbecker* even though accepting that the language of condition used is very wide and that the circumstance that the condition is aimed only at fraudulent conduct is a factor to be kept in the foreground of the mind when considering the meaning and effect of the condition, and accepting that the main objects of condition 3 are to lend protection to the insurer against fraudulent claims and to discourage attempts to gain undue advantage by lodging falsely inflated claims, reasoned that there is a less strong need for the Court to "lean towards upholding the policy and against producing a forfeiture."

[25] In the final result the court, per Millar JA was not persuaded that the answer to the problem is to be found simply in the wide literal meaning of the words used in policy condition. Taking the cue from *Russell N.O. and Loveday N.O. v Collins Submarine Pipelines Africa (Pty.) Ltd.* **1975 (1) S.A. 110** at p. 129, where the Court had accepted that ultimately the problem of interpretation of an insurance policy was:-

> "one of arriving at the intention of the parties from the terms of the contract considered as a whole", and that the intention "was to be looked for on the face of the policy in the words which the parties themselves have chosen to express their meaning."

[26] But further argued that it not infrequently happens that the parties use simple words, in themselves unambiguous, but which cannot readily or reasonably be applied in their literal sense to all the situations to which their agreement was directed. In such cases an element of ambiguity arises from the fact that "an absolutely literal interpretation" may be wholly or substantially impracticable, or productive of startling results which could hardly have been intended. (See *MacGillivray and Partington*, ibid,
[31] *In Walker's Fruit Farms Ltd. v Sumner,* 1930 T.P.D. 394 at p. 401, GREENBERG, J., held that where a party repudiates a contract and the other party elects to accept such repudiation so that the contract then comes to an end, the latter party is not precluded by reason of termination of the contract, from suing for money which had already accrued in terms of the contract prior to its termination. A differentiation was made between a scenario where a policy fraudulently concluded as a result void ab initio from inception and one that is cancelled as a result of malpractice.

[27] Millar JA went further in *Lehmbecker* to point out that:

> "It is noteworthy and of considerable significance that when dealing with "false claim clauses" substantially similar to condition 3, the Courts and writers on the subject of insurance pointedly bring out the differences between the two sets of circumstances and allow for such differences when applying the clause. Thus, in Vol. 25, para. 425 of Halsbury's Laws of England (4th Ed.) we find these passages: -
>
> > "A condition subsequent affecting the policy is a condition relative in its essence to duties after the inception of the policy which by necessary intendment or express agreement affects the continued existence of the policy in the sense that if there is a breach, the other party may treat the policy as at an end. The avoidance of such a policy can only date from the breach; up to that date the policy is fully effective so as to entitle the assured to recover in respect of any loss which occurred before the breach." (his underlining.)"

[28] Referring to Ivamy, at p. 292, Millar JA remarked that "it is to similar effect; conditions which relate to matters arising after conclusion of the contract do not, he says, render the policy void ab initio but the policy may be avoided by the insurer "as from the date of the breach, and at p309 the learned author says that if the insured's

loss takes place before the breach, “he is not precluded from recovering in respect of it, since the policy, at the time of loss, was still operative.”(See also the cases referred to in note 17 on p309. He further pointed out that:

> “The significance of these and other similar comments is that they are made in respect of clauses similar to condition 3 and certainly in respect of clauses which provide that "all benefit" or "all claim" shall be forfeited. What emerges from all this is that the words "all benefit" or "all claim" have obviously been given, by the Courts and by the learned authors mentioned above, the sort of "gloss" to which MacGillivray and Parkington refer, in the sense that despite the comprehensiveness of the word "all" in its literal connotation, valid claims previously made by and accrued to the insured in terms of the policy, have been taken to be unaffected by the forfeiture provision; and, in my view, rightly so. Indeed, the words "all benefit under this policy shall be forfeited" upon the making of a fraudulent claim, are at least clearly capable of bearing the meaning that as from the time that the fraudulent claim is made, the insured shall have no further benefit or claim under the policy; and, therefore, that valid claims already accrued (and, a fortiori, valid claims already paid out to the insured) remain inviolate and untouched by the subsequent, unrelated fraudulent claim. It therefore cannot be said that condition 3 unambiguously provides for forfeiture of valid claims which had accrued prior to the fraudulent claim. (my emphasis)

