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House of Commons
Treasury Committee

Review of the reports into the failure of HBOS

Fourth Report of Session 2016–17



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Fourth Report of Session 2016–17

*Report, together with formal minutes
relating to the report*

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The Treasury Committee

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1 Introduction

Why HBOS failed

1. In 2007 there was a sharp deterioration in credit conditions and an increasing number of UK financial institutions began to run into difficulty. Initially HBOS, as one of the UK's larger banks, was viewed by some as a safe harbour in challenging times.¹ However, beginning in the spring of 2008, investors and depositors began to question its ability to weather the storm facing the UK and global economies.² These concerns were validated later in the year when HBOS was forced, along with RBS, to seek emergency liquidity assistance (ELA) from the Bank of England.³
2. In 2012, the Financial Conduct Authority (FCA) and Prudential Regulation Authority (PRA) began work on a review intended to examine the causes behind the collapse of HBOS. This review culminated in a report - 'The failure of HBOS plc (HBOS)' - published in November 2015, which identified a number of reasons why HBOS failed.⁴
3. The cost of both HBOS's and the regulator's failings was high. Although HBOS was acquired by Lloyds TSB in 2009, a number of government-led financial interventions were needed to stabilise its balance sheet, eventually totalling over £20 billion.⁵

The role of HBOS's Board

4. While the PRA/FCA report into the failure of HBOS makes clear that broader macroeconomic conditions both before and during the crisis had a role to play, there were also a number of factors specific to HBOS that made the firm particularly vulnerable to a change in external conditions.⁶ Charts 1 and 2 illustrate the extent to which HBOS's share price and CDS spread underperformed relative to other banks during the crisis.⁷
5. First, the PRA/FCA report attributes ultimate responsibility for HBOS's failure to its Board. In particular, the report argues that the Board failed to instil an appropriate culture at HBOS or to set out a clearly defined risk appetite for the firm, both of which had significant consequences for HBOS's business strategy.⁸ The report also finds that the Board did not provide effective challenge to the HBOS executive during the review period. For instance, there was little evidence of the Board debating the firm's reliance on wholesale funding or the risks associated with high levels of asset growth. The outcome of this was that the risks facing HBOS at a Group level were never fully articulated or addressed.⁹

1 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 132

2 Ibid, p 21

3 Ibid, p 14

4 Ibid, p 9

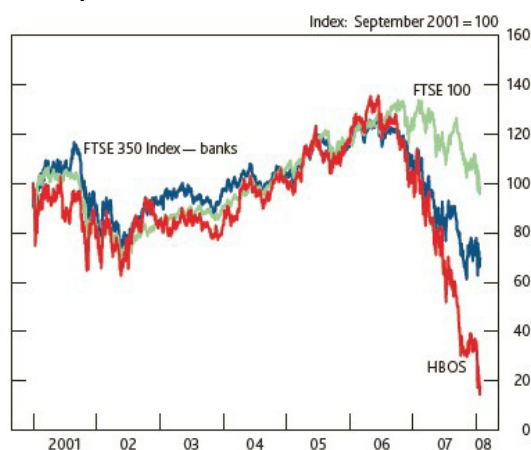
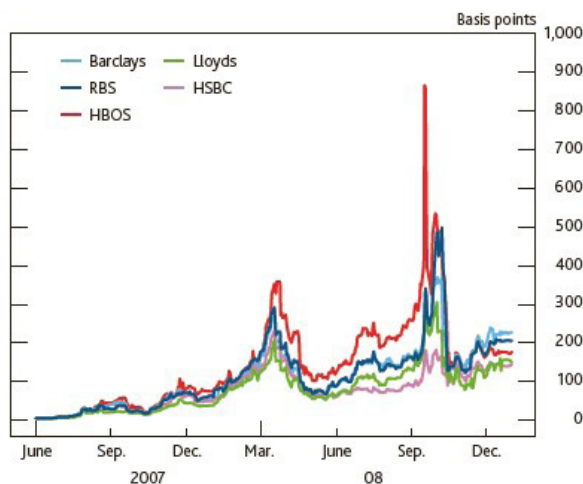
5 Parliamentary Commission on Banking Standards, Fourth Report of Session 2012-13, "An accident waiting to happen" – The failure of HBOS, HL Paper 144/HC 705, 4 April 2013, Para 2, p 3

6 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 14

7 Charts 1 and 2: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 21 [Chart 1.1-1.2]

8 Ibid, p 14

9 Ibid, pp 29-30

Chart 1: HBOS and other large UK banks' share prices**Chart 2: Large UK banks' three-year CDS spreads on subordinated debt**

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, Bloomberg

6. In attempting to explain the failure of the Board to address the risks facing the firm, the PRA/FCA report suggests that “as a group, the non-executive directors (NEDs) on the Board lacked sufficient experience and knowledge of banking.”¹⁰ For example, only one of the twelve NEDs on the Board during the review period held direct banking experience.¹¹ The report argues that this lack of expertise hindered the ability of the NEDs to hold executive management to account. The Board was also responsible for the bank’s business strategy, but only played a small role in its formulation.¹²

Business strategy

7. HBOS’s business strategy was also identified by the PRA/FCA report as a key factor in explaining the failure of the bank, in particular HBOS’s focus on a series of ambitious growth and market share targets. The report notes:

The Group put itself under pressure to maintain an increasing level of income. As margins declined on all forms of lending, a search for yield pushed it towards more risky propositions. Each of the lending divisions experienced an increase in its risk profile as it sought to grow income levels.¹³

8. One consequence of this strategy was that as returns declined in some areas of the business, pressure increased for other parts of HBOS to compensate for this by growing faster. This was the case in 2007 when growth targets for the Corporate division were revised up to offset falling returns in the Retail division.¹⁴ This posed risks as it was undertaken at a time when the Corporate division already had significant exposures on its balance sheet to the highly cyclical commercial real estate and construction sectors. For example, the PRA/FCA report notes that by the end of 2007 almost half the Corporate

¹⁰ Ibid, p 29

¹¹ Ibid

¹² Ibid, p 30

¹³ Ibid, p 18

¹⁴ Ibid, p 79

division's lending (£68bn) was directly to, or dependent upon, the property sector. This was up from just over a third of lending in 2001.¹⁵ The Corporate division also took equity stakes in businesses, adding to its risk profile.¹⁶

9. In theory, HBOS's International division, another area earmarked for higher growth, could have been a source of diversification for the Group. The PRA/FCA report notes, however, that the International division's lending was often concentrated in similar sectors to the Corporate division, meaning it was also exposed to a cyclical downturn in commercial property markets.¹⁷ The outcome was that the decision to respond to lower growth in retail by pushing for higher growth in other areas of the Group increased HBOS's overall risk profile. It also led to a significant expansion in its asset base, particularly in the International and Corporate divisions, as shown in table 1.¹⁸

10. The PRA/FCA report also identifies problems within HBOS's Treasury division. The report notes that, from 2004 onwards, HBOS's Board took the decision to allocate more of the Treasury portfolio away from gilts towards AAA rated securities.¹⁹ Although this was not uncommon by the standards of the time, it would add to HBOS's difficulties during the financial crisis. For instance, the report cites the disclosure by the firm in its 2007 trading statement, showing it held significant amounts of Asset-Backed Securities (ABS) and Alt-A mortgages in its debt securities portfolio, as a factor that led to a deterioration in investor sentiment regarding the firm.²⁰ The deficiencies in credit ratings generally, as well as the decline in market liquidity, also meant that many assets within the secondary liquidity portfolio, such as ABS, would have been poor substitutes for gilts during the crisis.²¹

11. Although other UK banks also had ambitious growth targets during this period, the PRA/FCA report asserts that a combination of factors within HBOS's business plan generated unique balance sheet vulnerabilities.²² One area of weakness was HBOS's funding profile. Customer loan growth exceeded customer deposit growth by five percentage points over the review period, meaning HBOS became increasingly reliant on wholesale funding. For example, from 2004 to the end of 2007, HBOS's wholesale funding needs increased £95bn; its loan to deposit ratio also increased sharply.²³

12. The PRA/FCA report notes that HBOS's Board was aware of the firm's reliance on wholesale funding. The Board's concerns, however, mainly related to the risks this posed to future growth, rather than to the soundness of the bank. Thus, although some mitigating action was taken by the Board, HBOS's overall funding requirements remained large on an absolute basis and would leave the firm vulnerable to the deterioration in credit

15 Ibid, p 62

16 Ibid, p 18

17 Ibid

18 Table 1: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 24 [Table 1.1]. Notes from report: HBOS Annual Reports and Accounts and Review calculations. 2004 has been adjusted to reflect the introduction of International Financial Reporting Standards from 2005. A number of transfers of business took place between the divisions in 2007 and 2008. No adjustments have been made to restate the earlier periods for these transfers (e.g. the European corporate business of International transferred to Corporate in 2007 and is only shown as part of Corporate for 2007 and later. Prior to 2007 this business is included within International).

19 Ibid, p 120

20 Ibid, p 21

21 Ibid, p 131

22 Ibid, p 24

23 Ibid, pp 26-27

conditions and the securitisation market in 2007–08.²⁴ HBOS's funding position was also complicated by its commitments to its Asset Backed Commercial Paper (ABCP) conduits such as Grampian.²⁵ The result was that as the crisis worsened, HBOS initially had to increase its reliance on central bank funding schemes, as well as reducing the average term of its borrowing, before eventually even exhausting these options.²⁶

Table 1: HBOS total assets and growth by division 2004–08 (as at 31 December)

£ billion	2004	2005	2006	2007	2008	Compound annual growth
Retail	209	225	243	260	266	6%
Corporate	82	87	97	122	128	12%
International	37	50	61	76	68	16%
Banking divisions	328	362	401	458	462	9%
Treasury and Asset Management	85	107	107	120	147	15%
Total banking activities	413	469	508	578	609	10%
Insurance and other group items	64	72	83	89	81	6%
Total group assets	477	541	591	667	690	10%

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, HBOS Annual Reports and Accounts, Review calculations

Weak controls and risk management

13. The problems posed by HBOS's business strategy were exacerbated by the bank's deficient control and risk management framework. HBOS, in common with several other financial firms, operated a three lines of defence risk management model. The first line consisted of the divisional-level risk management framework, followed by the second line of Group risk functions, and finally the third line of the various Group audit and internal audit bodies.²⁷

14. The PRA/FCA report found problems with all three components of this framework. The report states that divisional-level controls were often "ineffective" and "did not keep pace with the rapid growth that these divisions experienced".²⁸ This was then compounded by weaknesses within other parts of the Group's control framework. The Group risk function, the second line, suffered from high levels of staff turnover and a lack of expertise.²⁹ The report also found little evidence of challenge from the third line, the Group Audit Committee.³⁰ Alongside the Board's failure to establish a risk appetite for the firm, this meant HBOS lacked the means effectively to measure and control the risks resulting from its business strategy.

²⁴ Ibid, p 27

²⁵ Ibid

²⁶ Ibid, pp 135-6

²⁷ Ibid, p 198

²⁸ Ibid, p 30

²⁹ Ibid, p 225

³⁰ Ibid, p 31

15. The dangers posed by HBOS's business strategy and weak controls became apparent during the financial crisis. Despite the sharp deterioration in macroeconomic conditions, the Corporate division continued to grow its balance sheet up until the summer of 2008. Besides weaknesses in HBOS's risk management framework, this also reflected a number of other problems within the firm.³¹ First, the report notes that the bank adopted a culture of lending "through the cycle".³² This meant that it continued to extend loans to certain clients in spite of the worsening economy. Secondly, even when the decision was taken to halt asset growth, HBOS struggled to do so. This was partly a result of HBOS's weak loan distribution function, as the Corporate division would often grant loans it intended to distribute without first lining up a set of buyers.³³ Once the syndication market turned, this meant Corporate had to keep a series of loans on its balance sheet that it had intended to sell down.

The FSA's supervision of HBOS

16. The PRA/FCA report also concludes that there were failings in the FSA's supervision of HBOS. According to the report's findings, these were caused by senior FSA management devoting too little attention and resource to prudential oversight of HBOS. The resulting supervisory regime was reactive, placed too much trust in senior HBOS personnel and did not adequately monitor the credit and liquidity risks facing the bank.³⁴ The regulatory failings identified in the PRA/FCA report are discussed more fully in Chapters 3 and 4 of this report.³⁵

Role of the Parliamentary Commission on Banking Standards

17. The Parliamentary Commission on Banking Standards (PCBS) published its own report into the failure of HBOS in April 2013.³⁶

18. The PCBS's report identified the risks posed by HBOS's decision to adopt a strategy of "aggressive, asset-led growth across divisions".³⁷ It estimated that over the period 2001–08, total HBOS loan growth outpaced customer deposit growth by five percentage points, a similar figure to that established by the PRA/FCA report, increasing HBOS's reliance on wholesale funding.³⁸ Despite this, in evidence to the PCBS, some former HBOS executives and Board members argued that HBOS's strategy had been relatively conservative.³⁹ The PCBS disagreed with this view, however, noting that following the onset of the financial crisis, impairments in HBOS's loan book were much higher than other comparable banks; the PCBS estimated that the 2008 Corporate division loan book suffered impairments of up to 20 per cent.⁴⁰ To the PCBS, this suggested that HBOS's growth was neither conservative nor the result of superior performance but stemmed from a high-risk strategy.⁴¹

31 Ibid, pp 78-80

32 Ibid

33 Q 68

34 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 15

35 The main findings of the PRA/FCA report are outlined in full in Appendix 1.

36 Parliamentary Commission on Banking Standards, Fourth Report of Session 2012–13, "An accident waiting to happen" – The failure of HBOS, HL Paper 144/HC 705, 4 April 2013

37 Ibid, para 19, p 8

38 Ibid, para 16, p 7

39 Ibid, paras 17-18, p 8

40 Ibid, para 28, p 12. An impairment charge is defined in the PRA/FCA report as the estimated loss on an impaired asset that is charged to the income statement

41 Ibid, paras 30-32, p 13

19. In line with the PRA/FCA report, the PCBS found that HBOS's Corporate division had concentrated exposures to certain sectors of the economy, including a large portfolio of loans to property-based borrowers. In some cases the Corporate division also provided a "complete funding package", which sometimes included taking equity stakes in businesses. The PCBS noted that some elements of the Corporate division's strategy were also replicated in the International division, especially the focus on the property sector. As a consequence, impairments in the International division were eventually even higher as a proportion of loans than in Corporate.⁴²

20. The PCBS similarly concluded that the quality of the internal control environment within HBOS was poor. One significant problem was HBOS's federal structure.⁴³ In theory the bank's various divisions could still be controlled by the Group. Yet the PCBS heard evidence that the amount of challenge of the Corporate and International divisions by Group-level executives was low, meaning there was not an effective central check on these divisions' strategies.⁴⁴ A second problem was deficiencies within the Group risk function, which the PCBS described as a "cardinal area of weakness".⁴⁵ Again, to an extent this was found to be because the "centre of gravity" lay with the divisions and was due to a lack of expertise in certain key risk roles.⁴⁶ Overall these flaws contributed to a weak control environment, leading to HBOS incurring significant losses during the crisis.⁴⁷

21. The time constraints imposed on the PCBS meant there were a number of points where it was unable to conduct further analysis. It therefore identified eight areas where it requested the regulators undertake additional work. These are addressed in an appendix to the PRA/FCA report.⁴⁸ This report seeks to focus more closely on the lessons for regulators from the HBOS reports, rather than the specific decisions and individuals responsible for HBOS's demise, given that the PCBS - and now the regulators - have covered the latter in extensive detail.

22. The Parliamentary Commission on Banking Standards' (PCBS) report, published in April 2013, reached similar conclusions to those of the regulators. Both emphasised the primary responsibility of the Board for determining HBOS's business strategy, the poor state of HBOS's internal controls and the risks posed by high rates of asset growth as key factors in explaining the demise of the firm. The PCBS report argued that many of these shortcomings were unique to HBOS. The scale of its losses could not just be blamed on the deterioration in the UK and global economies at the time of the financial crisis. This assertion was supported by evidence in the final regulators' report, showing that impairments as a percentage of the loan book were twice as high at HBOS as at RBS.

42 Ibid, pp 9-15

43 Ibid, para 53, p 19

44 Ibid

45 Ibid, para 64, p 22

46 Ibid

47 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 71-72. "Impairment losses on loans and advances experienced by RBS between 2008 and 2011 amounted to £38 billion or 4.5% of its 2008 loan book. This was less than the £44.7 billion impairment losses incurred by HBOS over the same period, at a loss rate of 10%."

