Financial Services Authority

FINAL NOTICE

To: **UK Insurance Limited**

FSA Reference Number: 202810

Address: The Wharf
Neville Street
Leeds
LS1 4AZ

Date: 17 January 2012

1. ACTION

1.1. For the reasons given in this notice, the Financial Services Authority (the FSA) hereby imposes on UK Insurance Limited (UKI) a financial penalty of £2,170,000 for the failings of Direct Line Insurance Plc (Direct Line) and Churchill Insurance Company Limited (Churchill) for breach of Principle 2 (skill, care and diligence) of the FSA's Principles for Businesses (the Principles) which occurred between 8 April 2010 and 16 April 2010 (the Relevant Period).

1.2. The FSA takes this action against UKI for Direct Line and Churchill's breach of Principle 2 during the Relevant Period.

1.3. Direct Line and Churchill (together, the Firms) breached Principle 2 during the Relevant Period. Since then, the relevant business and liabilities of the Firms have been transferred to UKI. Therefore, UKI is responsible for paying the financial penalty of £2,170,000 in respect of the Firms' breach of Principle 2.

1.4. The Firms agreed to settle at an early stage of the FSA's investigation. They therefore qualified for a 30% (Stage 1) discount under the FSA's executive settlement procedures. Were it not for this discount, the FSA would have imposed a financial penalty of £3.1 million on the Firms.

2. SUMMARY OF REASONS

2.1. The Firms breached Principle 2 because they acted without due skill, care and diligence in the way that they responded to the FSA's request to provide it with a sample of their closed complaint files. The Firms' breach of Principle 2 resulted in the FSA receiving files which had been altered improperly. These alterations were the consequence of inadequate measures taken by the Firms to ensure that 50 files specifically requested by the FSA would not be altered improperly. This failure occurred following a file review exercise started three weeks before the collation of the 50 files. Prior to the start of the earlier exercise, management had told staff during a conference call that if they were found not to be operating to the required standards, they would face internal disciplinary investigation. This message to staff increased the risk that files would be altered improperly.

2.2. Of the 50 closed complaint files that were ultimately provided to the FSA by the Firms:

(1) 27 had been altered before they were provided to the FSA;

(2) 28 documents within 27 files had been altered or created; and

(3) 7 internal documents contained staff signatures forged by one staff member.

2.3. The Firms' breach of Principle 2 did not result in any customer detriment. Nor did it have a significant impact on the FSA being able to review the Firms' complaints handling processes using different methods. Nevertheless, it is unacceptable for the FSA to receive any files which are not a true representation of a firm's work. This applies regardless of the substance of the alterations, which in this case were minor in nature. Firms must therefore take robust steps to ensure that the FSA receives accurate information.

2.4. The FSA views these failings as serious because:

(1) the FSA requires information it requests from firms to be submitted in its original state and not altered. Submitting altered information undermines the FSA's ability to supervise effectively the financial services sector and meet its objectives of protecting consumers and promoting market confidence; and

(2) the Firms are part of RBS Insurance which is a prominent institution with significant operations in the UK. RBS Insurance is the second largest general insurance provider and the largest personal insurer in the UK. The size and potential consumer impact of RBS Insurance's operations require a significant degree of supervision from the FSA. The FSA relies on the receipt of accurate information from RBS Insurance in order to supervise its operations effectively.

2.5. The majority of the alterations made to files were minor in nature and included the addition of telephone voice recording reference numbers, the correction of typographical errors and grammar and the re-ordering of existing information.

2.6. The FSA has been able to rely on a detailed internal investigation carried out by the Firms, the scope of which was agreed with the FSA.

3. DEFINITIONS

3.1. '**110 File Review**' means the review of 110 closed general insurance complaint files conducted by the Third Party between 1 March 2010 and 9 March 2010.

3.2. '**The Act**' means The Financial Services and Markets Act 2000.

3.3. '**CAR**' means the Case Assessment Report which was an internal document used by Customer Relations staff to summarise the nature of the complaint, the processes they followed to investigate it, the evidence that they relied on when handling the complaint, the reasoning process followed and the conclusion reached. The CAR was introduced by the Firms as a tool to improve the standard of their complaints handling. The document was devised and introduced by RBS Insurance in conjunction with the Third Party as a tool to improve the standard of complaints handling.

