UNITED NATIONS DISPUTE TRIBUNAL

Case No.: UNDT/NBI/2022/066
Judgment No.: UNDT/2023/034
Date: 25 May 2023
Original: English

Before: Judge Francesco Buffa

Registry: Nairobi

Registrar: Abena Kwakye-Berko

YAGOUT

v.

SECRETARY-GENERAL
OF THE UNITED NATIONS

JUDGMENT ON LIABILITY

Counsel for the Applicant:
Self-represented

Counsel for the Respondent:
Esther Shamash, UNDP

Introduction

1. The Applicant, an Executive Assistant with the United Nations Development Program ("UNDP"), holding a fixed-term appointment at the G-5 level and based in Sana'a, Yemen, challenges the decision to dismiss him from service of the Organization.

Facts and procedural background

2. The Applicant was separated from service with compensation *in lieu* of notice, pursuant to staff rules 10.1(a) and 10.2(a)(viii), and without termination indemnities. He was dismissed from service of the Organization for submitting three health insurance claims to Cigna which were fraudulent.

3. Locally recruited staff outside Headquarters with a UNDP appointment, like the Applicant, have health insurance for themselves and their family under the Medical Insurance Plan ("MIP"). The MIP is a self-insurance plan, which the insurance company Cigna administers on behalf of UNDP, reviewing claims submitted by, and processing reimbursements to, insured claimants. UNDP is responsible for covering the costs of any reimbursements Cigna processes, so any loss attributable to reimbursements by Cigna represents a direct loss to UNDP.

4. Since 27 June 2013, the Applicant had been enrolled in Cigna's MIP. His spouse, Ms. NAY was also enrolled in this plan as the Applicant's dependent.

5. There were three claims submitted to Cigna on behalf of the Applicant, respectively on 1 November 2018, 17 March 2019, and 12 April 2021.

6. The Applicant's wife submitted the first claim, in her name, for two hearing aids. That invoice was for USD900. The Applicant submits that he became aware of this claim during the investigation by the Office of Audit and Investigations ("OAI").

7. The Applicant submits that he was also unaware of the second claim that was submitted in his wife's name for USD5,794.43.

8. The third claim was for a 14-day COVID treatment package for USD12,853.10. This claim in 2021 was in the Applicant's name.

9. On 1 July 2021, Cigna reported allegations that the Applicant had submitted fraudulent medical claims. UNDP/OAI assessed the complaint and conducted a formal investigation.

10. On 6 August 2021, OAI notified the Applicant that he was the subject of an investigation. He was interviewed on 12 August 2021.

11. On 30 September 2021, OAI sent the Applicant the draft Investigation Report.

12. On 3 October 2021, the Applicant sent his comments and additional evidence. Upon review of the comments and evidence, OAI revised the Investigation Report.

13. On 2 March 2022, the Applicant was charged with entitlement fraud and given time to respond to the charges, which he did. UNDP concluded that the charges were substantiated and on 22 June 2022, the Applicant was informed that the Associate Administrator had decided to impose the sanction of dismissal.

14. On 8 August 2022, he filed an application before the Dispute Tribunal sitting in Nairobi to challenge the Respondent's decision to dismiss him from service of the Organization.

15. The Respondent filed his reply on 7 September 2022.

16. On 17 February 2023, the Tribunal issued Order No. 046 (NBI/2023) finding that the case could be adjudicated on the basis of the case record, without holding a hearing, and inviting the parties to file their respective closing submissions.

17. On 16 March 2023, the parties filed their submissions as directed.

Parties' submissions

18. It is the Applicant's case that the impugned decision was "reckless, exaggerated, and arbitrary given the fact that the staff member did not commit direct misconduct." He was entirely unaware that his wife had submitted those claims and was fully cooperative in the investigations. The Applicant submits that the third claim was entirely legitimate.

19. He also submits that the Organization acted unfairly in dismissing him from service. An informal resolution of the dispute between him and Cigna should have been attempted for a "reasonable solution." His impeccable performance and work ethic should have been considered in mitigation when the impugned decision was being made.

20. The Respondent's position is that the impugned decision was both appropriate and proportionate, and therefore lawful.

