Gibraltar Public Services

Ombudsman

Annual Report 2016

"If everyone is moving forward together, then success takes care of itself."

The Gibraltar Public Services

Ombudsman

"If everyone is moving forward together, then success takes care of itself."

Henry Ford

The masculine form is used in this text to designate both male and female, where applicable.

The Gibraltar Public Services
Ombudsman

March 2017

The Honourable Fabian Picardo Q.C. M.P.
Chief Minister
Office of the Chief Minister
No. 6 Convent Place
Gibraltar

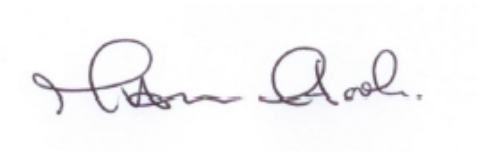
Dear Mr. Picardo,

Annual Report 2016

It is an honour for me to present the Public Services Ombudsman's seventeenth Annual Report. This report covers the period 1st January to 31st December 2016.

This report has been prepared in accordance with the Public Services Ombudsman Act 1998. It contains summaries of investigations undertaken and completed during this period together with reviews and comments of the most salient issues of this last year.

Yours sincerely



Mario M Hook
Ombudsman

Statutory Obligations, Fairness and Equity

In February 2016 a Senior Head of a Public Service wrote to us on his retirement and inspired us with his thoughts and well wishes. His remarks were as follows:-

'Please allow me to place on record the very high esteem I have of you and your staff. You (and when I say you I include all the members of your dedicated staff) have proved to me, time and again, that aside from your statutory obligations as Ombudsman, you are extremely just and fair in your investigations but more importantly, you go out of your way to uphold fairness and ensure that the members of the public are treated equitably.

His kind words were very well received and brought to light our commitment and vision to always strive to be customer focused and to help public services understand what is meant by providing a first class public service to their customers. Our aim has always been to provide an independent, high quality complaint handling service that rights individual wrongs and drives improvements in public services.

The letter from the Senior Officer further stated:

'I have greatly appreciated, and indeed admired, how you've always looked at the human side of the complaint, which is something that can so easily be overlooked and put aside. By so doing, not only have you significantly assisted many helpless individuals but you have rightly gained the respect and admiration of many civil servants. I must honestly say that I have learned a lot from you and for this I am extremely grateful to you and your team.'

A true sense of understanding of the citizen is needed from all front-line staff in all public services and at the Gibraltar Ombudsman's Office we try and remind all public services of this. As Mahatma Ghandi so eloquently reminds us in his words of wisdom 'a customer is not an interruption to our work, he is the very purpose of it'. Compassion for the client and his/her difficulties is the key in handling complaints, even when a client has no cause for complaint, the mere fact that he is receiving a high quality service where he is being respected and heard will go a long way in resolving the issue at hand.

The common aim of any ombudsman is to defend citizens' rights and to ensure that the public enjoys the services of citizen-friendly, transparent, ethical, and accountable public administrations. So the human being at the counter with his particular needs must therefore never be overlooked or dismissed.

All public services must strive to see a reflection of their own humanity in the person they are serving.

TABLE OF CONTENTS

INDEX OF STATISTICS

COMPLAINTS HANDLING SCHEME (HEALTH)

TABLE

CHARTS

PUBLIC SERVICES OMBUDSMAN

TABLES

CHARTS

1
Introduction

The Ombudsman's Seventeenth Annual Report

Words of Wisdom

A customer is the most important visitor on our premises.

He is not dependent on us

We are dependent on him.

He is not an interruption to our work

He is the purpose of it.

He is not an outsider to our business

He is part of it.

We are not doing him a favour by serving him

He is doing us a favour by giving us an opportunity to do so.

Mahatma Ghandi

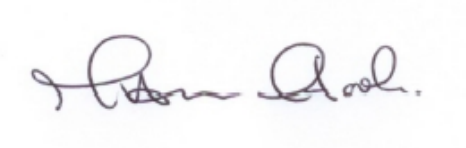
INTRODUCTION

This will be my last Annual Report as I am due to step down as Pubic Services Ombudsman for Gibraltar on 31 March 2017. I was appointed Public Services Ombudsman on the 1st January 2003 making this my fourteenth Annual Report.

Serving the people of Gibraltar has been an honour and a most humbling experience. The Ombudsman is very often the only hope of obtaining justice for those who, after having exhausted their avenues of redress, continue to face the impenetrable wall of bureaucracy. Of course, an Ombudsman is not an aggrieved person's lawyer; he is an advocate for truth and justice. The Ombudsman ensures that any complaint brought to his attention is considered and investigated thus enabling him to deliver his opinion.

I firmly believe that I have carried out my duty with the utmost of respect towards complainants and towards those entities under the jurisdiction of the Ombudsman. If I have ever failed anyone in the performance of my duty, then please accept my most sincere and humble apologies.

Finally, my review could not be complete without expressing my heartfelt and sincere thanks to my staff who have encouraged, assisted me and stood by me when faced with difficult issues. Of course, we have also rejoiced together whenever we have achieved our goals but especially whenever we have been able to deliver what we continually strive for, a truly first class service for the benefit of those who seek our assistance.



Mario M Hook
Public Services Ombudsman

INTRODUCTION

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Ombudsman's Review 2016

OMBUDSMAN REVIEW 2016

Gibraltar Health Authority

The Ombudsman has enjoyed jurisdiction over the Gibraltar Health Authority since April 2015.

In order to meet Government's manifesto commitment/policy, the Complaints Handling Scheme (CHS) (under an arms length agreement with the Ombudsman) was established to become the entry portal for all complaints pertaining to GHA.

The CHS has been a huge success story dealing with all sorts of enquiries (now taken over by the introduction of PALS (Patient Advocacy and Liaison Service) within the GHA structure) and complaints.

The CHS was tasked in dealing with complaints at first instance and trying to resolve the issue and thus the grievance for the person at the earliest possible moment; I am pleased to say that this objective has been met thanks to the efforts of both the CHS staff and the GHA who has collaborated with CHS to ensure early resolution of complaints.

Those complaints that are beyond the early resolution type of investigation provided by the CHS are referred to the Ombudsman for a more in-depth and exhaustive investigation. In some cases the Ombudsman's investigation requires a referral to UK clinical advisers in respect of issues raised by the complaints.

I have to place on record my satisfaction at the assistance provided by GHA staff when we carry out investigations; a task which would prove almost impossible or at least much more laborious without their help.

It is also important to note that the results of our investigations are being closely considered and acted upon by the GHA managers. Our investigations are being used as learning tools and possibly to instigate change where it is considered adequate.

This is important because the majority of those who bring a complaint about GHA do so "… so that it does not happen to others…"

Civil Status and Registration Office

This Department provides an array of services to the public and we hardly ever receive complaints regarding the majority of these services. However in the general area of "immigration" the complaints in the last few months have multiplied. These complaints are in respect of arbitrary decisions and delay.

I am aware that there are aspects of immigration that require obtaining and considering information, but it is wholly unacceptable to keep people waiting for long periods for decisions to be made. There is an urgent need to review procedures in this area and it is my hope that the Administration will take note of the many complaints that have been lodged but perhaps more significantly of the anguish, anxiety and inconvenience that the present poor process has on people whilst awaiting for a decision that may take months to make.

Own Motion Investigations

The ability of the Ombudsman to investigate any issue of his own motion is a much desired (almost necessary) tool for the Ombudsman to have.

At present, the Ombudsman can only investigate matters within his jurisdiction upon the receipt of a written complaint from a member of the public. This follows the steps of the UK Ombudsmen who do not enjoy statutory Own Motion provisions. This contrasts sharply with the vast majority of Ombudsmen who enjoy the ability of conducting investigations out of their own motions without the need for a written complaint.

By way of comment, the Ombudsmen and legislators of Scotland, Wales and Northern Ireland are reviewing the position in the UK and my belief is that the Ombudsmen of those jurisdictions will soon enjoy the ability to initiate investigations of their Own Motion. The reason why Own Motion is available to Ombudsmen is to allow the investigation of matters which are brought to their attention but where people may be reluctant to make written complaints for a variety of reasons.

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2.1 Conferences, Meetings and Seminars

2.1.1 Conference hosted by the Scottish Public Services Ombudsman ("SPSO") on 15th March 2017

It has always been part of the Gibraltar Public Services Ombudsman's ethos for staff to participate in international events. Attendances within the wider Ombudsman arena provide opportunities to extend our knowledge, share our experiences and working practices and to network amongst colleagues.

Our Senior Investigating Officer and Front Line/First Contact Officer attended an "Improvement Conference Programme" entitled "Making the most of complaints" hosted by SPSO in Edinburgh in March 2017.

The working day consisted of a series of talks delivered by public sector organisations followed by workshops which were divided into three main themes. The first addressed the analysis of complaints in order to drive improvements, the second focussed upon making the most of learning; the final theme concentrated on complaint handling improvements.

The central issues insofar as Gibraltar Public Services Ombudsman staff were concerned were the following:

1. The importance of utilising collected data for driving improvement (in the absence of which, data collection would be a pointless exercise).

2. The need to empathise with the Complainant's perspective. If a specific complaint was held to be unfounded after it had been investigated, why was that decision reached?

3. Complainant's look to be treated with respect and learning can be gained from mistakes made- "your most unhappy customers are your greatest source of learning." It is as a result of listening to complainants who feel that they have not been properly served that there is scope for improvement in working practices.

4. Making the most of learning is an active process that needs to be properly managed in order to improve the Ombudsman's public service. "Naming and learning not naming and shaming."

The Gibraltar delegates shared the view that the issues discussed at the conference were of particular relevance to their day to day work environment, particularly since the Gibraltar Public Services Ombudsman practiced an open door policy where complainants would ordinarily be attended to in person and without the need for a pre booked appointment.

Given the "hands on" nature and style of the Gibraltar Ombudsman's interaction with complainants, the conference material was deemed to be most beneficial in the continuous strive to improve our working practices and public service delivery.

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2.1.2 Provision of expert independent clinical advice on health complaints

As mentioned in previous Annual Reports, in April 2015, the Gibraltar Public Services Ombudsman ("GPSO") was granted jurisdiction to investigate health complaints made by persons aggrieved by specific actions taken by the Gibraltar Health Authority ("GHA").

In order to facilitate the acceptance and subsequent investigation of health complaints, the "Complaints Handling Scheme" ("CHS") was created. This entity was and continues to be housed at St Bernard's Hospital, for ease of complainant's accessibility. An arms-length agreement was put in place between GPSO and CHS where CHS would accept, investigate and attempt to resolve health complaints at first instance. Failure to achieve that goal or complaints necessitating independent clinical advice as a result of their complexity would, with the Complainant's prior written consent, be transferred to GPSO for further investigation and expert clinical advice requests where required.

In order to ensure fairness and independence in the provision of clinical advice, in addition to quality assurance, GPSO entered into agreements with the Parliamentary and Health Service Ombudsman in the UK ("PHSO") for the purpose of requesting clinical advice via PHSO which would then be either provided to us by their internal assessors or outsourced by PHSO on our behalf to medical specialists within their approved specialisms panel. It should be noted that UK Public Services Ombudsmen (namely PHSO themselves, together with the Scottish, Welsh, Irish and Northern Irish Ombudsmen) all made use of this service.

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From left to right: Steffan Sanchez, IT Administrator; Sarah de Jesus, Complaints Handling Scheme (Health) Coordinator; Douglas Ressa, Surveys; Nadine Pardo-Zammit, Public Relations Officer; Mario Hook, Ombudsman; Susan Hudson, Policy and Communications Manager for the Public Services Ombudsman for Wales; Nicholas Caetano. Senior Investigating Officer; Karen Calamaro, Investigating Officer and Daniel Romero, Complaints Handling Scheme (Health) Coordinator

2.2 Distribution of Ombudsman's Annual Report 2015

The Ombudsman team distributed copies of the Ombudsman's 16th Annual Report outside Parliament House on 4th August 2016.

On this occasion, the Ombudsman team was joined by Ms Susan Hudson, Policy and Communications Manager for the Public Services Ombudsman for Wales. As a member of the Ombudsman's Management Team, Susan is responsible for advising and supporting the Ombudsman on all matters of corporate governance and public accountability. This includes the preparation of the Ombudsman's Annual Report, corporate strategic planning and acting as Secretary to the Advisory Panel and the Audit and Risk Assurance Committee. This also involves appearing before the National Assembly for Wales' Committees, supporting the Ombudsman in his presentations before those Committees. Parallel to the distribution of the Annual Report the Ombudsman also conducted a public survey on the Gibraltar Public Services Ombudsman Office.

Ombudsman's Awareness Day —Distributing copies of our 16th Annual Report

2.3 Ombudsman Survey

Parallel to the distribution of the 16th Annual Report outside Parliament House on 4th August 2016 the Ombudsman also conducted a public survey on the Gibraltar Public Services Ombudsman Office. Seventy five passers-by, randomly chosen, agreed to participate in the survey.

Ninety six percent were aware that there was an Ombudsman in Gibraltar and 92% knew what his role was. Most people who took the survey knew the location of our office (81%) and as Gibraltar is quite small in land area with a population of about 32,000, word of mouth (43%) will always be the best way to find out about the Ombudsman although in this day and age media coverage (TV, local newspaper, website and social media) also play an important role in letting people know about our office and service. On average about a third of the people (30%) (35% last year) who took the survey have used our service, which shows that 1 in 3 people in Gibraltar have visited our office since it opened its doors to the public in 1999. Our service-users are (85%) satisfied with the service being provided and it is very likely that if the need arises most members of the public (99%) would make use of the Ombudsman's services.

The Complaints Handling Scheme (CHS) which has been designed to be the entry portal for all complaints made against the Gibraltar Health Authority (GHA) is regulated by the Gibraltar Public Services Ombudsman. Since it is a relatively new service that we provide we asked the public if they were aware that the Ombudsman office can investigate complaints against the GHA. The survey showed that 42% were aware that the Ombudsman investigated health complaints; this is a relatively low figure so the Ombudsman will actively continue to

1 Are you aware that Gibraltar has an Ombudsman?

Yes	**96%**
No	**4%**

2 Do you know what the role of the Ombudsman is?

Yes	**92%**
No	**8%**

3 Are you aware of the location of our office?

Yes	**81%**
No	**19%**

4 How do you know about the Ombudsman?

Word of mouth	**43%**
Local Radio/TV/Newspaper/Web	**35%**
Personally knows staff member	**9%**
Common knowledge	**7%**
Work related	**6%**

5 Have you ever made use of the Ombudsman's services?

Yes	**30%**
No	**70%**

6 If so, were you satisfied with the service given?

Yes	**85%**
No	**5%**
Not satisfied completely	**10%**

7 If the need arises would you make use of the Ombudsman's services?

Very likely	**99%**
Not likely at all	**1%**

8 Are you aware that the Ombudsman investigates health complaints?

Yes	**42%**
No	**58%**

2.4 Complaints Handling Scheme Office (GHA)

2.4.1 Number of GHA Complaints

Complaints/enquiries at CHS continue on the increase

This year, the Complaints Handling Scheme – Health (CHS) received 399 Complaints/ Enquiries. The busiest months were May and June with 41 entries recorded in each month. The average number of complaints/enquiries received per month has increased from 27 of last year to 33 in 2016.

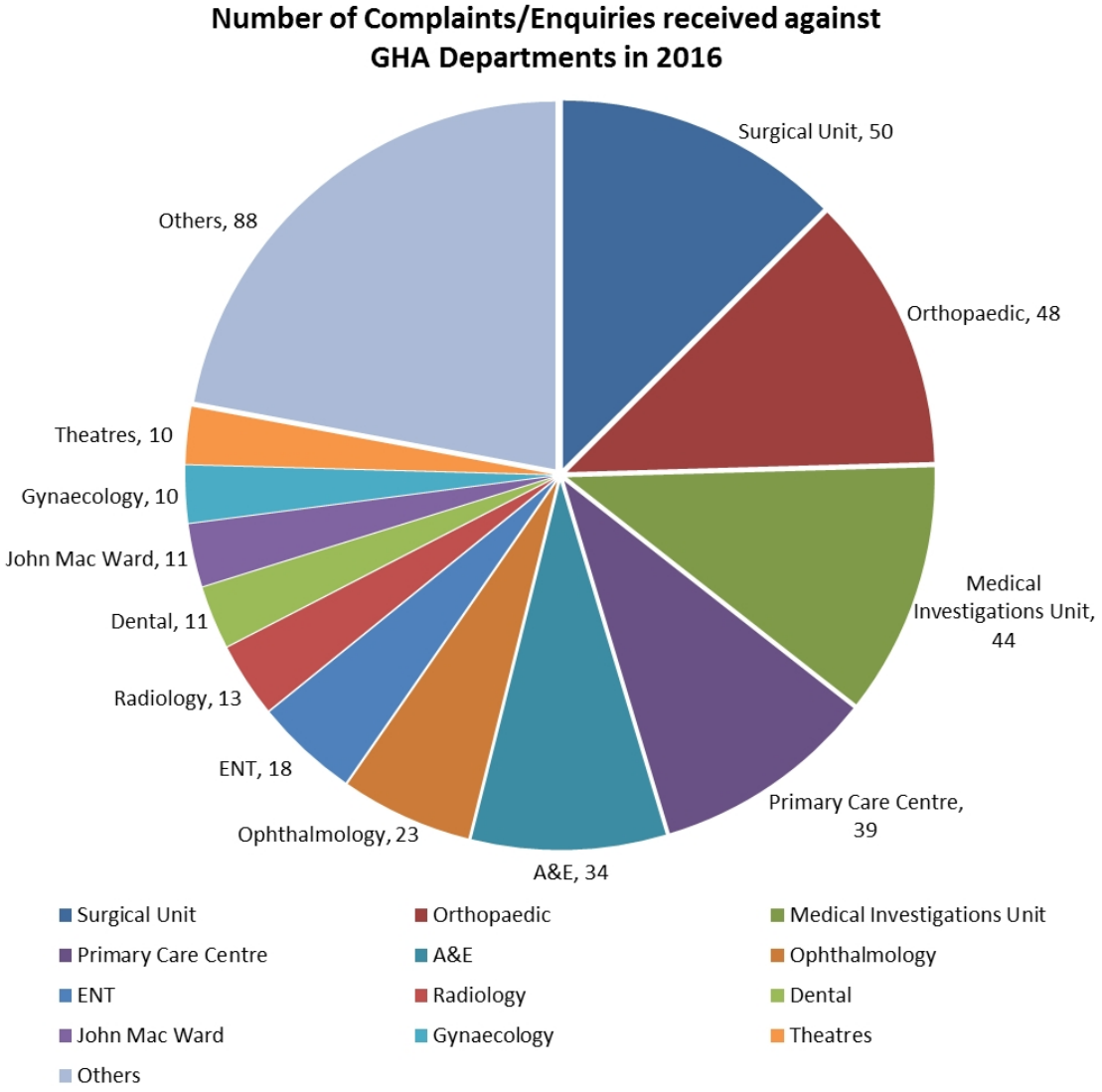
Due to the CHS Office opening to the public in April 2015 and not being able to cover a full working year the only way to successfully obtain an evenly balanced comparison between 2015 and 2016 was to count the number of complaints/enquiries that we received on both years from April to December. By carrying out this estimate we can highlight that this year there has been an increase of 52 complaints/enquiries received at the CHS Office during that period, nearly 6 more complaints/enquiries per month than in 2015. Now that the CHS is well established in Gibraltar it will be interesting to note if there will be a further increase of complaints/enquiries in 2017.

Table 1 – GHA Complaints received per month (1st January 2016 to 31st December 2016)

Table 1	2015	2016
	Complaints/Enquiries	Complaints/Enquiries
January	-	38
February	-	29
March	-	37
April	30	**25**
May	19	**41**
June	28	**41**
July	27	**28**
August	36	**34**
September	17	**29**
October	27	**37**
November	36	**36**
December	23	**24**
TOTAL	243	399

2.4.2 GHA Departments (Clinics/Units/Wards/Centres)

The trend of Complaints/Enquiries at the CHS has continued similar to last year, once again the same departments comprise the 'Top Five' in respect to all the complaints/enquiries we have received against the Gibraltar Health Authority in 2016, the only difference is that they are in a different order to last year. This year the Surgical Unit tops the list with 50 complaints/enquiries, the Orthopaedic Department follows closely with 48, the Medical Investigations Unit has 44, the Primary Care Centre 39, and closing the 'Top Five' is the A&E with 34; see Chart 1 below.

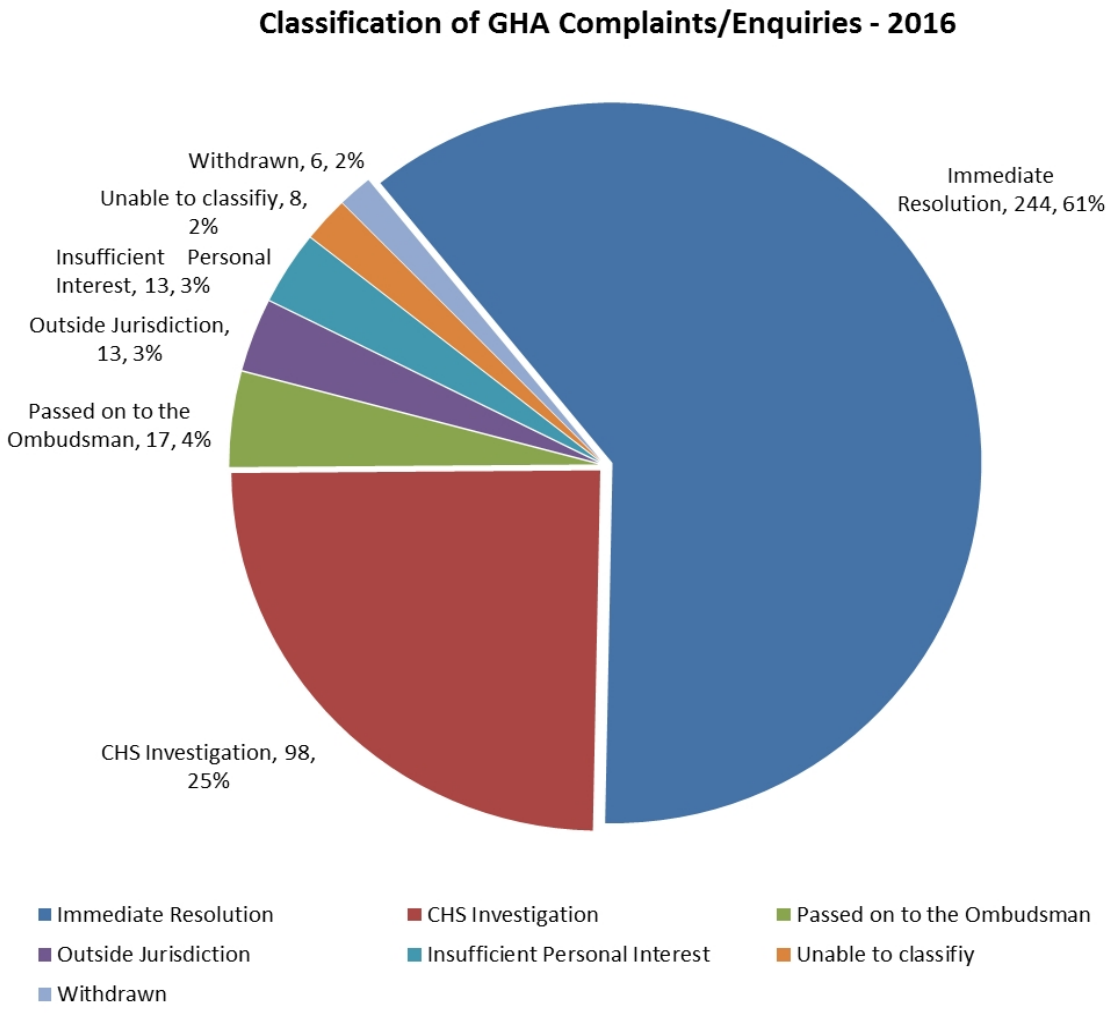


'Other' GHA Departments with complaints/enquiries under double figures such as Physiotherapy, Neurologist, Records, Tertiary Unit, Sponsored Patients, Facilities, Victoria Ward, Dudley Toomey Ward, Pain Clinic, Pathology, Urologist, Ambulance, Elderly, Maternity Ward, Dermatology, Paediatrics, Stores, Mental Health, Spinal Clinic, Accounts, Call Centre, Cancer Screening, Diabetic Clinic comprise the remaining 88 complaints/ enquiries against the GHA.

2.4.3 Classification of GHA Complaints

There were 399 Complaints/Enquiries this year out of which 244 were speedily resolved, i.e. fell under the classification of Immediate Resolution.

One quarter of the complaints/enquiries were investigated thoroughly by the CHS team as it involved examining more complex issues (serious allegations brought by the Complainants and their respective actions taken by the staff at the GHA) that demanded presenting letters to the GHA.

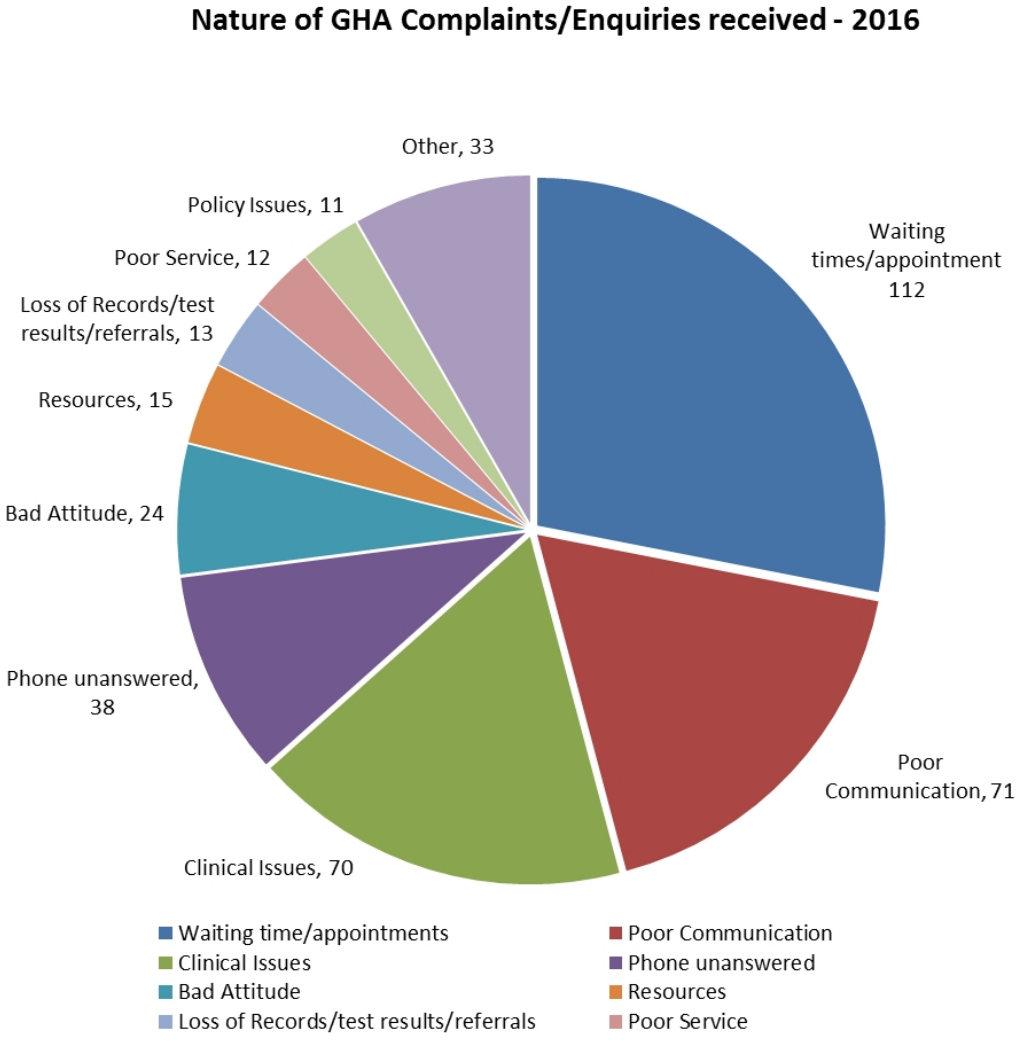


17 (4%) Complaints were also passed on to the Ombudsman for further investigation as the majority of these cases warranted clinical advice. Full investigation reports are carried out and included in our Annual Report. See Gibraltar Health Authority, Page 54.

13 (3%) were closed as outside jurisdiction, another 13 were classified as 'Insufficient Personal Interest' and 6 were withdrawn soon after the complaint being submitted at the CHS.

2.4.4 Nature of GHA Complaints

There were a number of situations where the basic standards of healthcare were not met, at the very least at an administrative level, with excessive waiting times for appointments and treatment, these amounted to 33% of all complaints/enquiries received in 2016.



In one instance there was a Complainant unhappy that he had to cancel his son's dental appointment due to important mock exams and the only availability was 6 months later. Another patient was waiting to be seen at the Spinal Clinic and according to Orthopedics there was a 7 months waiting time and last but not least a patient was told that he could not get his biopsy carried out due to the Consultant/Specialist that was treating him had recently retired so he had to wait a couple months uncertain as to what would happen with the possibility of having cancer before another Consultant/Specialist could take over and carry out the biopsy. It is evident that the main reason for all the different types of delays and excessive waiting times being experienced by its users at the GHA is attributed to the shortage of staff and resources or poor administration. Poor communication (18%), clinical issues (18%), phones unanswered (10%) and bad attitude (6%) towards patients are also quite common in nature.

2.5 Principles of Good Administration

Gibraltar Public Services Ombudsman Principles for Remedy

The Ombudsman in Gibraltar has certain principles that guide the way in which he provides a solution to an injustice or hardship caused by a body's maladministration or poor service. The first step in this process is that the complainants identify the remedy they seek, so as to ascertain that the Ombudsman is best placed to deal with any particular case. The main remedies the Ombudsman can provide are an apology, an explanation, correction of an error or an agreement to change practices, procedures or systems.

The Ombudsman will study each case to find out which remedy is most suitable for each case, based on these principles. They are not designed to limit but to provide a framework for the Ombudsman's work, therefore assuring an agreed redress for the complainant in the event where a public service fails the user.

Six Principles

Principle 1: Putting things right
The Ombudsman's role is to help the person affected enough so that they can carry on as if they had never been failed by the public service or never been the victim of any maladministration. Even if the Ombudsman cannot put right that injustice sustained by the individual the service should try to point out what is wrong to make recommendations to the relevant governing body so as to assure nobody else falls victims to such an injustice.

Principle 2: Being open and accountable
Clear reasons for the decisions taken by the Ombudsman should be published in the report over any complaint. This procedure would give any relevant public body the opportunity to take the recommended action published in the Ombudsman's annual report. He or she then has the power to contact Parliament if this advice is ignored, so as to assure accountability for its actions.

Principle 3: Empowering
The appropriate remedy will be decided by taking into account the views and circumstances of the complainant. However, the Ombudsman must put across exactly what can be achieved in each case so as to manage those expectations.

Principle 4: Being fair, reasonable and consistent
The Ombudsman will treat each case without bias or partiality, considering it on its own merits to ensure the remedy is reasonable to the injustice that has occurred. To be fair on both the complainant and the public body, the Ombudsman shall put across a draft version of the final report so that their views can be considered, although in the end the Ombudsman has the final word.

Principle 5: Being proportionate
The remedy recommended by the Ombudsman must be fair and proportionate to the injustice suffered by the complainant, ensuring all circumstances are taken into account in each case.

Principle 6: Ensuring and monitoring compliance
In the situation where a public body does not take into account the recommendations of the Ombudsman a 'special report' can be issued to the governing body or Parliament so as to push for legislative change. Such an action requires the Ombudsman to check routinely with public service providers to ensure compliance with recommendations. This same governing body can itself be considered to be in maladministration if it does not comply with such a report.

The Principles of Good Administration

GETTING IT RIGHT

Having appropriately trained staff that act according to statutory powers, duties, rules and policies governing the service they provide.

BEING CUSTOMER FOCUSED

Highlights dealing with customers helpfully, sensitively and bearing in mind individual circumstances and needs.

BEING OPEN AND ACCOUNTABLE

Refers to being as transparent and as open as the law. Giving reasons for decisions and keeping records.

ACTING FAIRLY AND PROPORTIONATELY

Refers to treating people impartially, with respect and courtesy, and ensuring decisions are proportionate and fair.

PUTTING THINGS RIGHT

When mistakes happen, Entities should acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.

SEEKING CONTINUOUS IMPROVEMENT

Highlights the importance of accepting complaints as constructive criticism and a golden opportunity for reform.

3
Case Reports

BUSINESS LICENSING AUTHORITY

Case Not Sustained

CS/1127

Complaint against the Business Licensing Authority ("BLA") (formerly the Trade Licensing Authority "TLA") as a result of the BLA "not printing all the licences which were initially approved" upon converting the Company's trade licence to a business licence (the "Conversion")

Complaint

The Complainant complained that further to the Conversion, the BLA failed to grant the Company a business licence with all the corresponding business licencing classes as were set out in the Company's previous trade licence. The Complainant complained that the Conversion was therefore not a "like for like" conversion from a trade licence to a business licence.

The Complainant explained that he made an application on the Company's behalf (on the 3rd September 2015) to extend its existing trade licence as follows: "welding and steel works, general mechanics, plumbing, hire and sale of machinery equipment and tools, carpentry, vehicle recovery and salvage, general underground utilities and steel works, scrap metal recycling and rubbish; and the sale and dealing importation and exportation of the above."

No objections were received by the TLA and after considering the matter the extension was approved at a TLA meeting on the 23rd September 2015.

The following day, the TLA subsequently wrote to the Complainant stating that the application had been approved but that the TLA was of the following opinion:

1. *" Welding and steelworks: this activity is covered in your existing Trade Licence under the specified business; construction and refurbishment [section];*

2. *General mechanics, hire of machinery equipment and tools, vehicle recovery and salvage, general underground utilities and steel works, scrap metal recycling and rubbish* ***are not specified businesses*** *and we are not able to grant a licence for such a business activity under the Trade Licensing Act;*

3. *Importation; "Importation" is defined in the definition of Trade, as set out in Section 2 (1) Trade Licensing Act;*

4. *Exportation: The export of goods are regulated under the provisions of the Imports and Exports (Control) Regulations 1987."*

Accordingly, the TLA communicated that they had extended the Complainant's licence to "*Trade in: machinery equipment and tools [carrying on] a Business as: Plumbing & Carpentry."*

Note: the extension under the Trade Licensing system was granted to the Complainant's Company save for those categories which were not at the time licensable by the TLA. Within the wording of the extension, the terms "machinery" and "equipment" were contained. These terms subsequently became an issue for the Complainant at the time of converting the Company's licence when the Trade Licensing Act was repealed and the new Fair Trading Act commenced, on the 7th October 2015.

The Complainant was invited to attend TLA offices to undertake the necessary administrative arrangements and advised that the prescribed fee for the issue of the Trade Licence was £25.00

On 7th October 2015 the Fair Trading Act 2015 ("FTA") commenced and established the Office of Fair Trading ("OFT") and the BLA. In accordance with the FTA, the functions of the TLA had been transferred and subsumed within the remit of the OFT and were undertaken by the BLA. As a result all pre-existing trade licences required conversions to new business licences, issued in accordance with the FTA.

Having been presented with the Company's new converted business licence, the Complainant disagreed with the conversion applied by the BLA in the granting of the Company's new business licence. He was of the view inter alia, that they were not acting fairly in the conversion of the terms of the pre-existing trade licence to the new categories of goods set out in the OFT's new Approved Goods List for the Company's new business licence. Since the text of his approved application stipulated the words "general mechanics …..sale of machinery, equipment and tools…… and importation and exportation of the above", the Complainant was of the opinion that the extension to his licence should have authorised the Company to have traded in mechanics, equipment and tools of a general nature (namely, the ability to trade in all the classes of business which the Complainant considered appropriate or beneficial to his business interests).

The BLA was of the view that the extension would (and was) granted in line with the nature of the Complainant's previous trade licence and business activities and of course, subject to statutory definitions and regulations and on the basis of the OFT's Approved Goods List, as explained in their letter to him. The Complainant did not share that view and would not accept the class of goods that the BLA had considered were appropriate (which was based on the Company's previous trade licence) and as a consequence, he did not renew the licence.