48 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 362-75 [Appendix 4]

2 Setting up the HBOS review

23. Initially the regulators did not plan to undertake a review into the failures of either RBS or HBOS, despite the significant amount of taxpayer money used to save both institutions. In the case of RBS, the FSA's first response was to limit itself to a 298-word statement following the conclusion of its enforcement action.⁴⁹

24. The Treasury Committee at the time viewed the FSA's approach as inadequate, as it did not acknowledge the significant public interest in the RBS case. Consequently, the Chairman of the Committee wrote to Lord Turner, the then Chairman of the FSA, to seek a commitment from the regulator that it would agree to conduct a more in-depth study into the failure of RBS.⁵⁰ The FSA accepted the Treasury Committee's view that it should undertake a full review into the collapse of RBS. In a later evidence session, Lord Turner acknowledged that the FSA should have realised that the case of RBS deserved a "public accountability report."⁵¹

25. Following this change of policy, the Treasury Committee also pushed for the FSA's report into RBS to be bolstered by the input of independent reviewers. These would be industry experts, appointed by Parliament, with a mandate to oversee the regulators' work. They would offer guarantees as to its quality and impartiality. The Committee viewed this as necessary because a central component of the reviews would be an assessment of the regulators' actions, both before and during the financial crisis, meaning that, without this independent review, the FSA would be marking its own homework.⁵² The FSA agreed to this condition and the Treasury Committee in the last Parliament appointed two experienced practitioners to the roles of independent reviewers.⁵³

26. By calling for both a review into the failure of RBS and the use of independent reviewers, the Treasury Committee established a precedent for undertaking reviews of other major bank failures. In 2011, Lord Turner acknowledged this and its relevance to HBOS in a letter to the Committee, saying "there is therefore a public interest in knowing what happened at HBOS as well as at RBS."⁵⁴ This led the FSA to launch a separate review to understand the reasons behind the failure of HBOS.

Appointment of the review team

27. The FSA agreed to conduct a review into the failure of HBOS in 2011. However, Lord Turner indicated that work on the review would not start until the FSA had concluded its enforcement actions in relation to HBOS.⁵⁵ In a hearing with the Committee in December 2015, following the publication of the final reports, Andrew Bailey (at the time the CEO of

49 Treasury Committee, Fifth Report of Session 2012–13, The FSA's report into the failure of RBS, HC 640, 16 October 2012, Para 1, p 5

50 Ibid, Para 2-3, p 5

51 Oral evidence by Lord Turner of Ecchinswell to the Treasury Committee, Independent review of the Financial Services Authority's report on the failure of RBS, 30 January 2012, Q 88-89

52 Treasury Committee, Fifth Report of Session 2012–13, The FSA's report into the failure of RBS, HC 640, 16 October 2012, para 3, p 5

53 The independent reviewers were Sir David Walker and Bill Knight

54 Letter from the Chairman of the FSA to Chairman of the Treasury Committee, 11 July 2011

55 Ibid

the Prudential Regulation Authority) defended this decision, arguing that it was the result of legal advice.⁵⁶ The consequence was that the FSA did not fully begin work on the HBOS review until September 2012, almost four years after the bank had failed.⁵⁷

28. In the intervening period the FSA, with Treasury Committee involvement, agreed the underlying terms of reference for the HBOS report.⁵⁸ The purpose of the review was defined as being to achieve three things:

Explain and describe: why HBOS failed; the supervision of HBOS;

Assess the FSA's enforcement investigations following the failure of HBOS [...] ;

Inform a wider internal and public understanding of the causes of failure during the crisis (to the extent not already covered by the RBS report).⁵⁹

29. The regulators' review was to be overseen by a sub-Committee of the FSA Board chaired by Sir Brian Pomeroy, a non-executive director at the FSA.⁶⁰

30. The preparation and publication of the review's final report was complicated by the coming into force of the 2012 Financial Services Act. The Act determined that the Financial Services Authority would be split into two new bodies: the PRA and the FCA. The initial view of the regulators was that the review should be taken on by the FCA. However, the Treasury Committee disagreed with this approach given that prudential policy and banking supervision, which were arguably the most relevant policy areas in relation to the failure of HBOS, would sit within the PRA. As a result, the regulators eventually agreed that the report would be jointly published by the PRA and FCA; responsibility for the production of the report was transferred to a Steering Committee of both the FCA and PRA Boards. As before this Steering Committee was chaired by Sir Brian Pomeroy (who became a NED at the FCA) and included Board members from both the FCA and PRA.⁶¹

31. After officially commencing work in September 2012, the report then reached the Maxwellisation stage in July 2014, the process whereby those who stand to be criticised in a public report are given an opportunity to respond to criticisms prior to publication. Following this, the report was then re-Maxwellised in the summer of 2015, a further opportunity for those criticised in the report to respond if the nature of the criticism had changed from the original draft. The report was eventually published in November 2015.⁶² A full timeline is in box 1 below.

56 Q 136

57 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 9

58 *Ibid*, pp 354-56 [Appendix 2]

59 *Ibid*

60 *Ibid*, p 352

61 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 352. The Steering Committee included Andrew Bailey and Charles Randell from the PRA, and Amelia Fletcher from the FCA, as well as Sir Brian Pomeroy

62 *Ibid*, p 9

Box 1: Key events in HBOS failure and review

Timeline of key events	
Date	Event
2001	
September	HBOS formed from the merger of Halifax and Bank of Scotland
2006	
July	Andy Hornby becomes Group CEO of HBOS
2007	
July	Sir Hector Sants replaces John Tiner as CEO of the FSA
2008	
April	HBOS announces £4bn capital raising
October	HBOS seeks emergency liquidity assistance, receives £11.5bn in government support
2009	
January	Lloyds TSB acquires HBOS, HBOS announces pre-tax loss of £10.8bn for 2008
March	FSA commences enforcement investigations
2011	
December	FSA publishes report into failure of RBS
2012	
September	FSA begins work on the HBOS report
2013	
January - December	Independent reviewers appointed and begin work, PCBS publishes own HBOS report
2014	
January	Andrew Green QC appointed to lead independent enforcement review
July - November	Maxwellisation of HBOS reports begins
2015	
November	Reports published

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015

Role of the independent reviewers

32. As in the case of the RBS report, the Treasury Committee insisted on the use of Committee-appointed independent reviewers for the HBOS review. The intention behind their use remained the same: to provide Parliament and the public with the assurance that the regulators' report was a fair and balanced assessment of the available evidence. In

2013, the Treasury Committee in the last Parliament accordingly appointed Stuart Bernau and Iain Cornish as the independent reviewers - their terms of reference, published on 1 March 2013, were set as:⁶³

To review and report on the extent to which the FSA report on the failure of HBOS is a fair and balanced reflection of the available evidence; [and]

To review and report on whether the FSA's report is a fair and balanced summary of the [Financial Services] Authority's regulatory and supervisory activities in the run up to the failure of HBOS.⁶⁴

33. Although the Treasury Committee appointed the independent reviewers, they remained free to interpret their terms of reference as they saw fit. Both confirmed this in their written evidence to the Committee, noting that they had seen no evidence to support the view that the Committee had "orchestrated" the review.⁶⁵ They similarly stated that they had received "no direction from the Chairman", on how to carry out their work or how to reach their conclusions.⁶⁶ Both independent reviewers also sought to emphasise that, despite the earlier PCBS study into the failure of HBOS, their conclusions were based solely on the evidence that they saw themselves, noting that this "extended beyond that available to the PCBS".⁶⁷

34. The Financial Services Authority failed to instigate a full review into the collapse of HBOS and RBS. This is extraordinary in itself. They resisted doing it even after strong prompting from Parliament. The unacceptability - not just to specialists following this issue, but also to a wider public - of their original decision not to undertake a full review eluded them for too long.

35. It is regrettable that the FSA (and subsequently PRA & FCA) agreed to undertake these reviews only following sustained pressure from the Treasury Committee over a number of years. In the case of the HBOS reports, the Treasury Committee insisted on the innovative arrangements originally used for the RBS review, with Committee-appointed independent reviewers given the task of overseeing the regulators' drafting of the reports.

Impact of the independent reviewers

36. As detailed in their written evidence to the Committee, the independent reviewers had a significant impact on the content and direction of the PRA/FCA report. First, they noted that early on in the review process they were quick to identify the need for additional analysis and material for certain sections of the report, including submitting over a thousand detailed comments on the preliminary drafts.⁶⁸ This covered a significant

63 Iain Cornish and Stuart Bernau were reappointed by the current Committee in 2015 following the May 2015 General Election.

64 Treasury Committee, Independent Review of Financial Services Authority's report on the failure of HBOS – Terms of Reference, 1 March 2013

65 HBO001

66 Ibid

67 Ibid

68 Ibid, p 2

range of topics such as the requirement for a more detailed analysis of loan quality within the Corporate division and an assessment of the extent to which the Capital Requirements Directive (CRD) IV framework might have prevented HBOS's failure.⁶⁹

37. A second area of focus for the independent reviewers was testing both the process by which the PRA/FCA review team reached its conclusions and whether the Maxwellisation process was fair. In the case of the latter, the independent reviewers noted the processes adopted by the review team had been "reasonable and robust".⁷⁰ On the former, the independent reviewers identified more problems in the early drafts of the review, particularly in section four of the report, which covered the FSA's supervision of HBOS. This included instances when the early drafts were structured in a way that appeared inappropriately to "soften" the report's conclusions regarding FSA supervision.⁷¹ The independent reviewers also highlighted that the evidence-gathering process for the section on FSA supervision was not always consistent with that for the sections on HBOS. One example was the fact-finding interviews, conducted by the PRA/FCA team working on the HBOS review, with former FSA staff. The independent reviewers felt these interviews had a more "sympathetic" tone compared to those conducted with former HBOS staff by a third party for the other sections of the report.⁷²

38. The third area of intervention by the independent reviewers was in the part of the PRA/FCA report covering the original enforcement action taken by the FSA against HBOS executives following the bank's failure. Both reviewers noted in their written evidence to the Committee that this was the part of the report over which they had "greatest concerns".⁷³ This reflected their disquiet over the proposed scope of the chapter on enforcement and concerns over whether it would address the central issue of whether the original enforcement process had considered a wide enough range of HBOS executives for potential investigation. In evidence, Iain Cornish stated:

The first draft was very superficial. Even a cursory look at the underlying raw material highlighted the issues that Andrew Green has highlighted. It was not obvious at all why decisions had been reached. That was the only section of the first draft that we saw that had been written not by the review team but by members of the enforcement team, so we felt very queasy about that.⁷⁴

39. Having reached this conclusion, the independent reviewers recommended that this part of the review should be run independently of the regulators and should include an assessment of the reasonableness of the FSA's enforcement actions.⁷⁵

40. In evidence to the Committee, Sir Brian Pomeroy suggested that concerns with the early drafts of the enforcement section may have reflected the fact that the initial terms of reference only asked for an explanation, not an assessment, of the FSA's enforcement actions; he added that the drafts had also not yet been reviewed by the HBOS report

69 Ibid, pp 3-4

70 Ibid, p 5

71 Ibid, p 6

72 Ibid, p 7

73 Ibid, p 6

74 Q 59

75 Qq 59-62

Steering Committee. Nevertheless, Sir Brian accepted, with these caveats, that the initial drafts of the enforcement section had been “self-exculpatory”.⁷⁶ The independent reviewers’ initial concerns were evidently justified.

The Green report

41. The Treasury Committee and regulators acted on the recommendation of the independent reviewers to have an independent person undertake the review of enforcement.⁷⁷ Andrew Green QC was appointed to lead the enforcement review in January 2014, which was subsequently turned into a separate report.⁷⁸

42. The terms of reference stated that Andrew Green’s report should “assess the reasonableness of the scope” of the FSA’s original enforcement investigations, and also offer an opinion as to whether the “regulators should consider afresh whether any other former members of HBOS’s senior management should be subject to an investigation with a view to prohibition proceedings”.⁷⁹ A protocol agreeing the details of the management of the Green report was shared with the Chairman of the Treasury Committee.⁸⁰ Andrew Green’s report was eventually published alongside the PRA/FCA report in November 2015. Its findings are discussed more fully in Chapters 3 and 5 of this report.⁸¹

43. The decision to appoint Stuart Bernau and Iain Cornish as independent reviewers proved to be of great value. The independent reviewers revealed that the first drafts of the HBOS reports had been superficial. In the case of the enforcement section, they had such grave concerns that they argued this particular section should be written independently of the regulators. An impartial assessment of the FSA’s actions with respect to enforcement has been essential. Without it, the regulators would have been marking their own homework.

44. The independent reviewers also made numerous requests for further analysis and detail. They carried out quality assurance on both the regulators’ report and the Maxwellisation process. Consequently, their input was crucial, both in raising the standard of the HBOS reports and in providing assurance that the reports’ findings are a fair and balanced reflection of the available evidence. Parliament and the public can now have more confidence that these final reports give a full summary of the causes of the failure of HBOS.

45. The Committee would like to reiterate its thanks to the independent reviewers and Andrew Green for the considerable time and effort that they devoted to the HBOS review.

76 Qq 105-108

77 Qq 105-109

78 Q 42

79 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 354-56 [Appendix 2]

80 Andrew Green QC, Report into the FSA’s enforcement actions following the failure of HBOS, 19 November 2015, Annexe 2

81 The main findings of the Green report are summarised in Appendix 2, while its recommendations are in Appendix 4.

Delays to publication

46. The publication of the HBOS reports occurred seven years after the bank's failure. Evidence seen by the Committee suggests there were a number of reasons why it took so long.

47. The first reason was that the regulators chose to wait until after they had concluded all HBOS-related enforcement action before starting the report. Andrew Bailey supported this decision, saying that the "very strong legal advice [...] is not to carry out a report of this nature while enforcement proceedings are taking place".⁸² Nevertheless, this decision had consequences. The independent reviewers in particular emphasised that the long delays in starting the report led to a deterioration in the available evidence.⁸³

48. The independent reviewers also noted that another cause of delay in the early drafts was that the regulators had not "dug into sufficient detail to reach meaningful conclusions" on the reasons behind the failure of HBOS.⁸⁴ The independent reviewers reflected that, having already done a report into RBS, the regulators "felt that they had covered a lot of this ground and understood a lot of the issues."⁸⁵ The consequence of this was that the independent reviewers had to request significant additional analysis, adding time to the reporting process. They also requested the creation of the separate enforcement review led by Andrew Green QC. In short, efforts to ensure a more objective and thorough report added more time to the reporting process.

49. Concerns have been raised about the length of time it took to reach publication of the HBOS reports. Beyond the FSA's initial reluctance to conduct a review at all, the primary cause of this delay was the decision by the FSA not to start the HBOS review until it had concluded enforcement action in 2012. The regulators have indicated that this was a result of legal advice.

50. It is likely that a future bank failure would result in subsequent enforcement action, which may be a lengthy and complex process. It is unacceptable, however, that the public should have to wait so long for an explanation of what went wrong in cases of major bank failure. In the light of legislative changes since HBOS's collapse, the Treasury and the regulators need to explain to the Treasury Committee what steps they can take to ensure that reviews of this type - which in future will be led by independent persons - can be run, at least in part, alongside enforcement investigations. An arrangement where the public must wait several years for a review even to start would be wholly unsatisfactory.

Maxwellisation

51. One of the most significant reasons the reports were only published in November 2015 was the process of Maxwellisation. Andrew Bailey pointed out that the regulators received 1,425 representations from 82 parties in the first round of the Maxwellisation process and

82 Q 135

83 HBO001

84 Q 59

85 Q 57

then a further 227 representations in the re-Maxwellisation.⁸⁶ Andrew Bailey claimed that the latter process was partly necessary because criticism of certain individuals was intensified as a result of the original Maxwellisation process.⁸⁷

52. Evidence taken by the Committee on the effects of the Maxwellisation process was mixed. Andrew Bailey noted that in certain instances it led to the regulators uncovering additional evidence. This was because sometimes, in the process of making representations, a person would reveal additional information relevant to the inquiry.⁸⁸

53. Andrew Bailey noted, however, that Maxwellisation was an intensive process, requiring significant periods of prolonged attention from the Steering Committee overseeing the reports, and that “it all took a hell of a long time”.⁸⁹ Sir Brian Pomeroy stated that those who were Maxwellised had made full use of the facility provided by the law.⁹⁰ When asked whether there was merit in a closer examination of Maxwellisation, Andrew Bailey added that:

What I do not know is how long Maxwellisation is taking in these other inquiries; I have no idea about that. It would be interesting to know the answer to that question.⁹¹

54. Andrew Green also acknowledged that Maxwellisation had consequences, accepting that while he “found the Maxwellisation process really quite helpful and relatively painless”, with a broader public inquiry he could see that things “can easily get out of hand”.⁹²

55. The Maxwellisation process has attracted considerable controversy. It is clear that a balance needs to be struck between the rights of those criticised and the need for the timely publication of important reviews. This is vital to ensure that the public receives the explanation they deserve in cases of major financial failure.

56. Recognising this, in March 2016 the Treasury Committee commissioned a review into Maxwellisation. This is being conducted by Andrew Green QC, focusing on inquiries and investigations of a financial nature. The aim of the review is to set out what the law requires and the typical problems caused by Maxwellisation. It may also attempt to establish a set of principles, or make recommendations, to help guide future financial inquiries and investigations in their use of Maxwellisation, to ensure that the process is fair and proportionate.

Future reviews

57. At the time of the collapse of HBOS and RBS there was no statutory provision for the commissioning of the reviews. Instead, the combination of the regulatory reports with independent oversight was an innovation, devised by the Treasury Committee, as a means to ensure that the public at least received some explanation as to what went wrong at HBOS and RBS.