3.4. '**Customer Relations'** means the Firms' department which handled complaints from their UK insurance customers. Customer Relations consisted of approximately 350 staff spread over eight locations: Birmingham, Bromley, Cardiff, Doncaster, Glasgow, Leeds Headrow, Leeds Wharf and Leeds Pudsey.

3.5. '**DEPP**' means the FSA's Decision Procedure and Penalties Guide.

3.6. '**File Completeness Review**' means the review of approximately 5,000 closed general insurance complaint files conducted by the Firms between 20 March 2010 and 31 March 2010.

3.7. '**Firms**' means Direct Line Insurance Plc and Churchill Insurance Company Limited.

3.8. '**The FSA**' means The Financial Services Authority.

3.9. '**The Programme**' means the Firms' complaints handling programme which was the Firms' new action plan for improving their complaints handling processes.

3.10. '**Relevant Period**' means 8 April 2010 to 16 April 2010.

3.11. '**Third Party**' means a major accountancy firm employed by the Firms between June 2009 to June 2010, to assist with improving the complaints handling process and operation of the Programme.

4. FACTS AND MATTERS

4.1. The Firms operate within RBS Insurance, which is a division of the Royal Bank of Scotland Group. RBS Insurance is the second largest general insurance provider and the largest personal insurer by gross written premiums in the United Kingdom (UK).

4.2. Direct Line was regulated by the FSA from December 2001 to December 2011 to perform a number of regulated activities, including carrying out contracts of insurance. In December 2011, Direct Line's business and its liabilities transferred to UKI. UKI also operates within RBS Insurance.

4.3. Churchill has been regulated by the FSA since December 2001 to perform a number of regulated activities, including carrying out contracts of insurance. In December 2011, the vast majority of Churchill's business and liabilities transferred to UKI

although Churchill remains a FSA-regulated entity, with a small remaining amount of liability although no ongoing business.

4.4. In May 2009, the FSA carried out a review of the Firms' complaints handling capability and identified a number of areas where improvement was needed. Consequently, the Firms designed a new action plan for improving their complaints handling process (the Programme) with the assistance and support of the Third Party. The FSA monitored the progress of the Programme from its inception through monthly meetings with the Firms' management in charge of the Programme.

The Firms' complaint files

4.5. The Firms held records of complaints from their insurance customers which evidenced how they had dealt with those complaints.

4.6. The Firms' Customer Relations staff used an electronic system to record notes on the complaints that they had handled. These notes would describe telephone calls and correspondence between staff and the complainant, the actions that staff had taken to investigate the complaint (including whether an external expert such as a surveyor for a household insurance claim had been engaged to assess the complaint), and how the complaint had been resolved.

4.7. As part of the Programme, the Firms introduced an electronic document called the Case Assessment Report (CAR) as a tool to improve the standard of their complaints handling. The CAR document was an internal document containing specific sections which had to be completed by staff to summarise the evidence that they had assessed when handling the complaint, the reasoning process they had followed and the conclusion they had reached. The CAR document also summarised key actions taken such as correspondence with the customer. The CAR document had been introduced as a control mechanism to ensure that staff considered and recorded all relevant information in deciding the outcome of the complaint and to improve the Firms' ability to monitor that staff had taken all necessary procedural steps.

4.8. Some of the Firms' offices held both paper and electronic records whilst other offices held their records in electronic form only.

The FSA's assessment of effectiveness of complaint handling

4.9. In a meeting with the Firms on 23 February 2010, and confirmed by letter dated 25 February 2010, the FSA indicated its intention to undertake some work to assess the effectiveness of complaints handling as a result of the Firms' Programme. In particular, the FSA indicated that it would assess this through undertaking a sample of file reviews on closed complaints.

4.10. In order to do this, the FSA requested that the Firms supply a list of general insurance complaints closed within the period from 1 February 2010 to 31 March 2010 from which the FSA would select a sample to review. The FSA requested that all files subject to review should have been through the Firms' new complaints handling process.

4.11. In its letter, the FSA confirmed that it would need to see any relevant evidence supporting the conclusions reached by the Firms on the complaints. The letter stated that it would be very helpful for the files to include:

- a summary and timeline of events;
- all correspondence to and from the complainant (and claimant/customer);
- the evidence used to make a judgement on the decision of the complaint (and the claim/sale);
- copies of the evidence considered for the complaint and for the claim/sale;
- any call recordings which are integral to understanding the decisions made in the complaint file (and claim/sale file) if these are readily available;
- any supporting documentation / information / intelligence that may have been used in making the decision on the complaint and on the claim/sale; and
- any documentation which records the decision on the complaint and on the claim/sale.