Numerous telephone calls and exchanges of correspondence followed. The OFT's Chief Executive Officer ("CEO") also engaged in correspondence with the Complainant, clearly explaining matters and inviting to meet the Complainant to explain issues. The invitation was rejected since the Complainant stated he preferred to keep a written record "for future reference."

As a result of the Complainant's dissatisfaction with the state of affairs, he lodged a complaint with the Office of the Ombudsman.

Investigation

The Ombudsman presented the complaint to the now BLA.

The BLA immediately contacted the Ombudsman via telephone and suggested a meeting in his office to review and explain the issues causing the Complainant concern.

The meeting was attended by the CEO, the Secretary to the BLA, the Ombudsman and his Senior Investigating Officer.

The Complainant's application was reviewed, as was all correspondence which followed between the Complainant and TLA/BLA. Statutory provisions, the nature of the Complainant's business and the distinct classes of business activities over which the BLA had granted applications generally were also examined and discussed. The BLA made it clear that it had no issue whatsoever in issuing the Company with a new business licence on a "like for like" basis. The Ombudsman was able to verify that the Complainant had indeed been informed of that position on numerous occasions and that the Complainant had also been invited to meet at the BLA for a further explanation of the issues and ultimately, to renew his licence. The Ombudsman was informed how it had been explained to the Complainant on numerous occasions that all previous licensable activities contained within the Complainant's pre-conversion trade licence had been granted to the Complainant's Company. The Ombudsman had also been informed that it had been explained to the Complainant that he could have continued to have engaged in all related non-licensable "services" which the Company had provided in the past (as contained in a letter by the OFT to the Complainant dated 16th December 2015). Furthermore, the Ombudsman was satisfied that it had been repeatedly explained to the Complainant that if he chose to apply for licences in relation to trade/s that his Company had previously engaged in (upon proof thereof), said licences would have been granted under the new regime. However, the Complainant chose not to continue to engage in services previously provided nor to make fresh applications for a trade licence extension/s since he held the view that his Company was entitled to trade over the entire spectrum of "goods, equipment, machinery and tools."

Given the substantive meeting held in addition to his review of all the documentation with which he had been presented by the Complainant, the Ombudsman considered that he was in possession of sufficient information to draft a report on the Complainant's complaint.

Conclusions

The Ombudsman was of the view that it was unrealistic and farfetched for the Complainant to have expected the BLA to have granted the Company authority to trade in an unlimited class of goods on the basis that he had drafted the extension applied for with the use of generic terms, e.g., "general mechanics," and as a result of not having received objections to the application from the public.

It was reasonable for the BLA to have carried out the Conversion in line with the Company's previous trade licence and the class of goods/nature of work with which the Company was associated. It was in the Ombudsman's mind, also proper that the BLA would not extend the new business licence to activities already covered under the previous trade licence or to business activities which were unspecified and, to have explained to the Complainant orally and in writing, that he could continue to provide non-licensable services previously undertaken by his Company, as well as applying for trade licence extensions under the new licensing regime, upon proof of business activity in a given trade.

The BLA had, subsequent to the Conversion, invited and accepted representations from the Complainant to extend the new business licence in light of the contents of the Company's previous trade licence. Despite a four month delay on their part in considering the Complainant's arguments (as a result they stated, of the BLA having concentrated their resources on finalising the Approved Goods List), they issued a letter to the Complainant, further extending his new business licence to cover classes of goods which he had argued his company had an interest/dealings in. Licence fees for said informal extension to the business licence were issued to the Complainant, but he chose not to renew his application based upon his argument that his company was entitled to further extensions to cover inter alia all "goods, equipment, machinery and tools".

To the Complainant's mind, "goods" and "equipment" for instance, entitled him to trade in all known classes of goods and equipment, in accordance with a literal dictionary definition of the same. He therefore sought written explanations from the BLA as to why all the classes of goods that he had applied for, had not been granted. The reply to the Complainant's request stated that they did not agree with the Complainant's contention that he was entitled to trade in all "goods" and "equipment" as per a dictionary definition. They also set out that they could not provide the Complainant with individual written reasons as to why a licence to trade in each class of goods had not been granted since inter alia they had already "discussed the issues with the Complainant at length." Despite that, the BLA offered to once again verbally discuss issues with the Complainant (in the presence of his legal representative if he wished).

The Ombudsman further noted that despite the BLA's delays which were not desirable, they had acted appropriately and in accordance with good administrative practice in repeatedly corresponding with the Complainant and further, in affording him the opportunity to provide evidence (such as invoices or works orders) that the Company was trading in a specific class of business with the intention of them extending the licence to cover that proven trade. They informed the Complainant in writing that if representations were made, they would be reviewed and the BLA would "endeavour to consider their inclusion." That suggestion was also rejected by the Complainant.

As stated above, multiple offers to meet the Complainant to discuss the Complainant's concerns were made at various stages but rejected by the Complainant.

Classification

That the BLA had not printed all the licences which had been initially approved: **Not Sustained**

Rationale

Although the TLA had met on the 23rd September 2015 and "approved" the Complainant's application, they almost immediately issued him with a letter (on the 24th September 2015) communicating their decision and setting out their opinion on the Complainant's application. The letter explained that for the reasons set out therein, the TLA had extended the Complainant's trade licence to "Trade in: machinery equipment and tools Business as: Plumbing and Carpentry."

Ombudsman Note:

Further to the conclusion of this investigation, the CEO wrote to the Ombudsman. His letter repeated the position previously communicated to the Complainant that should the Company accept the "like for like" conversion and pay the commensurate filing fees, it could subsequently apply for an extension to its business licence under the Fair Trading Act ("FTA") 2015, for the business to trade in all of the goods and services the Complainant was arguing the Company should have featured on its licence.

The letter went on to explain that the process for an extension was fairly simple as set out in section 9 FTA. There were also guidelines about how to apply for an extension on the OFT's website along with the relevant forms (www.oft.gov.gi). It was further stated that section 59 FTA created a statutory presumption to be able to carry on business in Gibraltar subject to obtaining the required licence.

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The Ombudsman was also grateful for the information provided that should the BLA secretariat not agree to the grant of the extension, there existed a right of appeal which could not be rejected without a hearing. Should the appeal prove unsuccessful, the Complainant would have further recourse to appeal the BLA's decision to the Magistrates court in accordance with the provisions of the Fair Trading (Appeal) Regulations 2015.

The Ombudsman thanked the OFT as he was duly satisfied with the mechanisms in place and with the explanations provided in that regard. He also took note of the fact that the OFT had successfully converted circa one thousand licences for local businesses and, that their raison d'etre was "to facilitate business."

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CIVIL STATUS AND REGISTRATION OFFICE

Case Sustained

CS/1097

Complaint against the Civil Status and Registration Office ("CSRO") in relation to CSRO's non-replies to two letters sent to them by the Complainant requesting residency.

Complaint

The Complainant complained that he had written two letters to CSRO on the 17th March and 15th April 2014 requesting residence for his Moroccan family but that to the date of filing his complaint with the Office of the Ombudsman in May 2014, he had not received any replies.

The Complainant was a British national who had lived and worked in Gibraltar all of his adult life. He was a pensioner with the intention of retiring in Gibraltar. His wife and two younger children however lived in Morocco. The Complainant therefore made a request to CSRO that they be allowed to reside in Gibraltar with him as a family.

The Complainant's wife held a multi-entry visa to visit Gibraltar at her leisure since the Complainant was suffering from poor health as a result of a work related injury he suffered in the past.

On the 9th December 2013 the Complainant wrote to CSRO requesting that his wife and two younger children be allowed to reside with him in Gibraltar on a permanent basis. On the 11th December 2013, he received a letter from CSRO explaining that he needed to apply for permission by providing them with his naturalisation certificate, marriage certificate, evidence of income, his wife's passport and her birth certificate, together with his children's passports as well as his identification card. He was also asked to supply a letter from his landlord stating that there was no objection to the family living with the Complainant at his current address.

After making attempts to deliver the requested documentation at CSRO offices and having allegedly been verbally informed there that he was not entitled to bring his wife and children to Gibraltar on a permanent basis because he was ill, the Complainant wrote to CSRO on the 17th March 2014 and attached copies of the documentation to his letter. He delivered the letter by hand. He chased the letter on the 15th April 2014. No replies were received.

Frustrated with the state of affairs, the Complainant lodged his complaint at the Office of the Ombudsman.

Investigation

The Ombudsman wrote to CSRO on 12th May 2014 setting out the complaint and seeking their comments. The Ombudsman requested information on the steps taken by them in the processing of the Complainant's application, since receipt of his letters dated 17th March and 15th April 2014.

CSRO wrote to the Ombudsman on the 30th May 2014 and apologised for the delay in reply. It was explained that the Complainant's wife had been initially granted a one month visa waiver on the 1st July 2013 to enable her to visit her sick husband in Gibraltar. That was extended on humanitarian grounds on the 14th August 2013 for a period of six months (expiry date on 14th February 2014).

It was during the period that the visa waiver extension ran, that the Complainant wrote to CSRO (9th December 2013) requesting permission for his wife and two children to permanently reside with him in Gibraltar. CSRO stated how that letter was acknowledged and how the necessary documentation which the Complainant had to submit with the application, was explained to him.

CSRO's letter went on to state how they heard nothing more from the Complainant until the 17th March 2014 (when the documents which had been previously requested were submitted by the Complainant's wife). Unfortunately, according to CSRO, those documents were not supported with a covering letter and for that purpose, were rejected at the CSRO counter, (a practice which, the Ombudsman has been informed has since then ceased). Thus instead of accepting the documentation, the Complainant's wife was informed that she had outstayed her visa waiver and that she should seek a further extension in writing. However, instead of seeking the extension, the Complainant's wife returned that day and submitted the 17th March 2014 letter with the documents which had been sought. CSRO admitted that "unfortunately, that letter together with a subsequent reminder dated 15th April 2014 were left unanswered".

As a result, CSRO confirmed to the Ombudsman that the Head of CRSO ("Head") had issued instructions that the Complainant "be sent an apology and that his case be processed immediately". The Ombudsman was able to confirm that the letter of apology was sent with immediate effect.

The Complainant also received a letter from CSRO dated 30th May 2014 which stated that his "request for permits of residence which would enable [his] non-EEA visa requiring wife and two children to reside with [him] in Gibraltar is being processed".

Despite CSRO's explanations, three months elapsed and the Complainant's application did not appear to have progressed.

The Ombudsman again wrote to CSRO in September 2014 setting out that despite their earlier correspondence, almost six months had elapsed from the date of the application and the Complainant was yet to receive an answer. The Ombudsman stated that he understood (from telephone conversations held with CSRO) that one of the reasons for the delay was the amount of the Complainant's household income. The Ombudsman was informed by the Complainant that he was in receipt of a monthly state pension of £573.00, in addition to Community Care payments of £624.00 every three months and that his monthly rent was £50.00. This information was facilitated by the Ombudsman to CSRO in his letter. In conclusion, the Ombudsman again sought CSRO's comments in respect thereto together with confirmation of what the current minimum financial household income threshold was. Finally, the Ombudsman also requested an indication as to when the Complainant could expect to receive a substantive reply to his application.

As no reply to the Ombudsman was forthcoming, a chaser letter was sent in October.

Given the lack of acknowledgment or replies to the Ombudsman's correspondence, an additional letter was sent to CSRO on the 12th November 2014, stating that the non-replies were hampering the Ombudsman's investigation into the complaint. The Ombudsman also stated in no uncertain terms that delays in replying to his letters constituted an act of maladministration on CSRO's part and that he expected a reply by return.

The Ombudsman further explained that the Complainant's wife had complained that she had recently attended the CSRO counter on several occasions for the purpose of requesting an update, and that she was not at all happy with the service provided. According to her, the Clerk at the counter would simply inform her (without checking any records), that she would have to wait for a written update.

The Ombudsman considered this to be quite condescending given that the substantive complaint was that no written answers had been provided to the letters the Complainant had sent CSRO.

The reply the Ombudsman received from CSRO was apologetic in its introduction. It further explained that requests for visas to enable non-EU visa requiring spouses of British Overseas Territories Citizens (Gibraltar) to enter Gibraltar and take up residence, were processed by CSRO but later referred to HM Government of Gibraltar ("Government") for consideration on file. Since the case had already been referred to Government, CSRO explained that much of the information they provided the Ombudsman was from memory given that the majority of the Complainant's papers had been transferred.

The chronology of events was repeated (from recollection). The Ombudsman was also reminded that an apology to the Complainant for non-reply to his letters of 17th March and 15th April 2013 had been sent. CSRO further explained that the delay was partly attributable to the fact that they needed to ensure that in cases of this nature, all relevant facts had to be provided by CSRO to Government. In view of that, CSRO stated that research was required on their part into the Complainant's landlord's letter (submitted to CSRO on 17th March 2013), which had clearly stated that the Complainant's wife already resided with him in Gibraltar. As a result of that statement, CSRO carried out a further search of their civilian registration cards whether that was indeed the case. It was established that the Complainants wife had applied for the waiver in August 2013, that it had been granted and subsequently extended on two occasions for her to be able to care for her sick husband, with the date of expiry being February 2015. The mistake lie in that the request for the permit extensions were placed inside the visa waiver file and subsequently deposited in the "Visa Waiver Cabinet". As a result, the processing of the application was delayed and in CSRO's words "could not have been provided sooner". The Head of CSRO reiterated that the mishap had been his fault entirely. The letter also stated that the processing of the request had been completed and submitted to Government for their consideration on 11th November 2014 (8 months after the application had been lodged).

CSRO wrote to the Complainant on the 21st January 2015. It was explained that "one of the factors that are taken into consideration when Government is asked to consider such requests [for permits of residency] is that the person who is requesting such permits is able to maintain and accommodate his wife and minor children in Gibraltar without recourse to public funds. In your case, account has been taken of the fact that you are an old age pensioner and will be unable to fully maintain and accommodate your wife and two daughters in Gibraltar. However, it has been decided to approve the issue of a permit of residence for your wife only. This would enable her to continue to take care of you in Gibraltar."

The Complainant was further informed that his wife should apply for a civilian registration card and corresponding permit of residence which would be issued on a six monthly renewable basis.

The Ombudsman issued a letter to CSRO on 24th February 2015 alluding to previous telephone conversations held with CSRO on the issue of minimum household income. This, the Ombudsman was informed at the time, could be an issue affecting the Complainant's application. CSRO confirmed at that stage that they would be asking for a "policy steer" in that regard. Given that conversation, the Ombudsman, in his 24th February letter, requested information as to whether the "policy steer" had been obtained and if not, what the financial threshold was for household income in regard to requests for residency from non EU national married to British Nationals.

The reply that followed stated that the minimum financial threshold used for all cases was whether the person could maintain his/her family and, that the criterion was supplied and utilised by Government's Statistics Office.

Consequently, the Ombudsman contacted the Government's Statistics Office. They, in turn, advised the Ombudsman that they did not calculate the minimum income threshold and that the Ombudsman should contact CSRO for assistance!

Conclusions

Although the Ombudsman accepted CSRO's repeated apologies and explanations for the delays in answering correspondence, that did not excuse the fact that it took them an excessive amount of time to respond to the Complainant's letters and process the application for onward transmission to Government, (as advised by the Head).

It may well have been the case that the delay was caused as a result of the application for residency being misfiled (as explained by the Head). However, although the possibility of human error always exists, the delays caused were inexcusable, particularly given the fact that the Complainant's wife would often attend the CSRO counter for updates. Instead of constantly dismissing her and advising her that she should have waited for an update in writing (which was ironic given that her complaint related to non-replies), alarm bells should have rang as to the fact that the matter was taking too long and that something was amiss. It was the Ombudsman's view that had the Complainant/his wife not been as insistent as they were and had the Ombudsman not intervened, it was likely that the filing error would have been discovered at a much later date if at all and consequently, the mistake would not have been rectified when it was.

It should be noted though that when the error was discovered, CSRO actioned and dispatched the application to Government, almost immediately.

The Ombudsman also found that the delays in answering his letters (which in some cases extended to various weeks) was not good administrative practice and as pointed out to CSRO at the time "are viewed as acts of serious maladministration which bring the office of the Ombudsman into disrepute as we are unable to proceed with our investigation and consequently not provide timely replies to the Complainant."

Additionally, the fact that no copies were kept by CSRO of paperwork received and subsequently transferred to Government for the latter to make a decision was also considered by the Ombudsman to constitute poor administrative practice by CSRO. The taking of copies would obviate the need to respond to correspondence from "memory" and could also save all parties concerned time, in the event of loss of documentation.

Finally, the Ombudsman also opined that the fact that the entity which established the household minimum income threshold could not be identified and consequently, that the criterion applied could not be provided for his consideration, was poor practice.

Classification

Non-replies to the Complainants letters dated 17th March and 15th April 2013 to the date of filing the Complainant's complaint- **Sustained**

Case Sustained

CS/1098

Complaint against the Civil Status and Registration office ("CSRO") in relation to the lack of a written reply to a letter the Complainant sent to CSRO in September 2014 requesting residency for his wife.

Complaint

The Complainant complained that he wrote to CSRO in September 2014 requesting that his wife be granted residency in Gibraltar in order to allow her to live with him. To the date of the Complainant lodging his complaint with the Office of the Ombudsman in June 2015, no written reply had been received to his letter.

The Complainant, who was a British national, was aggrieved because he had not received a written reply to his request for the grant of residency to his Moroccan wife. The request was made on the 5th September 2014. CSRO replied to the Complainant on the 14th September 2014 stating that in order for the application to be processed, he would need to provide numerous documents as outlined in their reply. The Complainant alleged that he then proceeded to promptly submit all the relevant documentation to support the application for his wife's residency.

Nine months elapsed from the date of the request to the lodging of the Complainant's complaint with the Ombudsman. During that period, all the Complainant received was a holding reply (verbal) from CSRO. The Complainant further alleged that the verbal exchange had only materialised as a result of the numerous complaints of delay he had made at the CSRO's counters.

The verbal reply was made by a CSRO senior employee who allegedly informed the Complainant that his case was "complicated". Apparently, CSRO was of the view (communicated to the Complainant by the mentioned employee), that the Complainant's household income was insufficient to maintain himself and his wife. The Complainant took offence at that assumption and strongly disagreed with that view. He stated that he was in receipt of a monthly pension of £420 and a further £600 from "community care" every quarter. The Complainant explained that in total, his monthly income was £620. From that amount he paid a monthly rent of £60 with the rest being spent on bills, food and other living expenses. Offended and frustrated by the state of affairs, the Complainant lodged his complaint with the Office of the Ombudsman in June 2015.

Investigation

The Ombudsman presented the Complaint to CSRO by letter dated 13th April 2015 setting out the complaint and requesting CSRO's comments.

A prompt reply followed by the head ("Head") of CSRO who stated that he had personally investigated the Complainant's case. He thanked the Ombudsman for having brought the complaint to his attention. In respect of the delay encountered, no excuses were made and it was freely admitted that the Complainant's file had been "misplaced, explaining the reason for its tardiness".

The Ombudsman was informed that in order to obviate the situation reoccurring, CSRO had established a new procedure whereby all cases received at their office counter would be recorded in an electronic register which would be monitored by the Head and all his senior staff.

The letter concluded by offering the Complainant an apology for the inconvenience caused with the added assurance that his case had been dispatched to HM Government of Gibraltar ("HMGG") for final consideration. As soon as CSRO were informed of the decision, they would, in turn, contact the Complainant and communicate the outcome.

The Office of the Ombudsman, in accordance with internal working practices, contacted the Complainant to update him on the position.

Two months elapsed and since no further communication was received by CSRO, the Ombudsman issued a chaser letter. The reply that followed stated that the matter had indeed been referred by CSRO to HMGG on the 16th April 2015 and that it was still under consideration.

Towards the middle of July 2015, the Ombudsman sent CSRO another reminder, requesting that they chase HMG for a reply on the matter.

The Complainant's wife (whilst in Gibraltar under a visitor visa) had been diagnosed with "metatastic breast cancer with a terminal prognosis". The necessity to finalise the residency issue was therefore of utmost importance.

On the 31st July 2015, the Complainant met with the Ombudsman and provided him with a letter issued by CSRO, dated 24th July 2015. The letter (which the Ombudsman observed was only two sentences long and lacked any explanation whatsoever for the decision reached), comprised entirely of the following; "I refer to your application for a permit of residence in respect of your above named wife. I regret to inform you that the decision has not been approved."

Conclusions

The Ombudsman acknowledged CSRO's explanation in relation to the loss of the Complainant's application. He noted and accepted the apology provided by CSRO and the confirmation that the matter had been transferred to HMGG for the final decision to be taken.

The Complainant had promptly provided all the information and documentation that had been requested of him by CSRO in September 2014. The Ombudsman was of the view that at the very least, The Complainant should have been provided with an explanation as to why the request had been denied and why the criteria applied had not been met.

Despite being unable to question or challenge the merit (or otherwise), of the decision communicated in CRSO's letter to the Complainant, the Ombudsman was grossly disappointed and dissatisfied with the content of the letter in that it lacked any form of explanation for the decision taken. The standard applied by CSRO in its letter delivering the decision, fell far short of any acceptable benchmark of good administration.

The Ombudsman would now expect CSRO to offer the Complainant a full written explanation (copied to the Ombudsman), of why the application had not been approved and with details of any appeals procedure in existence.

Classification

Sustained

Ombudsman Note

It was of particular relevance for the Ombudsman to acknowledge that despite the non -approval of the residence permit, (and as a result of the Complainant's wife terminal illness which was communicated by the Ombudsman to HMGG and CSRO by email dated 31st July 2015), CSRO immediately initiated the necessary proceedings which concluded in the temporary regularisation of her immigration status. It was noteworthy however, that only as a result of knowledge of the Complainant's wife ill-health did matters progress when in the Ombudsman's view, they should have done so as a matter of course at an earlier stage. HMGG also took the view, on humanitarian grounds and upon medical advice, to continue to treat the Complainant's wife at St Bernard's Hospital at the taxpayers cost, due to her serious and prolonged illness.

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Case Sustained

CS/1111

Complaint against the Civil Status & Registration Office ("CSRO") as a result of non-reply to emails; and lack of response regarding Complainant's husband's ("Husband") immigration status.

Complaint

The Complainant explained that her Husband, a Jamaican national, and his son, had resided with her in Government rented accommodation ("Flat") until the 1st March 2015 when she claimed that he physically abused her which led to his arrest by the Royal Gibraltar Police ("RGP"). According to the Complainant, the same situation had arisen on three previous occasions and that incident had been the last straw.

By way of background, the Complainant described how in order for her Husband to obtain a residence permit in Gibraltar, she was asked by CSRO to sign a document ("Document") stating that as long as her Husband and his son resided in Gibraltar she would be held fully responsible for them and any change in circumstances would be immediately notified to CSRO.

On the 30th June 2015, the Complainant informed CSRO via email about the breakdown of the marriage as a result of her Husband's abusive behaviour and the fact that he no longer lived in the Flat. The Complainant referred CSRO to the Document and advised that she was complying with their instructions in notifying the change in circumstances. She requested that the email be forwarded to the Head of CSRO ("Head") and any other pertinent authority.

On the 7th and 8th August 2015 the Complainant sent an email to CSRO in which she informed them that her Husband would be attending Court in respect of the physical abuse incidents. She explained she wanted him removed from the tenancy agreement of the Flat but had been informed by the Housing Authority (landlord) that proof of legal separation or divorce had to be submitted before the removal could be undertaken. The Complainant claimed her Husband had refused to sign the separation agreement for fear of losing his residence permit. She stated that his behaviour had changed after they married when he became abusive to the point that she feared for her life. The Complainant believed the change was due to her Husband believing that his status had been secured as a result of the marriage. In her emails, the Complainant requested a meeting with the Head to discuss the situation she was enduring as a result of her Husband's actions.

CSRO responded to the Complainant the following day and informed her the emails had been forwarded to the Head. By the 20th August 2015 the Complainant had received no reply. She therefore emailed and hand delivered a copy of her correspondence to the Head. In that email she explained she would be meeting two senior officials to discuss her situation and once again asked for a meeting with him.

Not having received a response from the Head by the end of November 2015, the Complainant lodged her complaint with the Ombudsman. In her letter of complaint she also asked the Ombudsman to clarify the grounds upon which her Husband and his son were able to continue to reside in Gibraltar now that the marriage had broken down as they were only meant to be in Gibraltar due to the marriage.

Investigation

In his initial response to the Ombudsman, the Head provided background information. He explained that the Complainant first came to his attention in late March 2014 when she wrote to CSRO in support of her then boyfriend's (later Husband) request for a visa to come to Gibraltar to get married and reside thereafter. The visa was granted and they were married on the 14thApril 2014. Later that month, the Complainant requested that her Husband and his son be allowed to reside in the Flat with her and her three children. Within a month, before CSRO submitted her request for approval, the Complainant wrote to CSRO and informed them she had been the victim of domestic violence and asked that they cancel the request and his visa and deport him. The following day CSRO responded to her and stated that they accepted the withdrawal of the request but informed her that the visa was valid until the 28th June 2014 and they could remain in Gibraltar at a different address. The Complainant then informed CSRO that she would try and work things out with the Husband and asked for CSRO to proceed with the request for them to reside in the Flat. CSRO responded that the application had been cancelled and they would have to reapply. They reapplied on the 23rdMay 2014. On the 11th June 2014 the Complainant's request was submitted and approved two days later.

CSRO continued by stating that almost a year later the Complainant again informed them that her Husband had been abusive and she had commenced legal proceedings to separate. The Complainant informed them that the Husband now lived at a friend's house.

In reference to the Complainant's unanswered emails of the 3rd and 20th August 2015, CSRO stated that she wrote seeking help of an unspecified nature as a result of issues which had arisen from the alleged domestic abuse and the fact that she feared for her life. CSRO claimed that the Complainant was verbally informed that a meeting with the Head would not serve any useful purpose and she should inform the RGP. CSRO stated they had always attended to the Complainant's 'reasonable requests' in a polite and timely manner but on this occasion could not as it appeared that her ultimate goal was to have her Husband and his child deported. CSRO explained that if they were to proceed with the deportation, a Court hearing would have to be listed and any deportation would be based on the strength of a Court Order.

Further to the above, the Ombudsman requested a copy of the signed Document. CSRO responded that the Complainant never submitted the 'formal undertaking' but provided the unsigned copy dated 20th June 2014. In essence, the undertaking stated that the application for a permit of residence had been approved for the Husband, on the condition that he:

- Remained married;
- Continued to live with his wife;
- His wife made herself responsible for his accommodation and maintenance.

CSRO required the wife to provide a formal written undertaking confirming the conditions were understood and accepted, and an assurance that CSRO would be informed of any changes in respect of the conditions. CSRO stated in the undertaking that residence permits and visa waivers were issued on a six monthly renewable basis until further notice.

In April 2016, upon further enquiry from the Ombudsman, the acting Head of CSRO ("Head 2") explained that when a spouse was admitted for residency, he or she was able to register with the Ministry for Employment (with the object of finding employment) given that he/she had been issued with a residence permit as a spouse of a 'Gibraltar belonger'. The Husband succeeded in obtaining employment shortly after his arrival and continued to work for the same employer when the marriage broke down. Head 2 denied that they had ever informed the Complainant that her Husband would be deported if the marriage broke down. Furthermore, she confirmed they had searched through immigration files and not found any record of deportations resulted from breakdown in marriages. Head 2 believed this was due to the fact that once a person was admitted for residency and secured employment in Gibraltar it would be very difficult to ask the employer to revoke the work permit. She also stated it would be difficult to commence deportation proceedings against individuals unless the Court directed those proceedings.

Head 2 stated that the Complainant had approached the Offices of the Chief Minister for the purpose of finding out if anything could be done to deport her Husband and his underage son and a meeting was arranged which took place in September 2015. According to Head 2, at that meeting the Complainant was told that there was nothing that could be done to assist her but she was informed that Social Services would be contacted based on her allegations in relation to her Husband's son (the Complainant had stated that the son resided in separate accommodation to that of her Husband's. Head 2 confirmed to the Ombudsman that Social Services had been informed). She was further advised to continue to contact the RGP if she was harassed by her Husband but that it would be up to her legal representative and not the Government of Gibraltar to argue her case in Court. It would also be the courts prerogative to initiate deportation proceedings against her Husband if that was considered necessary. Head 2 did not know the outcome of the divorce proceedings but imagined that neither the Magistrate nor the RGP had initiated deportation proceedings. Head 2 informed the Ombudsman that the Husband continued in employment, had moved from the matrimonial home and now resided in privately rented accommodation with his son.

The Ombudsman prodded further into why CSRO required that Gibraltarians who married non-EU nationals should sign an undertaking confirming the conditions set out in the Document. In the Complainant's case, all the conditions had been breached and ultimately had no bearing vis-à-vis the renewal of residence permits because her Husband had a work permit and was employed locally. The Ombudsman formed the view that the confirmation he sought was substantiated by the information provided by Head 2 that there was no record of deportations in immigration files as a result of breach of the conditions set out in the Document.

CSRO responded that they had changed the Document and provided a copy of it. The Ombudsman found that in the new version, the permit of residence was issued on the conditions that:

1. The persons remained married;
2. The person sponsoring the application financially supported the applicant to the extent that they would not be a burden on public funds;
3. Continued to reside together;
4. The sponsor accommodated the applicant at his/her own expense;
5. Informed the CSRO of changes in circumstances.

CSRO stated that when the Husband arrived in Gibraltar both he and his son were financially dependent on the Complainant and were issued with six monthly residence permits. As the Husband obtained employment he was no longer considered a dependent. He was a work permit holder and was issued a yearly residence permit. His son has remained in Gibraltar as his dependent.

The Ombudsman contacted the Director of Employment ("Director") for further information on work permits which appeared to supersede residence permits. The Director explained that if a non-EU national who worked in Gibraltar lost his job and was unable to find another, it would be the CSRO's decision whether to renew or not the six monthly residence permit. In the Complainant's case, the fact that the Husband had a son would be a contributory factor in the CSRO's decision.

Regarding the inclusion and exclusion from the Flat's tenancy, the Ombudsman sought information from the Housing Authority. They advised that the Husband's and son's inclusion was made on the 20th June 2014 but no exclusion had been carried out, despite a copy of the decree absolute (divorce) having been provided by the Complainant. The explanation given was that the rental for the Flat was in arrears and Government had in January 2016 introduced a new policy whereby no amendments could be made to tenancies in arrears.

The Ombudsman contacted and notified the Complainant of the above. The Complainant settled the arrears and the tenancy amended on the 9th May 2016 to remove the Husband and his son.

Conclusions

Complaint 1 - Non-reply from CSROto Complainant's emails - Sustained

The Ombudsman sustains this complaint. Despite the CSRO claiming they had verbally responded to the Complainant's emails, she maintains she never received a response, and CSRO have no evidence of the verbal notification. Administrative good practice on the part of CSRO would therefore have been to respond to her in writing, clearly setting out the fact that CSRO could not assist her in any way and directing her to RGP and her legal adviser. Not having done so at a timely stage has resulted in the Ombudsman's investigation. Notwithstanding, the Ombudsman's involvement has served to bring to the forefront the function of the Document and information in relation to residence and work permits.

Complaint 2 - No response from CSRO regarding Husband's immigration status –Sustained

The Ombudsman sustains this complaint, tied to Complaint 1. The reason why the Complainant contacted CSRO was to inform them that the conditions of the Document had been breached and because she assumed that breach would result in the Husband's deportation. As the Ombudsman's investigation has found, that was not the case.

Although at the meeting at the Offices of the Chief Minister the Complainant was advised that there was nothing that could be done for her, the Complainant believed that CSRO as a separate entity had the powers to assist her. CSRO should have written or met with the Complainant and clarified her misconceptions.

Document

The Ombudsman compared the Documents (CSRO declarations) and noted that despite CSRO's assertion that the declaration had been amended, on analysis, the conditions were the same albeit differently set out. CSRO have not provided a reasonable explanation as to the function of the Document and so the Ombudsman maintains that the Document serves no purpose other than to leave open to interpretation to both sponsors and applicants the consequences of breach of conditions. The Ombudsman notes that this argument is further substantiated by the fact that despite the Complainant not having signed the undertaking, CSRO took no steps to rectify the anomaly.

The Ombudsman is critical of the Document as it appears to be almost worthless and of poor legal standing and as such either a revised workable version should be introduced or the Document done away with in order to avoid in future, the creation of expectations, similar to those created in the Complainant's case who, faced with the violent actions of her Husband, believed her problems with him would be resolved because of the existence of the Document. The Complainant believed that because the marriage broke up the Husband and son would be asked to leave, regardless.
Classification

Complaint 1 - Non-reply from CSRO to Complainant's emails – Sustained

Complaint 2 - No response from CSRO regarding Husband's immigration status – Sustained

Recommendations

The Complaint brought to the Ombudsman partly pivoted around a document ("Document") which the CSRO had asked the Complainant to sign at the time when her boyfriend, soon to be husband, and his son, applied for a residence permit in Gibraltar. In summary, the Document was a formal undertaking that the permit had been approved by the CSRO on the condition that the Complainant and her Husband remained married, continued to live together and she made herself responsible for his and his son's accommodation and maintenance. CSRO further required that the Complainant inform them of any change in those conditions. When the marriage broke down, the Complainant immediately notified CSRO on the expectation that her Husband would be deported due to the conditions of the Document having been breached. In the course of the Ombudsman's investigation it emerged that once a person was admitted for residency and secured employment in Gibraltar it would be very difficult to ask the employer to revoke the work permit. It would also be difficult to commence deportation proceedings against those individuals unless the Court directed those proceedings.

In light of the above, the Ombudsman is critical of the Document as it appears to be almost worthless and of poor legal standing and, as such, either a revised workable version should be introduced or the Document done away with in order to avoid in future, the creation of expectations, similar to those created in the Complainant's case who, faced with the violent actions of her Husband, believed her problems with him would be resolved because of the existence of the Document. The Document led the Complainant to believe that because the marriage was broken the Husband and son would be asked to leave, regardless.

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Case Not Sustained

CS/1114

Complaint against the Civil Status and Registration Office ("CSRO") in relation to (1) a deduction in monies which according to the Complainant should have been fully reimbursed to her and (2) that her email was allegedly blocked by CSRO when she expressed her dissatisfaction at the state of affairs.

Complaint

The Complainant felt aggrieved and complained that bank charges incurred as a result of monies having being credited to her personal account by CSRO, should have been reimbursed to her by CSRO. She further complained that she thought it very unprofessional that her email address had been blocked by CSRO after she persistently complained about matters.

Background

The Complainant explained that an error had been made by CSRO with the booking of her marriage ceremony in December 2015. The Complainant had requested that the ceremony take place at the Registry Office but CSRO incorrectly booked the Sunborn yacht hotel. As a result, the amount of £307.50 (Euros 447.41) as opposed to the previously agreed figure of £134.50, was deducted from her bank account.

The Complainant brought the error to CSRO's attention, which they noted. Arrangements were made by them to reimburse the Complainant. However, as a result of the bank transfer and because the monies were credited from CSRO's account in Gibraltar to the Complainants designated Spanish bank account, bank charges in the sum of £12.50 were deducted from the amount transferred to the Complainant. Instead of receiving the full amount of £307.50, she received a net reimbursement of £295.00

The Complainant considered it unreasonable that she was "financially penalised" for an error caused by CSRO. Her view was that the bank charges should have been met by CSRO and not deducted from the amount which was owing to her.

Additionally, the Complainant informed the Ombudsman that she had made written requests (via email) for CSRO members of staff to take ownership of her complaint and reimburse the full amount owing to her, to no avail. Furthermore, the Complainant alleged that CSRO blocked receipt of emails from her address to the three CSRO email addresses she had corresponded with.

Unhappy with the state of affairs, the Complainant lodged her complaint with the Office of the Ombudsman on the 26th February 2016.

Investigation

The Ombudsman reviewed copies of email exchanges between the Complainant and CSRO which the Complainant had provided. The correspondence reflected the initial agreement between the parties as to the date, location and fee payable for the Complainant's marriage, as well as the error in the deduction of monies that CSRO had made. It was also clear that CSRO had confirmed that an immediate and full refund would be made and that the Complainant should settle the originally agreed fee in person, at CSRO offices, prior to her marriage ceremony.

The Ombudsman proceeded to present the complaint to CSRO on the 17th March 2016, setting out the Complainant's grievances and requesting CSRO's comments. Given that no reply was forthcoming, a chaser letter was sent on the 8th April 2016.

CSRO issued the Ombudsman with a written reply (for and on behalf of the head of CSRO), by letter also dated 8th April 2016, (received by the Ombudsman on the 21st April 2016).