86 Qq 124-26

87 Qq 126-7

88 Qq 127-9

89 Q 129

90 Q 133

91 Q 134

92 Q 47

58. Among the witnesses seen by the Committee there was agreement that, in future, inquiries of this type should be conducted differently. In their written evidence the independent reviewers noted:

We would not agree that the Review has got to that point in anything like an optimal way. Indeed the exercise has been a good illustration of why any report of this nature should be produced independently, under the framework of the specific provisions in the Financial Services Act 2012.⁹³

59. The independent reviewers codified this view by making a formal recommendation that future reviews be conducted independently.⁹⁴ This point of view was also endorsed by Andrew Bailey, who noted in evidence that:

Our very strong view is that future reviews should not be done on the basis that these past reviews have been done; they should all be done by independent people. It is a much better way of doing it.⁹⁵

60. The Financial Services Act 2012 now makes provision for future inquiries to be commissioned by the Treasury. Section 68 of the Act, provides that the Treasury may arrange independent inquiries when events have occurred in relation to:

Listed securities or an issuer of listed securities ... which posed or could have posed a serious threat to the stability of the UK financial system or caused or risked causing significant damage to the interests of consumers⁹⁶

61. Section 69 of the Act confers on the Treasury the power to appoint a person to hold the inquiry. However, the Treasury can also, through direction of the appointed person, control the scope, length and conduct of the inquiry. These directions also allow the Treasury to suspend or discontinue an inquiry.⁹⁷

62. Both the regulators and the independent reviewers supported the view that future inquiries into major bank failures should best be conducted wholly independently of the regulators. The Committee agrees. The Government has already partially addressed this in the provisions contained in the Financial Services Act 2012. In theory, the Act goes some way towards providing what is needed. In practice, the legislation remains defective. It is far from satisfactory that the Treasury retains the authority to prevent an inquiry under the Act, even when both the regulators and the Committee may have concluded that one is necessary. There may be a case for a Treasury override in the national interest in exceptional circumstances, accompanied by an obligation to report to the House. However, the current legislation has gone too far. The Treasury has arrogated to itself full control over the scope and continuation of any inquiry. The case for an amendment to the Act, overriding this blocking power, is therefore strong.

93 HBO001

94 Ibid, p 10

95 Q 111

96 Financial Services Act 2012, Part V, Section 68

97 Ibid, Part V, Section 69

63. In the meantime, steps must be taken to ensure that the independence of such inquiries is safeguarded in future. At a minimum, the Treasury should be required to gain agreement to the terms of reference from the person appointed to chair the inquiry and from the Treasury Committee. Such permission should also be sought if the Treasury seeks to discontinue an inquiry under the Act.

3 Monitoring the regulators

Regulatory failings

64. The PRA/FCA report into the failure of HBOS identified a number of shortcomings in the FSA's regulatory approach. The report summarises these as the following:

The FSA Board and executive management failed to ensure that adequate resources were devoted to the supervision of large systemically important firms such as HBOS. This gave rise to:

- i. A risk assessment process that was too reactive, with inadequate consideration of strategic and business model related risks;
- ii. Insufficient focus on the core prudential risk areas of asset quality and liquidity in a benign economic outlook; [and]
- iii. Too much trust being placed in the competence and capabilities of firms' senior management and control functions, with insufficient testing and challenge by the FSA.⁹⁸

65. The subsequent evidence sessions with the Committee drew out some additional themes that contributed towards regulatory failings in the case of HBOS and other UK banks.

Regulatory leadership

66. A common feature of the reports into RBS and HBOS was the failure by the FSA Board to adopt an appropriate strategy for prudential supervision. One reason for this was that prudential supervision fell relatively low down the list of the FSA's priorities at the time. Two reasons were advanced as to why this was the case. First, Sir Brian Pomeroy noted that at the time the outlook and experience of the UK and global economies had been "benign", with developed economies enjoying several years of moderate, non-inflationary growth.⁹⁹ The HBOS report notes that this sat alongside the common belief in policy-making circles that "financial innovation and complexity had made the financial system more stable".¹⁰⁰ Hence, the probability assigned to the emergence of a serious prudential problem remained low.

67. The second reason advanced why prudential supervision received relatively little attention by the FSA Board was because the Board had chosen to make conduct issues a priority. In explaining why this was the case, Andrew Bailey suggested that the FSA was carrying out a "catching-up agenda", to reflect the fact that the previous financial regulator, the Bank of England, had spent little time on conduct issues up to that point.¹⁰¹ This meant both the FSA Board, and consequently FSA resources, focused on conduct

98 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 14-15

99 Q 139

100 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 251

101 Q 139

policy, especially the Treating Customers Fairly initiative. He added that during the crisis, the focus of the regulators' work swung back in the opposite direction, and prudential matters received significantly more Board attention than conduct issues.¹⁰²

68. The overall consequence of both factors was that the FSA Board spent a very limited amount of time considering prudential matters before the crisis. The report into the failure of RBS found that only one out of 61 major items discussed by the Board over the period January 2006 to July 2007 related to prudential banking matters.¹⁰³ The HBOS report also notes:

The FSA Board did not play any operational role in decisions relating to the supervision of specific firms. The Board did though receive briefings on current issues, including major firm-specific issues, from executive management and so was in a position to ask questions and challenge assumptions. However, no prudential issues were raised in relation to HBOS in the pre-crisis period in board reports from either the Chief Executive, Mr Tiner, or the Managing Director for Retail Markets, Mr Briault.¹⁰⁴

69. The FSA Board was therefore, to an extent, reliant on senior executives bringing prudential matters to its attention. However, prudential issues also received relatively little attention from the FSA's executive team; of the 229 items reported by the Managing Director of Retail Markets to the Board from January 2006 to July 2007, only five concerned prudential banking issues.¹⁰⁵ The PRA/FCA report also notes that:

The [FSA's] executive management team had very little proactive engagement with Retail firms and their supervision teams, unless there was crystallised risk.¹⁰⁶

70. The main responsibility for liaison with HBOS often rested with the manager of the Supervision team, a relatively junior official.¹⁰⁷ The PCBS noted in its report that:

Too much supervision was undertaken at too low a level - without sufficient engagement of the senior leadership within the FSA. The regulatory approach encouraged a focus on box-ticking which detracted from consideration of the fundamental issues with the potential to bring the bank down.¹⁰⁸

71. The question of whether prudential supervision was adequately resourced was another issue raised by the HBOS report. It states that "while ExCo [The FSA's executive committee] did have high-level discussions about resourcing and priorities, it neither had in-depth discussions, nor received detailed management information, about specific aspects of the operating model, such as the supervisory resource per firm or the balance of work between conduct and prudential issues."¹⁰⁹ The PRA/FCA report states the

102 Q 145

103 Treasury Committee, Fifth Report of Session 2012-13, The FSA's report into the failure of RBS, HC 640, 16 October 2012, Para 52, p 24

104 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 259

105 Treasury Committee, Fifth Report of Session 2012-13, The FSA's report into the failure of RBS, HC 640, 16 October 2012, Para 52, p 24

106 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 264

107 Ibid, pp 274-5

108 Parliamentary Commission on Banking Standards, Fourth Report of Session 2012-13, "An accident waiting to happen" – The failure of HBOS, HL Paper 144/HC 705, 4 April 2013, Para 85, p 28

109 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 32

consequence of this was that the team responsible for supervising HBOS was arguably too small; the numbers are shown in table 2.¹¹⁰ It also had to spend much of its time focusing on the implementation of conduct rules, in addition to monitoring prudential risk (this is discussed further in chapter 4).¹¹¹

Table 2: FSA supervision team resources

	January 2005	May 2006	August 2007	June 2008
Wider team total ^(b)	7	7	10 ^(c)	9
HBOS total	5.5	5.5	6	7
RBS total ^(d)	7	7.5	4.5	7

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015

72. The PRA/FCA HBOS report contains findings similar to those of the original regulatory report into the collapse of RBS. Both illustrate the extent to which the FSA paid insufficient attention to prudential matters in the lead up to the financial crisis. In its own report into the failure of RBS, the Treasury Committee in the last Parliament concluded that this was a serious indictment of the FSA's senior management and leadership, in particular the Chairman and Chief Executive in place at the time. The evidence seen by the current Committee regarding HBOS strongly supports this original assessment.

Communication between senior and junior employees

73. The Committee also heard evidence suggesting that there was at times a significant disconnect between the priorities set by senior management and actions taken by junior employees. In particular, this was a theme of the Green report into the FSA's enforcement actions.

74. The Green report notes that in the period following the collapse of HBOS, the FSA's senior leadership attempted to encourage ambitious enforcement action. The report quotes Sir Hector Sants as saying:

Throughout this process from the outset that senior management of the FSA as a whole, executive committee as a whole, and I in particular made it very clear that we expected, as is the statutory duty of the FSA, that any enforcement action that could be taken here should be taken ... it was very important, if there were cases to be taken, they should be taken because Parliament and the public rightly would expect the FSA to do it.¹¹²

110 Table 2: Ibid, p 274 [Table 4.2]. Notes: (a) Resources are estimates and expressed as full time equivalent. The figures include the manager and associates on the supervision team. For the purpose of these figures, it is assumed that the manager spent 80% of their total time on HBOS and 20% on wider team responsibilities. (b) Team total includes individuals supervising all firms in the wider team portfolio: HBOS, A&L, NAG and SJP. (c) There were two new graduates on the team at this point. (d) RBS figures taken from The RBS Report. As set out in The RBS Report, the RBS and Barclays supervision teams were merged under one manager with effect from February 2007. The figures for August 2007 and June 2008 assume the resource on the team was split equally between the two firms.

111 Ibid, pp 274-5

112 Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, p 20

75. The Green report then goes on to note that:

In their Report interviews, Ms [Margaret] Cole [former Director of Enforcement at the FSA], Mr Walker (Head of Department of Retail 1, in Enforcement) and Mr Jones (Manager in Enforcement who subsequently led the Enforcement investigation case team in the investigation of Mr [Peter] Cummings) all accepted that this was the tone and/or message from the FSA's senior management.¹¹³

76. Nevertheless, the Green report concluded that the eventual enforcement investigations were not reasonable partly because they did not give proper consideration to a wider range of HBOS executives.¹¹⁴

77. In evidence to the Committee, Andrew Green noted that there was indeed a "significant mismatch" between what Sir Hector said and what the Enforcement team actually did.¹¹⁵ Specifically, Andrew Green pointed out that the Enforcement division instead adopted an approach where they "simply would not investigate unless they took the view that there was a very good chance of a successful outcome".¹¹⁶ Andrew Green further noted that:

Again surprisingly, Sir Hector Sants appears to have been entirely unaware of the fact that enforcement was adopting a rather different approach, and indeed he appears to have been unaware of the fact that enforcement had concluded that the statutory threshold test for investigating Andy Hornby was met.¹¹⁷

78. Part of the problem appears to have been different interpretations of what constituted an ambitious approach. For instance, the report quotes Margaret Cole as stating that the investigation of Peter Cummings (former CEO of HBOS Corporate division) alone was "... ambitious in scope, given that this wasn't the only thing that was going on ... I felt it would have been less ambitious, and ducking the issue somewhat, to have gone against the firm". Similarly, a more junior enforcement employee is quoted in the Green report as stating that he "felt at the time with this portfolio of cases [...] we were quite ambitious."¹¹⁸

79. In terms of assigning responsibility for this apparent communication failure concerning the implementation of the tone on ambitious enforcement, Andrew Green noted "it is very difficult to say", but that "ultimately, where a chief executive sets a particular tone, if that tone is not followed through, the chief executive must bear responsibility for that".¹¹⁹ Andrew Bailey agreed with this in evidence, noting "there was a comment, which I think Andrew Green made yesterday, that the tone from the top, the tone that Hector gave, was not being followed through. It is the responsibility of the CEO to ensure that that does happen, and it didn't. That is a very clear message from the Green report, it seems to me."¹²⁰

113 Ibid

114 Ibid, pp 4-6

115 Q 23

116 Q 23

117 Q 23

118 Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, p 38

119 Qq 23-4

120 Q 114

80. The FSA's senior leadership, in particular Sir Hector Sants, claimed to want to pursue an ambitious enforcement strategy in response to the financial crisis. Andrew Green's report demonstrates that such a strategy was not implemented successfully. This is deeply concerning. It is also of considerable concern that, at the time when the FSA's Enforcement division was first considering enforcement action, it failed to consider the full range of relevant individuals (formerly employed by HBOS), that is those for whom the statutory threshold test for conducting an investigation had been satisfied. The only person that it considered for investigation was Peter Cummings. Responsibility for these omissions and failures, and for the procedural failures summarised in paragraphs 150 and 151, rests with Sir Hector Sants, as CEO of the FSA.

Individual responsibility at the regulator

81. One area of disagreement between Andrew Green and the regulators was the decision by the review Steering Committee not to allow him to name regulatory employees in his report below the level of Director.¹²¹ Andrew Bailey argued that the regulators' approach was justified because it was consistent with the process that had been used in the production of the RBS report, and was also informed by the future application of the Senior Managers Regime.¹²² Additionally, in the regulators' view, those below the level of Director "did not hold positions of responsibility", as they did not set the direction or strategy of supervision and regulatory policy.¹²³ Andrew Bailey also queried whether the public interest would be served by naming less senior employees, suggesting that there was nothing that would be learnt about the FSA in the context of the failure of HBOS from publishing the names of the employees concerned.¹²⁴

82. In both his report and in evidence to the Committee, Andrew Green suggested that, in the interests of transparency, all employees relevant to his report should be named.¹²⁵ Hence Andrew Green added that "I certainly take the view that it was in the public interest that there should be full transparency, so it is not in the public interest that there has not been full transparency."¹²⁶ When questioned on why the regulators had taken a different view, Andrew Green stated:

There were two grounds, as far as I recall. The first was that identifying less senior personnel would perhaps inhibit their decision-making processes or inhibit robust decision-making going forward. The second reason was that they wanted to protect their employees. The view that I took, first of all, was that neither of those reasons was sufficiently compelling to remove people's names. In any event, the first of those reasons did not strike me as a particularly compelling reason at all.¹²⁷

83. In defending his position, Andrew Green cited an example from his report of when employees below the level of Director had played an important role in setting the strategy taken towards enforcement in the HBOS case. This was a meeting of FSA employees on

121 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 353 [Appendix 1]

122 Q 100

123 Q 100

124 Q 104

125 Q 9

126 Q 11

127 Q 10

9 January 2009 when it was decided to pursue enforcement action solely against Peter Cummings. Andrew Green noted that all four attendees at the meeting were below the level of Director and consequently had to be anonymised in his report.¹²⁸ This was despite the fact that the narrow investigative focus agreed at this meeting was a source of direct criticism within the Green report.

84. The independent reviewers also noted in their written evidence that they thought there was a case to be made to publish the name of an official who had been a Head of Department in the Supervision area of the FSA, prior to the financial crisis.¹²⁹ In their view this was justified on the grounds that the person in question was a senior manager, as categorised by the review, and had played “a pivotal role between front line supervision and ExCo members”, a potentially important factor in some of the FSA’s supervision failings. This request was denied, partly for “ongoing operational reasons”.¹³⁰

85. Both the independent reviewers and Andrew Green concluded that the HBOS reports should have named some employees below the level of Director. The Treasury Committee agrees with them. The evidence in the reports shows that less senior employees can have a significant impact on regulatory strategy and outcomes.

86. The policy of naming individuals should be flexible. In most cases it may be appropriate to offer anonymity to employees below the level of Director. There should, however, be scope for exceptions. In future, those leading a review should have the freedom to determine if the public interest would best be served by naming particular employees.