4.12. The FSA's request for paper files meant that, where documents were held electronically, the Firms would need to print out their electronic records to ensure that the FSA could review complete complaint files.

110 File Review

4.13. As preparation for the FSA file review, management asked the Third Party to conduct a review of 110 of the Firms' closed complaint files. This review was conducted in a similar way to the review that would be undertaken by the FSA and 28% of the 110 files failed the review.

4.14. The majority of the 28% had failed because evidence which had been relied upon by the complaint handler when dealing with the complaint had not been included in the paper file.

The Firms' response to the 110 File Review

4.15. The Firms were disappointed by the results of the 110 File Review and were concerned about the potential customer detriment this could imply as well as the FSA taking Enforcement action against them for poor complaints handling. Senior management decided to carry out a number of immediate follow-up actions, including:

(1) the arrangement of a conference call with all Customer Relations staff to discuss the results and the consequences of the 110 File Review; and

(2) a review of closed complaint files.

16 March 2010 conference calls

4.16. On 16 March 2010, the Firms' Customer Relations management conducted two conference calls. The first call was attended by case handlers within the Customer Relations staff from all sites and the second call was attended by their team leaders. Approximately 200 Customer Relations staff attended the conference calls. During both calls, similar messages were delivered which were:

(1) there had been a 28% failure rate from the 110 File Review;

(2) the level of failure was unacceptable;

(3) the failures highlighted during the 110 File Review could potentially lead to the Firms being placed into Enforcement by the FSA, which management and staff would be held personally accountable for;

(4) the FSA would be reviewing closed complaint files in 8 working days' time;

(5) all complaint files closed since the end of January 2010 needed to be in a state that would pass FSA endorsement and if that required staff to review closed files, then staff were encouraged to do so straight away;

(6) that if staff changed things now and took immediate action, this would be viewed as an extremely positive result;

(7) staff should think about what they could do in the next 8 working days to get to a satisfactory situation and to ensure that files were of an acceptable standard; and

(8) that anyone found not to be operating to the required standard would face disciplinary investigation, particularly if the under performance was due to a lack of care or due diligence.

4.17. The Firms also reminded Customer Relations staff during the conference calls that the most important thing was to get the right outcome for customers and, in particular, to "*do the right thing for customers*".

4.18. At the time of the 16 March 2010 conference calls, approximately 10% of staff were already on performance improvement plans as a result of a strategy to improve standards. A failure to reach the required performance levels set out in the performance improvement plan could potentially result in formal disciplinary proceedings. There was, therefore, already an awareness amongst staff that disciplinary action was a real possibility. This increased the risk of staff altering files in an improper way.

File Completeness Review

4.19. The Firms decided that files which had been closed between 1 February and 31 March 2010 should be reviewed as this would capture all files from which the FSA would select its sample. The Firms called this file review exercise the 'File Completeness Review'.

4.20. The File Completeness Review had two main objectives:

(1) to identify any complaints which needed to be re-opened because the wrong outcome had been reached for the customer; and

(2) to ensure that paper complaint files were complete. This meant that if records were held electronically, those records had to be printed out for the paper file. As part of the File Completeness Review, the Firms asked staff to add evidence that had been relied upon in reaching a decision for the customer

where that evidence was already referred to in the file. For example, if a file showed that the complaints handler had relied on a specific clause within a policy booklet whilst dealing with the complaint but that policy booklet was not on the file, staff could add the policy booklet to the file. The addition of evidence already referred to in the files was consistent with the FSA's letter to the Firms of 25 February 2010.

4.21. Early in the File Completeness Review, the Firms identified a significant risk that staff might make improper alterations to files. The Firms subsequently took steps to mitigate this risk. These steps included issuing instructions to staff on how to undertake the File Completeness Review, visits conducted by the Firms' Risk department to offices where the File Completeness Review was taking place and the Third Party's monitoring of the progress of the File Completeness Review.

4.22. Of the 50 files that were eventually provided to the FSA, only five files were altered during the File Completeness Review. These alterations were made to the CAR document and included in four cases the addition of reference numbers and amendments to the dates noted in the file. In the last case, the CAR document was altered to detail that a fault with the way in which the policy had been sold to the customer had been identified and reported internally by the complaints handler.

