In re Ochani (No. 3)

Judgment 1857

The Administrative Tribunal,

Considering the third complaint filed by Mr Parmanand Sachanand Ochani against the World Health Organization (WHO) on 15 May 1998, the WHO's reply of 31 July, the complainant's rejoinder of 12 August and the Organization's surrejoinder of 13 November 1998;

Considering Articles II, paragraph 5, and VII of the Statute of the Tribunal;

Having examined the written submissions and decided not to order hearings, which neither party has applied for;

Considering that the facts of the case and the pleadings may be summed up as follows:

A. The background to this case is set out in Judgment 1856 also delivered this day on Mr Ochani's second complaint.

On 29 December 1995 the complainant submitted a claim under the Staff Health Insurance scheme for reimbursement of his son's dental treatment in September 1995. The Organization considered that two amounts on the dentist's receipts had been altered and an investigation followed. On 9 April 1996 the Administration sought clarification from the dentist concerned, which was received on 23 May, and the Regional Personnel Officer asked the complainant to provide a written explanation to say why the figures did not tally. He was on sick leave from that date until 26 May, and on his return to duty he asked for more time in which to provide his justification for the discrepancy. By a letter to him of even date a personnel officer set a new time limit of 17 June, which was later extended to 21 June at the complainant's request.

The complainant enquired on 29 May about the reimbursement of local currency medical bills presented in 1996 on 22 January, 11 March and 10 May. However, on 30 May 1996 the Regional Personnel Officer informed him that "pending the outcome of the investigation" settlement of his outstanding health insurance claims had been suspended and reimbursement would not be "effected at the present time". The complainant protested but, in a letter of 14 June, the secretary of the Regional Surveillance Committee made it clear to him that his insurance had not been stopped, that the Headquarters Committee was to review his case on 25 June and invited the complainant to provide his comments to the Committee by the 24th.

By a letter of 22 July the complainant asked the Regional Personnel Officer to have the undisputed medical insurance claims released to him and claimed a payment of "24% commercial interest for misutilising [his] monthly contributions plus unpaid reimbursable amounts". He appealed to the regional Board of Appeal on 24 August against the suspended settlement of his outstanding health insurance claims.

Meanwhile, in the light of a decision taken on 31 July to dismiss the complainant with effect from 5 August 1996 the Regional Surveillance Committee reconvened. It decided to settle the claims that were in order, thereby excluding the disputed dental bills, a claim submitted out of time, and others not substantiated by proper evidence.

In its report of 3 February 1998 the headquarters Board of Appeal to which the matter was referred by the complainant recommended the rejection of his appeal. The Director-General endorsed that rejection on 5 March 1998, which is the decision under challenge.

B. The complainant pleads that in "terminating his health insurance cover while simultaneously continuing his membership" of the Staff Health Insurance scheme the Administration committed "a gross impropriety and a grave injustice". It imparted "two punishments for one cause of action" as it instituted disciplinary proceedings against him and also stopped his health insurance cover.

He submits that on return from sick leave at the end of May he had requested an extension of the time limit for explaining the discrepancy in the receipts as he was unaware of the correspondence exchanged during his leave by

the Administration and the dental surgeon: he became aware of it only after his dismissal. Without waiting for his explanation the Administration took "punitive action" against him by withholding payment of his local currency bills. Denying him reimbursement while collecting monthly contributions from him was tantamount to "cheating". He affirms that the action taken against him infringed Rules 562 and 564 of the Staff Health Insurance inasmuch as it was within the power only of the Director-General to take the course of action adopted by the Administration. Besides which the Organization gave no reason for withholding refunds on undisputed medical claims.

In this third complaint he seeks: (1) an award of moral damages of 200,000 United States dollars; (2) a payment to him of "24% commercial interest on the reimbursable funds denied to him and on the misutilisation of the monthly contributions recovered from him"; and (3) an award of 10,000 dollars in costs.

C. In its reply the WHO argues that it was justified in suspending refunds of the complainant's outstanding health insurance expenses as a "provisional and precautionary measure" to protect the Organization. The complainant had delayed providing his written explanation for over two months.

At no time did the Organization terminate his health insurance cover. The letter of 14 June to the complainant from the secretary of the Regional Surveillance Committee made that clear to him. In the end it settled all the claims properly submitted, thereby rendering his complaint devoid of any cause of action.