[29] Finally Millar JA concluded at [20] that:

> “A provision requiring forfeiture of honest claims made under and in terms of a valid policy of insurance and which had accrued and become due and payable prior to the subsequent breach causing the premature termination of the policy, would surely be nothing less than a penalty. And it could be a penalty grossly and intolerably disproportionate to the breach, which would be the case if the accrued, valid claims ran into hundreds of thousands of rands and the subsequent fraudulent claim was of relatively insignificant value.’

[30] In *casu*, following the principles enunciated above, it should be of significance that the claim for all the benefits alleged to be affected arose from a single incident. The breach was committed on 16 December 2016 on the submission of the claim that partly constituted of a fraudulent and partly credible claim, following the loss that ensued from the single incident of 11 November 2016. Accordingly, since avoidance of such a policy can only date from date of the breach; up to that date the policy is fully effective so as to entitle the Defendant to recover in respect of any loss which occurred before the breach. A breach committed when claiming benefits of a loss that has accrued prior thereto, if following the reasoning as per mentioned authorities should not taint the part of the claim that is credible since the loss (entitlement to claim/recover) accrued prior the breach.

[31] However it is of further significance that the policy between the Plaintiff and the Defendant also encompasses the renowned provision in clause 5.13. It reads: “All benefits in terms of this Plan in respect of any claim will be lost and this Plan

may be voided or cancelled at our discretion:" inter alia, If any claim or part thereof under this Plan is in any way fraudulent.' 'Lost' connoting forfeiture. The parties clearly bound themselves in clear terms to the application of forfeiture. Indeed, such words as stated in their policy were said to be clearly capable of bearing the meaning that "as from the time that the fraudulent claim is made, the insured shall have no further benefit or claim under the policy", forfeiture being applicable to all benefits in respect of the claim as at date of breach, which is the date of the fraudulent claim.

[32] The Plaintiff voided the contract from date of incident as per the policy. The end result of such voidance affecting the whole claim, even though breach occasioned by only a part of the claim. The question is whether at the time of breach the whole claim or only the fraudulent part of the claim was affected. Taking note of the provision of the policy that reads "we reserve the right to cancel your Plan and claim repayment from you for any amounts we have paid in settlement of your claim if you breach or fail to comply with our claim procedure and the rules set out in this Plan Guide."

[33] In *Lehmbecker* it was noted that in *Daff v Midland Colliery Owners Mutual Indemnity Co.,* (1913) 82 L.J.K.B. (H.L.) 1340 at p. 1352, and with reference to an indemnity given by the company to its members against all claims arising out of an accident, LORD MOULTON said that

> "if the accident occurs within the protected period such an indemnity at once vests in the member." In the same case, LORD SHAW (at p. 1345) affirmed that was "too late in the day to question the doctrine that on the occurrence of an accident, a right in the nature of a vested right to compensation is conferred upon the injured workman", and held further that the Indemnity Company, which was held to be an insurer in respect of loss accidentally suffered by a workman, incurred liability as insurer upon occurrence of the accident. In Walker's Fruit Farms Ltd. v Sumner, **1930 T.P.D. 394** at p. 401, GREENBERG, J., held that where a party repudiates a contract and the other party elects to accept such repudiation so that the contract then comes to an end, the latter party is not precluded by reason of termination of the contract, from suing for money which had already accrued in terms of the contract prior to its termination.(Pty) (See also Crest Enterprises/Ltd. v Rycklof Beleggings (Edms) Bpk, **1972 (2) S.A. 863** (A.D.) at p. 870, where it was pointed out that when GREENBERG, J. used the word "accrued" in the context of the principle enunciated by him, he meant "accrued, due and enforceable"; see also B.K. Tooling (Edms) Bpk v Scope Precision Engineering (Edms) Bpk, 1979 (1) S.A. 391 A.D, at p. 424). Upon application of the principle that termination of the contract in such a case applies only "to the executory portion thereof" and has no effect upon accrued rights under the contract, the respondent would not be entitled to repudiate claim "B".