Instructions for and collation of 50 files

4.23. On 8 April 2010, the FSA sent the Firms the list of 50 files that it wanted to review. The FSA requested the files to be provided as soon as possible.

4.24. After 8 April 2010, the 50 files were reviewed and collated by Customer Relations staff in the sites where the files were located and 27 of the files were altered. The majority of these alterations took the form of amendments to existing documents, particularly CAR documents.

4.25. Collation of the files was overseen by a Customer Relations Manager who received instructions from the Customer Relations Director on 8 April 2010 that the files should be collated and dispatched as quickly as possible. As part of these instructions the Customer Relations Director stated that the Firms could only be judged on what they provided to the FSA and Customer Relations staff should check the files to ensure that all relevant evidence was included without changing the recorded history of the complaint. The Customer Relations Director further stated that he was not expecting the review to take a long time and should be more like a *"10 minute scan"*. In practice, however, staff conducted a far more detailed review than was intended of the files.

4.26. No written or oral instructions were issued to staff involved in collating the files which set out with sufficient clarity that whilst files should be complete (by adding any evidence which was referred to in the file but which was missing from it because, for example, it was held electronically) they should not be otherwise altered. Specifically, no clear instructions were given that the internal CAR documents should not be altered or updated. It was particularly important for clear instructions to be given because the 16 March 2010 conference calls increased the risk that files could be altered improperly.

4.27. Prior to the files being sent to the FSA, consistent with normal practice, they were sent to the Risk department for a very high level review of their contents. The Third Party was also involved in carrying out this high level review. Neither the Risk department nor the Third Party checked the 50 files for improper alterations.

4.28. The 50 files were sent to the FSA by the Risk department between 14 April 2010 and 16 April 2010.

Alterations within the 50 files

4.29. The FSA received information that the 50 files might contain documents that the Firms had altered or created in response to the FSA's request to review the Firms' complaint files. As a result, the FSA undertook a short notice visit to the Firms' Leeds offices on 16 June 2010.

4.30. Shortly thereafter, the Firms conducted an extensive and detailed internal investigation, the scope of which was agreed with the FSA. Analysis of the evidence obtained as a result of that investigation revealed that:

(1) 27 of the 50 files had been altered before they were provided to the FSA; and

(2) 28 documents within 27 complaint files had been altered or created.

4.31. The alterations were predominantly to CAR documents although two internal copies of customer letters also contained minor alterations. Alterations were made to sections of the CAR documents setting out how Customer Relations staff had assessed the relevant evidence and reached their conclusions.

4.32. These alterations were not made transparently and therefore the FSA would not have been able to identify that documents had been changed from their original state.

Forged signatures

4.33. In addition to the alterations, seven internal documents, including four CAR documents, contained forged staff signatures.

4.34. One member of Customer Relations staff had forged the signatures of colleagues who were absent from the office because this member of staff was under the impression that it was obligatory for CAR documents to contain the signature of the original case handler of the complaint.

5. FAILINGS

5.1. On the basis of the facts and matters set out above, the FSA considers that the Firms have breached Principle 2 of the FSA's Principles. The regulatory provisions relevant to this Final Notice are referred to in Annex A.

5.2. The Firms breached Principle 2 because they failed to take adequate steps to ensure that the 50 files would not be improperly altered before they were provided to the FSA. In particular, the Firms did not:

(1) issue clear written or oral instructions to staff involved in collating the files stating that the 50 files should not be altered beyond adding in evidence which was already referred to in the files but which was missing from the files;

(2) clarify that CAR documents should not be altered or updated; and

(3) ensure that the 50 files were collated by individuals who had not worked on the files.

5.3. These steps were particularly important because the 50 files were collated shortly after staff had been told that if complaint files did not meet FSA standards internal disciplinary action may be taken against them. This message to staff increased the risk that files would be altered improperly. Whereas the Firms took steps to mitigate the risk of staff altering files improperly during the File Completeness Review, no such steps were taken to ensure that staff would not alter the 50 files which were provided to the FSA.

5.4. The Firms' breach of Principle 2 resulted in the FSA receiving 27 files which had been altered improperly.

6. SANCTION

6.1. The FSA's policy for imposing a financial penalty is set out in Chapter 6 of DEPP. In respect of conduct occurring on or after 6 March 2010, the FSA applies a five-step framework to determine the appropriate level of penalty. DEPP 6.5A sets out the details of the five-step framework that applies in respect of financial penalties imposed on firms.

