UNITED NATIONS DISPUTE TRIBUNAL

Case No.: UNDT/NBI/2025/071
Judgment No.: UNDT/2025/083
Date: 6 November 2025
Original: English

Before: Judge Sean Wallace

Registry: Nairobi

Registrar: Wanda L. Carter

BUBEGA

v.

SECRETARY-GENERAL
OF THE UNITED NATIONS

JUDGMENT

Counsel for Applicant:
Ana Giulia Stella, OSLA

Counsel for Respondent:
Wei Zhuang, DAS/ALD/OHR, UN Secretariat
Talha Konukpay, DAS/ALD/OHR, UN Secretariat

Introduction

1. The Applicant is a former Disarmament, Demobilization and Reintegration Assistant working with the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo ("MONUSCO").

2. On 11 July 2025, he filed an application contesting the Administration's decisions to recover the amount of USD23,677.19 following an investigation against him. The Applicant also requests that his name be removed from "ClearCheck", a United Nations screening database.

3. The Respondent filed a reply on 15 August 2025 arguing that the contested decisions are lawful.

4. Pursuant to Order No. 148 (NBI/2025), the Tribunal determined that an oral hearing was not necessary for adjudication of the case and directed the parties to file closing submissions, which they did on 15 September 2025.

Facts

5. The factual background of this case is very similar to that in an earlier application filed by the Applicant, Case No. UNDT/NBI/2024/047 ("*Bubega I*"). The facts of that case relevant to the present case are reproduced below.

6. On 30 December 2020, the Finance Division of the Department of Management Strategy, Policy and Compliance ("DMSPC") submitted to the Investigations Division of the Office of Internal Oversight Services ("OIOS") a report of possible misconduct relating to medical insurance claims for the Applicant in the amount of USD23,677.19.

7. On 28 July 2021, OIOS visited a Medical Service Provider ("MSP") in Bukavu, Clinique Saint Luc de Bukavu ("CSL/BKV"), and met with CSL/BKV's Medical Director. OIOS provided him with a list of provider claims[1] including those

[1] Under the United Nations Medical Insurance Plan ("MIP"), claims can be submitted directly by the Medical Service Provider ("MSP') or by the staff member for reimbursement if the bill was

of the Applicant; however, the Medical Director could not find the Applicant's medical documents during the OIOS visit.

8. On 31 July 2021, the CSL/BKV Medical Director sent OIOS several emails providing various documents regarding the Applicant's medical treatment.

9. On 13 August 2021, OIOS interviewed the Applicant as a subject of the investigation.

10. On 31 December 2023, the Applicant separated from the Organization after 17 years of service having reached the mandatory retirement age. The Administration withheld the Applicant's pension benefits because it did not release his pension forms to the United Nations Joint Staff Pension Fund ("UNJSPF").

11. On 24 January 2024, MONUSCO Human Resources informed the Applicant that they would put his final payment processing on hold pending completion of the medical insurance investigation.

12. On 12 July 2024 the Applicant filed *Bubega I* contesting the 24 January 2024 decision delaying the issuance of his P.35 and PF.4 pension forms until the conclusion of the OIOS investigation.

13. On 9 August 2024, the Office of Human Resources ("OHR") sent the Applicant a memorandum setting out formal allegations of misconduct ("Allegations Memorandum") and a letter from the Assistant Secretary-General ("ASG/OHR") requesting him to indicate if he was willing to cooperate with a post-separation disciplinary process and to keep the documentation provided to him in the disciplinary process confidential. He agreed to cooperate.

14. The Applicant responded to the allegations on 15 October 2024.

15. On 12 April 2025, the USG/DMSPC concluded that,

> (i) it is established, by a preponderance of the evidence, that you failed to notify Cigna or the Organization of a false provider claim

paid by the staff member. The former are referred to as "MSP claims" while the latter are called "Plan Member claims".

