LSB

Lending Standards Board

Follow-up Review of

Contingent Reimbursement Model Code for Authorised Push Payment Scams

Approach to Reimbursement of Customers – Provision R2(1)(c)

Summary Report

June 2021

Contents

Introduction 1

1. Executive Summary 2

1.1 Key Findings 2

1.2 Objectives and Scope 4

1.3 Methodology and Approach 5

2. Detailed report 7

2.1. Governance, controls and oversight 7

2.2 Policy and process 8

2.3 Training and support 9

2.4 Effective warnings 10

2.5 Approach to reimbursement and the application of provision R2(1)(c) – Reasonable basis for belief 11

2.6 Vulnerability 14

2.7 Communications 15

2.8 Aftercare support 16

3. Conclusions and next steps 18

Introduction

The Contingent Reimbursement Model Code (CRM Code) was launched on 28 May 2019 and sets out good industry practice for preventing and responding to Authorised Push Payment (APP) scams. The Code aims to achieve this by requiring that signatory firms put in place measures to reduce the occurrence of APP scams, and by ensuring that customers, who bank with a firm that is a signatory, will be reimbursed if they have been the victim of an APP scam and were not to blame for the success of the scam.

The CRM Code was developed through collaboration between consumer and industry groups, to reduce the impact of APP scams on customers, micro-enterprises and small charities by introducing measures that would reduce the occurrence of such scams and see victims reimbursed. The Code provides protections to customers when they authorise a transfer of funds executed across Faster Payments, CHAPS or an internal bank transfer that turns out to be a scam.

On 1 July 2019, the Lending Standards Board (LSB) became the independent governing body of the CRM Code. The LSB is the primary self-regulatory body for the banking and lending industry, driving fair customer outcomes within financial services through independent oversight. Our registered firms comprise the major UK banks and lenders, credit card providers, debt collection agencies and debt purchase firms. Adherence to our Standards of Lending Practice and the other Codes of Practice which sit within our remit is a clear indication that a registered firm is committed to best practice in the treatment of its personal and business customers.

Our role is to monitor signatory firms' implementation and ongoing adherence to the CRM Code, to ensure its effectiveness and to maintain and refine it, as required.

This report focuses on a specific section of the Code, relating to the reimbursement of customers who have fallen victim to an APP scam. The Code requires that where a customer has been the victim of an APP scam, firms should reimburse the customer. The Code allows for exemptions to this under section R2(1) of the Code.

Under provision R2(1)(c), a firm can decline to reimburse a customer where, in all the circumstances at the time of the payment, in particular the characteristics of the customer and the complexity and sophistication of the APP scam, the customer made the payment without a reasonable basis for believing that:

- the payee was the person the customer was expecting to pay;
- the payment was for genuine goods or services; and/or
- the person or business with whom they transacted was legitimate.

When relying on an exemption, the Code requires that 'the assessment of whether these matters can be established should involve consideration of whether they would have had a material effect on preventing the APP scam that took place'.

1. Executive Summary

Background

We undertook a thematic review of provision R2(1) (c) in October 2019, the summary report for this review is located here. Following this piece of work, we committed to undertake a follow-up review which would assess the progress made by firms, in respect of their individual reports, in implementing and embedding required actions. The timescales for the follow-up review to be completed was Summer 2020. However, due to the impact of the Coronavirus pandemic, the review was delayed until March 2021.

The initial review was conducted across the eight original signatory firms. However, for the purposes of this follow up review, we have included all nine signatory firms.

We acknowledge that both customers and firms will have been affected by the pandemic and therefore, where appropriate, consideration has been afforded when collating our findings and the required actions of firms.

1.1 Key Findings

From our initial review in 2019, the main areas of concern fell within four key areas:

- **Reimbursement -** Judgements about reimbursement were not always made in the light of the full circumstances of the case or a judgement of what consumers may have believed at the time but were often driven by narrower process considerations. The presumption in the Code that victims should be reimbursed unless there is a clear ground for attributing blame to the customer was reversed so that the customer was held liable in many cases where the bank was not.
- **Effective warnings -** The issuing of a warning was sometimes treated as a strict measure of a customer's liability regardless of how effective the warning was or whether the customer had a reasonable ground for not acting on the warning.
- **Customer vulnerability -** The identification of vulnerability and customers' susceptibility to scams was not very well developed. Questioning of customers who reported falling victim to a scam was often closed and did not allow for the clear identification of any vulnerability. In a small number of cases, evidence of vulnerability was available, but was not always used as a consideration for reimbursement.
- **Record keeping -** Documentation of the rationale for the decision to decline reimbursement varied across firms and at some was non-existent. Customers themselves were often not informed of how a decision had been taken to deny reimbursement and were often given no opportunity to address the grounds on which the firm was holding them liable for the success of the scam.