[34] At the time of the breach, the right to claim all the benefits on the insured risk that were ultimately paid had already accrued to the Defendant. The Application of

the principle means that due to the fact that the breach was committed during the execution phase, the termination on breach supposes that it applies to the executory portion that is tainted by fraud not to the rights that had already validly accrued and or been settled. Any claims that have accrued prior the breach are enforceable against the Defendant and those settled inviolate. As it has been decided that despite the comprehensiveness of the word "all" in its literal connotation, valid claims previously made by and accrued to the insured in terms of the policy, have been taken to be unaffected by the forfeiture provision;

[35] Therefore, forfeiture that includes valid clams will result on a penalty. Contrary to the Defendant's argument, in terms of the Conventional Penalties Act 15, of 1962 (CPA) a penalty is enforceable but it may be revised if the amount of the penalty is out of proportion to the prejudice suffered; see s 3 of CPA. The question to be established is whether the effect of forfeiture as a penalty intended by the policy would be grossly and intolerably disproportionate to the breach/prejudice as feared and envisaged in Lembecke, a concern which seems appropriately to have occupied all the authorities mentioned. It is significant that in *Lehmbecker* the claims were separate and arose from different or separate risk incidents, the disproportionality apparent.

[36] The effect of ordering a repayment of the amount paid for benefits that have rightly accrued and were due and payable at the time of payment would seemingly be disproportionate to the breach, taking into consideration that the Defendant has not been unjustly enriched by the payments on the valid loss since the right to compensation had already accrued prior the breach. The Plaintiff has not shown that the amount of the valid benefits it requires to be repaid is in anyway proportional to the loss or prejudice it has suffered as a result of the breach. The fraudulent claim is, however, of no consequence to the accrued valid claims that were paid, in that it did not affect the insurer's position as to its prejudice; see *Papagapiou v Santam Ltd.* (58/2005) [2005] ZASCA 140 (30 November 2005) at para 9. The Plaintiff has referred to *Papagapiou* to support its argument for the forfeiture of a benefit in the instance of use of fraudulent means to gain a benefit. It is however an oddity as *in casu* the particular claim upon which forfeiture is sought covers valid claims untainted by the fraud. Therefore, there is no justification for the penalty as per terms of the contract to be enforced. The Plaintiff is therefore entitled to only a repayment of all the amounts it paid on the fraudulent part of the claim.

The factual issue

[37] On the factual issue to be determined the Plaintiff carried the onus to prove the actual amount that is due, or the extent of the Defendant's liability.

The trial

[38] As far as the factual dispute is concerned, when the trial was previously postponed by Ranchod J, he ordered that the parties in finalising the matter follow a procedure as stipulated in the order, inter alia, that parties file their witness statement setting out their evidence in chief no later than 30 days before the trial date. No later than 15 days each party to indicate if it disputes the evidence contained in any witness statement filed by the other, whereupon the witness will have to give oral evidence. If a witness' statement is not disputed, that evidence becomes common cause and the witness need not be called. If a party indicates that it disputes the evidence of a witness then that witness may be called to give evidence and may be cross examined.

[39] The Defendant gave an indication that he was not going to lead any evidence. He also had not filed witness affidavits by the period stipulated in Ranchod J's order. He instead served a notification indicating that he disputes the evidence of some of the Plaintiff's witnesses that have filed Affidavits and would like to subject them to cross examination. On the 5th February 2021, a few days before trial, the Defendant's attorney indicated that the Defendant does not accept the evidence of Ms Maria Fourie in respect of the damages to his house and the extent of his alleged liability to repay the amounts that have been paid to him**,** and would like to cross examine her.

[40] The Defendant proceeded to insist on the Plaintiff leading evidence on the amounts that it claims are to be repaid, alleging that not all the payments made that are reclaimed were in relation to claim 1340670 which is the claim tainted by fraud and put the Plaintiff to the proof thereof. According to the Plaintiff's further particulars, it had no proof of payment except for the generated report on payments.