> concerning your treatment; and (ii) the remaining allegations against you are established by clear and convincing evidence; (iii) your conduct is in violation of staff regulations 1.2(b) and 1.2(q), as well as section 10.1 of ST/AI/2015/3; (iv) your conduct amounts to serious misconduct; (v) in view of the facts established, the requirements of staff rule 10.1(b) are met regarding a financial loss in the amount of US$ 23,677.19, in that your actions have been determined to be at least grossly negligent; and (vi) your procedural fairness rights were respected throughout the investigation and the disciplinary process.
>
> On the basis of the foregoing considerations and as more fully set out in the Annex to this letter, the USG/DMSPC has determined that, had you remained in the service of the Organization, you would have received the disciplinary measure of, at least, separation from service with compensation in lieu of notice, and without termination indemnity, in accordance with staff rule 10.2(a)(viii), effective upon your receipt of this letter. As a consequence of this decision, you will be listed in ClearCheck, a highly secure centralized database that contains the names of individuals who have a record of serious misconduct. The database may be accessed by UN System organizations, for reference checking purposes.
>
> Further, the USG/DMSPC has found that you are required to reimburse the Organization for the financial loss suffered by the Organization in the amount of US$ 23,677.19, in accordance with staff rule 10.1(b). Therefore, the USG/DMSPC has decided that the amount of US$ 23,677.19 will be recovered from you, in accordance with staff rule 10.2(b)(ii).

This is the contested decision in this case.

16. The Applicant filed this application challenging the contested decision on 11 July 2025.

Parties' submissions

17. The Applicant's principal contentions are:

a. The factual basis for the post-separation sanction imposed on him has not been established to the requisite standard.

b. The investigation presented a misleading narrative crafted to support a predetermined conclusion.

c. The presented materials do not constitute clear and convincing evidence that he was involved in providing false medical claims.

d. He had no control over which documents the Organization's Medical Insurance Plan ("MIP"), Cigna, received, and he placed trust in CSL/BKV as a legitimate and serious medical facility.

e. The sanction of separation and reimbursement of funds that he did not receive (Cigna paid the clinic) is arbitrary, unduly harsh and grossly disproportionate.

f. The investigation and disciplinary process against him did not respect his due process rights, primarily as a result of the prolonged delay in the investigation.

g. He did not participate in any coordinated effort with CSL/BKV to defraud Cigna.

18. The Respondent's principal contentions are:

a. The submission of 12 false provider claims implicated the Applicant by his unequivocal confirmation that he received the treatments in his email to Cigna on 24 September 2019, in relation to seven of the 12 false provider claims, and during his interviews with OIOS, when confronted with medical documents, regarding the remaining five claims.

b. The Applicant unambiguously stated that all treatments were correct when he was inquired by Cigna about the authenticity of seven selected treatments.

c. The Umoja records, car logger records and the witness statement of his supervisor clearly and convincingly show that the Applicant reported for work during the purported hospitalization periods.

d. The Applicant admitted to having signed four blank invoices for two MSPs, CSL/BKV and SH who actively engaged in the medical insurance

fraud scheme. By affixing his signature to these blank documents, the Applicant enabled the MSPs to submit false provider claims for his purported treatments, without exercising any due diligence to review or verify the content of the completed documentation thereafter.

e. Even if the Applicant did not actively engage in the submission of the false provider claims, he remains liable for the improper use of the documents he signed, thereby assuming full responsibility for their improper utilization.

f. With respect to another two claims, the Applicant does not dispute their falsehood, asserting that CSL/BKV might have submitted them without his knowledge. However, the Applicant failed to duly notify Cigna or the Organization of these two false claims, despite receiving notification of them.

g. The remaining claim was established at least on a preponderance of the evidence that the claim is false and the Applicant failed to duly notify Cigna or the Organization of the false claim, despite receiving notification from Cigna of it.

h. The Administration correctly determined that the Applicant's actions amount to serious misconduct.

i. The sanction is proportionate to the offence.

j. The Applicant's rights to due process were respected.

Considerations

19. According to art. 9.4 of the Tribunal's Statute, in reviewing disciplinary cases,

> the Dispute Tribunal shall consider the record assembled by the Secretary-General and may admit other evidence to make an assessment on whether the facts on which the disciplinary measure was based have been established by evidence; whether the established facts legally amount to misconduct; whether the applicant's due process rights were observed; and whether the disciplinary measure imposed was proportionate to the offence.

20. In *Sanwidi* 2010-UNAT-084, para. 40, the Appeals Tribunal clarified that:

> When judging the validity of the Secretary-General's exercise of discretion in administrative matters, the Dispute Tribunal determines if the decision is legal, rational, procedurally correct, and proportionate. The Tribunal can consider whether relevant matters have been ignored and irrelevant matters considered and also examine whether the decision is absurd or perverse.