Step 1: disgorgement

6.2. Pursuant to DEPP 6.5A.1G, at Step 1 the FSA seeks to deprive a firm of the financial benefit derived directly from the breach where it is practicable to quantify this.

6.3. The FSA has not identified any financial benefit that the Firms derived directly from their breach.

6.4. Step 1 is therefore £0.

Step 2: the seriousness of the breach

6.5. Pursuant to DEPP 6.5A.2G, at Step 2 the FSA determines a figure that reflects the seriousness of the breach. Where the amount of revenue generated by a firm from a particular product line or business area is indicative of the harm or potential harm that its breach may cause, that figure will be based on a percentage of the firm's revenue from the relevant products or business area.

6.6. The FSA considers that the revenue generated by the Firms is not an appropriate indicator of the harm or potential harm caused by their breach of Principle 2. The breach relates to the Firms' response to the FSA's request to review their complaint files and the breach is not related to revenue. The FSA has not identified an alternative indicator of the harm or potential harm caused by the Firms' breach and so, pursuant to DEPP 6.5A.2G(13), has determined the appropriate Step 2 amount by taking into

account those factors which are relevant to an assessment of the level of seriousness of the breach.

6.7. The factors the FSA has taken into account in assessing the seriousness level reflect the impact and nature of the breach, and whether it was committed deliberately or recklessly. The FSA assesses the level of seriousness on a sliding scale between levels 1 and 5, with level 5 representing the most serious breaches and level 1 representing the least serious. DEPP 6.5A.2(11) lists factors likely to be considered 'level 4 or 5 factors'. The FSA does not consider that any of these apply.

6.8. DEPP 6.5A.2(12) lists factors likely to be considered 'level 1, 2 or 3 factors'. Of these, the FSA considers the following to be relevant:

(1) the Firms did not make any profit or avoid any loss as a result of the breach, either directly or indirectly; and

(2) there was no loss or risk of loss to the Firms' customers.

6.9. The FSA also considers that the following factors are relevant:

(1) the submission of altered information undermines the FSA's ability to supervise effectively the financial services sector and to meet its objectives of protecting consumers and promoting market confidence;

(2) the 16 March 2010 conference calls had increased the risk of improper alterations being made to files but inadequate steps were taken to manage this risk during the collation of the 50 files;

(3) the Firms are part of RBS Insurance which is a prominent institution with significant operations in the UK. RBS Insurance is the second largest general insurance provider and the largest personal insurer in the UK. The size and potential consumer impact of RBS Insurance's operations require a significant degree of supervision from the FSA. The FSA relies on the receipt of accurate information from RBS Insurance in order to supervise its operations effectively; and

(4) the majority of the alterations made to the 50 files requested by the FSA were of a minor nature and the breach did not have a significant impact on the FSA's ability to review the Firms' complaints handling processes using different methods.

6.10. Taking all these factors into account, the FSA's view is that this is a 'level 3' breach in terms of seriousness. The FSA considers that, in order to reflect the seriousness of the breach, the Step 2 figure should be £3.1 million.

Step 3: mitigating and aggravating factors

6.11. Pursuant to DEPP 6.5A.3G, at Step 3 the FSA may increase or decrease the amount of the financial penalty arrived at after Step 2, but not including any amount to be disgorged as set out in Step 1, to take into account factors which aggravate or mitigate the breach.

6.12. The FSA considers a mitigating factor to be that the FSA has been able to rely on the detailed internal investigation conducted by the Firms which included forensic document reviews and interviews with staff, and the provision to the FSA of the underlying evidence gathered during that internal investigation.

6.13. The FSA considers an aggravating factor to be the fact that the alterations were identified by the FSA rather than the Firms.

6.14. The FSA considers an additional aggravating factor to be the fact that this is the second Enforcement action within one year against members of the RBS Group relating to failings within a complaints handling area.

6.15. Taking into account all these factors, the FSA considers that no adjustment to the Step 2 figure is necessary resulting in a figure of £3.1 million at the end of Step 3.

Step 4: adjustment for deterrence

6.16. Pursuant to DEPP 6.5A.4G, if the FSA considers that the figure arrived at after Step 3 is insufficient to deter the firm who committed the breach, or others, from committing further or similar breaches then the FSA may increase the penalty.