CSRO explained that they had started corresponding with the Complainant in October 2015 and that they had done so for a couple of months. They informed the Ombudsman that the Complainant provided them with the required documents for the marriage ceremony. Dates, times and venues were also discussed. The booking was eventually made for December 2015, with the ceremony to take place at the Registry Office. CSRO openly admitted that they had erroneously charged the Complainant the sum of £307.50 (being fees for an outside marriage i.e., not at the Registry Office). They also stated (as was indeed the case), that they immediately proceeded to refund said fees and that in order to effect the transfer and in line with HM Treasury's policy, they required bank details in order to credit the Complainant's account with the amount due. The Complainant provided CSRO with her Spanish bank account details for that purpose.

It was also explained to the Ombudsman how the full amount of £307.50 was refunded. The bank imposed transfer fees of £12.50 which they automatically deducted from the Complainant's account. The letter went on to state that "the CSRO did not impose any charges."

In regard to the allegation that the Complainant's email was blocked, CSRO confirmed that that was not the case. "It is impossible for staff to block any incoming emails and this can be verified by the IT Department. I can assure you that this has not been done. The latest email to [the Complainant] was sent by myself on 26th February 2016."

Conclusions

Although the Ombudsman was sympathetic with the Complainant, he was of the view that in having corresponded with the Complainant on multiple occasions, having admitted the error in relation to the amount that they had debited from the Complainants account and, having taken the necessary steps to make an immediate rectification of that error, CSRO had acted fairly and reasonably in the circumstances and in accordance with good administrative practice.

It was an unfortunate occurrence that the bank imposed a charge (£12.50) on the amount transferred. However, the charge had not been imposed by CSRO nor was it within their ambit of control. For that reason, the Ombudsman saw no justifiable reason why CSRO would have to settle that charge and reimburse the Complainant for it.

Insofar as the allegation of the blocking of the Complainants email address by CSRO was concerned, the Ombudsman accepted CSRO's explanation in that regard, provided in their letter to the Ombudsman dated 8th April 2016.

Ombudsman Note: Further to the Complainant's review of this report in draft form for factual comments (as per the Ombudsman's standard practice), the Complainant expressed the view that if indeed "it was impossible to block her emails", it may well have been that CSRO chose to ignore them.

The Ombudsman took the view (based on supposition), that it may have been the case that once CSRO confirmed the transfer of monies, they may have considered the matter closed and decided to no longer correspond with the Complainant. If indeed that was the case, the Complainant should have been advised that her e-mails on a matter which CSRO considered closed would no longer be entertained. Based upon this, the non-replies to the Complainant's correspondence after the return of fees via the bank transfer, would constitute a practice not in keeping with good administrative practice.

Classification

That the deduction in monies imposed by the bank should have been reimbursed by CSRO- not sustained ;

That CSRO "blocked" the Complainant's email when she expressed her dissatisfaction at the state of affairs- not sustained (See Ombudsman note above).

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EMPLOYMENT SERVICE

Case Partly Sustained

CS/1083

Complaint against the Employment Service as a result of the Complainant being verbally informed that he had to pay double rent for a number of months because he did not leave the temporary hostel site once the Tower Hostel was made habitable after fire damage; no reply to letter of complaint to the Employment Service and the alleged inadequate system for payment of rent for Government Hostels.

Complaint

The Complainant was aggrieved and raised the following complaints against the Employment Service ("ES") the entity with responsibility for Government Hostels at the time of lodging these complaints:

1. Verbally informed that he had to pay double rent for a number of months because he did not leave the Queen's Hotel (temporary hostel site) once the Devil's Tower Hostel was made habitable (after fire damage);
2. Non-reply to letter of complaint to the Employment Service dated 12th November 2014;
3. No adequate system for payment of rent for Government Hostels and on most occasions, no one in the office to receive payment.

The Complainant explained to the Ombudsman that as a result of a fire at the Government owned Devil's Tower Hostel ("DTH") in July 2014, residents were temporarily relocated to the Queen's Hotel. He recalled that at a later stage the Hostels Manager told him he needed to return to the DTH but alleged to have replied to him that he did not feel the DTH had been made habitable. Furthermore, the Complainant informed the Hostels Manager that he had been allocated a Government flat ("Flat") and preferred to remain at the Queen's Hotel whilst making the Flat ready for occupation, similar to the action taken by other residents. According to the Complainant, he was at a later stage verbally informed by the Hostels Manager that he had substantial rent arrears and those had increased due to having been charged double rent since having been asked to return to DTH; i.e. rent was charged for the Queen's Hotel and DTH. The Complainant believed the action taken by the ES was very unfair, especially due to the casual manner in which he had been asked by the Hostels Manager to return to DTH and due to not having been informed of the consequences of not relocating.

Regarding the rent arrears, the Complainant informed the Ombudsman that these had also accumulated due to his having withheld payment of rent which stemmed from an issue he had with the state of the bathrooms in DTH which he claimed needed to be cleaned and renovated and because he was waiting for a claim against Government to be considered in respect of substantial personal losses suffered as a result of the fire. The Complainant stated he would pay his rent but highlighted that his rent book was burnt in the DTH fire and he had no way of finding out how much he owed. The Complainant stated he had sent a letter to the ES in November 2014 in which he had requested, amongst other issues, that they notify him of the amount of rent he owed but claimed not to have received a reply. In the letter to the ES, the Complainant raised the issue that he had attempted to make rental payments at the Hostels Manager's offices at the ES on numerous occasions between mid-October and the beginning of November 2014 but that there had been no one in the office. He had ultimately resorted to calling the Hostels Manager on his mobile phone to arrange to make payment. The Complainant felt that an adequate system had to be put in place for residents to be able to pay their rent.

The Complainant lodged his Complaints with the Ombudsman in January 2015.

Investigation

The Ombudsman presented the Complaints to the newly appointed Director of Employment by way of letter dated 29th January 2015. Despite numerous attempts from the Ombudsman to obtain the information required it was not until May 2015 when the ES informed the Ombudsman, in a course of a telephone conversation, that responsibility for the Government Hostels no longer fell under the ES but under the Ministry for Economic Development and as such the person who had previously held the post of Director of Employment, now Director for Economic Development, was responsible.

The Ombudsman was frustrated at the fact that he had been liaising with the ES for a number of months, only to be informed at an unacceptable late stage, that they were not responsible for the hostels. The Ombudsman's view on the delay, which he made clear to the ES, was that had the ES made this known at an earlier stage, the investigation would have progressed at a considerable rate rather than the unnecessary delays experienced. The Ombudsman requested an explanation from the Director as to the reasons for the delay in providing that information but this was never received.

The Ombudsman contacted the Director for Economic Development who explained that further to a ministerial reshuffle in December 2014 he was asked by the Minister for Economic Development to join him in the Ministry for Economic Development and that in February 2015 it was decided that the Government Hostels should come under the Ministry for Economic Development.

The Ombudsman presented copies of documentation related to the complaints to the Director for Economic Development. The latter responded promptly and advised that he had been unaware that the Ombudsman had only recently been advised by officials at the ES that responsibility for the DTH had been transferred to the Ministry for Economic Development as a result of which, the Ombudsman's investigation had suffered substantial delay and would be providing the information required by the Ombudsman.

The Director for Economic Development reverted in July 2015 and stated he had spoken to the Hostels Manager about the Complainant. The Hostels Manager confirmed he had verbally informed the Complainant about having to return to DTH as was done with all the other DTH residents who had been temporarily relocated to the Queen's Hotel. No written notification was made. According to the Hostels Manager, all residents returned with the exception of the Complainant and it was made very clear to him at the time that he was occupying two hostel rooms and failure to release the room at the Queen's Hotel would result in double the room rate being charged. According to the Hostels Manager, the Complainant took no notice of the instruction to relocate.

Regarding the Complainant's allegation that the DTH was not habitable, the Director for Economic Development advised that was not the case as all other residents of DTH returned without complaints. The Director of Economic Development believed that the Complainant simply did not wish to move his belongings twice, i.e. to DTH and then to the Flat.

Regarding the Complainant having stated that he would not make rental payments because he was pursuing a claim against damages resulted from the fire, the Director for Economic Development stressed that the Complainant had taken unilateral action without any formal notice or agreement and therefore continued to owe rent.

As to the arrangements for rental payments to be made to the Hostels Manager, the Director for Economic Development advised that Hostels staff visit the facilities on Friday's to collect room rent and the Complainant had no reason to visit the ES premises.

The Director for Economic Development suspected the Complainant had no intention to pay rent arrears and stated that he had openly admitted this in conversation with the Hostels Manager and support staff.

Conclusions

Complaint 1 - Verbally informed that he had to pay double rent for a number of months because he did not leave the Queen's Hotel (temporary hostel site) once the Devil's Tower Hostel was made habitable (after fire damage) - Sustained

This investigation corroborated the Complainant's claim that he was verbally informed by the Hostels Manager that he had to leave the Queen's Hotel and return to DTH and that no written notification had in fact been sent to either the Complainant or any of the other residents. Although the Hostels Manager asserts that all residents except the Complainant returned to DTH further to the verbal communication it goes without say that faced with a stalemate situation, the Hostels Manager should have written to the Complainant advising him of the deadline by which he had to leave the Queen's Hotel and informing him of the consequences if he failed to comply, e.g. double the rent accruing or other measures if necessary to escalate action.

The Ombudsman noted that the Director points vis a vis rent witheld by the Complainant, that he did so without '...any formal notice or agreement and therefore continued to owe rent'; the same would apply to the Ministry for Economic Development.

The Ombudsman finds maladministration in the manner in which the Hostels Manager failed to deal with this situation.

Complaint 2 - Non-reply to letter of complaint to the Employment Service dated 12th November 2014 - Sustained

The Ombudsman finds gross maladministration in respect of this Complaint. Further to not having replied to the Complainant's letter, the ES also failed to provide any response to the Ombudsman despite the letters having been addressed to them. The result was that the Complainant is to date still waiting to be notified in writing of the amount he owes in rent plus arrears.

The Ombudsman is completely disenchanted with the ES as a result of the incompetent manner in which they have chosen to act vis a vis complaints to the Ombudsman against the ES. Whilst a number of years ago, the Ombudsman presented the ES as an example of good administration, that has now long ceased to be the case, not least due to the fact that in the last four years, three different persons have held the post of Director of Employment which has inevitably had direct consequences on service users and especially to the ES' administrative machinery.

Complaint 3 - No adequate system for payment of rent for Government Hostels and on most occasions, no one in the office to receive payment – Not-Sustained

The Ombudsman does not sustain this Complaint. The fact that the Complainant had the Hostels Manager's mobile phone number implies that the Complainant was in a position to contact the Hostel Manager prior to visiting the ES offices and making concrete arrangements with him in order to settle the rent arrears. Furthermore, according to the ES' Senior Executive Officer, other ES employees would have been able to take the rent money from the Complainant and supplied a receipt. Failing this, the Hostels Manager and support staff visit the hostels on Friday's for the purpose of rent collection. Notwithstanding, the Hostels offices at the ES premises should be manned and on occasions when it is not, at the very least, a notice to placed on the door advising hostels residents of who to approach in the ES for assistance.

In view of the Complainant's offer to settle the rent arrears, as set out in his letter of the 12th November 2014, the Ombudsman advises the Hostels Manager to notify the Complainant in writing of the amount owed and that this be settled expeditiously by the Complainant.

Classification

Complaint 1 - Verbally informed that he had to pay double rent for a number of months because he did not leave the Queen's Hotel (temporary hostel site) once the Devil's Tower Hostel was made habitable (after fire damage) – Sustained

Complaint 2 - Non-reply to letter of complaint to the Employment Service dated 12th November 2014 – Sustained

Complaint 3 - No adequate system for payment of rent for Government Hostels and on most occasions, no one in the office to receive payment – Not-Sustained

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Case Partly Sustained

CS/1086

Complaint against the Employment Service as a result of the Complainant allegedly having been informed by the Employment Service that there were no suitable vacancies for her as she was not Gibraltarian; and for the non-reply to letters sent to the Director of Employment.

Complaint

The Complainant was aggrieved because she claimed to have been informed by the Employment Service ("ES") that there were no suitable vacancies for her as she was not Gibraltarian. She was further aggrieved because she had not received replies to two letters sent to the Director of Employment ("Director 1") in September and October 2014.

The Complainant, a Spanish national of Moroccan origin, claimed to have lived and worked in Gibraltar for almost thirty years. In May 2014 she registered as unemployed with the ES and received unemployment benefit for a period of thirteen weeks, August 2014. Throughout that period, the Complainant stated to have regularly visited the ES offices for assistance in finding employment but claims to have been told that there were no suitable vacancies for her (Complainant required work as a cleaner).

Paradoxically, the Complainant alleged that a number of unemployed friends who had gone through the naturalization process and were now Gibraltarians visited the employment officers on the same day as her and were given the choice of several vacancies as cleaners. The Complainant stated that on one occasion, when one of her Gibraltarian friends was contacted by the ES in relation to a vacancy for cleaner she accompanied her in the hope of finding a job herself. Upon arriving at the offices, the Complainant alleged she was asked to present her ID card and then asked to wait outside (the Complainant's ID was a Civilian Registration Card and not a Gibraltar ID) as there were no suitable vacancies for her because she did not have a Gibraltarian ID card.

By September 2014, the Complainant was in a desperate situation due to not having been able to find suitable employment and wrote to Director 1 with her plight. In that letter, the Complainant informed Director 1 about the incidents experienced at the ES and requested his assistance in finding employment due to her dire financial situation. Not having received a reply by October 2014, the Complainant sent a second letter but once again did not receive any response. The Complainant hand delivered both letters to the ES offices.

In November 2014 the Complainant lodged her complaints with the Ombudsman.

Investigation

The Ombudsman's letter presenting the Complaints to Director 1 was sent out on the 27th November 2014.

In December 2014, as a result of a ministerial reshuffle, Director 1 was asked to join the Ministry for Economic Development as Director for Economic Development and in January 2015 a new officer was appointed Director of Employment ("Director 2"). Under the circumstances, and in order to arrive at a speedy resolution to this Complaint, the Ombudsman wrote to Director 2 summarising the details of the case and requesting his comments. Despite this, no progress was made in this case until May 2015 and only after several chasers and a deadline for submission of information set by the Ombudsman in which he informed Director 2 that failure to adhere to the deadline could result in his statutory powers being invoked and proceedings issued against Director 2 on the grounds of obstruction and an Order sought from the Supreme Court, compelling Director 2 and the ES to comply with the Ombudsman's requests. Director 2 apologised and explained that he was undertaking the functions of Director of Employment parallel to running the Department of Social Security in his role as Principal Secretary. Managing those two significant departments had undoubtedly, adversely affected the timely delivery of the information requested by the Ombudsman. The Ombudsman accepted the explanation.

The ES responded and informed the Ombudsman that it was highly likely that the Complainant had gone to the Economic Development & Employment Company known as "EDEC", on one of her visits to the ES offices (both offices located in the same building at that time) and highlighted that EDEC was solely for assistance to unemployed British citizens residing in Gibraltar. EDEC fell under the remit of the Ministry for Economic Development. The ES added that at the time when the complaint originated, ES held vacancies pertaining to the gaming and catering industry and EDEC had everything else. The ES assured the Ombudsman that was no longer the case and vacancies were back with the ES (the table in page 4 on this report appears to substantiate this information).

In July 2015, the Ombudsman wrote to Director 1 requesting his comments on the information provided by the ES in relation to EDEC. By October 2015 with no reply having been received and no developments on the outstanding issues, the Ombudsman arranged a meeting with Director 1 which was held in October 2015.

Director 1 explained that the ES' functions were twofold:

1. For local companies to register for the purpose of employment; i.e. to keep a register of the persons the company employed, contracts, etc. and to ensure compliance with legislation. When vacancies arose, companies had to notify the ES and vacancies were registered with the ES.

2. For persons seeking employment whereby they would attend the ES offices to check the vacancies available. Persons would either ask at the ES counter check the vacancies posted on the notice board. Persons seeking employment would see an employment officer.

EDEC

In the case of EDEC, Director 1 explained that this entity provided an incentive to some companies that wanted to employ people. EDEC would pay the employees' salaries for the first few months (akin to the volunteer training scheme and part of the Government strategy for employment) at the conclusion of which, if the person was not employed by the company the employer had to repay the totality of salary paid in that period.

To qualify for training assistance through EDEC, Director 1 confirmed that service users needed to be British Citizens resident in Gibraltar and at the time of application, unemployed.

In relation to the complaint of non-reply, the Ombudsman once again contacted Director 2 and a response was received on the 27th October 2015. The latter apologised on behalf of Director 1 for not having replied to the letters in September and October 2014 which he believed were the result of an oversight.

For completion of records, the Ombudsman requested a copy of the records held at the ES in respect of the Complainant's work history. Regarding vacancies she had been offered during her period of unemployment – May 2014 to October 2015 – these were as follows:

May 2014	2 vacancies (kitchen assistant & chef)
August 2014	3 vacancies (kitchen staff & chef)
February 2015	1 vacancy (cleaner)
March 2015	1 vacancy (cleaner)
August 2015	3 vacancies (cleaners & sales assistant)

It was noted that the Complainant had found employment as a cleaner on the 14th October 2015.

Conclusions

Complaint 1: Claimed to have been informed by the Employment Service that there were no suitable vacancies for her as she was not Gibraltarian – Not Sustained

The findings of the Ombudsman's investigation indicate that the Complainant must have approached EDEC in her quest for employment and not the ES, on the occasion when she was informed that she did not have a Gibraltar ID card and as such no suitable vacancies could be offered to her. The table (see page 51) denotes that the Complainant was offered a number of vacancies which corroborates the information provided by the ES that for a period of time, the ES only had catering and gaming vacancies and EDEC had all vacancies pertaining to other sectors. The change (vacancies reverting back to ES) is noted in the table above in that no cleaning vacancies were offered between May and August 2014 but are recorded between February and August 2015.

EDEC was an entity created to assist both local employers and prospective employees in the initial stages of employment. The criteria required to qualify for training assistance through EDEC was that persons should be British Citizens resident in Gibraltar and at the time of application, unemployed. The Complainant did not meet those requirements. Notwithstanding, it is understandable that the Complainant was not aware that she had approached EDEC instead of the ES on the occasion when she was informed that there were no suitable vacancies for her as she was not Gibraltarian, due to the fact that both EDEC and the ES were at the time when the complaint arose located in the same building.

Complaint 2: Non-reply to two letters sent to the Director of Employment in September and October 2014 – Sustained

The Ombudsman sustained this complaint. Despite the fact that Director 1 moved from his directorship in the ES in December 2014, the letters were hand delivered by the Complainant to the ES offices in September and October 2014, i.e. three and two months respectively prior to the move; ample time for Director 1 to have issued a response. Notwithstanding the aforementioned, Director 2, subsequent to his appointment and despite having been briefed by the Ombudsman at the initial stages of taking over the position, provided neither a reply nor an apology to the Complainant. Furthermore, it took a year for Director 2 to provide an explanation to the Ombudsman in respect of the non- replies.

The Ombudsman is disappointed at the disproportionate delays experienced in the last few years in respect of responses and information from the ES with regards this and other investigations into complaints against the ES. Although the fact remains that there have been three different individuals in as many years carrying out the functions of Director of Employment which has undoubtedly contributed to the delays in the provision of information to the Ombudsman, this cannot serve as a valid excuse to either service users or the Ombudsman.

Classification

Complaint 1: Claimed to have been informed by the Employment Service that there were no suitable vacancies for her as she was not Gibraltarian – Not Sustained

Complaint 2: Non-reply to two letters sent to the Director of Employment in September and October 2014 – Sustained

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GIBRALTAR HEALTH AUTHORITY

The CHS was established in April 2015 as an independent complaints mechanism for the sole purpose of accepting, investigating and resolving complaints filed by service users against the GHA. The CHS enjoys an arms- length agreement with the Office of the Gibraltar Public Services Ombudsman whereby in the event that complaints cannot be resolved at first instance, the Ombudsman has a discretionary power in law to accept the transfer of a specific complaint, with the complainant's prior consent in writing].

[Ombudsman Note: The background is mainly based on the version of events provided by the Complainant, including supporting documentation, at the time of lodging the Complaint with the Ombudsman]

Case Not Sustained

HLTH 2015-1

Complaint against the Gibraltar Health Authority ("GHA") as a result of the GHA's alleged failure in informing the Complainant of a pre assessment and surgical appointment date.

Complaint

The Complainant was aggrieved that the GHA contacted him on the actual date that a surgical procedure had been scheduled for him which he did not attend. The Complainant claimed not to have had prior notice of the procedure by GHA staff.

Background

The Complainant explained that he suffered a broken Achilles tendon (left), on the 27th February 2014 in Spain where he received emergency medical treatment. Due to the nature of the injury and the apparent need for almost immediate surgery, he was offered the possibility to undergo surgery in Seville Spain, in the event that he would have experienced delay in being able to have it performed in Gibraltar.

The Complainant further explained that he attended the accident and emergency department ("A&E") at St Bernard's Hospital on the 28th February 2014, where a half caste was fitted to his leg. He was asked to make arrangements for an appointment with the relevant orthopaedic surgeon ("the Surgeon"). The Surgeon attended upon the Complainant on the 5th March 2014 and although subsequent to his examination he confirmed that an operation was necessary and should be performed imminently, he could not provide the Complainant with a date for the procedure since according to the Complainant, it was necessary to have an ultrasound taken first. The Complainant alleges that the surgeon advised him that he would see him again, after he had undergone the ultrasound at the radiology department ("Radiology").

After the Surgeons nurse refitted the caste to the Complainants leg, the Complainant made his way to Radiology. Once there, he was allegedly informed that there was no radiologist available until the following week. The Complainant enquired about a second radiologist but was told that although he too was out, he would be returning later.

The Complainant made his mobile number available to Radiology with a view to being contacted upon the second radiologist's return. Having received no telephone call by late afternoon that day, the Complainant telephoned Radiology himself. He was informed that although his case had been classified as "urgent", no action could be taken given that the ultrasound could not be performed until the following week.

Given the sense of urgency and the previous offer for the operation to be undertaken in Seville, the Complainant contacted the surgeon there and enquired about viability and costs. It was confirmed to him that the operation could be performed the following afternoon (5th March 2014).

The next day, while driving to Seville, the Complainant received a telephone call from the assistant surgeon at GHA ("Surgeon 2") asking where he was since he was expected for a pre-operative procedure at Dudley Toomey ward, St Bernard's Hospital. The Complainant was surprised to hear this and explained to him all the developments (or in his view, lack thereof), which had led to his decision to be operated in Spain. Given that the operation was urgent and that arrangements had been made for Seville, he would continue his journey and have it performed there. Surgeon 2 wished him luck.

Dissatisfied with the position, the Complainant telephoned Radiology to enquire whether there had been any progress with his ultrasound. It was confirmed that there had not. The Complainant returned Surgeon 2's call to inform him of this. The alleged response was that "there are ways of having pushed it through." Despite that, the Complainant confirmed that it was too late to cancel the Seville admission.

It later transpired that when the Complainant made an attempt to recover his costs from the GHA, the position adopted by the GHA was that the Complainant had been informed of the scheduled pre-operative procedure and that the Complainant simply failed to appear. The Complainant disputed and continues to dispute that allegation and when he requested proof of the means by which he was informed, it was never provided.

As a result of exchanges of correspondence and meetings with the GHA Medical Director ("the Medical Director") and Chief Executive ("the Chief Executive") the GHA took the view (after examining the Complainant's case file) that the Complainant was not entitled to reimbursement of his costs. As a result of his dissatisfaction with the outcome, the Complainant lodged his complaint with the Complaints Handling Scheme ("CHS") on the 2nd April 2015.

Investigation

CHS investigation/review

The CHS presented the complaint to the GHA on the 10th April 2015 setting out the facts as alleged by the Complainant and requesting their comments.

From the information received in reply and the inquiry undertaken by the CHS, together with the fact that it had been decided by the GHA and communicated to the Complainant that he would not be reimbursed for the costs of his surgery undertaken in Seville, the CHS took the view that they could not resolve the issue at first instance. As a result, they suggested that the Complainant transfer his complaint to the Office of the Ombudsman for investigation.

The Complainant agreed. Once all the relevant consent and waiver of confidentiality forms had been executed, the Ombudsman took custody of the Complainants file and initiated his own investigation.

Ombudsman Investigation

The Ombudsman reviewed all the correspondence and documentary evidence contained within the GHA files.

In essence, it was established from the review of the information/notes provided, that the Complainant suffered his injury on or around the 28th February 2014 and was attended to by an A&E doctor who referred him to the trauma clinic. The Complainant subsequently attended the trauma clinic on Tuesday, the 4th March 2014, and was examined by a locum orthopaedic consultant ("the Locum"). The Locum advised that it was his last working day in Gibraltar and that he would need to speak with the Surgeon for further review and management. The Locum had requested that the Complainant had to be given an appointment for the following day, Wednesday (being the day that orthopaedic clinics ran).

The Complainant was seen the following day (Wednesday 5th March 2014) by the Surgeon. Given the need to treat the injury urgently and in keeping with the notes made available to the Ombudsman for his review, surgery was arranged for the next available slot; that date being Friday 7th March 2014. The anaesthetist ("the Anaesthetist") on call was immediately contacted (in the presence of the Complainant), for the purpose of conducting the patients pre-assessment. The Anaesthetist advised, that the Complainant could be admitted the following day for that purpose and that all the necessary pre-assessments were to be carried out on Thursday 6th March 2014 for surgery on Friday 7th March. The Complainant was allegedly informed of all developments in person, as was the duty sister.

According to the notes, the Complainant "did not turn up…as instructed" on the 6th March. He was telephoned by Surgeon 2 from the orthopaedic-trauma team. The Complainant answered the call stating that he was in the outskirts of Seville where he would be seen by an orthopaedic consultant and operated that same day. Surgeon 2's written account states that he emphasized to the Complainant that all arrangements were in place to operate that Friday. The Complainant replied that the Seville surgeon would operate on the ruptured Achilles tendon by means of minimal access surgery (a different and less invasive approach to that which the Surgeon advised he would undertake) and, which the Complainant preferred for obvious reasons. Surgeon 2 informed the Ombudsman that at that point in the telephone conversation, the Complainant stated that he would proceed with the operation in Seville. Surgeon 2 wished him well and the Complainant thanked him for all his efforts.

Soon after that conversation, the Surgeon enquired why the Complainant had not turned up for his pre-operative admission. Surgeon 2 then informed him about the Complainant's decision. The Surgeon's comment to this was that he had sensed during his first consultation with the Complainant that he had already made up his mind to undergo surgery in Spain, particularly after he had advised him on the procedure and surgery recovery time (to which the Surgeon's nurse was witness.

Prompted by the Ombudsman, the Medical Director asked the Surgeon for his comments on the complaint made by the Complainant. The Surgeon gave a written account on the 5th February 2015. He alluded to the chronology of events, adding that the Complainant was seen at the first available opportunity following the Locum referral and that the operation had been scheduled for the next operating day. According to the Surgeon, it was the Complainant who unilaterally decided to have his treatment undertaken in Spain and that "no such case has ever been sent abroad for surgery as our own results are 100% [effective], so much so that patients are able to return to sporting activities like tennis etc."

The Surgeon was emphatic that the Complainant "chose to go to Seville to have surgery only to return with complications" [which the Ombudsman has been informed were subsequently treated by the Surgeon at the GHA]. Accordingly, the Surgeon's view was that…." The funding of treatment for private surgery in this situation would mean acceptance by the authorities that service was not provided to him here [GHA]. This [would] be quite contrary to the truth".

Subsequently, the Ombudsman sought further clarification from the Surgeon on the following issues:

1. Whether or not despite the pre-operative admission arrangements having been made, the Surgeon had requested tests from Radiology for an ultrasound and that as a result, a "slot" for the operation could not be given?

If so, was any appointment made at Radiology for such test to be undertaken? (the Complainant alleged he was referred to Radiology as an "urgent" case but that he was never contacted for the tests, this being the reason why he decided to have the surgery performed in Seville).

2. Finally, by what method was the Complainant informed he would be operated on March 7th?

In reply to the queries, the Surgeon invited the Ombudsman to a meeting at his clinic to discuss the issues.

At the meeting which ensued, the Surgeon explained the circumstances which led to the referral to his clinic (which the Ombudsman was already aware of). The Surgeons notes confirmed that the Complainant was seen at A&E on the 28th February at 10:30am. According to the notes, the Complainant stated that he had taken pain relief and that he had had an ultrasound carried out in Spain privately on the 27th February thereby obviating the need to have it repeated in Gibraltar. The Complainant stated that he already had a follow up appointment in Spain and he appeared to be seeking treatment from the GHA only to further ease the pain. An enquiry was made by A&E as to the fitting of a caste/crutches (caste was fitted). That same day, at 13:30 hrs, the patient appeared to change his mind and indicated that he wanted his trauma care transferred to the GHA. It was at that stage that he was booked to be seen at the trauma clinic – the appointment was scheduled for the 4th March and referred by the visiting Locum to the Surgeon the following day.

The Surgeon, (with the aid of his full notes) had a specific recollection of this case. He stated that after clinical examination, his conclusion was that the injury was a classic Achilles tendon tear and that it could only be treated with immediate surgery- hence the reason why arrangements were made with the Anaesthetist immediately for the pre-operative procedure the following day and for the operation the next. The Surgeon advised the Complainant that he would need a "full repair and graft" and advised him he could do it on his "first operation list" since he had been notified of a cancellation from another patient.

The Surgeon also explained to the Ombudsman that the operation was listed without the need for further tests. He specifically stated that he had not requested tests from Radiology or any other GHA department. This type of injury only required a clinical diagnosis, there was no need for any further tests.

In the "orthopaedic operation list" which the Surgeon made available to the Ombudsman (providing him with a copy for the purposes of his investigation), there was a note signed and dated by Surgeon 2 which gave the Orthopaedic nurse the instruction to "liaise with the bed manager as this patient needs admission tomorrow for tendon-Achilles repair. Anaesthetist has advised admission tomorrow for Friday surgery".

According to the Surgeon, the Complainant was aware of the scheduled procedures as they were being arranged in situ and in his presence given the need to operate "urgently". Casually, the notes also showed that the Complainant had alluded to the fact that he was having treatment in Spain. The Surgeon went on to explain the telephone call made by his clinic (Surgeon 2) at the time of the Complainant's pre-operative procedure absence, since he was on his way to Seville.

The Surgeon specifically recalled the case given the fact that apart from complete notes which were available for him as an aide memoire, his clinic also treated the Complainant for a post -operative infection on the 10th April 2014 after his return from Spain.

Conclusions

The Ombudsman had no reason to disbelieve the Complainant's version of events. Nonetheless, the GHA's account of the circumstances surrounding the complaint by way of the written information provided, the meeting held between the Ombudsman and the Surgeon and the notes to which the Surgeon referred to in the Ombudsman's presence, constituted, in the Ombudsman's mind, clear evidence that all arrangements had been formalised to admit the Complainant for almost immediate pre-operative and surgical procedures.

The allegation that the Complainant was not informed of this fact could only attributed to confusion or miscommunication given the speed by which matters were arranged, although having said this, the Complainant appeared to be present whilst matters were being progressed. On that basis and on the balance of probabilities, the Ombudsman did not sustain the complaint.
Classification

That the GHA failed to inform the Complainant of his surgical date - Not Sustained

The Ombudsman was unable to favour the Complainant's version of events over the GHA's explanations of what occurred.

Considerations

In order to avoid confusion when procedures and operations are scheduled at short notice, the Ombudsman considered it prudent for the GHA to provide patients with written communication of the agreed arrangements, which notice could be countersigned by patients as "accepted". The Ombudsman would be making representations to the Chief Executive on that basis.

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Case Partly Sustained

HLTH 2015-7

Complaint against the Gibraltar Health Authority ("GHA") as a result of the alleged lack of care shown to the Patient in that his illness was misdiagnosed and subsequent treatment was delayed.

Complaint

The Complainant was aggrieved by the alleged lack of healthcare received by the Patient from the GHA. She claimed that the Patient was misdiagnosed at the start of his illness and that as a result, treatment was delayed. Additionally, the Complainant claimed that a care plan was not communicated to the Patient nor was it appropriately adhered to.

The Complainant explained by way of background that she first wrote to the GHA Chief Executive in December 2011. She lodged a complaint against the Patient's Neurologist and in relation to the mismanagement of his medical condition. The Complainant stated in her letter that the Patient's symptoms (constant headaches, dizzy spells and disorientation), were diagnosed as migraine. Despite being prescribed medication, the symptoms persisted. It was in fact his general practitioner, after examining an MRI Scan, who informed the family that the Patient has suffered/was suffering from mini -strokes.

A subsequent appointment was obtained for the Neurologist. According to the Complainant, he trivialised the seriousness of the alleged strokes and continued to ask the Patient about his migraines. The Complainant was unhappy with the consultant's approach.

It was only after attending the memory clinic that the diagnosis was changed to "vascular dementia".

In early 2015, the previous diagnosis of vascular dementia was discarded and "arthritis" was identified as the cause of the Patients symptoms.

The Complainant holds the view that this diagnosis will also be brushed aside. The Complainant complains that to date, the diagnoses have not been properly investigated by the GHA (despite her having met the Chief Executive, Minister for Health and the then existent in-house complaints office (prior to the creation of the CHS).

Following exchanges of email correspondence between the Complainant and the GHA Complaints Coordinator, the Coordinator mailed the Complainant on the 6th May 2015, stating that the plan of action was that "[The Patient is waiting for an appointment with the pain clinic for infiltrations- a date to be given asap- I believe a date of 12th April was given, if this does not prove efficient, then an alternative could be a treatment of Botox offered in a Tertiary Referral Unit in Spain ("Unit")- transport would be arranged- [The Complainant] to confirm to the Pain Clinic Doctor if these infiltrations are working or not and this information would be passed to [the medical Director]."

The Complainant claimed that the Patient did receive treatment on the 12th April 2015 but that they subsequently received a telephone call on the 4th or 5th of June stating that they had missed an appointment (despite having received no notice of it).

A second bout of treatment was administered although according to the Complainant, it was different to the first and "*certainly not conducted at the same Unit where he had been previously treated .*"

Since then, the allegation was that no further updates or appointments had been received.

The Complainants concerns were:

That given the series of misdiagnoses, treatment had been delayed and that the Patient's condition had worsened as a result.

The Complainant has also expressed deep concern and frustration at her claim that the Patient's care plan was not adhered to but instead, altered without consulting or informing him. Additionally, the Complainant opined that "*to misdiagnose is a serious issue and one that deserves an explanation.*"

Investigation

CHS investigation/review

The CHS presented the complaint to the GHA in writing on the 9th December 2015 setting out the facts as alleged by the Complainant and requesting their comments. From the information received in reply and the inquiries undertaken by the CHS, the CHS took the view that they could not reconcile matters or properly assess the complaint since there were numerous medical issues which required consideration. As a result, they suggested that the Complainant transfer his complaint to the Office of the Ombudsman for investigation.

The Complainant agreed. Once all the relevant consent and waiver of confidentiality forms had been executed, the Ombudsman took custody of the Complainants file and initiated his own investigation.

The Ombudsman reviewed all the correspondence contained within the GHA files. Given that the matters being complained against were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent specialist medical advice to the United Kingdom.

The questions presented to the expert assessor (a general practitioner) by the Ombudsman, and the replies received (summarised for the purposes of this report) are contained below.

The GP noted the background as follows:

"Mr PJ, a 59 year old man at the time of the complaint, was being treated by his general practitioner for raised blood pressure. He reported headaches to his GP and a "fuzzy head." His GP referred him to a neurologist. He was subsequently seen by various secondary care physicians and had a number of investigations. Mr PJ also reported memory problems and was seen in the memory clinic. He was informed of the cause of the headaches by the secondary care physicians. Mr PJ had ongoing problems with pain and was referred to the pain Clinic by his GP. At this consultation further investigations were carried out and a different diagnosis reached to account for Mr PJ's symptoms. Mr PJ and his wife have concerns about the care he received regarding these problems."

Ombudsman Question

Given the symptoms presented by the Patient were the proper tests conducted?

Expert Reply

The expert stated that the Patient was being treated by his GP for high blood pressure and that from the information reviewed, it appeared that when the Patient reported feelings of a "fuzzy head" the GP referred him for secondary care for further investigation. That was following a six month history over which time there would be better blood pressure control with medication.

"The Patient was assessed by a Secondary Care Physician. He was subsequently referred onto more specialist secondary care physicians (ENT; Neurology).