21. The Appeals Tribunal, however, underlined that "it is not the role of the Dispute Tribunal to consider the correctness of the choice made by the Secretary-General amongst the various courses of action open to him", or otherwise "substitute its own decision for that of the Secretary-General". *Id*. In this regard, "the Tribunal is not conducting a "merit-based review, but a judicial review", explaining that a "judicial review is more concerned with examining how the decision-maker reached the impugned decision and not the merits of the decision-maker's decision." *Id*., at para. 42.

Were the facts upon which the contested decision was based established?

22. In this case, the parties both agree that the facts must be established by clear and convincing evidence. Thus, this standard will be applied to the analysis.

23. As per the sanction letter dated 12 April 2025, the contested decision was based on a determination that:

a. The Applicant was involved in the submission of 12 false provider claims (claim numbers 2, 4 - 14) by confirming them either in his email to Cigna on 24 September 2019, or during his interviews with OIOS, whereas he reported for work as indicated by his Umoja records, car logger records and his supervisor's statements to OIOS.

b. There is clear and convincing evidence that the Applicant failed to duly report two false provider claims (claim numbers 1 and 3).

c. There is preponderance of evidence that the Applicant failed to duly report (claim number 15).

d. There is clear and convincing evidence that the Applicant signed blank invoices for MSPs.

A) Submission of 12 false provider claims

24. In his rebuttal of the determination that he submitted 12 false provider claims, the Applicant submits:

a. The medical documentation related to the 12 claims was submitted directly by CSL/BKV and he had no control over which documents were provided to Cigna. As such, any discrepancies in the submitted documentation cannot be attributed to him.

b. With respect to his email of 24 September 2019, he did not undertake a detailed verification of each claim prior responding to Cigna's enquiry of 17 September 2019. At that time, he had no reason to question the reliability of CSL/BKV, which had been used both by him and his family. His response was based on good faith and reflected his general acknowledgement of using the facility, not a detailed audit or confirmation of each transaction.

c. Car logger data similarly does not rise to the level of clear and convincing evidence against him. The data is not consistently reliable and cannot be used as definitive proof of his physical presence during the periods in question. He frequently left his driver permit in the office vehicle, and it was not uncommon for other staff members to use it in his absence. This undermines the credibility of using logger data to directly link car movement to him personally.

25. The details of all the claims are summarized in a table contained in the sanction letter which is reproduced below:

No.	Facility	Claim date	Admission	Discharge	Claim (US$)	Paid (US$)
1	CSL/BKV		3-Jun-15	8-Jun-15	2,485.20	1,665.09
2		23-Nov-15	23-Aug-15	28-Aug-15	1,087.45	728.59
3		5-Apr-16	1-Feb-16	16-Feb-16	3,857.30	3,857.30
4		24-Nov-16	11-Sep-16	11-Sep-16	421.00	267.12
5		22-Feb-17	7-Dec-16	13-Dec-16	2,436.40	2,192.76
6		4-Apr-17	26-Jan-17	31-Jan-17	2,554.40	2,298.96
7		7-Apr-17	28-Feb-17	5-Mar-17	2,146.40	1,931.76
8		10-Aug-17	13-Jun-17	13-Jun-17	445.00	320.40
9		25-Aug-17	7-Jul-17	11-Jul-17	1,435.40	1,148.32
10		29-Aug-18	1-Feb-18	8-Feb-18	5,808.80	4,240.42
11		24-Sep-18	16-Feb-18	16-Feb-18	311.00	199.04
12		17-Oct-18	14-Aug-18	18-Aug-18	2,839.12	2,011.30
13		7-Nov-19	28-Sep-18	28-Sep-18	432.00	276.48
14		27-Mar-19	15-Feb-19	22-Feb-19	3,312.76	2,243.33
15		15-Apr-19	31-Mar-19	31-Mar-19	463.00	296.32
Total					**29,572.23**	**23,677.19**

26. The Applicant confirmed that he received the treatment giving rise to these claims, either in an email to Cigna on 24 September 2019 or in his interviews with OIOS. As noted above, most of these claims were for lengthy hospital admissions including seven for a week or longer.

27. However, UMOJA records showed that the Applicant reported for work during these periods, even when the claim was for hospitalization for multiple days. (These records were certified by the Applicant to be correct.) Car logger records show that the Applicant's driver's permit was used to operate United Nations vehicles during four of the treatment periods (claims numbers 5, 6, 8 and 14). The Applicant's supervisor said that the Applicant had not been ill or hospitalized prior to 2020 and that the Applicant did not inform him of any hospitalization during the period of the claims.