Conflict of interest at the regulators

87. In 2004 James Crosby, at that time CEO of HBOS, joined the FSA Board. He stood down from the position of HBOS CEO in 2006, but remained on the FSA Board, becoming Deputy Chairman of the latter in 2007. He later resigned from his position on the FSA Board in 2009 following allegations relating to his handling of changes made to the Group Regulatory Risk role within HBOS during his time as CEO.¹³¹

88. The PRA/FCA HBOS report includes an assessment of James Crosby’s position on the FSA Board. The report states that it found no evidence that he influenced the supervision of HBOS. It adds that this was partly because the “FSA Board did not play an operational role in decisions relating to the supervision of individual firms, including HBOS”.¹³²

89. The report does note that while he was still at HBOS, James Crosby “tended to contact the manager of the Supervision team directly to discuss issues, which contributed to the firm’s perceived ‘open and co-operative’ relationship with the FSA.”¹³³ This was slightly different to the behaviour of the typical bank CEO, who usually communicated directly with more senior FSA management.¹³⁴ The report then summarises by stating:

128 Q 10

129 HBO001

130 Ibid

131 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 261-2

132 Ibid

133 Ibid

134 Ibid

Clearly this is a subjective area, but Mr Crosby's presence on the FSA Board may have been a factor in his open dialogue with the supervision team. Furthermore, it is possible that Mr Crosby's presence on the FSA Board could have resulted in the FSA treating HBOS more leniently, although the Review found no evidence of this.¹³⁵

90. The PRA/FCA report also concludes that there was no evidence of James Crosby being involved in, or aware of, the FSA's decision-making process in relation to Basel II implementation at HBOS in 2007.¹³⁶

91. Despite this, the regulators noted in their report's recommendations, that both the PRA and FCA should review their conflict of interest policies to "ensure that the risks associated with including serving industry practitioners as non-executive directors on their Boards are adequately managed."¹³⁷

92. The Treasury Committee in the last Parliament addressed the question of conflict of interest on regulatory Boards. In its report on the failure of RBS, the Committee noted that:

We agree with the suggestion of our specialist advisers that the PRA Board should have independent members with extensive current or very recent market experience. We recognise the potential for conflicts of interest [...] the interpretation of what constitutes a conflict needs to be assessed on a case-by-case basis at the time of appointment, and particular conflicts should be dealt with by committees as they arise.¹³⁸

93. The Committee subsequently recommended that if a conflict did arise on a regulatory Board, "the rest of the Board, led by the Chairman, should therefore exercise its judgement as to how to deal with it, as is standard practice on the Boards of major public companies." The Committee also noted that such a process needed to be supported by a clear set of published rules, agreed by the Board.¹³⁹

94. The Treasury Committee has also had to revisit these issues in the current Parliament during the appointment of Dr Gertjan Vlieghe to the Monetary Policy Committee. In the light of the concerns raised by the Treasury Committee about its management of conflict of interest in this case, the Bank of England subsequently agreed to undertake a review of the MPC's code of conduct.¹⁴⁰

95. It is right that the regulators should review their conflict of interest policies for appointments to their Boards. The Treasury Committee has repeatedly identified this as a crucial issue for regulatory governance. Conflict of interest policies must not be allowed to exclude access by regulators to much needed industry expertise. But regulators also need to have, and to be seen to have, a set of robust procedures for dealing with a conflict of interest when it does arise.

135 Ibid

136 Ibid

137 Ibid, p 39

138 Treasury Committee, Fifth Report of Session 2012-13, The FSA's report into the failure of RBS, HC 640, 16 October 2012, Para 57, p 25

139 Ibid

140 Treasury Committee, Second Report of Session 2015-16, The appointment of Dr Gertjan Vlieghe to the Monetary Policy Committee of the Bank of England, 13 October 2015, HC 497, Para 4, p 4

96. These objectives are not irreconcilable. Best practice in the private sector can provide a guide. Regulators need at all times to maintain the highest standards with respect to conflict of interest. The Committee will seek assurances from the relevant regulatory Boards that such procedures are in place.

4 The FSA's approach to supervision

97. In 2004, the FSA sent an interim 'ARROW' assessment to HBOS which highlighted a number of weaknesses within the firm.¹⁴¹ In particular, the FSA emphasised the need for HBOS to embed an appropriate risk management and control environment, given the ambitious level of growth being pursued by the firm. The ARROW assessment also cited the risks posed by the Corporate division's exposure to commercial property and the need for HBOS to have a contingency plan in the event that it faced funding difficulties.¹⁴² As the PRA/FCA report notes:

These priorities were set out in the January 2004 interim ARROW letter and were a reasonable and early articulation of the risks that would eventually crystallise and cause HBOS to fail.¹⁴³

98. The fact that these risks were allowed to eventually crystallise and contribute to HBOS's failure four years later suggests that there were deficiencies in the FSA's supervision of the bank.

99. One theme identified by the PRA/FCA report was the willingness of the FSA to rely on HBOS's senior management and controls to resolve prudential issues as they arose. In practice, this meant that the FSA would assign actions to the firm and then:

request confirmation that the actions had been undertaken but the level of supervisory follow up would be based on judgements about the amount of reliance that could be placed on the firm and the perceived importance of an issue.¹⁴⁴

100. Over time, the FSA's willingness to rely on HBOS's senior management appears to have increased. In particular, this supervisory approach was codified as part of the FSA's 'regulatory dividend' policy.¹⁴⁵ This meant that firms that co-operated with the FSA and were thought to have effective control frameworks would benefit from less intensive supervision.

101. In the case of HBOS, the application of this policy meant that in 2006 the FSA reduced the number of items outstanding on the firm's Risk Mitigation Programme (RMP), a running list of the main concerns the FSA wanted HBOS to address, and transferred some to the less intensive Close and Continuous supervision process (C&C).¹⁴⁶ As the report notes:

The initiative did result in key issues being removed from supervision's only formal tracking framework as the discipline of setting milestones for review or deadlines for action to be taken did not apply to the C&C programme. As a consequence, the pace of remediation of issues appears to have slowed.

141 The ARROW risk assessments were one of the FSA's supervisory tools. It allowed FSA staff to investigate various business and control risks within a firm.

142 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 267

143 *Ibid*

144 *Ibid*, p 253

145 *Ibid*, p 277

146 *Ibid*, pp 277-8

For example, some issues included in the April 2008 RMP ... were broadly similar to issues identified in the December 2004 ARROW and subsequently transferred to C&C supervision in June 2006.¹⁴⁷

102. The report adds that the decision to reduce the number of items on HBOS's RMP led to an "even greater reliance being placed on HBOS senior management and Group control functions to confirm that issues had been addressed".¹⁴⁸ The FSA, meanwhile, only conducted limited amounts of testing to check whether problems had been fully resolved.¹⁴⁹

103. The FSA also appeared willing to accept the assurances and judgement of HBOS's senior managers in other significant areas. An example of this was HBOS's decision to appoint a non-specialist to the role of Group Risk Director, a post with important responsibilities in terms of risk management and dealing with the FSA's Supervision team. Although the FSA queried the appointment, it did not prevent it from taking place.¹⁵⁰ In evidence to the Committee, Andrew Bailey said that this was not a reasonable decision. Comparing this to the current regime, he added:

If somebody had no background in risk, they would have to have some very special talent that had not been previously revealed to be acceptable for the role.¹⁵¹

104. The FSA's reliance on HBOS to resolve prudential and conduct issues proved damaging because HBOS's control framework was ultimately shown to be deficient. The PRA/FCA report highlights that, while in many areas HBOS's approach was coherent on paper, it was often implemented poorly, such as the three lines of defence model discussed earlier in this report (see Chapter 1). The reliance on HBOS's controls was also misguided because of the poor state of the management information collected by the firm. The PRA/FCA report notes that this was especially the case in the Corporate division. For instance, a 2008 internal HBOS document recorded concerns that, among other things, collateral values were not being accurately recorded.¹⁵² The PRA/FCA report adds that the poor state of corporate management information became more important during the crisis as it "disguised the extent to which lending was continuing to grow despite the decision to slow it down and provided misleading information on exposures."¹⁵³

105. The problems of poor management information also extended to the 'Blue Book' provided to HBOS's Board, which the PRA/FCA report found often included "an imbalance in coverage given to 'good' news relative to 'bad' news".¹⁵⁴ In theory, HBOS's Board should have been the ultimate check on the risks taken by the firm. The PRA/FCA report suggests, however, that HBOS's earlier success meant key Board members displayed a degree of complacency about the risks facing the bank.¹⁵⁵

147 Ibid, pp 278-9

148 Ibid, p 279

149 Ibid

150 Ibid, p 321

151 Q 155

152 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 212

153 Ibid

154 Ibid, pp 210-11

155 Ibid, p 207

Process over substance

106. Besides the decision to rely on HBOS's senior management, the FSA's approach to supervision was also undermined by the emphasis placed on a number of process, rather than judgement, intensive tasks. The most notable example of this was the implementation of Basel II standards. This absorbed significant supervisory resource and became the major theme of the supervisory relationship with HBOS. As the PRA/FCA report notes:

In the long run, some benefits might have resulted from this new bank capital adequacy regime, which required more detailed assessment of asset-specific risks. However, considerable work was still required by HBOS in 2008 and many planned model changes were not approved prior to its failure. As a result, the devotion of significant FSA resources to Basel II implementation did not make a significant contribution to making HBOS, or any other major bank, more robust in the face of the financial crisis.¹⁵⁶

107. There is also the risk, identified by the PCBS, that the use of the Basel framework ultimately distracted the FSA from focusing on the key prudential risks within HBOS's balance sheet.¹⁵⁷ The PCBS noted regulators needed:

to avoid placing too much reliance on complex models rather than examining actual risk exposures. Regulators were complicit in banks outsourcing responsibility for compliance to them by accepting narrow conformity to rules as evidence of prudent conduct. Such an approach is easily gamed by banks, and is no substitute for judgement by regulators.¹⁵⁸

108. The PRA/FCA report also cites the decision by the FSA to develop a new ARROW II framework as an example of an initiative that resulted "in too much focus on process rather than substance".¹⁵⁹

109. The consequence of both the reliance on HBOS's senior management and the heavy burden of process-led work meant that the FSA's supervisory regime paid inadequate attention to the important issues of asset quality and liquidity.

110. Stuart Bernau supported this assessment, suggesting that the time spent on conduct and other matters meant the regulators "had not really focused on the capital implications of a downturn in the economy or the liquidity position".¹⁶⁰ In evidence to the HBOS review, some FSA staff at the time appeared to justify the less intensive and ultimately reactive regime, as well as their unwillingness to criticise banks' business models, on the need to avoid becoming shadow directors. The report notes that:

FSA executive management did not define it as part of supervision's role to criticise a firm's business model and FSA staff were told that they should not get into the position of being shadow directors. As a result, supervisors did not always reach their own judgements on the key business challenges and

¹⁵⁶ Ibid, p 256

¹⁵⁷ Parliamentary Commission on Banking Standards, Fourth Report of Session 2012-13, "An accident waiting to happen" – The failure of HBOS, HL Paper 144/HC 705, 4 April 2013, Paras 83-85, p 28

¹⁵⁸ Parliamentary Commission on Banking Standards final report, Changing banking for good, 12 June 2013, HL Paper 27-I/HC 175-I, Vol II, Para 158, p 148

¹⁵⁹ PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 253

¹⁶⁰ Q 54

strategic risks in firms' business models, based on in-depth, rigorous review. Without in-depth analysis of a firm's strategy, the supervision team's ability to assess the adequacy of the underlying control framework was undermined. FSA staff could have done this without acting as shadow directors.¹⁶¹

111. Andrew Bailey agreed with this, noting that he did not feel that becoming a shadow director was actually an "issue".¹⁶²

112. These supervisory failings were discussed extensively by the PCBS which summarised its concerns by stating:

From 2004 until the latter part of 2007 the FSA was not so much the dog that did not bark as a dog barking up the wrong tree. The requirements of the Basel II framework not only weakened controls on capital adequacy by allowing banks to calculate their own risk-weightings, but they also distracted supervisors from concerns about liquidity and credit; they may also have contributed to the appalling supervisory neglect of asset quality.¹⁶³

113. The FSA initially demonstrated a good grasp of the problems that would cause HBOS to fail, yet over time the quality of supervision deteriorated markedly. The focus of the FSA's work shifted to process or box-ticking exercises, at the expense of prudential oversight of the firm. The consequence was a supervisory approach that failed to engage with the prudential risks accumulating on HBOS's balance sheet. The Committee agrees with the PCBS's assessment that this was thoroughly inadequate.

114. The decision to assign a lower priority to prudential supervision did not occur by accident, but by design. The FSA Board and senior FSA executives chose to focus the organisation's attention on conduct issues and the implementation of Basel II. They also supported a supervisory approach that placed a growing reliance on HBOS's senior management to rectify prudential concerns. The FSA rightly held the Board of HBOS responsible for the firm. But it did too little as a regulator to ensure that HBOS was taking the necessary remedial action on areas of prudential concern. In particular, the FSA had an inadequate understanding of the asset quality and liquidity risks within the firm.

115. The case of HBOS demonstrates that detailed rules are no substitute for high-quality supervision. The challenge now for regulators is to rely less on bureaucratic processes and instead to demonstrate that they can exercise more balanced judgement across a complex financial system. This is no easy task.

External pressure

116. The PRA/FCA report argues that other factors, specifically the external environment in which the FSA operated, also influenced the approach to regulation. This included:

¹⁶¹ PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, pp 253-4

¹⁶² Q 162

¹⁶³ Parliamentary Commission on Banking Standards, *Fourth Report of Session 2012-13, "An accident waiting to happen"* – The failure of HBOS, HL Paper 144/HC 705, 4 April 2013, Para 84, p 28

A sustained political emphasis on the need for the FSA to be a light-touch regulator in order to retain the international competitiveness of the UK's financial system... [and]

A consensus among practitioners and policy-makers that financial innovation and complexity had made the financial system more stable at a time of benign economic conditions.¹⁶⁴

117. In evidence to the Committee, Iain Cornish - one of the independent reviewers - agreed that there had been an agenda of light touch regulation, although he added that the FSA Board had been very comfortable to “buy into” that particular approach.¹⁶⁵

118. In evidence, Andrew Bailey also picked up on this theme, noting that prior to the crisis the FSA's job was made harder as many external observers viewed HBOS as a success story, and the financial industry in general as the “goose that was laying the golden egg”, and cautioned against tougher supervision.¹⁶⁶ In contrast, Andrew Bailey added that in future the regulator needed to ensure it did not “bend either way” in response to external pressure, and instead applied a consistent standard of regulation.¹⁶⁷

119. This aspiration is reflected in one of the PRA/FCA report's recommendations around the “will to act”, which states:

Where intervention is warranted, the regulators must be willing and able to do so free from undue influence, in particular when markets are benign and in the face of changing public policy priorities.¹⁶⁸

120. The regulators have repeatedly asserted that they operated in an environment which encouraged ‘light touch’ regulation. This point may have merit but it does little to justify the severe flaws in the supervision of HBOS. In its report on RBS, the Treasury Committee in the last Parliament correctly identified that the FSA was given statutory independence to enable it to resist political pressure. The FSA's past recourse to political encouragement to promote ‘light touch’ regulation does not inspire confidence in the new regulators' capacity to demonstrate the independence required by their statutory mandates. In future, if the regulators do feel under such pressure, it is their duty to inform Parliament. The Treasury Committee will expect them to do so.

Regulatory reform

121. Since the financial crisis there have been a number of changes intended to establish a more appropriate regulatory regime. Many of these have followed from the recommendations of the Parliamentary Commission on Banking Standards and Independent Commission on Banking. Following significant pressure from the Treasury Committee and PCBS, the Financial Policy Committee has been granted powers over the leverage ratio, and there is now a provision to electrify the ring-fence, the mechanism that gives the regulator the power potentially to restructure banking groups.¹⁶⁹ On conduct,

¹⁶⁴ PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 251

¹⁶⁵ Q 54

¹⁶⁶ Qq 162-3

¹⁶⁷ Q 170

¹⁶⁸ PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 39

¹⁶⁹ Parliamentary Commission on Banking Standards, Statement by the former members of the Parliamentary Commission on Banking Standards, 4 November 2014

March 2016 has seen the introduction of a new Senior Managers and Certification Regime, to replace the Approved Persons Regime. In addition, the development of the ‘twin peaks’ system, whereby the old FSA was split into separate prudential and conduct regulators, has sought to address the problems identified in the HBOS report of seeking to balance these two policy areas.

122. The financial crisis exposed major shortcomings in the existing approach to financial regulation. While there was a consensus that reform was needed, it nevertheless took significant pressure from the Treasury Committee and the PCBS to ensure that the Government followed through with a number of much needed changes. This included securing powers over the leverage ratio for the Bank of England and the provision to electrify the ring-fence. As a result, the regulators now have a better set of tools at their disposal. The Treasury Committee expects the regulators to demonstrate independence in their use.

123. Both the new powers gained by regulators and their poor performance prior to the crisis increases the need to ensure that regulators are challenged and required to explain their actions and decisions. This is primarily a duty for Parliament in general, and the Treasury Committee in particular. The new accountability arrangements - including new powers for the Treasury Committee over the appointment of the Chief Executive of the FCA - are an improvement. But it is not yet clear that the current framework is satisfactory. The Treasury Committee will need to consider this issue further in the light of the changes made by the Bank of England and Financial Services Act 2016.

