PUBLIC SERVICES OMBUDSMAN

ANNUAL REPORT 2019

The Ombudsman provides a service to the public that is:

- **Impartial**
- **Independent**
- **Free of Charge**

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1) OMBUDSMAN'S INTRODUCTION

This is the Public Services Ombudsman's 20th Annual Report. It will be my final report before I step down as Public Services Ombudsman at the end of my term of office on 26 June 2020.

As I mentioned in my previous Annual Reports, the Ombudsman's work has developed significantly over the years and the Ombudsman's Office is now firmly established as an institution in Gibraltar that provides an important check on Government departments and other providers of public services.

Service

The impartiality and independence of the Ombudsman's Office ensures that the public is provided with an effective mechanism for highlighting and dealing with any maladministration or injustices caused. The service provided by the Ombudsman is free of charge. It is an important service without which many people in our community would have little opportunity to obtain redress or understanding of their grievances against the public administration.

I am delighted that so many people in our community make use of the service provided by the Ombudsman's Office. The team at the Ombudsman's Office is open to the public on a daily basis. We are here to assist members of our community with any difficulties that they may have with the services provided by Government departments and other public service providers.

Recommendations

The issues that are highlighted by members of the public, in this respect, also help in identifying areas where there is maladministration. This enables the Ombudsman to recommend any changes that may be required to systems and procedures by providers of public services and to improve their service to the public. The recommendations made by the Ombudsman are normally respected and followed by Government departments and public service providers. However, there have been a number of cases recently where the Ombudsman's recommendations have not been addressed in a timely manner by the public service provider.

'The Ombudsman provides an important check on Government departments and other providers of public services'.

Findings of maladministration and the consequent recommendations made by the Ombudsman in previous annual reports, and which are still pending a satisfactory resolution by the relevant public service provider, have been included in this report.

Role in the Community

The Ombudsman's Office has an important role to play in our community. It has a dedicated and highly competent team of officers who are eager to help the general public with their specific complaints and who are fully committed to making a meaningful contribution towards improving the delivery of our public services and the promotion of good administrative practice for the benefit of the whole community.

Dilip Dayaram Tirathdas MBE, JP
Public Services Ombudsman
30th April 2020

2) HIGHLIGHTS FOR 2019

- **Some findings of maladministration and the consequent recommendations made by the Ombudsman in previous annual reports are still pending a satisfactory resolution by the relevant public service provider.**

- **The majority of complaints received by the Ombudsman continue to be in respect of the Housing Authority and the Civil Status and Registration Office.**

- **Housing Department failing to follow its own established written rules and procedures under the Housing Allocation Scheme Rules.**

- **Gibraltar Parliament passed a Resolution providing for the Public Services Ombudsman Act 1998 to be reviewed in order to enable the Office of the Public Services Ombudsman to launch investigations of its own motion or own initiative.**

GBC interviewing the Ombudsman outside Parliament Building on the day of distributing the Ombudsman's 20th Anniversary Booklet

2.1 RECOMMENDATIONS MADE IN PREVIOUS ANNUAL REPORTS STILL PENDING A SATISFACTORY RESOLUTION

Findings of maladministration are addressed by the Ombudsman by making formal recommendations to the public service provider concerned. In some instances, our findings are also addressed to the Chief Secretary, particularly where the Ombudsman's recommendations includes a proposed amendment to legislation, which is designed to avoid continued maladministration and injustices of a similar type.

Although the Ombudsman does not have powers under the Public Services Ombudsman Act 1998 to compel public service providers to implement or act upon his recommendations, these recommendations are usually followed by them.

In his last Annual Report, the Ombudsman made a number of recommendations following his investigations and findings of maladministration.

The following findings of maladministration and the consequent recommendations made by the Ombudsman in previous annual reports are still pending a satisfactory resolution by the relevant public service provider:

Gibraltar Electricity Authority

Brief Outline of Complaint

The Gibraltar Electricity Authority threatened the Complainant with the disconnection of the supply of electricity to his current home and business premises. The Authority informed the Complainant that they reserved their right to refuse to supply him with electricity at any future address, unless the historic debt, which referred to bills that were more than 22 years old, was settled by him within 21 days.

Recommendations and Outcome

The Ombudsman recommended that the Government should issue the following revised conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act, in order to prevent injustices of this type, following the amendment to the Limitation Act on 27th July 2016:

Proposed revised conditions and procedures

The Ombudsman recommended that the conditions and procedures to be followed by the Authority when considering whether to refuse or discontinue the supply of electricity to consumers because of the non-payment of arrears should be revised, as follows:

a) any refusal or discontinuance of supply of electricity should only be considered by the Authority in respect of arrears which are more than 60 days and no more than 6 years old;

b) any arrears which are more than 6 years old, which prior to the amendment to the Limitation Act would have been statute-barred, should be followed up by the Authority by way of legal proceedings and not by way of a refusal or discontinuance of the supply of electricity.

In the case of the Complainant in question, the Ombudsman pointed out that the Authority was unlikely to have been able to recover these historic arrears through legal proceedings. The debt that was purportedly due by the consumer is reflected in an inactive account in the Authority's computer system with the relevant computer entry being over 22 years old. The Authority no longer has detailed records of what exactly these arrears refer to.

In the circumstances, the Ombudsman recommended that the Authority should consider giving the Complainant a refund of the £518.42.

(The full report can be found on pages 61 to 71 in the Ombudsman's Annual Report 2017)

Housing Authority (1)

Brief Outline of Complaint

The Complainant was removed from the tenancy of the flat in Gibraltar where he had been living, together with his parents. He asked the Housing Authority to regularise the position as his removal from the tenancy was clearly a mistake.

The Housing Authority requested the Complainant to provide them with proof of residence in the form of a bank statement, ID card or other 'proof of residence' document. The Complainant provided the necessary documentation, including his ID card; health card, bank statement, life insurance letters, a copy of Supreme Court jury summons, a copy of his entry in the register of electors, and a copy of his car insurance. All these documents clearly showed that his address was, beyond any doubt, the flat in question.

However, despite this required proof having been provided by the Complainant and despite the fact that the Housing Authority agreed that the Complainant met the full eligibility criteria to be included in his parent's tenancy, the Authority refused to amend the tenancy on the grounds that his wife was a Spanish national whose main residence was in Spain.

The Ombudsman found that his wife stayed in the flat in Gibraltar occasionally, but that she was currently residing in Spain, together with her parents. The reason for this was to enable her to look after her elderly mother.

The Housing Authority claimed that they were following their 'unwritten policy' that both husband and wife were required to reside together in the same flat in Gibraltar before any amendment could be made to the tenancy.

Recommendations and Outcome

The Ombudsman found that the Complainant had indeed submitted sufficient proof of his residence in Gibraltar, as was required by the Housing Authority.

The Ombudsman also noted that, had the Complainant remained single, the Housing Authority would have had no problem in including him in the tenancy. However, because he is now married and his wife currently lived in Spain with her elderly parents, the Housing Authority had refused to include him in the tenancy of his flat in Gibraltar.

The Ombudsman was of the view that the decision taken by the Housing Authority was clearly unreasonable and unfair and based on irrelevant grounds. The special family circumstances of this case were not taken into account and the Ombudsman recommended that the position should be regularised by the Authority, as soon as possible.

(The full report can be found on pages 72 to73 of the Ombudsman's Annual Report 2017)

Housing Authority (2)

Brief Outline of Complaint

The Complainant was aggrieved because the Housing Authority had denied her application for inclusion in the Housing Waiting List.

In this case, the Ombudsman also recommended that the policy guidelines that were being relied on by the Housing Authority should be published, as not doing so made it impossible for applicants to identify the full requirements for eligibility for inclusion in the Housing Waiting List.

Despite the Ombudsman's recommendations in his report, the Housing Authority informed the Ombudsman that they could not accept the recommendations. Their position was that the Complainant's application had already been assessed in accordance with the established policy based on the Housing Allocation Scheme (Revised 1994) and that the Housing Authority explained its policies, procedures and protocols upon request as well as providing an extract of the relevant section in writing when necessary.

In the Ombudsman's view, all protocols and policies need to be published and made readily available to the public in order to ensure procedural transparency in public services.

(The full report can be found in the Ombudsman's Case Book 2018)

Housing Authority (3)

Brief Outline of Complaint

The Complainant was a single mother of three children who lived in Government rented accommodation ("her apartment"). The monthly house rent for her apartment was £63.54, which she paid from her social assistance benefits. The Complainant had applied to the Housing Authority for rent relief on a number of occasions but this had been rejected on the grounds that the Housing Authority considered that the Complainant could afford to pay the rental of her apartment from her social assistance benefits.

Recommendations and Outcome

The Housing Authority provided the Ombudsman with a copy of the assessment of the Complainant's rent relief application. The Authority also provided details of the formula that had been used to calculate the rent relief payable, in accordance with the provisions of the Housing (Rent Relief) Rules 2009 ("the Rules"). The Rules set out the rent relief payable as the net difference between (a) the weekly statutory rent, as prescribed by the Rules and (b) 25% of the applicant's household weekly income less an allowance for the persons residing in the household.

The Ombudsman noted that the allowances deductible from the weekly statutory rent under the Rules were as follows:

Married person over 65 years of age	£64.00 per week;
Single person over 65 years of age	£46.00 per week;
Married person under 65 years of age	£57.90 per week; and
Single person under 65 years of age	£36.80 per week.

The Rules provide for a further deduction of £0.60 to be made for any children residing in the household. The Ombudsman noted that this allowance is not for each child but was fixed at £0.60 even if there were a number of children residing in the household.

The Ombudsman found that the total allowance deductible under the Rules, as applicable to the Complainant, was £57.60 per week in respect of herself as a single mother and 60p per week for her three children. The Ombudsman was of the view that the allowance for the children was unrealistic and unfair especially when compared with the allowance deductible for an adult. The Ombudsman also found that there was an error in the formula as set out in the Rules. The formula prescribed under the Rules is currently as follows:

RR = WSR less ([(**GWI** x 12/52.2) – A]/4) less £0.60 (where a claim includes children)

(Note: RR is the 'Rent Relief payable per week'; WSR is the 'Weekly Statutory Rent; **GWI is the 'Gross Weekly Income**'; and A is the Allowance)

The Ombudsman informed the Housing Authority of the error in the formula under the Rules – which referred the GWI (Gross Weekly Income) instead of GMI (Gross Monthly Income). The Ombudsman pointed out that the correct formula should read as follows:

RR = WSR less ([(**GMI** x 12/52.2) – A]/4) less £0.60 (where a claim includes children)
(Note: **GMI is the Gross Monthly Income**)

The Ombudsman advised the Authority that they should arrange for the necessary correction to be made, as outlined above.

As regards the low level of allowance that was deductible in respect of children under the Rules, the Ombudsman suggested to the Housing Authority that they should consider reviewing this allowance to a fairer and more realistic level.

Driver and Licencing Department

Brief Outline of Complaint

The Complainant had purchased a 'personalised number plate' for his daughter as a birthday present. The fee paid by the Complainant for the personalised number plate was £200.

The Complainant's daughter had obtained a car loan to fund the purchase of her new car. As a consequence of this, both the car and the personalised number plate had been registered in the name of the loan company. This was solely to provide the loan company with security for the car loan.

When the car loan had been fully repaid by the daughter she requested that the personalised number plate be registered in her name. However, the Driver and Licencing Department ("the Department") required the payment of a further fee of £250 to amend the registration of the personalised number from the loan company to her name.

Recommendations and Outcome

The Ombudsman was of the view that the 'transfer' of the registered ownership of the car from the loan company to the buyer upon the repayment of the car loan was not a case of a buyer 'disposing of a vehicle', as envisaged by the legislation. It was simply a case where the loan company was releasing its security over the car and the related personalised number plate upon the borrower having repaid the car loan in full.

It was clearly unfair for the Department to require the buyer, who had already paid £200 for her personalised number plate, to pay an additional fee of £250 for the same personalised number on the same vehicle.

In the circumstances, the Ombudsman recommended that the Department should refund the £250 to the Complainant's daughter by way of an ex-gratia payment.

The Head of the Licensing Authority, informed the Ombudsman that the Department was not minded to make an ex-gratia payment to the Complainant, as recommended by the Ombudsman.

The Department nevertheless agreed to arrange to display a notice on its premises clearly explaining that, in instances where a vehicle registration bearing a personalised number plate was recorded in the name of a loan company as security, the personalised licence plate holder would have to pay a second time for the same personalised number plate, upon discharge of their loan.

The Head of the Licensing Authority also informed the Ombudsman that the major car loan company concerned in this case ("the Company") had agreed that all future hire purchase contracts made between the Company and a vehicle purchaser would contain a clause clearly explaining that the fee payable for the personalised number plate would have to be paid again upon satisfaction of the loan.

The Ombudsman continues to be of the view that the current practice by the Department of charging the same buyer twice for the same personalised number plate is unfair and should be reviewed.

(The full report can be found on pages 114 to117 of the Ombudsman's Annual Report 2017)


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2.2 ISSUES HIGHLIGHTED IN INVESTIGATIONS CARRIED OUT BY THE OMBUDSMAN IN 2019

Other than complaints received against the Gibraltar Health Authority, which are now being handled, in the first instance, by the PALS Office which is situated in the hospital building, the majority of complaints received by the Ombudsman continue to be in respect of the Housing Authority and the Civil Status and Registration Office.

The main issues complained about during the year continue to be as follows:

Housing Authority

- The lack of transparency in the administration of the approved Housing Allocation Scheme.

The Ombudsman has recommended that full details of the approved Housing Allocation Scheme be published. He has pointed out to the Authority that an important principle of good administration is to be open and clear about policies and procedures and to ensure that any information and advice provided is clear, accurate and complete.

- Unreasonable and unfair decisions regarding applications for inclusion in the Housing Waiting List and not providing applicants with reasons for their non-inclusion in the Housing Waiting List;

- Delays in answering correspondence;

- The refusal to provide the Ombudsman with a substantive reply on the grounds that a decision made by the department was based on Government policy – see paragraph below on 'Maladministration –v – decisions based on Government policy'.

Civil Status and Registration Office

- Continuous deferrals (in some cases applicants have been waiting in excess of five years) for decisions on applications for residence permits; exemption from immigration requirements and naturalisation and a failure by the CSRO to inform applicants of the reason for the deferral.

- Unreasonable and unfair administrative procedures regarding applications for the issue and renewal of Civil Registration Cards and ID cards. This includes the unreasonable proof of residence requirement (including the production of a copy of their residential tenancy agreement) for applicants who have clearly been living in Gibraltar for many years and who may not have a formal tenancy agreement in their name. This is not a feasible or indeed reasonable requirement due to the reluctance by many private-sector landlords to confirm, acknowledge or extend tenancies, even in the case of the spouse and children of their legal tenants.

The Ombudsman is increasingly concerned about the procedures being adopted by the CSRO in considering applications for residence permits, especially in respect of the spouses and children of British Citizens who are living and working in Gibraltar. The Ombudsman is of the view that the procedure being adopted by the CSRO in refusing to approve residence permits for the spouses and children of British Citizens appeared to be verging on unconstitutional behaviour, contrary to Article 8 of the European Convention of Human Rights, 'the right to respect for a person's private and family life …', which is enshrined in section 7 (1) of the Constitution of Gibraltar.

The Ombudsman is of the view that a British citizen living in Gibraltar has a Constitutional right to enjoy family life without interference from Government. This includes the right of a worker or pensioner in Gibraltar to bring his wife and children from abroad to live with him and for the family to enjoy the same rights, benefits and advantages as other nationals of Gibraltar.

The Ombudsman recommended that the CSRO should amend their procedures, in this respect, as follows:

- Where a Gibraltarian or British Citizen (of whatever ethnic origin), who is working and living in Gibraltar and has proved to have adequate means and adequate accommodation, is married to a non-Gibraltarian or non-British national, the Government through CSRO should not place unnecessary and unreasonable barriers to the granting of permits of residence for their spouse and children.

- The CSRO should cease to involve private-sector landlords in the application procedure, especially in the case of long-term non-Gibraltarian and non-British tenants who have provided CSRO with an Affidavit confirming their long-term residence in Gibraltar. Otherwise, private sector landlords would, in effect, be using the CSRO to help them to evict their tenants rather than such landlords using the established legal route that would normally be required in such cases.

- Lack of transparency in the criteria required to prove 'sufficiency of income' in applications for Residence Permits. The Ombudsman has recommended that the CSRO should be open and clear about this policy and ensure that any information and advice provided is clear, accurate and complete.

- Delay in answering correspondence;

- Poor customer service by staff at the public counters;

'The Ombudsman looks at Complaints made by individual citizens who feel that they have been unfairly or poorly treated by Public Bodies'.

2.3 MALADMINISTRATION –V – DECISIONS BASED ON GOVERNMENT POLICY

As mentioned in my previous Annual Reports, under the Public Services Ombudsman Act 1998 ("the Act"), the Ombudsman is empowered to investigate any administrative action taken by or on behalf of any Authority to which the Act applies and where a complaint has been duly made to the Ombudsman by a member of the public claiming to have sustained an injustice as a consequence of maladministration.

However, the Act provides that the Ombudsman is not authorised to question the merits of Government policy. This has been an issue that has caused problems in the past and, to a limited extent, continues to do so.

The Ombudsman has, on a number of occasions, been unable continue with an investigation where a public service provider has claimed that a decision has been made following Government policy, albeit that the Ombudsman's view has been that the decision taken by the public service provider was as a consequence of maladministration leading to unfairness and an injustice caused to the Complainant.

The Ombudsman's contention is, and has always been, that the Ombudsman's statutory competence and powers of scrutiny are much wider. A claim by a public service provider that a decision is 'a matter of Government policy' and not 'a matter of administration' should not prevent the Ombudsman from continuing with his investigation of the complaint and reporting on the matter, especially where a clear injustice has been caused as a result of such decision.

An example of this problem was in relation to the refusal by the Housing Department to accept applications for Government housing from British Citizens, despite the applicants having a legal right to permanent residence in Gibraltar.

The point raised by the Ombudsman's Office, in this regard, was that, under the current Housing Allocation Scheme Rules, persons who are not registered Gibraltarians, but who at the time of application, have a right of permanent residence are eligible to apply for Government Housing.

The following is the relevant extract of Section 4 of the Housing Allocation Scheme Rules (Revised 1994):

"PERSONS ELIGIBLE TO APPLY FOR GOVERNMENT HOUSING
The following persons are eligible to apply for Government housing –

(a) persons who are registered in the Register of Gibraltarians;

(b) persons who are not registered Gibraltarians, but who at the time of application, have a right of permanent residence;

(c) persons who are British Dependent Territories citizens by virtue of a connection with Gibraltar, as defined by the British Nationality Act 1991."

The reply from the Housing Department was that the Housing Allocation Scheme Rules have to be read in conjunction with Housing Department policy. The reply went further to suggest that the Ombudsman should therefore not pursue this matter as "it has been the long-standing practice of the Ombudsman not to comment on policy".

The Ombudsman replied as follows:

"It is true that under section 18 (5) of the Public Services Ombudsman Act 1998, the Ombudsman is not authorised or required to question the merits of Government policy.

The relevant section in the Public Services Ombudsman Act 1998 reads as follows:

Powers in relation to Ministers or officers of the Crown
18 (5) It is hereby declared that nothing in this Act authorises or requires the Ombudsman to question the merits of Government policy or a decision taken without maladministration by any Authority in the exercise of a discretion vested in that Authority.

However, the issue in this case is not about Government policy. It is about the Housing Department failing to follow its own established written rules and procedures. This clearly falls under the ambit of administrative action and maladministration. I should be grateful if you would review this matter and arrange for the Housing Authority or Housing Department to send me a substantive reply on this issue."

At the time of writing this report, no satisfactory reply has been forthcoming from the Housing Authority.

2.4 OWN MOTION INVESTIGATIONS

On 20th December 2019, the Gibraltar Parliament passed a Resolution providing for the Public Services Ombudsman Act 1998 to be reviewed in order to enable the Office of the Public Services Ombudsman to launch investigations of its own motion or own initiative, as recommended by the Public Services Ombudsman in 2016. This Parliamentary Resolution has been warmly welcomed by the Ombudsman.

The ability of the Ombudsman to investigate issues of maladministration, without having to rely on receiving a written complaint from the public, will certainly contribute to the delivery of administrative justice in Gibraltar.

This would also enable the Ombudsman to investigate cases of maladministration that are brought to his attention by people who may be reluctant to make a written complaint, which invariably happens in practice for a variety of reasons.

In open letters to the press, the two previous holders of the post of Public Services Ombudsman, as well as the present incumbent of the post, pointed out that the Ombudsman in Gibraltar was among very few such ombudsmen worldwide who were not empowered to conduct 'Own Motion Investigations'. They all agreed that the power to conduct 'Own Motion Investigations' was a much desired and necessary tool for an Ombudsman to have in pursuit of administrative justice. They also shared the view that the ability of the Ombudsman to investigate any issue of maladministration, without having to rely on receiving a written complaint from the public, should not be underestimated.

The present Ombudsman further suggested that, given that it had now been 20 years since the establishment of the Office of the Ombudsman in Gibraltar, the powers available to the Ombudsman under the Public Services Ombudsman Act, 1998 should be reviewed in order to bring these in line with current internationally accepted standards.

In this respect, the Ombudsman would welcome the full adoption of the 'Venice Principles' in Gibraltar. These are a set of internationally accepted standards for the proper functioning and independence of Public Services Ombudsmen.

The Ombudsman is of the view that these international standards should be implemented in Gibraltar, as is being done in other European countries and indeed in many other countries in the world with advanced democratic societies like ours.

The following Resolution was approved by the Gibraltar Parliament on 20th December 2019:

THIS HOUSE:

NOTES:

1. that it has been 21 years since the House of Assembly passed the Public Services Ombudsman Act ('the Act') unanimously, with the support of the GSLP in its then role of official Opposition in November 1998;

2. that 2019 marks the 20th anniversary of the appointment of the first Public Services Ombudsman under the Act by motion of the House of Assembly, which motion also enjoyed the support of the then GSLP Opposition; and

3. that the office of the Public Services Ombudsman enjoys the full support of all members of this Parliament.

FURTHER NOTES:

the publication by the Public Services Ombudsman of its Annual Report for 2018 as well as the recommendations contained therein;

ACKNOWLEDGES:

the Government's support for the review and modernisation of the function and powers of the Public Services Ombudsman;

AND RESOLVES THAT:

the Act should be reviewed to enable the office of the Public Services Ombudsman to launch investigations of its own motion, as recommended by the Public Services Ombudsman in 2016.

3) OMBUDSMAN'S ROLE & FUNCTION

The Office of the Ombudsman was opened in Gibraltar over 20 years ago, in April 1999. Before that date, there was no independent and dedicated point of contact available to the public for the submission of complaints against any act of maladministration by a Government Department or Public Service.

The opening of the Office of the Ombudsman was therefore a big leap forward in the availability of administrative justice in Gibraltar, outside of the judicial process. This was particularly the case for those citizens who did not have the required resources to pursue their grievances in court or indeed for those citizens who did not have the required 'networking' to afford them any realistic opportunity to pursue redress for their grievances against public bodies.

The Public Services Ombudsman Act 1998 was passed by the then House of Assembly on 10th December 1998 and the services of the Office of the Ombudsman became available to the public, free of charge, for the protection of the individual rights and interests of the citizens of Gibraltar.

Who is the Public Services Ombudsman?

Dilip Dayaram Tirathdas MBE, JP
BA, BSc (Hons), LLB (Hons), FCIB, Barrister-at-law

Dilip Dayaram Tirathdas was appointed to carry out the functions of Ombudsman on an acting basis on 1st April 2017, His appointment was subsequently confirmed by Parliament by way of Resolution on 26th July 2017. The appointment was approved with effect from 26 June 2017 for a term of three years.

The Ombudsman is supported by a team of five officers, as follows:

Nicholas P Caetano, LLB (Hons), Barrister-at-law
Deputy Public Services Ombudsman, Head of Investigations and Staff Manager

Steffan Sanchez
Information Systems Support Executive Officer and Human Resources Manager

Nadine Pardo-Zammit

Executive Assistant to the Ombudsman and Public Relations Manager

Karen Calamaro

Executive Senior Investigating Officer and Finance Manager

Sarah De Jesus El Haitali, BA (Hons), LLM

Executive Investigating Officer

(Daniel Romero, Executive Investigating Officer, who also forms part of the Ombudsman's Office complement, was seconded to the GHA's Patients Advocacy and Liaison Office 'PALS' with effect from 1st January 2018)

The Public Services Ombudsman and his Team:

Photo from left to right: Karen Calamaro - Executive Senior Investigating Officer and Finance Manager**; Nicholas P Caetano,** Deputy Public Services Ombudsman**; Steffan Sanchez -** Information Systems Support and Human Resources Manager**; Dilip Dayaram Tirathdas MBE JP -** Public Services Ombudsman**; Sarah De Jesus -** Executive Investigating Officer and **Nadine Pardo-Zammit -** Executive Assistant to the Ombudsman and PR Manager

What services does the Ombudsman provide?

The Ombudsman investigates complaints by the public about any acts or omissions by Government entities, agencies and authorities.

The aim of the Ombudsman is to 'put things right' for members of the public who may have suffered hardship or an injustice resulting from the maladministration or poor service by a Government department or Authority.

Access to the Ombudsman's services is free of charge to the public. If the Ombudsman is not able to deal with a particular matter, the Ombudsman will provide the public with advice on where best to direct the complaint.

What complaints can the Ombudsman investigate?

The Ombudsman normally investigates a complaint if this has not been adequately dealt with under the complaints procedure of the public service provider concerned. The Ombudsman therefore serves as a complaint mechanism of last resort.

The Ombudsman will investigate a complaint against a public service provider who has:

- failed to deal with a complaint adequately under its complaints procedure;
- not followed its established administrative rules, procedures and practices;
- failed to respond to letters or other correspondence promptly and satisfactorily;
- treated a complainant unfairly, unreasonably or in an improper manner;
- been careless or negligent in the service provided;
- taken a decision based on irrelevant grounds or based on incorrect or incomplete information;
- taken a decision without proper authority to do so;
- taken too long to deal with a matter, without reasonable excuse.

What complaints cannot be investigated by the Ombudsman?

There are some complaints against public service providers that the Ombudsman cannot normally investigate. These include complaints where:

- the Ombudsman considers that the Complainant has an alternative and more appropriate remedy by way of proceedings in any court of law, board of enquiry or tribunal;

- the Ombudsman considers that the Complainant has a more appropriate remedy by way of legal action for a claim relating to medical negligence or malpractice by medical professionals.

The Ombudsman will therefore not normally look at complaints related to:

- Clinical judgment by medical professionals, including diagnoses and treatment;

- Negligence or Malpractice by Doctors and other Medical Professionals;

- Employment Issues such as recruitment; pay and conditions of employment; and contracts of employment; and

- Other issues that may be subject to legal proceedings before the courts or independent tribunals.

What remedies can the Ombudsman provide?