We have found that there have been varying degrees of progress made with respect to individual firm action plans from the initial review, and as a result, many actions remain open. From a total of 86 actions across all firms, there remain 46 still open. This is not the level of progress in implementing actions that we would have expected. Across all firms, we identified

a mix of actions not being completed at all or evidence unavailable to show what has been implemented.

Overall, there appears to be a significant disconnect between the actions firms purport to have taken and the results of our validation exercise conducted through the case sample testing within this follow-up review. We have identified weaknesses and issues related to each of the key findings reported in our initial review and are therefore still unable to close the majority of the action plans.

In addition to these key themes not being fully remediated, we have identified other areas of concern during this follow-up review, including:

- **Claim investigations exceeding 15 and 35 days** – Examples across individual reviews highlighted that firms are operating outside of Code requirements, with respect to delivering an outcome response within 15 days (or 35 days in exceptional circumstances). Where delays to outcome responses were outside of required timescales, there was little evidence of interim updates being provided to the customer to inform them of the delay and when to anticipate a response. This is a breach of provision R3(1) of the Code and firms are expected to remediate this finding swiftly. Whilst this was evidenced during our case file testing, we had received prior notification from some firms of the issues in this area, via regular breach reporting and also recent CRM self-attestation submissions.
- **General case handling / understanding of the Code** – Incorrect information provided to customers regarding the timescales for a reimbursement outcome, as well as poor explanations or no explanation of the reimbursement process and liability assessment, was evidenced across many firms. There was also a clear indication that some employees require further training to ensure they have an understanding of both internal processes and the requirements of the Code.
- **Determining reasonable basis** - Overall, the sample testing identified that there is a significant proportion of responsibility placed on the customer as to whether they had met a 'requisite standard of care'. Whilst there is some connection between a test that applies a standard of care and a test that applies a reasonable basis for belief, they are not the same thing. It is important to reiterate that the Code binds firms and not customers and that by applying a standard of care test, this places the onus on the customer to meet a set of standards before they can be reimbursed. However, the Code is clear in its intention that customers should be reimbursed unless the firm can establish any of the five matters set out in the Code, one of these being there was not a reasonable basis for belief, rather than the customer not meeting a pre-determined list of requirements that they are unaware of, and, in many cases, would be unable to meet. In addition, where firms were looking for a reasonable basis for belief, the expectation on what would be reasonable for a customer was often unattainable or the expectation set too high.

Further detail about key areas of concern that have been identified as part of this follow-up review is contained within the detailed report. We are concerned that these new findings, together with those originally identified, are likely to cause failures in the ability of firms to provide good outcomes for customers.

As such, following the issue of individual report letters to each firm, we have set out timebound actions for remediation to take place and have written to the Chief Executive of each firm to clearly set out our expectations of each firm's compliance with our requirements and the deadlines for completion.

1.2 Objectives and Scope

The objective of this review was to assess and understand the actions taken by firms to implement and embed the improvements as set out in the reports from our initial review in 2019, necessary to ensure the requirements of the Code are being met. This review focussed on the requirements of provision R2(1) (c), assessing whether a customer had a reasonable basis for belief when making an authorised push payment, which subsequently turns out to be a scam, having regard to the circumstances of the scam and the individual.

The review included sample testing of APP scam claims for each firm, across a range of scam types and channels. To aid with consistency, the sample number of claims was aligned to that used in our initial review.

The points highlighted below formed the scope of our initial review in 2019. As mentioned previously, the current review was designed as a follow up with individual firms to test their overall compliance and completion of their related action plans.

The initial review considered:

- how firms have interpreted and defined the requirements of provision R2(1) (c) and the extent to which this is consistent across the industry;
- the policies and processes firms have in place to assess claims under the Code, and to consider how the requirements around reasonable level of care are applied in the assessment of customer liability;
- the level and depth of staff training in place across all relevant teams, to support the provision of customer liability assessments and the interpretation of reasonable level of care;
- the warnings firms have in place to safeguard the customer from falling victim to a scam[1];
- when considering the characteristics of the customer in an assessment of an APP claim, the processes firms have in place to identify customers vulnerable to APP scams, including triggers and methods of identification and the extent to which this impedes the customer's ability to protect themselves from falling victim to the scam;
- where a firm's investigation into a claim determines the customer has not met a reasonable level of care, the after-care support provided to customers to prevent the customer from falling victim to APP scams in the future;
- the governance, oversight and controls in place to ensure there is adequate visibility and accountability for decisions, and the dissemination of key management

[1] This element was not reviewed in detail due to the LSB conducting a specific review of the Effective Warnings provisions of the Code during 2020. Action plans for which are still in progress.

information to deliver fair and, where appropriate, consistent outcomes for victims of APP scams; and
- the level and depth of oversight firms have in place to assess the effectiveness of the policies, processes and controls in place, in relation to provision R2(1) (c).