Evidence on the amount paid

[41] Ms Maria Fourie ("Fourie") employed as a Claims Assessing Manager and the head of the Claims Assessment Department at the Plaintiff was then led in evidence on behalf of the Plaintiff. She confirmed that her Department is responsible for assessing fairly, accurately with thorough validation the claims. All the facts on the fraud being common cause, she mainly testified about the process followed by the Plaintiff in the investigations conducted on the claims that led to the termination of the contract of insurance. Accordingly, the investigators report to her directly. They will therefore bring to her attention any suspicious claim. After she has considered the said claims she will direct as to how it must be investigated.

[42] She had received a report on the Defendant's fraud and confirm that after the insured incident, the Defendant falsely issued 6 invoices, C1 for R72 000 dated 10 – 30 November 2016-, C2 for R176 700 dated 1 December 2016 to 1 January 2017, C3 for R176 700 dated 1 Jan to 1 Feb 2017, C4 for R176 700 dated 1 March – 1 April 2017, C5 for R170 000 dated 1 April -1 May 2017 and C6 for R85 500 dated 1 May – 16 May 2017 to which she had access. She explained the process for payment of the invoices, that prior to payment being approved and processed, an investigation is conducted. A validation process by the Plaintiff then had to take place. The investigation showed that the invoices were false. On the suggestion put

to her that some of the invoices were however not paid, she said C1 to C3 that equals R425 400.00 was paid as the investigation showed. When the Defendant's matter was discussed at the Claims Forum meeting and the Claim Forms submitted, she was on leave. She therefore could not testify on the payment of the balance on the invoices. Although she did not attend the meeting, she was aware of what was discussed in the meeting. She however could only confirm whatever was said after the meeting.

[42] The objective of the Investigating Committee's outcome is that client were not unduly enriched. There were 4 further claims requested after the particular claim was served. She could not ascertain if payment made. However, a recommendation was made by the Claims Investigator to the Claims Forum. She however has no personal knowledge of the decision they took as she was not part of it.

[43] She recognised the letter of cancellation and demand to the Defendant dated 17 June 2017, signed by the Chief Operating Officer. She did not compile the letter and could not confirm who did. She also could not confirm what happened after the letter with regard to subsequent demands or claims and payment in relation to the specific claims. Probe was done in relation to payments made on the Agreement of loss. Annexure **D1** of an amount of **R72 0000** signed on 5 December 2016 on the claim no: 1340670 and for Annexure **D2** on an amount of **R347 414.00** with no second page and **D3** a repeat of Annexure D2 so therefore the same as on p263. She could not comment why signatures were appended on different days on D2 that is on 02 March 2017 and D3 signed on 26 January 2017, even though they both refer to the same amount. She confirmed that she was speculating when she said they are one and the same based purely on the dates. On **D4** that the amount of **R176 200** was agreed to by Mr Masindi on **2 March 2017**. She could not explain why on **D5** for the amount of **R27 000** there is no signature or date on the agreement of loss. She confirmed that on **D6** the amount is **R121 366.67** and was signed for on 21 March 2017 by Masindi. On **D7** there are 2 pages and the document signed on 26 April 2017 for an amount of **R75 000**. On **D8** the agreement of loss shows a settlement amount of **R483 798.08 signed on 19 May 2017**.

[44] She confirmed that the agreement of loss will not indicate proof of payment. She could not comment on the indication in Nerissa Reddy's witness statement of various amounts paid with no reference to or record of claim numbers. According to her the claim number noted in the Excel document (which is the spreadsheet) confirms the policy number, claim number 1340670 and reference in the bank statement. She pointed out that Reddy's witness affidavit on paragraph 6.2 does however refer to the claim number 1340670. Paragraph 5.1 corresponds to D1 on Page 650 of the bundle referring to an amount of R72 000, although she could not confirm if it was the same amount as in the agreement of loss. For the payments on paragraph 5.2, 5.3 and 5.4 (which are the 2 amounts of R53 333.33 and R1 273 366.67) there is no agreement of loss that corresponds to the payments. She confirmed that it would appear that the agreement of loss is not noted there. In respect of the amount of R347 414 in paragraph 5.5 reflecting payment on 30 January 2017 she could not confirm that it is the exact payment referred to in D2 agreement of loss. She said she can confirm Paragraph 5.6 onwards on R27 000

does not correspond with payments in D3 but based on a review. Reddy referred to one payment in that account.