28. The information also showed that CSL/BKV submitted an unusually high number of claims for the Applicant and/or his family (119 claims between 2015 and 2020).

29. The Applicant claims that both the UMOJA leave records and the car logger data are unreliable. However, this claim is unsupported by any evidence (beyond his *ipse dixit*) and does not make sense.

30. Specifically, he says that leave dates were often communicated verbally rather than officially recorded and that, like many of his colleagues, he did not consistently enter his sick leave days in Umoja. As for the car logger data, he says that he frequently left his driver permit in the office vehicle, and it was not uncommon for other staff members to use it in his absence. This undermines the credibility of using logger data to directly link car movement to him personally.

31. The Applicant's argument regarding the inaccuracy of UMOJA records ignores the fact that he was required to certify, both monthly and annually, that the records were accurate as required by ST/AI/1999/1 (Recording of attendance and leave). Since the records at issue were certified, he cannot now dispute their accuracy.

32. Similarly, the Applicant's argument regarding the car logger data is premised on his assertion that he knowingly permitted others to use his driver permit to access an official vehicle. This practice, if true, would violate MONUSCO/AI/2015/22 (Regulations governing the use of MONUSCO issued Driving Permits). In that regard, the Chief of Transport Section in Goma, MONUSCO, told OIOS that lending a driver's permit or starting a United Nations vehicle for another person is strictly forbidden. The Applicant has not refuted this averment. In sum, the Applicant's assertion does not undermine the credibility of the logger data - it undermines the Applicant's credibility.

33. Next, the Applicant rejects the statement from his supervisor regarding his presence/lack of absence on the dates in question because he claims that the supervisor was not the person who approved his absences. In his interview, the Applicant described the process as follows: "I'm sending the message to my

colleague who works from the administration. And I'm giving him my password of Umoja. And he's doing it." However, the Applicant has not identified that person, and when asked to provide the email or message wherein he sent the colleague his UMOJA password, the Applicant changed his story to say these communications were done via phone call.

34. Additionally, this story contradicts the Applicant's interview statement that "[i]n our office, we need to ask our supervisor which date we want to go on leave, when he says that it's okay, you need to do your demand, send your demand and if its approved you can leave … You're doing your leave request and there is a table you show that and you need to choose, which supervisor need to approve." This is consistent with staff rule 6.2(g) and ST/AI/1999/13 which require the Applicant to inform his supervisor of any "absences for reasons of health." By his own admission, the Applicant's supervisor is an integral part of the sick leave approval process and would know about his absences. Thus, the Tribunal rejects this argument.[2]

35. The Applicant next asserts that the medical documentation related to the 12 claims was submitted directly to Cigna by CSL/BKV and that any discrepancies in the submitted documentation cannot be attributed to him. However, the record shows that Cigna contacted the Applicant on 17 September 2019 as part of a random verification process and asked him to confirm whether the admissions set out in claim numbers 5, 6, 7, 9, 10, 12 and 14 actually took place. The Applicant responded a week later confirming those admissions: "I have just received your message confirming medical care for my dependants. I admit that this is the only medical facility I often use for my care and that of my dependants, and all the care is accurate."

36. Further, in his OIOS interviews, the Applicant also confirmed the admissions giving rise to claim numbers 2, 4, 8, 11 and 13. With his confirmations, the

[2] In his second interview with OIOS on 8 March 2024, the Applicant stated that he had been hospitalized on 13 June 2017 after fainting at work. It is inconceivable that the supervisor would not know if the Applicant had fainted at work, requiring hospitalization.

Applicant verified the claims and vouched for them. The Applicant cannot now disclaim any knowledge of the veracity of these claims.

37. The Tribunal finds that it has been established by clear and convincing evidence that the Applicant submitted 12 false provider claims.

B) Failure to report two false provider claims (claim numbers 1 and 3).

38. In the sanction letter, the Organization found that the Applicant had failed to notify either Cigna or the Organization of two false provider claims (claim numbers 1 and 3), although he had been notified of these claims. Specifically, it found that automatic notifications from Cigna were sent to the Applicant's United Nations email address giving details of these claims; that the Applicant admitted that he logged into the Cigna account twice monthly to check on invoices and reimbursements; that the Applicant did not dispute that claims 1 and 3 were false; and that he did not explain why he failed to notify either Cigna or the Organization of these false claims. The sanction letter also referenced UMOJA and car logger records showing that the Applicant was present at work on the dates in question.