Mr PJ had a number of investigations organised by the secondary care physicians- CT scan; MRI scan; PET scan. He was also assessed by the memory clinic and had clinical assessments of his memory carried out. These were instigated by secondary care to try to investigate the problems Mr PJ was referred to them with.

The GP referral to secondary care was appropriate. As a GP, I would be guided by secondary care colleagues as to which investigations to perform in a Patient I had referred to them with PJ's problems."

Ombudsman Question

Were the diagnoses presented over time reasonable in the circumstances?

Expert Reply

"These diagnoses were proposed by secondary care following investigations they requested and the results of these investigations. As a GP, I would be guided by secondary care colleagues as to a diagnosis in a patient I had referred to them with PJ's problems.

If there was any doubt in the diagnosis, referral to other alternative specialists or for a second opinion from the same speciality could be made by the GP. However, it seems in the case of the Patient that this was done by the secondary care physician."

Ombudsman Question

Was it appropriate to refer the Patient to the pain clinic?

Expert Reply

"This was an appropriate referral given that other avenues of care and investigation had been explored in secondary care. The Patient was still experiencing discomfort despite taking pain killing medication. He saw the GP regarding this. It would be appropriate in such a case as this to access further specialist help in managing pain when the GP's had exhausted the options available to them. Therefore a referral to the pain clinic was appropriate."

Ombudsman Question

Have the Patient's treatment and care plan been managed in accordance with standard/good practice?

Expert Reply

"The GP was managing the Patient's blood pressure. Uncontrolled high blood pressure could have been the cause of his fuzzy head. When the GP managed to control the blood pressure and the Patient's symptoms continued, Mr PJ was referred for more specialist input. This was appropriate. The care provided by the GP, from the correspondence available to me, falls within the range of acceptable practice."

Ombudsman Question

What is the expert's view on the treatment offered (pain clinic) and would it have been possible to have diagnosed the condition at an earlier stage had the proper tests been conducted?

Expert Reply

"Mr PJ has had an MRI scan of his cervical spine organised by the Pain Specialist. This showed some damage to the cervical vertebrae which the Pain Consultant attributes to the pain Mr PJ was experiencing.

Investigations requested previously were done so on the basis of Mr PJ's presentation to the clinician at the time. Mr PJ saw a neurologist and an ENT specialist. Investigations they requested were based on their assessment of the Patient."

Expert Conclusion

"The care PJ received from his GP over this time falls within the range of acceptable practice.

Given the expert's conclusion and in order to appropriately consider and subsequently classify this complaint, the Ombudsman expressed the view that further advice was indeed desirable.

A secondary piece of advice was requested and was issued based on the Ombudsman's previous questions.

The advice was provided by an NHS Consultant Nephrologist and Physician with inter alia extensive clinical experience across a wide range of general medical problems, both in the acute setting and chronic disease management.

The second expert provided the following background and chronology:

"[The Patient] was referred by his GP to secondary care with complaints of fuzziness and light headedness in 2009. He was seen by a Consultant Physician in September 2009 and investigated. PJ had a history of hypertension, which was reasonably well controlled. In October 2009, the Consultant Physician referred him to a Neurologist, mentioning the fact that [the Complainant] had noticed some loss of recent memory. A CT head scan was normal. In April 2010, the Consultant referred PJ onto an ENT Consultant because of his complaint of hyperacusis (excessive loudness). In November 2010, the Neurology Consultant, could not identify any clear abnormality and concluded that PJ could be suffering from chronic migranious headaches and possibly drug side effects. In October 2010, PJ had an ENT review in which it is documented that they found no objective abnormality in the audiogram.

In June 2011 PJ had a brain MRI Scan which showed microvascular changes. The Consultant Physician then referred him to the Memory Clinic in 2012 and it is documented that his memory was deteriorating more quickly, along with continuing headaches and hyperacusis. After clinical assessment and a PET Scan was conducted by the Memory Clinic Consultant, there was no evidence of dementia (as per reviewed notes referred to dated December 2012).

In January 2013, the Patient was reviewed by a Neurologist who documented that he had had transient weakness on the left side, which had recovered spontaneously. He concluded at the May 2013 review that small vessel disease was the likely explanation for the Patient's symptoms.

An MRI Scan of the spine in September 2014 showed evidence of a central C5/6 disc protrusion, later 6/7 disc protrusion and other degenerative changes."

Summary of Ombudsman Question as cited by the Expert: "Patient complained of headaches, dizzy spells and disorientation. Wrongly diagnosed with vascular dementia. Treatment delayed?"

Expert Reply

"There are three parallel issues here which need to be considered separately. The first is hyperacusis which has not been fully explained despite full investigations. The provisional impression was that it was simply related to [the Patient's] hearing impairment related to high noise levels at work.

The second issue of memory loss has never been confirmed- all the evidence suggests is that he has no dementia. When the Patient complained of transient left sided weakness, it was not unreasonable to speculate that this and the reported memory loss were possibly linked to the small vessel disease shown on the earlier MRI, leading to possible vascular dementia. That did not actually lead to a formal diagnosis of vascular dementia, and in retrospect, it was incorrect.

The third issue was the headache, which was most likely related to his cervical spine disease, and was diagnosed quite late. The clinical entry by the Consultant Physician on the 19th July 2012, clearly records occipital headache, but the issue is confounded by a number of associated symptoms, which are distractors.

In my opinion, the Patient should have had a cervical spine MRI towards the end of 2012, or even early 2013, after the neurological review in January 2013"

In response to the questions:

"Wrong diagnosis? - In a complex case such as this, where the diagnosis is not clear, provisional diagnoses are made and are acceptable. The situation gets clarified with the passage of time. "Mini strokes" and "vascular dementia" were empirical diagnoses made on the basis of what the Patient reported- which doctors cannot simply ignore, and are duty bound to think of diagnostic possibilities. The cervical arthritis was of course a definite diagnosis, which was probably responsible for the patient's chronic headaches (which were misdiagnosed as migraines). **Rather than considering these a change in diagnosis, they should be seen as evolving diagnoses. Having said that, there was a significant delay in reaching the diagnosis of cervical arthropathy and disc protrusion."**

"Was the treatment reasonable? - The answer is yes with one caveat- the cervical MRI should have been undertaken 18-24 months before it was."

Expert Conclusion

"The Patient suffered from multiple and confusing symptoms. Initial suspicion of dementia was fully justified, but was not confirmed. Hyperacusis remains unexplained. Headaches, previously labelled migrainous, probably emanated from cervical spine disease, which was diagnosed late".

Ombudsman Conclusion

In essence, the first piece of clinical advice obtained by the Ombudsman in this case concluded that the Patient's GP had acted within "the range of acceptable practice" insofar as the Patient's care was concerned.

The clinical advice received in respect of secondary care summarised the position that rather than having considered that the GHA "changed" the Patient's diagnosis from "mini- strokes" to "vascular dementia" and then "cervical arthritis," the correct way to view the changes would have been to regard them as "evolving [and not changing] diagnoses."

The expert also opined that the treatment given was reasonable save for the issue of the cervical MRI delay which should have been conducted by the GHA at a much earlier stage (18-24 months).

The Ombudsman therefore made the following classifications based upon the expert advice received.

Classification

(1) Alleged lack of care shown to the Patient by the GHA in that his illness/condition was misdiagnosed:-Not Sustained.

(2) Delay in the treatment provided to the Patient:- Sustained in part- (insofar as the Cervical spine MRI was concerned which should have been conducted at a much earlier stage).

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Case Partly Sustained

HLTH 2015-8

Complaint against the Gibraltar Health Authority ("GHA") as a result of the alleged lack of care shown to the Complainant by a GHA Gynaecologist.

Complaint

The Complainant lodged a complaint regarding the healthcare received by a GHA Gynaecologist ("the Gynaecologist") in the treatment of her ovarian cysts.

The Complainant explained that she suffered from heavy continuous bleeding and irregular periods since early 2012. She stated that her condition was monitored at GP level and later referred to the Gynaecologist who, after performing internal procedures, informed her that she was suffering from ovarian cysts on both ovaries. The Complainant explained that although the Gynaecologist monitored her situation for a few months to see if the cysts would disappear, they continued to grow. Arrangements were eventually made for their removal in the summer of 2013.

Following the removal surgery, the Complainant alleged that the Gynaecologist never performed a post-surgery review.

She claimed that two weeks after her surgery she started bleeding regularly in the same manner that she done prior to the surgical intervention. She proceeded to contact the Gynaecologist's nurse to inform her of her symptoms. The Complainant was offered an appointment for June 2014 (almost one year after her surgery). The Complainant stated that throughout 2014 she had to be administered iron injections on a daily basis, as a result of suffering from anaemia due to the continuous bleeding.

During her appointment with the Gynaecologist in June 2014, the Complainant alleged to have been informed she had ovarian cysts once again, and that she would require a second surgical procedure in February 2015. She has claimed that once the surgery had been concluded, she was rushed back to theatre as she had been informed that something had gone wrong during the operation and that a blood clot had appeared. The Complainant stated to the CHS that to date, she is still unclear as to why she was taken back to theatre that day. Once again, she claimed that she was not given a post-surgery review appointment.

The Complainant explained that two weeks after her second cyst removal surgery, the bleeding returned. She stated that she called the Gynaecologist's nurse for an appointment and was allotted one for the 4th May 2015. Meanwhile, the Complainant felt obliged to seek medical attention from a private clinic where she was put on a hormonal coil which she was told would alleviate the bleeding. The Complainant has further informed us that when she attended the private clinic, she was again told that her cysts had returned.

During the GHA appointment of the 4th May 2015, the Complainant has alleged that the Gynaecologist seemed disinterested in her as a patient and commented that she "should carry on attending the private clinic for her ovarian cyst problems." The Complainant has explained that ever since she started suffering from her medical problem she has never felt "cared for" by the Gynaecologist , who she claims, made no attempts to explore alternative avenues for treatment. The Complainant also alleges that the Gynaecologist refused to refer her to a different practitioner, despite her request for this.

The Complainant's concerns were twofold:

1. The Gynaecologist's alleged failure to address her healthcare issue considering the fact that she had to undergo two cyst removal surgeries.

2 Why the Gynaecologist did not offer her alternative treatment options and why did she not accede to her request for a second opinion.

Investigation

CHS investigation/review

The CHS presented the complaint to the GHA in writing on the 20th May 2015 setting out the facts as alleged by the Complainant and requesting their comments. Given that no reply was forthcoming, a chaser letter was sent on the 18th June 2015. [The Gynaecologist however maintained that she provided GHA management with a written reply by 29th May 2015 which had not been made available by the GHA to the Ombudsman.]

From the information received in reply and the inquiry undertaken by the CHS, the CHS took the view that they could not resolve the issue at first instance since there were medical issues which required consideration . As a result, they suggested that the Complainant transfer her complaint to the Office of the Ombudsman for investigation.

The Complainant agreed. Once all the relevant consent and waiver of confidentiality forms had been executed, the Ombudsman took custody of the Complainants file and initiated his own investigation.

The Ombudsman reviewed all the correspondence and documentary evidence contained within the GHA files. Given that the matters being complained against were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent medical advice to the United Kingdom.

The questions presented to the expert by the Ombudsman, and the replies received (summarised for the purposes of this report) were:

Ombudsman Question

Were the proper tests conducted on the Complainant given the nature of her [medical] complaint?

Expert Reply

The expert commented that one of the confusing factors of this complaint was *"that the patient's symptoms were to do with abnormal menstruation, and her treatment was all to do with her cysts". According to the expert, "it appear[ed] that the ovarian cysts were not symptomatic and the impression was, that they were discovered by chance on the ultrasound at the initial clinic visit on the 3rd June 2015. At that stage, the period problems had improved (according to the Gynaecologist) and it was therefore reasonable to look into the cysts instead".*

According to the Royal College of Obstetricians and Gynaecologists (RCOG) Greentop Guideline no 62- Management of Suspected Ovarian Masses in Pre-menopausal Women" the recommendation is:

"6.1 Women with simple ovarian cysts of 50-70mm in diameter should have yearly ultrasound follow-up and those with larger simple cysts should be considered for either further imaging (MRI) or surgical intervention.
6.2 Ovarian cysts that persist or increase in size are unlikely to be functional and may warrant surgical management."

The medical expert opined that given that according to the Gynaecologist's notes the cyst was simple in appearance- of a maximum diameter of 59mm, it would therefore have been suitable for the monitoring approach initially. From her notes, the Gynaecologist did record that that option was discussed, but that the Complainant "was keen for a laparoscopy".

Given that request, the expert was of the view that it was "probably reasonable to agree to surgery".

"The surgery involved drainage (aspiration) of the right ovarian cyst. RCOG guideline 62 states:

6.5 Laparoscopic management of presumed benign ovarian cysts should be undertaken by a surgeon with suitable experience and appropriate equipment, whenever local facilities permit.

6.6 Aspiration of ovarian cysts, either

vaginally or laparoscopically, is less effective and is associated with a high level of recurrence."

The expert admitted to have had no information as to the Gynaecologists experience in performing minimal access surgery. "Aspirating the cyst was unlikely to be effective in the long run given the high rate of recurrence; this is what occurred; therefore for treatment of the cyst, an ovarian cystectomy, rather than aspiration, should have been carried out at the time of the first procedure."

It was also opined that the ultrasound performed on re-referral in 2014 showed that the cyst had a "septum". "[That] counts as a complex cyst. RCOG Guideline 62 suggests (paragraph 4.2) that when an ovarian cyst is not simple, a measurement of serum marker CA125, to assess the risk of malignancy, should be performed. There is no mention or reference to [that] test in the [Gynaecologist's] notes and therefore I assume it was not done."

The expert also stated that there was no evidence of investigation or treatment for the prolonged and irregular periods at the time of re-referral. "Given [the Complainant's] pattern of bleeding, and the fact that this problem was her main complaint, it should have been investigated/treated. The most sensible option would have been to conduct a hysteroscopy at the same time as the laparoscopy, and to offer insertion of the Mirena [coil] at the time of the procedure, which would have been the appropriate treatment at that stage. Mirena insertion was eventually performed by the private gynaecologist."

NICE Guidance CG44 "Heavy Menstrual Bleeding" states:
1.2.13 "If appropriate, a biopsy should be taken to exclude endometrial cancer or atypical hyperplasia. Indications for a biopsy include, for example, persistent intermenstrual bleeding".

The medical opinion obtained by the Ombudsman also stated that *"given the variable cycle length which the Complainant was suffering, it would be regarded as intermenstrual bleeding and should have been investigated as such. The second operation was performed on 11.02.15 and involved, that time, ovarian cystectomy (Laparoscopic removal of the cyst from the ovary rather than simply draining it).* ***That was the correct management of the cyst."***

To summarise the first question posed by the Ombudsman, namely, were the proper tests conducted on the Complainant given the nature of her [medical] complaint?

The expert expressed the following views:

1 "Given the Complainant's request for surgery, it was reasonable to offer laparoscopy as treatment for her ovarian cyst.

2 Aspiration of a persistent ovarian cyst is known to be ineffective. As this was a planned elective procedure, an ovarian cystectomy ***should have probably been performed*** *at the first operation in 2013.* [Upon her review of the Ombudsman's completed report, the Gynaecologist did not agree with that view].

3 In 2014, after re-referral, the ovarian cyst was complex (septated) and CA 125 measurement ***should have been performed.*** *The cyst was however eventually shown to be benign so no harm occurred from the omission.*

4 In 2014, it appears that [the Complainant's] period problems were overlooked and investigation and treatment of that problem ***should have taken place****-this would logically have been hysteroscopy, with offer of Mirena insertion at the same time."*

Ombudsman Question

Was repeated surgery to remove the ovarian cysts necessary?

Expert Reply

"This is discussed and answered above. If ovarian cystectomy instead of aspiration had been performed the first time, ***repeated surgery would not have been necessary".*** [The Gynaecologist was of the opinion that the chosen path was a lower risk procedure].

Ombudsman Question

Was it necessary to rush the Complainant back to theatre after the second surgical procedure?

Expert Reply

"*It appears that a haematoma had gathered around one of the laparoscopic ports at the second operation. This is a recognised complication of such surgery.* ***It was correct*** *to evacuate under anaesthetic".*

Ombudsman Question

Was it reasonable not to explore alternative treatment?

"It does appear that the alternative treatments for the ovarian cysts were discussed at the initial consultation in 2013 (i.e, monitoring versus surgery). In 2014, the main complaint was that of irregular menses and this was not addressed. Instead, the focus remained on the ovarian cyst, treatment of which was not going to affect the menstrual bleeding. ***The menstrual problem should have been addressed at that stage".***

Ombudsman Question

Was it reasonable not to examine the Complainant post-surgery as alleged?

Expert Reply

Unless there was a specific complaint about (for instance) poor healing of the laparoscopy ports, examination would not have been mandatory in the expert's opinion at that stage, as it was unlikely to have shown anything. In addition, the Complainant had since seen another gynaecologist who had conducted an examination.

Ombudsman Question

Did the gynaecologist act reasonably and/or to the required standard generally?

Expert Reply

The expert stated in no uncertain terms that he would be critical of the Gynaecologist's care in three respects. These were:

1 "Aspiration of the ovarian cyst, and not cystectomy, at the first procedure- if aspiration was planned, then the [Complainant] should have been warned about the high chance of recurrence, especially as the surgery was specifically planned to treat the cyst (RCOG Greentop Guideline 62). [The Gynaecologist however felt that aspiration was the appropriate cause of action].

2 Failure to investigate or address the main problem of irregular and heavy periods at the time of the second referral in 2014 (NICE CG44).

3 Failure to action the [Complainant's] request for a second opinion made following the re-referral in 2014 (Established good practice). [This claim was denied by the Gynaecologist in her comments]".

[Ombudsman Note]: As per the Ombudsman's standard practice on reports at the draft stage, the Gynaecologist was given an opportunity to comment on the factual content of the same, as highlighted throughout the report in brackets in respect of clinical issues.

In relation to her alleged failure to offer the Complainant a second opinion on her medical condition (over which the expert was critical), the Gynaecologist, in her written comments, did claim that she did acknowledge the Complainant's right to a second opinion and according to her, did advise the Complainant to go and see her GP for that purpose. The Gynaecologist also claimed that she wrote to the relevant GP stating that the Complainant may be seeking an alternative view. The Gynaecologist also informed the Ombudsman that she advised the Complainant how to go about obtaining a second opinion and further stated that she did not know why the Complainant did not follow that route (the claim of a second opinion was strongly denied by the Complainant).

The Gynaecologist stated "*I had seen [the Complainant] in June 2014 when she was keen on early laparoscopy but stated in August that she was not sure if she wanted surgery. I was happy to go along with this plan. I did not have a problem with her seeking a second opinion through her GP. I arranged a further ultrasound scan in October 2014 and she chose to come back to see me on the 20th October."*

Ombudsman Conclusion

Based upon the expert medical opinion, the Ombudsman reached the view that there were aspects of the Complainant's care which were reasonable and in keeping with established guidelines and practice, and some which were not.

The Complainant's primary complaint was the Gynaecologist's alleged failure to address her healthcare issue considering the fact that she had to undergo two cyst removal surgeries. According to the expert advice obtained, "an ovarian cystectomy should have probably been performed at the first operation in 2013". Additionally, "the [Complainant's] period problems were overlooked and investigation and treatment of that problem should have taken place". It was clear to the Ombudsman based upon the medical advice, that although the Gynaecologist was correct in offering a laparoscopy (as advised by the expert practitioner), had standard practice and the relevant guidelines been followed, the second surgical intervention and the continuation of the bleeding remedied by inserting a Mirena coil), could have been avoided altogether. **Classification**: Sustained in part

In relation to the second limb of the complaint, namely, that the Gynaecologist failed to offer alternative treatment and failed to action the Complainant's request for a second opinion, the expert was also critical of that course of action. However, since such a claim was denied by the Gynaecologist, the Ombudsman was unable to reconcile the versions presented and for that reason, was unable to classify that complaint. **Classification:** Unable to classify.

Case Partly Sustained

HLTH-2015-12

Complaint against the Gibraltar Health Authority ("GHA") as a result of the alleged misdiagnosis, the failure to perform necessary tests and the alleged lack of care shown to the Complainant by the GHA.

Complaint

The Complainant was aggrieved due to the following:

(i) Alleged Misdiagnosis;
(ii) Alleged Failure to Perform Necessary Tests;
(iii) Alleged Lack of Care by Dudley Toomey Ward Doctor.

The Complainant stated that on Saturday 11th July 2015 at around 18.00 hours she suffered a sharp back pain and attended the GHA's Accident & Emergency Department ("A&E"). Blood and urine samples were taken and the Complainant told she was suffering a renal colic (pain caused by kidney stones). An ultra sound scan ("USS") would be required to confirm this and the Radiology Department would be in contact with the Complainant to arrange an appointment. A painkiller was administered and a prescription issued for painkillers; the Complainant was discharged. Hours later, the Complainant's symptoms returned, this time more severe, and she again attended A&E; the same process ensued. Four or five hours later and still in severe pain, the on-call surgeon examined her. He concurred with the diagnosis but again highlighted an USS would be required. The Complainant's husband enquired as to when it would be performed and was told by the on-call surgeon not to worry as she would be admitted to St Bernard's Hospital ("SBH") and the ward consultant would see her that day and make the arrangements. The Complainant was admitted to Dudley Toomey Ward ("Ward") at around 07.30 hours by which time the pain had exacerbated.

Due to the extreme and persistent pain she was enduring, the Complainant insisted she needed to see a doctor and was told by the Charge Staff Nurse (in charge of the Ward) ("CSN") that Dr A would be carrying out the Ward rounds during the course of the morning. Hours later, Dr A not having examined her and the painkillers not having reduced the pain, the Complainant again approached the CSN. She contacted Dr A and minutes later returned and informed the Complainant that she had spoken to him and he would not be seeing her that day as she did not have a life-threatening condition.

As the day progressed and the excruciating pain persisted, the Complainant asked her husband to help her. He approached the CSN so that she would once again contact Dr A. Shortly after the CSN informed them that Dr A had reiterated his earlier statement to other staff members; he would not be seeing the Complainant that day.

The following day, Monday 13th July 2015, the Complainant stated she was seen by a group of doctors amongst whom she recognized Dr B and Dr C. One of the doctors asked her about the origin of the pain and subsequently advised she would be sent for an USS which was performed shortly after. According to the Complainant, whilst the radiologist ("Radiologist") was conducting the USS he told her he could not detect kidney stones. The Complainant pointed to the area where the pain was and upon investigation the Radiologist identified a floating blood clot on the Inferior Venae Cavae ("IVC") vein.

According to the Complainant, the Radiologist told her she could not get out of bed or even cough to prevent the clot from dispersing. The Complainant was shocked at the news, especially considering she must have had the life threatening condition for at least the past two days and gone undiagnosed whilst she continued with a normal routine like showering, walking around the Ward, etc.

After the USS the Complainant returned to the Ward. By 16.30hours and not having received any news from the medical team, the Complainant's mother (retired nurse) contacted the Clinical Nurse Manager ("CNM") for assistance. The Complainant claimed the CNM contacted Dr D who immediately transferred her to the Critical Care Unit ("CCU") where one-to-one care was provided and where she was informed that urgent arrangements for her to be transferred to a Tertiary Referral Unit in Spain ("Unit") would be made. The Complainant was transferred by ambulance escorted by a specialist team and arrived at the Unit at 22.30 hours. The Complainant stated she was immediately taken to the operating theatre and a filter fitted in the IVC to prevent the floating clot from travelling up to her lungs or heart. This was followed by a CAT Scan (computerized axial tomography) the following day which found that a small section of the floating clot had come apart from the main clot and entered the lung.

At the time of lodging this complaint (30th July 2015) the Complainant's clot was being monitored to ascertain if it was indeed shrinking and to determine if the filter could be removed.

The Complainant felt very aggrieved as she felt the situation could have been avoided, especially if an USS had been performed from the start, and lodged her Complaints with the Ombudsman.

Notwithstanding, the Complainant was extremely grateful to the CNM whose actions she believed had saved her life.

Investigation

The Ombudsman requested information from the various medical professionals involved in the Complainant's case and reviewed the medical notes.

A&E Attendance 1 (Medical Notes)

The Complainant's first attendance at A&E was at 17:54hours on the 11th July 2015. Blood and urine samples were tested and an x-ray of the abdomen performed [the x-ray report dated 13th July 2015 concluded there was no evidence of radiopaque gallstones]. Medication was administered to the Complainant during her time at A&E and she was diagnosed with a biliary versus renal colic. According to the medical notes, once the Complainant felt better she left A&E with a prescription for painkillers and a request from A&E to Radiology for an USS appointment to be arranged.

A&E Doctor 1

The Ombudsman requested a statement from A&E Doctor 1 who attended to the Complainant at the first attendance at A&E, primarily to establish whether an x-ray investigation was in keeping with GHA standard practice for suspected gallstones and biliary/renal colic and as to why an x-ray was requested rather than a CT or USS. Furthermore, the Ombudsman requested information on how the x-ray investigation contributed in the diagnosis.

A&E Doctor 1 provided a detailed report on the initial interview and the examinations performed which led to the diagnosis.

In relation to the x-ray investigation he explained that although the most desirable imaging investigation would have been an USS those were not often done out of hours and they had to work with the resources available at that time. X-rays provided useful information not only of radiopaque stones but of obstructions. In the Complainant's case the x-ray served to exclude complications such as obstruction or pneumopertioneo [The term pneumoperitoneum refers to the presence of air within the peritoneal cavity (http://emedicine.medscape.com/article/372053-overview)]. A&E Doctor 1 stated that the diagnosis was mainly clinical as occurred frequently in A&E where they have to be efficient and make proper use of resources. In the same way that a CT scan was not requested for every head injury based on clinical examination and history, it was not necessary to request an USS for every single patient attending A&E with abdominal pain. The majority of patients presenting symptoms of biliary and renal colic were discharged without an emergency USS which would only be requested if severe complications were suspected like an obstruction, which was not present in the Complainant's case.

A&E Attendance 2 (Medical Notes)

The Complainant attended A&E a second time, 12th July 2015 at 03.00 hours, and after further medication administered and blood results received it was decided to admit the Complainant for further investigation. The Complainant was admitted to SBH at 07.00 hours with a provisional diagnosis of cholecystitis – faecal loading [a period of approximately thirteen hours had elapsed between the Complainant's first attendance at A&E and being admitted to SBH].

A&E Doctor 2

The Ombudsman directed his enquiry to A&E Doctor 2 in relation to the change from the initial diagnosis to cholecystitis. A&E Doctor 2 provided a detailed account of the clinical examination undertaken and to the fact that his diagnosis was based on the Complainant's interview, repeat blood tests showing raised blood markers, ongoing symptoms for the previous six hours and pain unsettled over six hours. The Complainant was started on antibiotics and referred to the surgical doctor for his review and further management and investigations.

Dr A Not Having Undertaken Ward Round on 12th July 2015

The statements provided by the CSN and the staff nurse ("SN1") looking after the Complainant in the Ward on the 12th July 2015 corroborated the Complainant's statement that Dr A did not carry out the Ward round on Sunday 12th July 2015. The CSN explained that the Ward round should have been carried out during the morning and as that had not materialised by midday she telephoned Dr A who responded he would not be going to the Ward that day. The CSN stated she was confused at Dr A's statement as it was unusual for something like that to happen and she apologised to the Complainant who was very upset at the situation. The CSN advised they would call the Non-Consultant Hospital Doctor ("NCHD1") to review her but would also try to contact Dr A again. During the course of the afternoon, the SN1 reported to the CSN that the Complainant had increased pain. The NCHD1 was informed and further analgesic prescribed.

The CSN contacted Dr A a second time to update him on the Complainant's condition and he reiterated his earlier response; he would not be visiting the Ward. No reason was provided.

The Ombudsman made enquiries from the Medical Director as to the GHA's procedure in place when a situation as the one related above arose. The Medical Director responded that if a GHA member of staff had a concern regarding a doctor who refused to see a patient they should contact the clinical manager and he/she would contact the doctor to attend to the patient. If the doctor still refused, the clinical manager would contact the GHA executive director on call to look into the situation.

Contacting Dr A

Whilst undertaking the investigation into the Complaints, the Ombudsman was informed Dr A no longer worked for the GHA. The Ombudsman wanted to afford Dr A the opportunity to comment on the allegations against him and requested from the GHA's Human Resources Department, Dr A's contact details. The Ombudsman initially found the GHA's Human Resources Department uncooperative in respect of disclosure of details (a separate section below addresses this issue) but finally managed to make contact via email with Dr A. His first response stated he did not recall the events and demanded the medical notes in the Complainant's case to defend the 'false allegations'. Further communication between the Ombudsman and Dr A ensued and to summarise, further to the Ombudsman having sent Dr A the statements provided by medical staff in the Ward (anonymised), Dr A concluded the allegations were malicious and false. Dr A stated he did not recall the details of the alleged incident but affirmed he had never refused to see or assess a patient when called to do so, whether on duty or not.

Diagnosis on the 13th July 2015

From the statement of the staff nurse who looked after the Complainant on the 13th July 2015 ("SN2") and Dr B who was part of the team who undertook the Ward round on that day, it was established that an USS was requested and performed that same morning. The medical notes record that immediately after the USS the Radiologist telephoned Dr B to advise that the results showed there was a large floating thrombus within the IVC. From Dr B's statement to the Ombudsman it is noted that immediately after that conversation, Dr B explained the results to the Complainant and staff at Ward. Clexane 120mgs (an anticoagulant which stops blood clots from forming and can stop blood clots that have formed from growing bigger) was given to the Complainant and a new set of blood tests requested. At 12.15 hours Dr B contacted the medical Non Consultant Hospital Doctor covering emergencies ("NCHD2"). He explained the USS results and requested a review and takeover of the Complainant. The NCHD2 asked for an email to formalise the referral which Dr B duly complied with at 12.26 hours. The NCHD2 responded fifteen minutes later confirming they were taking over under their haematologist. Dr B subsequently attempted to contact the surgical consultant but was unsuccessful. He had no further involvement in the case.

The CNM's statement to the Ombudsman stated that around 16:00 hours on the 13th July 2015, the Complainant's mother in a distressed state contacted her for help. Since being informed of the thrombosis of the IVC which required immediate review/assessment for medical or surgical intervention neither the medical or surgical consultants had reviewed her, produced a care plan or assessed her for medical or surgical intervention. According to CNM at the same time, Ward staff contacted her to advise that they could not contact NCHD2 reference the plan of care for the Complainant. CNM went to Ward and requested one of the staff nurses to transfer the Complainant to a side room next to the Ward staff office and to commence half hourly observations. CNM then went to the CCU to make arrangements to transfer the Complainant there for cardiac monitoring. CNM briefed Dr D and asked him to review her. Dr D, after reviewing the Complainant, made arrangements to contact the Unit for an urgent transfer for a cardiology/vascular assessment; the transfer was carried out that evening.

The Ombudsman enquired as to the reasons for the time-lapse on the part of the NCHD2 in implementing the takeover of the Complainant's case. NCHD2 confirmed he had accepted the Complainant when he was made aware of the diagnosis by Dr B, at that time she was on full dose Clexane, the recommended treatment for the condition. NCHD2 stated that perhaps he did not understand the grade of the thrombosis and is why he did not make further arrangements immediately. [Ombudsman Note: The Ombudsman reviewed the email sent to NCHD2 by Dr B and noted there was no reference in the content of said email to the case being urgent or an emergency].

Clinical Advice

For the purpose of this investigation, the Ombudsman obtained independent clinical advice from a consultant in emergency medicine, a radiologist and a consultant vascular surgeon ("the Advisers").

(i) Alleged Misdiagnosis

The Advisers concurred that given the symptoms presented by the Complainant, the differential diagnosis of gall stones or cholecystitis was reasonable; a clot in the IVC is fortunately a rare diagnosis.

The Advisers reported that identifying a clot, usually in the leg, before it breaks off and travels to the lung would prevent a pulmonary embolism. The diagnosis is usually made by symptoms of pain and swelling on the leg. If those were not present then it was usually chest pain and breathlessness from the pulmonary embolism that would be the first indication of the clot being present. In the Complainant's case it is not known whether the right upper quadrant pain was a symptom from the IVC clot, perhaps causing venous engorgement in the liver or one of the kidneys, or due to the pulmonary embolism giving referred pain. Both were unusual presentations of a clot.

Regarding the diagnosis by the Radiologist, the Advisers stated that finding the clot suggested a high level of skill from the person performing the study; not identifying the clot would not have been a failing at that stage as there were several overlying structures. The tests for the suspected diagnosis of the renal colic (IVU or CT) would not have made the diagnosis.

The Advisers stated that the Complainant's case was an unusual presentation of symptoms and the diagnosis picked up by chance when an USS was being performed with the primary aim of looking for gall stones. The Advisers maintained that the Complainant was very fortunate the diagnosis was made and she was saved by a very astute ultrasound operator who identified the IVC thrombus. The Advisers suspected it would not have been likely that the surgical consultant (Dr A) if he had attended the Ward round and examined the Complainant, would have arrived at that diagnosis.

(ii) Alleged Failure to Perform Necessary Tests

The Advisers considered that the proper tests had been conducted.

The Advisers stated that for the investigation of cholecystitis, established good practice would include investigation with CT scan or IVU ((intravenous urography) an x-ray of the urinary tract following an injection of contrast or dye) at the A&E attendance. Ultrasound scan is generally the investigation of choice for the diagnosis of gallstones; in the UK a scan may be deferred to be performed as an in-patient or outpatient investigation. [Ombudsman Note: The Ombudsman made enquiries with the Medical Director with regards the criteria applied by A&E doctors in order to request an USS. The Medical Director responded that A&E had access to radiology requests if they felt the case was urgent; this included USS, CT scan and conventional radiology].

Based on the information from the Medical Director regarding A&E access to radiology investigations, the Advisers noted that the A&E doctors had access to urgent Radiology, including ultrasound and CT which could have been obtained at the Complainant's A&E attendance. Considering cholecystitis was suspected, the Advisers concluded that further specialist imaging should have been requested.

The Advisers concluded that an ultrasound at the A&E attendance would have been best practice if cholecystitis was suspected but as the Complainant had a good initial response to fluids, analgesics and anti spasmodic, deferring an USS to the next day would be acceptable practice.

Notwithstanding the above, the Advisers agreed that neither a CT scan of the abdomen looking for stones in the kidneys or ureters, or an IVU would have identified the presence of the blood clot in the IVC or the pulmonary embolism as they were not targeted to do so.

(iii) Alleged Lack of Care by Doctor A

Approximately forty two hours elapsed between the Complainant's first attendance at A&E and the clot being identified by the Radiologist. The Ombudsman requested clinical advice on what the consequences of the clot going undiagnosed could have been.

The Advisers stated that it appeared there were no consequences. In theory the Complainant could have had further emboli, perhaps possibly large enough to be fatal but she did not. As already stated above, the Advisers concurred she was saved by a very astute ultrasound operator on the 13th July 2015 who identified the IVC thrombus and the probable diagnosis of pulmonary embolism. The Advisers suspected the diagnosis would likely not have been thought of by Dr A if he had examined the Complainant.

The Advisers stated that the tests for the suspected diagnosis of renal colic, IVU or CT would not have made the diagnosis of IVC thrombus.

Conclusions

(i) Alleged Misdiagnosis – Not Sustained

The root of this complaint is a clinical issue and as such, the conclusion arrived at by the Ombudsman has to largely take into account, the clinical advice provided for the purpose of this investigation.

In effect, the Advisers consensus was that based on the symptoms presented by the Complainant, the differential diagnosis of gall stones or cholecystitis was reasonable.

The Advisers stated that a clot in the IVC was fortunately a rare diagnosis; the Complainant's symptoms being unusual presentations of a clot.

Alleged Failure to Perform Necessary Tests – Not Sustained

A&E Doctor 1 requested an x-ray of the abdomen at the Complainant's first attendance at A&E.

The explanations he provided as to not having requested an USS were twofold:

(i) Those were not often done out of hours;

(ii) The x-ray did not show an obstruction.

Based on the Complainant's symptoms, clinical investigation and x-ray results, A&E Doctor 1 decided the Complainant's case did not warrant an emergency USS. Furthermore, A&E Doctor 1 informed the Ombudsman that the majority of patients who presented symptoms of biliary and renal colic were discharged without an emergency USS, which would only be requested if severe complications were suspected like an obstruction, which was not seen in the x-ray taken in the Complainant's case.