[45] Dealing with D4 to D7, asked if the amount in D4 for R176 700 on paragraph 5.7 of Reddy's statement correspond with payment on 6 March 2017 (signature payment is on 2 March 2017 on agreement of loss). She said she cannot confirm if there is an agreement of loss for D5 for the amount of R27 000 on paragraph 5.6 of Reddy's Affidavit on payment made. On paragraph 5.8.1 Reddy makes reference to agreement of loss on D6 for R121 265.67. On paragraph 5.9 the agreement of loss on D7 is for R75 000. Fourie said she won't be able to comment to the fact that on D8 on p273 the amount of R453 798.00 or R480 000 is a discrepancy, and the fact that there is no corresponding amount on Reddy statement alleged to have been paid to Masindi or anybody else. In respect of Paragraph 5.10 to 5.12 she was asked if she will be able to say if the amounts of R31 384.00, R80 430.780 and R182 958.56 therein were paid in respect of the claim. Also on paragraph 5.13 to 5.18, that is R100 000.00, R104 309 28, R20 520.00, R8 497.36, R8 037.00 and R9 428.94 if she can say any of these payments were in fact made in respect of claim 1340670. Fourie's response was that it was paid in respect of this claim. It was then pointed out that there is no reference to the claim number. She was then asked if she can confirm that it is correct that the reference number is the only indication that some payments relate to this claim. She confirmed that the amounts in the agreement of loss correspond to the narration by Reddy. It was indicated to her that some of them do not correspond and not known in respect of which claim the payments were made. It was put to her that the evidence of Reddy is hearsay.

[46] Ms Reddy, who is the head of Finance Operations in her witness affidavit confirmed that, with regard to the amounts paid to the Defendant or on his behalf that the spread sheet included as item 14 of Plaintiff's trial bundle is an automatically generated record of payments made by the Plaintiff to the Defendant. The spread sheet is generated by the Plaintiff's paradigm system. Each transaction automatically recorded. It is the Plaintiff internal record of payment. Because the system does not depend upon human beings to input the data, there is no risk of human error. In her experience the record of all payments made by the Plaintiffs are completely accurate.

[47] The calculations of the amount alleged to have been paid according to Ms Reddy's affidavit totals R1 594 980.12, although she stated that the total payment made to the Defendant or on his behalf was R1 563 935.46. Reddy also refers to an amount of R1 647 592.67 being the total accepted by the Plaintiff in the agreement of loss on claim 1340670. She pointed out that on the agreement of loss, the Plaintiff accordingly accepted liability for more than he should have. However, the error was corrected when it came to payments on the claim. She confirmed that the Defendant was paid what was due to him in respect of the invoices presented by him or third parties who completed the work for his benefit. In that regard this is supposed to be proof as well that he was paid all the amounts that were presented in his invoice for the alternative accommodation.

Quantification of emergency accommodation payments - and Evidential value to be attached to the spreadsheet.

[48] The Defendant argues that Reddy's statement contains inadmissible hearsay evidence that should be excluded from consideration. As Reddy was not in charge of the payment but testified that records automatically generated on payment. However, somebody must be making the payment who can check against what they have paid to see if payments correctly registered.

[49] The Defendant is however not in a position to dispute the evidence of Ms Reddy as in accordance with the Order of Ranchod the witness statement is admissible if no indication is made by the date of trial if it is disputed. The evidence has then become common cause. It is significant that the Plaintiff needed the invoices for the amounts that were to be paid to the Defendant for the emergency accommodation without which they would not have been able to quantify the amount. The quantification of the amount that was to be paid should be possible from the invoices that were submitted by the Defendant and from the direct payments made to the Defendant as reflected in the spreadsheet. The total is R675 000.00.