21. The 2018 claim was certified as correct and true, but the vendor never issued an invoice for this sale and had no record of a sale of hearing aids for Ms. NAY. The Applicant states that the Respondent does not dispute that this claim was fraudulent and admits receipt of the reimbursement of USD600 from Cigna.

22. The investigation revealed that the second claim was also false. Lebanon Hospital has no record of having treated the Applicant's wife for the condition named in the invoice, nor is there a record of an invoice being issued in the Applicant's wife's name for the amount claimed. In respect of this claim, the Applicant conceded that he received "approximately US$5,000" as reimbursement from Cigna.

23. The Applicant told investigators that he signed both claims and was reimbursed for them. His contention before the Tribunal that he was unaware that his wife had submitted these claims is different from what he told the investigators and is not credible.

24. The Applicant submitted a claim for 9,100.00 Jordanian Dinars (equivalent to USD12,853.10) based on an invoice for a COVID treatment package from Istiklal Hospital in Amman, Jordan, which bore the name of Dr. Mohammad Salem Al-Najjar on 12 April 2021. The evidence and the investigation reveal that this claim was also false. Mr. Fawaz Daoud, Finance Director, Istiklal Hospital told OAI that this invoice was not authentic; that the stamp on the invoice was fake; that there was no doctor named Dr. Mohammed Salem Al-Najjar employed at the hospital; and that they had no record of the Applicant on file.

25. When speaking to the investigators, the Applicant informed them that "[he] did not know that the invoice that was given to [him] was not authentic at that time. It was only until the investigation that [he] realized that [he] was robbed and defrauded." His submission to the Tribunal is entirely different; he also does not address the evidence provided by the Hospital.

26. The Applicant's statements to the investigators are at complete variance to his submissions before the Tribunal. Further, the Applicant does not address or refute the evidence of the hearing aid vendor and Lebanon Hospital which prove that the 2018 and 2019 claims were fraudulent.

27. It is the Respondent's case that there is sufficient and cogent evidence, that is both clear and convincing, to support the charges preferred by the Organization.

Considerations

Standard of review

28. In reviewing a disciplinary measure, the Dispute Tribunal should determine: (a) whether the alleged facts have been established; (b) whether the established facts constitute misconduct; (c) whether the disciplinary measure is proportionate to the offence; and (d) whether due process was respected (see *Molari* 2011-UNAT-164 and *Masri* 2010-UNAT-098).

(a) Whether the alleged facts have been established

29. The application is ill-founded.

30. The evidence on records supports the charge that the Applicant engaged in entitlement fraud by claiming healthcare expenses he had not incurred.

31. First of all, the Tribunal is of the view that the Applicant is responsible for all the reimbursement claims to Cigna.

32. While the Applicant admitted that he himself presented the third claim, the Applicant's claim that it was his wife, not he, who submitted the first two claims to Cigna contradicted his statements to the OAI investigators during his interview. In any case, this fails to address the undisputed fact that Cigna has a password-protected online claim system for receiving and processing claims. If the Applicant's wife had access to the Applicant's credentials and password for the Cigna platform, that could only be because the Applicant provided her with those credentials, so the Applicant was responsible for the fraud that was perpetrated as a result.

33. In any case, by the declaration to Cigna on the veracity of the claims, and by certifying that the documents were correct and true, the Applicant assumed any responsibility for the reimbursement claim.

34. It is also decisive to consider that the Applicant directly benefitted from the fraud, given that, as the Applicant admitted to OAI in his interview, the reimbursements went into his bank account. Moreover, the fact that the Applicant was the only person to benefit further undermines his claim that his wife committed the fraud without his knowledge.

35. The evidence on record establishes that the invoices were not authentic.

36. As to the first reimbursement claim, related to hearing aid devices from a company called "Atwar for Hearing Care" ("Atwar") in Sana'a, Yemen, the Atwar Executive Manager, stated that the document submitted to Cigna was not an invoice

establishing proof of purchase, but only a limited time offer at a specific price. He also indicated that Atwar had no record of a sale associated with this offer, meaning that the Applicant did not incur this expense.