The Public Services Ombudsman can offer a range of potential non-judicial remedies, which can include but are not limited to recommending to the Public Service Provider that it should:

- provide an apology;

- give an explanation;

- correct an error;

- change its practices, procedures and systems.

How are complaints dealt with?

Many complaints are resolved by the Ombudsman's Office reasonably quickly. However, where the issues raised by Complainants are more complex, then more detailed investigations are usually required.

The Ombudsman uses an inquisitorial approach when carrying out his investigations as opposed to the adversarial approach used by the courts.

The Ombudsman investigates complaints by examining the relevant information available from both the complainant and the public service provider. This may include interviews with the relevant people involved with the complaint, including the calling and examination of witnesses; an examination of the relevant files, documents and other records available to the public service provider; an examination of any letters or other correspondence between the complainant and the public service provider; obtaining advice from relevant experts, including clinical assessors; and obtaining a written report from the public service provider.

Against which specific entities can a complaint be made to the Ombudsman?

A complaint to the Ombudsman may be made against any of the following entities:

- Gibraltar Government departments and agencies;
- Royal Gibraltar Police;
- Gibraltar Health Authority;
- Gibraltar Broadcasting Corporation;
- Gibraltar Development Corporation;
- Employment and Training Board;
- Tourism Board;
- Development and Planning Commission;
- Transport Commission;
- Care Agency;
- Gibraltar Electricity Authority;

- Gibraltar Sports Authority;
- Gibraltar Culture and Heritage Agency;
- Borders and Coastguard Agency;
- Housing Works Agency;
- Calpe House, London and Calpe House Trust;
- Gibraltar Office in London;
- Gibraltar Office in Brussels;
- New Hope Trust/Bruce's Farm Rehabilitation Centre;
- The University of Gibraltar (but only in respect of a complaint by a student);
- Any person, company or other entity providing the following public services under a contract or licence issued by the Crown or a statutory body:
    - Supply of telecommunication services;
    - Supply of water services;
    - Collection of any moneys payable to the Government;
    - The operation of any Registry;
    - Environmental or public health control services;
    - Clamping, tow-away or traffic management;
    - The cleaning or upkeep of any part of the public highway or planted areas adjacent thereto;
    - Refuse collection or incineration services;
    - Car parking services;
    - The management of:
        - Alameda Gardens;
        - John Mackintosh Hall;
        - Gibraltar Museum;
        - Gibraltar Airport Terminal; or
        - Any site, property or facility belonging to the Crown.

- Property management;
- Property agency;
- Rates collection services;
- Land property services;
- Immigration services;
- Entry point control;
- Terminal security;
- Philatelic supplies; and
- Emergency and transfer ambulance services.

'We listen carefully to Complainants and the Organisations we investigate. In an investigation we do not take sides, but are able to ask questions on behalf of Complainants.'

3.1 OMBUDSMAN'S STRATEGIC OBJECTIVES

Strategic Objective (1) - To provide an efficient and effective mechanism for the public to be able to complain about any maladministration by Public Service Providers

The aims and objectives of the Public Services Ombudsman include the provision of a simple and straightforward mechanism for people to be able to complain about any maladministration by Public Service Providers.

It is important for our office that people who make a complaint to us are listened to and treated fairly. The Ombudsman's Office staff aim to deal with complaints efficiently and effectively and in addition to providing a suitable remedy and effective redress for the Complainant, a further important aim is that the learning from such complaints is used to improve the delivery of our public services.

The Public Services Ombudsman is charged by statute with the task of investigating grievances, submitted by way of complaint, of administrative action taken by or on behalf of the Government and providers of certain services to the general public. The Ombudsman's Office also provides the public with a valuable source of information and guidance about the public administration in Gibraltar.

Strategic Objective (2) - To raise general standards in the delivery of public services

One of the underlying aims of the Office of the Ombudsman is the raising of standards in the delivery of public services, for the benefit of the whole community.

We do this on a daily basis by following up specific complaints from the general public and by making recommendations for the improvement of service provision, beyond simply settling the individual dispute. In this respect, we also address systemic issues and suggest improvements to be made, where possible.

Strategic Objective (3) - To improve the in-house complaints handling procedures by public service providers

Members of the public are required to submit their complaint to the relevant Public Service Provider, in the first instance. This is so that the public service provider has an opportunity to put things right, as soon as possible. It is therefore important that Public Service Providers have an effective and efficient in-house complaints procedure in place.

The Ombudsman's Office continues to review all such in-house complaints procedures and following up on those public service providers that have still to set up an in-house complaints procedure.

'We learn from engagement with complainants and organisations we investigate to improve our accessibility, efficiency and effectiveness and the quality of our decisions'.

Strategic Objective (4) - To promote public awareness of the role and function of the Ombudsman

It is important for the Ombudsman to promote public awareness of the role and function of the Ombudsman and the rights of people to complain. 'A right to complain is not a right if a person is not aware of its existence.' If an individual believes that the dispute or situation remains unresolved after having made their complaint to the relevant public service provider, they can then refer the matter to the Public Services Ombudsman who will review and investigate the complaint further.

In this respect and as part of the Ombudsman's Office 20th Anniversary 'celebrations', a booklet was prepared and issued to the public. This booklet outlines the '20 Year Journey of the Gibraltar Public Services Ombudsman.'

The booklet was distributed directly to the public at a special event arranged for this purpose, outside the Parliament Building on 12th November 2019.

Ombudsman and his staff outside Parliament Building

Ombudsman's staff interacting with members of the public in Main Street

A commemorative postage stamp was also issued to mark this important anniversary in the Ombudsman's calendar and this was followed by the minting of a £5 commemorative legal tender coin.

Commemorative legal tender coin issued for public circulation

Commemorative Postage Stamp issued to the public

3.2 PRINCIPLES FOR REMEDY

There are **six** internationally accepted Principles for Remedy that have been approved and adopted by the Gibraltar Ombudsman's Office. These principles have been approved and adopted by the following Public Services Ombudsmen:

1) Public Services Ombudsman - Northern Ireland;
2) Public Services Ombudsman - Wales;
3) Ombudsman and Information Commissioner - Ireland;
4) Public Services Ombudsman - Gibraltar;
5) Parliamentary Ombudsman – Malta
6) Parliamentary & Health Services Ombudsman – United Kingdom
7) LGO and Chair of the Commission for Local Administration - England; and
8) Public Services Ombudsman - Scotland

The Principles for Remedy provide an agreed framework for the remedies that are applied by Public Services Ombudsmen when dealing with cases of maladministration. The principles were approved on 14th November 2017 and the document was formally signed on 8th March 2018.

Public Services Ombudsmen – Principles for Remedy

What is the purpose of this guide to the Principles for Remedy?

This is a guide to explain how Public Services Ombudsmen in the United Kingdom and Ireland, Malta and Gibraltar (the Ombudsmen[1]) aim to put things right for members of the public who have suffered injustice or hardship resulting from maladministration or poor service by a public body in their jurisdiction. This guide outlines the Ombudsmen's general approach to recommending remedy for injustice and is based on the PHSO Principles for Remedy. In setting out six guiding Principles for Remedy, the aim is to achieve a consistent approach to remedy by the Ombudsmen.

[1] In this document, Ombudsman and Ombudsmen are to read as interchangeable.

It is important that both members of the public and public service providers in their jurisdiction are aware of how decisions on an appropriate remedy for injustice resulting from maladministration have been arrived at in any case. These Principles for Remedy are an agreed framework for the Ombudsmen to reference in order to inform, where appropriate, their approach to remedy.

What do we mean by remedy?

Identifying and where possible remedying an injustice or hardship caused by a body's maladministration or poor service is a key function of an Ombudsman. Members of the public when making a complaint to an Ombudsman are invited to identify the remedy or outcome they seek. This is important so that the Ombudsman can decide whether or not an alternative legal remedy exists for the injustice complained of, as there may be a more appropriate course of action for the complainant to pursue. Ombudsmen offer a flexible range of potential non-judicial remedies that can be applied in any case. Ombudsmen remedies can include but are not limited to:

- an apology
- an explanation
- correction of an error
- an agreement to change practices, procedures or systems
- financial redress

How can this guide be used by Ombudsmen?

It is a matter for each of the Ombudsmen to decide on an appropriate remedy based on the identified maladministration and injustice suffered by the individual in any case. This guide is not intended to limit the Ombudsmen in the exercise of their discretion in any particular case. The Ombudsmen's Principles for Remedy are intended as an agreed normative framework to inform their approach to remedy where public services have been found to have failed and also as a reference point for Ombudsmen when developing more detailed guidelines relevant to their particular legal framework.

PRINCIPLES FOR REMEDY

1 To put things right

The overarching principle when considering a remedy for injustice is to restore the individual back to the position they were in prior to the maladministration or poor service taking place. That may include recommending the award of the benefit to which the individual was entitled but had not received because of the failings of the public body concerned or recommending payment for a loss suffered as a result of the maladministration. Ombudsmen may also recommend payments for upset or 'time and trouble' where appropriate.

However, the outcome of maladministration or poor service cannot always be rectified or circumstances reversed. In such cases by offering a particular remedy the Ombudsman seeks to, at the very least, remedy the injustice sustained by the individual.

In a particular case 'Putting things Right' may also require a consideration of remediation for the public in general. In cases where the maladministration affects more than one individual because systemic failings have been identified, the Ombudsman will seek to remedy this by making recommendations in the public interest for systemic change.

Putting things right might also involve an Ombudsman drawing the attention of the relevant governing body (Parliament, Assembly, or full council of the relevant local authority) to a specific legislative failing which has resulted in an injustice.

2 To be open and accountable

The Ombudsman should be open and clear about the reasons why they have recommended a certain type of remedy. This includes publishing on their website their specific policies on remedy and providing detail of the injustice they are seeking to address by their recommendation, as well as explicit reasons for that recommendation in their report to the body and complainant.

Where a body fails to comply with a recommendation this will be reported openly and publicly to the relevant Parliament, Assembly or full council of the relevant local authority, so that the public body is accountable for its actions.

To enable public bodies to be aware of Ombudsmen's recommendations for remedy in particular cases, these will be reported on in an annual report and case digest which will be published.

3 To be empowering

The Ombudsman will take into account the views and circumstances of the complainant and consider what remedy they are seeking. In addition, where appropriate, the Ombudsman will consider the views of the complainant in relation to the issue of remedy. However, at the outset the Ombudsman should manage the expectations of a complainant regarding remedy and redress, and what can be achieved as ultimately, the Ombudsman will decide what is an appropriate remedy within the scope of his/her remit, in any particular case.

4 To be fair, reasonable & consistent

The Ombudsman will treat each case on its own merits and consider the specific circumstances of each case, ensuring that the remedy recommended is reasonable once all aspects of the injustice have been considered.

Ombudsmen may delegate decision making to staff in their offices in relation to recommending a remedy in certain cases. However, Ombudsmen will ensure that in deciding on an appropriate remedy, there is consistency with previous decisions and also a consistency in approach in reaching a decision about what is an appropriate remedy. In the case of a recommendation for financial redress, consistency does not refer to the monetary amount offered for a particular type of complaint. Where the Ombudsman is recommending financial redress and as no two complaints are ever exactly the same, the Ombudsman will consider carefully the nature of the injustice sustained and whether it is possible to put the person back in the position they would have been in but for the maladministration or service failure identified.

The Ombudsman will seek to be fair and act without bias or prejudice in addressing individual cases for remedy. To ensure a fair process the Ombudsman will indicate to both the complainant and the public body in advance of a final report on an investigation his/her considerations for remedy (in draft form) and will consider the parties views. Although, ultimately, the final recommendation is a matter for the Ombudsman.

5 To be proportionate

The Ombudsman will recommend an appropriate remedy which is fair and proportionate in all the circumstances and having particular regard to the nature of the injustice caused to the complainant by the maladministration or poor service.

6 To monitor and ensure compliance

Public Service Ombudsmen have powers to bring to the attention of their legislature (that is Parliament or Assembly or the full council of the relevant local authority) where a recommendation has not been met by the body. This is an important function of an Ombudsman as it is to the relevant legislative or governing body that he or she must report the failings in such circumstances. This in turn requires an Ombudsman, as a matter of good practice, to check routinely with public service providers to ensure that a recommendation has been fully complied with. Failure to comply with an Ombudsman's recommendation may be the subject of a 'special report' by the Ombudsman to the relevant legislature or governing body as this failure can constitute maladministration.

3.3 THE VENICE PRINCIPLES

The Venice Principles represent a set of internationally accepted standards for the proper functioning and independence of Public Services Ombudsmen.

The Ombudsman wrote to the Chief Secretary on 2nd July 2019 to inform him about the Venice Principles and to mention that he fully supported the implementation of these internationally accepted standards in Gibraltar. The Ombudsman mentioned to the Chief Secretary that it would be great if these international standards are implemented in Gibraltar, as is being done in other European countries and indeed in many other countries in the world with advanced democratic societies like ours. He also recommended that Government should give some consideration, in due course, to enshrining the Venice Principles in the Public Services Ombudsman Act.

On 2nd May 2019, the Committee of Ministers of the Council of Europe endorsed the "Principles on the Protection and Promotion of the Ombudsman Institution" ("The Venice Principles"). The 25 Principles were adopted by the Venice Commission on 15th March 2019 at its Plenary Session.

The Venice Commission is the European Commission for Democracy through Law. It is an advisory body of the Council of Europe, whose primary task is to assist and advise individual countries on constitutional matters in order to improve the functioning of democratic institutions and the protection of human rights.

In a recent press release issued by the Council of Europe, the importance of the role of Public Services Ombudsmen and the significance of the Venice Principles were explained, as follows:

> "…..Ombudsmen are important for democracy, their services are free, and are thus accessible to individuals who cannot afford to pursue their complaints through the courts. They can take action independently against maladministration and alleged violations of human rights and hence play a crucial role with regard to the governments and parliaments which must accept criticism. As an interface between the administration and the citizens they are at times the first or the last resort to set a human rights violation straight.

Ombudsmen now have a unique international reference text listing the legal principles essential to their establishment and functioning in a democratic society. Drawn partly from a diversity of existing models in the world, the 25 principles are the most comprehensive checklist ever compiled..... They are meant to consolidate and empower ombudsmen institutions, which play a crucial role in strengthening democracy, the rule of law, good governance and the protection and promotion of human rights and fundamental freedoms."

The 25 Venice Principles are as follows:

1. Ombudsman Institutions have an important role to play in strengthening democracy, the rule of law, good administration and the protection and promotion of human rights and fundamental freedoms. While there is no standardised model across Council of Europe Member States, the State shall support and protect the Ombudsman Institution and refrain from any action undermining its independence.

2. The Ombudsman Institution, including its mandate, shall be based on a firm legal foundation, preferably at constitutional level, while its characteristics and functions may be further elaborated at the statutory level.

3. The Ombudsman Institution shall be given an appropriately high rank, also reflected in the remuneration of the Ombudsman and in the retirement compensation.

4. The choice of a single or plural Ombudsman model depends on the State organisation, its particularities and needs. The Ombudsman Institution may be organised at different levels and with different competences.

5. States shall adopt models that fully comply with these Principles, strengthen the institution and enhance the level of protection and promotion of human rights and fundamental freedoms in the country.

6. The Ombudsman shall be elected or appointed according to procedures strengthening to the highest possible extent the authority, impartiality, independence and legitimacy of the Institution. The Ombudsman shall preferably be elected by Parliament by an appropriate qualified majority.

7. The procedure for selection of candidates shall include a public call and be public, transparent, merit based, objective, and provided for by the law.

8. The criteria for being appointed Ombudsman shall be sufficiently broad as to encourage a wide range of suitable candidates. The essential criteria are high moral character, integrity and appropriate professional expertise and experience, including in the field of human rights and fundamental freedoms.

9. The Ombudsman shall not, during his or her term of office, engage in political, administrative or professional activities incompatible with his or her independence or impartiality. The Ombudsman and his or her staff shall be bound by self-regulatory codes of ethics.

10. The term of office of the Ombudsman shall be longer than the mandate of the appointing body. The term of office shall preferably be limited to a single term, with no option for re-election; at any rate, the Ombudsman's mandate shall be renewable only once. The single term shall preferably not be stipulated below seven years.

11. The Ombudsman shall be removed from office only according to an exhaustive list of clear and reasonable conditions established by law. These shall relate solely to the essential criteria of "incapacity" or "inability to perform the functions of office", "misbehaviour" or "misconduct", which shall be narrowly interpreted. The parliamentary majority required for removal – by Parliament itself or by a court on request of Parliament- shall be equal to, and preferably higher than, the one required for election. The procedure for removal shall be public, transparent and provided for by law.

12. The mandate of the Ombudsman shall cover prevention and correction of maladministration, and the protection and promotion of human rights and fundamental freedoms.

13. The institutional competence of the Ombudsman shall cover public administration at all levels.

    The mandate of the Ombudsman shall cover all general interest and public services provided to the public, whether delivered by the State, by the municipalities, by State bodies or by private entities. The competence of the Ombudsman relating to the judiciary shall be confined to ensuring procedural efficiency and administrative functioning of that system.

14. The Ombudsman shall not be given nor follow any instruction from any authorities.

15. Any individual or legal person, including NGOs, shall have the right to free, unhindered and free of charge access to the Ombudsman, and to file a complaint.

16. The Ombudsman shall have discretionary power, on his or her own initiative or as a result of a complaint, to investigate cases with due regard to available administrative remedies. The Ombudsman shall be entitled to request the co-operation of any individuals or organisations who may be able to assist in his or her investigations. The Ombudsman shall have a legally enforceable right to unrestricted access to all relevant documents, databases and materials, including those which might otherwise be legally privileged or confidential. This includes the right to unhindered access to buildings, institutions and persons, including those deprived of their liberty. The Ombudsman shall have the power to interview or demand written explanations of officials and authorities and shall, furthermore, give particular attention and protection to whistle-blowers within the public sector.

17. The Ombudsman shall have the power to address individual recommendations to any bodies or institutions within the competence of the Institution. The Ombudsman shall have the legally enforceable right to demand that officials and authorities respond within a reasonable time set by the Ombudsman.

18. In the framework of the monitoring of the implementation at the national level of ratified international instruments relating to human rights and fundamental freedoms and of the harmonization of national legislation with these instruments, the Ombudsman shall have the power to present, in public, recommendations to Parliament or the Executive, including to amend legislation or to adopt new legislation.

19. Following an investigation, the Ombudsman shall preferably have the power to challenge the constitutionality of laws and regulations or general administrative acts. The Ombudsman shall preferably be entitled to intervene before relevant adjudicatory bodies and courts. The official filing of a request to the Ombudsman may have suspensive effect on time-limits to apply to the court, according to the law.

20. The Ombudsman shall report to Parliament on the activities of the Institution at least once a year. In this report, the Ombudsman may inform Parliament on lack of compliance by the public administration. The Ombudsman shall also report on specific issues, as the Ombudsman sees appropriate. The Ombudsman's reports shall be made public. They shall be duly taken into account by the authorities. This applies also to reports to be given by the Ombudsman appointed by the Executive.

21. Sufficient and independent budgetary resources shall be secured to the Ombudsman institution. The law shall provide that the budgetary allocation of funds to the Ombudsman institution must be adequate to the need to ensure full, independent and effective discharge of its responsibilities and functions. The Ombudsman shall be consulted and shall be asked to present a draft budget for the coming financial year. The adopted budget for the institution shall not be reduced during the financial year, unless the reduction generally applies to other State institutions. The independent financial audit of the Ombudsman's budget shall take into account only the legality of financial proceedings and not the choice of priorities in the execution of the mandate.

22. The Ombudsman Institution shall have sufficient staff and appropriate structural flexibility. The Institution may include one or more deputies, appointed by the Ombudsman. The Ombudsman shall be able to recruit his or her staff.

23. The Ombudsman, the deputies and the decision-making staff shall be immune from legal process in respect of activities and words, spoken or written, carried out in their official capacity for the Institution (functional immunity). Such functional immunity shall apply also after the Ombudsman, the deputies or the decision-making staff-member leave the Institution.

24. States shall refrain from taking any action aiming at or resulting in the suppression of the Ombudsman Institution or in any hurdles to its effective functioning, and shall effectively protect it from any such threats.

25. These principles shall be read, interpreted and used in order to consolidate and strengthen the Institution of the Ombudsman. Taking into consideration the various types, systems and legal status of Ombudsman Institutions and their staff members, states are encouraged to undertake all necessary actions including constitutional and legislative adjustments so as to provide proper conditions that strengthen and develop the Ombudsman Institutions and their capacity, independence and impartiality in the spirit and in line with the Venice Principles and thus ensure their proper, timely and effective implementation.

The full text of the Venice Principles can be downloaded from the Gibraltar Public Services Ombudsman's website at www.ombudsman.org.gi.

'Ombudsmen are important for democracy, their services are free, and are thus accessible to individuals who cannot afford to pursue their complaints through the courts.'


Public Services Ombudsman
20th Anniversary
of the establishment of the
Office of the
Ombudsma
in Gibraltar
1999-2019
20th Anniversary

4) DIARY OF EVENTS FOR 2019

Meetings and Seminars

Ombudsman Association's Casework Interest Group Meeting – held in Cardiff on 12th April 2019

A meeting of the Ombudsman Association's Casework Interest Group was held in Cardiff on the 12th April 2019.

Over twenty delegates attended the meeting and the Gibraltar Public Services Ombudsman was represented by the Senior Investigating Officer, Karen Calamaro and Deputy Ombudsman Nicholas Caetano.

Casework Interest Group meetings provide a forum for discussion and networking for professionals in the Ombudsman field. They also provide an excellent opportunity for delegates to advance on concepts and ideas which undoubtedly result in an improved service to the public.

At this meeting, a presentation on 'Recommendations' was delivered by Robin Harris from the Office of the Immigration Services Commissioner and by Karen Calamaro from the Gibraltar Ombudsman's Office.

The objective of this exercise, which is still work-in-progress, is to obtain information from both the public and private sector Ombudsman organisations on how they make effective recommendations by ensuring that these are proportionate, appropriate and SMART (an acronym for the 5 elements of specific, measurable, achievable, relevant, and time-based goals).

The feedback and results of this project were put to members at a presentation in the Ombudsman Association's Conference held in Belfast on the 21st May 2019.

Presentations on GDPR and Compliance were delivered at this meeting as well as an update provided by the Ombudsman Association's Director, Donal Galligan.

Meeting of the Public Sector Ombudsman Group ("PSOG") held in the offices of the Northern Ireland Ombudsman in Belfast on 20th May 2019 and in the offices of the Scottish Public Services Ombudsman in Edinburgh on 6th November 2019

The Public Sector Ombudsman Group ("PSOG") held its bi-annual meeting in Belfast, on Monday 20th May 2019. The PSOG meeting was chaired by Marie Anderson, the Public Services Ombudsman of Northern Ireland.

The PSOG held its next bi-annual meeting of the year in Edinburgh, on Wednesday 6th November 2019. This meeting was chaired by Rosemary Agnew, the Scottish Public Services Ombudsman.

The Public Services Ombudsman of Gibraltar attended both these meetings, together with the Deputy Ombudsman.

PSOG meetings provide Public Sector Ombudsmen with a forum for the exchange of ideas at first hand and an opportunity to discuss areas of common interest. The PSOG meetings also enable Ombudsmen to provide each other with updates on the work carried out in their respective countries and offices.

PSOG members include the Public Services Ombudsmen of the Republic of Ireland; Northern Ireland; Scotland; Wales; the United Kingdom Parliamentary and Health Service Ombudsman; the Local Government and Social Care Ombudsman of England; the Housing Ombudsman in England, the Parliamentary Ombudsman of Malta and the Public Services Ombudsman of Gibraltar. The Director of the Ombudsman Association also attends these bi-annual meetings.

On the meeting held on 20th May 2019, PSOG members were pleased to welcome the Public Services Ombudsman of the Falkland Islands, Mr Dick Sawle, who joined the meeting as an observer.

Further PSOG meeting held in Manchester on 28th January 2020

This PSOG meeting, which was attended by Public Services Ombudsmen only, was chaired by Bob Behrens, the United Kingdom Parliamentary and Health Ombudsman. Among the topics discusses were the Venice Principles and Own Motion Investigations.

The Gibraltar Public Services Ombudsman took the opportunity to present the Ombudsmen with a Gibraltar Public Services Ombudsman 20th Anniversary commemorative legal tender coin.

The 26th Annual General Meeting and Conference of the Ombudsman Association - held in Belfast on 21st and 22nd May 2019

The Ombudsman Association ("OA") 26th Annual General Meeting ("AGM") was held at the Hilton Belfast Hotel, in Belfast on 21st and 22nd May 2019. The Gibraltar Public Services Ombudsman is full voting member of the OA and he attended the AGM and the 2-day Conference that followed this meeting, together with the Deputy Ombudsman.

During the AGM, the annual accounts of the OA were approved and a number of new members were elected to serve on the Board.

The 2-day Conference that followed, which was attended by over 100 delegates from around the world, provided a good opportunity to meet and exchange ideas with other ombudsmen and to participate in various workshops. Workshops attended at the Conference included 'Effective Recommendations'; and 'Providing Value and Impact'.

Workshop on 'Effective Recommendations'

Gibraltar's Deputy Ombudsman, Nicholas Caetano and Robin Harris from the Office of the Immigration Services Commissioner in the United Kingdom jointly chaired the workshop on 'Effective Recommendations' and provided useful feedback on the project undertaken in this regard by The Ombudsman Association's Casework Interest Group.

5) PERFORMANCE REVIEW FOR 2019

A total of 353 complaints were received by the Office of the Public Services Ombudsman during 2019. A total of 371 complaints were finalised during the year, as shown below:

Complaints not yet finalized – brought forward from 2018	68
Complaints received during 2019	353
Complaints finalized during the year 2019	371
Complaints not yet finalized – carried forward to 2020	50

Of the 353 Complaints received this year, 33 related to private entities, including issues regarding private housing rent and repairs, legal issues and financial matters.