Out of Scope

Whilst the review scope did not include a detailed assessment of other provisions within the CRM Code, consideration and understanding was required of other areas of the Code to allow for conclusions to be drawn in relation to the overall objectives and findings of the review.

1.3 Methodology and Approach

Firms were requested to submit a range of information which was split into two distinct areas. The first information request was in relation to individual action plans issued after our initial review and included a request for a detailed update on progress, together with evidence in support of the work completed. Firms provided regular updates on progress within the interim period between the full thematic review and the follow-up. This assisted our final review of individual action plans, to provide initial assurance that each action had been dealt with appropriately. Following this assessment, we held remote management meetings to discuss the responses further and aid our understanding.

The secondary information request was focussed on testing a sample of cases across a broad spectrum of APP scams, where the firm's investigation into a claim concluded that the customer has:

- met the reasonable basis; or
- not met the reasonable basis.

Where the firm's assessment concluded that the customer had not met reasonable basis, we also reviewed a range of cases where the customer had:

- accepted the decision; or
- disputed the decision, which had resulted in a complaint, but the customer had not escalated their complaint to the Financial Ombudsman Service (FOS).[2]

The review of case files was conducted remotely in a secure manner with all precautions taken to ensure confidentiality and security of customer information.

The information obtained from the initial desk-based review, management meetings and sample testing, forms the basis of whether we believe individual actions have been:

- completed satisfactorily;
- are embedded and working well; and
- enable action plans to be closed.

The review was conducted across several key stages as follows:

[2] The purpose of this review is to assess firm's interpretation of provision R2 (1) (c) and the practical implementation of this in customer claims under the Code.

- We held a roundtable with all nine signatories of the Code on 14 January 2021. The purpose of this meeting was to run through the scope and approach for the follow-up review and to understand any complexities and challenges with undertaking the review remotely under current restrictions.
- To make the process as efficient as possible, we asked firms to complete a request for information. This request provided details around the claims handling approach and claims handling data requirements for the sample testing element of the review.
- We then selected a sample of cases. These were the cases that were monitored as part of the remote desk-based assessment of claims cases.
- We issued an additional information request for an update from each firm with respect to their individual action plans from the initial review. Evidence to support the progress and developments was also requested.
- We completed a desktop review of the information received, followed up by desk-based assessments of the returned claims data. Management meetings were also held with firms where applicable, to further aid our understanding.
- Following the review, we held a close-out meeting with each firm to discuss the initial findings from the review. This was followed up with a further request for information where we considered this necessary to our assessment.
- An individual report, setting out our findings from the assessment, has been issued to each firm, providing an update on individual findings, and highlighting any new areas of concern that have arisen from the follow-up review assessment

At the time of this review, the UK was still under COVID – 19 lockdown restrictions, resulting in all of the reviews being conducted remotely. Firms provided us with all data and information necessary to conduct our reviews, ensuring that we were able to carry out a thorough and detailed follow-up assessment.

2. Detailed report

2.1. Governance, controls and oversight

This follow up review was intended to understand the progress firms had made against actions placed upon them in the 2019 review and to test cases to assess how effective changes have been in delivering fair customer outcomes. Where applicable, the review of individual action plans aimed to draw out the progress made and feedback has been provided to the firm by us, where it has been identified that further work is still required.

The full thematic review conducted in 2019 raised concerns with respect to appropriate levels of visibility through firms' governance structures, linked to sufficient second line compliance and third line audit oversight. From the actions taken and evidence provided, we are satisfied that, in the majority of firms, there is now adequate visibility within the second and third lines of defence.

However, sample testing undertaken for this review has highlighted concerns with respect to the effectiveness and robustness of Quality Assurance (QA) and Quality Checking (QC) controls in place for first line operational departments. Our case file testing evidenced that frontline employees demonstrated a poor understanding of Code expectations and requirements. Whilst this is linked to the need for further training, we also have concerns that some of the issues we highlighted as part of our testing have not been identified through internal first line assessments.

There was limited evidence of firms utilising Root Cause Analysis (RCA) with respect to complaints that have been raised, in particular where the decision has been overturned, to improve claims handling processes and consistency with decisioning. However, across most firms, we were able to evidence that improvements have been made in the assessment of cases when these result in a complaint.

Alongside our oversight work, we have also recently completed a review of the CRM Code. One output from this review was the introduction of Code provisions focusing on requirements for Governance and Oversight[3]. These new provisions introduced into the Code should assist firms in the embedding of governance processes, with the new provisions designed to ensure that firms have a governance framework, appropriate to the size of the firm, which supports the ongoing oversight of the Code's requirements at all levels within a firm.