6.17. The FSA considers that the Step 3 figure of £3.1 million is appropriate to meet its objective of credible deterrence.

6.18. The penalty figure after Step 4 is therefore £3.1 million.

Step 5: settlement discount

6.19. Pursuant to DEPP 6.5A.5G, if the FSA and the firm on whom the penalty is to be imposed agree the amount of the financial penalty and other terms, DEPP 6.7 provides that the amount of the financial penalty which might otherwise have been payable will be reduced to reflect the stage at which the FSA and the firm reached agreement. The settlement discount does not apply to the disgorgement of any benefit calculated at Step 1.

6.20. The FSA and the Firms reached an agreement at Stage 1 and so a 30% discount applies to the Step 4 figure.

6.21. Step 5 is therefore £2,170,000.

Proposed penalty

6.22. The FSA therefore proposes to impose a total financial penalty of £2,170,000 on UKI for the Firms' breach of Principle 2.

7. PROCEDURAL MATTERS

Decision maker

7.1. The decision which gave rise to the obligation to give this notice was made by the Settlement Decision Makers.

7.2. This Final Notice is given to UKI under, and in accordance with, section 390 of the Act.

Manner of and time for payment

7.3. The financial penalty must be paid in full by UKI to the FSA by no later than 31 January 2012, 14 days from the date of the Final Notice.

If the financial penalty is not paid

7.4. If all or any of the financial penalty is outstanding on 1 February 2012, the FSA may recover the outstanding amount as a debt owed by UKI and due to the FSA.

Publicity

7.5. Sections 391(4), 391(6) and 391(7) of the Act apply to the publication of information about the matter to which this notice relates. Under those provisions, the FSA must publish such information about the matter to which this notice relates as the FSA considers appropriate. The information may be published in such manner as the FSA considers appropriate. However, the FSA may not publish information if such publication would, in the opinion of the FSA, be unfair to UKI or prejudicial to the interests of consumers.

7.6. The FSA intends to publish such information about the matter to which this Final Notice relates as it considers appropriate.

FSA contacts

7.7. For more information concerning this matter generally, contact Suzanne Maughan of the Enforcement and Financial Crime Division of the FSA (direct line: 020 7066 5042 / fax: 020 7066 5043)

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William Amos
FSA Enforcement and Financial Crime Division

ANNEX A
RELEVANT STATUTORY PROVISIONS, REGULATORY REQUIREMENTS AND FSA GUIDANCE

1. STATUTORY PROVISIONS

1.1. The FSA's statutory objectives, set out in section 2(2) of the Act, are market confidence, financial stability, consumer protection and the reduction of financial crime.

1.2. Section 206 of the Act provides:

"*If the Authority considers that an authorised person has contravened a requirement imposed on him by or under this Act, it may impose on him a penalty, in respect of the contravention, of such amount as it considers appropriate*."

1.3. The Firms and UKI are authorised persons for the purposes of section 206 of the Act. The requirements imposed on authorised persons include those set out in the FSA's Principles and Rules made under section 138 of the Act.

2. REGULATORY PROVISIONS

2.1. In exercising its power to issue a financial penalty, the FSA must have regard to the relevant provisions in the FSA Handbook of rules and guidance (the FSA Handbook).

2.2. In deciding on the action proposed, the FSA has also had regard to guidance published in the FSA Handbook and set out in the Regulatory Guides, in particular in the Decision Procedure and Penalties Manual (DEPP).

Principles for Businesses (PRIN)

2.3. The Principles are a general statement of the fundamental obligations of firms under the regulatory system and are set out in the FSA's Handbook. They derive their authority from the FSA's rule-making powers as set out in the Act and reflect the FSA's regulatory objectives. The relevant Principle is as follows:

Principle 2 (skill, care and diligence) provides:

"*A firm must conduct its business with due skill, care and diligence*."

Decision Procedure and Penalties Manual (DEPP)

2.4. Guidance on the imposition and amount of penalties is set out in Chapter 6 of DEPP. Changes to DEPP were introduced on 6 March 2010. The FSA has had regard to the appropriate provisions of DEPP.

2.5. DEPP 6.1.2G provides that the principal purpose of imposing a financial penalty is "*to promote high standards of regulatory and/or market conduct by deterring persons who have committed breaches from committing further breaches, helping to deter other persons from committing similar breaches, and demonstrating generally the benefits of compliant behaviour.*"