Complaints received by the Office of the Public Services Ombudsman in the last 5 years

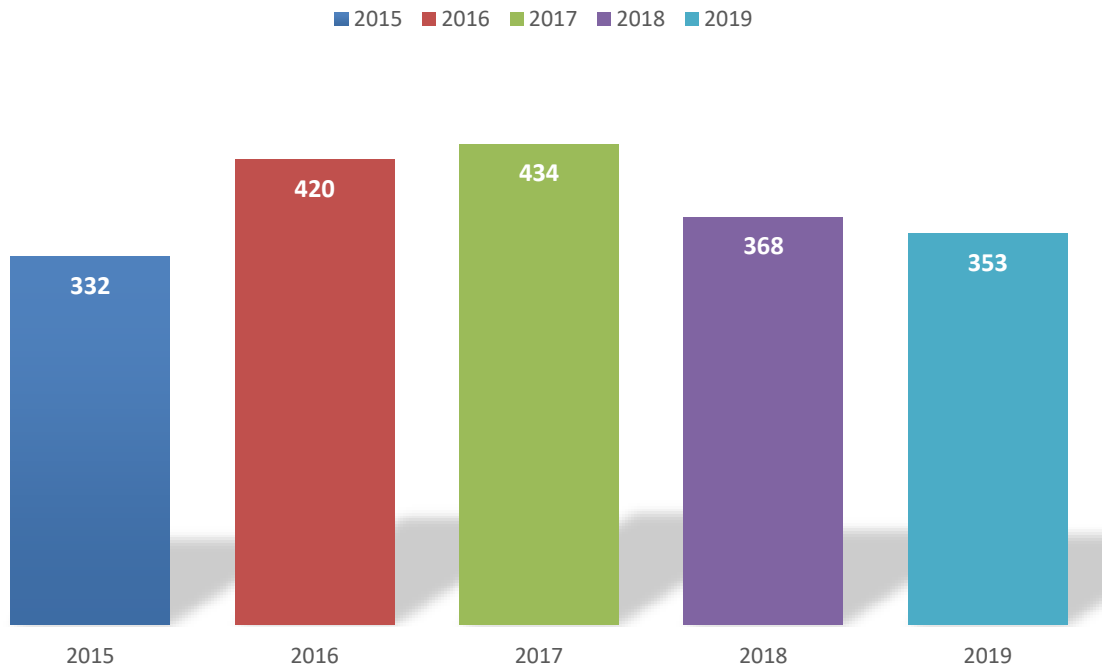


Figure 1

The remaining 320 Complaints related to Government departments, agencies and other public service entities.

A total of 127 complaints were received against the Housing Authority in respect of housing matters. This represented 40% of the total number of complaints received that were within the Ombudsman's jurisdiction. These complaints included issues such as the delay in the allocation of Government housing; the refusal of applications on social or medical grounds and the non-reply or delay in replying to letters.

This year there were 52 complaints against the Civil Status and Registration Office (CSRO). This represents an increase of 20 complaints over the previous year. The complaints related to issues such as delays by the CSRO in dealing with applications for residence permits (in some cases applicants have been waiting for more than 5 years) and delays in dealing with applications for exemption from immigration requirements and naturalisation.

We also received a substantial number of complaints about alleged unfair administrative procedures exercised by the CSRO regarding applications for the issue and renewal of Civil Registration Cards and ID cards.

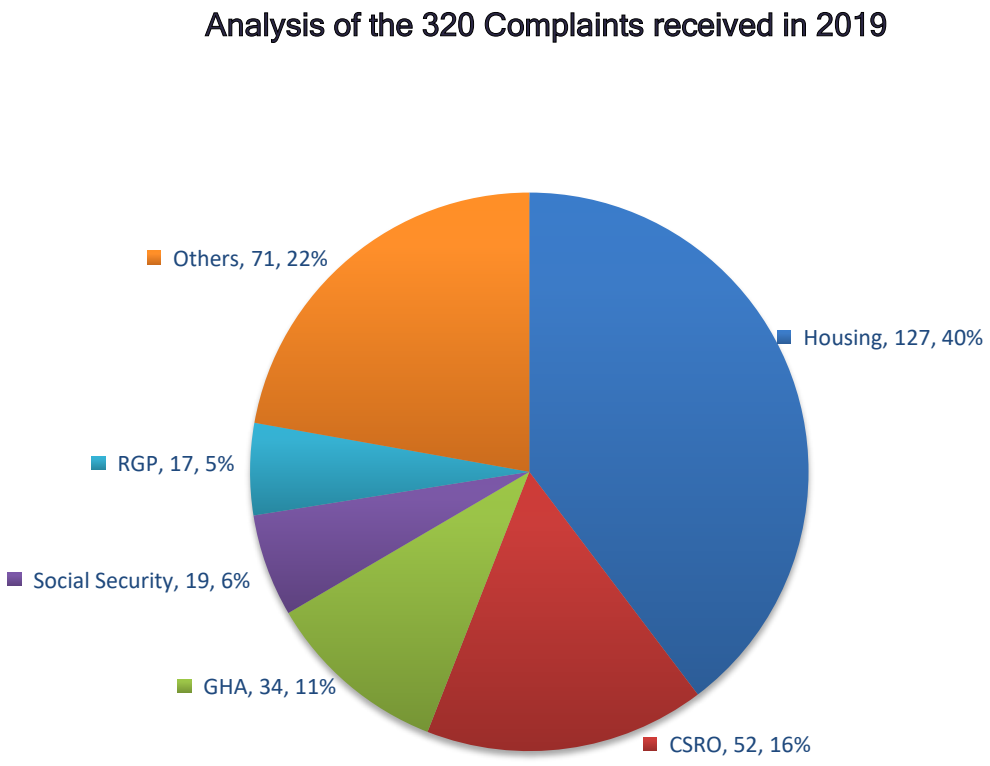


Figure 2

A total of 34 complaints were received against the Gibraltar Health Authority (GHA). This constitutes a 60% increase in the number of complaints received against this Authority.

A total of 737 complaints have been received by the Office of the Ombudsman against the Housing Authority during the last five years. However, this year has seen a significant decrease in the number of complaints received against the Housing Authority, a reduction from 173 complaints received last year to 127 this year.

Number of complaints received against the Housing Authority (HA) and the Civil Status & Registration Office (CSRO) during the last five years

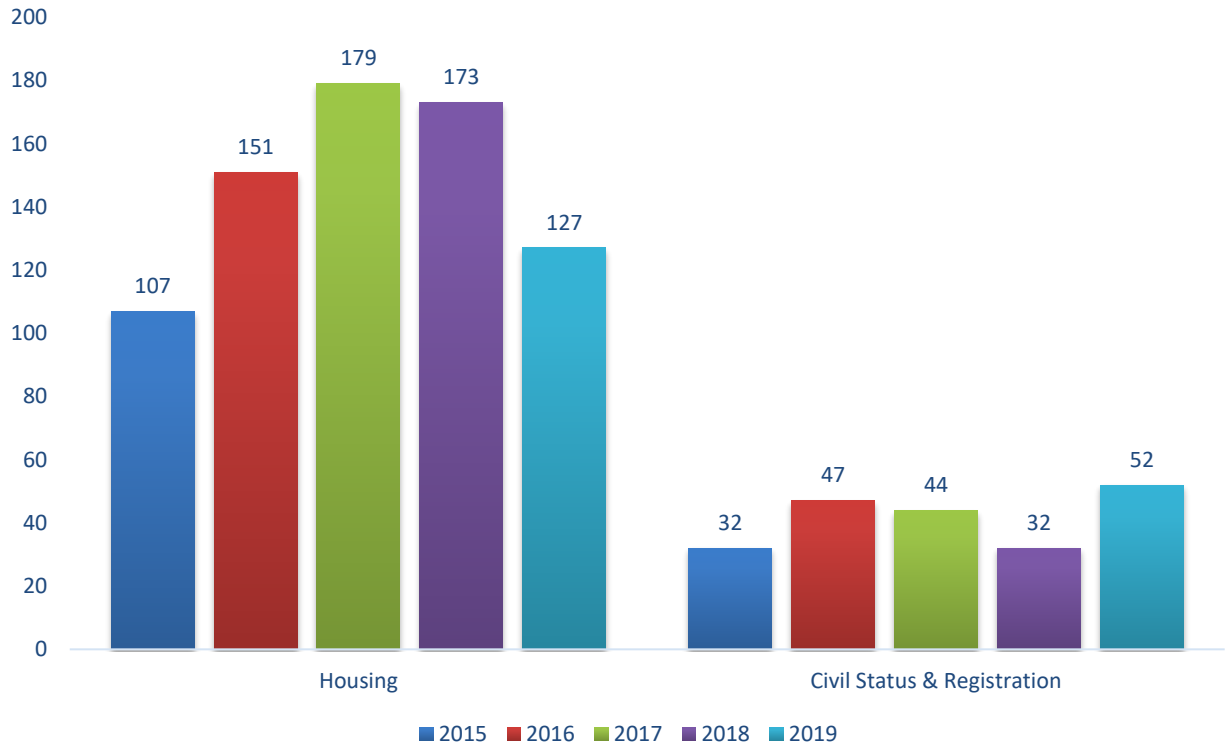


Figure 3

The CSRO has attracted 207 Complaints at the Office of the Ombudsman during the last five years. This represents an average of 41 complaints per year.

The following is a breakdown of the 371 complaints that were finalised this year:

- 51 complaints were classified as being 'Outside the Ombudsman's Jurisdiction';

- 126 complaints were closed as it was considered that the Complainant(s) had not exhausted all their avenues of redress with the Public Service Provider concerned. These refer to complaints that are lodged at the Ombudsman's Office without the Complainant having formally submitted their complaint to the relevant Public Service Provider, in the first instance. Before a complaint is made to the Ombudsman, the Complainant is required to try and resolve any issues directly with the Public Service Provider concerned under the Service Provider's own internal complaints procedure;

- 154 complaints were classified as dealt with by 'Immediate Resolution';

- 20 complaints were settled informally.

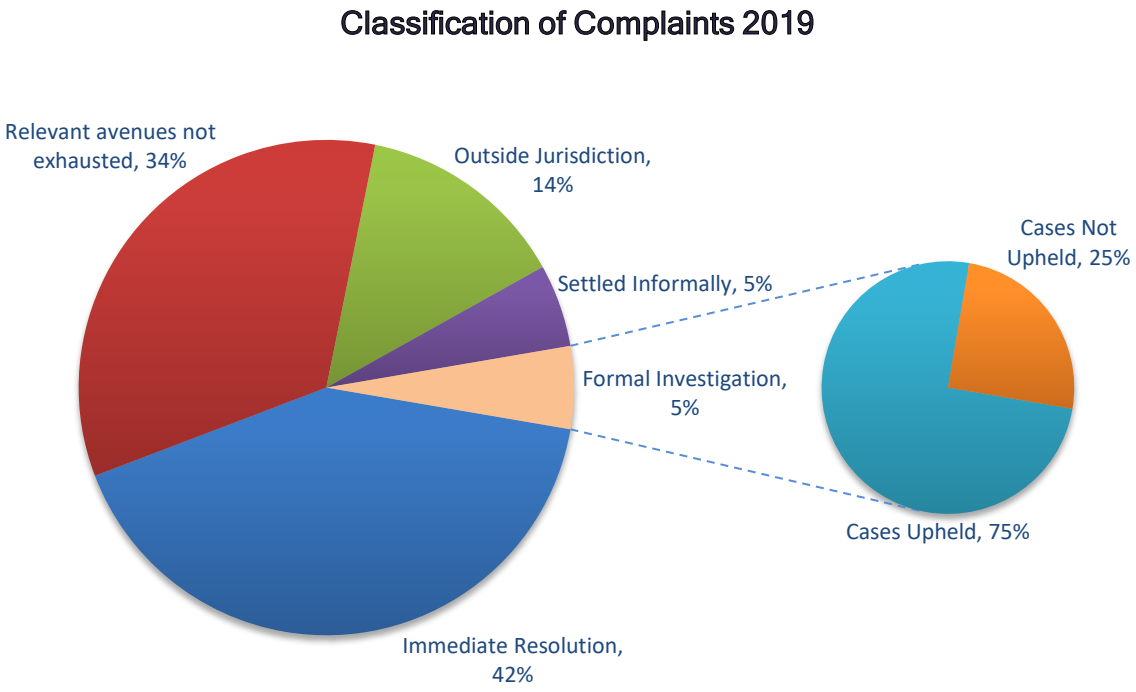


Figure 4

- 20 complaints were followed up by the Ombudsman with 'Formal Investigations', which were concluded by the end of the year. A detailed report has been written for each of these investigations. (See Casebook 2019 on page no.69). 15 of these complaints were upheld or partly upheld, whilst 5 of them were not upheld.

Formal Investigations in 2019

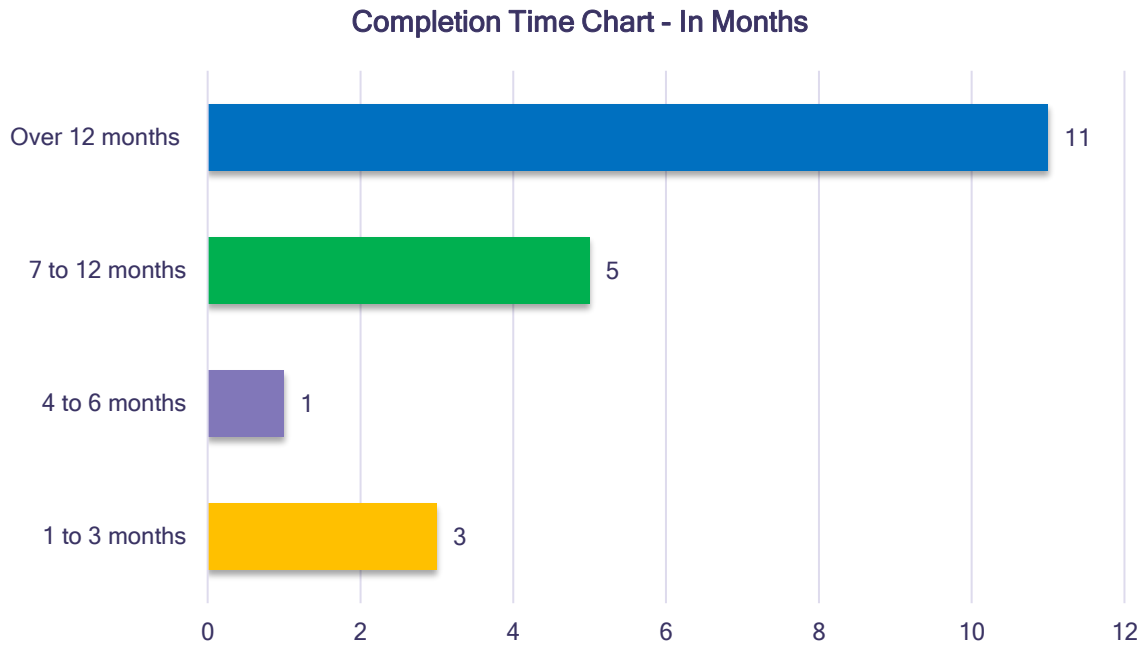


Figure 5

Of the investigations completed during 2019, the average time taken by the Ombudsman's Investigations Team to complete a 'Formal Investigation' on a complaint requiring a detailed report has been 14 months.

'The Office of the Ombudsman has received 8,637 Complaints since it was established in 1999.'


2016

6) APPENDIXES

6.1 DELEGATION OF DUTIES AND DECISION-MAKING AUTHORITY BY THE OMBUDSMAN

Under Section 7 (2) of the Public Services Ombudsman Act 1998.....the Ombudsman may –

(a) authorise any officer appointed under subsection (1) to carry out any function conferred by this Act on the Ombudsman;

(b) designate that particular officers appointed under subsection (1) solely carry out functions under this act relating to the investigation of actions against the Gibraltar Health Authority.

The following officers are currently appointed by the Ombudsman under section 7 (1) of the Public Services Ombudsman Act 1998:

Deputy Ombudsman

Nicholas Caetano

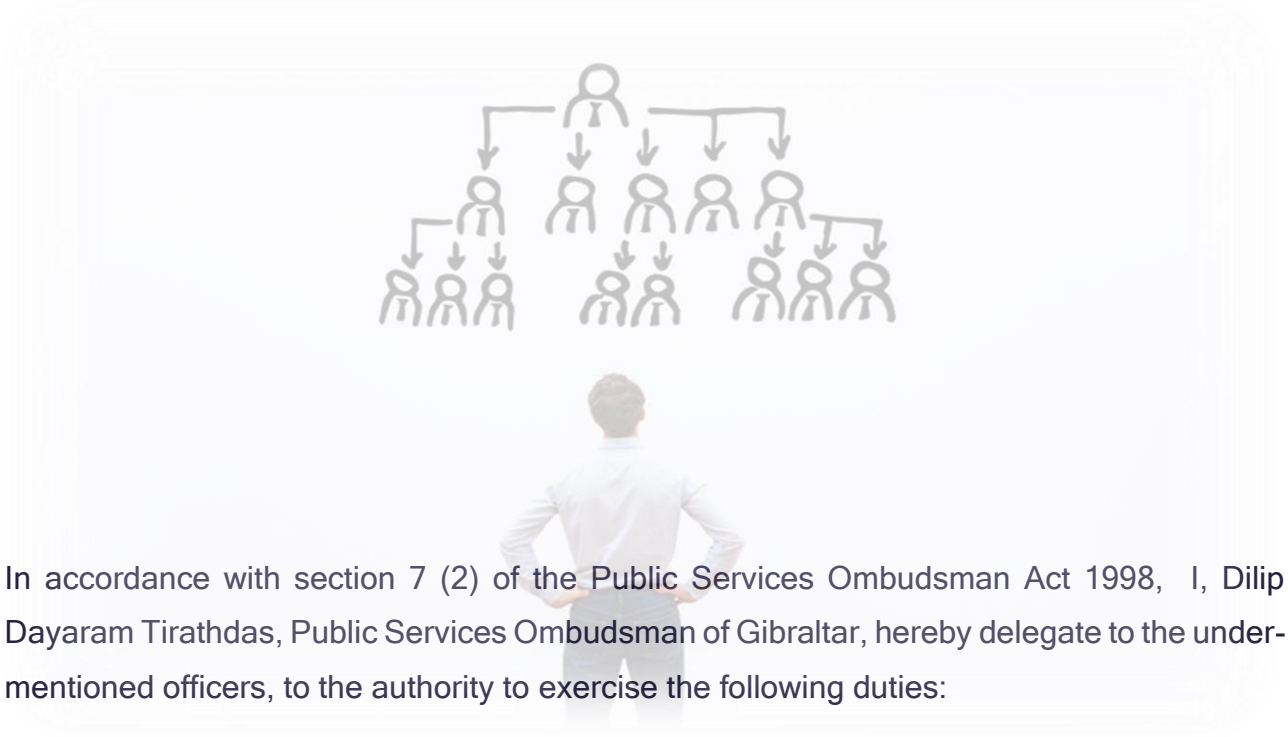
Executive Officers

Executive Senior Investigating Officer and Finance Manager
Karen Calamaro

Executive Assistant to the Ombudsman and Public Relations Manager
Nadine Pardo-Zammit

Executive Officer - Information Systems and Human Resources Manager
Steffan Sanchez

Executive Investigating Officer
Sarah de Jesus El Haitali



In accordance with section 7 (2) of the Public Services Ombudsman Act 1998, I, Dilip Dayaram Tirathdas, Public Services Ombudsman of Gibraltar, hereby delegate to the under-mentioned officers, to the authority to exercise the following duties:

	Authorised Officers
	Any one of the following:
Absence Provision	
Where a member of staff is not contactable or unavailable due to sick leave, annual leave or other absence, for a period beyond which a decision cannot be delayed, the authority is delegated as follows:	• Deputy Ombudsman • Finance Manager • Human Resources Manager
Imprest/ Petty Cash Account	
Purchases from Office Imprest - up to £50	• Finance Manager
Overtime	
Approval of Staff Overtime	• Deputy Ombudsman
Gibraltar Health Authority	
Investigation of actions against the Gibraltar Health Authority	• Deputy Ombudsman • Executive Investigating Officer
Time Off in Lieu	
Approval of Time Off in lieu, up to 3 days	• Deputy Ombudsman • Human Resources Manager

Approval of Annual Leave or Other leave	
Up to five consecutive days	• Deputy Ombudsman
	• Human Resources Manager
Media and Public Relations	
Contacts with the media and Public Relations, including arranging and organising public events to raise awareness of the Office of the Ombudsman	• Public Relations Manager
Finance	*Two signatories required, as follows :*
Submission of Payment Vouchers to the Treasury	• Deputy Ombudsman • Finance Manager
Requests for goods and services over £500	• Deputy Ombudsman • Finance Manager
	Any one of the following:
Requests for goods and services up to £500	• Deputy Ombudsman • Finance Manager • Human Resources Manager
Complaint Handling	
In the absence of the Ombudsman, deputising for the Ombudsman in all matters, including the approval of reports and recommendations resulting from the investigation of complaints.	• Deputy Ombudsman

6.2 PUBLIC SERVICES OMBUDSMAN - PRINCIPLES OF GOOD GOVERNANCE AND MISSION STATEMENT

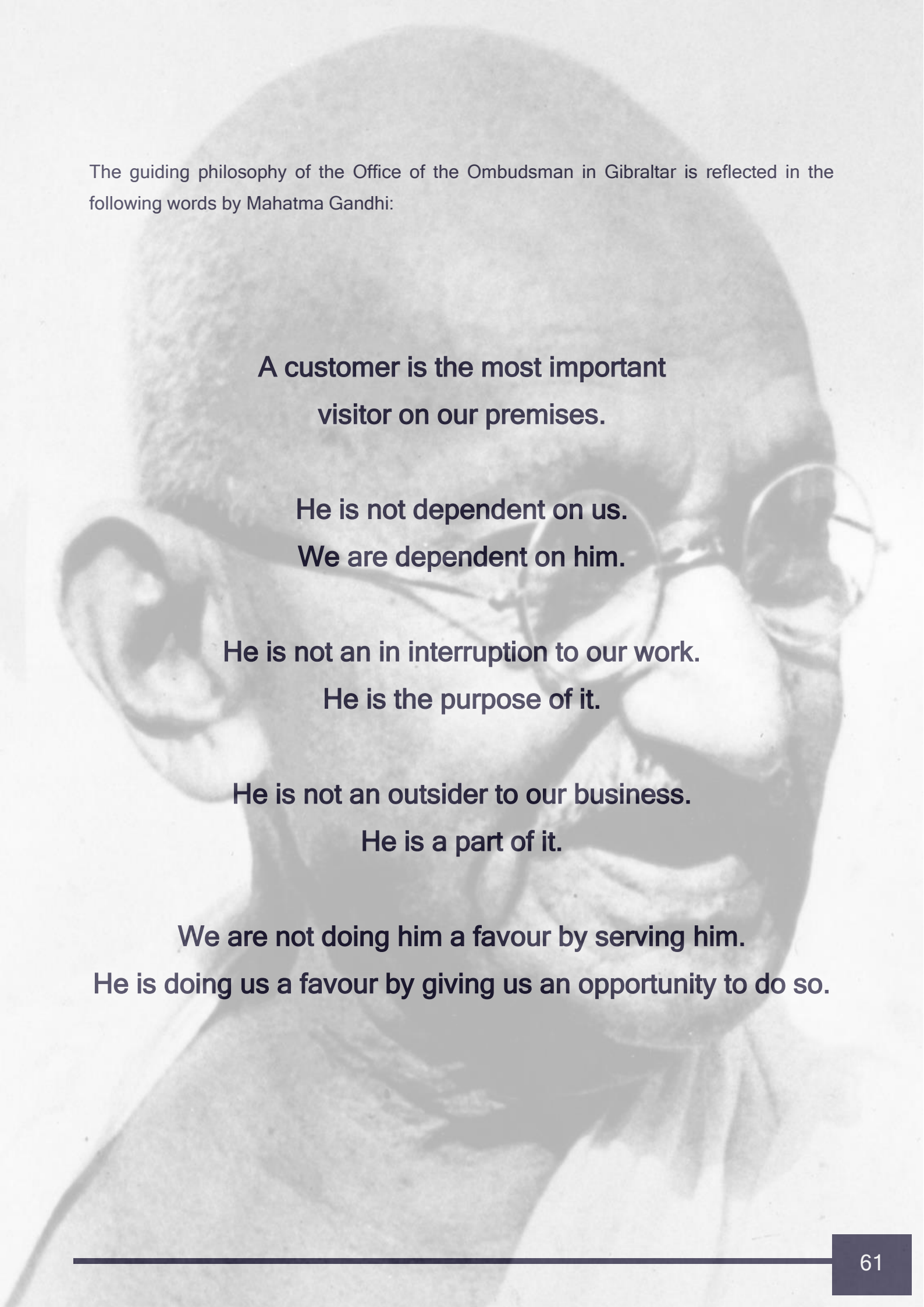
The Public Services Ombudsman Act 1998 created an Ombudsman for Public Services in Gibraltar in order to serve all those who approach him with a grievance that has potentially been caused by the Public Administration.

The Act empowers the Ombudsman to investigate the reasons giving cause to such grievances and, where possible, to suggest changes to the system in order to minimise any repetition of such incidents.

The Public Services Ombudsman therefore serves as an independent "external audit" on the services provided by the public administration encouraging a healthier democracy and a strengthening of our constitutional rights.

In providing its service to the public, the Office of the Ombudsman will comply with the following Principles of Good Governance:

- Independence
- Openness and transparency
- Accountability
- Integrity
- Clarity of purpose
- Effectiveness



The guiding philosophy of the Office of the Ombudsman in Gibraltar is reflected in the following words by Mahatma Gandhi:

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 in interruption to our work.
He is the purpose of it.

He is not an outsider to our business.
He is a 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.

6.3 PUBLIC SERVICES OMBUDSMAN - RECEIPTS AND PAYMENTS ACCOUNT FOR THE THREE YEARS ENDING 31ST MARCH 2020

	Approved Estimate 2019/2020	Revised Estimate 2018/2019	Actual 2017/2018
Receipts			
Contribution from Government - CFC	**£ 467,000**	**£440,000**	**£417,523**
Payments			
Salaries	350,000	336,000	332,224
Overtime	4,000	4,000	1,593
Allowances	6,000	6,000	4,773
Social Insurance Contributions	16,000	15,000	13,286
Pension Scheme Contributions	45,000	39,000	31,306
Relief Cover	1,000	0	0
Sub-total (Personal Emoluments)	422,000	400,000	383,182
General Expenses	3,000	3,000	2,496
Electricity and Water	2,000	2,000	1,642
Printing and Stationery	4,000	4,000	5,177
Telephone	5,000	4,000	3,600
Office Cleaning	5,000	4,000	3,816
Publications	1,000	1,000	272
Conferences, Training and Travelling	10,000	11,000	10,215
Computer and Office Equipment	4,000	3,000	2,131
Clinical Assessors	10,000	7,000	3,996
Office Expenses at St. Bernard's Hospital	1,000	1,000	996
Total Payments	467,000	440,000	417,523

6.4 COMPLAINTS ABOUT THE SERVICE PROVIDED BY THE OMBUDSMAN'S OFFICE

Our Service

We are committed to offering a high standard of service. We take any complaints about our service seriously and aim to address any areas where we have not delivered to the standards we expect of ourselves. We value such complaints and use the information from them to help us improve our services.

If something goes wrong or you are not satisfied with the service provided by the Ombudsman's Office, please tell us. You have the right to complain if you feel that we have failed in the service that we have provided to you.

What is a Service Complaint?

A service complaint is an expression of dissatisfaction from one or more customers or members of the public about the standard of service that we have provided. You can complain about things like:

Standard of Service

Failure to provide a service, or inadequate standard of service.

Process

Failure to follow the appropriate administrative process.

Requirements

How we met your needs. Did you find we investigated your case thoroughly enough?

Treatment

Treatment by or attitude of a member of staff towards you.

Communication

How we communicated with you. Have we updated you adequately enough throughout the investigation?

Time Taken

How long we took to deal with your case. Was it reasonable the time taken to deal with your complaint?