The WHO did not infringe the applicable rules. In the event of fraud being proved, suspension or exclusion from health insurance benefits "effectively apply" from the date of the fraud. A combined reading of WHO Manual paragraph IV.1.320 and Insurance Rule 562 did allow the Organization to take dual measures in the form of disciplinary action and a stoppage of insurance cover.

Without the falsification of the receipts no precautionary measure would have been necessary. The complainant's claim for moral damages is therefore "frivolous" and he adduces no evidence of injury.

D. In his rejoinder the complainant insists that there is no provision in the Health Insurance Rules for "provisional" or "conservatory" action.

He requests reimbursement of a bill dated 28 October 1994 for 110.50 dollars for medical treatment, which was considered out of time by the Organization under Health Insurance Rule 350, and also claims reimbursement of sums of 434 dollars and 51.66 dollars that it claimed were "not supported by official receipts".

In view of the "vindictiveness" shown by the Organization and its "transgression of law" and WHO rules, he presses his claim for compensation "plus any further relief that the Tribunal may deem fit".

E. In its surrejoinder the WHO submits that the complainant's request in his rejoinder for reimbursement of "improperly submitted" health insurance claims is a new plea. In any event it correctly applied Rule 350 in rejecting his outdated claim. The claim for 434 dollars was not backed up with proof of payment, and the one for 51.66 was not reimbursed for want of any details of the treatment provided.

It reiterates the arguments put forward in its reply and repeats that it was justified in taking the precautionary measure of suspending reimbursement until after the investigation, and the complainant suffered no injury. It reimbursed all his undisputed claims on 26 February 1997.

The complainant cited Rules 562 and 564 concerning "full or partial suspension or exclusion of the benefits and entitlements of the participant concerned". No decision under those rules was ever taken, and they do not apply to his case. He does not allege the infringement of any other rule; neither could he as no rule precluded the precautionary step the WHO took.

CONSIDERATIONS

1. The complainant was employed by the WHO at its Regional Office for South-East Asia (SEARO) in New Delhi as from 1988. On 29 December 1995 he made a Staff Health Insurance claim for reimbursement of dental expenses to the value of 2,662 United States dollars, submitting in support two altered receipts. By letter dated 31 July 1996 he was dismissed for misconduct with effect from 5 August 1996. Judgment 1856 (*in re* Ochani No. 2), delivered today, sets out the facts leading to his dismissal.

2. On 9 April 1996 the complainant was asked to submit, by 19 April, his written explanation as to the alterations and discrepancies in his claim. He asked for, and was given, extensions of time until 21 June.

3. The claim made by the complainant on 29 December 1995 was for a total of 4,019.63 dollars. Later, he made three more claims, dated 22 January, 11 March and 10 May 1996 for Indian rupees 5,800, 3,232.90, and 38,368.07, respectively.

4. The complainant's present grievance arises from a letter dated 30 May 1996 from the Regional Personnel Officer informing him that "pending the outcome of the investigation into [his] staff health insurance claims, the settlement of all outstanding claims has been suspended".

5. In his reply dated 10 June, the complainant questioned what he called the suspension of his Staff Health Insurance coverage, particularly as the WHO was continuing to collect monthly insurance contributions from him.

6. Under Staff Health Insurance Rules 560, 562 and 564 (quoted in Judgment 1856, at 15) a decision regarding the suspension or exclusion of insurance benefits and entitlements could have been taken only by the Director-General, on the recommendation of the Headquarters and the Regional Surveillance Committees.

7. On 14 June the secretary of the Regional Surveillance Committee replied to the complainant, stating that his insurance coverage had not been stopped; that the Regional Surveillance Committee, having concluded that a *prima facie* case of attempted fraud had been established, had recommended to the Headquarters Surveillance Committee (through the Regional Director) the full suspension of his insurance benefits and entitlements; that the Headquarters Surveillance Committee was to consider his case on 25 June; and that he had the right to communicate his comments to the Headquarters Surveillance Committee by 24 June. He added that the Administration was justified in withholding payment of the complainant's claims pending a final decision under Rule 562.

8. Thereafter the complainant was informed that the Headquarters Surveillance Committee had met and decided to postpone its review until the Administration had concluded its investigation in terms of Manual paragraphs IV.1.310-345. By letter dated 5 July, the Regional Personnel Officer reiterated that his outstanding claims would not be settled pending a final decision.