39. In response to this allegation, the Applicant repeats the same rebuttals as examined above, which are again rejected in this context. Moreover, the Tribunal finds it simply incredible that the Applicant, who claims to check the claims online regularly, would overlook these two claims for lengthy hospital stays. Claim number 1 covered the period of 3 to 8 June 2015 (six days) at a cost of USD2,485.20. Claim number 3 covered the period of 1-16 February 2016 (16 days) at a cost of USD3,857.30. Claims of these amounts and for these lengthy admissions would stand out to the alleged patient reviewing them and certainly would cause further inquiry or reporting.

40. It is notable that the Applicant does not dispute the falsehoods of these claims. Again, the Applicant fails to address his legal obligation to ensure that all claims and supporting documents submitted to Cigna are accurate in his rebuttal. In this respect, section 10.1 of ST/AI/2015/3 (Medical insurance plan for locally recruited staff at designated duty stations away from Headquarters) provides:

> The subscriber and his or her enrolled family members are expected to fully comply with the present administrative instruction and the member plan description document of the third-party administrator. Since the health insurance coverage is provided to eligible family members upon the request of the staff member or retiree, he or she is responsible for ensuring that all claims submitted, including those relating to services for family members, are accurate, complete and comply with MIP rules. Accordingly, the staff member or retiree shall be held ultimately responsible for any acts committed by his or her covered family members to fraudulently obtain, attempt to obtain or abuse the benefits under MIP.

41. In view of this evidence, the Tribunal finds that there is clear and convincing evidence that the Applicant failed to report the two false claims, Claim Numbers 1 and 3.

C) Failure to report claim number 15.

42. In the sanction letter, the Organization found it established by a preponderance of the evidence that the Applicant failed to notify Cigna or the Organization of a false provider claim (claim number 15) for hypertension services allegedly rendered on 31 March 2019. This was based on the following facts:

a. The Applicant's statements during his first interview with OIOS that he could not confirm the treatment;

b. The automatic notifications were sent to the Applicant's United Nations email address when a claim was submitted, and he was able to see all claim information online;

c. An informative report from Cigna's Fraud Investigation Unit ("FIU") indicating that CSL/BKV colluded with MONUSCO staff and that fictitious invoices were systematically submitted for treatments that could not have taken place;

d. Information that CSL/BKV submitted an "unusually high" number of claims for treatment of the Applicant's family amounting to more than USD170,000;

e. A Cigna settlement note showing that Cigna paid the clinic a total of USD296.32 for this claim, which is the amount of financial loss suffered by the Organization in relation to this claim;

f. The Applicant's confirmation, in his second OIOS interview and his comments to the allegations of misconduct, that he recalled being treated for hypertension in 2019, which the Administration found to be not credible because of his inability to confirm the claim during his first interview;

g. The "claim for medical expenses totalling USD463.00 is unusually high for an outpatient day treatment;"

h. The Applicant's supervisor did not recall his having been sick during the period of alleged treatment and there are no certified Umoja records for the date of treatment "as it fell on a weekend;" and

i. The Applicant did not dispute that he had signed three blank invoices for CSL/BKV, "which strongly suggested that he facilitated or, at least, turned a blind eye to submission of false provider claims."

43. The Applicant takes issue with the Administration's credibility determination (para. 41(f) above) saying that his "later recollection of a hypertension treatment in 2019 should be seen as a good-faith effort to clarify the record – not as evidence of inconsistency."

44. The Applicant also argues that he had no control of the documents submitted directly to Cigna by CSL/BKV; that the Cigna FIU report was not direct evidence against the Applicant; and that he signed blank invoices because he placed trust in CSL/BKV and thought that signing these invoices was a routine administrative procedure.

45. In reviewing this evidence, the Tribunal notes that, in contrast to claim numbers 1 and 3, the Applicant did not admit that claim number 15 was fraudulent. Also, no Umoja or car logger records prove the claim was fraudulent by placing the Applicant at work when the alleged treatment took place. So, the question becomes:

what evidence is there that the claim was fraudulent, which is a necessary element of this allegation? The Tribunal finds that there is none.

46. With respect to this allegation of misconduct, the Administration's finding seems to be based on mere suspicion and surmise. For example, Cigna's conclusion that CSL/BKV colluded with MONUSCO staff does not tell a factfinder whether this particular claim was the product of collusion. Nor does the "unusually high" number of claims for CSL/BKV treating the Applicant or his family. At best they raise suspicions that justify further inquiry.