What is not covered by the Services Complaints Process?

There are some things that we cannot deal with through our service complaints handling process. This would include where you are unhappy about our decision on your complaint. The following are not covered by our service complaints process:

- an expression of disagreement about our decision on a complaint or the evidence taken into account in reaching that decision
- an attempt to reopen a previously concluded service complaint or to have a service complaint reconsidered
- a request for information
- issues that are in court or have already been heard by a court or a tribunal

Who can complain?

Anyone can make a complaint to us, including the representative of someone who is unhappy with our service.

How do I complain?

Our 'Service Complaints Form' is available at our offices at 10 Governor's Lane. This can also be downloaded from our website at (www.ombudsman.org.gi).

Note: you need to download the form and save it to your computer before filling it in to save the information.

Complete the Service Complaints Form and send it to the Public Services Ombudsman at the following address:

- **by email**: servicecomplaints@ombudsman.gi ; or
- **by post**: Public Services Ombudsman, 10 Governor's Lane, Gibraltar

We will always ensure that reasonable adjustments are made to help customers access and use our services. If you have trouble making a complaint or would like this information in another language (e.g. Spanish or Arabic) or another format (such as in larger font) please contact us.

You can also make a complaint **by phone** at telephone number (+350) 20046001 or **in person at our office** at 10 Governor's Lane. It is easier for us to resolve complaints if you make them quickly and directly. So please talk to a member of our staff who will try to resolve any problems on-the-spot.

How long do I have to make a complaint?

Normally, you must make your complaint within one month of the event you want to complain about, or of finding out that you have a reason to complain.

In exceptional circumstances, we may be able to accept a complaint after the time limit. If you feel that the time limit should not apply to your complaint, please tell us why.

What happens when I have complained?

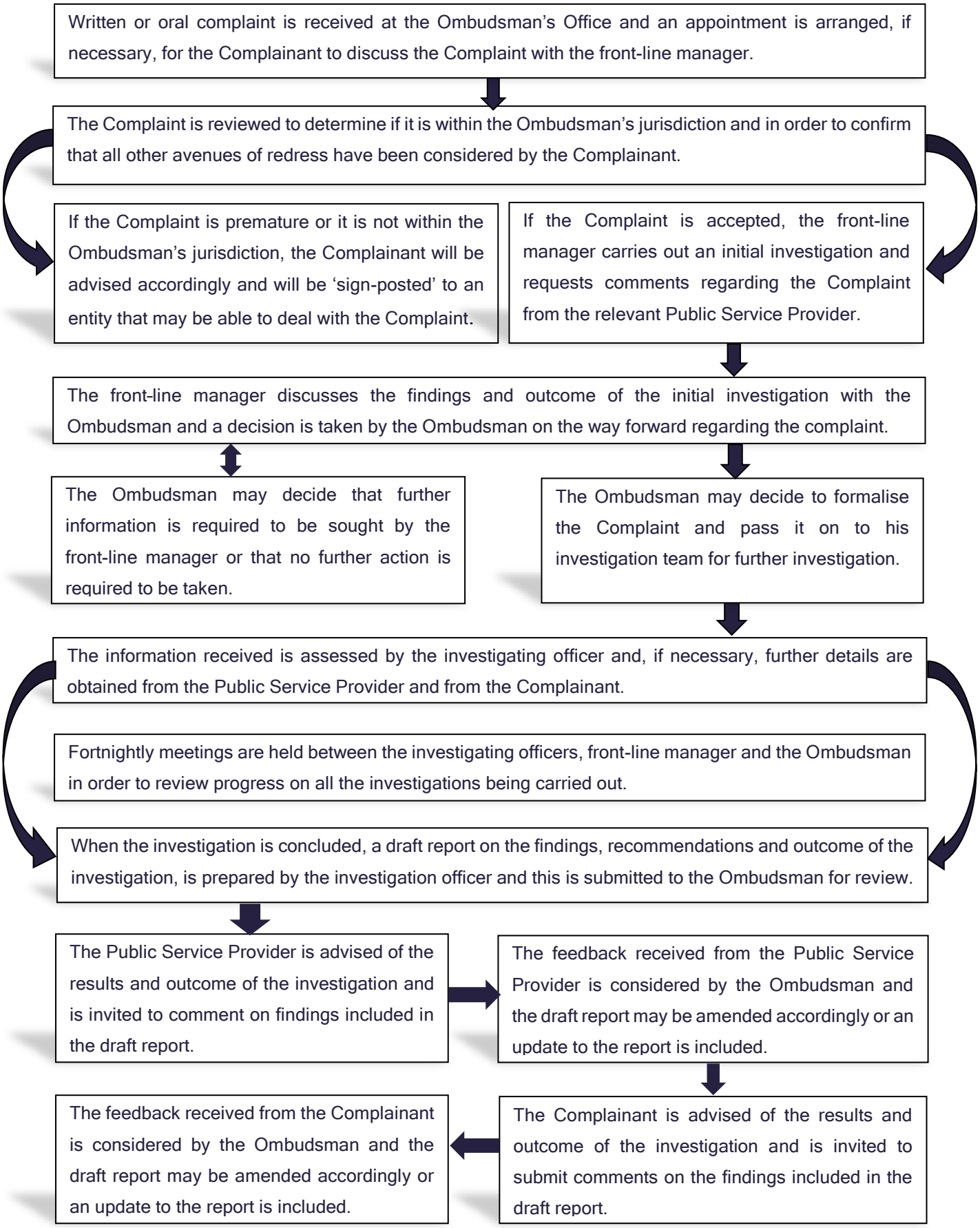
We aim to resolve complaints quickly. This could mean an on-the-spot apology and explanation if something has clearly gone wrong. We will try to take immediate action to resolve the problem whenever this is possible.

If your complaint is not resolved then it will be considered by a senior manager. They will respond to your complaint within twenty working days or less, unless there are exceptional circumstances. Occasionally, we may have to extend this timeline. We will only do so when this will make it more likely that we can resolve your complaint.

What if I'm dissatisfied?

You can take your complaint in person directly to the Public Services Ombudsman. A meeting with the Public Services Ombudsman will be arranged for you, as soon as possible. The Ombudsman's decision on your service complaint will be final. There are no appeal rights or further stages.

6.5 PUBLIC SERVICE OMBUDSMAN - FLOW CHART ON HANDLING OF INVESTIGATIONS



The Ombudsman forms a final opinion on the findings of the investigation and a decision is made regarding the outcome and recommendations.

(a) Complaint is sustained. or (b) Complaint is not sustained.

A copy of the final report is sent to the Chief Secretary for the Chief Minister's consideration of any material deemed in the public interest appropriate to exclude in the Annual Report – as provided for in Section 20 (4) of the Public Services Ombudsman Act.

The Ombudsman's recommendations contained in the reports are followed up by the investigation officer who conducted the investigation. This is to ensure that the necessary action to regularise the maladministration identified in the report is taken by the relevant Public Service Provider.

7) OMBUDSMAN'S CASEBOOK

CIVIL STATUS AND REGISTRATION OFFICE (CSRO)

Case 1

Complaint

The Complainant complained that he submitted an application for Exemption from Immigration Requirements ("Application for Exemption") under section 12(2) of the Immigration Asylum and refugee Act on the 27th November 2015. The Complainant is aggrieved by the fact that there have been numerous delays in the process and that to date, (almost three and a half years later), his application continues to be "deferred".

Background

[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.***

The Complainant made numerous references to the renewal of his civilian registration card. Although that matter was not directly related to this complaint, the Ombudsman referred to that issue (as contained below), by way of introductory background.

The Complainant was first issued with a civilian registration card with one year's validity on the 25th June 2010 on the basis that he was self-employed. A subsequent application was issued in October of that same year noting a change of address. In November 2011 an application was made for the renewal of said card (as a self- employed person). A card with a validity of five years (expiring on 27th July 2016) was subsequently issued by CSRO.

Time elapsed and two weeks prior to the expiration of the card, the Complainant applied for its renewal. Although the original card had been granted on the basis that the Complainant was self-employed, it transpired that he was actually not registered as such. Therefore, in order to renew the card, the Complainant needed to be "classed" under one of the following statutory heads: "job seeker", "employed", "self-employed" or "self- sufficient". Despite not falling within any of the required heads, and despite the Ombudsman being informed that CSRO had issued the Complainant with a civilian registration card, which also enabled the Complainant to obtain a GHA GPMA medical health card, the Complainant alleged that he was in fact issued a healthcare card (valid for one year) without having an id card.

In order to enable the Complainant to renew and since he was not self-employed at the time but living off his savings and carrying out voluntary work, CSRO suggested that the Complainant either describe his status as a "job-seeker" or as "self-sufficient". The Complainant was not a job-seeker. As a result, the written insertion of the "self-sufficient" head on the renewal form was carried out by a CSRO staff member (in the Complainant's presence). The Complainant alleges that, although he protested at the time, that act hampered the naturalisation application which followed. The Complainant is adamant that had he not been described as "self-sufficient" by CSRO on the form, the ensuing Application for Exemption would have been granted without the delays and deferments encountered.

Ombudsman note: the Complainant alleged that he was issued a health card.

Investigation

The Ombudsman wrote a letter presenting the complaint to CSRO setting out the Complainant's grievance and requesting their comments.

Based upon the review of correspondence provided by CSRO, extensive notes and paperwork provided by the Complainant, and from further perusal of email correspondence together with the Complainant's verbal accounts of his version of events, the Ombudsman ascertained the following:

On the 27th November 2015 the Complainant submitted his Application for Exemption on the basis that he was employed, with average earnings stipulated/recorded in the form. The Complainant also provided a copy of a tax code dated November 2015. According to the Complainant, *"[my] application was thoroughly checked at the [CSRO] counter when I handed it in. The CSRO does not accept incomplete applications or applications that don't qualify all and every requirement. This is a de facto acceptance that the file is complete and eligible for British Citizenship. The CSRO person at the counter told me after checking [the papers] that the application [would] sail through the system and that it should take approximately six months."*

The Complainant also stated that when he submitted the form, he had informed CSRO counter staff that he had just left his previous employment and that he was going to spend a few months working on a local voluntary project for which he would receive no remuneration. He presented documents of his investments as proof that he would not be a "burden" to the community. He was however, allegedly told that "*this was not important and [CSRO did not attach] the investment papers to [his] file as they were not needed."*

CSRO later claimed that the fact that the Complainant had ceased economic activity in November 2015, came to their attention during the renewal of his civilian registration card in July 2016. In addition, the Complainant was not registered as either a "job-seeker", "employed" or "self-employed". As a result, CSRO wrote to him on the 1st February 2017 (14 months after the application had been made), deferring the application and requesting evidence of the ability to financially maintain himself, namely, "self-sufficiency".

The Complainant was obviously disappointed to have received notice of the deferral and the request for information, such a long time after the date the application form had been submitted. The time lapse was also at odds with the "*six month*" estimate he had been given at the CSRO counter when the form was handed in.

In response to that request, the Complainant immediately provided a copy of his investments (Ombudsman note: under the established criteria these investments did not meet the threshold for the Complainant to be classed as "self –sufficient"). The Complainant held the view that he should not have been classed as self-sufficient because he did not meet the strict financial criteria nor did he hold private medical insurance. The Ombudsman on the other hand, opined that the description/guidelines for self-sufficiency had not been strictly applied. He was of the view that the stance taken by CSRO was that all the Complainant had to prove was that he would not be a financial burden on the state. Had strict criteria been applied, the Complainant would not have been classed as "self-sufficient" because he would have failed the test.

The Complainants employment status changed in May 2017 when he commenced full time employment. After informing CSRO of that fact, CSRO resubmitted the Application for Exemption in October of that same year. The application was deferred again with evidence of sustained employment sought a year later- in July 2018. By that time, the Complainant had ceased employment (as a result of an allegation of unfair dismissal with tribunal proceedings currently ongoing), and was unable to provide the required proof.

CSRO's stance was and continues to be that the application was not delayed because they had described the Complainant as "self-sufficient" on the 2016 civilian registration card renewal form. According to them, that description was accurate and representative of the Complainants true status at the time the Application for Exemption was made. The Ombudsman concurs with that view.

As matters stand at the time of drafting this report, almost three and a half years have elapsed and the Complainant is in the same position as he was in November 2015, insofar as his Application for Exemption is concerned.

Ombudsman Note

Before delivering his conclusion over this complaint, the Ombudsman notes that during the course of this investigation, particularly at a time proximate to the drafting of this report, the Complainant has made various associated allegations relating to the matter complained of, against other public departments and statutory bodies. Since the Ombudsman is statutorily disallowed from becoming involved in, or opining over parallel disputes or investigations, the content of this report has been based exclusively on the complaint made to this office, namely, whether the Complainant has been the subject of maladministration as a result of delay in CSRO's processing of his Application for Exemption.

The question the Ombudsman must therefore consider is whether the Complainant has been subjected to maladministration by CSRO or whether the delay has been caused by his own failure to provide the necessary evidence or explanations to enable CSRO to grant his application?

Conclusions

The Complainant is preoccupied and aggrieved by two matters. The first being the fact that CSRO staff suggested and proceeded to describe him as "self-sufficient" on the application for the renewal of the civilian registration form (which the Complainant alleges has been the cause of his application not being granted) and second, with the delay in processing the application which has led to the outcome of "deferral" on both occasions. The following paragraphs address each matter in turn:-

1. <u>The Complainant being described as "self-sufficient".</u>

It is apparent and undeniable that at the time the application was made, the Complainant, as he himself has stated, was not a "job seeker" nor was he "employed" or "self -employed". The "self-sufficient" head was therefore suggested to him, reportedly as a means to assist, (which the Ombudsman has no reason to disbelieve). That description was inserted on the form, in the Complainant's presence. It is not the case that the Complainant subsequently discovered that the form had been amended or tampered with, after it had been submitted or whilst it was being processed.

The Ombudsman is also of the view that being classed as "self-sufficient" and the deferrals which subsequently followed, provided the Complainant the opportunity to prove that he was, in fact, not a financial burden to the state. The Ombudsman opines that had the Complainant been described as "employed" or "self-employed" (which he was neither at the time), may have resulted in the application being **denied** altogether, as opposed to deferred (as it was). The description as "self-sufficient" therefor, may well have been beneficial to the Complainant, although he did not agree with this view.

For the above reasons, the Ombudsman seriously doubts the existence of any *mala fides* on CSRO's part.

2. <u>The delay in processing the Application for Exemption.</u>

The Ombudsman holds the firm view that irrespective of the merits of any given application, or the criteria or policy applied in relation thereto or indeed, the actual decision itself- namely whether an application is granted, refused or deferred, the amount of time the Complainant has had to endure from the date of the application (November 2015), to the second deferral (July 2018), can in no measure be deemed to be acceptable from an administrative standpoint. The delay in the Complainant's case constitutes bad practice.

Classification

Delay in the process for a decision on the Complainants Application for Exemption- Sustained

(Report extracted from Case No 1169)

CIVIL STATUS AND REGISTRATION OFFICE (CSRO)

Case 2

Complaint

The Complainant was aggrieved because of the delay on the part of CSRO in providing a decision to her Application.

Background

[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].*

In December 2016 the Complainant applied for Gibraltarian Status under Section 9 of the Gibraltarian Status Act. In January 2018, not having received a decision from CSRO to her Application, the Complainant put her complaint to the Ombudsman. She explained that during the preceding year she had contacted CSRO for updates on the status of her Application and was on each occasion informed that it was being processed and she would be advised of the outcome as soon as it was made known to CSRO. The Complainant provided the Ombudsman with copies of the email exchanges between her and CSRO as well as a copy of her email complaining to CSRO about the delay. The Head of CSRO's ("Head") response on the 12th January 2018 to her complaint explained that applications for Gibraltarian Status under the discretionary provisions of Section 9 of the Gibraltarian Act required thorough checks of all the documentation provided. The process was lengthy as applications were submitted for consideration in batches, and her Application, along with others received at the time, were presently being considered. The Head stated that although he was aware that a significant amount of time had lapsed since she had submitted the Application, he was unable to advise her of a timescale as a number of factors could impact on the evaluation process. Notwithstanding, he assured the Complainant that as soon as an outcome was communicated to CSRO, they would contact her.

Investigation

The Ombudsman referred to Section 9 of the Gibraltarian Status Act which states the following:

Registration of other persons

9. The Minister may, in his absolute discretion, order the registrar to register any person who satisfies the Minister that –

(a) he is a British Overseas Territories citizen by virtue of his connection with Gibraltar, or Gibraltar or Great Britain is his country of origin;

(b) he is a British national;

(c) he is of good character;

(d) he has sufficient knowledge of the English language;

(e) he has his permanent home in Gibraltar;

(f) he has been resident in Gibraltar for a continuous period of ten years immediately preceding the date of application; and

(g) he intends to make his permanent home in Gibraltar.

The Ombudsman contacted CSRO with respect to this complaint and was informed that since the continuous residence period for British nationals to be eligible to apply for Gibraltarian Status was reduced from twenty five years to ten years, there had been a substantial increase in the number of applications. The Ombudsman arranged a meeting with the Chief Secretary to discuss the matter of delays on the part of CSRO when dealing with British nationality applications as well as Gibraltarian Status applications [Ombudsman Note: The Ombudsman was at that time undertaking a systemic investigation into complaints against CSRO for the delay in providing decisions to British nationality applications]. The meeting was held in May 2018 and the systemic issue of delays was discussed with the Chief Secretary who concluded that he would look into the matter and revert.

In June 2018, the Ombudsman wrote to the Head requesting an update on the status of the Application. The Head responded that the Application was received on the 6th December 2016 and was processed, case-worked and submitted for consideration to the Minister for Personal Status (Chief Minister) ("Minister") on the 9th May 2017.

The Head stated that the Complainant had contacted their offices on a number of occasions requesting updates but noted that the replies provided very little new information as the Application was still under consideration and yet to be determined. The Head stated that although it went without say that a shorter time frame would improve the exemption process, they were fully aware of the Minister's significant workload and responsibilities and the fact that careful consideration and evaluation of each case took time as each was assessed individually on its merits. The Head advised that further information or details on the exemption process at ministerial level could be obtained from the Office of the Chief Secretary. Notwithstanding, the Head highlighted that the exemption process had been reviewed in late 2017 and written communication to applicants was now issued periodically in order to keep applicants updated throughout the process. The Ombudsman made further enquiries from CSRO in respect of the information and documentation gathering exercise for the purpose of processing the applications. CSRO advised that upon submission of applications with supporting documentation, the latter was verified for the purpose of establishing that the criteria required was met. Once the verification process was completed, if applications met all the requirements, CSRO would state in their report that the applicant was entitled to apply as they met the criteria and would firmly recommend the approval of the application. The batch of applications would be passed to the Chief Secretary who would review them and raise any concerns or queries with CSRO before these were passed on to the Minister for a decision. CSRO clarified that applications were sent to the Chief Secretary's Office in batches and not on a one by one basis.

The Ombudsman wrote to the Chief Secretary to enquire about the reason(s) as to why at ministerial level, decisions would appear to be unnecessarily delayed, considering that CSRO had undertaken a rigorous verification process. The Chief Secretary responded that Gibraltar had entered a critical time and we should all be aware of the Minister's significant responsibilities and workload against the backdrop of Brexit (United Kingdom's departure from the European Union).

The Ombudsman further enquired from the Chief Secretary as to whether CSRO and his office were considering putting in place an accurate system of information and management of expectations of service users in cases similar to that of the Complainant's. The Chief Secretary responded that arising from complaints received by CSRO, a number of existing processes had been assessed to reduce timeframes and improve overall communication with clients, including referring cases to the Minister on a more regular basis.

The Chief Secretary advised that written communication was now periodically sent out by CSRO to applicants to keep them abreast of developments and added that the prospect of e-Gov should certainly improve systems.

On the 6th September 2018, the Complainant informed the Ombudsman that she had received a letter from CSRO which informed her that her Application had been approved.

Conclusions

The Complainant, a British national who had resided in Gibraltar for a period of over ten years, applied for Gibraltarian Status on the 6th December 2016. The decision to approve the Application was made in September 2018, a period of approximately twenty months elapsed from the date of submission of the Application to the date when the decision was notified to the Complainant. From those twenty months, CSRO took a period of five months to process and case-work the Application, after which, further to verification, the Application was sent to the Chief Secretary (as part of a batch of applications) to review and raise any concerns prior to passing these on to the Minister, a process which took fifteen months. The reason provided by the Chief Secretary for the time taken to provide the decision was given as being due to increased workload and responsibilities of the Minister with responsibility for 'Personal Status' due to 'Brexit'.

The Ombudsman is aware of the impact on workload that 'Brexit' has had at ministerial level as well as at senior civil servant level. Notwithstanding this, the fifteen month period taken to provide the Complainant with a decision on whether her Application for Gibraltarian Status had been approved or not, considering that CSRO had already undertaken the methodical due diligence process and submitted a report when they passed the documentation on to the Chief Secretary to then pass on to the Minister, was unacceptable. During that twenty month period, the Complainant was informed at various stages that her Application was being considered but at no point was she given any substantial information as to why the decision process was taking so long. The fact remains that despite Brexit, the Complainant's case for consideration is another facet of the Minister's role which has to be absorbed and resolved within an acceptable timeframe.

Regarding CSRO's role further to having passed on the Application to the Minister, the Ombudsman notes that CSRO have not provided any documentation to show that they have exercised their duty of care to the service user, in this case the Complainant, in pursuing a decision from the Minister once the Application was sent to his office, and as such, sustains this complaint against CSRO. It is CSRO who are tasked with providing a public service and the only point of contact with service users in cases like the Complainant's.

Classification

Sustained

Recommendations

In order to prevent a recurrence of an unacceptable delay in relation to decisions by the Minister for Personal Status, for approval or refusal of applications for Gibraltarian Status and to provide an adequate duty of care to the service user, CSRO should establish a process to make enquiries on a regular basis with the Minister's office about the status of outstanding applications and update applicants accordingly.

(Report extracted from Case No 1170)

CIVIL STATUS AND REGISTRATION OFFICE (CSRO)

Case 3

Complaint

The Complainants had the following complaints against the CSRO:

1. The CSRO's marriage registry application did not make reference to the CSRO's terms and conditions;
2. The terms and conditions stated that a member of staff would contact them to explain what documents were required to be submitted but Complainants stated that did not happen;
3. The Complainants do not understand why when they attended CSRO offices, Complainant 1 was asked for details of his military service which were difficult to provide and were confidential;
4. Complainants claimed they were not informed beforehand that it was their responsibility to ensure that transport arrangements to the wedding venue were made for the registrar (CSRO's officiant);
5. Complainants offered to pay CSRO for the registrar to make his own transport arrangements with the taxi company to get to the wedding venue but that was refused;
6. Refund of £37.50 for marriage certificates and Apostille refused at CSRO counter due to Complainants not being able to produce a copy of the receipt of payment;
7. Non-reply by CSRO to Complainants email dated 30th October 2018 in which they requested refund for marriage certificates and Apostille.

Background

[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].***

The Complainants wanted to marry in Gibraltar and in April 2018 commenced the wedding arrangements from their country of residence. On the 10th April 2018 and availing themselves of the CSRO's website and online facilities, they signed and returned the CSRO's pertinent form ("Form") to book a registrar to conduct the marriage ceremony. The Complainants noted that until their arrival in Gibraltar in November 2018, shortly before the marriage was due to take place, that was the only Form they had signed and stated that the

Form did not make reference to 'terms & conditions' ("T&C") which CSRO referred them to at a later stage. Further to reviewing the T&Cs they noted that these stated that the T&Cs were not exhaustive and that a member of CSRO staff would contact them to discuss their personal circumstances and any other documents required. The Complainants stated that was never the case.

The Complainants stated that prior to their arrival in Gibraltar days before the wedding, they had not been informed by CSRO either by email correspondence, telephone or any other means of communication that it was their responsibility to ensure that the registrar made it to the marriage ceremony venue on the agreed date and time.

On the 24th November 2018, the Complainants claimed that they were accompanied by a Commissioner for Oaths to the CSRO offices to complete the registration process. The Complainants were taken aback by the fact that it was obligatory for Complainant 1 who had been in the military service to provide CSRO with precise details of his service which included his official number; according to the Complainant this was confidential and generally only disclosed to military personnel or the police service.

The Complainants stated it was at that visit during the registration process that they were informed by a member of CSRO staff that it was their responsibility to book a taxi to get the registrar to the marriage ceremony venue. Complainant 1 explained that he had frequently visited Gibraltar and knew from experience how difficult it would be to pre-arrange a taxi to be somewhere at a stated time so claimed he offered CSRO an additional £60- for the registrar to call a taxi as and when he required to be collected. CSRO refused the offer and the staff member reiterated that it was down to them to ensure that the registrar made it to the wedding venue.

The Complainants stated they paid £37.50 for the marriage certificate and for the Apostille (an official Government issued certificate added to documents so they will be recognised when presented in another country). The Complainants recalled the counter clerk having written out a receipt but could not remember if they picked it up, dropped it or simply lost it. The Complainants highlighted that the production of the receipt became very important later on in the week.

The Complainants claimed to have visited two taxi ranks but stated that taxi drivers refused to take a booking unless credit card details were provided there and then. According to the Complainants, not a single taxi driver could provide them with an estimate of the costs, how to pre-book and pre-pay or the whereabouts of the taxi office. The Complainants contacted

the events coordinator of the wedding venue so that she could make the pertinent arrangements but stated she also refused although she contacted CSRO to enquire about the procedure. She reverted to the Complainants and advised that they would need to organise the registrar's transfer and that someone should meet the registrar outside the venue and pay the taxi. The events coordinator offered assistance by advising the Complainants that they could book a taxi, provide details and payment method and then receive an invoice at the venue when the payment had been processed. According to the Complainants, on the 28th October 2018 they finally tracked down the taxi office, pre-booked and paid for a taxi but were told that they could not be provided with an official receipt with details of passenger name and date and time of collection, something which the CSRO's T&C required them to submit.

By that point, the Complainants stated that they felt it would be inappropriate to be married by an official who was not capable of getting himself to the marriage venue. Furthermore, the Complainants claimed that they were given to understand that female registrars frequently made their own way to the off-site venues, an allegation which the Complainants stated was at a later stage refuted by the Head of CSRO ("the Head"). The Complainants visited CSRO offices to request a change of registrar and claimed to have been told that a change was possible and that the request should be made by email. According to the Complainants, during that attendance they were able to make eye contact with the other registrar who was at the time dealing with other clients and they claimed that she 'gesticulated the actions of riding her bike to the venue' which the Complainants understood clearly insinuated her intentions to make her own way to the wedding venue. According to the Complainants, they were assisted by a third party at that visit to CSRO who confirmed that based on the other registrar's actions the pre booked taxi could be cancelled (the Complainants stated that was not done at that stage).