9. The complainant appealed to the regional Board of Appeal on 24 August 1996 against the decision to suspend reimbursement of his outstanding insurance claims. There was undue delay by the regional Board in dealing with that appeal, and at the complainant's request the headquarters Board of Appeal decided on 17 June 1997 to allow him to appeal to it directly. On 3 February 1998 the Board concluded that the Administration's decision to suspend temporarily payment of outstanding claims pending the outcome of the inquiry was justified, and recommended dismissal of the appeal. On 5 March 1998 the Director-General accepted that recommendation. The complainant now impugns that decision, asking the Tribunal to award him 200,000 dollars on account of material, moral, punitive and exemplary damages, and interest at 24 per cent on "the reimbursable funds denied to him and on the misutilisation of the monthly contributions recovered from him". He claims costs.

10. While that appeal was pending, the Regional Surveillance Committee met on 27 September 1996 and decided that "all the pending claims, excluding the disputed ones, be reviewed as to their correctness/genuineness and settled as soon as possible". Thereupon, dealing with his first claim, the Administration disallowed the disputed claim of 2,662 dollars, and allowed a sum of 615.17 dollars in respect of the balance. The other three claims were allowed in full, except for a sum of 470 Indian rupees. It is not disputed that those sums were paid on 26 February 1997, and that the complainant did not seek administrative review in respect of any of the claims disallowed.

11. The complainant contends first that the WHO was guilty of a gross impropriety and a grave injustice in terminating his insurance cover while simultaneously continuing his membership of the Staff Health Insurance scheme by collecting monthly contributions from him; that the Administration blatantly violated Rules 562 and 564 of the Staff Health Insurance (in that it was only the Director-General who could have decided on suspension or exclusion from the benefits of membership in the health scheme), and Manual paragraphs II.9.490 and IV.1.310-345 (in that disciplinary proceedings not required under the Insurance Rules were instigated); that it acted as an authority parallel to the Regional Surveillance Committee; and that even the Director-General did not have the power to impose two punishments (i.e. instituting disciplinary proceedings and stopping his health insurance cover).

12. A fraud or an attempted fraud in respect of the funds of the insurance scheme gives rise to two distinct issues: continued participation in the scheme, and the imposition of disciplinary measures on the guilty staff member. The Tribunal held in Judgment 1856 (under 17) that Staff Health Insurance Rules 560, 562 and 564 and Manual paragraphs IV.1.310-345 recognise the right of the Administration to take disciplinary proceedings in respect of allegations of fraud or attempted fraud.

13. The complainant's insurance cover was not stopped or suspended. The question of whether his claim for 2,662 dollars was genuine had necessarily to be resolved before it was settled; withholding payment pending investigation was therefore quite proper. Further, if that claim was found to be fraudulent, the question would then have arisen as to whether the Director-General should order the complainant's suspension or exclusion from the benefits to which members are usually entitled; and such an order might have become ineffective if in the meantime the Administration had settled all subsequent claims. Withholding settlement of subsequent claims, even though genuine, was thus a justifiable and prudent measure to preserve the *status quo*; it was not a punishment. The fact that subsequently, in pursuance of the decision of the Regional Surveillance Committee, apart from the disputed claim of 2,662 dollars, all the other duly established claims were paid, demonstrates that the complainant's insurance cover continued, and that the collection of monthly contributions was proper. It also confirms that the Administration did not usurp the functions of the Director-General in regard to suspension or stoppage of cover.

14. The Tribunal holds that the complainant's first set of contentions is devoid of merit.

15. The complainant further submits that the WHO violated the Staff Rules by failing to (a) notify him of any charge, (b) establish any charge, and (c) define what misconduct he had committed. Those are matters relevant only to his dismissal and have been dealt with in Judgment 1856.

16. The complainant goes on to allege incomplete consideration of the facts, but that plea cannot be entertained as he gives no particulars.

17. Finally, in his rejoinder the complainant, for the first time, seeks to question the disallowing of some of his requests for reimbursement. The Tribunal rejects this claim as being irreceivable for failure to exhaust the internal remedies.

DECISION

For the above reasons,

The complaint is dismissed.

In witness of this judgment, adopted on 7 May 1999, Miss Mella Carroll, Vice-President of the Tribunal, Mr Mark Fernando, Judge, and Mr James K. Hugessen, Judge, sign below, as do I, Mrs Catherine Comtet, Registrar.

Delivered in public in Geneva on 8 July 1999.

Mella Carroll
Mark Fernando
James K. Hugessen

Catherine Comtet

Updated by PFR. Approved by CC. Last update: 7 July 2000.