The new Code provisions will become effective on 14 June 2021 and will help to mitigate the concerns identified as part of this review. However, firms should be clear that the requirements we have identified to improve their governance and oversight of the Code should be actioned within the timeframes specified within individual firm reports.

[3] https://www.lendingstandardsboard.org.uk/updates-to-the-crm-code-published-by-the-lsb/

Areas for improvement:

- First line controls should be reviewed and further enhanced to ensure firms are able to gain assurance that any enhanced training has embedded, that correct processes are being followed in line with Code requirements and appropriate customer outcomes are being achieved.
- RCA should be undertaken for overturned outcome decisions following a complaint, including those received following a FOS decision, to help improve current investigation processes. This point is reflected also within the changes to the CRM Code that were published in April 2021 – Provision GO (8). These changes come into effect from 14 June 2021.

2.2 Policy and process

Within the initial thematic review, it was highlighted that firms were struggling to strike the balance between reviewing each case individually on its own merit and relying on a checklist approach or system-driven process to determine liability. Although there have been some improvements identified across individual firms, there were still examples where 'decision tree' type models are being followed. It was clear that where firms are still using this approach, in some cases the process may not always take into consideration the uniqueness and individuality of the scam. Applying a 'one size fits all' process identified that the nuances of each scam were not always being recognised, resulting in inconsistencies of Code application and customer outcomes.

Where system-driven processes were utilised, we found that their design seemed to be focused on attributing blame to someone within the liability assessment. In most cases this seemed to go against the customer. This is explored further in the later sections of this report, such as where the provision of warnings is being used as a strict liability measure and where the level of questioning and the requesting of evidence and, ultimately, the assessment of a customer's reasonable basis for belief, have been observed as requiring improvement.

Within a number of firms, it was apparent that the required timescales for managing claims was not being met. The Code requires firms to make a decision on reimbursement within 15 days or up to 35 days in exceptional circumstances. Whilst there are sometimes extenuating circumstances why these timescales may not be met, customers should still be updated throughout the process so they understand what is happening and when they can expect a decision to be made. It should also be noted that these timescales are related to the decision on reimbursement. Therefore, if this decision has been reached, there should not be a delay in informing the customer due to attempts to repatriate funds from the receiving bank.

It is acknowledged that COVID-19 will have caused resource challenges. However, firms should ensure that the impact on the customer is not exacerbated due to these challenges and should have suitable mitigations in place to ensure that detailed and fair investigations are being undertaken of each case.

Areas for improvement:

- Discussions with customers should not be process-led or scripted and should draw out the full circumstances of the customer and the scam in sufficient detail. Firms should

ensure that claim investigations are assessed on their merits and are supported by processes that allow for claims handlers to fully explore the circumstances surrounding the scam, along with requesting evidence to support the customer's claim (where available and appropriate).

- Timescales for making decisions on reimbursement need to be improved to ensure that firms are meeting the 15- or 35- day limits, as set out in the Code. Where this is not achieved, customers must be kept informed of the delay and the reasons why. It is expected this issue will be remedied swiftly across the industry and we will closely monitor firms' progress.

Example of good practice:

- There were examples where firms had mechanisms in place for complicated scam types to be escalated to senior members of the team for review. There were also examples of scam specific forums being used to discuss such cases amongst the firms' teams. This provided opportunity for the intricacies of the scam to be discussed at a more in-depth level with input from senior stakeholders.

2.3 Training and support

Since the initial thematic review, improvements have been made to the content of training material and the initiatives that are designed to support colleagues with their understanding of the Code's requirements. However, further work is required.

The sample testing completed as part of the follow-up review identified that there is a distinct disparity between the level and detail of training provided across firms, as evidence of actions being completed following our initial review to improve training material content, and the actual output and quality of work being provided by frontline teams and operational departments. Across many case examples, there seemed to be a real lack of understanding by front line employees about the Code, what the Code has been designed to achieve and the specific requirements placed upon firms to meet these requirements. We also observed, in a small number of cases, that customer facing employees did not fully know or understand their internal claim investigation processes. This resulted in extended wait times, a poor customer experience and potentially poor customer outcomes.

It should be noted that the competence of employees at a firm level did vary and that there were examples of employees demonstrating a good level of understanding of the Code's requirements and the firm's internal structure. However, this was inconsistent, even within the same firm.

Firms must review their first and second-line controls currently in place to ensure that they are appropriate in identifying and capturing any areas of concern or gaps in knowledge and understanding of their teams. This should be used to continually enhance the training being delivered and further used to provide ad-hoc and refresher training, where appropriate. Consideration should also be given to ensuring that other departments which support the investigation process are also furnished with the same level of understanding of the Code. This would include, but not be limited to, call centre, customer care and complaint handling teams.