The Complainants sent their request for the change of registrar to the CSRO explaining their reasons and suggesting that if the present CSRO marriage fees were not sufficient, these should be increased to cover transfer fees for the registrar. A response was received from the Head enquiring as to why they deemed the original registrar unacceptable. The Complainants provided their reasons and the Head replied with the following points:

- The transport arrangements were not ones imposed by the registrar but a prerequisite as contained in the Marriage & Civil Partnerships in Gibraltar Guidance Notes & Registrar Booking Form [Ombudsman Note: These have previously been

referred to within this report as T&Cs and will now be described as “Guidance Notes & Form”];

- the Complainant signed the Guidance Notes on the 10th April 2018;
- If transport was required, CSRO would inform the clients of the need and arrangements to be made, at the time when the couple attended CSRO offices prior to the wedding date;
- CSRO would require written confirmation that the transport for the registrar had been arranged;
- the Head was unable to provide an alternate officiant;
- the Head failed to understand who had given the impression that another registrar would not require transport.

The Complainants wrote back to the Head and stated that whilst they had already explained the reasons for the request to change the registrar, the bride-to-be preferred a female registrar and having seen the latter the previous day, explained that she had agreed that she would be available and happy to replace the other registrar. The Complainants alleged that she had also confirmed that the pre-booked taxi was not required as she was able to make her own way to the venue.

The Head responded that he was surprised that the Complainants had stated the female clerk would be able to perform the ceremony and would not require transport as she and a female colleague were scheduled for counter duties the following week (date of Complainants wedding) and were both aware that transport was habitually required when ceremonies were performed during normal working hours. The Head had spoken to the female clerk the Complainants had referred to and stated that she refuted having spoken to them about the issues raised. She did however recall speaking to a third party who without explanation informed her that the Complainants did not want the registrar to perform the ceremony. The Head had spoken to that third party and the latter had confirmed that the female clerk did not inform him that she could perform the ceremony and did not discuss transport. The third party stated that the female clerk had told him that the Complainants should write to CSRO and explain their position. The Head reiterated he would be unable to provide an alternate officiant.

Complainant 1 was extremely upset at being in effect accused of deceit and untruths and questioned why he would want to ruin what was supposed to be a happy occasion. In a subsequent email that same day, the Complainants requested that the Head arrange for a refund in cash of £37.50 for the following day as they would not need the marriage certificates and Apostille, as the Complainants had decided to cancel the wedding.

The following day the Complainants visited CSRO and stated that whilst the female clerk (which the Complainant had described as the other registrar) confirmed that they had made payment and that this was recorded in the receipt book, 'an obtuse gentleman' (the Complainants stated that the third party assistant had informed them that that was the registrar) refused the refund on the grounds that they could not produce a copy of the receipt. The Complainants explained that after a week of intense pressure and wedding plans being ripped apart, they were unable to control their temper, and prior to leaving CSRO offices, informed them that they would lodge their complaints with the Ombudsman.

Investigation

The Ombudsman put the complaints to the Head and in the interim, requested a copy of the Guidance Notes & Form.

The Ombudsman reviewed the document and noted that the Guidance Notes were made up of ten pages, followed by the Form, followed by two pages for debit/credit card details and on the last page a document check list. In page 6, under the heading 'The Ceremony', paragraph 4 stated:

[1] *"If the ceremony is to take place at an approved venue, it is your responsibility to arrange, provide and pay transport to convey the Registrar to and from the ceremony venue. If transport is required, this office will inform you of the need, and arrangements are to be made when you come in to complete your paperwork. This office will require written confirmation that the transport for the Registrar has been arranged."*

In page 7 the heading 'Cancellation & Amendments' reads as follows:

[2] *"All fees are non-refundable and non-transferrable. Therefore no monies will be returned in the event that you need to cancel a ceremony, change the name of the applicants or change the date of a ceremony that has already been confirmed."*

In page 7 under the heading 'Important' it reads as follows:

[3] *"Finally, please note that the information above is intended as a general guide to the basic legal requirements. It is not exhaustive and does not cover every situation. When you book your ceremony, a member of staff will discuss your own circumstances, the requirements that will apply to you and the documents that you will need to provide."*

Beneath the above paragraph the applicant was requested to sign and date the document to verify that they had read the Guidance Notes.

Complaint (i): The CSRO's marriage registry application did not make reference to the CSRO's terms and conditions

The Head responded to the Ombudsman and explained that all the necessary information in relation to documents and pre-requisites that couples must comply with in order for a marriage ceremony to be officiated in Gibraltar was provided in the Guidance Notes. The Head stated that at the time when the Complainants made their initial enquiry they were provided with a copy of the Guidance Notes. To substantiate this information, the Head provided the Ombudsman with a copy of the page which had been signed by Complainant 1 dated 10th April 2018, confirming that he had read and understood the Guidance Notes & Registrar Booking Form.

The Ombudsman visited the Gibraltar Government website to download and print only the Form (what he believed had been done by the Complainants) but noted that the online document was the same as what had been sent by the Head, i.e. the Guidance Notes followed by the Form, credit/debit card details and document check list. In order to get to the Form, persons accessing the document would have to go through the Guidance Notes.

Complaint (ii): The terms and conditions stated that a member of staff would contact them to explain what documents were required to be submitted but the Complainants stated that did not happen

Regarding a member of CSRO not having contacted the Complainants, the Head provided copies of emails between the Complainants and CSRO. The first email was from the Complainants dated 10th April 2018 in which they thanked CSRO for having contacted them that morning to discuss their future wedding plans. In that email they informed CSRO that they were no longer using the company they had contracted (for the purpose of the wedding arrangements), and noted that they had asked for the time of the wedding to be changed

from 13:00 hours to 14:00 hours for which they also thanked CSRO. The Complainants attached documentation which they understood had already previously been submitted by the company and enquired about card payment methods.

On the 16th April 2018, the Complainants emailed CSRO requesting confirmation of receipt of the documents sent.

CSRO responded on the 23rd April 2018 and confirmed that all documents had been checked and were in order. CSRO requested that they provide their preferred date and time for the wedding ceremony.

The Complainants responded and provided the information and they asked if there was anything else they needed to do. They also enquired about payment methods.

On the 25th April 2018, CSRO emailed the Complainants and attached a receipt of payment for the upcoming ceremony.

Complaint (iii): The Complainants do not understand why when they attended CSRO offices Complainant 1 was asked for details of his military service which were difficult to provide and were confidential

The Head stated that the staff at the Marriage Section of the CSRO were highly experienced and would have no reason to request unnecessary confidential information.

The Head stated that whilst the details of the couple's current occupation/rank/profession was a prerequisite for marriage, there was no reason for the couple to furnish the CSRO with any specific details as stated by the Complainants. The Head had discussed the matter with both counter clerks and they had totally refuted the Complainants' allegations.

Complaint (iv): Complainants not informed beforehand that it was their responsibility to ensure that transport arrangements to the wedding venue were made for the Registrar (CSRO's officiant)

The Head referred the Ombudsman to page 6 of the Guidance Notes (as per [1] above).

The Ombudsman contacted the Head to expand on the part of the Guidance Notes which stated:

"If transport is required, this office will inform you of the need, and arrangements are to be made when you come in to complete your paperwork."

The Head explained that on occasions, when several weddings take place consecutively at the same venue, as the registrar is already at the venue because of the first ceremony, there is logically no need for further transport arrangements.

Complaint (v): Complainants offered to pay CSRO for the Registrar to make his own transport arrangements with the taxi company to get to the wedding venue but that was refused

The Head referred to the Complainants' suggestion of CSRO organising the transport arrangements in future, instead of those arrangements having to be made by the persons getting married -of course for a fee. The Head reverted by confirming that the suggestion had been noted and taken on board but highlighted that was the first time that they had been made aware of any difficulties in arranging transport. At a subsequent meeting between the Head and the Ombudsman, the Head stated that logistically it would be very difficult for CSRO to make those arrangements. He explained that it was usually the wedding planner company that handled those arrangements and pointed out that the Complainants' arrangements had originally been initiated by a wedding planner company.

The Ombudsman noted the difficulties highlighted by the Complainants in booking a taxi and decided to contact the taxi service to experience the issues first hand. The Ombudsman found the contact details for the taxi office online at www.gibtaxi.com and telephoned their offices. The telephone was answered promptly and the Ombudsman enquired on how to go about booking a taxi for the purpose of transporting a local registrar to a wedding ceremony venue. The Ombudsman was informed that they would require the details of the person contracting the service, details of the passenger, pick up and drop off locations, date and time. The Ombudsman enquired if credit card details were required and he was informed that they were not; payment would be directly to the taxi on the day.

Complaint (vi): Refund of £37.50 for marriage certificates and Apostille refused at CSRO counter due to Complainants not being able to produce a copy of the receipt of payment

Complaint (vii): Non-reply by CSRO to Complainants email dated 30th October 2018 in which they requested refund for marriage certificates and Apostille

The Head confirmed that the Complainant had not received a written reply to his email but he had provided a verbal reply at the CSRO counter. The Head stated he was called by staff to the counter because of the Complainants' unacceptable outburst at the clerk attending to them; the Complainants had demanded 'in a rather deplorable tone' a refund for the marriage certificates, fees which the Head reiterated, were non-refundable and non-transferrable (as set out in the Guidance Notes). Notwithstanding this, the Head stated he had been prepared to exceptionally refund the fees upon production of the receipt. The Head stated that the Complainants insisted that they had not been given a receipt and made no attempt to listen to what was being said, thereby failing to hear his name and grade. As a result, the Complainants believed him to be the registrar who was supposed to have married them and who required the taxi to be organised beforehand.

Conclusions

Complaint (i): The CSRO's marriage registry application did not make reference to the CSRO's terms and conditions – Not sustained

The Ombudsman did not sustain this complaint. The signed copy of the form substantiated that the Complainants had read and understood the Guidance Notes.

Furthermore, when the Ombudsman visited the Gibraltar Government website to download the Guidance Notes & Form he noted that the latter was located towards the end of the document, after the Guidance Notes, so the Complainants had an opportunity to refer to the Guidance Notes on the way down the document to arrive at the Form.

Complaint (ii): The terms and conditions stated that a member of staff would contact them to explain what documents were required to be submitted but Complainants stated that did not happen – Not sustained

The emails provided by the Head confirmed that the Complainants had been contacted by CSRO, the documents required had been submitted and duly checked by CSRO and confirmed to be in order.

Complaint (iii): The Complainants do not understand why when they attended CSRO offices he was asked for details of his military service which were difficult to provide and were confidential – Unable to Determine

Whilst the Complainants claimed that Complainant 1 was asked by CSRO staff about confidential details of his military service, the Head, further to having spoken to the pertinent staff members, refuted this allegation.

This situation is one where it is one party's word against the other and there is no evidence for the Ombudsman to establish who was telling the truth. Notwithstanding this, based on the Head's statement, this information was irrelevant for the purpose of the marriage.

Complaint (iv): Complainants not informed beforehand that it was their responsibility to ensure that transport arrangements to the wedding venue were made for the Registrar (CSRO's officiant) – Not sustained

The Ombudsman did not sustain this complaint as he was satisfied that this information was contained in the Guidance Notes in page 6, under the heading 'The Ceremony' paragraph 4 as follows:

"If the ceremony is to take place at an approved venue, it is your responsibility to arrange, provide and pay transport to convey the Registrar to and from the ceremony venue. If transport is required, this office will inform you of the need, and arrangements are to be made when you come in to complete your paperwork. This office will require written confirmation that the transport for the Registrar has been arranged."

Regarding the CSRO's requirement for written confirmation that the transport for the registrar had been arranged, the Ombudsman noted the Complainant's statement that the taxi company would not provide an official receipt with details of passenger name and date and time of collection. If that was indeed the case, CSRO would have been aware from previous cases that this was not provided by the taxi company and a letter from the Complainants confirming the arrangements would have sufficed, especially as the above section does not specify who has to provide the confirmation.

Complaint (v): Complainants offered to pay CSRO for the Registrar to make his own transport arrangements with the taxi company to get to the wedding venue but that was refused – Not sustained

The Ombudsman did not sustain this complaint. As explained in the conclusion of Complaint (iv) above, the current procedure in place with regard to transport for the registrar to the wedding ceremony venue as per the Guidance Notes is that the onus is on the couple getting married, or their representative, to make the pertinent arrangements not the CSRO.

The Ombudsman did not encounter any problems when he made enquiries over the phone with the taxi company on how to go about booking a taxi for the registrar. The Ombudsman found the system in place to be quite straightforward and did not require the person booking to provide credit/debit card details.

Whilst the Ombudsman understands that the circumstances of the Complainants were such that they had no one they could delegate the responsibility of payment for the taxi at the time when the registrar was dropped off for the wedding ceremony, the Ombudsman found that Complainant 1's concerns to book a taxi based on past experiences were unfounded in this case.

Complaint (vi): Refund of £37.50 for marriage certificates and Apostille refused at CSRO counter due to Complainants not being able to produce a copy of the receipt of payment – Not-sustained

The Ombudsman did not sustain the above complaint. As an exception to the rules which clearly stated that fees were non-refundable and non-transferrable, the Head stated that he would refund the £37.50 upon production of the receipt. The Complainants were unable to produce this.

Although not sustaining the complaint, the Ombudsman noted that the Head had agreed to exceptionally refund the £37.50 upon presentation of the receipt. The Complainants were not able to provide said receipt but verification of payment of those fees could be made by CSRO from their office receipt book where there would be a copy of the receipt made out to the Complainants. Under those circumstances, the Ombudsman suggested that CSRO refund the £37.50.

Complaint (vii): Non-reply by CSRO to Complainants' email dated 30th October 2018 in which they requested refund for marriage certificates and Apostille – Sustained

The Ombudsman sustained the complaint of non-reply. It has been established in the course of this investigation that the Complainants last attendance at CSRO counter ended abruptly. Under those circumstances and upon receipt of the Complainants email, the CSRO should have replied to the Complainants concluding the matter.

Classification

Complaint (i): The CSRO's marriage registry application did not make reference to the CSRO's terms and conditions – Not sustained;

Complaint (ii): The terms and conditions stated that a member of staff would contact them to explain what documents were required to be submitted but Complainants stated that did not happen – Not sustained;

Complaint (iii): The Complainants do not understand why when they attended CSRO offices he was asked for details of his military service which were difficult to provide and were confidential – Unable to Determine;

Complaint (iv): Complainants not informed beforehand that it was their responsibility to ensure that transport arrangements to the wedding venue were made for the Registrar (CSRO's officiant) – Not sustained;

Complaint (v): Complainants offered to pay CSRO for the Registrar to make his own transport arrangements with the taxi company to get to the wedding venue but that was refused – Not sustained;

Complaint (vi): Refund of £37.50 for marriage certificates and Apostille refused at CSRO counter due to Complainants not being able to produce a copy of the receipt of payment – Not sustained; However, the Ombudsman suggested that CSRO refund the £37.50 to the Complainants on the strength of the copy of the receipt available from their office receipt book where there would be a copy of the receipt made out to the Complainants.

Complaint (vii): Non-reply by CSRO to Complainants email dated 30th October 2018 in which they requested refund for marriage certificates and Apostille – Sustained.

Update

As a gesture of goodwill, and further to the Ombudsman's suggestion, the Head of CSRO exceptionally agreed to the refund of £37.50.

(Report extracted from Case No 1185)

GIBRALTAR ELECTRICITY AUTHORITY (GEA)

Case 4

Complaint

The Complainant had purchased a new apartment in Gibraltar. He explained that to his mind he had experienced a number of failings in service-delivery relating to his electricity account with the Gibraltar GEA. His email of complaint to the Ombudsman Office and accompanying letters set out the following issues:

1. Electricity account not opened in his name at the time of application and no follow-up contact made with the Complainant.
2. Date of liability not honoured, this being 5th March 2018.
3. Evidence of confusing numbering on the meter next to his, not addressed by GEA.
4. Unsatisfactory complaints procedure.

Background

[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.***

1. Electricity application

Even though the Complainant visited the GEA's customer services counter on 17th July 2018 and was informed that access to set up the electricity account would be gained from the site office and as such there was no need for him to be present, the electricity account was never set-up as allegedly agreed.

No follow-up contact was made with the Complainant to reschedule the appointment and he only found out that the account was not in his name in February 2019 when he requested an electricity bill. Subsequently, there was another alleged failure regarding the setting-up of the account when the transfer of accounts from the developer to the owner, also failed to take place.

The Complainant feels he has been blamed by the GEA for not having been present at the first appointment (17th July 2018). The Complainant feels frustrated with this "finger pointing" as he was, according to his version of events, informed that there was no need for him to be present. He is also being accused of failing to reschedule this appointment, but the

Complainant alleges he was not informed that the electricity set up had been unsuccessful, and for that reason alone, would not have been aware that it needed to be rescheduled.

2. Commencement date of liability.

An officer ("Officer") from the GEA allegedly accepted responsibility for these oversights and on the 20th February 2019 apologised verbally to the Complainant and his wife in person. According to what the Complainant perceived, the decision to apologise was not taken out of the Officers own initiative but after what appeared to be a conversation with management in the 'back office' at the time. The Officer confirmed on two occasions that the Complainant would only be liable for usages from 5th March 2019 and the meter reading would be taken as from that date and set out in his first bill.

The fact that the Complainant attended the GEA office on the stated date and spoke to said Officer has been acknowledged by the GEA customer services manager (confirmed via a CCTV recording). However, the decision to invoice the Complainant from the specified date (5 march 2019) "has not been honoured". Instead, as a resolution, the Complainant was told that usage from 17th July 2018 to 21st September 2018 would be charged to the residential developer, but that he would be liable from 21st September 2018 onwards. The decision was based on the fact that the electricity supply, although not in the Complainant's name, meant that he was able to consume the utility whilst living in the Property.

The Complainant, is not at all happy with this decision. He states that the Property had been empty since July 2018 apart from a '*couple of weeks earlier this year* (2019)' and, that more importantly, the developer had been making use of it during the construction and snagging phases. The unit itself had also been utilised for storage. The Complainant therefore argues that the account was never set up in his name and as such he should only be liable as from 5th March 2019 onwards (as he had been previously informed).

3. Confusing numbering on meter and high reading

The opening reading which the Complainant is being made liable for is 468 (£265.18) which according to the Complainant does not reflect the alleged low usage of a flat that has not been lived-in. The Complainant has no confidence in this meter reading especially since it was never mentioned in previous correspondence but only in the final stages of the complaint stage.

The Complainant took photographs of the meters which he alleged showed confusing numbering, (Two meters had '26' noted on them and the pipes were crossing over each other). The Complainant therefore questioned whether that may have resulted confused figures on the issued bill. In fact, the Complainant stated, the adjacent meter, also labelled 26, had a reading of 580 which fell in line with the reading of 468 taken in September 2018. The issue has not been addressed by Gibraltar Electricity Authority (GEA) in their letters to the Complainant.

4. Complaints procedure.

The Complainant is not happy with the complaints handing procedure. The procedure is not published and even though he was verbally informed that letters of complaint should be addressed to the CEO, he found that he received replies from the Customer Service Manager who had dealt with his complaint at the initial stage. There was therefore no 'two-tier stage complaints procedure' as he was led to believe.

The conclusion of the exchanges in correspondence entered into between the Complainant and the GEA was, in essence, that the GEA considered that since the Complainant became the legal owner of the flat in question on the 8th June 2018, units of electricity consumed from that date would have to be settled by him, and that payment should have been made not later than sixty days from the date of the bill. However, The GEA assured the Complainant that since the Ombudsman would be conducting an investigation into the complainant, recovery of the amount due would be deferred until such time as the Ombudsman delivered his findings.

Investigation

After reviewing all correspondence provided by the Complainant, the Ombudsman presented the Complaint to the GEA in writing. The Ombudsman's letter to the GEA Chief Executive ("CEO") set out the complaint in detail, (as contained in the "Background" section hereinabove). Comments were sought from the GEA under each specific heading.

Electricity Application

The GEA explained how the Complainant attended their offices on the 17th July 2018 to submit the form for electricity supply upon which he was issued with an appointment for inspection of the electrical installation within the Property for the 28th August at 9:30am.

The letter continued to state how it had always been GEA practice to advise all applicants that they, or someone appointed by them, must be present at the premises to be inspected at the time of the appointment. It further stated how only on the third appointment was someone able to inspect the electrical installation at the Property.

GEA explained how in the majority of similar cases, the onus to contact their Customer Services Office to reschedule an appointment lies with the applicants, simply because any periods of non-supply would cause an inconvenience to owner/occupiers. In specific relation to the Arches development, arrangements had been made with the developer for the electricity supply to be left connected until such time as homeowners had submitted their applications, so as not to inconvenience individuals in having to wait for their electricity supply to be connected.

It was not until February 2019 that the Complainant made contact with the GEA to inform them that he had not received an electricity bill and that he required one for other purposes. According to the GEA, since having submitted his application form in July 2018, he did not query the fact that he had not been paying electricity consumption over a six month period.

Commencement date of liability

The CEO confirmed that the Officer who dealt with the Complainant at the GEA counter in February and March 2019, had only recently been transferred to the Rosia Road offices and was not aware of the arrangements in place (the Ombudsman was unsure whether that ignorance related to the fact that appointments had to be rescheduled by applicants or that it had been agreed with the developer that the electricity supply would remain connected until such time as the property owners submitted their individual applications.)

Insofar as the Complainant's version of events is concerned, namely, that the Officer confirmed her decision on the date of liability with management in the "back office", the CEO rebutted said version, further stating that the alleged confirmation never occurred. According to the CEO, the Complainant made a supposition which he would not have been able to either confirm or deny, since any conversation would have taken place in private, behind closed doors.

It was, according to him, also important to note that on neither occasion that she attended upon the Complainant, did the Officer state she had spoken to or conferred with Management regarding the liability matter.

The CEO did admit in his letter to the Ombudsman (and to the Complainant in a telephone conversation on the 7th May 2019), that the Officer had provided him with erroneous information "*due to the fact that she had only been at the Rosia Road offices for a short period of time and was in fact inexperienced, and uninformed of the arrangements made with the developer*". In the telephone conversation, an apology was offered to the Complainant for having been misinformed as to the date of liability, and was also told of the decision taken by GEA in terms of charges for the electricity consumed. Said decision was based on the fact that the developer had advised that they would pay for all charges in relation to all properties still under their control or use up to the 21st September 2019.

On that date the GEA visited the development and obtained meter readings for each individual meter from which homeowners would then be liable for any electricity consumption made thereafter. The meter reading taken relating to the Complainant's property was 468, and instructions were issued to AquaGib for the Complainant's bill to be adjusted to reflect said reading.

In their letter, the GEA also disputed the Complainants assertion that the Property had remained empty since July 2018 apart from *"a couple of weeks earlier this year (2019)"*. Records obtained from the Smart Meters (provided to the Ombudsman) showed that there had been constant consumption since September 2018. It was only after the reading taken in April 2019 that the Property appears to have been vacated gradually and the electricity supply disconnected on the 29th July 2019, at the Complainant's request.

Confusing numbering on meter and high reading

The electricity bill issued by AquaGib Limited with a value of £265.18 relates to the period 21st September 2018 up to the 6th April 2019 and corresponds to the Property's meter, as explained to the Complainant in the telephone conversation referred to earlier in this report.

The CEO also questioned how the Complainant had formulated his allegation of confused readings and had obtained photographs of meters. That could, in his view, only have been so by the Complainant illegally entering/trespassing meter rooms to which he had no right of access and which, more importantly, could have posed a health and safety risk to him. In any event, the allegation of "confused readings" were denied and as explained to the Ombudsman at a subsequent meeting held, regardless of any labelling which may have been present or attached to meters, the GEA was confident that all supplies and meters at the Arches had been properly verified and matched accordingly.

Complaints Procedure

According to the CEO, the Complainant was advised that if he wished to make a complaint he was to write in to (address and contact name provided) and that upon receipt of such mail, an internal investigation would be, and was conducted in this case.

Conclusions

This complaint was not easy to reconcile for the reason that the Complainant and service provider both offered the Ombudsman very distinct versions of events, based on fact.

The Complainant was understandably frustrated by the inaccurate/erroneous information he was given by a GEA employee and which he relied upon, whereas the GEA continues to seek payment for a service provded. Irrespective of whether the Property was occupied by the Complainant at the time and independent of whether the service contract was registered under his name or otherwise, the supply of electricity was a live utility, available to the Property for immediate use by the occupier. Consumption undeniably took place.

For the GEA to have had an "*inexperienced"* employee, "*uninformed of the arrangements made with the developer"* was not only undesirable but perhaps even negligent on the part of the utilities provider. That aspect fell well short of the administrative standard expected of a reputable energy provider. Credit however should be given to the GEA for having apologised to both the Complainant and Ombudsman for that error. Based upon the admittance by the CEO that their Officer was "inadequate", the Ombudsman accepts the Complainants version of events in relation to the information provided to him, that it was not necessary for him to be present for the connection of the electricity account. Despite that, the associated allegation that confirmation was sought from the "back office" cannot be accepted or denied by the Ombudsman, since the version given by the Complainant is merely a supposition which he did not witness.

Although the wrong information was indeed given to the Complainant in relation to the date from which he would be liable for payments, that information cannot be relied upon to obviate liability when (1) there was an agreement in place between the GEA and the developer, specifically in relation to dates as from when the developer would no longer be liable and responsibility for the settlement of bills would pass to individual owners and (2) there is no denying the fact that there was an electricity supply to the Property on the dates in dispute and, that the Complainant had already taken legal ownership over the Property prior to those dates, by way of lease. Additionally, the consumption readings made available

to the Ombudsman from September 2018 to April 2019 do show regular use of electricity over that period.

That consumption must be paid.

The Ombudsman would suggest that the Complainant settle the amount due and owing and if in fact can prove that consumption was used by the developer, he should seek to recover said monies from the developer in any private and parallel action. That is a matter which need not concern the GEA. The fact that a utilities service was available to the Property legally owned by the Complainant is a determining factor in establishing responsibility for payment.

In relation to the allegation of the confusing readings, although as pointed out by the GEA, the Complainant should not have gained access to the meter rooms, it appears that despite that, no explanation has been given to him in order to allay his concerns. The Ombudsman is satisfied with the GEA's reassurance that all supplies and meters had been properly verified and accordingly matched but admittedly, an explanation in clear terms should be provided to the Complainant if it hasn't been done so already.

Finally, and in relation to the Complaints procedure, although the Complainant was provided with an email address and his complaint was subsequently accepted and addressed, it would be advisable that such an important public body within our community, publish leaflets and incorporate a section within its website informing service users of their rights and of complaints procedures available. In fact, the Ombudsman would take this opportunity to urge all essential service providers within Gibraltar to do so.

Classification

1) Electricity account not opened in his name at the time of application and no follow up contact made with the Complainant- **Sustained** (although the GEA had no obligation to do so).

2) Date of liability not honoured, this being 5th March 2018- Not Sustained (the date of liability communicated to the Complainant was erroneous and not binding)

3) Evidence of confusing numbering on the meter next to his, not addressed by the GEA- **Sustained** (no explanation given)

4) Unsatisfactory complaints procedure-Sustained in part.