Not enough capital

124. The supervision of HBOS took place in the context of internationally agreed regulatory standards of the time. For much of the review period HBOS was judged against the capital standards set out under Basel I, although the firm transitioned to the newer Basel II framework towards the end of the period.¹⁷⁰ Under the Basel frameworks, banks were required to hold certain amounts of capital in relation to their risk weighted assets. The type of capital was not uniform and included Tier 1 and 2 instruments alongside common equity. The FSA also set out its own standards for UK banks, which were higher than the minimum standards agreed under the Basel framework.¹⁷¹ For most of the period in question, the HBOS Board maintained a capital target well above the minimum ratios.¹⁷² HBOS was also in line with its peers in terms of capital strength.¹⁷³

125. The onset of the financial crisis and the significant losses suffered by HBOS on its lending revealed that HBOS had insufficient loss absorbing capital to cope with its estimated £26bn of losses.¹⁷⁴ Notably, this meant that without significant capital injections from the

170 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 28

171 *Ibid*, pp 140-41

172 *Ibid*, p 140

173 *Ibid*, p 28

174 *Ibid*, p 139 [£13.5bn of capital on a Basel III standard]

UK taxpayer and Lloyds, HBOS would have become insolvent; the extent of HBOS's losses relative to capital are shown in table 3.¹⁷⁵ As the PRA/FCA report states, these events indicated that the prevailing approach to capital among banks was "inadequate".¹⁷⁶

126. The fact that HBOS lacked sufficient capital to survive its losses highlights a number of failings in the previous Basel capital regime. One significant issue was that the Basel framework in place at the time did not require banks to hold enough common equity as a proportion of their total capital. As the PRA/FCA report states:

HBOS did not have enough high-quality capital to absorb the losses it incurred between 2008 and 2011. The Basel I and Basel II regimes were built on the misunderstanding that the lower tiers of capital instruments could absorb losses in a going concern state short of resolution. This was wrong.¹⁷⁷

Table 3: Movement in total equity between 2007 and 2011

	£
Total equity as 31 December 2007	22.2
Net losses (January to August 2008)	(0.3)
HBOS April 2008 share issue	4.0
Dividends ^(b)	(1.3)
Shareholders' funds as at August 2008 ^(c)	24.6
September results ^(d)	(3.1)
Shareholders' funds as at September 2008 ^(e)	21.5
Cumulative loss October 2008 to 2011 (after inclusion of a subvention payment of £3 billion from LBG and gains of £2.9 billion on LBG's capital management exercises in 2009 and 2010)	(21.3)
UK Government capital injection 2009 (£8.5 billion ordinary shares and £2.8 billion preference shares) ^(f)	11.3
LBG capital injections 2009 ^(g)	14.0
LBG capital management exercise 2009 and 2010 ^(h)	2.6
Redemption of UK Government and other preference shares 2009	(4.3)
Other reserve movements	0.4
Total equity at 31 December 2011	24.2

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, HBOS Annual Reports and Accounts, HBOS Board management information, Review calculations

127. A second related issue was the limited risk sensitivity of the Basel I system. The PRA/FCA report highlights how HBOS's Corporate division's average risk weight was little changed between 2004 and 2007, even though the Corporate division was increasingly

175 Table 3: Ibid, p 148, [Table 2.24]. Notes: (b) The final 2007 ordinary share dividend (£1.2 billion) and preference share dividends. (c) The last reported position in the management accounts prior to 1 October 2008, the point of failure. (d) Due to Corporate impairment losses, the effects of market dislocation in September on security values and write-down on BankWest. (e) Shareholders' funds reported in the management accounts as at the approximate point of failure, but prepared after that date. (f) The measures announced by the UK Government 8 October 2008. The £2.8 billion preference shares are net of expenses (£0.2 billion). (g) These injections were also used to redeem HBOS preference shares (including those issued to the UK Government). (h) The various capital management exercises raised £5.5 billion in 2009 and 2010, of which £2.6 billion was recognised as share premium on the conversion of debt into shares and £2.9 billion was recognised directly in the income statement, as the debt was bought back at below its carrying value.

176 Ibid, p 139

177 Ibid, p 146

taking more risk.¹⁷⁸ The fact that this was not identified by the risk weight system, however, gave undue comfort to HBOS and the regulators that the bank was in a strong position. As the PRA/FCA report notes, poor risk measurement meant HBOS “overstated the return for the risk taken”.¹⁷⁹

128. Following a request from the independent reviewers, the PRA and FCA included an assessment in their report of how HBOS would have fared under a Basel III framework.¹⁸⁰ The results indicate that as of end December 2007, HBOS would already have been in breach of the minimum standards set by Basel III.¹⁸¹ This would have had important consequences for HBOS, as it would have been denied permission to pay dividends until this standard was met.¹⁸²

Table 4: Summary of the estimated impact of Basel III capital calculations as at 31 December 2007

	£ billion
Additional capital to meet the Basel III:	
Minimum standard (4.5%)	1.4
Capital conservation buffer (2.5%)	7.7
Systemically significant buffer (3%)	9.4
Sub-total	18.5
Pillar 2 capital requirement and other tools (2.5%–3%)	8.9
Total additional capital requirement	27.4
Less additional capital to meet the minimum standard. This is on the assumption that the firm must still meet this requirement while covering its losses	(1.4)
Additional capital required by Basel III available to cover losses	26.0
Cumulative net loss 2008 to 2011	26.0

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, firm regulatory reporting to the FSA, Annual Report and Accounts, Review Calculations

129. Therefore, overall the findings suggest that HBOS would have needed to hold significantly more capital than it did prior to the crisis in order to meet Basel III minimums. However, whether this would have been enough to cover all its losses depends on uncertain assumptions regarding the size of its Pillar II and cyclical buffers, as illustrated in table 4.¹⁸³ The PRA/FCA report concludes that even given the difficulties in accurately estimating HBOS’s Basel III position, the overall higher levels of equity required by Basel III meant:

It seems likely that HBOS would have responded to a Basel III regime by significantly amending its business model. For example, the Group may not have pursued the significant asset growth that it achieved [...]¹⁸⁴

130. The pre-crisis standards governing bank capital requirements were not fit for purpose. Inaccurate risk weights, and a lack of emphasis on the holding of core equity,

178 Ibid, p 147

179 Ibid

180 Ibid, pp 149-51

181 Ibid, p 149

182 Ibid, p 150

183 Table 4: Ibid, p 150, [Table 2.25]

184 Ibid, p 150

allowed banks such as HBOS to create the illusion of prudence, when risks were in fact increasing. Basel III has rightly put much more emphasis on the need for banks to hold more equity capital. Nevertheless, residual uncertainties about the risk weighting system, the scope for some banks to measure risk using their own internal models, and the subjective nature of some asset valuations, mean that the capital ratios cannot provide complete reassurance. The onus is now on the Bank of England, given its significant new powers, to exercise judgement about whether the banking system is appropriately capitalised. The Treasury Committee will be investigating these issues in more detail during the course of its forthcoming inquiry into bank capital.

5 Enforcement - The way ahead

The FSA's enforcement powers

131. This section of the report provides a short summary of the FSA's enforcement powers and processes at the time of HBOS's collapse. A more detailed account is provided in Part B of the Green report.

132. The Financial Services and Markets Act 2000 provided the statutory basis for the FSA's operations, requiring any firm conducting a regulated activity to be authorised by the FSA. Those members of a firm responsible for performing controlled functions also had to be approved by the FSA as being fit and proper to hold that particular position.¹⁸⁵ The FSA judged the conduct of approved persons against statements of principle and could take disciplinary action against an approved person if it appeared that person was guilty of misconduct. This covered either a failure of the person to comply with one of the statements of principle, or that the person had been knowingly concerned in a breach by the authorised firm under the Financial Services Act.¹⁸⁶ Importantly, however, Andrew Green's report notes:

[the] FSA would not bring disciplinary proceedings against an approved person for misconduct merely because a regulatory failure had occurred in an area of the business for which that person was responsible... More was needed i.e. 'personal culpability'.¹⁸⁷

133. Proceedings into potential misconduct by individuals were judged against the civil standard, meaning that guilt would be determined on a balance of probabilities basis, rather than requiring proof beyond all reasonable doubt.¹⁸⁸ If found guilty, the most notable sanctions open to the FSA were to impose a financial penalty and/or to prohibit a person from undertaking a regulated activity in the financial services industry.¹⁸⁹

134. Commenting on the overall legal regime in place at the time for conducting enforcement investigations into misconduct, Andrew Green acknowledged that it was "difficult to bring successful enforcement action against senior bankers" and that the regulatory scheme "did not ... encourage an ambitious approach".¹⁹⁰ Explaining why this was the case, he added:

There can be little doubt that establishing 'personal culpability' was a difficult task in the context of the failure of a substantial multi-divisional corporate entity such as HBOS, where strategy was frequently the result of collective decision-making by a Board over an extended period of time.¹⁹¹

135. Andrew Green suggested that the statement of responsibilities under the new Senior Managers Regime may improve things in future, noting:

185 Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, pp 7-8

186 Ibid, p 9

187 Ibid

188 Ibid, pp 9-10

189 The legislation governing the time limit for bringing misconduct proceedings was originally two years and was subsequently amended, extending the period first to three, and then to six years

190 Ibid, p 87

191 Ibid

[...] the allocation of responsibilities in this way will enable the regulator to decide, at an early stage, if this is somebody we should be investigating, and then we would investigate them and decide whether, ultimately, we are going to be able to establish personal culpability in subsequent prohibition or misconduct proceedings.¹⁹²

136. Andrew Green’s assessment that the regulatory regime in place at the time of HBOS’s collapse did not encourage ambitious enforcement action is concerning. The Committee agrees with this assessment. In order to be a credible last line of defence, there must be a perception that regulators are able to undertake even the most challenging and complex of cases. It is to be hoped that the Senior Managers and Certification Regimes will enhance the credibility and fairness of enforcement in future, given that they should lead to much clearer lines of individual responsibility. If the regulators find in future that these changes are not enough to establish a credible enforcement regime, they should say so.

The enforcement context within the FSA

137. The Green report outlines the normal procedure for an enforcement case at the time within the FSA.¹⁹³ Typically a referring department (Supervision in the case of HBOS) would raise a potential matter for investigation with the Enforcement division. Enforcement and Supervision would then engage in discussion and reach a joint decision about whether to pursue the case. At this point a member of staff within the Enforcement division would typically become the Project Sponsor.¹⁹⁴ The FSA had at the time some limited internal guidance for helping staff decide which cases to pursue. Following a review of this guidance, the Green report notes that:

It is apparent from the above that the FSA would not conduct an investigation merely because the statutory threshold test ... was met. Rather, the FSA, in deciding whether or not to conduct an investigation ... would consider “all the relevant circumstances” ... by reference to ‘assessment criteria’/‘referral criteria’ which included consideration of the ‘regulatory objectives’ and whether the issue being considered was relevant to the FSA’s ‘strategic priorities’.¹⁹⁵

138. Once the decision to investigate had been made, the Enforcement division would appoint an investigation team and issue a Memorandum of Appointment of Investigators to the subject of enforcement action. Following the completion of the investigation, Enforcement would produce a Preliminary Investigation Report setting out the evidence and assessment of the case. This was then subjected to review by an FSA lawyer and, following this, would be sent to the subject of the investigation for comment.¹⁹⁶

139. A decision was then taken by the Project Sponsor (typically a member of Enforcement) and the legal reviewer. If it was agreed to take enforcement action, a case would be submitted to the FSA’s Regulatory Decisions Committee (RDC). The latter was a function within the FSA, separate to Enforcement, tasked with reaching judgements over cases. If the RDC

192 Q 3

193 A full timeline of the relevant enforcement events in the case of HBOS is contained in Appendix 6.

194 Andrew Green QC, Report into the FSA’s enforcement actions following the failure of HBOS, 19 November 2015, pp 12-13

195 Ibid, p 14

196 Ibid, p 16

agreed the case had merit, it would inform the subject of investigation, who could then make representations to the RDC. Following this, the RDC would issue its final decision. A decision adverse to the subject could be appealed by the subject in the Upper Tribunal. If the FSA wanted to reach a settlement with the subject of an investigation, it could do so through a separate process.¹⁹⁷

Andrew Green's assessment of the FSA's HBOS investigations

140. The Green report highlights numerous instances of deficiencies in the FSA's approach to enforcement action following the collapse of HBOS. According to Andrew Green, one of the FSA's first major shortcomings was its failure to conduct a reasonable decision-making process in the period between December 2008 and late February 2009.¹⁹⁸ In his criticism of the FSA's approach, he states that the FSA did not give "proper consideration" to the investigation of other HBOS Board members and executives i.e. other than Peter Cummings.¹⁹⁹ This failure to conduct a reasonable initial decision-making process was then compounded by the subsequent failure properly to consider the scope of the initial investigations i.e. whether it should be wider than just Peter Cummings.²⁰⁰ The Green report makes clear that these problems stemmed from, among other matters, a number of procedural and institutional limitations within the FSA.

Improving co-ordination

141. In order to rectify the failings discussed above, the Green report makes a number of recommendations to improve future enforcement procedures.²⁰¹ One of these is for the regulator to take steps to improve communication between Enforcement and Supervision during an investigation.²⁰² This reflects the fact that the current set-up of Enforcement means Enforcement personnel will be reliant on supervisors to draw their attention to areas of developing concern. In the HBOS case this mattered because asset quality in other areas of HBOS's balance sheet, especially the International and Treasury divisions, began to deteriorate rapidly as the financial crisis progressed.²⁰³ The Green report notes, however, that there was a failure to pick up on this change in circumstances in the enforcement process, stating:

During the Report interviews, it became apparent that some former FSA employees thought that the possible expansion of the scope of an investigation was a matter for Supervision to raise with Enforcement; others thought it was a matter for Enforcement to raise with Supervision; and others thought it was a matter which would be raised by a dialogue between Supervision and Enforcement²⁰⁴

197 Ibid, p 17

198 Ibid, p 4

199 Ibid, p 4

200 Ibid, p 4

201 Ibid, pp 91-92

202 Ibid, p 91

203 PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 26

204 Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, p 69

142. As a result of this lack of communication, Andrew Green argues that the enforcement process began, and remained, too narrowly focused on HBOS's Corporate division.²⁰⁵

Clearer decision-making

143. Another of the Green report's recommendations concerns pre-referral decision-making, the stage of the enforcement process during which the regulator decides which (if any) investigations to start. Andrew Green suggests that before making a referral in connection with a case, the regulators should "identify each firm or individual in respect of whom the statutory threshold test for conducting an investigation is met".²⁰⁶

144. Again, this recommendation draws on some of the key failings uncovered by the Green report. In particular, the FSA's Enforcement division failed to keep a clear record of which HBOS executives had met the statutory bar for investigation. This was also not clearly communicated to senior management. As the Green report notes, one of the most striking instances of this was when Sir Hector Sants was apparently not informed that Andy Hornby (CEO of HBOS 2006–09) had met the statutory bar for investigation (see Chapter 3).²⁰⁷

145. Andrew Green argues in his report that, once the regulators have noted every person or firm which has met the bar for investigation, they should then also clearly record which cases they will and will not pursue, along with explanations for the chosen course of action.²⁰⁸ This change would potentially help to address another key problem identified in the Green report: that when deciding whether to undertake an investigation into certain individuals, the FSA would first attempt to assess the probable chances of achieving disciplinary success in the case. As the Green report notes:

the problem with this approach was the difficulty in accurately evaluating the prospects of success in disciplinary proceedings before an investigation had even begun. This approach, therefore, had a tendency to discourage the FSA from starting investigations even though the threshold test for investigating was met and even though the public importance of investigating was high.²⁰⁹

Internal procedure and standards

146. A further common theme throughout the Green report is the repeated occurrences of poor record keeping. In one instance, the report identifies a crucial meeting on 9 January 2009, the outcome of which was to determine that the FSA would make the Corporate division of HBOS and Peter Cummings the focus of its investigations. Yet Andrew Green goes on to note that:

There appears to be no attendance note of the meeting, or any other clear record of the matters discussed; and none of the people who attended that meeting could remember anything about it in their report interviews.²¹⁰

205 Ibid, p 69

206 Ibid, p 91

207 Ibid, p 89

208 Ibid, p 91

209 Ibid, pp 87-88

210 Ibid, p 23

147. The problem of poor record keeping was also identified at a more senior level. In his report, Andrew Green cites the example of when the FSA's executive committee (ExCo) was considering whether it should begin work on the HBOS report while enforcement action against Peter Cummings was continuing. In this case, Andrew Green states that "insofar as a decision was made on this important issue, any such decision is not properly recorded in the poorly drafted ExCo minutes. This is an unsatisfactory situation."²¹¹ The Green report finds that the ExCo minutes were also deficient on a separate occasion, when ExCo was considering a potential investigation of Andy Hornby.²¹² The Green report addresses this by recommending a much higher standard of minute taking at ExCo in future.²¹³

Next steps

148. A further recommendation from the Green report was that:

Given the inadequacies in the FSA's decision-making processes [...], the FCA and/or the PRA should now consider whether any other former senior managers of HBOS (including, but not limited to, Mr Hornby and Lord Stevenson) should be the subject of an enforcement investigation with a view to prohibition proceedings. There is plainly a public interest in this being considered afresh.²¹⁴

149. Andrew Bailey and Sir Brian Pomeroy both indicated during their hearing that they did not object to any of Andrew Green's recommendations.²¹⁵ The FCA and PRA have since publicly announced that they are undertaking investigations into some former HBOS executives.²¹⁶

150. The scope of the FSA's original HBOS enforcement investigations was not reasonable. There were also significant procedural failings. In particular, the FSA's Enforcement division formed the view in early 2010 (having not considered the position in 2009) that the statutory threshold test for starting an investigation had been met in the case of Andy Hornby (CEO of HBOS 2006–09), but it decided not to investigate him. However, because of a failure in communication, the Enforcement division never informed Sir Hector Sants of its view that the statutory threshold test for investigating Andy Hornby had been met.