Areas for improvement:

- Firms should ensure that there are robust controls in place to provide assurances that the training being provided is achieving the desired outcome. This should be supported by effective Quality Assurance processes which draw out any further training needs, so that continuous improvement can be made in this area.
- Once a training framework has embedded, firms should ensure there is a clear plan for reviewing the materials and providing refresher training.

2.4 Effective warnings

When assessing the provision of warnings in conjunction with provision R2(1)(c), the follow up review has replicated the same approach as the full thematic review. We have looked at the extent to which firms used the display of warnings when considering whether customers met a reasonable level of care, rather that the effectiveness, or otherwise, of the warnings themselves on a customer's decision to proceed with a payment.

A full thematic review against provision SF1 (2) – effective warnings - was undertaken in 2020. This looked specifically at the processes and controls in place across firms and whether they enabled the firm to provide effective warnings, that would discourage a customer from proceeding with a payment which might result in them being a victim of an APP scam.[4]

As identified previously, there were many examples across the case reviews completed where firms continue to use the provision of a warning as a strict liability measure, when assessing the customer's reasonable basis for belief. For example, when the warning was displayed and not acknowledged by the customer, the customer was automatically being held liable. The circumstances at the time of the payment, in particular the characteristics of the customer and the complexity and sophistication of the APP scam, were not always considered in conjunction with providing a warning during the payment journey.

Other case examples identified that there was limited questioning to understand why customers may not have reacted to the warnings that had been presented. This is an important consideration, especially for more sophisticated scams, as it may help to draw out the extent to which social engineering may have been used to circumnavigate warnings being provided by firms.

Confirmation of Payee (CoP) warnings that were presented as part of the online and digital payment journeys were also used by some firms as a strict liability measure. For example, when a CoP response was presented to the customer and the customer chose to proceed with the payment, the customer was being held liable. Whilst the Code does have a section dedicated to CoP, this has not yet been made effective and therefore does not allow firms to take the customer's response to the CoP message into consideration as a strict liability measure.

[4] The summary report for the effective warnings review can be located here.

The PSR issued a direction for the UK's six largest banking groups, covering around 90% of bank transfers, to fully implement CoP. While some firms beyond the six banking groups directed by the PSR have voluntarily introduced CoP, not all Code signatories have. Further work is also expected to expand the coverage of CoP to other firms.

We also found differences in approach between firms in the recording of which warning had been presented to customers. Where this information was recorded, it enabled all pertinent information to be considered as part of the liability assessment and therefore it should be made clear to the customers the impact this may have on the outcome of their claim.

It should be noted that some firms have yet to introduce effective warnings across all of their payment channels. This gap was identified as part of our earlier thematic review of provision SF1(2) – effective warnings. We continue to track the progress being made to implement these warnings via individual action plans. When we assessed cases where a warning was not displayed but should have been, we evidenced that firms would often hold themselves liable, or partially liable, even where firms did not think the customer had a reasonable basis for belief in making the payment.

Areas for improvement:

- The provision of a warning should not be used as a strict measure of liability for declining reimbursement. All the circumstances in relation to the scam should be considered to assess the customer's reasonable basis for belief and hence inform the firm's reimbursement decision. This is an area which requires immediate remediation action given we raised this issue in our initial review in 2019.
- CoP should not be used as a strict measure of liability in declining reimbursement.
- Firms should consider how they can evidence or record which warning has been provided and whether it was the most appropriate in terms of content and timing.
- Investigation processes should be enhanced to fully understand why the customer may have proceeded to make a payment after receiving a warning and to determine if there is still reasonable basis for continuing with the payment.

2.5 Approach to reimbursement and the application of provision R2(1)(c) – Reasonable basis for belief

The key focus within our initial thematic review was to understand how firms are approaching claims and assessing whether customers had a reasonable basis for believing the payment and/or beneficiary were genuine. The follow-up review has provided the opportunity to determine whether all actions have been completed and are embedded within firms. The review of customer cases, over a different time frame, provided an opportunity to validate the progress that had been made across the key areas of concern from our initial review.

We have identified that a number of issues remain relating to the assessment of liability and whether a customer had a reasonable basis for proceeding with the payment. Some of these issues stem from the points raised earlier around process-driven assessments, as well as the provision of an effective warning being used as a strict measure of a customer's liability. However, we also identified other areas for concern.

For most firms, the initial call from the customer was taken by employees within a centralised team, before being transferred to scam specific departments for further investigation. These First Point of Contact teams (FPoC) established the details of the claim and undertook questioning to establish specifics of the scam. This information should be recorded for review by scam investigators. It should be noted that there were nuances in approach across firms, with some having an initial triage process and then the detailed questioning being undertaken within the scam's teams. What was not clear from the case testing was whether any secondary discussions had involved a review of the original customer conversation. Relying purely on case notes raises a risk that not all pertinent information has been recorded which could impact the liability assessment.