Recommendation

In relation to the financial issue (namely, payment of the outstanding invoice), the Ombudsman can only recommend and not enforce or Order. With that proviso in mind, the Ombudsman would suggest that the Complainant settle the outstanding bill and recover all or part thereof from the developer if it is just and reasonable to do so.

It is undeniable that electricity was consumed in the Property on the specified dates and as such, the GEA should be paid for the service.

Update

Further to the issue of this report the Complainant remained dissatisfied with the commencement date of liability issue.

He further stated that he had only accessed the meter room because it was situated next to the lift with no signs or messages warning not to enter. This room was left open from when the development was complete until he questioned meter usage/confusion, at which point the room was locked.

(Report extracted from Case No 1204)

GIBRALTAR HEALTH AUTHORITY (GHA)

Case 5

Complaint

The Complainants were a male and female couple where for ease of reference, the female will be referred to in some sections of this report as the Patient ("the Patient") and the male will be referred to as the Partner ("the Partner")].

The Complainants were aggrieved against the GHA due to the following:

(i) Inappropriate treatment given to the Patient by the A&E Doctor in St Bernard's Hospital.

(ii) Erroneous results given to the Patient in relation to a HCG test carried out on the 20th July 2016 which meant that the Patient carried a non-viable foetus without knowing for approximately three weeks.

(iii) Traumatic situation unnecessarily augmented by the Consultant Gynaecologist's alleged ill-treatment of the Complainants and his resistance to administering the Patient with Anti-D, even though NHS guidelines allegedly recommended it.

Background

[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].***

The Complainants explained by way of background that on the 17thJuly 2016, when the Patient was seven weeks pregnant, she woke up to light bleeding and lower back pain, as a result of which, the Complainants attended the A&E Department at St Bernard's Hospital. Whilst there, the Patient was attended by the A&E doctor ("A&E Doctor") who after examining the Patient, he prescribed HCG blood tests ("HCG test") to ascertain whether the pregnancy was progressing normally. The Complainant further explained that the A&E Doctor advised that the HCG test was to be repeated three days later (20thJuly 2016) to compare levels. They stated that the A&E doctor did not recommend scanning as he was of the opinion that at the early stage of 7 weeks, it would not have been possible to "*see anything*".

By way of further background, the Complainants informed the Ombudsman that they brought to the attention of the A&E Doctor the fact that the Patient's blood was RhD negative and the Partner's RhD positive. They explained that during the Patient's first pregnancy, they were counselled about the risks of this.

According to the UK National Health Service ("NHS") website, this meant that there was a possibility that the foetus could inherit the Partner's RhD positive blood type. The website stated that during any pregnancy "*small amounts of the foetus's blood can cross the placenta and enter the mother's blood stream and if this transfer of blood occurs from a RhD positive foetus to a RhD negative mother, then the mother's immune system will see the foetus's blood as "foreign" and she will produce antibodies which destroy all the foetus's blood cells in the mother's circulation*". The NHS website further stated that the medical profession were very aware of this problem and were able to *"prevent the mothers' immune system from "learning" to make RhD antibodies for herself by giving her injections of Anti-D gammaglobulin".*

The Complainants informed the Ombudsman that the Patient was administered with Anti-D ("Anti-D") at 28 weeks gestation during her first pregnancy.

Given the above, the Complainants informed the Ombudsman that, at the time of the events, the Patient was concerned that the bleeding incident might have caused her to produce antibodies against the foetus in case the foetus was RhD positive. The Complainants explained that they shared their concerns with the A&E Doctor and they were allegedly informed by him after consulting with the duty Consultant Gynaecologist ("Consultant Gynaecologist") that at the stage the pregnancy was at (7 weeks), it was not necessary to administer the Anti-D.

On the 20th July 2016, the Complainants attended the A&E Department once again where the Patient undertook the second HCG test. The Complainants were advised by the nurse who undertook the test to phone the A&E Department later in the afternoon to obtain the results. The Partner explained that he phoned at around 2pm and the nurse "*confirmed to me (him), we suppose after consulting with the duty doctor, that the levels were okay and therefore the pregnancy was viable".*

On the evening of the 1st August 2016 the Patient had a further discharge of blood and a "*mucus-like opaque substance*" accompanied by lower back pain and cramps. As a result, they attended the Maternity Department at St Bernard's Hospital on the 2nd August 2016 given that the Patient was very concerned about the pregnancy and its potential viability.

The Complainants explained that they were seen by the Consultant Gynaecologist who happened to be on duty. They further commented that the Consultant Gynaecologist was allegedly *"rude*", "*uncooperative*" and "*lacking in empathy*" for their "*distressing*" situation. They also stated that the Consultant Gynaecologist commented that it was very irregular for him to see patients without a prior appointment and further stated that he "*did not have time to lose on scared patients that gleaned their information from the Internet*". The Complainants informed the Ombudsman that it was only after much "*anxious pressure*" from them, that the Consultant Gynaecologist reluctantly consented to undertake a Transvaginal Ultrasound (a medical ultrasonography that applies an ultrasound transducer in the vagina to visualize organs within the pelvic cavity). The ultrasound showed a foetus that was 6.5 weeks old with no heartbeat. At that point the Complainants explained that the Consultant Gynaecologist informed them that it could be that they had their dates wrong and that the pregnancy was not as advanced as they had suspected. He furthermore explained to the Complainants that the lack of a heartbeat could be as a consequence of the same. The Complainants stated that the Consultant Gynaecologist did not offer to administer the Patient with anti-D even though she had recently experienced a recent blood loss and he suggested a repetition of the ultrasound scan on Tuesday 9thAugust 2016, and another HCG test. They commented "*He gave us no further advice or information and sent us on our way"*.

On the 6thAugust, 3 days later, the Patient started "*bleeding profusely*" and consequently attended the A&E Department where they were attended to by the A&E Doctor who happened to be on duty again that day. They explained that while revising the Patient's notes and the HCG test values of the 17thJuly 2016 (undertaken by him) and 20thJuly 2016 (undertaken by one of the A&E nurses), the A&E Doctor informed the Complainants that contrary to the information verbally given to them via telephone on the 20th July in that the HCG test values were good and the pregnancy was "*viable*", in actual fact, the values of the 20th July were not good and the foetus had "*probably already started failing then, and that it was dead now*". The Complainants claimed that the A&E Doctor "*blamed*" them for not enquiring further as to the facts behind the HCG test values stating that they should not have "*trusted the system*". He allegedly explained to them that the HCG test value should have doubled in those three days and they had not, and they should have known that they had not. The Complainants commented that at that point they argued that they had done everything that they had been advised to do and that they had not thought to doubt the expertise of the hospital staff to give them the right information. They however maintained that the A&E Doctor "*persisted*" on blaming them for the oversight in what they believed was a "*blatant endeavour to take blame away from the GHA*". The Complainants informed the

Ombudsman that the A&E Doctor refused to divulge who the duty A&E doctor responsible for having checked and compared the HCG test results had been on the 20th July.

The A&E Doctor subsequently contacted the on call gynaecologist who once again, happened to be the Consultant Gynaecologist. As a result of the call, The A&E Doctor informed the Complainants that the Consultant Gynaecologist recommended that the Patient be administered medication for a Medical Management of Miscarriage ("MMM"). The A&E Doctor explained to the Complainants that one of the reasons for suggesting a MMM was due to the fact that the Consultant Gynaecologist had only slept three hours in the last twenty-four and would not trust himself with a Surgical Management of Miscarriage ("SMM"). The Complainants once again enquired about the Anti-D, however the A&E Doctor informed them that the Consultant Gynaecologist was of the opinion that this was still not necessary.

The Complainants informed the Ombudsman that given the above, they had become apprehensive about taking the medication for a MMM and sought an explanation from the on-call Surgical Non Consultant Hospital Doctor ("Surgical NCHD") responsible for accepting the Patient into the Surgical Ward at St Bernard's Hospital for the night.

The Complainants concurred that, as opposed to the A&E Doctor and the Consultant Gynaecologist, the Surgical NCHD was "*empathic*" and "*kind*" and based on his information, the Patient decided to take the medication for a MMM. The Patient consequently remained in St Bernard's Hospital and was seen in the morning by the Consultant Gynaecologist who after taking a history of the Patient's symptoms from the 17th July 2016 onwards, suggested that an immediate Transvaginal Ultrasound was required to see whether everything had been pushed out by the MMM or if, alternatively, a SMM was required. The Complainants explained that in their conversation with the Consultant Gynaecologist, they once again reiterated their concerns with regards to the Patient's RhD negative blood type and the possible need for Anti-D. They informed the Ombudsman that apart from the fact that they had been well aware of the potential risks of RhD negative blood type and pregnancy, they had spent a "*very anxious*" night researching the subject and the proper NHS procedure in these circumstances and according to their findings, they had reached the opinion that it was necessary to have the Anti-D within 72 hours of any bleeding or else the injection would have no effect. The Complainants claimed that the Consultant Gynaecologist did not agree that the Anti-D was necessary and informed the Ombudsman that seeing as there was a reluctance to administer the Patient with Anti-D, they challenged him and asked about the guidelines in place in the GHA with regards to the matter and stated that as a result, the Consultant Gynaecologist became "*highly defensive*" and reminded them that they were not doctors. They stated, "*He proceeded to search the internet himself to prove us wrong. After*

a few minutes of online searching, he abruptly said, we have to scan now". The scan revealed that the MMM had failed and that the foetus was still within the Patient. At this point, the Consultant Gynaecologist immediately requested a SMM and informed them that that he would administer the Anti-D injection after all. The Complainants commented "*It was evident that he had reached this conclusion after checking on the Internet and realising that his guidelines were outdated*."

The Complainants concluded their letter of complaint by stating that the SMM was "*scheduled quickly, and it was the Consultant Gynaecologist's intention to take the Patient directly from his office to the surgery. The nurse, who had been present throughout, said that this was not correct procedure and that the Patient should first go to the Surgical Ward to prepare for the procedure. The Consultant Gynaecologist insisted it was not necessary. Outside his office, the nurse severely criticised his manner, attitude and behaviour. She nevertheless insisted on following correct procedure and taking the Patient back to the Surgical Ward to prepare her for the SMM. The Patient had the procedure and is now in recovery. While we do not blame the miscarriage on the GHA, we do nevertheless strongly condemn the actions of two of the practitioners throughout the series of events occurring between the 17th July and the 7th August, 2016*".

The Complainants were aggrieved with the experience they had had at the GHA and lodged their complaints with the Ombudsman.

Investigation

The Ombudsman requested comments from the doctors who were the subject of the complaint via the Medical Director of the GHA as per usual practice and he also reviewed the Patient's medical notes.

The Medical Director

The Medical Director requested information from both practitioners involved and eventually informed the Ombudsman who chased the matter on two occasions that replies had not been forthcoming given that the Consultant Gynaecologist had been suspended in relation to other complaints where this particular one was included. He explained that the GHA were arranging for an external investigator to investigate this and the other matters and he would be in a better position to offer his comments once he had an outcome from the GHA external investigator. The Ombudsman agreed to hold the case in abeyance until such a date when

the outcome of the GHA's external investigation was made available to him and informed the Complainants who agreed to wait.

Seeing as by April 2017, the GHA was still not in a position to make the outcome of the external investigation available to the Ombudsman due to bureaucratic restrictions with regard to the suspension of the Consultant Gynaecologist, the Ombudsman suggested that in the meantime, the GHA provide him with comments from the A&E Doctor regarding his involvement in this case.

The A&E Doctor

The A&E Doctor explained in his statement that he initially saw the Patient on the 17thJuly 2016. He stated that the Patient had informed him that she had experienced a vaginal bleeding the day before with "*scanty spotting*" that same day accompanied by mild lower abdominal pain and she also made him aware of the fact that she was RhD negative and her first new born was too. He explained that on examination she showed "*no pallor*", her lungs were clear and cardiovascular examination was "*normal*". He furthermore stated that her abdomen was "*soft*" with "*mild lower quadrants tenderness*". He commented: "*There was no guarding and the examination evidenced tympani principally on her upper quadrants. Her blood pressure was 96/56 (the patient told me that she has a medical history of hypotension), pulse was 55, her oxygen saturations were 100% on air and her respiratory rate was 22. The Patient was afebrile at the time. My initial diagnosis was that of a possible miscarriage."*

The A&E Doctor informed the Ombudsman that a HCG test was carried out on the day in order to determine the level of her HCG hormone. The results were 57,421. He stated that the urine dip test performed was also positive for this hormone, and there were "*two pluses (++) of blood*". The A&E Doctor explained that he discussed the Patient's symptoms with the Consultant Gynaecologist and asked whether there was a need for a Kleihauerhauer test (a blood test used to measure the amount of foetal haemoglobin transferred from a foetus to a mother's bloodstream). He was nonetheless advised that there was no indication for this for a six week pregnancy but that it should be carried out at week eight. The A&E Doctor explained that he informed the Patient of his conversation with the Consultant Gynaecologist and planned for the Patient to repeat the HCG test in 24-72 hours. He stated, "*I explained to the Patient and her Partner that the level of 57,421 should at least double in those 2-3 days. I also explained to them the rest of the above including my conversation with the Consultant Gynaecologist regarding the Kleihauer test. I discharged the patient with advice to return to A&E before the 24-72 hours should she have any abdominal pain of vaginal bleed of concern to her. To this she agreed. Also, at the time of departure I told the*

Complainants that regarding the second HCG test, the numerical result should be physically viewed by them and discussed with a doctor so as to avoid any misunderstandings. They also agreed to this plan".

The A&E Doctor informed the Ombudsman that he was not present when the Patient returned for the second HCG test on the 20th July and was not there to see how the results were reviewed vis-a-vis the plan. He explained that it was not until the 6th of August 2016 when he was on shift, that he saw the Patient for the second time and at this point, the Patient was 8.5 weeks pregnant according to dates. He stated*, "The Patient had started with vaginal spotting on the day which had increased in a bleed accompanied with lower abdominal pain which felt like menstruation pain. The bleed was constant and she had used 3 pads since the onset of the bleed, whereas she would have used 1 pad otherwise for the same time period. The Patient also explained to me that the bleed was of fresh red blood with clots. On examination, she was not pale and her lungs were clear. Her abdomen was "soft" with "suprapubic region tenderness" in addition to an overall tympani. Her blood pressure was 106/61, pulse 75, saturations 100% on air with a respiratory rate of 16. She was afebrile. We reviewed her HCG results from the first time I saw her on the 17th July, which was 57,421 as stated above. The second HCG test which was taken on the 20th July was 63,150 (I was not present in A&E on that date) and 11,502 on the 6th August. Therefore the level had not doubled within 24-72 hours after the first consultation and on the 6th August 2016, it was in fact dropping. With this I made an impression of a miscarriage and referred her to gynaecology at the time…As I recall, the Patient became annoyed because they were not informed or were under the impression that the pregnancy was progressing normally. I explained to them that this was not possible as the HCG levels had not doubled between the 17th and the 20th July."*

The A&E Doctor assured the Ombudsman that he was not on shift the day that the information with regards the second HCG test was provided to the Complainants and commented, "*What I did state to them is that we had agreed to a plan for the time of the second test that the numerical level should be directly witnessed and discussed with the doctor. This would have avoided the miscommunication. Unfortunately the Complainants have stated that I was somehow blaming them for the information breakdown. Perhaps it was something in my delivery and I apologise if my message got across that way".*

The A&E Doctor explained in his letter to the Ombudsman that upon contacting the Gynaecology Department on the 6th August and discussing the Patient's case with the

Consultant Gynaecologist, he suggested that medication for a MMM be administered to the Patient but the Patient declined as she wanted to discuss with the Consultant Gynaecologist directly. This was in line with the Complainants' account.

The A&E Doctor concluded his letter by commenting: "*I can clearly state that as a past Public Health specialist, I am very committed to the principle that a patient should be the steward of their own health and with this responsibility comes the necessity that the patient needs to be fully informed and aware of the information pertaining to themselves. So my plan with them as to visually and verbally verify the HCG levels on the second consultation is something that I do with all couples. I am sorry if this was not understood and in fact added to their pain in that difficult time.*"

Meeting with Medical Director

Upon reviewing the A&E Doctor's statement and medical notes pertaining to the Patient's A&E attendances, the Ombudsman was concerned given that he was unable to verify who had seen the Patient on the 20th July 2016 given that the A&E notes for this date appeared to be incomplete. In fact, in comparison to the A&E attendance dated 17th July and 6th August 2016, the Ombudsman noted that with regard to the Patient's A&E attendance dated 20th July 2016, where the Patient informed the Ombudsman that she had had the second HCG test followed by a call to the A&E later on that same afternoon which confirmed that the pregnancy was viable, the Ombudsman noted that there were no nursing notes under the 'Nursing Notes' section from the nursing team who reviewed/triaged the Patient upon her arrival to A&E that day, or an entry under the A&E NCHD Notes section from the doctor who reviewed the HCG test results. In effect, the only documentation of the Patient's attendance to A&E that day was an entry stating the date and time of attendance and a note under the section captioned "*Treatments/Interventions*" stating that the Patient had required no treatment.

Given the above, and taking into consideration the A&E Doctor's opinion on the 6th August 2016, upon review of the results from the HCG test performed on the 20th July 2016 that suggested the pregnancy was in fact "*failing*" as opposed to being "*viable*" as communicated to the Complainants via a telephone call, the Ombudsman sought a meeting with the Medical Director in order to establish who had indeed seen the Patient on the 20th July 2016.

The Medical Director explained that, at the time of the events, the Gynaecology Department was lacking manpower and whereas normally the A&E Department would have referred cases like these to the Gynaecology Department, arrangements had been made whereby

the A&E Department were making up for the deficiency in the Gynaecology Department. This set-up he said was "*not ideal*".

The Medical Director was furthermore of the opinion that ideally, the Patient should have attended St Bernard's Hospital after the second HCG test was carried out on the 20th July 2016 to obtain both results and explanations and commented, *"all of which should have been recorded*". The Medical Director was nonetheless of the opinion that the Consultant Gynaecologist should have reviewed the Patient's results of the 20th July 2016 anyway but notwithstanding this, he agreed with the Ombudsman that the A&E doctor responsible for delivering the results on the 20th July 2016 should have counselled the Patient better with regard to the results obtained and prompted a plan of care. The Ombudsman was informed of who the A&E doctor responsible for the delivery of the 20th July 2016 results was in case a statement was required from him. However, the Ombudsman did not consider that this was necessary.

The Medical Director also informed the Ombudsman that although the GHA external investigation had now been conducted, a draft of which had been finalised, the GHA was still not at liberty to share the findings pending the Consultant Gynaecologist's comments and explained to the Ombudsman of possible further delays if a disciplinary route was taken with regard to the matter.

Clinical Advice

By June 2018, subsequent to numerous exchanges between the Ombudsman and the Medical Director regarding the subject matter, and given that the GHA had still not been able to make the outcome of the external investigation available to the Ombudsman, the Ombudsman reviewed all the correspondence and documentary evidence contained within the GHA files. Given that some of the matters being complained of were clinical in nature, the Ombudsman decided to request independent specialist medical advice from an expert ("Expert") in the United Kingdom. He decided to do so in order not to delay the matter any further in view of the time being taken in obtaining any findings from the GHA's own external investigation.

Notwithstanding the decision to request Expert advice, the Ombudsman contacted the A&E Doctor one more time in order to obtain further information with regard to the arrangement between A&E Department and the Gynaecology Department at the time, in order to provide the Expert with an accurate picture of the existing set-up at St Bernard's Hospital.

The A&E Doctor replied to the Ombudsman's queries and clarified that, at the time the events transpired, there was no systematic structure within the GHA for patients with early pregnancy problems to be automatically seen by a gynaecologist. He confirmed that the practice at the time was to have two HCG tests first and "*not necessarily be seen by a gynaecologist in a very early manner*".

The A&E Doctor informed the Ombudsman that since then, the GHA had undergone a restructure and an Early Pregnancy Assessment Clinic had been set up, where early pregnancy cases were now directly booked via the A&E Department's Front Desk booking facility by the A&E doctors which enabled patients to be seen by a consultant gynaecologist on the day or the next day.

Satisfied that he now had a full picture, the Ombudsman prepared a case file and dispatched it to the Expert in the United Kingdom. The questions presented by the Ombudsman to the Expert (a Consultant Gynaecologist with experience in managing early pregnancy problems) and the replies received (which have been summarised for the purposes of this report) were as follows:

Ombudsman's Question 1

The Ombudsman has been informed that at the time of the events there was no Early Pregnancy Assessment Clinic within the Gibraltar Health Authority and therefore cases such as these were dealt with in the A&E Department. The Ombudsman was able to ascertain from the A&E Doctor that two HCG tests were carried out (17th and 20th July 2016) but was unable to find any documentation to this effect in the A&E notes dated 20th July 2016. Can the expert offer advice on how HCG results are delivered to patients in similar cases?

Expert's Reply

The Expert explained that upon reviewing the Patient's medical notes he noted that the HCG test results of the 17th July 2016 were documented and communicated to the Patient as seen on (page 21 of the medical notes). However, with regard to the HCG test dated 20th July 2016, the Expert stated, "a *HCG blood test was performed on the 20th July 2016 as per results/statements. There is no documentation confirming that the test was done or results communicated. It is the responsibility of the person/service performing the test, to document contemporaneously and to effectively communicate the result within reasonable time [Good Medical Practice, General Medical Council]."*

Ombudsman's Question 2

Was it the correct procedure for the A&E Doctor who reviewed the HCG results on the 20th July 2016 to have stated that the second set of test results were that of a "viable pregnancy"? From the A&E Doctor's statement of 26th May 2017 (A&E Doctor who saw the Patient on the 17th July & 6th August 2016), the Ombudsman noted that the HCG levels had not doubled on the second result (as the A&E Doctor on the 17th July 2016 said that they should, to ensure a "viable" pregnancy).

Given the content of the file we have assumed (from a laypersons perspective) that A&E Doctor viewed the results of the second HCG test on the 20th July 2016 in isolation (without having compared them to the previous test carried out by his colleague on the 17th July 2016). What is the experts view on this if any?

Expert's Reply

The Expert stated, "*The notes indicate/infer that the patient did attend A&E on the 20th July 2016, and that a HCG blood test was carried out. There is no documentation confirming what information in relation to the results was given to the Patient".*

With regard to HCG levels in general, he explained that these usually doubled about every 2 days for the first 4-6 weeks of pregnancy. He stated, "*As pregnancy progresses, the doubling time becomes longer. By 6 to 7 weeks, HCG levels may take as long as 3 1/2 days to double. HCG normally reaches a peak level at about 8 to 10 weeks and then declines for the remainder of the pregnancy. The first HCG was > 50,000 on the 17th July 2016 and therefore the gestation was likely to be >6 weeks. In that context, the doubling rates can be unreliable".*

In regard to the Patient's 17th July 2016 attendance to A&E, the Expert further commented "*best practice would have been to perform an USS (ultrasound) but, I am given to understand that the trust did not offer a formal early pregnancy service, and in that context, the interpretation of the A&E Doctor that pregnancy was 'viable' based on either first or second HCG result or both, is acceptable. However, in absence of a formal early pregnancy service, a failure to follow the ad-hoc plan which was initiated on 17th July 2016 where the expectation was that the HCG results would double in 72 hours as an indicator of 'viability', is a failing in duty of care. In that context, there is no room for misinterpretation – the results on the 20th July 2016 should have triggered a formal request for gynaecology review and/or*

USS (ultrasound). The results should not have been viewed in isolation as per the plan made and communicated to the patient on the 17th July 2016".

Ombudsman's Question 3

The Patient and her Partner were of the opinion that Anti-D should have been administered to the Patient when she started bleeding. Can the expert offer advice of when if at all, Anti-D should have been offered?

Expert's Reply

The Expert stated that the guideline pertaining to this matter stated the following:

"*In pregnancies <12 weeks gestation, anti-D Ig prophylaxis is only indicated following ectopic pregnancy, molar pregnancy, therapeutic termination of pregnancy and in cases of uterine bleeding where this is repeated, heavy or associated with abdominal pain. The minimum dose should be 250 IU. A test for fetomaternal haemorrhage (FMH) is not required.*" https://onlinelibrary.wiley.com/doi/full/10.1111/tme.12091

The Expert informed the Ombudsman that although the evidence for the above guideline was not "*robust*", the GHA was correct in not administering Anti-D or performing a Kleihauer test during the Patient's first attendance to the A&E Department on the 17th July 2016 and during the Patient's second attendance on the 20th July 2016. The Expert further explained that the GHA had also proceeded in line with the above guideline in not administering Anti-D when the Patient was seen and scanned by the Consultant Gynaecologist on the 1st August where the Complainants were informed that the foetus was at 6 weeks gestation with no heartbeat. The Expert commented, "*A repeat scan was organised a week later on the 9th August, but the Patient presented with heavy PVB (bleeding) on the 6th August. Anti-D should have been administered at this stage, as per the above guideline, and if not at this stage then when she underwent a MMM later in day on the 6th August. As events transpired, she was given anti-D on the 7th August when she underwent a SMM.* He further commented, "A*nti-D is best given within 72 hours. There is some benefit up to 10 days later so 1 day delay was fine".*

Ombudsman's Question 4

The Ombudsman has been unable to obtain a statement from the Consultant Gynaecologist. However, in the opinion of the Expert, can any maladministration be identified in the procedure that was followed?

Expert's Reply

The Expert commented, "*The GHA offered the Patient a MMM which failed, following which she underwent an SMM. An MMM is an appropriate treatment option, but not because an SMM cannot be offered. It should be an informed choice, which it clearly was not. I do accept the argument that the Consultant Gynaecologist felt it was unsafe to offer immediate SMM due to reasons of exhaustion, in which case the SMM could have been safely deferred to the next day without recourse to MMM if this was not an informed choice of the Patient".*

Ombudsman's Question 5

Would the expert advising conclude that the patient received an acceptable and adequate level of care and that there has been no maladministration regarding the care afforded by the GHA to the patient?

Expert Reply

The Expert stated "*The failings in care have been outlined in response to previous questions, some of which have to be interpreted in context of there being no dedicated early pregnancy service/pathway for managing patients. The staffing levels where the Consultant Gynaecologist could not provide a safe SMM on the 6th August also need to be taken into consideration."*

Conclusions

(i) Inappropriate treatment given to the Patient by the A&E Doctor in St Bernard's hospital. - Not Sustained

The Ombudsman considered the advice provided by the Expert in relation to the Patient's A&E attendances dated 17th July and 6th August 2016 and took into consideration the fact that the A&E Doctor was not on duty on the 20th July 2016 and hence, not responsible for the assessment and delivery of the results from the second HCG test. The Ombudsman further noted the Expert's comments in that there was "*no dedicated early pregnancy pathway for managing patients*" and the fact that the A&E Doctor was working within the constraints of the existing set-up which the Medical Director referred to as *"not ideal".* With all of this in mind, and considering that the A&E Doctor was operating under the advice provided to him by the Consultant Gynaecologist, the Ombudsman did not sustain this complaint.