The Advisers concluded that an ultrasound at the A&E attendance would have been best practice if cholecystitis was suspected but as the Complainant had a good initial response to fluids, analgesics and anti-spasmodic, deferring an USS to the next day would have been acceptable practice.

Notwithstanding, the Advisers agreed that neither a CT scan of the abdomen looking for stones in the kidneys or ureters, or an IVU would have identified the presence of the blood clot in the IVC or the pulmonary embolism as they were not targeted to do so.

Based on the findings of the investigation the Ombudsman does not sustain this Complaint. As per the information provided by the Medical Director to the Ombudsman in the course of this investigation, A&E doctors have access to radiology requests if they feel the case is urgent and this includes USS, CT scan and conventional radiology, a fact which was corroborated by A&E Doctor 1. It was A&E Doctor 1's decision, based on his experience, not to request an USS at that attendance. When the Complainant returned hours later, A&E Doctor 2 left it to the surgical doctor to request further tests as he took the decision to request her admission to SBH.

(iii) Alleged Lack of Care by Dr A - Sustained

The Ombudsman sustains this Complaint.

Dr A, the Ward consultant on the 12th July 2015 did not undertake his Wardround.

When the Ombudsman made contact with Dr A he refuted the allegations.

Based on the findings of his investigation, the Ombudsman took the view that Dr A, in not attending to the Complainant, did not carry out his responsibilities as would have been expected. This must not be interpreted to mean that the Ombudsman is putting into question Dr A's medical abilities but rather the fact that there was maladministration in Dr A's action of not having attended the Ward round on the 12th July 2015 nor made arrangements with another consultant to cover his post on that day.

Although the clinical advice provided, points to the fact that the Radiologist in all probability saved the Complainant's life and Dr A would possibly not have thought of the diagnosis of IVC thrombus based on the symptoms presented by the Complainant, the Ombudsman cannot discard that there was a possibility that had the USS been carried out during the course of the 12th July 2015, an earlier diagnosis of the IVC thrombus could have been made and the pulmonary embolism possibly prevented. In health issues, it all comes down to the fact that if there is something that could have been done for a patient which was ultimately not done or delayed, the afflicted parties will be very aggrieved and blame that for the health problems derived thereof. Dr A's failure to carry out the Ward round or to have made arrangements for another consultant to examine the Complainant, inevitably resulted in delay in the USS being performed.

Referring to the information provided by the Medical Director regarding the procedure to be followed by staff nurses in charge of a ward at SBH when a situation similar to that described in this complaint arises, the Ombudsman is critical that procedure was not followed and would suggest that senior management circulate this information to pertinent staff due to this being a rare occurrence and many staff possibly not being familiar with the procedure. Notwithstanding, the Complainant was reviewed by the NCHD1 but he did not request the further investigation, another missed opportunity.

Ombudsman Note

The Ombudsman took over the remit of complaints made against the GHA in April 2015 and the Complaints Handling Scheme set up to be the entry portal for all complaints made against the GHA.

As such, it is understandable that teething problems would be inevitable. In order to facilitate the establishment of a cordial working relationship between both parties, the Ombudsman delivered numerous presentations to GHA staff which explained the functions of the Ombudsman. Despite this, in the course of this investigation, the Ombudsman encountered uncooperative behaviour from the Human Resources Department and the Radiology Department (when we requested a copy of the Complainant's x-ray) in relation to obtaining information and documentation for the purpose of the investigation. This has undoubtedly caused unnecessary delay to the investigation and was unwarranted as management in both departments should have been aware of the Ombudsman's powers under the Gibraltar Public Services Ombudsman Act 1998. Notwithstanding, in order to prevent a repetition of the situation in future, the Ombudsman met and corresponded with the General Manager of Hospital Services ("GM") on the matter. To conclude, the GM sent out a circular to the GHA's executive team, requesting that they make it known to heads of departments that the Ombudsman in undertaking an investigation is statutorily entitled under the Public Services Ombudsman Act 1998 to be provided with documentation he requires/requests and to timely replies to his enquiries.

Classification

Alleged Misdiagnosis – Not Sustained

Alleged Failure to Perform Necessary Tests – Not Sustained

Alleged Lack of Care by Dr A - Sustained

Ombudsman's Note:

The Advisers referred to the Radiologist as a very astute ultrasound operator. There was little doubt that in making his diagnosis he saved the Complainant's life.

The Ombudsman would encourage the GHA Management to commend the expertise shown by the Radiologist.

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Case Sustained

HLTH -2015-15

Complaint against the Gibraltar Health Authority ("GHA"), due to loss of the Patient's personal property at GHA premises by GHA staff.

Complaint

The Complainant was aggrieved as a result of a gold chain belonging to the Patient being misplaced when she handed it over to a nurse at St Bernard's Hospital (Dudley Toomey Ward), prior to surgery on the 28th October 2015.

The Complainant complained that an item of the Patient's jewellery (a gold chain claimed to have a replacement value of circa £200, which the Ombudsman was unable to verify) went missing whilst the Patient was being prepared for surgery at Dudley Toomey Ward. The Complainant was allegedly provided with a note by the Ward Sister ("the Sister") after the chain could not be found. The note stated… *"Chain lost after being given to student nurse for safe keeping- put in pocket of scrubs uniform and sent to laundry by mistake. Laundry have checked filters but have been unable to find it."*

Understandably the Complainant was unhappy by the loss of the item. He explained to the Ombudsman that it was of sentimental value to the Patient and that they entrusted the nurse with custody of it until the Patient was out of surgery.

Investigation

CHS Investigation/Review

The CHS presented the complaint to the GHA (Director of Nursing) on the 19th November 2015 setting out the facts as alleged by the Complainant and requesting his comments. Information was also sought on the GHA's policy and procedure regarding the handling of patients' property and valuables.

A reply from the Sister explaining the course of events that day was received.

The Sister stated that the Patient was admitted to the Ward with overnight acute abdominal pain and rushed into theatre as an emergency the following day- 28th October 2015- for an appendicectomy.

On the way to theatre, upon entering the theatre lift, the staff present at the time noticed that the Patient was still wearing a "fine yellow/bronze chain around her neck". The Sister explained to the CHS that since the student nurse had permission to follow the Patient into theatre and observe the operation, she personally handed the chain to the student nurse for safekeeping (as she would have been with the Patient until she came to, at the conclusion of the surgery). Unfortunately, the chain remained in the student nurse's theatre scrubs uniform which was sent to the hospital's laundry after the surgical procedure.

The Sister confirmed that she had attended the laundry department on several occasions and requested that they check the laundry filters, in an attempt to recover the missing item, to no avail.

She also stated in her account that they (nursing staff) would normally ask relatives to take possession of valuable property (but the Complainant was not in the ward at the time). Alternatively, they would send valuables to the "safe in the accounts department." Additionally, if patients left property in the hospital lockers, it was explained to them that the hospital did not make itself responsible for any loss.

Despite the Sister's reply, it was not made clear to the CHS that this was in fact GHA **policy**, but rather, "what was normally done."

Ombudsman Investigation

Given the administrative issue and the apparent lack of procedure surrounding the cause of this complaint, the complaint was transferred from the CHS to the Office of the Ombudsman, with the Complainant's consent, for further investigation and reporting.

The Ombudsman reviewed all the correspondence and documentary evidence contained within the GHA files.

Conclusions

Although the loss of the Patient's item of jewellery was obviously unfortunate, the Ombudsman formed the opinion that the circumstances which gave rise to the loss were as a result of carelessness alone. Upon review of all matters, he was satisfied that there was no *mala fides* involved by the staff concerned. For the sake of clarity, the Ombudsman pointed out that there had never been any allegation (of theft for example), made by the Complainant.

The Ombudsman expressed the view however, that the loss of patients' personal property whilst under the direct custody of GHA staff as a result of an accident, carelessness, negligence or by any other means was a serious and inexcusable event.

The fact that the loss of the item of jewellery in question was never disputed by the GHA could lead to no other finding than one of "complaint sustained" by the Ombudsman

Classification

That the GHA lost the Patient's personal property (gold chain) **-Sustained**

Considerations

Given the circumstances of this complaint, the Ombudsman saw fit to make a two-fold recommendation:

1. That a formal system be implemented whereby when items are accepted by the GHA from patients for safekeeping, they be properly logged and recorded, and that patients or authorised family members be obliged to sign a ledger upon deposit and receipt of the good/s.

2. That the GHA financially compensate the Patient in this case for her loss. (Insurance or replacement value).

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Not Sustained

HLTH 2015-16

Complaint against the Gibraltar Health Authority ("GHA") as a result of their alleged lack of care shown to the Patient during his admission at St Bernard's Hospital.

Complaint

The Complainant was aggrieved by the way in which the Patient was allegedly treated by the GHA. He lodged a complaint claiming that they failed to provide him with the appropriate care whilst he was admitted at St Bernard's Hospital.

The Complainant complained in respect of the healthcare provided to the Patient by the GHA during the period 21 July to 8 August 2015, as an in-patient at St Bernard's Hospital.

The Patient had been admitted into hospital on the 21 July 2015 suffering from terrible back pain and had trouble walking. After several tests were conducted he was diagnosed with liver malfunction and kidney failure.

He was subsequently admitted into the Critical Care Unit ('CCU') and although a CT scan was recommended by the intensivist, it was not performed because the in house scan had been replaced and the Patient was not fit to travel into Spain for that purpose.

The Complainant was of the view that a "back up" scan should have been made available and that would the scan have been performed, the Patient's life may have been saved. He believed that a contingency plan should have been put in place. The Complainant did not accept as reasonable, the fact that the appropriate tests were not conducted because the Patient was not in a fit state to travel.

The Complainant attributed the Patient's cause of death to the health providers' lack of duty of care shown towards him.

At the time that the events occurred, the Complainant discussed the lack of CT scan facilities with the Hospital's Senior Management, who allegedly did not know anything about the CT scan being out of service. Conversely, (according to the Complainant), the intensivist did state in a conversation with him, that Senior Management was indeed aware of the position.

The Complainant was advised to address the scan issue with the Consultant Radiologist, which he did. A meeting was held on the 27th July 2015. The Consultant Radiologist allegedly explained to the Complainant that Gibraltar's electricity supply would not support the CT scanner. The Complainant did claim however that Senior Management dismissed that view.

The Consultant Radiologist further explained that having a portable scanner in Gibraltar was not possible because the team necessary to operate it would have to be brought over from Spain. In any event that team would not be qualified to British standards and would thus be invalidated to operate the machinery in Gibraltar.

The Complainant found it unacceptable that because of a difference in medical standards the Patient was denied a CT scan that he considered, could have possibly identified the source to his medical conditions and perhaps even saved his life. He also found it unreasonable that a backup scan was not available and that the only option proposed by the GHA was transferring the Patient to a Tertiary Referral Unit in Spain ("Unit") for the scan. As explained above, that option was not exercised as a result of the Patient's delicate state of health.

Upon his insistence, the Complainant was advised by the CCU team to discuss the Patient's healthcare issues with the Hospitals' Medical Director. A meeting was arranged for the 28th July 2015. The Medical Director allegedly agreed that the Patient should have been transferred to the TRU for further investigation. He also assured the Complainant that he would be contacted in due course with a medical update.

Some days elapsed and whilst the Complainant was visiting the Patient at the CCU, one of the nurses on duty approached the Complainant. She asked him whether he had met the Medical Director. The Complainant replied that he had, on the 28th July. The nurse informed the Complainant that the Medical Director had requested to speak with the Complainant once more, to discuss the Patient's state of health. The Complainant confirmed to us that no one from the CCU nor any other GHA staff member had attempted to contact him to advise him on those issues, despite having had all his contact details as provided on the Patient's "next of kin" form. The Complainant expressed his astonishment at the lack of communication provided by the CCU, at such a critical time.

The Complainant was then able to briefly meet the Medical Director and was informed that the CCU staff were doing "*all they could do*" for the Patient.

Unfortunately the Patient passed away on the 8th August 2015.

On the 9th August 2015, the Complainant made his way to the CCU to try and obtain an explanation as to the cause of death and to request the Patient's medical notes. When the Complainant sought the notes he was told by a member of CCU staff that they did not have them at the Unit. The Complainant informed them that he had already enquired at the records department and that they had informed him that the notes had been tracked and located at CCU. The Complainant became concerned that something had gone medically wrong which had in his view, precipitated the Patient's death. He raised this with Senior Management who subsequently took ownership of the Patient's medical file. To the Complainant's dismay the file contained a contemporaneous "incident report from" which appeared to show that the Patient had suffered a cardiac arrest as a result of an alleged medical intervention performed which had been unsafe and had resulted from a lack of communication between the team.

Given the lack of communication experienced by the Complainant throughout the Patient's admission, including the cause of the Patient's death, together with the alleged lack of duty of care and "sub-optimal care" (as displayed on the "incident report from"), the Complainant lodged his complaint with the Complaint's Handling Scheme ("CHS") on the 18th November 2015, with a view to them formally investigating his complaint.

Investigation

CHS investigation/review

The CHS presented the complaint to the GHA in writing on the 24th November 2015 setting out the facts as alleged by the Complainant and requesting their comments. To the CHS's dissatisfaction, almost six months elapsed before all the information, documentation and statements requested by the CHS were finally made available to them for their review.

From the information received in reply and the inquiries undertaken by the CHS, the CHS took the view that they could not reconcile matters or properly assess the complaint since there were numerous medical issues which required consideration. As a result, they suggested that the Complainant transfer his complaint to the Office of the Ombudsman for investigation.

The Complainant agreed. Once all the relevant consent and waiver of confidentiality forms had been executed, the Ombudsman took custody of the Complainants file and initiated his own investigation.

The Ombudsman reviewed all the correspondence and documentary evidence contained within the GHA files. Given that the matters being complained against were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent specialist medical advice to the United Kingdom.

The questions presented to the expert (a consultant cardiothoracic anaesthetist) by the Ombudsman, and the replies received (summarised for the purposes of this report) were:

Ombudsman Question

From the tests conducted in July 2015 as a result of the Patient's symptoms, is the expert of the view that other tests/treatment should have been undertaken?

Expert Reply

The expert stated that the Patient presented the symptoms and signs of sepsis (as recognised by the GHA) and, that the initial approach taken by the GHA in the diagnosis of the condition "*was in line with medical guidance". "The results of blood tests, blood gas, blood culture, full blood count, urea and electrolytes, creatinine and a clotting screen confirmed sepsis. The high lactate level suggested severe sepsis".*

It appears [the Patient] was appropriately administered a broad-spectrum antimicrobial without delay… he was given intravenous fluids appropriately. There was intensive care involvement which initiated ventilation and vasopressor drugs to support low blood pressure."

In summary, the early recognition and management of sepsis appears to be in line with contemporary advice and guidance."

Ombudsman Question

Was the absence of a CT scanner reasonable and were/could other tests have been conducted with the same effect?

Expert Reply

"Clearly a key in management of sepsis is to make every attempt to identify a source of infection. ***However, this does not mandate a CT scan****. Guidelines emphasise that diagnostic imaging is used appropriately but are generally non proscriptive on what type of imaging. [The Patient] received an early ultra sound scan specifically looking for a focus of infection in his abdomen, particularly his gall bladder.*

A chest x-ray was also performed.

There seemed no possibility of an exploratory surgical approach because he was so unwell.

CT scan is mentioned but dismissed- there are several reasons for this. ***Patients can be so unstable that the risk of transferring them to a scanner (even within the same institute) outweighs the diagnostic value; [the Patient] was unstable with low blood pressure and unstable heart rhythm.***

From the complaint correspondence it appears that there was no access to a CT scan available in the [GHA] anyway.

However, there may never have been a surgical option to act on any findings.

…. CT scanning continued to be considered later in [the Patient's] admission in an attempt to identify such a source. ***However the overriding and ultimately fatal problem was liver and kidney failure****. Signs of active infection disappeared soon after directed antibiotic use. However, the nature of sepsis is that organ dysfunction continues despite apparent eradication of the triggering organism.*

In summary, if a CT scan had been available, [the Patient] would have received one as soon as he was stable enough for internal transfer. ***He was never stable enough for transfer to another Unit. A CT scan might have excluded some lines of enquiry but his treatment was not compromised as a result of any uncertainty.***

It did not appear from organisms cultured, or ultrasound, that the focus of infection was intra-abdominal even though presenting symptoms were suggestive.

Correctly diagnosed antibiotics rapidly reduced the source of infection- presumed from a soft tissue source in the mouth or even spine."

Ombudsman Question

Is the statement from the CCU Sister as to the lack of communication as to the Patient's cause of death, reasonable/established practice?

Expert Reply

The expert opined that he would not expect notes to be immediately released at the request of any individual who was not the Patient and that in her statement, the nurse was correct in that there would be a process to enable access to clinical notes.

"*In most hospitals requests for notes and concerns would be dealt with through a patient liaison service which I am sure must be in place [at the GHA].*"

Ombudsman Question

Does the Consultant Anaesthetist's statement create a cause for concern in relation to the standard of care afforded to the Patient?

Expert Reply

The assessor was of the view that the statement referred to periods of instability in the Patient's condition and that the incident reported… ***"did not necessarily highlight poor care".***

"However, it does give a strong impression of a team that lacks confidence in their roles and competencies, limited leadership and a culture too quick to apportion blame. This albeit limited snapshot also suggests a poor governance structure with escalation not necessarily being used to promote understanding and shared learning."

Ombudsman Question

Should a Consultant have been assigned to the Patient?

Expert Reply

The expert was unclear as to the exact grade and specialities of the clinical team in place and that an apparent lack of continuity (according to the Complainant's letter of complaint), added to his frustrations.

He did state however…. *"In most ITU settings, the consultant intensivist will be in charge for a block of time, such as a split week. Patients are admitted under another consultant such as the operating surgeon but the consultant intensivist would provide continuity of care and leadership during the ITU admission.* ***This system does not seem to be in place [at the GHA] although I cannot be sure."***

Ombudsman Question

What is the experts view regarding an email naming a specific nurse and consultant as "culprits"?

Expert Reply

"*This is an unfortunate term. At its most innocent it just highlights those as being involved. However, it has a sense of being excessively judgemental and accusatory.* ***My impression is one of general concern in governance terms."***

Ombudsman Question

Can the expert opine on the content of the "Incident Reporting Form" and assess whether the events recorded were a contributing factor to the Patient's subsequent death?

Expert reply

The view expressed was that the incident form described "*… a period of instability that required the patient in suffering a type of cardiac arrest. The incident is as a result of the doctor making attempts to improve the lung inflation with increased breaths. This is at the same time as the kidney machine was set to remove more fluid. The combined effect reduced [the Patient's] cardiac output and he suffered a cardiac arrest.* ***This was predictable but not inevitable.*** *Clearly members of the team were not communicating well in coordinating care around the Patient. A patient so critically ill as this would be subject to periods of such instability during even routine procedures.* ***Not all such incidents would generate and incident form. That does not mean that anything is covered up. However, this form should give more concern as to the working relationships… the tone and the limited anticipated outcome from this form gave the impression of a team that [was] not functioning well together."***

Ombudsman Question

Is the assessor able to comment on the last set of medical notes as to the condition of the Patient towards the end of his life and, could any further steps have been taken?

Could anything else have been done to avoid the Patient's death and were the actions taken by the GHA appropriate?

Expert Reply

The clinical assessor made it quite clear that during the last week of his life and stay at CCU [the Patient], "… *remained critically ill. At this point he had at least three organ failures- liver, kidney and respiratory. In addition, he had deranged blood clotting and signs of a brain condition- encephalopathy-probably related to his liver failure.*

Despite some marginal improvement in his oxygen requirement his chances of survival at this stage, I would estimate at less than five percent (5%). ***However the team continued to afford him maximal treatment… they were also taking advice from Kings Liver Unit in London.***

Attempts were made to awaken [the Patient] but he could not tolerate ventilation without sedation…. There had also been an attempt to manage without a kidney machine but his kidney function continued to deteriorate and dialysis was continued."

The expert also recorded how by the 5th August 2015, *"the Patient's condition continued to deteriorate".*

"There existed a medical note of CT discussion still at this late stage. "The [GHA] had still been unable to definitively discover a source of infection. A CT scan might have assisted as the cause could not have been clinically apparent… he remained critically ill but there is an entry suggesting a referral to a liver specialist…On the 8th August 2015 it appears that named drugs were administered following a fall in blood pressure. By the evening a decision not to resuscitate was made and cardiac arrest followed at 17.20 hours."

The expert, in summary, stated that the Patient, for the reasons given…. had *"a very poor chance of survival. It would not be overstating that he had* ***a zero chance of survival exhibiting that degree of organ failure.*** *The Patient exhibited poor prognostic factors placing him in a group with minimal chance of survival given even the most advanced care."*

It was further explained that particularly in his last few days there were, in general...*"reviews by clinical teams and apparent full intention to treat and escalate.* ***However, the quality of the note keeping (particularly final hours) does not provide assurance of a clear line of planning or communication.***

The final events are not described to give any clarity as to timings or cause of demise. ***I believe such an outcome was inevitable.*** *However the exact events, how the (appropriate) decision not to escalate was communicated and the final therapeutic actions are not recorded well.* ***Records are below what would be accepted as a good general standard of documentation."***

Expert Conclusion

"[The Patient] presented severe signs of sepsis and was managed according to accepted guidance. He died as a result of the devastating multi organ failure that follows onset severe sepsis. Although an organism was identified and targeted with appropriate antibiotics, the actual source within the body was never identified.

CT scan in the early phase of his illness would not, in retrospect, have greatly added to his management or significantly improved his chance of survival. CT scanning later in the illness might have provided a further opportunity to identify a source, but it still would not have added to the chances of survival."

Ombudsman Conclusion

Based upon the expert medical opinion, the Ombudsman reached the view that the clinical aspects of the Patient's care were within contemporary guidelines/practice and therefore reasonable in the circumstances. Further, the GHA did not fail to provide the Patient the appropriate care whilst he was an inpatient at St Bernard's Hospital.

Classification: Alleged lack of care shown to the Patient by the GHA whilst he was admitted at St Bernard's Hospital:- **Not Sustained.**

[Ombudsman Note: Despite the Ombudsman's finding pursuant to his investigation and the advice received, the Ombudsman expressed deep concern based on the unequivocal and repeated comments made by the clinical expert, insofar as the lack of communication, leadership, governance and learning outcomes on the part of the GHA were concerned in this case.

Given the grave nature of the non-clinical findings/observations, the Ombudsman would be discussing those significant aspects with the GHA Chief Executive Officer and St Bernard's Hospital Medical Director (and make the pertinent recommendations), to ensure that the necessary improvements by way of staff training or otherwise would be undertaken with immediate effect, in order to improve on those standards so harshly criticised by the clinical assessor. Said discussion would also address the following recommendations]:

Recommendations:

(1) The implementation of an in-patient liaison service by the GHA. The medical expert stated that *"requests for notes and concerns would be dealt with through a patient liaison service which I am sure must be in place [at the GHA]").* The Ombudsman was able to determine that such service is not in existence within the current GHA framework.

(2) That the Medical Director organise a debrief and reflection on the incident which gave rise to this complaint, with the aim of it serving as a staff learning outcome.

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Case Not Sustained

HLTH 2016-19

Complaint against the Gibraltar Health Authority ("GHA") as a result of the alleged lack of care shown to the Complainant's son ("the Patient") (deceased) by the GHA.

Complaint

The Complainant lodged a complaint regarding the healthcare (or lack thereof) the Patient received while under care at John ward, St Bernard's Hospital Gibraltar.

The nature of the Complainant's complaint was:

(i) Alleged lack of communication between doctors/nurses and the Patient/Complainant during a time of great suffering.

(ii) Alleged lack of professionalism by ward staff doctors and nurses in their patient care skills.

(iii) Alleged lack of compassion in the care of the Patient and the suffering the patient and his family went through as a result. The Complainant does not want any family to experience what her family went through.

The Complainant explained to the Complaints Handling Scheme ("CHS") that her son (aged 45) passed away on the 15th April 2015 at St Bernard's Hospital. The cause of death was diagnosed as Metastatic Lung Cancer. The family only learned that the Patient was suffering from terminal cancer on Monday the 13th April 2015 (two days before his death).

The Complainant explained the timeline of events as follows:

05/12/14 – The Patient has an operation to repair damage to the veins in his leg. The operation went well. The Complainant with the benefit of hindsight wanted to know how the cancer did not reveal itself in the pre-operation assessment (including the blood samples).

Early January 2015 – The patient began to complain about severe pains in his lower back and after going to his GP he was diagnosed with an infection and prescribed antibiotics.

Late January 2015 – Re-attends primary care and St Bernard's Hospital with severe pain in his lower back. He was prescribed pain killers, anti-inflammatories, volterol cream, and tablets for the veins.

30/03/15 – The Patient goes to A&E complaining of severe pain and saying that he is unable to move. His legs were examined by the doctor; an injection was administered and he was given a tablet for the pain. No x-rays or bloods were taken and he was discharged. A referral letter for physiotherapy was provided.

01/04/15 – An ambulance had to be called for the Patient as he could not breathe properly nor sit-up. Bloods were taken as was an x-ray. A doctor informed the Patient and the Complainant that the Patient was suffering from a severe infection and that he required admission to John Ward. He was administered Morphine for the pain and told that he may be transferred to the Tertiary Referral Unit (TRU) in Spain for a scan as the equipment in Gibraltar was not functioning.

02/04/15 – The Complainant felt anxious as she was told that her son could not be seen by a doctor as there was only one doctor in the entire hospital on duty that day (Maundy Thursday). The Patient was in terrible pain and as a result, the Complainant asked to see the ward doctor. She is allegedly told that she needed an appointment to speak to him.

03/04/15 – (Good Friday). The Complainant informed the CHS of her perception that she was thought of as a nuisance whenever she asked the nurses for help with her son's care. She explained an episode with a Ward Staff Nurse who allegedly showed no compassion towards her or the Patient. The Complainant further stated that during the nurses lunch break she was able to ask for someone to see the Patient in an attempt to alleviate his pain. Allegedly, the ward Staff Nurse subsequently attended and by the foot of the bed handed the Patient oral morphine liquid in a syringe and simply told him 'here you do it'. The Complainant was horrified with the lack of professionalism and lack of patient care. [*This allegation was denied by the staff nurse in question]*.

In the early evening, after having repeatedly asked for a doctor to examine the Patient, the Complainant was able to speak to one and to a ward staff nurse. She was told that the Patient had a very severe infection and that as a result, he would be transferred to the TRU. (Note: This was the second occasion that they had been informed of the infection and transfer. However, the Patient eventually passed away without having been escorted to the TRU for the x-ray).

04/04/15 – Only morphine was administered – no doctors attended to see the Patient or family.

05/04/15 – Easter Sunday – The Complainant complained that her son was not being seen to and wanted to know what the medical plan was. A ward doctor attended the Patient's bedside but he was asleep as a result of all the tablets and morphine administered. The Complainant was informed by the doctor in a private room that the Patient was suffering from colon cancer, in addition to an infection and a 'leak'. She was allegedly advised not to worry as it was all treatable and the Patient would be able to lead a normal life. She was also told that the Patient would be sent to Algeciras (in nearby Spain) for a scan. This, the Complainant stated, gave her some hope. The Patient was sent by ambulance to Algeciras Sunday afternoon.

07/04/15 – A Gastroscopy was undertaken (examination of the upper digestive tract (the oesophagus, stomach and duodenum) using an endoscope, to view the lining of these organs). More x-rays and bloods were taken.

08/04/15 – The Patient required three blood transfusions. He also suffered bleeding due to the Gastroscopy but the Complainant was told that that was not abnormal. The Patient's urine was very dark and the Complainant pointed that out to the nurses. The Complainant also expressed concern that the urine remained by the Patient's bedside for a few days and no one appeared to want to dispose of it.

09/04/15 – the Patient was moved to a side room. Two consultant's asked him whether he was back from the TRU to which he replied 'no, I am back from Algeciras'. The Complainant could not understand the confusion and asked the doctors if they had reviewed the results from Algeciras. The doctors allegedly did not answer her question and left, only to return later stating they had seen the results, which determined that the Patient had cancer of the bones and colon, that shadows in the lungs were visible as was a possible tumor in the stomach.

Pain relief was administered and the Patient and Complainant were informed that a pain clinician would attend. Both doctors allegedly comment that they are baffled as to how the Patient had so many cancers and why these did not appear in any of the original bloods taken before his operation in December and at the A&E on 1st April 2015.

10/04/15 & 11/04/05 (Friday & Saturday) More blood transfusions undertaken and pain relief administered.

13/04/15 – At 6am the Patient leaped out of bed and projectile vomited. There was blood on the walls and floor and the Patient was understandably very agitated. The Complainant called for the nurses who offered assistance. A doctor also attended. He allegedly took no action and did not examine the Patient. According to the Complainant, no compassion or clinical skills were shown at a time of great need and worry. The Complainant informed the CHS that she became annoyed and shouted at the Doctor, accusing him of having no heart or compassion for her or the Patient's needs. The doctor's alleged reply was that the Patient was not his patient. In view of that response, the Complainant asked the doctor to remove himself from the Patient's room and requested that he be transferred to intensive care ("ITU") immediately.

The Patient was indeed transferred to ITU. The Complainant had no complaints whatsoever over the care he received there. The Complainant questioned why the Patient was not admitted to ITU at an earlier stage given the number of blood transfusions at Ward level.

The Complainant then requested an appointment with the medical practitioner. At the appointment, she was informed that the Patient was very ill. He was given a prognosis of two and a half months if that, to live. The family were also told that the cancer would have been there for a while.

15/04/15 – The Complainant passed away two days later.

The Complainant was of the opinion that had the doctors and nurses acted sooner and with more interest and compassion the cancer may not have spread throughout the Patient's body. The Complainant would like some justice for what she and her son (Patient) went through, but mostly for the Patient; as a result of his suffering and horrible death which in her view was caused by the doctors and nurses alleged lack of care. The fact that it was Easter meant that everything was delayed and the Patient was not cared for as he otherwise may have been. The Complainant would not like any other family to go through the ordeal that she went through and for that reason, lodged her complaint with the CHS. The Complainant sought an explanation as to why, in her view, there was so many failings in the Patient's care. She required an explanation for what happened and a written apology for the suffering caused and the death of her son.

Investigation

Ombudsman note: *[The CHS was established in April 2015 as an independent complaints mechanism for the sole purpose of accepting, investigating and resolving complaints filed by service users against the GHA. The CHS enjoys an arms- length agreement with the Office of the Gibraltar Public Services Ombudsman whereby in the event that complaints cannot be resolved at first instance, the Ombudsman has a discretionary power in law to accept the transfer of a specific complaint, with the complainant's prior consent in writing]*.

CHS investigation/review

The CHS presented the complaint to the GHA in writing on the 15th May 2015 setting out the facts as alleged by the Complainant and requesting their comments. Given that no reply was forthcoming, a chaser letter was sent on the 18th June 2015.

From the information received in reply and the inquiry undertaken by the CHS, the CHS took the view that they could not resolve the issue at first instance since there were medical issues which required consideration . As a result, they suggested that the Complainant transfer her complaint to the Office of the Ombudsman for investigation.

The Complainant agreed. Once all the relevant consent and waiver of confidentiality forms had been executed, the Ombudsman took custody of the Complainants file and initiated his own investigation.

The Ombudsman reviewed all the correspondence, statements and medical/ documentary evidence provided by the GHA. Given that the matters being complained against were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent medical advice to the United Kingdom.

The questions presented to the expert by the Ombudsman, and the replies received (summarised for the purposes of this report) were:

Ombudsman Question

Given the symptoms presented, were the proper tests (if any) conducted at the primary care stage in early and late January 2015, when the Patient was prescribed antibiotics?

Expert Reply

"Yes."

"The Patient presented only with signs of a local infection in the left leg, with no complaints or signs that would point to a problem in the lungs or back. Bloods were tested and a swab taken for culture. The swab showed a growth of Enterobacter….I would not expect to have found any blood result that would or could have raised suspicion of occult cancer. Typically in this situation blood will have been checked for CRP (inflammatory marker), blood counts, cultures, electrolytes, kidney and liver functions. However, if by chance the serum calcium had been significantly elevated, that might have triggered suspicion of cancer (a non-specific finding related to bone metastases or bone marrow cancer)."

Ombudsman Question

Would it be reasonable to assume that the cancers would have revealed themselves in the bloods taken at the pre-op assessment in December 2014 and/or at A&E in April 2015?

"No".

"Typically pre-op bloods are to assess fitness for surgery, and would have included blood counts, electrolytes, and often kidney and liver functions. If a calcium had been checked and been elevated, that would have given a clue- but as I don't have those results I cannot comment. Cancers are generally not diagnosed by blood tests unless targeted tests are undertaken based on clinical suspicion- for example PSA is elevated in prostate cancer, alfa-foeto-protein is elevated in liver cancer, carcinoembryonic antigen is elevated in bowel cancer and so on. In this case, as there was no suspicion of cancer such tests were not indicated. In any case, there [are] no blood tests which are specific for lung cancer, so it could not have been diagnosed by [means] of a blood test."

Ombudsman Question

Given the level of pain the Patient complained he suffered, should specific tests have been conducted in March/April 2015 at A&E, or at the ward when admitted, instead of prescribing him pain killers and anti-inflammatories?

Expert Reply

"Pain relief is the first principle of medical treatment, and should be undertaken as a priority. That should not in any way slow down the carriage of appropriate tests. In this case, recognising that cancer was a serious possibility, they did proceed with the tests, the main one being the CT scan. They should have carried out simple x-rays of the chest and spine in the first place, on the day of admission. This does not seem to have happened (I could find no record of them). It is highly likely that these x-rays will have pointed to the correct diagnosis. The CT scan was unfortunately delayed, partly due to his pain being such that transferring him to another hospital for the scan was problematic.

However, even though the diagnosis may have been achieved soon after admission (on 1/4/15) it would have made absolutely no difference to the management or the sad outcome".

Ombudsman Question

Was it reasonable for doctors not to have met to discuss the Patient's symptoms and not to have explored a care plan/treatment, given that in effect, the Patient was admitted on 1st April 2015 and there was no diagnosis until the CT scan results revealing the cancers were reviewed on the 9th April?

Expert Reply

"It would be incorrect to say that there was no plan- the plan was to treat the pain and keep the Patient comfortable until the scan was done. Essentially no further plans could have been made until a diagnosis was forthcoming.

Even if (as said in question 2 above), the diagnosis had been made on the basis of simple x-rays on 1/4/15 nothing more could have been done until the scan. Even if the scan and bronchoscopy had been expedited and occurred a few days earlier, there would have been no positive impact on the outcome."

Ombudsman Question

Does the expert opine that the Patient should have received specific care or treatment whilst at the ward and which there is no evidence that the Patient received?

Expert Reply

"Possibly."

"As said above, there was no specific treatment that could have been administered to cure the cancer. However, local radiotherapy to the spine is a treatment that may be effective in relieving the pain associated metastatic bone deposits- if the diagnosis had been made early by x-rays. This will have been purely symptomatic, and will not have altered the outcome.

Ombudsman Question

Would the expert advising conclude that the Patient received and acceptable/adequate level of care?

Expert Reply

"Yes, with one reservation."

X-rays should have been carried out soon after admission which would have avoided 8 days of uncertainty, with regard to the diagnosis. That may have resulted in expediting the CT scan and the bronchoscopy. It will also have given more time for the Patient and family to come to terms with the fatal condition. However, it will not have made any difference to the unfortunate outcome."

Expert Conclusion

"The Patient developed occult lung cancer, which had spread to the bones, before presenting with severe back pain. There was a small delay in making the diagnosis, which would have had no impact on the fatal outcome. His management seemed appropriate [although the clinical notes are incomplete]."

Ombudsman Conclusion

The Ombudsman was sympathetic to the Complainant's complaint and although some aspects of the Patient's care (with specific regard to the alleged lack of communication and compassion) may not have been to the Complainant's satisfaction, the Ombudsman was unable to classify those aspects of the complaint since the allegations presented by the Complainant's were disputed by medical staff and could not be verified by independent means.

Based upon the expert medical opinion, the Ombudsman reached the view that the Patient's care (from a medical perspective) was not untoward and that it followed established medical practice.

In accordance with the medical expert's unequivocal clinical advice, the Ombudsman could not agree that the GHA had shown a lack of clinical professionalism in their treatment of the Patient. One aspect which according to the expert, the GHA could have conducted more efficiently and over which the Ombudsman was critical, was the fact that x-rays should have been taken on the Patients admission. This may have expedited the diagnosis but as also stated by the expert, the outcome, unfortunately, would have been no different. Be that as it may, the acceleration of the initial x-ray process (a view shared by the expert and Ombudsman) would have given the Patient, the Complainant and their family more time to have "come to terms with the fatal condition." This would have possibly provided the Complainant a small amount of closure following the death of her son (Patient).