151. The Committee finds this wholly unacceptable. Knowledge of which individuals had met the statutory test for investigation was crucial to allow the FSA's leadership to judge whether the scope of the HBOS enforcement investigations was appropriate. Furthermore, it is clearly unacceptable that important meetings and decisions among Enforcement staff, where major decisions were made concerning the scope of the HBOS enforcement investigations, went unrecorded. These oversights add to the already extensive evidence that the FSA was not up to the job. It was clearly a highly dysfunctional institution and its legacy continues to pose a major challenge for its successor bodies, particularly the FCA.

²¹¹ Ibid, pp 85-86

²¹² Ibid, p 35

²¹³ Ibid, p 92

²¹⁴ Ibid, p 5

²¹⁵ Qq 98-99

²¹⁶ Bank of England, News release - FCA and PRA investigations into HBOS Senior Managers, 28 January 2016

152. **Improvements in the approach taken to enforcement at the regulator are just as important as the new rules embodied in the Senior Managers Regime. Andrew Green makes several recommendations to deal with the severe procedural failings identified in his report. These include steps to require the regulators in future to retain a far clearer record of which persons have met the statutory threshold test for starting an investigation. It is welcome that the PRA and FCA have already incorporated Andrew Green’s recommendations in their recent consultation document. The establishment and performance of a new enforcement decisions committee at the PRA will also be carefully examined by the Treasury Committee in due course.**

Should enforcement and supervision be separated?

153. The Green report identified a number of failings in the level of dialogue and coordination between the Supervision and Enforcement divisions at the FSA, raising the question of how best to manage the relationship between these two regulatory functions. Although the FSA has since been disbanded, different parts of the former Enforcement division continue to reside alongside supervision functions in the FCA and PRA respectively. The question over how to manage the relationship between the two functions therefore remains relevant.

154. In 2013, the Parliamentary Commission on Banking Standards (PCBS) identified the relationship between the supervision and enforcement functions as an area of concern. In the PCBS’s view, there was an inherent tension between the two functions that could not easily be resolved.²¹⁷ First, the experience of the FSA proved that it was difficult to ensure that both functions received adequate attention within a single organisation. This was a particular concern during a period of financial crisis, when the FSA’s focus was on supervision and maintaining financial stability, at the expense of enforcement. Secondly, the PCBS noted that the two functions could suffer from having conflicting objectives. For instance, historical actions taken by Supervision could be relevant to an enforcement investigation. This had the potential to put the Enforcement division in a position where during an investigation it had to reach judgements on prior actions taken by supervisors.²¹⁸

155. Reflecting these concerns, and in order to address the inherent tension between the enforcement and supervision functions, the PCBS suggested that the FCA’s Enforcement division could be placed within a separate statutory body. This would ensure that both functions received adequate attention, as well as clarifying their objectives. Nevertheless, at the time the PCBS declined to make this a formal recommendation, as the regulators were already in the process of completing a preceding series of organisational changes.²¹⁹

156. By contrast, in December 2014, the Treasury completed a separate review into enforcement, in which it concluded against the case for separating enforcement and supervision. While the Treasury review accepted that there was the potential for a degree of tension between the two functions, it argued that co-operation between supervision and enforcement was likely to be “imperilled”, not improved, by separation.²²⁰ It was

217 Parliamentary Commission on Banking Standards final report, *Changing banking for good*, 12 June 2013, HL Paper 27-I/HC 175-I, Vol II, Paras 1199–1202, pp 521-22

218 Ibid

219 Ibid

220 HM Treasury, *Review of enforcement decision-making at the financial services regulators: final report*, December 2014, pp 10-11

suggested that this would follow from both practical difficulties, such as issues around information sharing, as well as the potential for the two different organisations to have divergent priorities.²²¹

157. In their hearing with the Committee, the regulators indicated that they supported the Treasury's conclusions that enforcement and supervision should stay within the same organisation. Sir Brian Pomeroy noted that there was a trade-off between "co-ordination, a free exchange of information and independence", but added that it was the FCA's view that co-ordination was facilitated by being in the same organisation, as was the effective use of the whole range of the FCA's tools. This, Sir Brian argued, justified "leaving things as they are".²²²

158. **In its final report, the Parliamentary Commission on Banking Standards identified some of the problems that arose as a result of keeping both the enforcement and supervision functions within a single regulator. The PCBS noted that both functions had different objectives which, at times, could be a source of tension, especially if the Enforcement division had to reach judgements about matters in which supervisors were involved at the time. There was also the danger that insufficient priority would be placed on enforcement within a larger organisation, reducing its effect as a credible deterrent. One solution discussed by the PCBS was to place the enforcement function into a separate statutory body. This option was subsequently rejected by a Treasury-led review.**

159. **Nonetheless, the findings of the Green report reveal that the relationship between enforcement and supervision within the FSA was indeed highly problematic. Keeping both functions within the same organisation did not result in a high degree of co-operation, undermining the argument that the two functions should remain under the same roof. In the light of this, the Committee believes the merits of structural separation bear re-examination.**

160. **First, the Committee notes that the collapse of HBOS, along with other UK financial institutions during the crisis, was the result of prudential failings. It is far from satisfactory that the bulk of enforcement staff and expertise still lies within the FCA, which has no role in prudential supervision of banks. An independent enforcement function could and should sit equidistant between the PRA and FCA.**

161. **Secondly, a separate statutory body would bolster the perception of the enforcement function's independence. The current system, whereby the same organisation both supervises, applies and prosecutes the law is outdated and can be construed as unfair. By moving enforcement away from supervision, it can focus independently on undertaking its key functions: interrogating evidence and assessing whether a regulatory breach has been committed. This could increase confidence in the impartiality of regulatory enforcement decisions, and facilitate objective scrutiny of supervisors' actions by enforcement staff.**

162. **Thirdly, separation would allow all three regulators - the FCA, PRA and an enforcement body - to enjoy much greater clarity over their objectives. There is a danger, especially with the FCA, that its multitude of objectives and initiatives are**

221 Ibid

222 Q 112

leading to regulatory overload. An FCA with fewer objectives, and a single separate body responsible for enforcement, would probably result in better accountability and better outcomes.

163. The Committee concludes that the case for structural separation has merit. The Treasury Committee expects the Treasury to appoint an independent reviewer to re-examine the case for a separate enforcement body.

6 The auditing of HBOS

The auditing of HBOS

164. The broader failings of bank audits were covered extensively by the Parliamentary Commission on Banking Standards. In its final report, the PCBS concluded that auditors, and the accounting standards they used, had fallen down in their duty to ensure the provision of accurate information to shareholders about companies' financial positions. This included a failure by auditors to act "decisively and fully to expose risks being added to balance sheets throughout the period of highly leveraged banking expansion."²²³

165. The PRA/FCA report contains a description of some of the key features and decisions specific to HBOS's financial statements during the period 2004–08.²²⁴ As the report states, the significant rise in impairments within HBOS's loan book in the period after it had received emergency liquidity assistance (ELA) from the Bank of England in 2008 is a notable part of the overall HBOS story. For instance, while impairments in the Corporate division were only £1.7bn at the end of Q3 2008, by the end of Q4, this had risen to £7.4bn; further detail is in table 5 below.²²⁵

Table 5: Published impairment losses HBOS Group 2008

£ billion	Impairments to end Q2 (as per interim Results published 31 Jul 2008)	Impairments to end Q3 (as per IMS published in Nov 2008)	Impairments to end Nov (as per interim Trading Update published Dec 2008)	Impairments to year end 2008 (as per Annual Report and Accounts, published Feb 2009)
Retail	0.7	1.2	1.7	2.2
Corporate	0.5	1.7	3.3	7.4
International	0.1			1.0
Treasury and Asset Management	nil	0.5		1.4
Other/rounding adjustment				0.1
Total	£1.3 billion	not published	not published	£12.1 billion

Source: PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015

166. One important element of HBOS's provisioning process was the practice in the Corporate division of putting loans into either good or bad books. The report describes how during the review period HBOS's auditors, KPMG, directly assessed loans in the bad book, but did not conduct the same level of direct testing on those loans in the good book. It subsequently transpired that the Corporate division had not been properly re-

²²³ Parliamentary Commission on Banking Standards final report, Changing banking for good, 12 June 2013, HL Paper 27-I/HC 175-I, Vol II, Para 181, p 157

²²⁴ PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, Chapter 2.11

²²⁵ Table 5: Ibid, p 168, [Table 2.26]. Notes: HBOS published a 2008 half-year financial statement, a Q3 Interim Management Statement Interim Trading Update, and a 2008 Annual Report and Accounts

categorising its loans into the bad book when they became distressed.²²⁶ Later in 2008, during preparations for the end-year financial statements, KPMG decided that HBOS's processes for assessing impairments and provisions "could no longer be relied on".²²⁷

167. During the oral evidence sessions with the Committee, there was a degree of debate about whether the pre-2008 approach was appropriate. Iain Cornish argued that:

Any key processes that the auditor is relying on to reach its conclusions, it feels to me, there is a case for saying they should have tested. In the case of HBOS, the process of allocating loans to the different buckets of performing, impaired and with or without loss was identified to be clearly deficient. You would expect the auditors to have looked at whether that process was working effectively before reaching conclusions about impairments.²²⁸

The relationship between KPMG and HBOS

168. The discussions held between KPMG and HBOS's senior management over the level of provisioning are also covered in the PRA/FCA report. Provisioning is the process whereby a bank decides how much to set aside to cover losses on impaired assets. It is not an exact science but a judgement, however there is an acceptable range. If provisions are set too low, they leave a firm exposed to further losses, but if they are set too high, they open the firm up to an accusation of being over pessimistic and reducing profits. A bank's auditors will review provisions as part of the process of signing off a firm's accounts. Therefore the dialogue between the firm and the auditors on provisioning is an important element in judging the performance of the auditors.

169. The PRA/FCA report highlights several instances when KPMG felt that the provisions initially suggested by HBOS's senior management, especially in 2007–08, were at the "lower end" of the acceptable range. Frequently this led to KPMG challenging the firm to set a higher level of provisions.²²⁹ The PRA/FCA report notes:

the degree of challenge that took place between senior management and some senior members of the Risk functions reflected a tendency within senior management to look towards the lower end of any range presented by those functions; and

the firm kept its auditors under pressure in an attempt to keep the figures low and proposed and tried to defend impairment figures which, following intense discussion, were increased to levels that the auditors viewed as just within the acceptable range.²³⁰

170. The independent reviewers concurred with this assessment. While noting that it was "one of the areas where it is hardest to tell exactly what happened", Iain Cornish continued by saying:

The sense that we get, as some of the material from KPMG suggests, is that the management put the auditors under a huge amount of pressure. There were

²²⁶ Ibid, p 169

²²⁷ Ibid, pp 184-5

²²⁸ Q 66

²²⁹ PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 169-90

²³⁰ Ibid, p 188

individuals within HBOS who felt that the behaviour of the senior management was inappropriate. There is an example of a senior individual in risk claiming that he was excluded from subsequent meetings, having identified the fact that he thought they were not provisioning adequately.²³¹

171. The PRA/FCA report also noted that the audit process in general appeared to give some HBOS senior executives and Board members false comfort. It adds that it was “the responsibility of the firm, its Board and its senior management (rather than the auditor) to assess impairments correctly and to make appropriate provisions”.²³²

Improvements to audit and accounting

172. In its final report, the Parliamentary Commission on Banking Standards considered a number of improvements that could be made to bank auditing. The PCBS noted that besides some of the well-documented deficiencies in International Financial Reporting Standards (IFRS), some evidence covering the process of implementing the standards themselves also raised questions whether that this had “led to an over-emphasis on compliance and box-ticking”.²³³ The PCBS acknowledged, however, that as accounting standards were set at an EU or international level, there was a limited amount UK authorities could do to change the IFRS standards themselves.²³⁴

173. Nevertheless, the PCBS did recommend that steps should be taken to enhance the role of audit, to help ensure that there was not a repeat of the failings seen prior to the financial crisis. This included the suggestion that a new set of accounting statements should be developed purely for use by the regulator.²³⁵ The PCBS also argued in favour of regular meetings between supervisors and the external auditors of banks.²³⁶ Andrew Bailey picked up on the latter point during the evidence sessions, noting that one of the things that “surprised and shocked” him, was the “mutual distrust” that had built up between the FSA and the auditors prior to the crisis.²³⁷ The findings from the PRA/FCA report illustrate this by showing that while some meetings between the FSA and KPMG did take place, these were infrequent and there was only a single telephone call in the whole of 2006 to discuss HBOS.²³⁸ Andrew Bailey added that this relationship was now being “rebuilt”.²³⁹

The role of the FRC

174. The PRA/FCA report does not posit an opinion as to the quality of the original auditing of HBOS. The regulators note that such an opinion would be outside their terms of reference and is the responsibility of the Financial Reporting Council (FRC).²⁴⁰

231 Q 77

232 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, pp 168-9

233 Parliamentary Commission on Banking Standards final report, *Changing banking for good*, 12 June 2013, HL Paper 27-I/HC 175-I, Vol II, Para 1028, p 458

234 *Ibid*, p 459

235 *Ibid*, p 463

236 *Ibid*, p 468

237 Q 184

238 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 273

239 Q 184

240 PRA and FCA, *The failure of HBOS plc (HBOS)*, 19 November 2015, p 167

175. The FRC first looked at the HBOS case in 2013, choosing to examine loan loss provisions in HBOS's Corporate division. At that time the FRC's conduct committee found that there were no "reasonable grounds" to suspect that there may have been misconduct in the auditing of HBOS.²⁴¹ The FRC committed at the time to reviewing the full HBOS report once it was published, in case there was further information that might inform an investigation.²⁴²

176. Hence, following the publication of the final PRA/FCA report in November 2015, the FRC indicated that it would check again to see if the reports contained any new evidence to warrant an investigation.²⁴³ At the same time, the Treasury Committee wrote to the FRC to urge it to reconsider the need for an investigation, given the significant public interest in HBOS.²⁴⁴

The FRC's handling of the HBOS case

177. During the evidence sessions, the Committee heard evidence to suggest there was some concern over the FRC's handling of the HBOS case. Iain Cornish noted that, based on the independent reviewers' observations of the process, the FRC demonstrated a "lack of curiosity" with regard HBOS; adding this seemed to suggest that the FRC had not run "the most diligent of processes."²⁴⁵

178. The timing of the FRC's decision not to investigate the HBOS case in 2013 was also discussed amongst the witnesses. Stuart Bernau noted that his impression was that the FRC had made a decision not to investigate before receiving a final referral letter from the PRA and FCA.²⁴⁶ Iain Cornish added that this argued for much more transparency around the FRC's decision-making process, which had not been subjected to the same level of scrutiny as the other regulators.²⁴⁷ The independent reviewers summed up their concerns in written evidence by recommending that the auditing of HBOS was an area in which the Treasury Committee may want "to take a continuing interest".²⁴⁸

179. The concern over the FRC's decision to announce it would not be investigating the HBOS case in 2013 was also raised by the regulators. Andrew Bailey noted in evidence his view that it was "sensible" for the FRC to reach their conclusions once the regulators had given them the "full final report and the full set of evidence". He added that it was an open question "as to on what basis they took the interim decision."²⁴⁹

180. In a letter to the Treasury Committee, the FRC denied that it has reached a "premature conclusion" as to whether to mount an investigation in 2013.²⁵⁰ The FRC subsequently

241 Financial Reporting Council, FRC statement following PRA/FCA review of HBOS, 19 November 2015

242 Ibid

243 Ibid

244 Letter from Chairman of Treasury Committee to Chief Executive of the Financial Reporting Council, 10 December 2015

245 Qq 71-72

246 Qq 71-3

247 Q 73

248 HBO001

249 Q 183

250 Letter from the Chief Executive of the Financial Reporting Council to the Chairman of the Treasury Committee, 15 December 2015

confirmed on 21 January 2016 that it had begun preliminary inquiries to consider whether there should be an investigation into the auditing of HBOS.²⁵¹ These would consider the extent to which KPMG, during the course of their audit:

considered the appropriateness of management's use of the going concern assumption in the preparation of the financial statements for the year ended 31 December 2007, and

considered whether there were material uncertainties about the entity's ability to continue as a going concern that HBOS needed to disclose in the financial statements.²⁵²

181. In response to the announcement of these preliminary inquiries the Treasury Committee wrote to the FRC to seek answers to some of the Committee's questions about how the FRC was planning to manage this process. This included the Committee's concerns about the extent of independent and external oversight of the FRC's work and the setting of the terms of reference for the inquiries.²⁵³ In June 2016, the FRC subsequently announced that it had commenced an investigation into KPMG's audit of HBOS for the year ended 31 December 2007.²⁵⁴

182. The Financial Reporting Council (FRC) decided not to investigate the auditing of HBOS in 2013, well before the completion of the final HBOS report. This was a serious mistake. The process by which it reached its decision suggests a lack of curiosity and diligence. These failures are all the more concerning given the scale of the problems at HBOS, and the clear public interest at stake. It is extraordinarily unhelpful that the FRC has taken so long and has belatedly reconsidered its position, only after considerable pressure from Parliament and the Treasury Committee. Following its preliminary inquiries, the FRC has now finally commenced an investigation into the auditing of HBOS.