(ii) Erroneous results given to the Patient in relation to a HCG test carried out on the 20th July 2016 which meant that the Patient carried a non-viable foetus without knowing for approximately three weeks. - Sustained

In relation to the complaint of erroneous results given to the Patient with regard to the second HCG test carried out on the 20th July 2016, the Ombudsman sustained this limb of the complaint based on the Expert's opinion and his comment that "*in the absence of a formal early pregnancy service, a failure to follow the ad-hoc plan which was initiated on the 17th July 2016 where the expectation was that the HCG results would double in 72 hours as an indicator of 'viability', is a failing in duty of care".*

(iii) Traumatic situation unnecessarily augmented by the Consultant Gynaecologist's alleged ill-treatment of the Complainants and his resistance to administering the Patient with Anti-D, even though NHS guidelines allegedly recommended it. -Not Sustained

In relation to the allegation that the Consultant Gynaecologist unnecessarily augmented the Complainant's traumatic situation due to his resistance to administer the Patient with Anti-D, the Ombudsman relied heavily on the Expert advice and on the Experts' comments with the regards to Anti-D in that "*There is some benefit up to 10 days later so 1 day delay was fine".* The Ombudsman was therefore not unable to sustain this complaint.

Classification

(i) Inappropriate treatment given to the Patient by the A&E Doctor in St Bernard's Hospital. – Not Sustained

(ii) Erroneous results given to the Patient in relation to a HCG test carried out on the 20th July 2016 which meant that the Patient carried a non-viable foetus without knowing for approximately three weeks. – Sustained

(iii) Traumatic situation unnecessarily augmented by the Consultant Gynaecologist's alleged ill-treatment of the Complainants and his resistance to administering the Patient with Anti-D, even though NHS guidelines allegedly recommended it. - Not Sustained

Update

Upon reading a draft of this report in June 2019, the Medical Director informed the Ombudsman that the procedure presently being adopted at the GHA regarding miscarriage was that upon diagnosis, patients were given all the options of MMM, SMM and Conservative (miscarriage to happen naturally without any intervention where the patient is

monitored by the hospital over a few weeks instead of having immediate treatment). He explained that GHA gynaecologists discussed the above options with patients in detail, and should the patient opt for SMM, the patient is subsequently booked in the next available slot in the surgical list. If on the other hand the patient opts for the MMM, this would take place the next day. Additionally, the Medical Director provided the Ombudsman with a draft leaflet containing thorough information on the different treatments for miscarriage which was being prepared to be handed to patients diagnosed with miscarriage.

(Report extracted from Case No 48 - Health)

Case 6

Complaint

Failure to follow up on Patient's test results. As a consequence, the Patient was subsequently admitted into St Bernard's hospital as the infection had exacerbated.

Background

[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].*

The Complainant was aggrieved by the fact that due to a lack of follow-up by the A&E doctor (A&E Doctor") who saw the Patient on the 17th March 2017 led to his deterioration to the point where he had to be admitted into St Bernard's Hospital on the 24th March 2017 with low blood pressure and 'kidney stress' resulting from an advanced Urinary Tract Infection ("UTI").

By way of background the Complainant explained that the Patient was taken to A&E on 17th March 2017 presenting UTI symptoms. The Complainant stated that the A&E Doctor ordered urine and blood samples to be taken and the Patient was prescribed antibiotics for a suspected UTI and sent home. She further explained that given the fact that by the 24th March 2017, six days after being on antibiotic treatment, the Patient's condition had still not improved and to make matters worse, he appeared to be deteriorating, the Patient was taken back to A&E where he was admitted into hospital as he was found to be suffering from 'kidney stress' resulting from an advanced Urinary Tract Infection ("UTI"). The Complainant informed the Ombudsman that during his hospital stay, an alternative antibiotic treatment was administered.

According to the Complainant, the A&E Doctor who had seen the Patient on the 17th March 2017 and who had requested the blood and urine tests should have reviewed the results and noted that the antibiotics prescribed (Ciprofloxacin) were resistant to the infection that the Patient was presenting.

The Complainant was informed that normal practice at A&E would have been for the doctor to have checked the results of the tests performed and in the event that the medication prescribed was not suitable with the presenting infection, the Patient would be called and

offered a new prescription for a different type of antibiotics. This, in Complainant's mind, may have avoided the Patient's deterioration and subsequent admission to St Bernard's Hospital.

The Complainant lodged her complaint with the Ombudsman as she wanted to know what went wrong with the care of the Patient.

Investigation

The Ombudsman requested comments from the A&E Doctor via the Medical Director of the GHA as per usual practice and he also reviewed the Patient's medical notes.

A&E Doctor

The A&E Doctor provided the Ombudsman with a statement containing an account of the treatment provided to the Patient on the 17th March 2017. She explained that on the day of the events, at about 00:45 am, the Patient attended the A&E department complaining of pain to his lower abdomen when he urinated. She further explained by way of information that the Patient had had a urinary catheter removed the previous day which he had previously inserted due to a urine infection which he had contracted as a result of a complication from a cystoscopy[2] procedure. The Patient had explained to her that after the removal of the catheter, he began to experience discomfort and frequency in urination. The A&E Doctor stated that when she examined him she found that "*he was not generally unwell or presented with fever*". She stated that his vital observations at the time were all within normal levels. Nevertheless, as she suspected and "*proven by the presence of leucocytes in the urine dipstick test, a urine infection was the likely cause for the patient's symptoms*". She explained that she then ordered a blood test to assess the Patient's "*kidney function* and in order to "*establish good level of haemoglobin*" and exclude infection in the Patient's blood stream. She commented that all results were satisfactory and as a result of this she started the Patient on a broad spectrum antibiotic. This she stated was "*according to the guidelines and a commonly prescribed choice when urine infection is possibly related to urinary catheter*".

[2] **There are 2 types of cystoscopy: a flexible cystoscopy and a rigid cystoscopy.**
Both involve passing a thin viewing tube called a cystoscope along the urethra (the tube that carries pee out of the body) and into the bladder, but they're done in slightly different ways. https://www.nhs.uk/conditions/cystoscopy/what-happens/

The A&E Doctor subsequently discharged the Patient with advice to drink plenty of fluids in order to flush the urinary system. She explained that she believed that the Patient was supposed to be reviewed by the urologist the following morning.

The A&E Doctor informed the Ombudsman that the Patient's urine sample was sent to the laboratory for "*culture*" and "*sensitivities*" which usually takes around three days for results to develop. She also informed the Ombudsman that after finishing her shift in the morning, she went on holiday and was away from work for a period of time.

The A&E Doctor explained that a few days after sending the urine sample to the laboratory, the results were sent to her hospital email which she was only able to check after her return from her holiday. She stated that during her period of absence, the Patient unfortunately returned to A&E with an infection which had worsened given that the *"germs creating the infection were not sensitive to the antibiotic prescribed*".

The A&E Doctor informed the Ombudsman that the system by which the A&E Department obtained microbiology results had recently been changed from a paper report sent to the A&E Department to results being sent electronically to the requesting doctor's email account. She commented where in the past results would, "*definitely be picked up by any doctor working at any given time, not necessarily the requesting doctor" and where action would be taken if noted resistance to antibiotic prescribed to patients by contacting the patient to collect the new prescription from reception",* this was no longer the case. The A&E Doctor informed the Ombudsman that the new system was, "*In principle very logical but unfortunately proven to be very impractical and dangerous from our point of view as it has just been proven by this case"*.

The A&E Doctor informed the Ombudsman that in 2017, the A&E staff had noted several complications with the new system adopted by the GHA;

1. The fact that A&E doctors were only able to access their GHA email accounts from within the hospital and via GHA computers. This meant, that if anything was sent to them while they were away from the hospital grounds, they would be unable to receive these emails.

2. The A&E Doctor explained that all results of blood tests as well as microbiology results requested by any particular A&E Doctor, were sent to their inbox on a daily basis. She stated that additionally, if abnormal values were to be noted by the laboratory, these emails were not flagged. This in her opinion "*implies having too many emails to open with several attachments in a time consuming manner in a department that is generally too busy to spend*

*hours in the computer reviewing results that most of the times have been already checked prior to discharge of patients (blood results).*The A&E Doctor felt that the way in which they received results before the new system was implemented meant that these were "*reviewed by any doctor in the department on daily basis as they arrived in the department and action taken immediately*".

The A&E Doctor concluded her statement to the Ombudsman by stating that she was sorry to hear the extent to which the Patient had deteriorated.

Medical Director

As a result of the A&E Doctor's account, the Ombudsman contacted the Medical Director expressing his concerns given that in the Ombudsman's mind, the A&E Doctor had highlighted an unsatisfactory state of affairs in regard to the delivery of laboratory results to the A&E Department.

The Medical Director subsequently copied the Ombudsman into his correspondence with the A&E Department where he asked them to find a workable solution to mitigate the problem. He suggested three possibilities;

1. That A&E Department request that the laboratory send paper copies of all results to A&E, i.e. to revert to using the old system.

2. That A&E doctors set up an "*auto rule*" in their email accounts to forward all laboratory results to the rest of the A&E team or a nominated person to receive the results in their absence.

3. Or alternatively, that the A&E Department request that the laboratory telephone the A&E Department to report all positive results coming from A&E which would alert the doctor on duty.

The Medical Director informed the Ombudsman in January 2018 that the A&E Department had implemented option two as a workaround solution whereby A&E doctors automatically had their emails forwarded to a colleague while they were away from the hospital.

Conclusions

The Ombudsman sustained this complaint as there was no doubt in his mind that the Patient suffered from the A&E Department's administrative arrangements or lack thereof.

During the course of his investigation, however, the Ombudsman was able to ascertain that rather than the failure being attributed solely to the A&E Doctor who was fully aware of the problem at the time, this was also a systemic failure on the part of the A&E Department and the GHA as the responsible authority.

Classification

Failure to follow up on Patient's test results. As a consequence, the Patient was subsequently admitted into St Bernard's hospital as the infection had exacerbated. – Sustained

Update

The Ombudsman was informed by the Medical Director in July 2019 that the GHA were exploring new ways in which to improve the checking of microbiology results requested by A&E given that the option implemented back in 2017 was not ideal.

Recommendation

That the GHA issue an apology to the Patient for their shortcomings in this case.

(Report extracted from Case No 49 - Health)

GIBRALTAR HEALTH AUTHORITY (GHA)

Case 7

Complaint(s)

1. Unhappy with the treatment received from Doctor 1 on 20th June 2017.

2. Unhappy with treatment received from Doctor 2 who admitted the Patient to St Bernard's Hospital on 21st June 2017.

3. Alleged misdiagnosis in relation to "P*ancreatitis*".

Background

[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].***

The Complainant explained that the Patient was a Crohn's disease sufferer and had been under the care of the GHA Consultant Gastroenterologist who was on annual leave when the Patient attended St Bernard's Hospital due to extreme back pain. She further commented by way of background that the Patient had been prescribed a new medication by the Consultant Gastroenterologist three weeks prior to the events which led to the complaint and he had been warned by the Consultant Gastroenterologist about the possible side effects of the medication, one of them being Pancreatitis (inflammation of the Pancreas).

The Complainant's and Patient's grievance began on the 20th June 2017, when the Patient began suffering from epigastric/back pain and attended the Accident & Emergency Department at St Bernard's Hospital ("A&E"). The Complainant stated that the Patient was assessed by an A&E doctor and referred to Doctor 1 ("Doctor 1") to whom she highlighted that the Patient had started a new treatment for Crohns, namely Azathioprine ("Azathioprine") three weeks previously, and "*emphasised*" that one of the possible side effects was Pancreatitis. She informed Doctor 1 that the Patient's symptoms seemed to be in line with the ones described in the Azathioprine leaflet and provided him with a copy of this. The Complainant informed the Ombudsman that Doctor 1 subsequently took a sample of the Patient's bloods and ordered an X-ray and when the results of both tests arrived, he informed them that the Patient was not suffering from "*Pancreatitis*". The Complainant stated

"*When the Patient's pain had settled after a few hours on intravenous medication, he was discharged home on Cocodamol (painkillers) and laxatives. We expressed our discontent at his (Doctor 1) decision but he told us there was nothing seriously wrong with the Patient and he couldn't justify admitting such a young man into hospital purely for monitoring purposes. We once again expressed our discontent but he stood his ground".*

According to the Complainant, that same evening, the Patient developed the same "*agonising pain*" for which he had attended A&E in the morning. The Complainant therefore called an ambulance and he was transferred back to A&E. On this occasion, the Patient was referred to a different doctor ("Doctor 2") who admitted him into hospital, ordered an MRI[3] and allegedly informed them that Doctor 1 should not have prescribed the Patient with painkillers nor laxatives.

The Complainant explained that the MRI was carried out on 22nd June 2017 and it showed *"thickening of the Terminal Ileum*" which she stated was related to his Cohn's disease. The Complainant informed the Ombudsman that the Azathioprine was stopped during the Patient's stay in hospital and he was instructed to continue taking it on the 24th June 2017 upon discharge from hospital. She stated "*He was discharged from hospital at lunchtime…..He took the Azathioprine when we got home. At 10pm that same day, he again developed excruciating pain. An ambulance transferred him to A&E where Morphine was administered by the nurse, and had to be repeated soon after the first dose as the pain would not subside*". The Complainant informed the Ombudsman that when Doctor 2 arrived at A&E, the Patient was still in "*agonising pain*" despite the Morphine administered. According to the Complainant, Doctor 2 suggested that the Patient's pain was due to something he had eaten, or because he had smoked too many cigarettes. The Complainant however, informed Doctor 2 that the Patient had not smoked at all that day and explained that he had only had a soft ice cream at lunchtime. She furthermore insisted that the pain the Patient was experiencing was not similar to his usual Cohn's flare-up. According to the Complainant, she urged Doctor 2 to administer the Patient more pain relief as it was "*very distressing to see the pain he was in*". She explained that Doctor 2 initially refused to administer more Morphine (pain relief) as she was of the opinion that this would cause constipation. Doctor 2 however agreed to admit the Patient into hospital once again for further tests and asked the Patient and his family to encourage him to keep his voice down from "*moaning very loudly*" as he was upsetting other patients. This the Complainant stated was very distressing as she found herself helpless and unable to help the Patient given

[3] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. https://www.nhs.uk/conditions/mri-scan/

Doctor 2's initial refusal to administer more Morphine. She stated that as a way forward she suggested that the Patient be moved to a side room so as to avoid his screams from disturbing other patients and continued to persuade Doctor 2 to administer further pain relief.

The following day, 25th June 2017, the Patient was seen by a Consultant in General Medicine. The Complainant explained that at this point, the Patient was still in pain, though not as severe. She further explained that the Consultant in General Medicine "*doubted*" that the Patient's pain was related to the thickening of the Terminal Ileum shown in the MRI carried out the 22nd June 2017 and prescribed continued intravenous Morphine, a CT[4] scan and a Gastroscopy[5]. He also asked the surgical team to examine the Patient. Surgical Consultant 1 and Surgical Consultant 2 visited the Patient later that day. According to the Complainant, the Patient was examined by Surgical Consultant 1 "*who didn't feel there was anything seriously wrong when palpating his stomach*". She stated "*Surgical Consultant 1 was against the Patient having a CT scan as he felt it would not show anything and it would expose him to unnecessary radiation*". The Complainant and her family however insisted that the Patient should have the CT scan performed in order to rule out all possible causes, including Pancreatitis, and according to the Complainant, their claim was supported by Surgical Consultant 2. The Patient went on to have the CT scan which the Complainant stated to have revealed that he may have indeed been suffering from Pancreatitis. The Consultant in General Medicine advised that the Patient stop Azathioprine or Steroids until he was seen by the Consultant Gastroenterologist who was due back from leave in a week's time.

On Wednesday 5th July 2017, the Patient was seen by the Consultant Gastroenterologist upon his return from annual leave. After looking at the CT scan and speaking to the Radiographer, he confirmed that the Patient had indeed been suffering from Pancreatitis, as diagnosed by the Consultant in General Medicine. The Complainant informed the Ombudsman that the Consultant Gastroenterologist had allegedly compared the CT scan performed on the 25th June 2017 to a previous one and the Patient's Pancreas showed a significant increase in size in the most recent CT scan. He explained that Pancreatitis did not always show in blood tests and furthermore, he confirmed that Pancreatitis had been caused by Azathioprine.

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[4] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. https://www.nhs.uk/conditions/ct-scan/

[5] A gastroscopy is a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestine (duodenum). The endoscope has a light and a camera at one end. The camera sends images of the inside of your oesophagus, stomach and duodenum to a monitor. https://www.nhs.uk/conditions/gastroscopy/

Dissatisfied with the treatment received from Doctor 1 and Doctor 2, the Complainant lodged her complaints with the Ombudsman as according to her "the *Patient had suffered unnecessary pain and distress due to a failure on the part of both Doctor 1 and Doctor 2 to deliver an accurate and timely diagnosis, and due to the mismanagement of his pain and symptoms, despite both of them being aware of his medical history and the fact that he was on Azathioprine".*

Investigation

The Ombudsman requested comments from Doctor 1 and Doctor 2 via the Medical Director of the GHA as per usual practice and he also reviewed the Patient's medical notes.

Doctor 1

In his statement to the Ombudsman, Doctor 1 explained that on 20th June 2017 when he was called by one of the A&E doctors to assess the Patient, his role as the "*on call medical doctor*" as per the instructions given to him by the GHA in relation to the procedure for medical admissions, was to ascertain the following: "*What was the potential diagnosis? Whether the patient could benefit from an admission? Outpatient follow up? Or a discharge with further follow up if required?"*

Commenting on his dealings with the Patient, Doctor 1 explained that on the 20th June 2017, he attended A&E and took a detailed history of the Patient's symptoms. He stated "*As you can see from the registered notes, the Patient presented with history of constipation and had commenced on Azathioprine 3 weeks prior to the presentation. No vomiting, no nausea, no fever. I went through his past medical history and past medications. I also went through his blood results and radiological results which you can see. I then took a thorough history and examined the Patient. On examination, the Patient was comfortable, pain free and observations were normal. After having all the facts in front of me, I specifically reported this on the electronic system in A&E…..Further to that, his Glasgow Score (a tool that helps us in diagnosing) for Pancreatitis was: Low Risk for Severe Pancreatitis."*

Doctor 1 informed the Ombudsman that after his consultation with the Patient on the 20th June 2017, the Patient "*looked well and keen to go home*". He stated that he discussed his findings with the Patient and his family and informed them of his diagnosis which was at the time, "*Gastritis and Constipation*". Doctor 1 commented "*the Patient was admitted the following day and was diagnosed with Acute Colitis and discharged home. Therefore there was no diagnosis of Pancreatitis. You wrongly involved me in the complaint as the Patient was diagnosed with Pancreatitis on his second admission which was days later… There was*

never a diagnosis of Pancreatitis on the MRI report which took place on 22nd July 2017 which I never had in front of me during my A&E diagnosis on 20th July 2017". Doctor 1 concluded his account of events to the Ombudsman by stating "*I therefore stand with my decision that at that point in time, and with the knowledge of blood results and radiographic imaging that I had in front of me, in conjunction with my clinical examination and judgement, I acted on the Patient's best interest without intentionally trying to cause any harm*".

Doctor 2

In her reply to the Ombudsman, Doctor 2 addressed the various complaints brought against her and explained that the reason why Pancreatitis was initially ruled out was due to various factors, one being the results of the blood tests performed on the Patient where his *Amylase*[6] levels appeared to be normal and were "*never raised*".

Furthermore, Doctor 2 explained that the MRI which she requested during the Patient's first admission into hospital on 21st June 2017 confirmed a Crohn's flare up and commented that the abdominal X-ray taken during his first attendance to A&E the previous day had confirmed *"severe constipation*". Doctor 2 stated, "*Initially the patient presented with 5 days history of constipation and abdominal pain. The Patient was pain free after receiving IV Hydrocortisone and laxatives for a couple of days*".

In regard to the CT scan performed the 25th June 2017, Doctor 2 stated that the CT report did not in fact report Pancreatitis. She stated, "*CT reported: Hepatobiliary appears unremarkable as well as the spleen, adrenals and kidneys. The pancreas is enhancing normally. There is minimal amount of free fluid in the right side of the pelvis. There is Crohn's disease of terminal ileum and there is also skip lesion in the distal ileum*". Doctor 2 further commented, "*Surgical Consultant 1 saw the Patient and he was not convinced it was Pancreatitis after receiving the CT report".*

Regarding the Complainant's allegation that Doctor 2 initially refused to administer the Patient with more Morphine, Doctor 2 explained that she initially refused as it had been less than an hour since the previous dose was administered and she had to allow some time for the pain relief to take effect. She also commented that she had to be careful not to overmedicate the Patient. Doctor 2 stated "*the Patient was admitted at 23:07. Morphine*

[6] Amylase is a protein made by your pancreas and by glands in and around your mouth and throat. It helps you break down carbohydrates and starches into sugar. It's normal to have some amylase in your blood. But too much of it could mean one of the ducts (tubes) in your pancreas is blocked or injured. https://www.webmd.com/a-to-z-guides/what-is-an-amylase-test

Sulphate IV 4 mg was given at 23:10, Morphine Sulphate IV 6mg was given again at 23:45, Morphine Sulphate IV 10mg given at 01:00; Morphine sulphate IV prescribed as needed 2-4 hourly 2.5-5mg. The drug chart will confirm".

Additionally, Doctor 2 highlighted that apart from the pain relief, the Patient was also administered IV fluids continuously during his first and second admission into hospital which she stated to coincidentally also be the recommended treatment for Pancreatitis.

Finally, in relation to the complaint made regarding her approach to the Patient's demonstrations of pain, Doctor 2 commented that on the day of the Patient's admission, she had been "very caring" and "sympathetic" with the Patient's condition and given her awareness that the Patient's family were outside the ward, she believed that it would benefit him if they joined him in what she described as a "*time of distress*" and hence the reason she invited them into the ward.

Consultant Gastroenterologist

In order to have a full picture of the Patient's medical condition, the Ombudsman requested a statement from the Consultant Gastroenterologist which he kindly provided albeit he was not a subject of this complaint.

The Consultant Gastroenterologist explained by way of background that the Patient had a diagnosis of "*steroid dependent small bowel Crohn's Disease with previous abscess formation and most recently Azathioprine induced Pancreatitis".*

By way of further background, he explained that the Patient had come under his care upon suffering from some complications where a CT scan had "*demonstrated inflammation to his ileum with a 5cm abscess thought secondary to a localised perforation*". For this, the Consultant Gastroenterologist treated the Patient "*conservatively*" with antibiotics and steroids, and commented that the Patient made a good recovery.

The Patient remained under his care and further tests revealed that he required a number of courses of steroids to manage his Crohn's Disease. The Consultant Gastroenterologist stated that in keeping with standard practice, he "*discussed the escalation of the Patient's therapy to include maintenance treatment in the form of Azathioprine*" and subsequent to a flare-up of his disease in May 2017, the Patient was "*counselled as to the risks of Azathioprine (including Pancreatitis) and started on this*".

Upon his return from a two week period of annual leave, the Consultant Gastroenterologist was informed of the Patient's admissions which had taken place during his absence and he arranged to see the Patient on the 5th July 2017. He explained that prior to seeing the Patient, he reviewed the MRI scan performed on 22nd June 2017 and CT scan performed on 25th June 2017 together with one of the GHA radiologists. The Consultant Gastroenterologist commented that with the benefit of hindsight and given that the Patient had been able to report a recurrence of pain and symptoms upon restarting Azathioprine, he came to the conclusion that the Patient may at the very least have been suffering from "*Azathioprine induced Pancreatitis"*

The Consultant Gastroenterologist informed the Ombudsman that he consequently began to explore other treatment methods available to the Patient in view of the fact that he was not able to tolerate Azathioprine.

Clinical Advice

Given that the matters being complained about were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent specialist medical advice to two experts ("Expert 1") and ("Expert 2") in the United Kingdom.

The questions presented by the Ombudsman to Expert 1 (a Consultant in Emergency Medicine and Honorary Senior Lecturer in Emergency Medicine for 33 years with experience in assessing and advising on cases of abdominal and back pain and of Pancreatitis.) and Expert 2 (a Consultant Gastroenterologist in a tertiary referral centre for inflammatory bowel disease and chairman of the British Society of Gastroenterology IBD section committee having published over 100 papers looking at various aspects of Irritable Bowel Disease) and the replies received (which have been summarised for the purposes of this report) were as follows;

Expert 1 – On the treatment offered to the Patient at A&E

Expert 1 thoroughly reviewed the documentation supplied from the three attendances to A&E on the 20th, 21st and 24th June and concluded that the Patient received adequate care from the A&E Department. In regard to the first A&E attendance dated 20th June 2017, Expert 1 commented "*The examination, blood tests and x-rays performed were appropriate for abdominal pain. The examination revealed only epigastric tenderness, the abdominal x-ray showed faecal matter and the blood tests showed non-specific, mildly raised inflammatory markers but were otherwise normal. It was reasonable for the A&E doctor to*

seek advice from the specialist medical team. The latter's findings were essentially the same as the A&E doctors'. The working diagnosis of a Crohn's flare-up by the A&E doctor was reasonable. I note that a subsequent MRI scan showed thickening of the terminal ileum consistent with Crohn's disease".

In regard to the second A&E attendance dated 21st June 2017, Expert 1 stated "*The differential diagnosis was again gastritis and an exacerbation of Crohn's. An infusion of sodium chloride was started at 08:20. Hyoscine butyl bromide was given intravenously at 08:14 and omeprazole 40 MG was given intravenously at 08:20. Blood tests were taken which showed that the renal and liver function were again normal; the amylase was slightly above normal at 95U/L (upper limit 90U/l), the troponin was normal, the c-reactive protein was raised at 76.2 mg/l (normal up to 5mg/l), the white cell count was raised at 13.5 x 109/l with 80% neutrophils. The lymphocyte count was slightly low, otherwise the complete blood count was unremarkable. The Patient was referred to the medical in-taking team*".

Commenting on the last attendance to A&E dated 24th June 2017, Expert 1 explained that on this occasion there were no entries in the medical notes by an A&E doctor and it appeared as though the Patient was assessed directly by a member of the in-taking medical team. She noted however from the A&E documents supplied that the Patient was "*given morphine 4 mg intravenously together with metoclopramide 10 mg intravenously at 23:10, hyoscine butylbromide 20 mg intravenously together with paracetamol 1g at 23.45 and morphine sulphate at 6 mg at 23:57. An intravenous infusion of normal saline was commenced at 00:01 and omeprazole 40mg was given intravenously at 00:01. Blood gases and blood tests were performed; the blood gases show that the Patient was hyperventilating and that his lactate was raised at 2.9 mmol/l (upper limit 1.6 mmol/l). Blood tests showed normal renal function, normal amylase at 82 U/l, normal liver function, a c-reactive protein of 7.7 mg/litre, a raised white cell count at 11.3 10x^{9}/l (neutrophils 78.4%); the complete blood count was otherwise unremarkable."* Expert 1 concluded that the tests carried out were appropriate.