Classification

(i) Alleged lack of communication between doctors/nurses and the Patient/Complainant during a time of great suffering- "**Unable to classify"**

(ii) Alleged lack of professionalism by ward staff doctors and nurses in their patient care skills (medical)- "**Not sustained"**

(iii) Alleged lack of compassion in the care of the Patient and the suffering that the Patient and his family went through as a result- **"Unable to classify".**

Update

The GHA provided the Complainant with a comprehensive apology.

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Case Sustained

HLTH-2016-20

Complaint against the Gibraltar Health Authority ("GHA") on behalf of his father, ("Patient") as a result of the alleged lack of duty of care by GHA nurse escort; the alleged lack of coordination between GHA and Tertiary Referral Unit in Spain ("Referral Unit") and the alleged lack of assistance from GHA's Accident & Emergency Department ("A&E") in relation to obtaining the Patient's medication

Complaint

The Complainant was aggrieved due to the:

(i) Alleged lack of duty of care by GHA nurse escort;
(ii) Alleged lack of coordination between GHA and the Referral Unit;
(iii) Alleged lack of assistance from GHA's A&E in relation to obtaining Patient's medication

The Complainant explained the Patient was transferred from the GHA's A&E Department to the Referral Unit on the 27th November 2015 as a result of his GP having diagnosed water in the lungs. The Patient was transferred in a GHA ambulance and accompanied by a GHA nurse escort ("Escort"). Aggrieved by several issues, the Complainant lodged his complaints with the Ombudsman on the 14th December 2015.

(i) Alleged lack of duty of care by GHA nurse escort

Background

The Complainant stated he arrived at the Referral Unit by car, approximately twenty minutes after the ambulance's arrival. The Complainant claimed he found the Patient unaccompanied in the waiting area of the Referral Unit's A&E. The Complainant asked the Patient about the Escort's whereabouts and he replied she had gone for a coffee. The Complainant made some enquiries at the Referral Unit's reception area and was informed the Escort had handed in the Patient's paperwork and left. According to the A&E receptionist they had called out the Patient's name on three occasions, but he had not responded. The Complainant could not understand how the Escort could have abandoned his 86 year old father and as such felt she had failed in her duty of care.

Investigation

The Escort provided a statement. She explained that when they arrived at the Referral Unit, admission paperwork was sorted out at the A&E's Department whilst she waited with the Patient at the entrance lobby. When the Patient was called for triage, the Escort wheeled him into one of the side rooms and spoke to the nurses who took over his care and proceeded to carry out the standard observations. The Escort handed in the pertinent documentation concerning the Patient and his health issues and informed staff that his son was travelling from Gibraltar and would arrive soon. According to the Escort, patients are usually taken into the day room of the A&E Department where other nurses look after them until they are transferred elsewhere. Escort nurses are not allowed to enter that area. The Escort stated that once she was satisfied that she had carried out her duty she handed over the Patient's passport and left to meet the GHA ambulance crew at the Referral Unit's canteen.

In December 2015, the Ombudsman made enquiries with SBH's General Manager Hospital Services regarding complaints (i), (ii) and (iii) and after numerous chasers finally obtained a response in July 2016; an unwarranted seven month delay as a result of which so much time had elapsed since the complaint was lodged that the Referral Unit advised that staff could not recall what had happened.

Notwithstanding, the Referral Unit explained the Patient had been sent to them directly from A&E at SBH because there were no beds available at SBH [Ombudsman Note: The GHA's Chief Executive, after reading the Ombudsman's report, disagreed with the Referral Unit's statement and clarified that the referral was based on clinical presentation].

The Referral Unit explained the established procedure in similar cases. Patients are admitted to the observation area of the A&E Department where they are assessed by medical staff. They are then administratively admitted and called by the triage nurse. The Referral Unit stated they could not make further comments regarding the handover due to the time elapsed and staff being unable to recall what had happened.

Conclusion

The Ombudsman investigated the admission process in place at the Referral Unit when GHA patients are transferred from SBH via ambulance and nurse escort.

The lengthy delay on the part of the SBH's General Manager Hospital Services affected the investigation in that the Referral Unit were unable to identify what had happened in the Patient's case due to the period of time elapsed. The Ombudsman was critical of the unexplained delay and for the avoidance of a similar situation in future, pointed the SBH General Manager Hospital Services to Section 25 of the Public Services Ombudsman Act 1998:

> **Offence of obstruction**
>
> 25.(1) Any person who, without lawful excuse, obstructs the Ombudsman or any member of his staff in the performance of their duties under this Act, or is guilty of any act or omission in relation to any investigation under this Act which, if that investigation were a proceeding in a court of law, would constitute contempt of court, shall be guilty of an offence.
>
> (2) Where an offence is certified under this section, the court may inquire into the matter and, after hearing any witnesses who may be produced against or on behalf of the person charged with the offence, and after hearing any statement that may be offered in defence, deal with him in any manner in which the court could deal with him if he had committed the like offence in relation to the court.

The admittance process explained by the Referral Unit appears to be smooth and straight forward but would point to some miscommunication issue within the A&E Department of the Referral Unit as the cause of the Patient having been released from the A&E observation area out to the waiting area of the A&E Department (albeit even if for ten minutes as according to the Complainant he arrived twenty minutes after the ambulance during which time the Patient had been administratively admitted and assessed by medical staff) after the Escort completed the handover. The only thing the Escort could have done differently is to have waited in the observation area with the Patient until the Complainant arrived but according to the Escort, they are not allowed in that area.

The Ombudsman does not sustain this complaint against the Escort but has identified that established procedure was not followed by the Referral Unit in this case. The Ombudsman proposes that the GHA should ensure the Referral Unit is aware of this complaint and in order to prevent future recurrences, that they ensure that staff at A&E is fully cognisant with the admittance procedure with respect to SBH patients who are transferred there.

(ii) <u>Alleged lack of coordination between GHA and the Referral Unit;</u>

Background

According to the Complainant, on the 11th December 2015 they were informed that the Patient could return to Gibraltar pending confirmation of bed availability at SBH and transported by ambulance back to Gibraltar. The Complainant approached the Referral Unit's receptionist to enquire about the timeframes and was informed that there were no beds available at SBH and he could not return to Gibraltar. Based on that information, the Complainant contacted the nurse of the doctor who had attended to the Patient. She telephoned the doctor who explained the Patient did not need to be admitted at SBH as he was being discharged and all that was required was an ambulance.

The Complainant spoke to the Welfare Officer at the Referral Unit to notify her that they were pending the ambulance transfer but when she contacted the GHA was informed they had no transfer request. The Welfare Officer asked them to wait a while longer.

Two hours later, the Complainant returned to the Welfare Officer and she put him in contact with the doctor who advised the Patient was being discharged and the GHA had informed them that the Patient had his own transport and did not need an ambulance. The doctor enquired if they had transport and the Complainant responded they had but feared something could happen to the Patient on the way back. The doctor reassured them.

Investigation

The Referral Unit's response, via the SBH's General Manager Hospital Services, stated that dependent on the bed situation at SBH, the Referral Unit's medical team were asked to re-evaluate patients to establish if it was clinically possible to be discharged home; that was what happened in the Patient's case. The medical team re-evaluated and considered the Patient safe to be discharged home. The Referral Unit stated there was coordination as the decision was a joint one and added that the Welfare Officer kept the Patient and his family updated on all the changes.

Conclusion

The explanation provided by the Referral Unit clarifies the changes in the sequence of events experienced by the Complainant and the Patient. The initial decision taken by the Referral Unit's doctor was for the Patient to be admitted at SBH via ambulance transfer. A decision which changed after the doctors at the Referral Unit medically re-evaluated the Patient's case, at the request of SBH due to a shortage of beds, and the Patient considered safe to be discharged home by private transport and not ambulance transfer.

The Ombudsman finds that there was miscommunication between the Referral Unit and the Complainant and Patient during the re-evaluation stage. This is substantiated by the fact that it was the Complainant who chased around the Referral Unit for information on the Patient's transfer and subsequent discharge.

The Ombudsman sustains this complaint but against the Referral Unit not the GHA. Notwithstanding, the latter should ensure that the Referral Unit have established procedures regarding communication with Patients and families in cases similar to this one.

(iii) <u>Alleged lack of assistance from GHA in relation to obtaining the Patient's medication</u>

Background

The day after the Patient returned to Gibraltar, Saturday 12th December 2015, the Complainant went to the A&E Department at SBH to find out where he could obtain a prescription for the new medicines prescribed to his father at the Referral Unit. Allegedly, the nurse that attended to him told him the medicine was not available in Gibraltar as they had been prescribed by a Spanish doctor. The Complainant went to Spain and purchased the medicine there.

The Complainant felt strongly that patients who returned from the Referral Unit should not have to chase around for their medication.

Investigation

SBH's A&E Department's response to the SBH's General Manager Hospital Services stated that the problem experienced by the Complainant was a frequent occurrence at their department. Patients discharged by the Referral Unit usually attended SBH's A&E Department shortly after, to request prescriptions from the doctor on duty who had never seen or treated said patient. SBH A&E Department stated the situation frustrated staff as they were left to:

- Contact on-call medical and surgical doctors who did not want to issue prescriptions because they had not seen the patients;

- Deal with angry patients and relatives.

SBH A&E Department highlighted there should be a system in place whereby the doctor at the Referral Unit discharging the patient could follow through the discharge and provide the patient with the adequate prescription.

SBH's General Manager Hospital Services informed the Ombudsman that the GHA and the Referral Unit had now introduced new protocols in respect of the issuing of medication to SBH patients at the Referral Unit and that medication prescribed now followed the British National Formulary.

In respect of this issue, the Referral Unit referred to a meeting with the GHA and the fact that they were trying to minimise inconvenience to patients as a result of the discharge prescriptions.

Conclusion

Gibraltar's geographical location is quite atypical and as such, gives way to complaints like the one set out above. Whilst the Referral Unit is located in the Spanish mainland (about one hour by road from Gibraltar) Gibraltar is a British territiory where the British National Formulary is followed with regards prescription guidance; needless to state that is not the same guidance document as the one followed by hospitals in Spain. Notwithstanding, the GHA has been using the services of the Referral Unit for a number of years now and as such should have established at the inception stage of the working relationship what has now been agreed, i.e. new protocols in respect of the issuing of medication by the Referral Unit to SBH patients and that prescribed medication follows the British National Formulary guidance.

The Ombudsman sustains this complaint but is satisfied that the anomaly has now been addressed.

Recommendations

None Made

Ombudsman Note

The Ombudsman would be discussing with the GHA's Chief Executive, the discrepancy between his statement and that of the Referral Unit's in respect of the reasons for referral for GHA patients.

Case Sustained

HLTH 2016-34

Complaint against the Gibraltar Health Authority ("GHA") as a result of the Radiology Unit at the GHA not accepting a doctor's hard copy for an x-ray request which was hand delivered by the patient and the lack of care and unreasonableness in asking the patient, to go back to her GP and ask for an electronic copy to be issued.

Complaint

The Complainant was aggrieved because

(i) Radiology Unit did not accept a doctor's hard copy for an x-ray request hand delivered by the patient. They instead stated that it needed to be sent electronically.

(ii) Lack of customer care and unreasonableness in asking the patent, to go back to GP and ask for an electronic copy to be issued.

The Complainant explained that on Monday 11th July 2016 she saw her General Practitioner ('GP'), who, on noting her past medical history and current breathing problems, advised that an x-ray be taken of her chest and a scan of her heart. The Doctor tried to send instructions for these procedures via computer, as per common practise, but due to a problem with the system at the time he could not send anything electronically. Telephone calls to the department also proved futile as no one appeared to answer the phone. All this was done in the Complainant's presence. The GP then proceeded to document his request on a 'GHA Radiology Department Examination Request Form' and made a note on the document for the reason why he had done a handwritten request. He noted his direct contact number on it for the Clerk to contact him if need be.

On Wednesday 13th July 2016 the Complainant went in person to the Radiology Department where she was firstly attended to by two trainees and a male clerk who she described as 'polite'. At the time she did not have the doctor's form with her and they informed her that unfortunately x-ray requests could only be accepted electronically. When she later produced the hard-copy of the doctor's request and asked to speak to a senior officer she was attended to by the 'Department Manager', a female officer, who she described as 'rude'.

The Complainant reports that the Department Manager waved the form in the air and told her that the doctor had rung the wrong telephone number and should have instead phoned the technicians not the Radiology Department. She then proceeded to advise the Complainant to go back to her GP, without any consideration for her welfare or time.

The Complainant states that it was a hot levanter day and that she informed the Manager that she was not her 'errand boy but a patient that might not be feeling well'. The Complainant states that she felt it was unreasonable that she should have been made to go back and sort out what in essence was an administrative issue.

The issue was solved when the Complainant managed to see her GP later on that same day back at the Primary Care Centre and he sent the form electronically, but all this at a great expense of time and frustration against the system.

Investigation

This Complaint was presented to the GHA for their comments and the Ombudsman was subsequently informed that the GHA could not accept paper requests as per '*departmental protocol*'.

The following points thus arose from the Complainant and the GHA's reply letter to the Ombudsman:

1, Should the GP have sent the Complainant off on an errand or should he have kept the request in-hand to do when the electronic service was back in operation?

2. After attending the Radiology Department should the Complainant have been made to go back to her GP when she clearly had a formal GHA form in-hand, albeit a hard copy and not the requested electronic version?

3. Was there customer care issues that need addressing in respect of the treatment the Complainant received by the Manager who attended to her at the Radiology Department?

Point 1. The fact is that the GP sent the Complainant on an errand to hand-deliver the request for an x-ray in good faith and in the hope that in this way the patient would be seen to sooner. He was concerned for her health and thus tried to expedite matters.

As a result of the complaint a streamlined system has now been introduced so as to avoid repetitions of this unfortunate incident. A new procedure has now been put in place so, where if a GP is unable to request an x-ray via the appropriate electronic channel, then the GP can send an email to the relevant department instead. A full contact list of the Radiology Department has been sent to all the GP's at the PCC so they may contact the relevant parties should the electronic system fail. This is a good example where a public body have used a complaint to improve on their public service delivery so that a service is developed. The above new procedure will now allay any concerns that GP's may have with regards to delays to patients receiving treatment.

Points 2 & 3. The Principals of Good Administration dictate that all public bodies should act according to their statutory powers and duties and any other rules governing the service they provide. They should follow their own policy and procedural guidance, whether published or internal, however, in some cases a novel approach may also bring a better service and public bodies should be alert to this possibility. This could have been the case in this particular incident. When a public service decides to depart from stablished good practice, they should simply record why. In this case the Officer could have taken the hard copy and noted the reason for doing so.

Conclusions

What should always be at the forefront of all public bodies and their representatives is that customers/patients need to be treated sensitively, bearing in mind individual needs. Public servants should respond flexibly to the circumstances of each case, and where appropriate, they should deal with customers in a co-ordinated way with other service providers to ensure their needs are met. In this particular case the Radiology Manager should have accepted the request form and liaised with the GP internally, herself. The fact is that the request had been made on the appropriate form, a 'GHA Radiology Department Examination Request Form' and should have been accepted. It must also be highlighted that the GP was able to send the request later on that same day electronically when he was approached by the patient, so had the Radiology Manager taken the form herself she could have asked this of the GP herself internally and not got the patient involved. This would have been considered best practise and being customer focused.

The Ombudsman is of the view that this type of incident is an example of where we can go wrong and where the customer's rights have been lost in a series of administrative red tape. Customer care should be at the forefront of all civil servants minds and should be applied across the board irrespective of protocol or established practises. Official procedures or systems are internal matters and customers should not have to find ways of overcoming them but should be helped by the people who work the system. The fact is that the Radiology Manager could have overridden protocol in this particular case and remembered that the customer is her main concern, especially where this person is also a patient with health issues. The Manager should have made it her prerogative to have helped not only the patient but also the system; as having to return to her GP meant that the Complainant took up the GP's time on an appointment that could have been utilised by another service user.

When mistakes happen, public bodies should apologise and acknowledge when things go wrong and put things right quickly and effectively.

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HOUSING AUTHORITY

Case Partly Sustained

CS/1103

Complaint against the Housing Authority for them having disagreed with the decision not to allow the Complainant to be included in the tenancy of his parents Government rented flat; over excessive delay in taking the decision; and the unprofessional manner in which the decision was communicated to him.

Complaint

The Complainant was aggrieved because:

(i) He disagreed with the Housing Authority's decision not to allow him to be included in the tenancy of his parents Government rented flat;

(ii) Excessive delay in coming to a decision;

(iii) Unprofessional manner in which the decision had been communicated to him.

The Complainant explained to the Ombudsman that in summer 2014 when he made enquiries with the Housing Authority for his wife ("Wife") to be included in the tenancy of his parents ("Parents") Government rented flat ("Flat"), he was informed that he was not included in the tenancy and would have to request an inclusion. The Complainant claimed to have been very surprised at the news but stated that after discussing the matter with the clerk at the counter he decided the situation would be more easily rectified if he requested to be officially included back in the tenancy. The Complainant felt there would be no reason for a delay or refusal on the part of the Housing Authority as:

(i) He had always lived with his Parents;

(ii) Never bought or rented a property in Gibraltar;

(iii) The Flat composition, a two bedroom property, was adequate to accommodate the two couples.

According to the Complainant, in summer 2014 he handed in to the Housing Authority the application for inclusion in the tenancy ("Application") for his Wife and himself (albeit noting in the Application that he had always resided with his parents) but stated the Housing Authority did not revert until the 26th February 2015 by way of letter addressed to his Parents (the tenancy holders). The response referred the Parents to the section in the Application which stated the reason for the submission of the Application (in relation to the Complainant) was that an error must have been made when the Parents exchanged flats (in 2006 in removing the Complainant from the tenancy) as the Complainant had always lived with his Parents. The Housing Authority informed the Parents that in their letter of March 2006 ("Letter") they had requested an exchange to the Flat, amongst other reasons, because the property they resided in at the time was too big as the *'children had long since married and left'*. Based on the aforementioned, the Housing Authority, in order to continue to process the Application, requested that the Parents provide them with the details of where the Complainant had resided since he married.

On the 10th March 2015, the Complainant's mother's ("Mother") response to the Housing Authority set out the circumstances of the case. She confirmed the Complainant had always resided with them and that since having married in 2000 to a Spanish national, divided his time between Spain and Gibraltar especially because he worked long unsociable hours due to shifts. The Wife remained in Spain as she supported her mother there and so kept her Spanish residency although she would occasionally also stay in the Flat.

The Mother explained that in 2014 the family's circumstances had changed in that her husband had been admitted to hospital suffering from severe Alzheimer's disease and the Complainant and his Wife were spending more time in Gibraltar supporting his parents, thus the reason for requesting that she be included in the tenancy.

The Mother referred to the Letter and explained she could not remember her husband having written it. Notwithstanding, she advised that at that time, her husband was already displaying early signs of dementia and would sometimes get confused and suffered memory loss. The Mother stated that it was true that two of her children had married and left home but not the Complainant.

The Mother requested a meeting with the Housing Authority which took place on the 4th May 2015, at the conclusion of which it was resolved that their case would be considered and a decision made within two weeks.

Not having received the decision by the 3rd August 2015 the Complainant emailed the Housing Authority. The latter's response on the 5th August 2015 was that his case would be reconsidered and a reply sent as soon as possible.

On the 28th August 2015 the Housing Authority responded by way of email and stated:

> *"After having checked our records it is noted that you are not permanently resident in Gibraltar thus the inclusion in your mother's tenancy denied. This was also confirmed by a survey conducted as part of the Government's Asset Register*."*

***[Ombudsman Note: Government Asset Register – Register of public housing stock.** Information obtained by housing officers' door to door survey to establish the condition of the properties and details of the persons resident in those properties. [Ombudsman Note: In Case 782 (2009) the Ombudsman recommended that information obtained should be verified and signed by tenancy holders but this exercise was undertaken in 2006, prior to that recommendation]].

In light of the Housing Authority's decision, the Complainant was at a loss. Apart from the casual manner in which the decision had been communicated to him (via email rather than on official letterhead paper) the Complainant explained he had provided significant documentation as proof that he resided in the Flat by way of ID card, health card, bank statements, life insurance letters, Supreme Court summons, register of electors (all those documents were addressed to the Flat). Furthermore, the Complainant highlighted he had never rented or bought a property in Gibraltar and as such his Gibraltar address had always been his Parents rented property; the Complainant could not understand the Housing Authority's decision.

The Complainant lodged his Complaints with the Ombudsman.

Investigation

The Ombudsman presented the Complaints to the Housing Authority.

Complaint (i) - Disagreed with the decision not to allow him to be included in the tenancy of his parents Government rented flat

To establish the Housing Authority's action of removing the Complainant from the Parents tenancy, the Housing Authority referred to and provided copies to the Ombudsman of:

(i) A copy of the Letter (Parents to Housing Authority dated 22nd March 2006 which preceded the application for exchange) referred to earlier in this report, which stated that the children had married and left and the reasons for requesting the exchange were due to the property having become too big for the aging couple and because they wanted to relocate to a flat nearer their daughter;

(ii) The Parents application for exchange of accommodation dated 12th June 2006 in which the only persons listed as residing in the property were the Parents;

(iii) The Flat's tenancy agreement (signed by the Complainant's parents in June 2006) in which again the only persons authorised to reside were the Parents;

(iv) An email of a survey (Government Asset Register) undertaken by the Housing Authority in July 2006 to establish family composition, condition of flat, etc. in which an officer physically visited the Flat.

Regarding the Housing Authority's decision not to include the Complainant back in the tenancy, the Housing Authority explained that the Complainant met the criteria to be included in his Parents tenancy and that had he not been married would have been considered on his own merits. Being married, the Housing Authority's position was that one of the parties could not reside in Gibraltar whilst the other did not, i.e. living apart, hence both the Complainant and his Wife had to qualify at the same time in order to be included in the tenancy.

The Housing Authority stated that had always been Government policy as the Housing Authority could not split up a married couple. The Ombudsman posed the question to the Housing Authority on whether the same policy would have been applied had the Complainant remained as an authorised tenant in the Flat, i.e. automatic inclusion of the Wife in the tenancy so as not to split up the marriage. Their response was no, the Wife would still have to meet the criteria to be eligible in her own right.

In order to qualify, the Complainant and his Wife would have to provide evidence of residency in Gibraltar by way of employment contracts, car insurance, etc. Whilst the Complainant could comply with the request, his Wife worked in Spain and still resided there the majority of the time. The Housing Authority's position was that until the Wife could provide proof that she lived in Gibraltar for a given period she would not be eligible to be included in the tenancy and as a result neither would the Complainant.

The Ombudsman was of the view that the manner in which the policy was being applied was penalising and causing hardship to the Complainant due to the unconventional circumstances of the case (the couple resided in different jurisdictions) and put this to the Housing Authority who suggested putting the case once again to the Housing Allocation Committee ("HAC") for consideration. The Ombudsman resolved to write to HAC setting out the Complainant's case, supporting the Complainant's request for inclusion in the tenancy.

The Ombudsman referred the Housing Authority to the documents provided by the Complainant amongst which were his ID and national health card which denoted the Flat's address and was therefore being accepted as valid by other Government entities as the Complainant's official residence. The Housing Authority responded that those Government entities did not undertake checks regarding local addresses and so the Ombudsman enquired as to the Housing Authority's position with regards notifying those organisations when a person was removed from the tenancy of a Government rented property. The Housing Authority responded that persons making use of parents' addresses in Gibraltar (those persons not authorised by the Housing Authority as tenants) was a 'grey area' but that in cases where benefits like schooling would be obtained through 'fraudulent' use of said addresses, the Housing Authority would inform the pertinent departments.

The Housing Authority referred to the meeting held with the Complainant in May 2015 at which he had informed them his intention was to purchase affordable housing. The Housing Authority stated they had informed the Complainant that to purchase a property in the new Government developments it was no longer a requisite to be an applicant in the Government housing waiting list [Ombudsman Note: The Complainant's concern was that he would be at a disadvantage over Government housing applicants who would possibly be given first choice on the properties].

The HAC meeting was held on the 22nd February 2016 and the Complainant notified of the outcome a week later. HAC's recommendation to the Housing Authority after having reviewed the case and having noted the Ombudsman's concerns was that they were unable to deviate from current policy and procedure in place. For completeness of records, the Ombudsman requested the full details of the policy and procedure. Further to chasing the request, the Housing Authority responded on the 3rd May 2016 and stated:

"This is an unwritten policy applied by the Department. In his case and as a family unit they would both need to qualify before inclusion is accepted, this helps to safeguard Government housing stock which is a limited resource."

Complaint (ii) - Excessive delay in taking the decision

The Housing Authority provided the Ombudsman with a copy of the Complainant's and his Wife's application for inclusion in the tenancy dated 12th January 2015.

Regarding the delay in reaching a decision, the Housing Authority initially stated in a letter to the Ombudsman in October 2015, that the delay had been due to the matter having been considered by HAC on several occasions since May 2015. At a meeting with the Ombudsman in November 2015, the Housing Authority rectified and advised that the delay had been due to the minutes of the meeting with the Complainant on the 4th May 2015 having been erroneously filed instead of being actioned. The Housing Authority stated the Complainant's case was considered by HAC in August 2015.

Complaint (iii) - Unprofessional manner in which the decision was communicated to him.

On the matter of having communicated the decision to the Complainant by email, the Housing Authority responded that the Complainant had communicated with them via email and as such did not believe that responding to him via email was inadequate.

Conclusions

Complaint (i) - Disagreed with the decision not to allow him to be included in the tenancy of his parents Government rented flat

In attempting to include his Wife in his Parents tenancy, the Complainant found out that the Housing Authority had not included him in the new tenancy pursuant to his Parents' move to the Flat. Since then, being included back into the tenancy as an authorised tenant had proven an impossible task.

The 'unwritten policy' applied by the Housing Authority to married couples in respect of eligibility for application to the Government housing waiting list which in this case was required in order to be included in the Parents' tenancy, was being applied in the Complainant's case despite the unconventional circumstances of the Complainant's marriage.

In this case, the Complainant due to work requirements and shifts divided his time between living in Gibraltar and Spain where his Wife worked and also looked after her mother. According to the Complainant, due to circumstances having changed on his side of the family since his father's admission to hospital as a result of which his Wife would now also be dividing her residence between Gibraltar and Spain, he set out to request his Wife's inclusion in the tenancy. In view of the difficulties he had experienced, the Complainant opted for the time being not to include the Wife in the tenancy as well as due to not being able to provide documentary evidence of her residing in Gibraltar at the present time. Notwithstanding, the Complainant maintained he had always resided with his Parents and as such the Flat was his home. Without the Complainant's knowledge and based on documentation at the time when the Parents requested an exchange, the Housing Authority did not include the Complainant in the tenancy.

Regarding the Complainant's eligibility to be included in the tenancy, the Complainant meets the Housing Authority's criteria in his own right. He works in Gibraltar, drives a locally registered car and provided pertinent car insurance documentation to substantiate this. He has never had any other known address locally, either through rental or purchase of property in Gibraltar. In keeping with Government policy that had the Complainant remained in the tenancy the Wife would not have been automatically included in the tenancy by virtue of the marriage and would have had to submit evidence that she was residing in Gibraltar to meet the criteria for eligibility the Ombudsman is of the view that the Housing Authority should reconsider the Complainant's case. The Ombudsman wished to emphasise that allowing the Complainant to be included back in the Parents tenancy would not cause any deviation from a standard inclusion, given that, if and when the wife ever requested to be included in the tenancy, she would need to meet the pertinent criteria.

Complaint (ii) - Excessive delay in taking the decision

The Housing Authority erroneously filed the minutes of the meeting with the Complainant in May 2015 instead of presenting his case to HAC for their consideration. It was only as a result of the Complainant's email in August 2015 enquiring about the decision that the Housing Authority were alerted to the error and rectified. Notwithstanding, although to err is human, the manner in which the Housing Authority rectified does not comply with the Principles of Good Administration ("Principles") and the Ombudsman therefore **sustains** this Complaint. The Principles advocate openness and accountability which the Housing Authority failed to provide to the Complainant in not informing him of the error and in not having apologised.

Complaint (iii) - Unprofessional manner in which the decision was communicated

The Ombudsman does **not sustain** this Complaint in view of the fact that the Complainant communicated with the Housing Authority via email and it was assumed that it was an acceptable means of communication. Furthermore, the Complainant if dissatisfied with having had the Housing Authority's decision communicated via email could have approached them and requested a letter.

Case Partly Sustained

CS/1104

Complaint against the Housing Authority after the Complainant having alleged that:-

(i) For the past three years, she and her two young children had been terrorised by a mentally unstable female neighbour ("Neighbour 1") and the Housing Authority had not deemed her case serious enough to warrant action or relocation, despite social workers substantiating the Complainant's concerns and supporting her request;

(ii) As landlord, the Housing Authority should review their Anti-social neighbour policy and make pertinent amendments to take responsibility and act accordingly rather than point the Complainant to the Royal Gibraltar Police;

(iii) The neighbour who resided above the Complainant ("Neighbour 2") was relocated due to problems with Neighbour 1, whereas she had pressed for a relocation for the past three years to no avail;

(iv) Dampness points not applied to the Complainant's housing application for a 4RKB as per Housing Allocation Scheme (Revised 1994).

Complaint

The Complainant lodged the above complaints against the Housing Authority.

The Complainant stated that for the past three years (2012 to 2015) she and her two young children (three and one years old) had lived in fear of Neighbour 1 due to the constant threats, abuse and persistent anti social behaviour ("ASB") against them, all of which had made her fear for their safety. By way of example of the ASB they were enduring, the Complainant stated her three year old daughter would constantly be woken up by Neighbour 1 thumping on the external wall of their flat, calling for the daughter to come out and play which undoubtedly terrified the young girl. Furthermore, Neighbour 1 had hit her daughter, broken her toys and cut her clothes. Incidents which had led to the Complainant and Neighbour 1 ending up in Court.

The Complainant explained that throughout that time she had approached the Housing Authority for assistance, including writing to them and forwarding RGP reports of incidents of the ASB from Neighbour 1 but their response had always been that they could not help because the matter fell beyond the Housing Allocation Committee's ("HAC") remit and she should make reports to the Royal Gibraltar Police ("RGP"). According to the Complainant, when she contacted the RGP they could do little to help as Neighbour 1's mental health issues were known to them and all they could do was visit the premises to try and speak to her.

The Complainant believed that the RGP would have been able to put their message across to Neighbour 1 if she did not have mental issues but in this case she felt that no matter how many warnings, it would come to nothing. The RGP had advised the Complainant to contact the Mental Health Team but when she did, the Complainant stated they too were limited in what they could do because she could not be admitted to a psychiatric ward.

The Complainant provided copies of letters sent by two social workers to Housing Authority in August 2014 and July 2015 in support of her request for relocation due to the anti social behaviour problems being experienced and also due to the dampness problems in the flat which were having a detrimental effect on the children's health.

HAC's consideration of the Complainant's case in August 2014 resolved that they were unable to assist with the request for relocation but agreed that she could seek an exchange of her own accord. Regarding the incidences with neighbours, HAC reiterated that these should be reported to the RGP as the matter fell beyond their remit.

The Complainant was further aggrieved because she could not understand how Neighbour 2 had been relocated because of the problems with Neighbour 1, and in contrast, nothing had been done about her case despite the fact she lived opposite Neighbour 1.

The Complainant had also written to the Minister for Housing for assistance with her case, and in October 2014 received a reply from his office informing her that they, together with the Housing Authority, were trying to find a solution to help her and her family.

In July 2015, and further to her case once again having been considered by HAC and no recommendation made, the Complainant lodged her complaints with the Ombudsman.

Investigation

The Ombudsman presented the Complaints to the Housing Authority and a delayed response for which the Housing Authority apologised, was received in mid-October 2015. The reply explained that since early 2014, HAC had considered the Complainant's case on four occasions and been unable to assist as the issues she raised were of an anti-social nature and therefore an RGP matter and beyond the Housing Authority's remit. The issues raised related to Neighbour 1 were forwarded to the Mental Health and Care Agency who were monitoring the situation.

The Housing Authority had provided information in relation to their ASB policy and procedure in a separate case being investigated by the Ombudsman. They explained that they would initially meet with the afflicted party to discuss their concerns and establish how they could assist. They would then write to the other party and inform them of their obligations under the Tenancy Agreement in respect of good neighbourly relations not to cause a nuisance to others, etc. If the anti-social behaviour persisted, the Housing Authority would then seek RGP assistance via the Police Neighbourhood Policing Unit and if required, seek legal assistance from their lawyers. In situations where a criminal offence had been committed, persons would be recommended to report the matter to the RGP.

Regarding Neighbour 2, the Housing Authority stated that he and his family were relocated as a result of an injunction issued against the Complainant's live-in partner (and father of the two children) ("Partner"), the result of the Partner having assaulted Neighbour 2, for which a Court hearing was pending.

The Ombudsman compiled the copies of the RGP report into a table and noted that during the period September 2013 to March 2014 (inclusive) there were twenty two reports recorded by the RGP of anti social behaviour.

On the matter of the Complainant's application for a 4RKB, her entitlement based on family composition, the Ombudsman resolved to establish whether the pertinent points had been compounded in the application. The Housing Authority advised that the points had been reviewed and the points awarded were in order apart from 50 points for sanitary conditions in her present flat which had not been included when her application was backdated to 2006. The points had now been added in the application. Regarding HAC awarding sanitary points, the Housing Authority stated that was not customary but the case would be referred for consideration.

In late October 2015, the Housing Authority informed the Ombudsman that due to the exceptional circumstances of the Complainant's case she had been made an offer of allocation which she accepted. The allocation being a 4RKB which would be sent out for refurbishment.

To expand further on some of the issues of this case, the Ombudsman met with the Housing Manager on the 3rd November 2015. She highlighted that the Minister for Housing was presently looking into establishing Anti Social Behaviour Orders ("ASBOs") and was presently looking into guidelines. By way of update, on the 17th June 2016, at the time of writing this report, the Ombudsman requested an update on this issue and was informed by the Housing Manager that legislation had been included in the Criminal Procedure & Evidence Act and this being handled by the RGP.

Regarding Neighbour 1, the Housing Manager stated that in similar cases they had referred the case to the Mental & Welfare officers and to the Care Agency and that there was a team in place to handle those cases but highlighted mental welfare cannot admit persons into hospital unless they are having a psychotic episode. If a person is under the effects of drug or alcohol, mental welfare officers cannot assist.

The Housing Manager explained that when a patient with mental issues is discharged from hospital, medical staff inform the Housing Authority and request a flat to be allocated to the person. The Housing Authority require that there is a care plan in place by the Mental Health team.

Regarding the relocation of Neighbour 2, the Housing Manager expanded on the matter and explained that there had been an incident in which the Partner bit Neighbour 2 and an injunction was issued as a result. The Housing Authority decided that because the Partner was a guest in the flat and they could not control his visits they would move Neighbour 2 out. The latter agreed to the proposal as he preferred that to having to call the RGP every time the partner visited. According to the Housing Manager they had never had a case where an injunction had been issued against one of the parties where the parties lived above each other.

In early December 2015, the Ombudsman sought information from the General Manager Mental Health ("Manager") in relation to the care plans put in place by the team when patients are discharged and allocated a flat. The Manager stated that there is nothing in law whereby a care plan can be enforced and is up to the patient to comply. By way of information, he mentioned that the Minister for Health is looking into amending the Mental Health Act for an order to be included for high risk patients to be admitted to hospital when professionals feel that this will **prevent** an incident, rather than waiting for something to happen and sectioning to occur, but that this was in its embryonic stage. Until then, the RGP are called when there is a disturbance and they make the assessment; if the need arises, the Mental Health Team will be contacted.

In Neighbour 1's case, the Manager explained the care plan involved her visiting the Community Mental Health Centre on a weekly basis and weekly or bi-weekly visits by nurses to her home.

The Manager highlighted that within the new hospital site there are a number of flats where patients who have been in hospital for a substantial period of time are moved into, around six months prior to being discharged. The setting enables patients to adjust during that period to living independently within a sheltered environment and the monitoring of the Mental Health Team.

For completeness of records, in late April 2016 the Ombudsman requested information from the Housing Manager about the Complainant's allocation and was informed that the property had been refurbished and returned to housing stock in mid-April 2016.