183. The auditing of HBOS is the one major element of the HBOS affair that has yet to be subject to adequate scrutiny. The Committee will expect the FRC to undertake an extremely thorough analysis of the HBOS case. Regardless of the outcome of the FRC's investigation process, it is likely that the Committee will want to consider its work and regulatory approach in more detail. The investigation announced on 27 June 2016 is better late than never. But the very tardy response by the FRC appears to be as inexplicable as it is unacceptable.

251 Letter from the Chief Executive of the Financial Reporting Council to the Chairman of the Treasury Committee, 21 January 2016

252 Financial Reporting Council, KPMG Audit plc's audit of HBOS plc, 21 January 2016

253 Letter from the Chairman of the Treasury Committee to the Chief Executive of the Financial Reporting Council, 3 February 2016

254 Financial Reporting Council press release, Investigation into KPMG Audit plc's audit of HBOS plc, 27 June 2016

Conclusions and recommendations

Introduction

1. The Parliamentary Commission on Banking Standards' (PCBS) report, published in April 2013, reached similar conclusions to those of the regulators. Both emphasised the primary responsibility of the Board for determining HBOS's business strategy, the poor state of HBOS's internal controls and the risks posed by high rates of asset growth as key factors in explaining the demise of the firm. The PCBS report argued that many of these shortcomings were unique to HBOS. The scale of its losses could not just be blamed on the deterioration in the UK and global economies at the time of the financial crisis. This assertion was supported by evidence in the final regulators' report, showing that impairments as a percentage of the loan book were twice as high at HBOS as at RBS. (Paragraph 22)

Setting up the HBOS review

2. The Financial Services Authority failed to instigate a full review into the collapse of HBOS and RBS. This is extraordinary in itself. They resisted doing it even after strong prompting from Parliament. The unacceptability - not just to specialists following this issue, but also to a wider public - of their original decision not to undertake a full review eluded them for too long. (Paragraph 34)
3. It is regrettable that the FSA (and subsequently PRA & FCA) agreed to undertake these reviews only following sustained pressure from the Treasury Committee over a number of years. In the case of the HBOS reports, the Treasury Committee insisted on the innovative arrangements originally used for the RBS review, with Committee-appointed independent reviewers given the task of overseeing the regulators' drafting of the reports. (Paragraph 35)
4. The decision to appoint Stuart Bernau and Iain Cornish as independent reviewers proved to be of great value. The independent reviewers revealed that the first drafts of the HBOS reports had been superficial. In the case of the enforcement section, they had such grave concerns that they argued this particular section should be written independently of the regulators. An impartial assessment of the FSA's actions with respect to enforcement has been essential. Without it, the regulators would have been marking their own homework. (Paragraph 43)
5. The independent reviewers also made numerous requests for further analysis and detail. They carried out quality assurance on both the regulators' report and the Maxwellisation process. Consequently, their input was crucial, both in raising the standard of the HBOS reports and in providing assurance that the reports' findings are a fair and balanced reflection of the available evidence. Parliament and the public can now have more confidence that these final reports give a full summary of the causes of the failure of HBOS. (Paragraph 44)
6. The Committee would like to reiterate its thanks to the independent reviewers and Andrew Green for the considerable time and effort that they devoted to the HBOS review. (Paragraph 45)

7. Concerns have been raised about the length of time it took to reach publication of the HBOS reports. Beyond the FSA's initial reluctance to conduct a review at all, the primary cause of this delay was the decision by the FSA not to start the HBOS review until it had concluded enforcement action in 2012. The regulators have indicated that this was a result of legal advice. (Paragraph 49)
8. It is likely that a future bank failure would result in subsequent enforcement action, which may be a lengthy and complex process. It is unacceptable, however, that the public should have to wait so long for an explanation of what went wrong in cases of major bank failure. In the light of legislative changes since HBOS's collapse, the Treasury and the regulators need to explain to the Treasury Committee what steps they can take to ensure that reviews of this type - which in future will be led by independent persons - can be run, at least in part, alongside enforcement investigations. An arrangement where the public must wait several years for a review even to start would be wholly unsatisfactory. (Paragraph 50)
9. The Maxwellisation process has attracted considerable controversy. It is clear that a balance needs to be struck between the rights of those criticised and the need for the timely publication of important reviews. This is vital to ensure that the public receives the explanation they deserve in cases of major financial failure. (Paragraph 55)
10. Recognising this, in March 2016 the Treasury Committee commissioned a review into Maxwellisation. This is being conducted by Andrew Green QC, focusing on inquiries and investigations of a financial nature. The aim of the review is to set out what the law requires and the typical problems caused by Maxwellisation. It may also attempt to establish a set of principles, or make recommendations, to help guide future financial inquiries and investigations in their use of Maxwellisation, to ensure that the process is fair and proportionate. (Paragraph 56)
11. Both the regulators and the independent reviewers supported the view that future inquiries into major bank failures should best be conducted wholly independently of the regulators. The Committee agrees. The Government has already partially addressed this in the provisions contained in the Financial Services Act 2012. In theory, the Act goes some way towards providing what is needed. In practice, the legislation remains defective. It is far from satisfactory that the Treasury retains the authority to prevent an inquiry under the Act, even when both the regulators and the Committee may have concluded that one is necessary. There may be a case for a Treasury override in the national interest in exceptional circumstances, accompanied by an obligation to report to the House. However, the current legislation has gone too far. The Treasury has arrogated to itself full control over the scope and continuation of any inquiry. The case for an amendment to the Act, overriding this blocking power, is therefore strong. (Paragraph 62)
12. In the meantime, steps must be taken to ensure that the independence of such inquiries is safeguarded in future. At a minimum, the Treasury should be required to gain agreement to the terms of reference from the person appointed to chair the inquiry and from the Treasury Committee. Such permission should also be sought if the Treasury seeks to discontinue an inquiry under the Act. (Paragraph 63)

Monitoring the regulators

13. The PRA/FCA HBOS report contains findings similar to those of the original regulatory report into the collapse of RBS. Both illustrate the extent to which the FSA paid insufficient attention to prudential matters in the lead up to the financial crisis. In its own report into the failure of RBS, the Treasury Committee in the last Parliament concluded that this was a serious indictment of the FSA's senior management and leadership, in particular the Chairman and Chief Executive in place at the time. The evidence seen by the current Committee regarding HBOS strongly supports this original assessment. (Paragraph 72)
14. The FSA's senior leadership, in particular Sir Hector Sants, claimed to want to pursue an ambitious enforcement strategy in response to the financial crisis. Andrew Green's report demonstrates that such a strategy was not implemented successfully. This is deeply concerning. It is also of considerable concern that, at the time when the FSA's Enforcement division was first considering enforcement action, it failed to consider the full range of relevant individuals (formerly employed by HBOS), that is those for whom the statutory threshold test for conducting an investigation had been satisfied. The only person that it considered for investigation was Peter Cummings. Responsibility for these omissions and failures, and for the procedural failures summarised in paragraphs 150 and 151, rests with Sir Hector Sants, as CEO of the FSA. (Paragraph 80)
15. Both the independent reviewers and Andrew Green concluded that the HBOS reports should have named some employees below the level of Director. The Treasury Committee agrees with them. The evidence in the reports shows that less senior employees can have a significant impact on regulatory strategy and outcomes. (Paragraph 85)
16. The policy of naming individuals should be flexible. In most cases it may be appropriate to offer anonymity to employees below the level of Director. There should, however, be scope for exceptions. In future, those leading a review should have the freedom to determine if the public interest would best be served by naming particular employees. (Paragraph 86)
17. It is right that the regulators should review their conflict of interest policies for appointments to their Boards. The Treasury Committee has repeatedly identified this as a crucial issue for regulatory governance. Conflict of interest policies must not be allowed to exclude access by regulators to much needed industry expertise. But regulators also need to have, and to be seen to have, a set of robust procedures for dealing with a conflict of interest when it does arise. (Paragraph 95)
18. These objectives are not irreconcilable. Best practice in the private sector can provide a guide. Regulators need at all times to maintain the highest standards with respect to conflict of interest. The Committee will seek assurances from the relevant regulatory Boards that such procedures are in place. (Paragraph 96)

The FSA's approach to supervision

19. The consequence of both the reliance on HBOS's senior management and the heavy burden of process-led work meant that the FSA's supervisory regime paid inadequate attention to the important issues of asset quality and liquidity. (Paragraph 109)
20. The FSA initially demonstrated a good grasp of the problems that would cause HBOS to fail, yet over time the quality of supervision deteriorated markedly. The focus of the FSA's work shifted to process or box-ticking exercises, at the expense of prudential oversight of the firm. The consequence was a supervisory approach that failed to engage with the prudential risks accumulating on HBOS's balance sheet. The Committee agrees with the PCBS's assessment that this was thoroughly inadequate. (Paragraph 113)
21. The decision to assign a lower priority to prudential supervision did not occur by accident, but by design. The FSA Board and senior FSA executives chose to focus the organisation's attention on conduct issues and the implementation of Basel II. They also supported a supervisory approach that placed a growing reliance on HBOS's senior management to rectify prudential concerns. The FSA rightly held the Board of HBOS responsible for the firm. But it did too little as a regulator to ensure that HBOS was taking the necessary remedial action on areas of prudential concern. In particular, the FSA had an inadequate understanding of the asset quality and liquidity risks within the firm. (Paragraph 114)
22. The case of HBOS demonstrates that detailed rules are no substitute for high-quality supervision. The challenge now for regulators is to rely less on bureaucratic processes and instead to demonstrate that they can exercise more balanced judgement across a complex financial system. This is no easy task. (Paragraph 115)
23. The regulators have repeatedly asserted that they operated in an environment which encouraged 'light touch' regulation. This point may have merit but it does little to justify the severe flaws in the supervision of HBOS. In its report on RBS, the Treasury Committee in the last Parliament correctly identified that the FSA was given statutory independence to enable it to resist political pressure. The FSA's past recourse to political encouragement to promote 'light touch' regulation does not inspire confidence in the new regulators' capacity to demonstrate the independence required by their statutory mandates. In future, if the regulators do feel under such pressure, it is their duty to inform Parliament. The Treasury Committee will expect them to do so. (Paragraph 120)
24. The financial crisis exposed major shortcomings in the existing approach to financial regulation. While there was a consensus that reform was needed, it nevertheless took significant pressure from the Treasury Committee and the PCBS to ensure that the Government followed through with a number of much needed changes. This included securing powers over the leverage ratio for the Bank of England and the provision to electrify the ring-fence. As a result, the regulators now have a better set of tools at their disposal. The Treasury Committee expects the regulators to demonstrate independence in their use. (Paragraph 122)
25. Both the new powers gained by regulators and their poor performance prior to the crisis increases the need to ensure that regulators are challenged and required to

explain their actions and decisions. This is primarily a duty for Parliament in general, and the Treasury Committee in particular. The new accountability arrangements - including new powers for the Treasury Committee over the appointment of the Chief Executive of the FCA - are an improvement. But it is not yet clear that the current framework is satisfactory. The Treasury Committee will need to consider this issue further in the light of the changes made by the Bank of England and Financial Services Act 2016. (Paragraph 123)

26. The pre-crisis standards governing bank capital requirements were not fit for purpose. Inaccurate risk weights, and a lack of emphasis on the holding of core equity, allowed banks such as HBOS to create the illusion of prudence, when risks were in fact increasing. Basel III has rightly put much more emphasis on the need for banks to hold more equity capital. Nevertheless, residual uncertainties about the risk weighting system, the scope for some banks to measure risk using their own internal models, and the subjective nature of some asset valuations, mean that the capital ratios cannot provide complete reassurance. The onus is now on the Bank of England, given its significant new powers, to exercise judgement about whether the banking system is appropriately capitalised. The Treasury Committee will be investigating these issues in more detail during the course of its forthcoming inquiry into bank capital. (Paragraph 130)

Enforcement - The way ahead

27. Andrew Green's assessment that the regulatory regime in place at the time of HBOS's collapse did not encourage ambitious enforcement action is concerning. The Committee agrees. In order to be a credible last line of defence, there must be a perception that regulators are able to undertake even the most challenging and complex of cases. It is to be hoped that the Senior Managers and Certification Regimes will enhance the credibility and fairness of enforcement in future, given that they should lead to much clearer lines of individual responsibility. If the regulators find in future that these changes are not enough to establish a credible enforcement regime, they should say so. (Paragraph 136)
28. The scope of the FSA's original HBOS enforcement investigations was not reasonable. There were also significant procedural failings. In particular, the FSA's Enforcement division formed the view in early 2010 (having not considered the position in 2009) that the statutory threshold test for starting an investigation had been met in the case of Andy Hornby (CEO of HBOS 2006–09), but it decided not to investigate him. However, because of a failure in communication, the Enforcement division never informed Sir Hector Sants of its view that the statutory threshold test for investigating Andy Hornby had been met. (Paragraph 150)
29. The Committee finds this wholly unacceptable. Knowledge of which individuals had met the statutory test for investigation was crucial to allow the FSA's leadership to judge whether the scope of the HBOS enforcement investigations was appropriate. Furthermore, it is clearly unacceptable that important meetings and decisions among Enforcement staff, where major decisions were made concerning the scope of the HBOS enforcement investigations, went unrecorded. These oversights add to

the already extensive evidence that the FSA was not up to the job. It was clearly a highly dysfunctional institution and its legacy continues to pose a major challenge for its successor bodies, particularly the FCA. (Paragraph 151)

30. Improvements in the approach taken to enforcement at the regulator are just as important as the new rules embodied in the Senior Managers Regime. Andrew Green makes several recommendations to deal with the severe procedural failings identified in his report. These include steps to require the regulators in future to retain a far clearer record of which persons have met the statutory threshold test for starting an investigation. It is welcome that the PRA and FCA have already incorporated Andrew Green's recommendations in their recent consultation document. The establishment and performance of a new enforcement decisions committee at the PRA will also be carefully examined by the Treasury Committee in due course. (Paragraph 152)
31. In its final report, the Parliamentary Commission on Banking Standards identified some of the problems that arose as a result of keeping both the enforcement and supervision functions within a single regulator. The PCBS noted that both functions had different objectives which, at times, could be a source of tension, especially if the Enforcement division had to reach judgements about matters in which supervisors were involved at the time. There was also the danger that insufficient priority would be placed on enforcement within a larger organisation, reducing its effect as a credible deterrent. One solution discussed by the PCBS was to place the enforcement function into a separate statutory body. This option was subsequently rejected by a Treasury-led review. (Paragraph 158)
32. Nonetheless, the findings of the Green report reveal that the relationship between enforcement and supervision within the FSA was indeed highly problematic. Keeping both functions within the same organisation did not result in a high degree of co-operation, undermining the argument that the two functions should remain under the same roof. In the light of this, the Committee believes the merits of structural separation bear re-examination. (Paragraph 159)
33. First, the Committee notes that the collapse of HBOS, along with other UK financial institutions during the crisis, was the result of prudential failings. It is far from satisfactory that the bulk of enforcement staff and expertise still lies within the FCA, which has no role in prudential supervision of banks. An independent enforcement function could and should sit equidistant between the PRA and FCA. (Paragraph 160)
34. Secondly, a separate statutory body would bolster the perception of the enforcement function's independence. The current system, whereby the same organisation both supervises, applies and prosecutes the law is outdated and can be construed as unfair. By moving enforcement away from supervision, it can focus independently on undertaking its key functions: interrogating evidence and assessing whether a regulatory breach has been committed. This could increase confidence in the impartiality of regulatory enforcement decisions, and facilitate objective scrutiny of supervisors' actions by enforcement staff. (Paragraph 161)

35. Thirdly, separation would allow all three regulators - the FCA, PRA and an enforcement body - to enjoy much greater clarity over their objectives. There is a danger, especially with the FCA, that its multitude of objectives and initiatives are leading to regulatory overload. An FCA with fewer objectives, and a single separate body responsible for enforcement, would probably result in better accountability and better outcomes. (Paragraph 162)
36. The Committee concludes that the case for structural separation has merit. The Treasury Committee expects the Treasury to appoint an independent reviewer to re-examine the case for a separate enforcement body. (Paragraph 163)

The auditing of HBOS

37. The Financial Reporting Council (FRC) decided not to investigate the auditing of HBOS in 2013, well before the completion of the final HBOS report. This was a serious mistake. The process by which it reached its decision suggests a lack of curiosity and diligence. These failures are all the more concerning given the scale of the problems at HBOS, and the clear public interest at stake. It is extraordinarily unhelpful that the FRC has taken so long and has belatedly reconsidered its position, only after considerable pressure from Parliament and the Treasury Committee. Following its preliminary inquiries, the FRC has now finally commenced an investigation into the auditing of HBOS. (Paragraph 182)
38. The auditing of HBOS is the one major element of the HBOS affair that has yet to be subject to adequate scrutiny. The Committee will expect the FRC to undertake an extremely thorough analysis of the HBOS case. Regardless of the outcome of the FRC's investigation process, it is likely that the Committee will want to consider its work and regulatory approach in more detail. The investigation announced on 27 June 2016 is better late than never. But the very tardy response by the FRC appears to be as inexplicable as it is unacceptable. (Paragraph 183)

Appendix 1: PRA/FCA report - Summary of main findings

- 1) On 1 October 2008 HBOS was approaching a point at which it was no longer able to meet its liabilities as they fell due and so sought Emergency Liquidity Assistance (ELA) from the Bank of England. While the failure of the Group was directly triggered by a lack of liquidity, in large part this reflected underlying concerns about the solvency of the firm - concerns that turned out to be justified.²⁵⁵
- 2) The failure of HBOS can ultimately be explained by a combination of factors:
 - (a) Its Board failed to instil a culture within the firm that balanced risk and return appropriately, and lacked sufficient experience and knowledge of banking.
 - (b) The result was a flawed and unbalanced strategy and a business model with inherent vulnerabilities arising from an excessive focus on market share, asset growth and short-term profitability.
 - (c) This approach permitted the firm's executive management to pursue rapid and uncontrolled growth of the Group's balance sheet, and led to an over-exposure to highly cyclical commercial real estate (CRE) at the peak of the economic cycle, lower quality lending, sizable exposures to entrepreneurs, increased leverage, and high and increasing reliance on wholesale funding. The risks involved were either not identified or, where identified, not fully understood by the firm.
 - (d) There was a failure by the Board and control functions to challenge effectively executive management in pursuing this course or to ensure adequate mitigating actions. HBOS's underlying balance sheet weaknesses made the Group extremely vulnerable to market shocks and ultimately failure as the crisis of the financial system intensified.
 - (e) There was an extended period of inflows of capital to developed economies, resulting in low yields, declining awareness of risk and asset price bubbles, in which market discipline - investors, analysts, rating agencies and other third parties - failed to constrain firms from undertaking risky strategies.
 - (f) An overall systemic crisis in which the banks in worse relative positions were extremely vulnerable to failure. HBOS was one such bank.
- 3) Ultimate responsibility for the failure of HBOS rests with its Board. However, another striking feature of HBOS's failure is how the FSA did not appreciate the full extent of the risks HBOS was running and did not take sufficient steps to intervene before it was too late.
- 4) The FSA Board and executive management failed to ensure that adequate resources were devoted to the supervision of large systemically important firms such as HBOS. This gave rise to:

²⁵⁵ All text in Appendix 1 from PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, p 14-15

- (a) A risk assessment process that was too reactive, with inadequate consideration of strategic and business model related risks;
- (b) Insufficient focus on the core prudential risk areas of asset quality and liquidity in a benign economic outlook; and
- (c) Too much trust being placed in the competence and capabilities of firms' senior management and control functions, with insufficient testing and challenge by the FSA.