47. The information about the amount of the claim (USD463.00) and the amount paid to CLS/BKV (USD296.32) also does not amount to evidence that the claim was fraudulent.

48. Similarly, the Applicant's ability to access Cigna claim information tells us only that he could see whether a claim was fraudulent; not whether this claim was fraudulent.

49. The Tribunal agrees with the Applicant that the Administration's credibility assessment was strained. His statement in the first OIOS interview is "For the questions with the treatment here, I cannot say … I cannot know the medicine they gave me." This answer is understandable when first confronted with a claim (out of 119 total alleged submitted by CSL/BVK for treatment of the Bubega family).

50. Moreover, the Applicant's subsequent "recollection" is quite vague:

> Q. "Do you remember being treated in 2019?"
>
> A: "Yes, I remember being treated in 2019."
>
> Q. "And for what illness?"
>
> A: "It's always the same illness, isn't it? I still have high blood pressure."
>
> Q: "So, for March 31, you said it was also high blood pressure?"
>
> A: "That's what I said. I still had high blood pressure."

This is hardly a "changing account [that] undermines his credibility."

51. More importantly, any lack of credibility is merely the basis for disregarding that person's statements. It is not substantive evidence, in this case, of fraud. Instead, it is the rejection of evidence (the Applicant's statement) and thus essentially the absence of evidence.[3]

52. That only leaves the undisputed fact that the Applicant signed blank invoices for CSL/BKV. As discussed below, this is the basis for a different finding of misconduct. However, there is no evidence that claim number 15 was submitted using a pre-signed invoice, and thus this is not evidence that claim number 15 was fraudulent. Accordingly, the Tribunal finds that this allegation of misconduct is not supported by even a preponderance of the evidence.

53. In *Asghar* 2020-UNAT-982, para. 35, the Appeals Tribunal held that

> A finding of fraud against a staff member of the Organization is a serious matter ... 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 … 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.

In the absence of any evidence that claim number 15 is fraudulent, the Administration's finding as to this allegation is unlawful.

D) Allegation that the Applicant signed blank invoices for MSPs, CSL/BKV and Skyborne Hospital.

54. The Applicant admitted in his OIOS interview, his comments to the allegations of misconduct, and his application that he signed blank invoices for MSPs. As such, the fact is undisputed.

55. In his application the Applicant tries to explain this saying that:

[3] As a simple example, finding that someone is not credible essentially means they are a liar. Thus, the court may reject their denials of culpability. However, that finding is not substantive evidence that the liar committed the crime. Not all liars are murderers.

> [o]n certain occasions, he signed incomplete invoices at the provider's request, based on the understanding – communicated by CSL staff – that this was a routine administrative practice. He had no reason to believe that it was an improper process or that he was being used to submit fraudulent claims. His actions were based on good faith and trust in the facility, not on any intent to deceive or to enable misconduct.

56. This explanation beggars belief. It is the equivalent of signing a blank cheque and entrusting it to strangers. The Applicant provides no rationale for how he arrived at the conclusion that this was a "routine administrative practice." He makes no reference to any of his colleagues doing the same. The fact that this practice is not routine is demonstrated by Information Circular 2016/003 of 9 February 2016 which required staff members to sign all invoices only after receiving medical treatment. The Applicant does not rebut this, and the Tribunal rejects his incredible claim of good faith and trust in CSL/BKV. Thus, this fact is established by clear and convincing evidence.

Do the established facts amount to misconduct?

57. The Applicant "denies in the strongest possible terms having violated UN staff regulations 1.2(b) and 1.2(q), as well as section 10.1 of ST/AI/2015/3 or any other fundamental rule." The basis for this denial is that the facts have not been established. However, the Tribunal has found that the facts have been established, so the premise of this argument is flawed. Thus, the argument is rejected.

58. Participating in a scheme involving fraudulent medical insurance claims is misconduct in violation of the cited provisions.

59. Staff regulation 1.2(b) provides:

> Staff members shall uphold the highest standards of efficiency, competence and integrity. The concept of integrity includes, but is not limited to, probity, impartiality, fairness, honesty and truthfulness in all matters affecting their work and status.

60. Staff regulation 1.2(q) in turn says that:

> Staff members shall use the property and assets of the Organization only for official purposes and shall exercise reasonable care when utilizing such property and assets.