37. As to the second reimbursement claim, the Hospital in Lebanon confirmed that the invoice submitted to Cigna had not been issued by the hospital, and that the patient, Ms. NAY, had not received the treatment.

38. As to the third reimbursement claim, that the Applicant directly submitted, based on an invoice for a Covid treatment package from Istiklal Hospital in Amman, Jordan, which bore the name of Dr. Mohammad Salem Al-Najjar, the record shows that Mr. Fawaz Daoud, Finance Director, Istiklal Hospital, told OAI that: this invoice was not authentic; that the stamp on the invoice was fake; that there was no doctor named Dr. Al-Najjar employed at the hospital; and that there was no record of a patient by the Applicant's name on their file.

39. The Applicant did not rebut any of the above-mentioned statements and did not provide any evidence to contrast it, showing that the medical intervention occurred, that there was payment requested by a real invoice, and that he paid the invoices.

40. Altogether the evidence is clear and convincing that the Applicant engaged in entitlement fraud. He falsely certified and submitted three Cigna claims; for which he was paid a total of USD17,171.26. He was not entitled to this reimbursement. As UNDP is self-insured, these funds represent a loss to UNDP.

41. This is enough to substantiate the accusation of having used false documents to receive improper and undue economic benefits from Cigna.

42. The United Nations Appeals Tribunal ("UNAT") in *Asghar* 2020-UNAT-982, paras. 35-36, laid down the essential elements to establish the charge of fraud and the applicable standard of proof:

> A finding of fraud against a staff member of the Organization is a serious matter. Such a finding will have grave implications for the staff

> member's reputation, standing and future employment prospects. For that reason, the UNDT generally should reach a finding of fraud only on the basis of sufficient, cogent, relevant and admissible evidence permitting appropriate factual inferences and a legal conclusion that each element of fraud (the making of a misrepresentation, the intent to deceive and prejudice) has been established in accordance with the standard of clear and convincing evidence. In other words, the commission of fraud must be shown by the evidence to have been highly probable. Fraud consists in the unlawful making, with the intent to defraud or deceive, of a misrepresentation which causes actual prejudice, or which is potentially prejudicial, to another.

43. In this case, the Tribunal finds that there is clear and convincing evidence that the Applicant submitted fraudulent medical claims for medical services that had not occurred.

(b) Whether the established facts constitute misconduct.

44. In the Tribunal's view, the Applicant's behavior falls within what the UNDP Policy against Fraud and other Corrupt practices (approved in October 2018) defines as fraud, which includes any act or omission whereby an individual knowingly misrepresents or conceals a fact to obtain an undue benefit or advantage. The Fraud Policy also provides as an example of fraud: "providing information in relation to a medical insurance claim or another entitlement that the claimant knows to be false."

45. Therefore, the established facts constitute misconduct.

(c) Whether the disciplinary measure is proportionate to the offence.

46. The Applicant has not challenged the proportionality of the measure. The Tribunal finds that the measure imposed was reasonable and not disproportionate.

47. The Tribunals have consistently ruled that misconduct involving intentional and deceptive conduct, particularly for personal gain, merit the most severe sanctions such as separation from service or dismissal.

48. Such measures have been found proportionate in cases of fraudulent conduct as "fraud undermines the very integrity of the Organization" (*Jaber et al* 2016-UNAT-634, 27).

49. In *Diallo* UNDT/2021/064, the Tribunal held:

> The practice of the Organization in cases involving staff submitting false claims for reimbursement of medical expenses is consistent in that disciplinary measures have been imposed at the strictest end of the spectrum, namely, separation from service or dismissal in accordance with staff rule 10.2(a). (See also *Madhi* 2010-UNAT-018).

(d) Whether due process was respected

50. Finally, the Tribunal notes that the Applicant's due process rights were respected during the investigation and disciplinary process. The Applicant has not submitted otherwise.

Conclusion

51. In light of the above, the application is dismissed.

(Signed)

Judge Francesco Buffa

Dated this 25th day of May 2023

Entered in the Register on this 25th day of May 2023

(Signed)

Abena Kwakye-Berko, Registrar, Nairobi