Appendix 2: Green report - Summary of main findings

- 1) My conclusion, in summary, is that the scope of the FSA's enforcement investigations in relation to the failure of HBOS was not reasonable. The decision-making process adopted by the FSA was materially flawed; and the FSA should have conducted an investigation, or series of investigations, wider in scope than merely into the conduct of Mr Cummings and the corporate division.²⁵⁶
- 2) In reaching this conclusion, the key points are as follows:
 - (a) The FSA failed to conduct a reasonable decision-making process in the period between December 2008 and 26 February 2009. In particular, the only person whose possible misconduct was given proper consideration for investigation during this period was Mr Cummings (in relation to the corporate division); the FSA gave no proper consideration to the investigation of any other individuals including former members of the Board (such as the former Group Chief Executive Officer, Andy Hornby, and the former Chairman, Lord Stevenson); and the FSA gave no proper consideration to an investigation of HBOS itself.
 - (b) The FSA, in the period after 26 February 2009, failed properly to consider the scope of the existing investigation. After 26 February 2009, the losses and impairments in other areas of the failed bank, particularly the international and treasury Divisions, were of such magnitude that the FSA should have considered other potential subjects for investigation including, in particular, the former Chief Executive Officers of the international and treasury Divisions. It failed to do so.
 - (c) The FSA should have investigated more broadly than simply Mr Cummings and the corporate division given, in particular, that it was aware (both in December 2008, and thereafter) that the problems within the bank at the time of its failure extended well beyond Mr Cummings and the corporate division, and given the public interest in suitably targeted enforcement action following the failure of this systemically important bank. The failure to investigate more broadly was not reasonable.
 - (d) The FSA, at a minimum, should also have investigated Mr Hornby from early 2009 (i.e. in addition to Mr Cummings), and the failure to do so was not reasonable. Further, the decision in March 2010 not to investigate Mr Hornby, even though the FSA rightly considered that the statutory threshold test for investigating his possible misconduct was met, was not reasonable.
- 3) On the positive side:
 - (a) The FSA's decision, in February 2009, to investigate Mr Cummings was a reasonable one.
 - (b) The FSA's decision, in April 2011, to investigate [Bank of Scotland] BoS was a reasonable one. However, the fact that it was not until early 2011 that the FSA first

²⁵⁶ All text in Appendix 2 from Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, pp 4-6

gave proper consideration to enforcement action against the firm (and even then only in relation to the corporate division) highlights the inadequacy of the FSA's decision-making process in the period leading up to 26 February 2009.

- (c) The FSA's decisions, in March and September 2012 respectively, to compromise the disciplinary and/or prohibition proceedings brought against BoS and Mr Cummings were reasonable. Those decisions reflected reasonable judgments as to what was realistically achievable by way of penalty in each case and the inherent litigation risks.

4) Given the inadequacies in the FSA's decision-making processes [...], the FCA and/or the PRA should now consider whether any other former senior managers of HBOS (including, but not limited to, Mr Hornby and Lord Stevenson) should be the subject of an enforcement investigation with a view to prohibition proceedings. There is plainly a public interest in this being considered afresh. In a Report interview, one senior former FSA employee expressed the view that "the people most culpable were let off"; he said that in his view those people were the former Group CEO and Chairman (i.e. Mr Hornby and Lord Stevenson); and he fairly accepted that "there was something unsatisfactory in the [initial] referral decision-making process whereby these people were not even considered" (i.e. for investigation). It is appropriate for this now to be considered afresh by the FCA and/or PRA.

Appendix 3: PRA/FCA report - Summary of recommendations

Management, governance and culture—Board responsibility

1) HBOS's business model was inherently vulnerable to an economic downturn or a dislocation in wholesale funding markets. This was the product of a flawed strategy which was implemented without due regard to basic standards of banking and risk management. Every member of a bank's Board of Directors must take responsibility as part of a collective for ensuring that its business model is sustainable and that the principle of safety and soundness is embedded in the organisation's culture; and directors who hold roles under the Senior Managers Regime will have specific accountabilities within this.²⁵⁷

Board composition

2) A feature of the HBOS Board was its lack of knowledge and experience of banking, which hindered its ability to challenge the firm's Corporate and international divisions effectively. A bank's Board of Directors should include non-executives with a diversity of experience, from inside and outside the banking sector. Moreover they must, between them, have the capacity and motivation to explore and challenge key business issues rigorously with the executives.

Senior management relationships with regulators

3) While the Senior Managers Regime will clarify accountabilities within a bank, it is vital that persons approved under this regime take ownership of their regulatory responsibilities and for executives to establish within their business areas a culture that supports adherence to both the spirit and letter of relevant requirements. They should proactively seek to identify threats to the firm's safety and soundness, and notify regulatory authorities where issues arise - not simply assume that risk management systems are adequate if regulators do not intervene.

Will to act

4) The PRA and FCA have both adopted forward-looking and judgement-led approaches to supervision in seeking to meet their statutory objectives. While it is not the role of the regulators to ensure that no bank fails, where the risks to their objectives are high they have statutory powers to intervene, for example to require a bank to change its business model. Where intervention is warranted, the regulators must be willing and able to do so free from undue influence, in particular when markets are benign and in the face of changing public policy priorities.

Supervision of international groups

5) A significant proportion of HBOS's balance sheet was derived from its overseas operations which grew rapidly during the review period, in particular in Australia and Ireland. While it is necessary for UK regulators of a consolidated international group to

²⁵⁷ All text in Appendix 3 from PRA and FCA, The failure of HBOS plc (HBOS), 19 November 2015, pp 38-39

place reliance on local regulatory authorities, the UK regulators should understand the scope of the oversight provided by the local regulator in determining the extent of that reliance. UK regulators should also have the level of understanding of the international businesses to be able to engage effectively with the firm and the local regulators as consolidated supervisor.

Conflicts of interest

6) UK financial services regulators should also guard against the risks of actual or perceived conflicts of interest arising from the composition of their Boards. The PRA/FCA report found no evidence that Mr Crosby exercised undue influence over the supervision of HBOS from his position as a member of the FSA's Board. However, relevant regulatory authorities should review their conflicts of interest policies to ensure that the risks associated with including serving industry practitioners as non-executive directors on their Boards are adequately managed.

Appendix 4: Green report - Summary of recommendations

1) The Terms of Reference invite me to make recommendations arising out of my findings. I have, therefore, set out below four recommendations. The FCA and the PRA have inherited the FSA's enforcement powers and therefore my recommendations are addressed to both of those regulators (referred to below as 'the Regulators').²⁵⁸

Recommendation 1: Pre-referral decision-making

2) Before making a referral in connection with a particular set of events, the Regulators should identify each firm or individual in respect of whom the statutory threshold test for conducting an investigation is met in respect of those events. The Regulators should create a record of the potential subjects of investigation so identified.

3) Having identified all potential subjects of an enforcement investigation, the Regulators should then decide, by considering the referral criteria, which, if any, of the potential subjects should, in fact, become the subject of an investigation. The Regulators should record the reasons why each potential subject is either being referred, or is not being referred, for investigation.

4) An identified individual (at an appropriate level of seniority) should be made responsible for this pre-referral decision-making process (i.e. from the point in time at which a referral is being considered) and, in particular, for determining the subject(s) for referral and the scope of that referral ('the Decision-Maker').

Recommendation 2: Ongoing dialogue between Enforcement and Supervision during an investigation

5) Following a referral to Enforcement, the Decision-Maker should meet regularly with a representative of the referring department (i.e. Supervision) and a representative of the Enforcement investigation case team. During that meeting the appropriateness of the scope of the ongoing investigation should be discussed. In particular, consideration should be given to (1) any matters that have arisen that might require the scope of the investigation to be reconsidered, and (2) whether there are other subjects in respect of whom the statutory threshold test for conducting an investigation are met and, if so, which potential subjects should be investigated by reference to the referral criteria.

6) Such meetings should take place at least quarterly and should be recorded; and a record should be made of the reasons why any new potential subject is either being referred, or is not being referred, for investigation.

Recommendation 3: Informing the subject of an investigation about the matters under investigation

7) The Memorandum of Appointment of Investigators ('MAI') issued to Mr Cummings did not communicate in any real sense the matters the FSA intended to investigate. By

²⁵⁸ All text in Appendix 4 from Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015, pp 91-92

the time the FSA had issued the MAI, it had already decided in broad terms the subject matter of the proposed investigation and had recorded this, succinctly, in the ERD (see for example the section of the ERD issued to Mr Cumming's entitled 'Summary of potential breaches of legislation or FSA Principles or Rules').

8) Unless the Decision-Maker considers there to be compelling reasons not to do so (such reasons being properly recorded), the Regulators should include within the MAI (or alternatively in a separate document which is also sent to the subject of an investigation) a succinct summary of the potential breaches and a succinct explanation of the matters that are said to give rise to those breaches. The level of detail envisaged is similar to the level of detail contained in the 'Summary of potential breaches of legislation or FSA Principles or Rules'.

9) This recommendation is consistent with the Government's sixteenth recommendation in HM Treasury's 'Review of enforcement decision-making at the financial services regulators: final report': "The government recommends that regulators provide more information within [MAI] or in accompanying documents, as to the basis for a subject's referral to enforcement. In particular, explanations for referral should link expressly to the published referral criteria, to enhance transparency."

Recommendation 4: Accuracy of ExCo minutes

10) The Regulators should put in place a system whereby minutes of ExCo meetings are properly reviewed and approved. The minutes of a meeting must accurately record the discussions and decisions that take place during the meeting as, otherwise, they are of limited use and potentially misleading. It is, therefore, important that a procedure is put in place whereby ExCo minutes are properly reviewed and approved.

Appendix 5: Independent reviewers - Summary of recommendations

Recommendations

- 1) We support the recommendations for firms contained in the Review and think it is important that they find their way into relevant supervisory communications and guidance so that they receive proper attention. However, we note that many regulatory changes have already been made as a result of the financial crisis and collectively these changes intend to address many of the failings identified in the Review.²⁵⁹
- 2) We also support the recommendations for regulators. In our view the ‘will to act’ where it is warranted, even in benign times and against apparently successful firms, is perhaps the most difficult and important future regulatory challenge and in our view this should be a constant area of vigilance for the Boards of the regulators.
- 3) We also make two additional observations which in our view arise from the Review:
 - (a) Stress testing is rightly a key pillar of the current approach to prudential regulation. However, as the Review illustrates, neither HBOS nor the FSA understood the quality of the firm’s assets until it was too late to make any difference. Asset quality encompasses quantitative, qualitative and judgemental elements, and without an accurate understanding of asset quality, stress testing is of fundamentally limited value. We would suggest therefore that it is essential for Boards of firms to ensure that their capital planning and stress testing processes are built on a comprehensive and accurate view of underlying asset quality.
 - (b) As well as a ‘systemic’ failure of regulation and supervision, the Review identifies operational failings in the delivery of supervision which might have been identified by better engagement and more effective oversight on the part of the Board and senior management of the FSA. Whilst regulatory governance has changed significantly with the introduction of the PRA and FCA, we nonetheless think it important that Boards of regulators reflect on the lessons which the Review holds for their own risk management and oversight frameworks to ensure that operational failings of the type identified in the Review do not occur again. The PRA and FCA have recently, and rightly, raised the standards against which Boards and senior management of banks and insurers will be held to account and it could be argued that many of those standards are equally relevant to those charged with governance and oversight of regulators.
- 4) Our final recommendation is that in the unfortunate event that a Review of this type is required in the future, it should be conducted completely independently, begun as quickly as possible after the event and resourced and managed so that it can be completed within a far shorter timescale.

²⁵⁹ All text in Appendix 5 from HBO001

Appendix 6: Timeline of original HBOS enforcement case

Timeline of key enforcement events ²⁶⁰	
Date	Event
2008	
October	HBOS fails
2009	
February	Peter Cummings referred to enforcement
March	FSA appoints investigators
May	FSA Board formally informed of enforcement action
2010	
March	Decision taken not to investigate Andy Hornby
2011	
February	Enforcement serves PIR on Peter Cummings
April	Enforcement submits case to RDC
May	Lloyds informed that BoS referred to enforcement
June	RDC issues warning notice to Peter Cummings
September	RDC issues warning notice to BoS
November - December	Peter Cummings and BoS submit response to RDC
2012	
March	Case against BoS settled, oral representations held at RDC in Peter Cummings' case
May - June	RDC issues decision notice. Counsel to Peter Cummings indicates intention to pursue judicial review
September	Final notice issued in Peter Cummings case

²⁶⁰ Source: Andrew Green QC, Report into the FSA's enforcement actions following the failure of HBOS, 19 November 2015

Formal Minutes

Monday 18 July 2016

The Rt Hon Andrew Tyrie MP, in the Chair

Members present:

George Kerevan Mr Jacob Rees-Mogg
Chris Philp

Draft Report (*Review of the reports into the failure of HBOS*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 183 read and agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No.134.

[Adjourned till Tuesday 19 July at 9.00am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 14 December 2015

Question number

Andrew Green QC, Independent Reviewer of FSA Enforcement Actions into HBOS [Q1–52](#)

Iain Cornish, Independent Reviewer/Committee Specialist Adviser, and **Stuart Bernau**, Independent Reviewer/Committee Specialist Adviser [Q53–97](#)

Tuesday 15 December 2015

Andrew Bailey, Chief Executive Officer, Prudential Regulation Authority, and **Sir Brian Pomeroy**, Non-Executive Director, Financial Conduct Authority [Q98–204](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

- 1 Stuart Bernau and Iain Cornish ([HBO001](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Reappointment of Robert Chote as Chair of the Office for Budget Responsibility	HC 459
Second Report	The appointment of Dr Gertjan Vlieghe to the Monetary Policy Committee of the Bank of England	HC 497
Third Report	The re-appointment of Ian McCafferty to the Monetary Policy Committee of the Bank of England	HC 498
Fourth Report	Appointment of Tim Parkes as Chair of the Regulatory Decisions Committee	HC 735
Fifth Report	Appointment of Angela Knight as Chair of the Office of Tax Simplification	HC 734
Sixth Report	Spending Review and Autumn Statement 2015	HC 638
Seventh Report	Reviewing the Office for Budget Responsibility	HC 514
Eight Report	The Treasury Committee's scrutiny of appointments	HC 811
Ninth Report	Re-appointment hearing of Dame Clara Furse and Richard Sharp	HC 895

Session 2016–17

First Report	The economic and financial costs and benefits of the UK's EU membership	HC 122
Second Report	Appointment of Jon Thompson as Chief Executive of HMRC	HC 232
Third Report	Appointment of Edward Troup as Executive Chair of HMRC	HC 498