However, in both the FPoC teams and scam specialist teams, we found that the questioning was often limited, very closed in nature and often appeared to be aimed at customers answering specific questions which firms could use as an admission of liability. In part this was also driven by decision tree processes followed by staff which were referenced earlier in this report, which again did not allow for a natural and open conversation. It is clear that there is a need for significant improvement within the first point of contact discussions, regardless of which team undertakes these, to ensure that the full details of the circumstances are fully explored and documented.

Across firms, there was also an inconsistent approach to requesting evidence from customers to support their claim under the Code and in a high volume of cases, there were examples of either no evidence being requested or being declined when offered by customers. Linking this to the concerns we have raised around whether claims investigators will re-review first point of contact calls with customers, there is the risk that vital information relating to the claim is being missed when assessing liability and determining reasonable basis for belief. This could lead to incorrect outcomes being provided to customers.

Once the claim details had been obtained from the customer, the liability assessment or investigation would be undertaken. Across a number of firms, this assessment appeared to involve placing a level of responsibility onto the customer to meet a requisite standard of care, often based on whether they had met their obligations under the Code. It is important to reiterate that while the Code binds firms, it cannot bind customers and therefore has not been drafted to place a specific set of requirements on customers. Under the Code, and in the context of this follow up review, the responsibility is on firms to determine whether the customer had a reasonable basis for belief when making the payment.

There is some connection between a test that applies a standard of care and a test which applies a reasonable basis for belief, however they are not the same test. The issue with applying a standard of care test is that it places the onus on the customer to meet a set of standards before they can be reimbursed. This is important to highlight because firms should be making a positive choice **not** to reimburse based upon a full assessment of the circumstances of the case, rather than on the customer not meeting a set of pre-determined standards or requirements.

In some cases, we believe that 'reasonableness bar' was set too high and the level of knowledge the customer was expected to have, or the number of checks the customer was

expected to have undertaken, were excessive and unreasonable. Linked to the above comments on the overall level of questioning and probing undertaken by firms requiring improvement, we had further concerns that what constitutes reasonable basis is being determined without the necessary information being obtained to make this judgement.

When explaining to customers the process of assessing their claim, nearly all firms focussed on the investigation being centred around the repatriation of funds from the receiving bank. Conversations with customers alluded to the fact that reimbursement would only be successful if the receiving bank had managed to freeze and return the funds. Whilst we acknowledge this does form part of the Code, this is a separate element to the liability assessment for the reimbursement process. We believe that customers were being given a false sense of the likelihood of reimbursement and incorrect information as to next steps in the investigation when emphasis was placed solely on recovery of funds from the receiving bank.

Linked to the above, we found that the recording of the rationale for the decision was absent or was uninformative in explaining the reasons behind why customers, and indeed the sending bank itself, were being held liable. Often the rationale was limited to just which party was held liable with no further context. This was then reflected in later communications with customers to explain the outcome of their claim and also for the complaint handling teams, where the customer pursues a complaint. Further details of our concerns are included within the communications section of this report.

Areas for improvement:

- Customers should be informed about what the assessment process entails, beyond just contacting the receiving firm; how the firm assesses liability in line with the Code; and how this will inform the outcome of the customer's claim for reimbursement.
- Customers should be provided with the opportunity to expand on the circumstances and detail of the scam at the initial reporting stage, and at later stages of the investigation, where necessary.
- As stated previously, the provision of a warning should not be used as a strict basis for denying reimbursement, as this is not in compliance with the Code.
- Firms need to be realistic in their expectations of what constitutes 'reasonable' when understanding the steps that the customer took to assure themselves that they were dealing with a genuine third party and take account of any element of social engineering which has occurred given the circumstances of the scam and the customer. There is a risk of non-adherence to the Code and poor customer outcomes if expectations are set too high. The correct test for firms to apply is that of the reasonable basis for belief test, as required by the Code, and not a standard of care test, which requires customers to meet a set of standards before being reimbursed.
- Firms should request sufficient evidence and accept evidence that is actively being offered from customers when investigating claims. This should be considered and used to assist in understanding the circumstances of the scam and the customer in proceeding with the payment.
- Firms should ensure that record keeping of scam claim investigations is detailed. Recording the rationale for how the decision has been reached is particularly important, especially in those cases where the customer has been held liable. Detailed

rationale for cases where the firm has been held liable can also be used to improve current processes and procedures. Justification of decisions around liability assessments and rationale for reimbursement, or decline, is a key part of being able to evidence compliance with the Code, whilst also of use to other functions within firms, such as complaints teams or Quality Assurance.