[50] The Defendant points out that the total of the invoices submitted by the defendant before the fraud was discovered only amounts to R425 400,00 (which is C1 to C3)[1]. The Defendant alleges that Ms Fourie had confirmed that the remaining invoices would not have been paid as the fraud was discovered during the claims validation process. However, Fourie had instead testified that when the Claim Forms were submitted and the Claims Forum meeting took place she was on leave. She therefore could not testify on the payment made on the balance of the invoices.

[51] Ms Reddy's testimony on the payments made to the defendant fails to identify the claim to which the payments relate. Ms Fourie has confirmed that the plaintiff processed 8 claims submitted by the defendant. Four of those claims were submitted subsequent to claim 1340670, the subject matter of this action. Although the minutes of the Claims Forum meeting record that the plaintiff resolved to reclaim all payments made to the defendant including those made on claim that followed claim number 1340670, it in the letter of termination demand only repayment of payments relating to claim 1340670.

[52] In paragraphs 3 and 4 of her statement Ms Reddy refers to item 14, the spreadsheet included in the trial bundle. The Defendant argue that item 14 in fact contains 6 spreadsheets identified as *1340670, Paid to client, Allsure Flood, Clint Shuster, Dry Force* and *Golden Mile.* Ms Reddy in her reference thereto does not identify which spreadsheet she refers to. In paragraphs 5.1 to 5.18 Ms Reddy repeats some of the information that she extracted from the spreadsheets. However, it is to be noted that Reddy indicated that the payments with regard to emergency accommodation were done directly to the Plaintiff compared to with regard to the

[1] Record item 5 p255, 256 and 257

reconstruction of the building whereupon service providers were also paid directly. The relevant part would therefore be “the paid to client” spreadsheet.

[53] Furthermore, the Defendant’s Counsel primarily argues that the contents of Reddy’s Affidavit is hearsay. He contends that the correctness of the spreadsheet identified as *1340670* is in anyway doubtful. The total of the amounts reflected thereon and described as *Rent and alternative accommodation* total R675 000,00[2]. However the total of the invoices submitted by the defendant before the fraud was discovered only amount to R425 400,00[3]. The spreadsheet indicates payments and therefore the total of the payments direct to the Defendant do reflect amounts that totals R675 000.00 which is for the rent and accommodation. It is prima facie proof of the payments. The issue is about whether or not full payment of the invoices submitted by the Defendant for the emergency accommodation was made, not about the timing of the submission of the invoices.

[54] In addition, it is argued that the spreadsheets have not been certified as provided for in subsection 15 (4) of the Electronic Communications and Transactions Act, 2002 (ECTA). Further that no evidence in respect of the factors mentioned in section 15 (3) is given. It is accordingly not possible for the court to determine what evidential weight should be given to the spreadsheet referred to by Ms Reddy, even if it is possble to determine which spreadsheet she referred to in paragraphs 3 and 4 of her statement.

[55] On the admissibility and evidential weight of data messages, s 15 provides that:

> (1) In any legal proceedings. the rules of evidence must not be applied so as to deny the admissibility of a data message. in evidence-
>
> (a) on the mere grounds that it is constituted by a data message; or
>
> (b) if it is the best evidence that the person adducing it could reasonably be expected to obtain, on the grounds that it is not in its original form.
>
> (2) Information in the form of a data message must be given due evidential weight.
>
> (3) In assessing the evidential weight of a data message, regard must be had to-
>
> (a) the reliability of the manner in which the data message was generated,
>
> (b) the reliability of the manner in which the integrity of the data message was stored
>
> (c) the manner in which its originator was identified; and
>
> (d) any other relevant factor.