61. Section 10.1 of ST/AI/2015/3 provides:

> The subscriber and his or her enrolled family members are expected to fully comply with the present administrative instruction and the member plan description document of the third-party administrator. Since the health insurance coverage is provided to eligible family members upon the request of the staff member or retiree, he or she is responsible for ensuring that all claims submitted, including those relating to services for family members, are accurate, complete and comply with MIP rules. Accordingly, the staff member or retiree shall be held ultimately responsible for any acts committed by his or her covered family members to fraudulently obtain, attempt to obtain or abuse the benefits under MIP.

62. The Applicant's clear participation in this fraudulent scheme violated the standard of integrity, honesty and truthfulness set out in staff regulation 1.2(b). It also clearly violated section 10.1 of ST/AI/2015/3.

63. As for staff regulation 1.2(q), the Respondent argues that the medical insurance plan "is funded by the Organization, and therefore, constitutes a property and asset of the Organization." The Applicant does not challenge this assessment, and the Tribunal accepts it. However, it is important to note that, even if the conduct in this case did not constitute a violation of staff regulation 1.2(q), the violations of staff regulation 1.2(b) and section 10.1 of ST/AI/2015/3 are sufficient to find that the Applicant committed misconduct.

64. In this respect and taking into consideration the Tribunal's findings above on the allegations against the Applicant, the Tribunal determines that the established facts prove that the Applicant violated staff regulations 1.2(b), (q) and section 10.1 of ST/AI/2015/3.

Were the Applicant's due process rights observed?

65. The Applicant argues that his due process was not respected because:

a. it took years for the OIOS to complete its investigation (from 2021- 2024) causing him significant harm;

b. the investigation report misleads in the way it represents the facts and intends to lead to an "already-made outcome"; and

c. all facts in support of the Applicant's position were completely dismissed.

66. With regard to the delay, the Tribunal has found in *Bubega I* that the Respondent did not act with diligence or dispatch in handling the investigation in this case. That said, the Applicant has failed to show what harm he has suffered as a result of that delay.

67. Although he claims his ability to recollect specific details and reconstruct events has been significantly impaired by the unjustified delay in the investigation process, the Tribunal gives that claim no credence.

68. The Applicant is not expected to remember each detail of his treatments, but he acknowledges that he could access the Cigna online application to review his claims and reimbursement records, which he also failed to do. Additionally, his financial records would reflect every legitimate claim, including the percentage of that claim that he was obligated to pay and, if he paid the entire bill and sought reimbursement, the Cigna reimbursement payments. Apparently, he made no effort to check these records regarding these 12 claims. The Applicant's failure to take any efforts to refresh his recollection indicates that his lost recollection is feigned. Accordingly, the Tribunal finds no nexus between the Organization's delay and the Applicant's purported inability to recollect details of the treatments.

69. The Applicant's remaining arguments come under his broader claim that the investigation and sanction were initiated and based on the presumption of guilt. This presumption of guilt then led to a misleading investigation report that dismissed facts supporting the Applicant.

70. First, it should be noted that this investigation in this case began on 17 September 2019 when Cigna contacted him as part of a random verification process. This then led to a broader investigation and, ultimately, the contested decision.

71. The Tribunal made its own, independent assessment of the facts as set forth above and reached the same conclusion. In addition, after reviewing the documentary record in this case including the investigation report, the Tribunal finds no evidence of a predetermined outcome. The Applicant does not specifically identify the facts that he alleges support his position. However, assuming that he is referring to his "vigorous" and "categorical" denials, these denials were not disregarded. They were rejected as not credible, for the reasons set out in detail above. Due process does not require any fact-finder to accept incredible evidence.

72. Accordingly, the Tribunal finds that the Applicant's due process rights were respected by the Organization at all stages of the investigation and post-separation disciplinary process.

Is the administrative measure to recover from the Applicant the financial loss to the Organization in the amount of USD23,677.19 proportionate to the offense?

73. As observed by this Tribunal last year, "the principle of proportionality has been described as meaning that the sanction "should not be more excessive than is necessary for obtaining the desired result." *Vanshelboim* UNDT/2024/072 (*en banc*), para.85 (citing *Machanguana* UNDT/2013/149, para. 48, and *Sanwidi* UNDT/2012/169).

74. In reviewing proportionality, the Tribunals do not substitute their views for that of the Administration. The Secretary-General has wide discretion to choose the most appropriate disciplinary measure amongst the various measures open to him. However, the exercise of that discretion is not unfettered, and the Tribunals have the authority to intervene when the sanction imposed is disproportionate or excessive. Rather than focusing solely on the misconduct, the test of proportionality is circumstantial, considering all relevant aggravating and mitigating factors.