2.6 Vulnerability

Our previous review highlighted a number of areas for improvement in the identification of customers vulnerable to scams and the use of this information within the liability assessment. We noted some improvements when reviewing the claims cases during this follow-up review and when vulnerability was identified, there were examples across firms where this was considered with respect to reimbursement decisions and when assessing liability. Some firms had also strengthened the way in which they record vulnerability, and this allowed historical vulnerable flags that had been placed on customer accounts to be considered and reviewed as part of the liability assessment. There was also evidence of firms utilising centralised records of vulnerability across their payment channels. This ensured consistency of approach for customers of these firms.

However, the sample testing highlighted that when the disclosure of vulnerability was not obvious or forthcoming from the customer, firms tended to struggle to identify these cases. This was not a systemic theme but there were noticeable inconsistencies with the identification of vulnerability, both at firm and employee level, in some firms. Some of this is a result of poor questioning of customers, which has been highlighted previously, and the need for awareness training on vulnerability to scams to be enhanced across the industry.

Staff have received generic training on dealing with customers in vulnerable situations, but we believe that there is more to be done in this space due to the specifics of the Code and the particular vulnerabilities that are often exploited in scam situations.

Areas for improvement:

- Firms must review their vulnerability training to ensure customer circumstances are fully considered. This should enable adequate questioning to draw out the customer's circumstances and understand how this has impacted their vulnerability to being scammed.
- Where a customer raises circumstances which were likely to impact on their ability to protect themselves from the scam, this information should be passed on to the investigator for inclusion within the assessment and to enable an immediate reimbursement.
- Firms should review and update their vulnerable customer policies to ensure these are aligned to the requirements of the CRM Code.

Examples of good practice:

- Following conclusion of the claim, customers would sometimes be handed across to more specialist teams with experience of dealing with customers in vulnerable circumstances. This helped to provide additional support outside of the scam claims process, where it was deemed helpful.

2.7 Communications

The outcome decision from claims was communicated across a variety of mediums including via letter, email and by phone. In the examples we reviewed where this outcome was delivered by phone, usually the phone call was supported by a letter or email. However, as mentioned previously, these conversations often focussed on the failure to repatriate any funds from the receiving bank, rather than the outcome of the actual liability assessment.

In the majority of firms, the letters and emails included within the case files appeared to be based on a standard template. This meant that there was not sufficient detail which allowed the customer to understand how the case had been assessed in line with the Code or the rationale for the outcome of liability assessments, both for decline and reimbursement decisions. On occasion the Code was referenced, however as mentioned earlier, the focus of the explanation was on the customer not meeting a standard of care where reimbursement was being denied.

It is acknowledged that firms need to be cautious in the level of information which is shared publicly, particularly from a fraud prevention perspective, as this may assist scammers with knowing how firms go about fraud prevention work. However, we feel that given the issues with internal recording of rationale for decisions, this is subsequently reflected in the level of detail provided to customers. This part of the process, across the majority of firms, requires considerable improvement. By improving internal record keeping, this will assist with reporting of the appropriate level of detail in relation to decisions to customers.

Due to the lack of clarity being provided to customers within outcome communications, there is a risk that important information on how the customer can further safeguard themselves is not being provided. Specific information on why the customer was found liable may assist with the education and raising awareness of how best to react to scam situations in the future. It may also prompt the customer into providing further evidence that could support their claim or prompt customers to challenge the outcome if they believe this to be unfair.

Details on how the customer can raise a complaint, either with their bank or the receiving bank, were often missing from the outcome communications across firms. This is a specific requirement of the Code and must be made clear within all outcome communications.

Areas for improvement:

- Customers should be provided with sufficient information to enable them to understand the rationale as to the outcome of their claim, particularly where this has been declined.
- Information relating to the customer's claim should not be templated to the extent that every customer receives exactly the same reasoning. By ensuring letters contain claim specific information, customers can understand clearly the liability assessment and importantly also how to ensure they do not fall victim to a similar scam in the future.
- Customer communications should reference any information and supporting evidence provided by the customer and clearly set out that the decision was based on the information provided by them, rather than focussed on the fact that the funds could

not be retrieved from the receiving bank. The customer should be made aware of their options if they wish to raise a further complaint against both the sending or receiving bank.

Example of good practice:

- Some firms used the outcome response letters to provide detailed and scam specific guidance on how best to handle these situations in the future. Direction on how customers can obtain literature relating to fraud prevention and signposting to support charities and advice centres was also evidenced.

2.8 Aftercare support

The approach to aftercare varied across firms. This seemed in most part due to the platforms via which firms interact with their customers, or down to the resource that firms deploy to support this process. In most cases, aftercare support was provided after the customer had raised their claim and was usually delivered towards the end of the call, often in a slightly scripted and generic manner.

There were some good examples across firms of tailored and measured aftercare support being provided, often by scam investigators rather than at FPoC. Conversations were often empathetic and supportive, with the messages clearly delivered on how customers can further support themselves. This resulted in the customer being more engaged and there was a sense that the information was being retained and would be of benefit for the customer. There were also examples of good signposting to external bodies, where customers could obtain further professional support if required.

