

The frauds and insurance: who pays in the end?

*Dr Alexander Ressos, TEP
Attorney-at-Law (Switzerland), Solicitor (Hong Kong),
Solicitor (England & Wales)*

When a fraud is discovered, the question of who pays arises between the banks, the insurers, the auditors, the inspectors and the management. The banks sought recourse against the credit insurers, who invoked the fraud exclusions in their policies, and against the inspectors and warehouse keepers, whose certificates had turned out to be false or complaisant. They also targeted the auditors, who had failed to detect the falsification of the accounts, as well as the directors, whose personal assets were often concealed or insufficient.¹ These disputes, conducted in Singapore, in London and sometimes in Geneva, lasted for years and returned to the banks only a fraction of their losses, the remainder being borne by their shareholders.

The lesson is one of prevention, as the previous section indicated, since recourse after the event remains uncertain, and one of contractual allocation of risk: the Geneva banks reviewed their insurance policies, their contracts with inspectors and warehouse keepers and their credit conditions, so that the fraud of a third party does not fall entirely on them. Honest traders bear the cost of this in the form of stricter conditions. Insurers and inspectors bear a share of it in the form of broader contractual liabilities, while the authorities draw from it increased requirements for traders.

1 Notes

1. Wikipedia (en), art. “Hin Leong”: settlement of September 2024 (around 3.59 billion dollars) between the Lim family, the liquidators and HSBC, and criminal conviction of 18 November 2024; GTR, “Qingdao’s legacy”: Mercuria v Citi litigation before the High Court in London concerning a 270 million dollar repo transaction on metals stored at Qingdao and Penglai, concluded by a settlement whose amount was not disclosed; Wikipedia (en), art. “Greensill Capital”: losses estimated at up to 3 billion dollars for investors in the Credit Suisse funds and claims of 587.2 million still owed by GFG Alliance (April 2024). ↩

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