Conclusions

Complaint 1: Complainant alleged that for the past three years, she and her two young children had been terrorised by Neighbour 1 and the Housing Authority had not deemed her case serious enough to warrant action or relocation, despite social workers substantiating the Complainant's concerns and supporting her request – **Sustained**

Complaint 2: As landlord, the Housing Authority should review their ASB policy and make pertinent amendments to take responsibility and act accordingly rather than point the Complainant to the RGP - **Sustained**

ASB is a reality which many persons unfortunately have endured, are enduring and will endure. In the most optimistic of outcomes, issues will be resolved but in case of a negative outcome, actions would undoubtedly escalate between parties which could result in injuries and even loss of life. In the Complainant's case, tackling the ASB issues was aggravated by the fact that Neighbour 1 suffered a mental illness and conventional approaches were futile. Under the circumstances, the RGP's intervention could not resolve the situation. As explained by the Manager, there was a care plan in place for Neighbour 1 but that covered only a very small percentage of time on a weekly basis, albeit it goes without say that Neighbour 1 was discharged because the Mental Health Team deemed her in a fit state to be discharged from hospital and integrated into society. Unfortunately, the RGP reports point to persistent ASB on Neighbour 1's part against the Complainant and her children who because of Neighbour 1's mental issues felt impotent to get through to her via the standard procedure. It is striking to note that despite the twenty two police reports recorded during a seven month period, the Mental Health Team did not appear to have reviewed Neighbour 1's situation vis a vis considering alternatives on how to integrate her back into society, especially due to the fact that two young children were being persistently affected and social workers substantiated the ASB issues were affecting them and the fact that the RGP could not treat her as they would persons not affected by mental illness.

Regarding the ASB procedure on the part of the Housing Authority, the Ombudsman noted that they would initially meet with the afflicted party after which they would write to the other party. It appears that because of the mental issues of Neighbour 1, they did not write to her and the Ombudsman would substantiate that was the case as no copy of said letter was submitted to the Ombudsman during his investigation. The Ombudsman further notes that despite the substantial number of RGP reports during the seven month period, the Housing Authority did not follow their established procedure with regards contacting their legal adviser on how to tackle this matter. The Ombudsman therefore sustains this Complaint.

Notwithstanding the above, the Ombudsman welcomes that legislation for ASBOs has now been included in the Criminal Procedure & Evidence Act and in May 2016, a fifteen year old girl became the first person to receive an ASBO from the Court as a result of having made life unbearable for many residents of Government owned estates throughout a prolonged period of time (Source: Gibraltar Chronicle 27th May 2016).

Complaint 3: Neighbour 2 who resided above the Complainant ("Neighbour 2") was relocated due to problems with Neighbour 1, whereas she had pressed for a relocation for the past three years to no avail - **Sustained**

The Ombudsman could not reconcile the Housing Authority's decision in this Complaint, i.e. to relocate Neighbour 2 despite him not even having requested this action. The Partner was not an authorised tenant in the flat and as such should not have required the Housing Authority's intervention in any way, moreso because he had an injunction against Neighbour 2 and if he had broken the conditions would have ended up in prison. In contrast, the Complainant's continuous requests for relocation, had been considered by HAC on numerous occasions and each time the decision was that they would be unable to assist her. There is therefore no coherent explanation for the Housing Authority's actions in relation to Neighbour 2. The Ombudsman sustains this complaint.

Complaint 4: Dampness points not awarded to the Complainant's housing application for a 4RKB as per Housing Allocation Scheme (Revised 1994) – **Not Sustained**

The Ombudsman was satisfied with the explanation provided by the Housing Authority with regards points awarded to the Complainant's housing application and does not sustain this Complaint.

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Case Sustained

CS/1107

Complaint against the Housing Authority ("HA"), as a result of their alleged inaction in carrying out emergency remedial works to the Flat or reallocating the Complainant to a suitable property.

Complaint

The Complainant complained that he had been suffering from water ingress in his Flat since 2002. The situation became so unbearable in 2011/12 that he felt he had no option but to move out of the property and rent a flat on the open market whilst he waited for remedial works to be undertaken by the Housing Works Agency ("HWA"). According to the Complainant, said works were promised but never materialised.

The Complainant explained that after he left the Gibraltar Regiment, he was pressured into finding accommodation quickly (since he had a family which he needed to rehouse) and was allocated the Flat in 2001. The Complainant has stated that he felt obliged to accept the Flat despite it being in a deplorable state of repair. According to him, there were wires hanging from the ceilings and there were no kitchen units or a bathroom suite. No repairs were carried out by the HA at the acceptance stage, as a result of which, the Complainant was left with no alternative but to effect repairs himself in order to "upgrade" the Flat to an acceptable standard.

Soon afterwards, the Flat begun to suffer dampness and water penetration in addition to a number of other repairs (*not specified*) which required attention. The Complainant stated to the Ombudsman that the Flat was so substandard that his young son's health was affected to the extent that he required hospitalization on a yearly basis for suspected bronchiolitis every time the winter set in. He also explained how he lodged numerous reports to the HA and HWA and despite repeated attendances to inspect the state of the property, nothing was done. The Complainant explained how he personally attempted to treat the dampness and paint ceilings since he was offered no assistance or support whatsoever.

In 2011, due to heavy and persistent rains, the Flat's bathroom light socket exploded and the entire dwelling was left with no electricity. On every occasion that the Complainant "*threatened to go public*" he would allegedly be told that matters "*were on hand*". However, no works were ever carried out. Some months prior to lodging his complaint with the Ombudsman, a HA employee inspected the Flat. A works estimate was prepared and a figure of £20,000 was calculated for repairs since the Flat was rendered "*uninhabitable"*.

Since matters did not progress, the Complainant lodged his complaint with the Office of the Ombudsman. The Complainant was of the view that his case was one of injustice and malpractice by the public entities concerned.

Investigation

The Ombudsman presented the complaint to the HA on the 30th July and sought comments confirming (or otherwise) whether works had been finalized. Two months elapsed and given that no reply was forthcoming, the Ombudsman wrote to HA seeking an urgent update and stressing the fact that the Ombudsman investigation was being hampered by their delay in furnishing him with the information previously requested.

The reply which followed from HA stated that a site inspection had been arranged for the 5th October 2015 in order to inspect the damage and necessary repairs to the Flat (which had allegedly been caused by a squatter who had taken possession of the Flat in the Complainant's absence). HA informed the Ombudsman that GGCCL would be attending the inspection and would add the *"extent of the damage caused by the squatter*" to the original specification for works. The Ombudsman was informed that the Complainant would also be attending with a surveyor (in order to pursue his claim). In conclusion HA stressed the fact that they had asked GGCCL to treat the matter as one of urgency.

[Ombudsman note: in 2011 a change in Government policy led to the abolishment of the Buildings and Works Department ("B&W") (the Government department tasked with maintaining public housing stock). The Housing Works Agency ("HWA") was created, which in order to clear an extensive backlog, would initially undertake internal repairs to properties in need within the housing stock, whilst external repairs would be tendered out to private contractors. The new administration delegated "GGCCL" with the award of tenders for external works to private contractors.]

Some months elapsed and with regret, the Ombudsman felt obliged to contact the HA once again, in writing. By letter dated the 11th December 2015, the Ombudsman reminded the HA of the facts of the complaint and further informed them that the Complainant had advised the Ombudsman that "*to date he was unable to move into [the Flat] as it was still not fit for habitation."* Comments and information were sought from the HA as to why the repairs were taking such an inordinate amount of time.

An Ombudsman Investigating Officer ("IO") attended a meeting with the HA (Housing Manager) on the 14th December 2015. In that meeting the IO was informed that based upon the report which was prepared as a result of the Flat inspection, it appeared that the problems in the Flat had been caused by "*a DIY job gone wrong."* Nonetheless, HA were examining the report and given the state of the Flat, would consider whether to offer the Complainant a complete refurbishment.

By the beginning of January 2016, it appeared that matters had not progressed despite the Complainant being assured that he would be contacted by the 11th January with a progress report.

Given that the issue appeared to be stagnant and considering the amount of time that the Ombudsman had been engaging in conversations and correspondence with HA, the Ombudsman decided it was time to draft this report.

Conclusions

The Ombudsman expressed disappointment at the huge delay the Complainant experienced in receiving any feedback or action from the HA/HWA in relation to the remedial works required in order to render the Flat habitable.

It was inconceivable to the Ombudsman that in this day and age, a Government tenant (particularly with a young family) was compelled to endure such an element of hardship, particularly when the "*uninhabitable*" state of the Flat was not being disputed.

However, as with previous reports on similar complaints received, where works to properties were outsourced to private companies via GGCCL and, over which the Ombudsman did not enjoy jurisdiction, the Ombudsman found himself unable to provide complainants with informed replies or concluding reports, since he found himself unable to engage with GGCCL directly.

[*Ombudsman note: The Ombudsman had made previous requests that his jurisdiction be extended to cover acts of alleged maladministration by GGCCL and would also be making a copy of this report available to the Chief Secretary for that very purpose]*

Classification

Sustained

Despite the Ombudsman not possessing the statutory powers to launch an investigation against GGCCL, he sustained the complaint based on the nature of the delay suffered by the Complainant. Whether such delays were at the hands of the HA, HWA or GGCCL the Ombudsman will never be able to ascertain.

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Case Partly Sustained

CS/1110

Complaint against the Housing Authority ("HA") as a result of the Complainant, a Government tenancy holder, not reconciling why the ("HA") had requested that she submit one year's worth of documentation as proof that she resided in Gibraltar and that a Government housing application form (for the purpose of relocation from her present accommodation) be stamped by the Civil Status & Registration Office ("CSRO")

Complaint

The Complainant, a Government tenancy holder, could not reconcile why the Housing Authority ("HA") had requested that she submit one year's worth of documentation as proof that she resided in Gibraltar and that the Government housing application form (for the purpose of relocation from her present accommodation) be stamped by the Civil Status & Registration Office ("CSRO")

The Complainant explained that she had been the tenancy holder of a Government rented property ("Flat") for over ten years and had in January 2016 visited the Housing Authority's offices to request a reallocation from the Flat. According to the Complainant she was informed by the clerk at the HA offices that she would need to complete a new housing application form ("Form") to be stamped by the Civil Status & Registration Office ("CSRO") confirming that she was a registered Gibraltarian. She was also required to submit one year's proof of residency in Gibraltar.

The Complainant felt that the requirements were excessive and bureaucratic and enquired as to why that was needed, considering she was and had been a Government tenant for over ten years. The clerk at the HA allegedly responded that it was normal procedure.

The Complainant had no choice but to comply with the requests but noted that the process had proven cumbersome and had delayed her application. The Complainant lodged a complaint with the Ombudsman.

Investigation

The Ombudsman presented the Complaint to the HA who responded that the Department's procedure for the application of reallocation stated that all prospective applicants must provide one year's proof of residency if the application had been duly stamped by the CSRO or ten years proof of continuous residency if the stamp was not obtained by the applicant.

HA stated that submission of proof of residency was mandatory, regardless of whether the applicants were new or existing. HA stated that the CSRO stamp does not prove residency in Gibraltar. The stamp serves as proof that the applicant is a registered Gibraltarian which allows for the HA to reduce the request for proof of residency from ten years to one year.

According to the HA being a Government tenant did not prove residency as there had been occasions when the Housing Authority had initiated repossession proceedings against tenants for improper use of properties.

Furthermore, there had also been occasions where a tenancy had been obtained by default, i.e. through separation in a marriage or death, and the tenant did not meet the requirements to become an applicant in his/her own right.

Conclusions

The HA are tasked with the management of public housing stock.

For the purpose of application for Government housing, the HA have historically applied the same procedure and made the same requirements from first time applicants as of existing Government tenancy holders requesting a reallocation.

The different applicants have to complete the same form. If the applicants are Gibraltarian, a stamp from the CSRO is required confirming that said applicants are registered Gibraltarians. Proof of one year's residency in Gibraltar is also required.

The Complaint brought by the Complainant was that the process to apply for reallocation was cumbersome and delayed her application for reallocation.

Based on the findings of this investigation, the Ombudsman partly sustains this complaint. Regarding applicants for reallocation who are Government tenancy holders, as is the Complainant's case, having the application stamped by the CSRO confirming that the person is a registered Gibraltarian should not be required by the HA if their initial application had been duly stamped.

The Ombudsman maintains that the initial application is held on file by the HA and the stamp can be easily verified by the HA rather than unnecessarily place the onus on the applicants.

As to the HA's reasoning in respect of the submission of proof of one year's residency at the time of application for reallocation from a Government tenancy, the Ombudsman believes that the HA are justified and correct in taking the opportunity to carry out a due diligence exercise at that time, based on the information provided by the HA.

The Ombudsman suggests that the HA consider removing the request for an application of reallocation to be stamped by the CSRO if the initial application on file has already been stamped.

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HOUSING WORKS AGENCY

Case Sustained

CS/1109

Complaint against the Housing Works Agency ("HWA") as a result of the Complainant not having salt water supply to his Government rented flat since June 2015

Complaint

The Complainant complained that he had not enjoyed a salt water supply to his Government rented flat ("the Flat") since June 2015. He alleged to have made numerous reports at the Reporting Office and complaints to the "Town Range Office" but up to the date of filing his complaint with the Office of the Ombudsman (in January 2016), the issue had not been resolved

The Complainant explained that for the past seven months, as a result of the lack of salt water supply, he has been unable to flush the toilet in the Flat and instead, had to use buckets of potable water for that purpose. The Complainant stated that when the problem first arose in June 2015, the entire block of flats within the housing estate did not have any salt water (for a period of approximately three months). However, by September 2015, all the other tenants' properties (except his), had their salt water supply reinstated

The Complainant stated that he has made numerous complaints over the matter by personally attending the Reporting Office situated in New Harbours. Despite his efforts, no action was taken to resolve the problem even though he was constantly assured that the matter would be resolved.

The Complainant had a young family of two children and was of the view that not having a salt water supply to his bathroom was not only unhygienic but also
an unnecessary cost to his household expenditure, (by having to use potable water for toilet flushing).

Investigation

The Ombudsman presented the complaint in writing to HWA on the 22nd December 2015, setting out the complaint and inviting comments.

A reply was received on the 11th January 2016.

HWA confirmed via email that they received a report from the Reporting Office (as part of the routine transfer of daily reports received there for onward processing by the HWA). That report, setting out the grievance, had initially been made by the Complainant to the Reporting Office in September 2015. HWA then proceeded to raise a works order (no 254094) for Gibraltar General Construction Company Limited ("GGCCL") to action, on the 4th September 2015.

[Ombudsman note: in 2011 a change in Government policy led to the abolishment of the Buildings and Works Department ("B&W") (the Government department tasked with maintaining public housing stock). The Housing Works Agency ("HWA") was created, which in order to clear an extensive backlog, would initially undertake internal repairs to properties in need within the housing stock, whilst external repairs would be tendered out to private contractors. The new administration delegated "GGCCL" with the award of tenders for external works to private contractors.]

HWA further explained to the Ombudsman in their reply that they had made further enquiries with GGCCL. GGCCL had informed them that the works were still ongoing and that a scaffold was being erected in order to carry out the external works required to reinstate the Complainant's salt water supply.

Given the nature of the reply received, the Ombudsman wrote to HWA and to the Housing Authority ("HA") in the expectation that the circumstances giving rise to the complaint would be urgently addressed.. In his letter, the Ombudsman expressed concern at the information previously provided, namely, that scaffolding was being erected at that late stage, (the Complainant had by then, been deprived of a salt water supply for a period of seven months). The Ombudsman reminded the HWA and HA of the Complainant's previous assertion that although the remaining residents of the block of flats had suffered from the same problem, the salt water supply to all other flats had been reinstated in September 2015.

The Ombudsman also informed the HWA and HA that a site inspection carried out by his office, together with conversations with the Complainant, had established that no scaffolding had been erected, despite the HA's letter of the 11th January 2016 which stated inter alia that *"...they are currently erecting a scaffolding in order to carry out the external works..."*

The Ombudsman considered and made very clear, that the appropriate duty of care had not been afforded to the Complainant. The facts of the case showed that the excessive delay was nothing short of "*disrespect for the rights of the tenant [Complainant]."*

Additionally, the Office of the Ombudsman requested information on the action GGCCL had taken from the date of the instruction (HWA's work order), to date. The letter concluded by giving notice that given the inordinate amount of time that the Complainant had been deprived of a salt water supply, he would be seeking compensation for the loss of that commodity.

A prompt email in response followed from the HWA. They stated that they had attended the Complainants Flat (that morning) having learnt from the Ombudsman, that GGCCL had not started erecting the scaffolding. It was also confirmed that HWA had again requested that GGCCL expedite the works (although it was also made known that HWA had *no "administrative, executive or operational authority over GGCCL [and that they could only] insist that they prioritize the matter."* However, the Ombudsman expressed the view that since HWA was tasked with conducting internal repairs to properties and private contractors would carry out external works (in this case GGCCL), it would be logical to assume that there would be some communication between them. It was also reasonable to assume that the HA would have some form of contact with the entities responsible for works (be they internal or external), over housing stock which ultimately HA managed and were responsible for.

The HWA, in an attempt to assist and alleviate the Complainant's problem, advised the Ombudsman that they would attend the Flat to attempt the installation of a temporary salt water supply. Unfortunately, that *bona fide* intention was followed by another email from HWA some days later, stating that they had attempted the temporary installation but unfortunately, it was impossible to carry out. Again, HWA confirmed that that they had established contact with GGCCL in an attempt to prioritize the matter.

One month elapsed and the Ombudsman wrote to HWA for an update. As a result, HWA issued a reminder to GGCCL. HWA copied the Ombudsman on GGCCL's subsequent reply which read; *"... these works were issued, quite some time ago to a company, Property Repairs Limited. I have just spoken to them and they assure me that these works were completed some time ago, they are nevertheless going to check later this morning."*

Given that a period of two weeks elapsed and the Ombudsman did not receive confirmation that the works had been carried out, frustrated by the lack of replies and perceived chaotic manner in which these matters were being handled, the Ombudsman proceeded to draft this report.

Conclusions

It was inconceivable to the Ombudsman that in this day and age, a Government tenant had been deprived of such a basic need- the supply of salt water to his flat- (and for such an extended period of time).

Complaints such as these create an uncomfortable situation for the Ombudsman in that he finds himself unable to provide complainants with informed replies or concluding reports, since his office does not enjoy jurisdiction over GGCCL or associated companies/sub-contractors employed for the purpose of carrying out works to properties on the Government housing stock.

The Ombudsman found it cumbersome that he enjoyed jurisdiction over the HA and HWA (the former entity being the one that allocates flats to tenants and the latter being the body which places works orders relating to said properties), but that he had and continues to have no power whatsoever to make contact or attempt to obtain answers from GGCCL who are so actively involved in building or remedial works to Government properties. This, he considered, was a disservice to the Government housing tenant in need of Ombudsman services.

The extension of the Ombudsman jurisdiction to investigate complaints where GGCCL is involved would in his view, further enhance the role of the Ombudsman in housing matters and would also contribute in the equitable management of citizens grievances in relation to housing.

Classification

For the reasons above given, the Ombudsman sustained this Complaint both against the HA and the HWA for their failure and inability to obtain prompt and effective information from GGCCL.

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INCOME TAX OFFICE

Case Not Sustained

CS/1091

Complaint against the Income Tax Office for having taken five years for tax returns to be assessed; and the failure for the Complainant's tax returns to be assessed prior to his retirement and leaving Gibraltar.

Complaint

The Complainant was aggrieved because there was a five year delay on the part of the Income Tax Office ("ITO") in respect of assessment of tax returns. The Complainant was further aggrieved because he was retiring and leaving Gibraltar and could not understand why his tax returns could not be assessed prior to his departure.

The Complainant explained that he was employed by a local company and that his contract would terminate in the course of the current tax year (July 2014 to June 2015). He claimed to have been overpaying Pay As You Earn ("PAYE") (tax deducted on a monthly basis) due to the deductions being made under the Allowances Based System ("ABS") of tax rather than the Gross Income Based System ("GIBS") and as such, believed he would be entitled to rebates.

In January 2015, the Complainant informed the ITO that upon termination of his contract he would return to the United Kingdom and asked the ITO to either immediately settle the monies owed to him in respect of the tax years 2009/10, 2010/11, 2011/12, 2012/13, 2013/14 and the current year, 2014/15, or if that was not possible, requested a meeting to discuss the matter.

The response provided by the ITO was that he would receive the pending assessments in due course as per usual, or if he was in fact leaving the jurisdiction, could claim for final assessments whereby those would be issued at the end of the current tax year or shortly after leaving Gibraltar, provided he submitted proof of leaving by way of flight tickets or utility bills for the new residence.

Not satisfied with the ITO's response, the Complainant queried their requirements and put to them that he owned a property in Spain and could provide utility bills from that address. He also enquired as to how proof of leaving Gibraltar could be provided if he walked across the land frontier. The ITO responded that if he could submit proof of having left Gibraltar as set out in previous correspondence, then assessments would be issued as soon as they were ready. The issuing of up to date assessments would not apply if the Complainant's new residence was located in Andalucia, Spain. ITO advised that they were in the process of issuing 2009/10 and 2010/11 assessments to all taxpayers. Regarding leaving Gibraltar, ITO stated they would prepare all outstanding assessments to date and issue them at the end of the current tax year.

The exchange of correspondence continued with the Complainant asking when he could expect the 2009/10 and 2010/11 assessments and was told by ITO they could not provide a date and was merely a question of waiting.

The Complainant requested from the ITO the forms he was required to complete to request the up to date assessments due to leaving the jurisdiction and these were provided.

The Complainant submitted the documentation required but was disappointed with the ITO regarding a number of issues which the Ombudsman has set out under the subheading 'Investigation', in a question and answer format.

The Complainant lodged his complaints with the Ombudsman in April 2015.

Investigation

The Ombudsman presented the Complaints to the Commissioner of ITO ("Commissioner") and included some of the Complainant's queries set out above.

On the 12th June 2015 the Commissioner replied and stated that the Complainant's assessments for the years 2009/10 and 2010/11 had just been issued and that they would contact him to advise accordingly.

Regarding the tax years 2011/12 onwards, the Complainant would be updated once he had left Gibraltar but highlighted that the debit/credit for those years would be insignificant as he was on the GIBS throughout those years (under the GIBS system a stipulated percentage of tax is deducted whereas under the ABS, the taxpayer is provided with a tax code dependent on allowances claimed).

The responses provided by the ITO to the issues raised by the Complainant are set out below.

1. The five year delay in the issuing of assessments to taxpayers and no timescale as to when the backlog would be cleared.

   In a previous investigation (Case 975 which can be found on the Ombudsman's website at www.ombudsman.org.gi) into a similar complaint, the Ombudsman found that under Section 34 of the Income Tax Act 2010, the Commissioner had six years in which to issue assessments, from the expiration of the date of the accounting period, i.e. the last day of a given tax year.

2. Unable to provide detailed information on when tax returns for the year 2009/10 would be completed.

   Based on the information in (1) above, the ITO had until the 30th June 2016 to issue 2009/10 tax returns.

3. Whether the ITO was satisfied to enforce the same requirements in cases where the taxpayers leaving the jurisdiction owed PAYE and whether in those cases the policy was always adhered to and debts settled.

   The ITO stated they had no comment to make.

4. Questioned the information being requested by ITO as proof of leaving Gibraltar was dependable.

   The utility bill was required to confirm the Complainant's new address.

5. The ITO were unable to provide a date by which the assessments would be processed after leaving Gibraltar;

   From a previous investigation (Case 949) the Ombudsman was aware, through information provided by the ITO, that the average time to process assessments in circumstances similar to that of the Complainant had been given as between two and four weeks, if all the pertinent documentation had been submitted and all PAYE payments settled by the employer and the person having left the jurisdiction. The ITO do not appear to have supplied this information to the Complainant.

6. In the United Kingdom, when there are delays on the part of the tax office in relation to the issue of assessments, interest is paid to taxpayers who have overpaid PAYE. Regarding paying interest on rebates, the Commissioner stated that it was not Government policy to do so. Neither was interest charged on payables until the assessments were issued and the payment due date expired.

By way of background information provided to the Ombudsman during the investigation in Case 949, the Commissioner stated that the practice adopted by the ITO of raising up to date assessments when an individual left the jurisdiction was an extra statutory concession granted by the Commissioner under Section 34 of the Income Tax Act 2010 which allowed him to exercise his discretion on this issue.

Regarding point 3 above, the Ombudsman notes that the Principal Auditor submits an annual report to Government in which areas of concern are highlighted. Should the issue raised by the Complainant be one that requires attention and changes to be implemented, the Principal Auditor would be the entity tasked to address the matter.

Conclusions

Complaint (i) - Taking five years for tax returns to be assessed

The reason given by the ITO with regards the six year period, not five years, for tax returns to be processed and assessments raised, was that under Section 34 (3) of the Income Tax Act 2010 the Commissioner has six years after the end of the year of assessment to make amendments to an assessment.

The Ombudsman does not find maladministration in this case as the ITO are acting within the parameters of what the Act allows. Notwithstanding, the Ombudsman would comment that there is no requirement for the ITO to maximise the application of this section. Although historically, years have transpired between a tax return being submitted and the date on which an assessment is issued, the ITO should be working towards reducing the timeframes.

Complaint (ii) - Does not understand why his tax returns cannot be completed before he retires and leaves Gibraltar and feels the policy is unreasonable

Based on the above, it is understandable that the ITO have to ensure that in order to fast track the assessments of certain taxpayers whose circumstances so require, a procedure is followed. In this case, the ITO need to establish that the taxpayer is permanently leaving Gibraltar and its 150 kilometre radius. The proof required to substantiate this is by way of flight tickets and/or a utility bill as proof of the new address. The ITO does not fast track assessments of persons retiring.

The Complainant is correct in stating that he can leave Gibraltar via the land frontier, not necessarily having to fly out, but in order for the ITO to process up to date assessments he had to complete a form attesting to the fact that his new place of residence was outside a 150 kilometre radius from Gibraltar. Therefore, although the Complainant owned a property in Spain, utility bills for that property would not have been acceptable if it was located within the stipulated radius. Although the area falls well outside the Gibraltar jurisdiction, the peculiarities of a land border used by cross frontier workers (persons residing in one country and crossing to another to work) calls for extraordinary measures to be put in place.

The Ombudsman does not find maladministration in the manner that the ITO dealt with the Complainant's case as they delivered a service within the established parameters. Notwithstanding, the ITO should have given the Complainant a timeframe by which to expect the assessment to be concluded as per the information provided to the Ombudsman in Case 949.

Classification

Complaint (i) - Taking five years for tax returns to be assessed – Not Sustained

Complaint (ii) - Does not understand why his tax returns cannot be completed before he retires and leaves Gibraltar and feels the policy is unreasonable – Not Sustained

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LAND PROPERTY SERVICES

Case Partly Sustained

CS/1106

Complaint against Land Property Services Limited ("LPS") and the Ministry for Housing ("MFH") in relation to (1) non-replies to letters and enquiries made regarding a vacant shed with the request that it be allocated to the Complainant and (2) Complainant displeased with the procedure/lack thereof for the allocation of sheds.

Complaint

The Complainant who was an elderly lady was aggrieved because she, (together with her daughter), wrote to the MFH and LPS about acquiring a shed for storage at Alameda Estate Gibraltar ("the Estate"). The Complainant claimed that to the date of filing her complaint with the Office of the Ombudsman, no replies had been received to her correspondence. Both the Complainant and her daughter were concerned and annoyed with the lack of procedure in awarding storage areas in the Estate. They alleged that allocations were made in an ad hoc haphazard manner.

The Complainant explained that she had written letters to the MFH as far back as 2008 and only one of her letters had been met with a reply on the 28th July 2008 (HA ref 207-49) (copy not found).The Complainant alleged that as a consequence of having complained verbally at MFH offices in relation to the non-replies, she was informed by them, that she had to take the matter of the allocation of the shed with LPS.

The Complainant complains that since then, she and her daughter have made numerous visits to LPS in order to enquire on the procedure for acquiring storage. They allege to have spoken to numerous officials all of whom concurred that a specific named person within LPS was responsible for storage allocation and that the Complainant's case file was on his desk.

As a result of not having ever allegedly received any written acknowledgments or replies from LPS, (the Ombudsman reviewed three unanswered letters addressed to LPS), the Complainant also claimed to have made numerous phone calls to them. The Complainant stated that the reply was always that LPS were waiting to hear from the MFH on the matter. The Complainant formed the view that "*….as with everything, no one wants to become responsible for anything and they pass the buck to each other. Nothing ever materializes."*

The Complainant was dissatisfied and frustrated at the system, particularly since she had been a Government tenant at the Estate for 67 years, *"perhaps the longest compared with any other tenant."* The Complainant was annoyed with the fact that she was told that her name had been placed on a waiting list in 2008 and that stores were allocated by date "of request order". Yet, in 2012 she learned that the new tenant of number 42 Victoria House had been allegedly allocated a flat with a store. In a letter she wrote to the MFH dated 3rd September 2012, the Complainant pointed out that fact and also stated that she could not understand how government allowed tenants to place cupboards and storage items in the communal areas which, to her mind, was also an abuse of the system which should be monitored. The Complainant alleged to have received no reply to that letter either.

Given the above state of affairs with which the Complainant was most unhappy, she lodged her complaint with the Office of the Ombudsman.

Investigation

The Ombudsman presented the complaint to the MFH and LPS separately, by letter dated 5th October 2015, setting out the Complainant's grievances and requesting comments.

LPS's Reply

LPS replied to the Ombudsman on the 20th October 2015. In their letter, they stated that the store allocated to the tenant which the Complainant referred to, had been vacated and surrendered in December 2012 as a result of water penetration. Requests for a quote for repairs to the store were made available to the Ministry for Housing before the subsequent allocation to the next tenant on the waiting list.

The letter went on to explain that the matter of repairs to the store was tabled at a meeting of the Land Management Committee ("LMC") on the 3rd April 2013. According to LPS, LMC instructed the MFH to obtain quotes for the repair of the store and additionally requested that LPS prepare a list of stores in the Estate which could be managed by the MFH (the reason for said management being that the stores were located within a **housing** estate and by implication, therefore the responsibility of the MFH). The list was forwarded by LPS to LMC on the 10th April 2013.

According to LPS's letter to the Ombudsman, LPS were unaware whether repairs to the store had been undertaken. They added that they were being "*pressed*" for allocation by one of the applicants who was on the stores waiting list (the Complainant) *"due to the cramped conditions at her flat after one of her daughters and granddaughter moved in with her for personal reasons. [The Complainant] was also willing to undertake the cost of repairing the shed herself if her request was approved."*

LPS admitted that *"although no written replies*" had been sent to the Complainant's letters, the stores issue "*had been discussed in person on a number of occasions with her when she has called in at our offices and the matter has been explained to her verbally."*

LPS's letter confirmed that the Complainant was in second position on the waiting list as provided by the MFH, having applied on the 21st July 2008. Another tenant (*name and address provided to the Ombudsman by LPS*), was in first position, having applied on the 27th June 2008. LPS proceeded to explain that the tenant in first position had become a tenant of the Estate after a flat exchange (which the Ombudsman considered was in keeping with the Complainants argument that a new tenant had been allocated a store), whereas the Complainant was one of the original tenants when the flats were allocated over 60 years ago.

The LMC considered the above on the 27th February 2015 and instructed that the store be offered to the next person on the waiting list by order of application, namely, the new tenant. LPS confirmed that a letter of offer was sent to him on the 5th March 2015 but to date, (20th October 2015) "*….unfortunately, we have not been able to obtain a reply from [him]."*

LPS disputed the specific allegation made by the Complainant that new tenant was allocated his flat with a store, for the reasons above given, namely, that he applied for the store in June 2008 (as soon as he moved into his new as indicated by the housing waiting list).

LPS concluded their letter to the Ombudsman by stating that responsibility for the stores waiting lists was compiled by the MFH although this had been transferred to LPS in 2009.

MFH's Reply

MFH confirmed to the Ombudsman that in the Complainant's initial letter to them, she requested the allocation of the store which was being vacated by the tenant of 42 Victoria House. That letter was replied to on the 28th July 2008; the Complainant was advised that her name had been added to the waiting list and that stores were allocated by date of request order.

The Complainant appealed against that decision on the 30th July 2008, stating, according to MFH, that she was both surprised and disappointed in the manner in which stores were allocated; and that in her view, they should be allocated to the longest residing resident of the block. That letter was replied to by MFH on the 7th August 2008 in which the Complainant was informed that the allocation of stores by date of request was the established allocation procedure at the time.

On the 3rd September 2012, the Complainant again wrote to MFH in regard to the allocation of a shed. MFH confirmed to the Ombudsman that in reply to that application, an interview was granted and attended by the Complainant on the 3rd October 2012. According to the minutes of the meeting which took place, the Complainant was again informed of the procedure in place which had not differed from the time upon which she had been previously advised of it by MFH. Likewise her position on the waiting list had not changed. She was also informed of the fact that LPS held stores independently in her residential area and she could apply directly to them if she desired.

The matter of the outside cupboards was not brought up at the meeting although it remained open for discussion. MFH advised the Ombudsman that *"...when the housing department receives complaints relating to cupboards, storage items or objects placed in communal areas, they are passed to the Housing Authority, who take the ultimate decision on whether any form of action should be taken."*

MFH also informed the Ombudsman that they were unsure as to why LPS had told the Complainant that they were waiting for them to provide a quote for the repair of the store as LPS stores were held independently from Housing Department stores and were allocated via a separate list.

It was also confirmed to the Ombudsman that MFH had checked the allocation of flat 42 Victoria House and that that dwelling had been allocated to the current tenant on the 16th June 2008. The store they were renting was leased directly from LPS and not the MFH.

Conclusion

The Ombudsman reached the view that the Complainant had suffered a lack of miscommunication from both entities concerned in relation to the separate store lists that were managed by the MFH and LPS respectively. The conflicting information provided to the Complainant caused her unnecessary confusion.

It was also clear to the Ombudsman from the replies received by both entities being complained against, that there appeared to be some uncertainty between them, particularly in relation to the requests made by the LMC for the compilation of the stores lists and for a quote for repairs from the MFH. In its reply to the Ombudsman, MFH stated in clear terms that they were unsure as to why LPS had informed the Complainant that they were waiting for information from the MFH, when their stores were held independently from LPS and allocated via a separate list.

Insofar as LPS's involvement was concerned, the Ombudsman considered that despite their attempts to provide explanations verbally, conflicting information (albeit with no *mala fides*) had been provided to the Complainant. LPS's admission to the Ombudsman, (in their written reply to him), that *"no written replies had been sent [to the Complainant's correspondence]"*, fell short of good administrative practice. It was always advisable to reply to correspondence in writing and to record/ file the same for future reference. This would have been in keeping with established practice and had that exercise been carried out by LPS, the Complainant's complaint may not have reached the Ombudsman.

In addition and as an ancillary observation, the fact that LPS had confirmed to the Ombudsman that they had written to the new tenant in March 2015 formally offering him the store, but that they had by October 2015 "*not been able to obtain a reply from him,"* and, that LPS had not acted on the non-reply, was to the Ombudsman's mind evidence of poor administrative procedure.

The Ombudsman queried LPS's rationale in not acting on the new tenants non-reply after a period of five months, particularly given that there were other tenants (amongst them the Complainant) desperately seeking a store allocation. The Ombudsman considered it would have been appropriate for LPS to have sent the new tenant a chaser letter stating that if they did not hear from him accepting the store or otherwise, by a specific date, he would waive his option to its allocation and that under those circumstances, the store would be offered to the tenant who was next on the waiting list (in this instance, the Complainant). The Ombudsman's view was not determined by the fact that the Complainant was second on the list and if LPS had followed the suggested course, the store would have been offered to her. The Ombudsman's opinion was based on good administrative procedure and fairness.

Classification: Sustained in part.

Non-replies to letters and enquiries made (to MFH and LPS) regarding a vacant shed and that it be allocated to the Complainant:

Complaint against MFH- **not sustained.** Complaint against LPS- **sustained.**

Complainant displeased with the procedure/lack thereof for the allocation of sheds: **not sustained**

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PORT AUTHORITY

Case Not Sustained

CS/1136

Complaint against the Port Authority ("PA") in relation to their decision to revoke a berth offered at the Mid-Harbour's Small Boat Marina ("MHSBM") and to relinquish a berth at Watergardens which the Complainant believed lacked legal and moral substance.