Through sample testing, however, there was limited evidence of any pro-active attempts to contact customers to provide aftercare at other points in the customer journey, apart from the point at which the initial claim was raised. Within outcome response communications, some firms would invite the customer to make contact if they had further support requirements, however the onus in most cases was placed on the customer to instigate this interaction.

Consideration should be given by firms to ensuring that aftercare is delivered at a convenient and considered part of the customer journey, which will be most effective in further supporting customers who have fallen victim to scams.

The Code states; '*GF(3)(a) - Firms should take reasonable steps so that outcomes for Customers who have been victims of an APP scam, whether they have been reimbursed or not, go further and include, for example, further education measures, referrals for advice, and other tools enabling Customers to protect themselves.'*

Areas for improvement:

- Firms should consider when and how best to provide aftercare to customers who have been the victim of a scam. It is important to provide good quality support and advice, aimed both at preventing a scam taking place and supporting those who have been victim to a scam.

- Consideration should be given to ensuring that aftercare is being delivered at the correct point in the customer journey.
- Firms should ensure consistency of the quality of aftercare that is being delivered within their operational departments.

Examples of good practice:

- Where agents took time to have quality and meaningful discussions with customers around how to avoid the specific scam relating to the case, customers seemed more receptive to the information they were being provided with and, in turn, it was felt that this would assist with preventing them from falling victim in the future.

3. Conclusions and next steps

The initial full thematic review and this subsequent follow-up assessment were undertaken to understand how the requirements of section R2 (1)(c) - Assessment of a customer's reasonable basis for belief - have been interpreted and implemented by firms and understood by staff when considering APP scam claims. The follow-up assessment has provided opportunity for us to assess the progress made with respect to individual firm reports from our previous review in 2019.

Our view is that, overall, there are a number of systemic failings relating to the implementation of the requirements of provision R2(1)(c) and that there is significant work to be undertaken by the industry to further strengthen adherence to these requirements. We found that there were varying degrees of progress made across firms with respect to their individual action plans from our initial review and that a number of actions remain open. Overall, we were unable to gain assurance that the steps taken by firms have mitigated fully the concerns and key themes raised within our previous thematic review in 2019. These concerns and issues must be rectified by firms as soon as possible.

Firms have faced a number of challenges during the past year due to the Coronavirus pandemic and we were cognisant of this throughout our review. However, this is not a justifiable reason for firms to have failed to improve on the concerns and issues identified in both our initial and this follow up review. Now more than ever, it is important that customers are protected from scams and reimbursed when they fall victim through no fault of their own. Firms should continue to take account of the environment in which customers are transacting and bear this in mind when investigating claims.

To this end, all firms have now received their individual follow-up review outcome letters. We have made clear to firms whether we feel actions have been closed or remain open. Where actions remain open, these have been allocated appropriate timebound deadlines and will be subject to further review by the LSB in due course to ensure that all deadlines are met. We will be following a similar format in relation to any new findings which have been raised with firms as a result of this follow-up review.

LSB Report Gradings

As part of our full thematic review, each firm would have received a grading within their individual report and action plan. The gradings range from *Red, Amber, Yellow* and *Green*. It is not our usual practice to apply gradings to each firm in respect of a follow-up review. However, given the nature of this review and the slow progress in remedying some of our previous issues and concerns, we have decided on this occasion to issue a downgrade from our initial review to some firms.

For those firms which have not been downgraded, we are concerned that their gradings have also not improved since our initial review, which again is indicative of the additional work which is required across the industry to meet the requirements of this section of the Code. Firms must consider a static grading or a downgrade very seriously and ensure that they meet

our timebound actions, highlighted within individual reports, to address the concerns in relation to their adherence to the Code.

To ensure the actions raised are given the highest priority within firms, we have also issued a letter and copy of each firm’s report to the Chief Executive of each signatory firm.

We are committed to assisting firms with their development and understanding of the Code, to ensure that correct customer outcomes are being achieved. Through the delivery of a roundtable to all firms prior to publication of this report, we have been able to share our findings and begin the process of providing further insight to firms on how they can meet their Code requirements. This is supported by the recent Code enhancements on Governance & Oversight which ensures that firms have the requisite framework, appropriate to the size of the firm, to support ongoing oversight of the Code’s requirements. The changes enhance and further strengthen current governance and oversight arrangements within firms and will help to mitigate some of the concerns identified as part of this review.

We will continue to work with the industry to increase the number of firms signed up to the Code. Whilst current signatories account for a large majority of market coverage, it is important that customers of other firms also benefit from the protections of the Code. We would encourage those firms not already signed up to consider the contents of this report and review their arrangements for dealing with APP scam cases.