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[2] Record item 14 p 346 lines 3,4,5,12,13 and 14
[3] Record item 5 p255, 256 and 257

> (4) A data message made by a person in the ordinary course of business, **or a copy or printout of or an extract from such data message certified to be correct by an officer in the service of such person, is on its mere production** in any civil, criminal, administrative or disciplinary proceedings under any law, the rules of a self regulatory organisation or any other law or the common law. **admissible in evidence against any person and rebuttable proof of the facts contained in such record, copy, printout or extract. (my emphasis)**

[56] Ms Reddy has as the head of Finance Operations in her witness affidavit confirmed in certification that, the spread sheet is an automatically generated record of payments made by the Plaintiff to the Defendant. The spread sheet is generated by the Plaintiff's paradigm system. Each transaction automatically recorded. It is the Plaintiff internal record of payment. Because the system does not depend upon human beings to input the data, there is no risk of human error. Furthermore, an Affidavit in terms of s 15 (4) has been filed by an officer of the bank Mr Joel Maboela. The allegations made in both Affidavits give perspective to the evidential weight to be placed on the document. In Reddy's experience the record of all payments made by the Plaintiffs are completely accurate. Whilst Mr Maboela confirms the spreadsheet to be a true and correct representation of the record which have been generated, stored sent or received by electronic means in accordance with the applicable section of the Act. In my view that complies with s15 (4) of ECTA.

[57] Lastly, Mr Steyn argues that Ms Reddy in paragraphs 5.1 – 5.18 does not state whether the payment relates to damage to the building, the household content or the rent and alternative accommodation, that is, which payments were made in respect of the claims not affected by the fraud and of the fraudulent claims. Mr Steyn reckons that the Agreements of loss[4] offer some assistance to the plaintiff. The amounts reflected on the Agreements of loss correspond with the payments referred in paragraphs 5.1[5], 5.5[6], 5.6[7], 5.7[8], 5.8[9] and 5.9[10]. There are no payments referred to in paragraphs 5.2, 5.3, 5.4, 5.10 – 5.18 that correspond with the remaining Agreements of loss[11].

[58] The plaintiff has according to Steyn only proved that it paid an amount of R819 380,67[12] to the defendant in total in respect of claim 1340670. What is more, only the payments referred to in paragraphs 5.1 and 5.7 correspond with the false

[4] Record item 6 p 261 -273
[5] Record item 6 p 261 D1
[6] Record item 6 p 263 D2
[7] Record item 6 p 268 D5
[8] Record item 6 p 266 D4
[9] Record item 6 p 269 D6
[10] Record item 6 p 271 D7
[11] Record item 6 p 264 D3 and p 273 D8
[12] The total of D1, D2, D4, D5, D6 and D7

invoices being the invoice dated 30 November 2016 for the amount of R72 000,00[13] and the invoice dated 1 January 2017 for the amount of R176 700,00[14]. There is admissible evidence that link any of the payments made that can be attributed to claim 1340670 to the invoice dated 31 January 2017 for the amount of R176 700,00[15]. The remaining false invoices[16] according to Steyn would not have been paid. In respect thereof its alleged that the plaintiff only proved, on the admissible evidence, that it paid an amount of R248 700,00[17] to the defendant.

[59] However there is testimony that there were direct payments in respect of the rent and accommodation made to the Defendant totalling an amount of R675 000.00 as proven in the "direct to client spreadsheet'. What was queried was that as at date of fraud only 4 invoices were issued however there is an indication that invoices were issued until 16 May 2017. It is also not the Defendant's case on the papers that not all the invoices it issued were paid.

[60] The amount repayable as occasioned by the termination of the policy due to the fraudulent claim therefore is an amount of R675 000.00 that was paid to the Defendant on the claim, together with any ancillary costs and expenses incurred by the Plaintiff in the processing of the claim.

Under the circumstances the following order is made against the Defendant:

1. . The Plaintiff's claim in an amount of R675 000.00 is upheld:
   Judgment is granted against the Defendant for;

2. Payment of the amount of R675 000.00;

3. Interest on the amount payable form 8 June 2017 to date of final payment;

4. Costs of suit on an attorney and client scale

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N.V. Khumalo
Judge of the High Court
Gauteng Division

On behalf of the Plaintiff: Luc Spiller
Instructed by : Keith Sutcliffe & Associates Inc
Ref: KJ Sutcliffe/6000948

[13] Record item 5 p 255 C1
[14] Record item 5 p 256 C2
[15] Record item 5 p 257 C3
[16] Record item 5 p 258 C4, p 259 C5 and p 260 C6
[17] The total of C1 and C2

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