O'Brien 2024-UNAT-1490, paras. 93 and 94. See also *Samandarov* 2018- UNAT- 859, para. 23.

75. In *Branglidor* 2022-UNAT-1234, para. 59, the Appeals Tribunal directed that "in determining the proportionality of a sanction, the UNDT should observe a measure of deference, but more importantly, it must not be swayed by irrelevant factors or ignore relevant considerations."

76. The Applicant submits that the disciplinary measure imposed on him is arbitrary, unduly harsh and grossly disproportionate. As the basis for this claim, he again argues that the facts have not been established and do not amount to misconduct. However, those arguments have already been analysed and rejected by the Tribunal in the preceding pages.

77. The Applicant then argues that the disciplinary measure was "*at least separation from service with compensation in lieu of notice and without termination indemnity."* However, that is a misreading of the sanction letter, which actually says "the USG/DMSPC has determined that, **had you remained in the service** of the Organization, **you would have received** the disciplinary measure of, at least, separation from service with compensation in lieu of notice, and without termination indemnity" (emphasis supplied). In context, it is clear that this statement in the sanction letter is hypothetical. The Applicant had left service by his own volition and thus a separation could not and was not imposed.[4]

[4] The Applicant noted his 17 years of previous service and argued that this was a mitigating circumstance. The sanction letter agreed and said it would have considered this if the Applicant had not already separated. "Accordingly, a disciplinary measure short of dismissal **would have been** appropriate. Nevertheless, the appropriate disciplinary measure accounting for this mitigating circumstance of long service still **would have** involved termination of Mr. Bubega's appointment, albeit by means of a less severe measure, as continuation of his employment had remained intolerable. In this regard, it was considered that in instances of dishonesty, the severity of the misconduct tends to outweigh other mitigating considerations, and the long service of Mr. Bubega **would not** have restored the mutual trust and confidence essential for his continued employment." (Emphasis added) Thus it is clear that this mitigating fact was considered by the Organization although, once again, this discussion is all just hypothetical since the Applicant had already left service prior to the imposition of the contested measure.

78. The disciplinary measure actually imposed was the Applicant being: "listed in ClearCheck, a highly secure centralized database that contains the names of individuals who have a record of serious misconduct"; and "required to reimburse the Organization for the financial loss suffered by the Organization in the amount of US$ 23,677.19." The application raises no arguments about the proportionality of these measures, nor did his comments in response to the allegations of misconduct. In his closing submission he merely claims that "reimbursement of funds that the Applicant did not receive (Cigna paid the clinic) is arbitrary, unduly harsh and grossly disproportionate." Nonetheless, the Tribunal will analyse the proportionality as required by art. 9.4 of the Tribunal's Statute.

79. Regarding the decision to recover USD23,677.19, the Tribunal finds that this decision is the epitome of proportionality. That amount represents the actual financial loss incurred by the Organization because of the Applicant's actions and inactions. Of course, in light of the Tribunal's finding above regarding claim number 15, that amount must be deducted from the USD23,677.19 amount to be recovered (leaving USD23,380.87 as the total debt owed to the Organization).

80. Whether or not the fraudulent claim was paid to the medical service provider or the Applicant is irrelevant, although a reasonable inference can be drawn from the evidence that the Applicant received some benefit from the provider for his participation in the scheme. Restitution for the Organization's loss is proportional.

81. The decision to list the Applicant in ClearCheck is really a binary decision: either the Applicant is listed or he is not. As such, it does not lend itself to a proportionality analysis. Having found that the Applicant has committed serious misconduct, it is appropriate to include him in a database containing "the names of individuals who have a record of serious misconduct." There is nothing disproportionate about that.

82. Accordingly, the Tribunal finds that the measures imposed were proportional to the offense.

Conclusions

83. In view of the foregoing, the Tribunal DECIDES:

a. the allegation of misconduct regarding claim number 15 has not been established against the Applicant;

b. all of the Applicant's other pleas are dismissed in their entirety; and

c. the Respondent shall deduct the amount of claim number 15 (USD296.32) from the USD23,677.19 to be recovered from the Applicant.

(Signed)
Judge Sean Wallace
Dated this 6th day of November 2025

Entered in the Register on this 6th day of November 2025

(Signed)
Wanda L. Carter, Registrar, Nairobi