Complaint

The Complainant was aggrieved because he was of the view that the decision made by the PA to revoke a berth offered to him at MHSBM was wrong. He was additionally dissatisfied that the PA had refused to return his original berth located at Watergardens which had been offered by him in exchange for the new berth (particularly since, the Complainant claimed, there existed no legal provision prohibiting an individual from simultaneously holding berths at Watergardens and the Cormorant Camber Club ("CCBOC") (the Complainant held both). Furthermore, the Complainant alleged that the PA had failed to properly control the berthing situation and that he had been made a victim of their bad practices.

By way of background the Complainant explained that in March 2016 he received a letter from the PA inviting him to take up a berth in MHSBM by surrendering his berth at Watergardens. The Complainant accepted the offer. He proceeded to pay his berthing fees. On the 25th May 2016 he received a telephone call from the PA wherein he was informed that his permit to moor at MHSBM would be revoked as it has been noted that he also held a berth at the CCBOC. He was advised that the qualification criteria for a berth at the new MHSBM did not allow for someone to be allocated a berth there if they already enjoyed the use of a berth at CCBOC. This was encapsulated in the 'Small Vessels (Mooring Control) Rules 2016' (schedule 4, Part I, F (D)).

The Complainant stated that there existed provisions within the 'Small Vessels (Mooring Controls) 1990 and 2016 Rules that allowed him to keep two berths and that during his meeting with two PA Officers he tried to seek a reasonable solution. He alleged however that were not open to any suggestions.

The Complainant stated that the CCBOC was not a designated area under the 1990 Mooring Rules and that the area of Watergardens named as Waterport Wharf was specified by coordinates that did not match their actual location. This error he alleged, was not rectified in the 2016 Rules. The Complainant was of the view that since the coordinates demarcating the areas did not match the actual site, the Rules therefore did not apply. His argument was that as a result, the PA could not exclude him from holding a berth in both marinas.

The Complainant further stated that Rule 10 (4) of the 1990 Rules stipulated that 'no locally based individual shall be entitled to or be granted more than two individual permits to moor small vessels in the designated areas'. This Rule he contended, favoured his position.

As a result of the above, the Complainant felt there were a number of flaws that showed that the PA had over the years, been unable to properly manage the Government Moorings. He expressed the view that he perceived himself as a victim of the PA's bad practises. By way of what he deemed to be a clear example of bad practice, he explained the case of a named boat owner who was allegedly allowed to register a boat without the legally required berth. The Complainant stated he did not object to this act at the time since he would never have guessed that the PA would have '*played him such as unjustified act of revoking his berth*' at Watergardens.

The Complainant wrote to the PA setting out his arguments and seeking that berth F46 at MHSBM be granted to him or that the original berth at Watergardens (No 14) which he had held since its construction, be returned. The Complainant received a reply from the PA stating that pursuant to legislation and Government protocols and in order to ensure transparency in the allocation of berths, his request could not be granted.

Frustrated with the state of affairs, the Complainant lodged his complaint with the Office of the Ombudsman.

Investigation

The Ombudsman wrote to the PA on the 19th September 2016 setting out the complaint and seeking their comments.

A subsequent reply to the points raised, stated as follows:

1 "**Feels that the decision made by the PA to revoke a berth offered in MHSBM was wrong"**

The PA confirmed that their decision was made in line with Government policy where no individual was allowed more than one berth in a Government sponsored marina and was also made in accordance with current legislation, that being the Small Vessels (Mooring Controls) Rules 2016. (It was established that the 2016 replaced the 1990 Rules). The Ombudsman's attention was drawn to S11(3) thereof which stipulated that "*no locally based individual shall be entitled to or be granted more than* ***one*** *permit to moor small vessels in the designated areas."*

2. "Aggrieved that the PA had refused to return his original berth at Watergardens which was offered in exchange for the new berth, especially considering that there was nothing in law which prohibited someone having a berth in Watergardens and CCBOC."

The letter in reply to the Ombudsman stated that the PA had again, made the decision not to return the Complainant's original berth in line with Government policy namely, that an individual who held a berth at CCBOC would not be eligible for a berth in another Government sponsored marina. PA further confirmed to the Ombudsman that they understood that the Complainant's CCBOC berth was taken up by the Complainant in late 2011 and that it was not declared by him to the PA at the time. "*The subsequent removal of the berth at Watergardens by the PA at the time [was] therefore justified."*

3. "Alleged failure of the PA to properly control the berthing situation making him a victim of their bad practices."

The PA made it emphatically clear that while they were disappointed that the Complainant remained aggrieved with the outcome of their decision, they were completely satisfied that procedures, policies and legislation had been followed and correctly adhered to. As a result the decisions taken by the PA not to return the Complainant's original berth at Watergardens whilst maintaining he was ineligible for one at MHSBM, stood.

The Ombudsman considered it desirable to issue a reply to the PA's letter. He was of the view that there existed certain issues relating to the circumstances surrounding the Complainant's complaint which required clarification.

The Ombudsman advised the PA that he had been informed that there were other berth holders currently occupying two berths. He asked the PA whether those permits had also been revoked and requested details of the number of users that the PA had written to, requesting the return of those second berths.

In relation to the legislation currently in place, the Ombudsman thanked the PA for informing him that the Small Vessels (Mooring Control) Rules 2016 repealed the 1990 rules. He did however remind the PA that ordinarily, new laws applied from the date of enactment and, given the previous statement from the PA that the Complainant had been in possession of two berths *"since late 2011"*, he enquired whether the legislation currently in force (passed as law in 2016), was being applied retrospectively.

As a final point, the Ombudsman sought confirmation that the PA's decision (which as stated by them had been taken in line with *"procedures, government policy and legislation")* was being evenly applied to all those holders in possession of multiple berths.

As a result of the Ombudsman's letter and prior to issuing him with a written reply, the PA invited the Ombudsman to a meeting to explain the historical background of the Complainant's complaint.

At the meeting, the PA stated that in 2011, whilst occupying his berth at Watergardens, the Complainant informed them that he was going to remove his small vessel from that berth for repair at CCBOB. It transpired that pursuant to repairs, the vessel remained moored at CCBOC and was not re-berthed at Watergardens (although the Watergardens berth was continued to be used by an independent holder with the Complainant's consent and at his expense but with the PA's knowledge), since it had been allegedly agreed that a new berth would be offered to the Complainant at MHSBM.

It was also confirmed that CCBOC had and continues to have a separate registration system of berth occupiers (not managed by the PA). For this reason, some years elapsed before PA realised that the Complainant held two independent berths at distinct marinas at the time he applied for a third berth at MHSBM.

The Ombudsman accepted the PA's contention that the Complainant was indeed aware that upon being offered a berth at MHSBM he would have to surrender his Watergardens berth. However, the mere fact that he already held a berth at CCBOC (without the PA's knowledge) automatically excluded him from applying for a new berth at MHSBM. PA did confirm that numerous applications from other individuals for a berth at MHSBM had not been accepted where applicants did not meet the criteria.

In their written reply to the Ombudsman's correspondence which followed, the PA stated that to their knowledge there were an additional two berth holders in the same position as the Complainant and "*the PA [was] liaising with them to address the anomaly."*

Insofar as current legislation was concerned, the PA stated that it was not being applied retrospectively but that the laws in force reflected what had previously been Government policy, in an attempt to provide clarity. They further confirmed that the PA was "*working extremely hard to ensure that the legislation [was] complied with in an effort to provide fairness to all those individuals seeking a mooring permit.*"

In conclusion to his investigation the Ombudsman issued a final letter to the PA. He sought details of the steps taken in order to determine the number of berth holders who held more than one berth and further requested details of specific actions undertaken (such as the issue of notices to surrender/quit). Information was also requested on the future enforcement procedures that the PA would embark upon in the event of berth holders' non-compliance, in order to ensure that all multiple berth holders were treated fairly and equally from an administrative perspective.

The PA in their reply stated that five instances of multiple berth holders in Government owned marinas had been identified and that the appropriate notices to the owners were being served.

Conclusion

The Ombudsman understood the Complainant's position that as a result of an invitation by the PA for him to occupy a new berth within the MHSBM, that offer was withdrawn once the PA had become aware that the Complainant was a multiple berth holder and further, that as a result of that fact, his Watergardens berth was also relinquished. The Ombudsman was satisfied however that the PA had adhered to the legislation in force, such legislation having been implemented in line with Government policy and procedures, to ensure that all owners or potential owners of vessels enjoyed an equal opportunity to a Government subsidised berth.

During the conduct of his investigation, the Ombudsman had discussed and reviewed the Small Vessels (Mooring Controls) Rules 2016. The legislation was clear that "*no locally based individual shall be entitled to or be granted more than **one** permit to moor small vessels in the designated areas.*" In accordance with that clause, the Ombudsman considered that the PA had acted properly insofar as the Complainant's complaint was concerned.

The Rules however also provided that "*where prior to the coming into force these Rules- a person has been granted more than one permit to moor small vessels in the designated area [specified] (as the Complainant had)…such permits shall remain in force notwithstanding [the prior exception] that no locally based individual shall be entitled to or be granted more than one permit….*"

Despite the above, the designated area referred to in the Rules referred to Watergardens and not to the MHSBM.

In practical terms, what that meant was that a single berth holder at Watergardens seeking a new berth at MHSBM would have to surrender the Watergardens berth. If, however, a berth holder held two berths at Watergardens for instance, those berths could be kept but the occupier would not be eligible to a new MHSBM berth. What was not permitted pursuant to policy was for a berth holder to occupy a berth at Watergardens and simultaneously at the independently ran CCBOC, and further seek to secure a new berth at MHSBM.

An anomaly was drawn by the Ombudsman between Government vessel moorings and the Government housing stock albeit, that the former did not constitute a "right" as determined by the Gibraltar Constitution Order 2006. Understandably, it was contrary to Government policy for an existing Government housing tenant to seek a new or alternative property from the housing stock without relinquishing occupation of their current tenancy. A similar policy (now enshrined in law) was being applied by Government in relation to small vessels, in an attempt to ensure equal treatment for all. The Ombudsman opined that was the right course to follow in the circumstances and in pursuance of fairness, equity and transparency.

The Ombudsman also considered the Complainant's contention that the "*designated areas"* specified had been done so in error and that since the coordinates did not match the area's actual location, the Rules in relation thereto did not apply.

Although from a technical perspective the Complainant was correct, the Ombudsman was of the view that in all probability, a court of law would dismiss the Complainant's argument since it could place emphasis on the intention of the legislature at the time the law (in this case, the demarcation), was drafted. It was to the Ombudsman's mind, indisputable that Government intended the demarcated area/s to reflect the marina/s. Said error could (and usually is) rectified by way of legislative amendment. Based upon that rationale, the Ombudsman could not accept the argument proposed by the Complainant.

Classification

In relation to the complaint that the revocation of the offer of a berth at MHSBM and the relinquishing of the Watergardens berth lacked legal (opinion reserved on moral) substance- **Not Sustained**

In relation to the complaint that as a result of legislative drafting error in the demarcation of designated areas the Rules did not apply**- Not Sustained**

Ombudsman Note

Despite the assurances provided by the PA that appropriate action was being/would be taken against multiple berth holders which the Ombudsman accepted without question, the Ombudsman would be keeping periodical checks to ensure that said action was being performed effectively and in keeping with established and fair administrative practice.

- -

4
Statistical Information

4.1 NUMBER OF COMPLAINTS

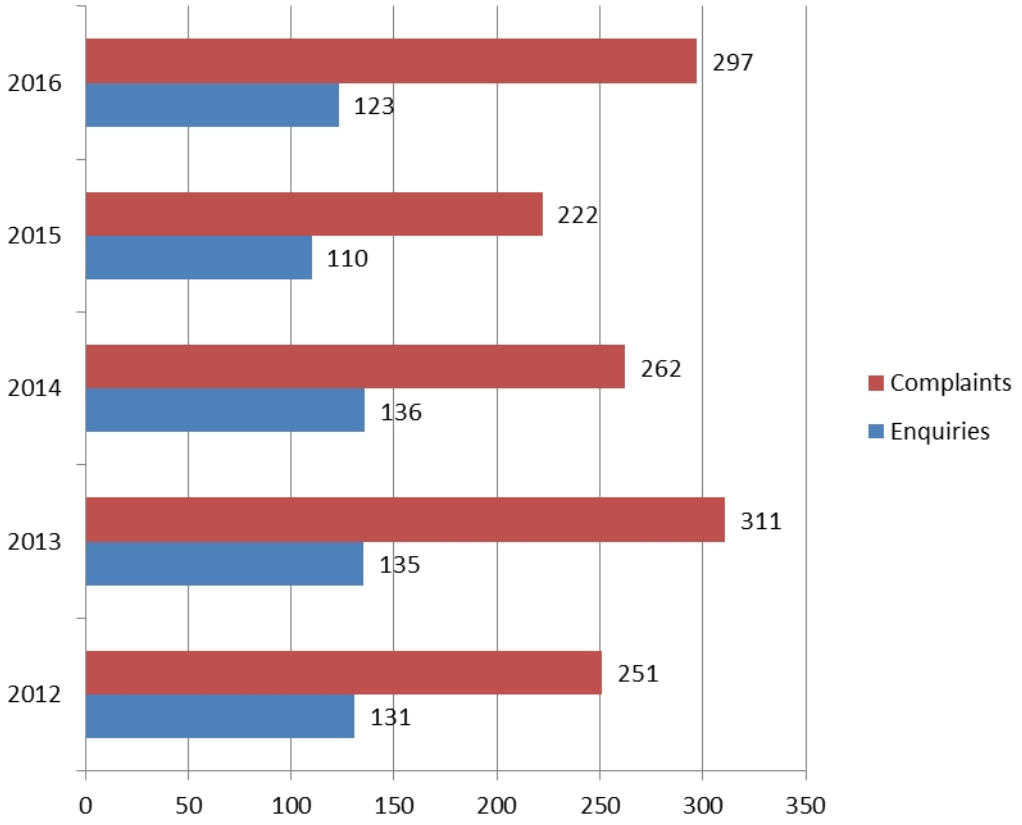
Complaints received, completed and current by month – 2015 & 2016

Table 1	2015			2016		
	Received	Completed	Current	Received	Completed	Current
			60			65
January	12	11	61	35	25	75
February	28	25	64	21	20	76
March	24	18	70	26	22	80
April	16	11	75	18	28	70
May	12	18	69	20	21	69
June	24	21	72	36	26	79
July	24	22	74	22	18	83
August	13	18	69	28	24	87
September	18	15	72	31	22	96
October	22	21	73	21	20	97
November	14	12	75	23	21	99
December	15	25	65	16	31	84
TOTAL	222	217		297	278	
Enquiries	110			123		

This year, we received 297 Complaints in our office, an increase of 75 Complaints compared to 2015, where we received 222 Complaints. Taking into account the active complaints brought over from the previous year, a total of 278 Complaints were completed by the end of this year which left 84 Complaints open by the end of 2016. This year we recorded 123 Enquiries, an increase of 13 compared to 2015, when we received 110.

4.1 (CONT)….

Chart 1 - Breakdown of Complaints and Enquiries received for last five years



This year we have received 297 Complaints and 123 Enquiries.

From the 297 Complaints we received 68 were either against private entities (such as private housing rent and repairs and legal matters) or public services over which we do not have jurisdiction. This left a total of 229 Complaints received against government departments, agencies and other entities which were within our jurisdiction.

(*See Table 2 Page 134*- ***Complaints/Enquiries received by departments/entities in 2016***).

4.2 GOVERNMENT DEPARTMENTS AND OTHER ENTITIES

The trend of Complaints has continued similar to previous years although this year there has been a significant increase in complaints against the Housing Authority (HA) with 95 complaints recorded against them. The Civil Status and Registration Office (33) and the Gibraltar Health Authority (29) also top the list attracting the highest number of Complaints.

Table 2- Complaints/Enquiries received against departments/entities in 2016

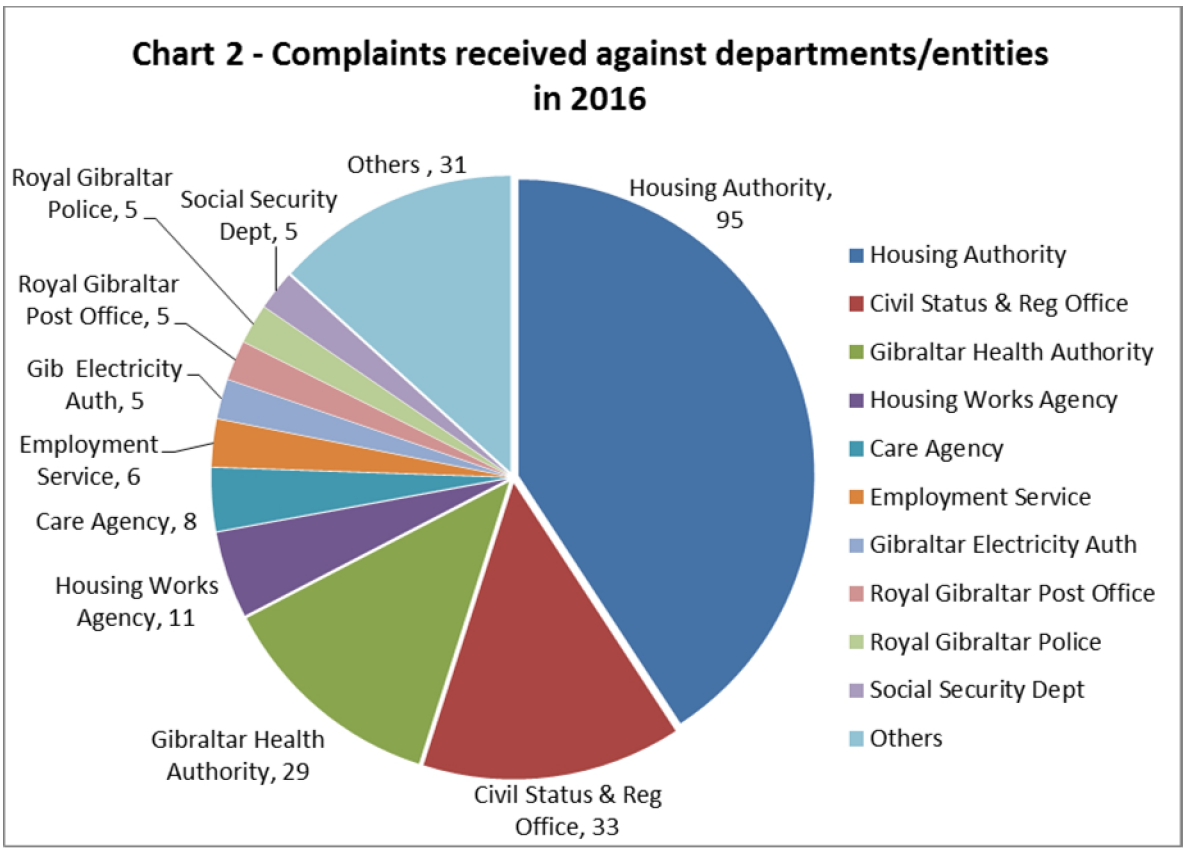
Dept/Agency	Enquiry	Complaint	Dept/Agency	Enquiry	Complaint
AquaGib	-	1	Housing Authority	56	95
Business Licensing Authority	-	1	Housing Works Agency	1	11
Care Agency	4	8	Income Tax Office	-	2
Civil Status & Registration	14	33	Land Property Services	2	2
Culture Office	-	2	Magistrate's Court	-	1
Education & Training	4	1	Office of the Chief Minister	1	1
Employment Service	7	6	Port Authority	1	4
Environment	-	2	Royal Gibraltar Police	6	5
Environmental Agency	-	2	Social Security	8	5
Gibraltar Electricity Authority	1	5	Supreme Court	-	2
Gibraltar Health Authority	12	29	Technical Services	1	-
Gibraltar Post Office	-	5	Transport & Licensing	-	2
Gibraltar Tourist Board	2	3	Treasury	-	1
			TOTAL :	120	229

As in previous years complaints relating to housing matters (42%) continue to be the most prevalent form of complaint lodged in our office. This year there has been 95 complaints, a 4% increase in proportion to the 229 complaints we have received this year against Government department and entities.

Last year the Ombudsman highlighted in his annual report that once the new Government Housing Schemes were completed he was of the opinion that complaints against the Housing Authority would most probably decrease and have a significant impact on our annual report for 2016 but that has not been the case. It can be seen from the statistical information gathered that the Office of the Ombudsman continues to receive housing complaints thick and fast, this is mainly due to the fact that the nature of complaints against this authority are very wide-ranging but nevertheless delay in carrying out remedial works and taking decisions over housing matters at times are not justified and seem to be prevail over other housing issues. One has to highlight as well the Housing Authority's Anti Social Behaviour policy which the Ombudsman thinks needs to be reviewed so that when an anti-social case comes to light, the authority can take responsibility and act accordingly rather than point the Complainant to another entity. The Ombudsman is of the thought that the Housing Authority needs to be more pro-active in assisting its tenants.

4.2 (CONT)….

This year the Ombudsman has formally investigated 29 complaints against the Gibraltar Health Authority (GHA), 10 complaints more than in 2015, this has been mainly due to complaints being in respect of issues requiring external clinical advice. Now that the Complaints Handling Scheme at the GHA is well established it will be interesting to see if this trend of GHA complaints will continue on the increase in 2017.

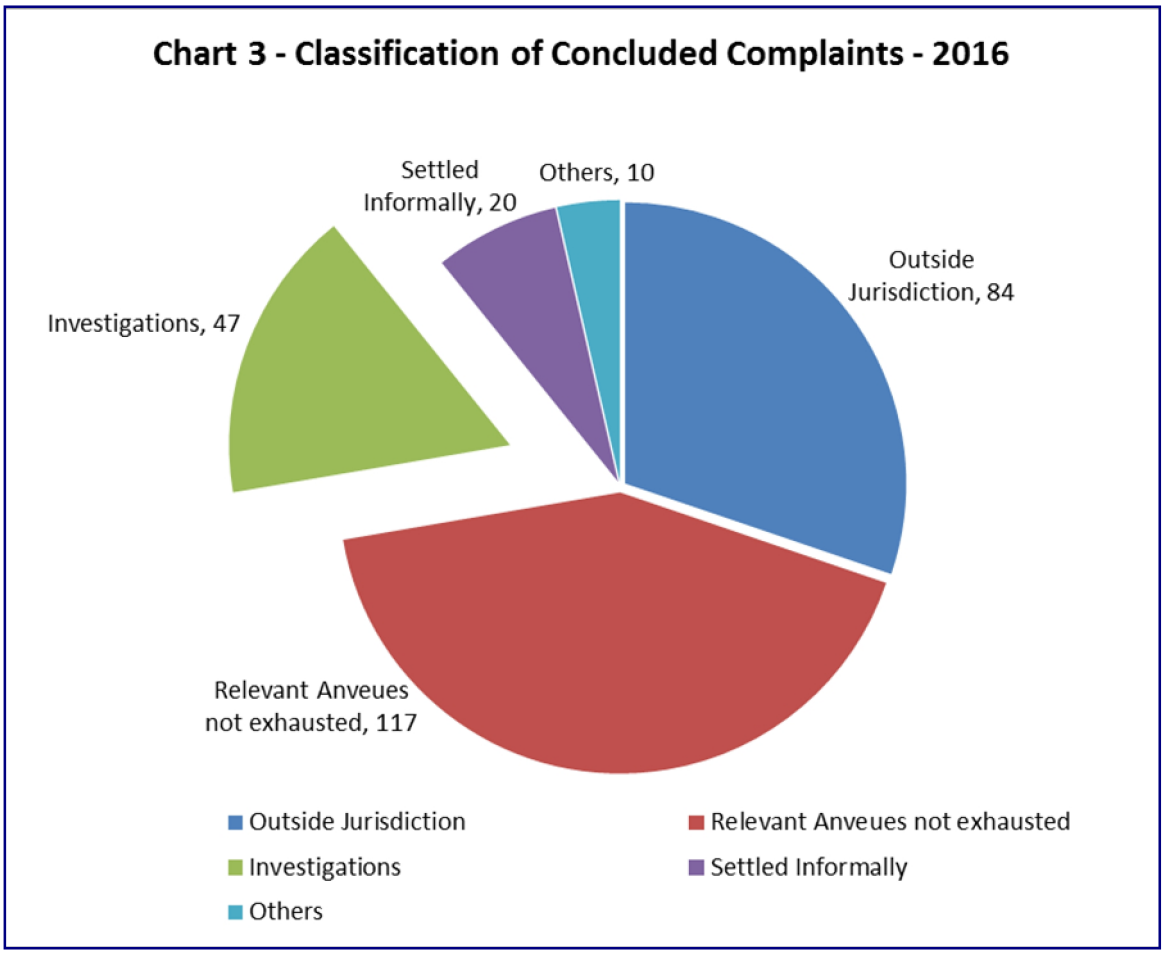


This year we also received 33 complaints against the Civil Status and Registration Office (CSRO), 21 complaints more than in 2015. Whereas last year 8% of the complaints we received were against this office, this year 14% of all the complaints received are taken up by this office. This year one has to highlight the inordinate delays and excessive amount of time for applications to be processed, be it Exemption from Immigration Control, Gibraltarian Status or ID cards, these complaints of delay against this office are becoming quite a common subject for the Ombudsman to look at. There have also been numerous complaints this year regarding non-replies to emails and letters of complaint. The Ombudsman feels that the slack and inattentive service the CSRO occasionally provides to their users (in particular at the time of writing this report) is of great concern to him and is committed in fully investigating all these complaints of this nature during the coming months.

We also have to highlight complaints against the Housing Works Agency, agency which is gathering popularity to the discontent of its users as complaints against this department have increased this year.

4.3 PROCESSING DATA

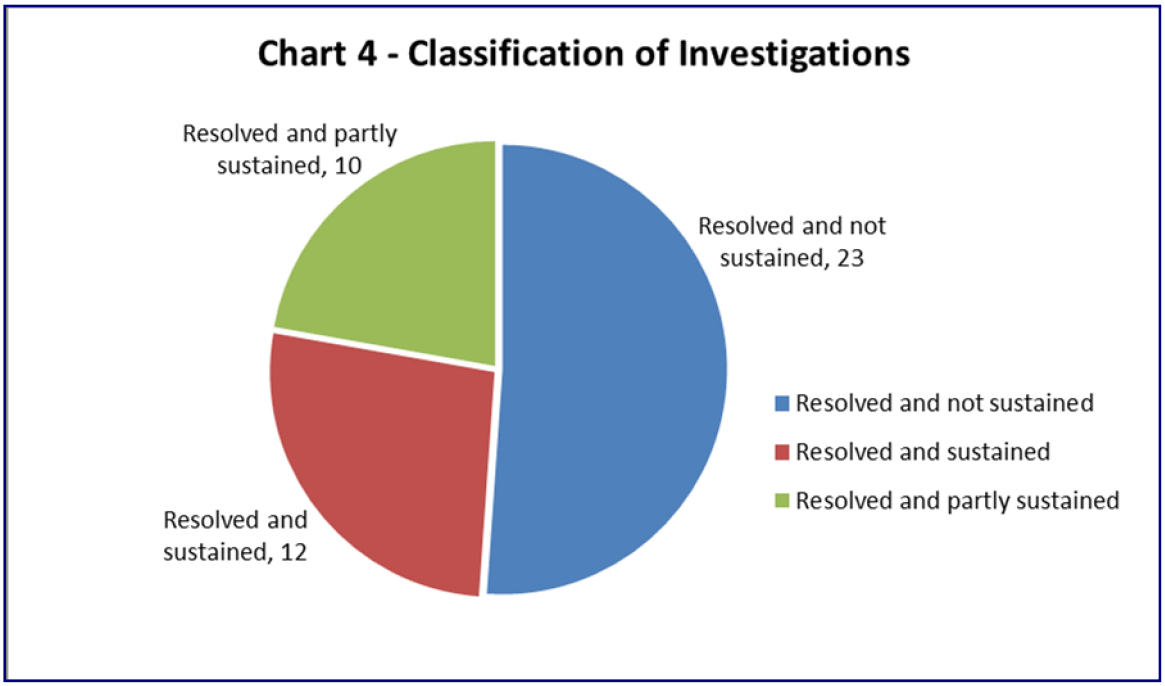
There were 278 Complaints classified this year out of which, 84 (68 were against private organisations and the remaining 16 although being against a government department/entity, it transpired that the matters raised within the complaint were also outside our jurisdiction) were classified as outside jurisdiction. 117 (42%) were closed as 'Relevant Avenues Not Exhausted' (RANE). These type of complaints are lodged in our office without the Complainant formally submitting them first to the relevant government department/entity hence we advise the Complainant to lodge their complaint first with the entity concerned so that they have the opportunity to deal with the matter before reaching our office. Some of the complaints are addressed by the government department/entity but regrettably other Complainants return to our office not satisfied with the replies received and in some cases without any sort of reply, the ones that return are investigated by our office.



Twenty (7%) of the Complaints were settled informally as they were resolved by assisting the Complainant without the need to initiate an investigation. A further 10 (4%) were classified as 'Others', they were either withdrawn or after our initial inquiries into the complaint there was insufficient personal interest shown by the Complainant.

4.3 (CONT)….

Forty seven Investigations (17%) were concluded by the end of the year. Out of the 47 investigations, 17 of them were resolved through informal action (5 Sustained and 12 Not Sustained) whilst the remaining thirty, (19 brought forward from 2015 and 11 from 2016).a full investigation (See page 27 to view case reports) was carried out and an extensive report written. Out of those 30, 7 were sustained, 10 were partly sustained, 11 not sustained and 2 were unable to be classified.



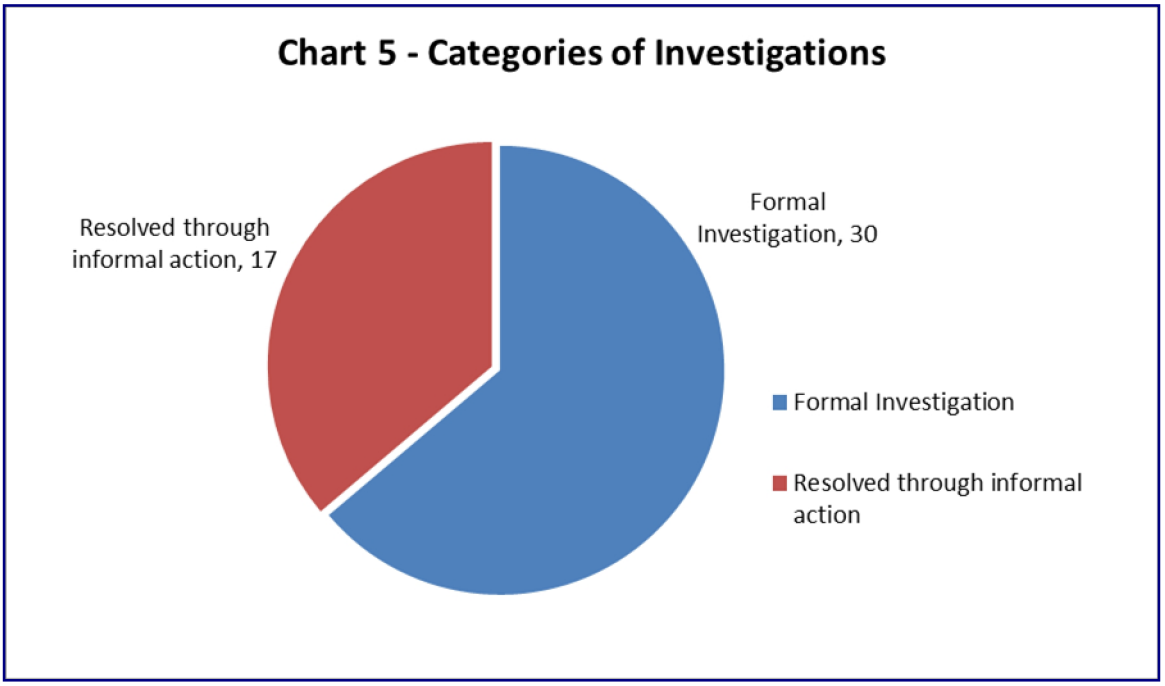
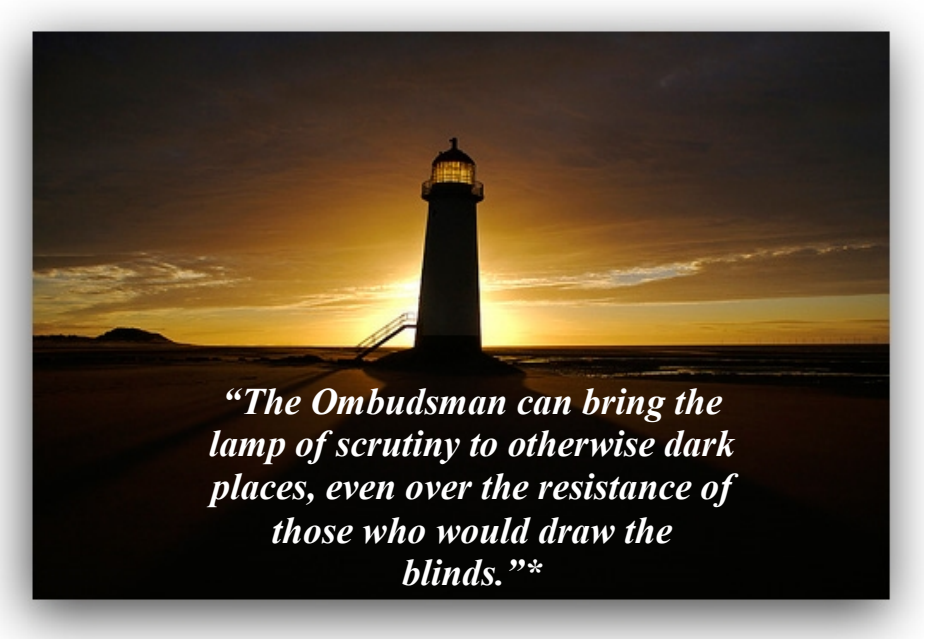


Table 3 - Breakdown of classification of complaints received by departments / entities in 2016

Dept/Agency	Avenues not ex-hausted	Out of Juris-diction	With-drawn/IPI, Trivial, Others	Formal Investigation		Resolved through informal action		Settled Informally	Open	Total
				Sustained	N/Sustained	Sustained	N/Sustained			
AquaGib	-	-	-		-		-	1	-	**1**
Business Licensing Auth	-	-	--	-	1	-	-	-	-	**1**
Care Agency	5	1	-	-	-	-	1	-	1	**8**
Civil Status & Registration	15	1	2	-	1	1	-	2	11	**33**
Culture Office	1	-	-	-	-	-	-	1	-	**2**
Education & Training	1	-	-	-	-	-	-	-	-	**1**
Employment Service	4	2	-	-	-	-	-	-	-	**6**
Environment	1	-	1	-	-	-	-	-	-	**2**
Environmental Agency	1	1	-	-	-	-	-	-	-	**2**
Gibraltar Electricity Auth	2	1	-	-	-	-	-	1	1	**5**
Gibraltar Health Authority	2	2	-	3	3	-	1	1	17	**29**
Gibraltar Post Office	2	1	-		-	-	-	-	2	**5**
Gibraltar Tourist Board	1	-	-	-	-	-	-	2	-	**3**

Table 4- Breakdown of classification of complaints received by departments / entities in 2016

Dept/Agency	Avenues not exhausted	Out of Jurisdiction	Withdrawn/IPI, Trivial, Others	Formal Investigation		Resolved through informal action		Settled Informally	Open	Total
				Sustained	N/Sustained	Sustained	N/Sustained			
Housing Authority	64	-	4	*1	-	-	6	7	13	**95**
Housing Works Agency	4	-	3	-	-	1	-	1	2	**11**
Income Tax Office	2	-	-	-	-	-	-	-	-	**2**
Land Property Services	1	1	-	-	-	-	-	-	-	**2**
Magistrate's Court	-	1	-	-	-	-	-	-	-	**1**
Chief Minister's Office	-	-		-	-	-	-	1	-	**1**
Port Authority	1	2	-	-	1	-	-	-	-	**4**
Royal Gibraltar Police	4	1	-	-	-	-	-	-	-	**5**
Social Security	4	-	-	-	-	-	-	1	-	**5**
Supreme Court	-	1	-	-	-	-	-	1	-	**2**
Transport & Licensing	1	-	-	-	-	-	1	-	-	**2**
Treasury	-	1	-	-	-	-	-	-	-	**1**
TOTAL:	**116**	**16**	**10**	**4**	**6**	**2**	**9**	**19**	**47**	**229**



*Milvain CJ – Re Ombudsman Act (1970) 72 W.W.R. 176(ALTA. S.Ct.)

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