Expert 1 – <u>On knowledge of Azathioprine and Pancreatitis at A&E</u>

Expert 1 explained that Azathioprine was a standard second line treatment for the induction of remission in Crohns where steroids alone were not enough. She commented "*Across all indications, Azathioprine is rarely associated with acute pancreatitis (1.5% in Weersma et al study) but patients with Crohns disease are more likely to get it. It is still a rare side-effect (4.9% in Weersma et al study) and I would not expect an A&E doctor to be aware of this phenomenon".*

She further explained that although the diagnosis of Pancreatitis was generally based on a "*characteristic pain*" and an "*amylase and/or lipase*" of 3 times normal, she commented "*I would expect A&E doctors to be aware that Pancreatitis can unusually present with a normal amylase but this is usually in the context of acute or chronic Pancreatitis, particularly from alcoholism, where the patient has had recurrent episodes of Pancreatitis which eventually damage the pancreas to the extent that it does not produce amylase as usual*. Expert 1 highlighted that in a young man with no history of alcohol abuse or previous Pancreatitis, it would be highly unusual to get a normal amylase in Pancreatitis and as such she was of the opinion that it was reasonable that Pancreatitis was not suspected by the A&E doctors.

Expert 2 – On Doctor 1's treatment received at A&E on 20th June 2017

Expert 2 was of the opinion that the treatment offered by Doctor 1 to the Patient on the 20th June upon being referred to him by the A&E doctor was appropriate. He concurred that the prescribed medication (laxatives and pain relief) was reasonable at that stage. Expert 2 explained that the documentation available to Doctor 1 on the 20th June 2017 indicated that the Patient's abdominal pain had settled during his visit to A&E and his "*biochemical tests*" as well as "*clinical features*", including his "*Glasgow*" score did not suggest Pancreatitis at that stage. As such, he was of the opinion that the decision not to admit the Patient for further tests on the 20th June 2017 was correct.

Expert 2 – On Azathioprine, Pancreatitis & Diagnosis

Expert 2 explained by way of information that the decision to start the Patient on Azathioprine by the Consultant Gastroenterologist in a patient with Crohn`s disease requiring multiple courses of steroids was "*entirely appropriate*" and "*the correct thing to do*".

Expert 2 further explained that Doctor 1 and Doctor 2 should not have been expected to know that Pancreatitis did not always show up in blood tests. He commented that this had been a very unusual situation given that diagnosis for Pancreatitis is usually based on blood tests.

He clarified however, that Azathioprine can sometimes cause abdominal pain that is not always associated with Pancreatitis and whether or not the Patient's Amylase was raised, in his opinion the Patient should have eventually been advised to stop taking Azathioprine. He stated, "*In a recent clinical trial that we ran with Azathioprine, an amylase that was twice the upper limit of normal was necessary to make the diagnosis. Therefore with this being normal, I would not expect the admitting doctors (Doctor 1 and Doctor 2) to make this diagnosis but the link between the symptoms and the medicine should have been made".*

He explained that although the knowledge that Azathioprine can cause abdominal pain that is not specifically Pancreatitis is relatively specialist knowledge as this was not in the *SPC*[7] or *BNF*[8] but was sometimes noted in clinical practice, in his opinion, given that there was a temporal relationship to the medication starting and the symptoms experienced by the Patient, it would have been reasonable to stop the medication and request an alternative gastroenterological opinion whilst the Consultant Gastroenterologist was on annual leave.

Expert 2 commented that if Azathioprine had been stopped and not commenced after the Patient's discharge from hospital on 24th June 2017, "*it was likely that the further bouts of abdominal pain would have been less severe or even avoided".* He however emphasised that he would not necessarily have expected the Azathioprine to have been stopped during the Patient's first A&E visit but that "*this should not have been restarted following the subsequent admission*". Expert 2 however highlighted "*I think this is dependent on specialist knowledge and is something that I would not necessarily expect general doctors especially if in training to know".*

When asked to comment on whether it was reasonable for the Patient to remain undiagnosed from the 20th until the 25th June 2017, he commented "*The initial tests did not show Pancreatitis and very reasonable investigations were undertaken which included the appropriate blood tests and an MRI scan. This gentleman suffered unpleasant symptoms but in the absence of specialist advice I am not sure this was avoidable. It should be noted that this is an unusual situation where the amylase is persistently normal, an MRI is normal. I would hope that this gentleman would make a full recovery and not have any long term problems related to this*".

Meeting with Consultant Gastroenterologist

Upon receiving Expert 2's advice, the Ombudsman met with the Consultant Gastroenterologist in order to discuss the following:

1). Clarify how he had arrived at his diagnosis using the same investigations available to Doctor 1 and 2, Surgical Consultant 1 and 2 and the Consultant in General Medicine. It is important to note however that during his second hospital admission, the Patient had already been advised to stop Azathioprine given that Surgical Consultant 2 and the Consultant in

[7] SmPC, or SPC, stands for Summary of Product Characteristics. The SmPC is used by healthcare professionals, such as doctors, nurses and pharmacists, and explains how to use and prescribe a medicine.
[8] The British National Formulary is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service. https://www.bnf.org/products/bnf-online/

General Medicine had suspected that the Patient was suffering from Pancreatitis following the CT scan performed on 25th June 2017.

2). Ascertain what arrangements if any were made by the GHA once he was on annual leave.

The Consultant Gastroenterologist informed the Ombudsman that it was the *oedema* (abnormal accumulation of fluid) around the patient's pancreas reported in the CT scan together with the benefit of hindsight and the fact that the patient was able to report a recurrence of pain after taking Azathioprine that convinced him he had been suffering from Azathioprine induced Pancreatitis.

In regard to Expert 2's comments that a gastroenterological opinion should have been sought in his absence, the Consultant Gastroenterologist explained that the GHA did not ordinarily appoint locums in his absence which is usually no more than two consecutive weeks and the existing arrangements were that consultants in General Medicine within the Medical Investigations Unit covered for his absences as he did when the consultants in General Medicine were away within the unit.

He furthermore explained that in the case of patients suffering from similar gastroenterological problems, the surgical consultants were generally approached as it transpired in the Patient's case and commented that he had no doubt that had the Patients' condition exacerbated while he was away, the GHA would have eventually referred him to a tertiary referrals centre in Spain for a more specialised gastroenterological opinion.

<u>Expert 2</u>

Following his meeting with the Consultant Gastroenterologist and for completeness, the Ombudsman contacted Expert 2, explained the discussion had with the Consultant Gastroenterologist and asked his opinion on whether or not the CT scan performed on 25th June 2017 should have alerted the surgeons that the Patient may have been suffering from Pancreatitis or any other pancreatic problem not related to his Crohn's disease.

In his reply to the Ombudsman's queries, Expert 2 stated "*I agree that the constellation of clinical symptoms, association with Azathioprine and to some extent the CT scan do suggest the diagnosis of Pancreatitis but if the CT is taken in isolation it does not, as read, give an immediate indication of Pancreatitis. Purely on the basis of the report the admitting doctor*

would be reasonable in not suspecting Pancreatitis and looking on this as a reassuring result. I think it is really only with specialist gastroenterology knowledge that the pieces of the puzzle can be put together" In reply to the suggestion that the Surgical Consultants were used as back up for the absence of the Consultant Gastroenterologist, Expert 2 was of the opinion that "*they often have very little specific knowledge of the drugs used in the treatment of Crohn's disease and some medical back up in the future would be useful".*

Meeting with Medical Director and Clinical Governance Manager

Following the advice received from Expert 2, the Ombudsman held a meeting with the Medical Director and the Clinical Governance Manager in July 2019 in order to discuss the suggestions made by Expert 2 and the possibility of locum cover for when the Consultant Gastroenterologist was away. The Medical Director explained that the GHA was not in a position to appoint locum cover and that current practice in cases requiring gastroenterological opinions was that patients would be referred to a tertiary referrals centre in Spain. The Medical Director commented that the reason why this was not done in the Patient's case was due to the complex nature of the case where the standard tests performed to diagnose Pancreatitis came up negative.

Conclusions

Based upon Expert 1 and Expert 2's medical opinion, the Ombudsman reached the view that the care afforded to the Patient at the A&E Department was reasonable and in keeping with established guidelines and practice. The Ombudsman was able to ascertain that although Doctor 1 was a member of the medical in-taking team and he assessed the Patient within the A&E Department, his treatment and decision not to admit the Patient for further tests on the 20th June 2017 was acceptable given the results of the tests available to him on that day. Furthermore, the Ombudsman was convinced that Doctor 1 was not at fault from the comments received from Expert 2 in that he would not have expected the Azathioprine to have been stopped during the Patient's first A&E visit.

The Complainant's primary complaint was that Doctor 1 and Doctor 2 failed to diagnose the Patient with Pancreatitis and treat him for this. It was clear to the Ombudsman based upon the medical advice, that although Doctor 2 was correct in not suspecting Pancreatitis, had a temporal relationship to the medication starting and the symptoms experienced by the Patient been made and the medication stopped and not commenced after the Patient's discharge from hospital on 24th June 2017, "*it was likely that the further bouts of abdominal pain would have been less severe or even avoided*". The Ombudsman however, considered the fact that Doctor 2 was a Non Consultant Hospital Doctor (NCHD) and the additional comments made by Expert 2 in that the decision to stop the medication was dependent on

specialist knowledge and it was something that he would "*not necessarily expect general doctors especially if in training to know".* For this, the Ombudsman could not attribute the failure of restarting the medication after the Patient's discharge on the 24th June 2017 to Doctor 2.

It was however obvious to the Ombudsman that the Patient would have benefited from specialist gastroenterologist knowledge given that in this case the standard tests carried out were inconclusive and according to the expert advice received, although the surgeons were used as back up, "*they often have very little specific knowledge of the drugs used in the treatment of Crohn's disease and some medical back up in the future would be useful".* The Ombudsman however noted the fact that it was the Consultant in General Medicine who suspected that the Patient was suffering from Pancreatitis following the CT scan performed on the 25th June 2017 and it was under his orders that the Azathioprine was stopped until the return of the Consultant Gastroenterologist who saw the Patient on the 5th July 2017. As such, the Ombudsman was not able to sustain the complaints against Doctor 1 and Doctor 2 and partly sustained the complaint for misdiagnosis against the GHA in recognition of the Patient's suffering from when the Patient was discharged on the 24th June 2017 until his symptoms alleviated subsequent to his second admission on the 25th June 2017.

Classification

1. Unhappy with the treatment received from Doctor 1 on 20th June 2017 – Not Sustained

2. Unhappy with treatment received from Doctor 2 who admitted the Patient to St Bernard's Hospital on 21st June 2017 – Not Sustained

3. Alleged misdiagnosis in relation to "P*ancreatitis*" – Partly Sustained

Recommendation

The Ombudsman recommended that this report be shared with A&E doctors within the A&E Department, the Surgical Consultants, and the consultants within the Medical Investigations Unit.

(Report extracted from Case No 57 - Health)

Case 8

Complaint

The Complainant was aggrieved by the care received following a surgical procedure which led to the Patient being transferred to a Tertiary Referrals Centre ("Tertiary Referrals Centre") in Spain due to excessive bleeding.

[Ombudsman Note: The Patient in this complaint underwent a surgical procedure which will be referred to in parts of this report as Procedure, rectocele repair or pelvic floor surgery].

Background

[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].***

The Complainant was aggrieved by the fact that the Patient suffered from extensive bleeding following a procedure which appeared to be at first hand a simple one. According to the Complainant, he was advised by the GHA that the Patient was in a critical condition prior to being transferred from the GHA to the Tertiary Referrals Centre.

By way of background the Complainant explained that the Patient was admitted to St Bernard's Hospital on the 15th March 2017 to receive a rectocele repair surgical procedure ("Procedure") which she had opted for following damage to her vaginal wall. He further explained that following the Procedure, the Patient's vagina was packed with gauze and a urinary catheter was inserted. He stated that the day after the Procedure the Patient's packing and catheter were removed and by the third day she was to be discharged. However, given that the Patient still had considerable bleeding and the family were concerned about her condition, Consultant Gynaecologist 1 (the gynaecologist who performed the Procedure) agreed to leave her admitted for further observation.

The Complainant informed the Ombudsman that the Patient continued to bleed whilst in hospital to the point that she had to resort to using adult nappies due to the continuous flow of blood she was experiencing. He stated that during her hospital stay, the family approached Consultant Gynaecologist 1 on numerous occasions and relayed their concerns but were informed that the symptoms the Patient was experiencing were normal following the Procedure and that the bleeding would dry up as the healing process progressed.

According to the Complainant, on the 21st March, six days after undergoing the Procedure, Consultant Gynaecologist 1 examined the Patient in the ward bed and informed her that there was slight bleeding from the incision site which he considered normal. He explained to the Patient that everything was healing adequately and discharged her from hospital.

The Complainant however claimed that the Patient continued to bleed abundantly and had to visit Consultant Gynaecologist 1 as an outpatient on two consecutive days following her discharge from hospital. During the first visit, the Complainant stated that Consultant Gynaecologist 1 cleaned the Patient's wound to remove the blood and applied Silver Nitrate on a raw spot he found on the incision site. Additionally, Consultant Gynaecologist 1 prescribed the Patient with oral antibiotics. According to the Complainant and the Patient, Consultant Gynaecologist 1 reassured them that the bleeding was normal and it would soon stop. During the second visit, Consultant Gynaecologist 1 packed the Patient's vagina with gauze and re-admitted her into hospital in order to remove her packing himself early the following morning.

The Complainant informed the Ombudsman that the following morning as Consultant Gynaecologist 1 removed the Patient's packing, he became increasingly concerned at "*the amount of blood that gushed out"* and conferred the Patient's case to Consultant Gynaecologist 2. He further explained that both consultants examined the Patient that same afternoon and decided that she needed Examination under Anaesthesia ("EUA") that day in order to review the original incision site. He explained however, that since the Patient had already eaten that morning, EUA was postponed until late in the evening so as not to suffer any adverse effects from the anaesthesia.

According to the Complainant, on the evening of the 24th March 2017, Consultant Gynaecologist 2 performed EUA on the Patient in the absence of Consultant Gynaecologist 1 given that he was travelling to the United Kingdom that same evening. The Complainant stated "*We were informed that the EUA would be to close the suture of the initial incision leading us to believe that the original operation had not been performed properly…. The EUA took over 2 hours and following several attempts, Consultant Gynaecologist 2 informed the family that she had been unable to suture the wound as the vaginal tissues were "all mushy and like jelly" and she needed a colleague to help her but that there was none because they were on leave. She could do nothing further and my wife (the Patient) was now bleeding profusely from the open wound. My wife (the Patient) was given blood transfusions but this was futile given that the wound had not been closed… Consultant*

Gynaecologist 2 further informed us that she would be transferring my wife (the Patient) to a Tertiary Referrals Centre in Spain as an emergency patient due to the unsuccessful intervention and the fact that my wife (the Patient) was now losing a considerable amount of blood."

The Complainant informed the Ombudsman that at approximately 2 am that same evening, the Intensive Treatment Unit ambulance from the Tertiary Referrals Centre arrived at St Bernard's hospital to transfer the Patient. He further stated that the family were informed by the emergency doctor on board the ambulance that the Patient was in a critical condition, haemorrhaging profusely and that the chances of her reaching the Tertiary Referrals Centre alive were very slim.[9]

Upon arrival at the Tertiary Referrals Centre, at approximately 4 am, the Complainant explained that further surgery was attempted by two gynaecologists at approximately 5 am and by 6 am, the family was informed that the wound had been closed and the haemorrhaging had been stopped. The Complainant stated "*This final intervention had taken less than an hour. In Gibraltar, the advice given to the family was that the vaginal tissues were in such a bad condition that they could not be sutured without a team of gynaecologists. This begs the question as to why my wife (the Patient) had not been transferred to the Tertiary Referrals Centre prior to the intervention in Gibraltar.*

The Complainant informed the Ombudsman that following the surgical intervention at the Tertiary Referrals Centre, the Patient was kept in the ITU for two days with *nil-by-mouth* as a precaution in case she required further interventions. He explained that on the second day following the surgery she developed right sided upper lobe pneumonia and was treated with two antibiotics intravenously to clear the infection in both her lungs and vagina.

The Complainant concluded his letter to the Ombudsman by stating, "*What is most surprising is that if the gynaecology surgeons in the Tertiary Referrals Centre were able to stop the bleeding after less than an hour, why wasn't the same expertise available in Gibraltar, for what was after all a relatively minor operation? One wonders at the professional judgement of Consultant Gynaecologist 2 who should have referred the matter to the Tertiary Referrals Centre immediately instead of single-handedly trying to correct the initial Procedure and making matters worse. This would have saved both my wife (the Patient) and her family a great deal of pain and despair.*

[9] For the benefit of the reader, the Tertiary Referrals Centre was approximately 120 Km away from Gibraltar.

As a result of all the above, the Complainant lodged a complaint on behalf of the Patient and urged the Ombudsman to review the "*quality of care*" and "*expertise"* in the Gynaecology Department at St Bernard's Hospital to avoid similar situations from arising in the future.

Investigation

The Ombudsman requested comments from Consultant Gynaecologist 1 and Consultant Gynaecologist 2 via the Medical Director of the GHA as per usual practice and he also reviewed the Patient's medical notes.

Consultant Gynaecologist 1

In his statement to the Ombudsman, Consultant Gynaecologist 1 explained that he initially saw the Patient and assessed her in clinic for the first time on the 23rd January 2017 as she was suffering from pain on micturition, lower abdominal pain and constipation. He clarified that she was referred to him by the Nurse Practitioner upon noting "*prolapse*" of the vaginal wall in addition to her other symptoms. By way of further background Consultant Gynaecologist 1 explained that the Patient had had three children by vaginal delivery, she had no history of bleeding per vagina and had also undergone "*abdominal hysterectomy at the age of 37 for uterine fibroids followed by laparotomy and bilateral salpingoophorectomy for pelvic pain*". He further commented "*Her significant medical history includes interstitial cystitis, hypertension, arthritis and cardiac pacemaker in situ...Clinical examination was essentially normal except for the surgical scar on the abdomen and grade 3 rectocele[10]. She had no cystocoele[11] and the vault was well supported.* Consultant Gynaecologist 1 explained that during the consultation he discussed the three options available to the Patient to manage her symptoms which included "*leave alone and physiotherapy, pessary or surgical posterior repair*". The Patient opted for surgical management and underwent surgery on the 15th March 2017 which Consultant Gynaecologist 1 stated was "*uncomplicated*". He commented that he reviewed the Patient a day later, removed her *packing* and *catheter* and seeing as she was well and he had noted no bleeding, he discharged her from hospital on the 17th March 2017 to be reviewed six weeks later as an outpatient in his clinic.

[10] A rectocele is a prolapse or 'falling down' of the bowel, which is slipping into the vagina. It is actually a problem with a weakness of the back wall of the vagina which prolapses, carrying with it the rectum, (part of the bowel), which lies directly behind the vagina.

[11] A cystocele, also known as a prolapsed bladder, is a medical condition in which a woman's bladder bulges into her vagina. Some may have no symptoms. Other may have trouble starting urination, urinary incontinence, or frequent urination. Complications may include recurrent urinary tract infections and urinary retention.

On the 18th March 2017 however, Consultant Gynaecologist 1 stated that he was informed by the staff at the surgical ward that the Patient was still admitted given that she had had residual urine of 150ml[12]. He commented "*She passed small amounts (less than 100ml) of concentrated urine. I was also informed that she only drank small amounts of fluid about 500 -1000ml per day. I advised that she increased her fluid intake and to have the residual rechecked.* Consultant Gynaecologist 1 further highlighted; "*Please note that urine output measurements are at best rough estimates since the Patient was incontinent from Interstitial Cystitis and wore a pad continuously even prior to the procedure*".

According to Consultant Gynaecologist 1 he reviewed the Patient during her extended ward stay on the 19th March 2017 as she complained of *bleeding per vagina* and pain on micturition and explained that he performed a vaginal examination with a speculum which showed a small amount of serosanguinous fluid of less than 5ml. He commented that he observed that the wound was clean and no active bleeding was noted. He stated "*I felt that the vaginal fluid may have been the urine in contact with the raw surgical area. With regard to the pain on micturition I also ascribed this to the Interstitial Cystitis as stated earlier*". He commented that notwithstanding this, the urine that was obtained was sent to be tested at the laboratory to exclude a urinary infection, and explained that the result of the tests carried out were negative.

In his statement to the Ombudsman Consultant Gynaecologist 1 stated that he planned to review the Patient at the surgical ward the following day (20th March 2017) but he believed that the Patient was discharged instead. He furthermore stated "*Some pages including the Consent Form are missing from her File".*

Consultant Gynaecologist 1's next review of the Patient was on the 21st March 2017 when the Patient self-referred to the Gynaecology Department complaining of vaginal bleeding. He commented that upon review of the Patient, she was not "*feverish"* and had "*good colour"*. He stated that he "*Again carried out a speculum examination and the findings were a small blood clot which was foul smelling. There was also a raw area at the vault but no active bleeding seen. I took a high vaginal swab, applied silver nitrate stick to the raw area and commenced the Patient on antibiotics pending the sensitivity result*".

[12] Residual urine test - This is usually done by carrying out an ultrasound scan of your bladder, although occasionally the amount of urine in your bladder may be measured after it has been drained using a catheter. A catheter is a thin, flexible tube that is inserted into your urethra and passed through to your bladder. https://www.nhs.uk/conditions/urinary-incontinence/diagnosis/

Consultant Gynaecologist 1 stated that it was at that point, that the Patient and the Complainant informed him that the Patient had always had bleeding problems even with minor procedures such as dental extractions. He commented "*This prompted me to request a review by the haematologist for clotting factor deficiency. She went home to be reviewed by the Haematologist the following day. The screening for clotting factor deficiency was normal"*. He further explained that he once again examined the Patient the following day given that she continued to complain of bleeding and staining her incontinence pad. He stated "*this also revealed only a serosanguinous fluid and no bleeding was seen. Up to that stage, I still entertained the idea that urine was possibly washing the raw operative area. I therefore put an indwelling urinary catheter and a pack in the vagina. She was admitted to the surgical ward for observation*".

Consultant Gynaecologist 1's final review of the Patient took place on the 24th March 2017 at 11 am. He stated "*the pack was removed and noted to be stained but no fresh bleeding. I advised that she stays in the ward and that the catheter be removed the following day. However 3 hours later, the nurse informed me that the Patient experienced a vaginal bleed after washing. When I arrived at the ward I noticed she had fresh blood. This was the first time I had seen fresh blood from the Patient since the Procedure"*. Consultant Gynaecologist 1 explained that as a result, he requested a colleague's opinion ("Consultant Gynaecologist 2"). He commented, *"…examination by Consultant Gynaecologist 2 did not show a bleeding point. At this stage we both agreed that the way forward was EUA in the theatre. This was performed by Consultant Gynaecologist 2 as she was on call that evening. I was unable to attend the theatre as I had to fly to the United Kingdom that evening. However, I kept in touch with her to get the report of the outcome and she informed me that she could not identify any bleeding point either and she had to pack the vagina and transfer the Patient to a Tertiary Referrals Centre*".

Consultant Gynaecologist 1 informed the Ombudsman that he subsequently contacted the Tertiary Referrals Centre where he was informed by the gynaecologist who performed the procedure that the Patient had had some suturing which stopped the bleeding and was improving. He concluded his statement to the Ombudsman by stating "*I subsequently met the Complainant along the Gynaecology Outpatient Clinic corridor as they had not attended the Clinic follow-up. I enquired about the Patient and he bluntly told me he was not speaking to me because we wanted to kill his wife (the Patient)".*

Consultant Gynaecologist 2

In her reply to the Ombudsman, Consultant Gynaecologist 2 addressed the various complaints brought against her and highlighted that she was pleased to read that the Patient was recovering. She stated "*I did and do apologise for the harrowing experience the lady suffered".* She further stated "...*Unfortunately the clinical notes are not complete, which means that a part of my reaction will be based on my memory".*

Consultant Gynaecologist 2 explained that on the 24th March 2017, Consultant Gynaecologist 1 requested her assistance in examining the Patient and stated that on examination, they noted "*clear vaginal bleeding and a smelly discharge and since the Haemoglobin dropped from 13.7 (pre- assessment 03-03-2017) to 11.5 (post-operative 20-03-2017) to 10.0 on the 23-03-2017 I advised to plan EUA together with Consultant Gynaecologist 1*".

In her statement, Consultant Gynaecologist 2 stated that prior to arranging for the EUA to take place that same day, she explained to the Complainant and the Patient the fact that that in general, under similar circumstances, she preferred to perform EUA together with a colleague. She however explained that she was unable to plan this with a colleague since the Patient had not fasted that day and this was necessary before administering anaesthesia. She stated "*the earliest we could plan the EUA was around 18:00 hrs, I tried to push it forwards since I knew that one of my colleagues was away on study leave and the other one would fly to the UK that evening, which would mean that there would be no second consultant to support*".

EUA

With regard to the EUA, Consultant Gynaecologist 2 explained that she was unable to stop the Patient's bleeding given that she was unable to locate the source. She stated, "*Inspection of the vagina was very difficult because of the narrow vagina. Necrotic vaginal tissue was noticed and clots were adhered. It was very difficult to recognise any healthy normal vaginal tissue and the cause of the bleeding could not be found. Several sutures were placed, but because of the necrotic tissue they did not hold. Every time I thought we stopped the bleeding it started oozing again. Because of the smell I also requested an X-ray in theatre to be sure no swab was left from the first procedure (which already took 30-45 min.) After applying more sutures (blind – no evident source of bleeding to be seen) a vaginal pack was inserted and the Patient transferred to the Intensive Care Unit ("the ICU")*".

Consultant Gynaecologist 2 concluded her account of the EUA by explaining that the Patient's estimated blood loss during the procedure had been approximately 400 ml and her clinical situation was stable but since they had already ordered bloods, they decided to start giving them, to prevent further dropping of the Haemoglobin and hence the blood transfusion the Complainant referred to in the background section of this report.

ICU

Subsequent to transferring the Patient to the ICU, Consultant Gynaecologist 2 updated the Complainant and her family about the EUA and according to her "*apologised about the whole situation*" as well as expressed her "*worries*", since she was not sure if the bleeding would stop given that she had been unable to locate the source. Consultant Gynaecologist 2 explained to the Complainant and the family that should the bleeding continue, she would advise for the transfer of the Patient to the Tertiary Referrals Centre specifically requesting them to have two consultant gynaecologists waiting to perform a second EUA given that as a result of the EUA carried out by herself, she knew that this would be a difficult procedure requiring two consultant gynaecologists.

Commenting on her review of the Patient after being transferred to the ICU after undergoing the EUA, Consultant Gynaecologist 2 explained that, the Patient was awake, alert, comfortable and self-ventilating on a facial mask. She further stated "*Because of the fact that there was still vaginal bleeding through the pack visible, the anaesthetist on call and I decided to start the transfer procedure to the Tertiary Referrals Centre, since at that moment, the Patient was still clinically stable (22.40 hrs)*".

Consultant Gynaecologist 2 explained that as per her advice, the anaesthetist contacted the Tertiary Referrals Centre, spoke to the consultant gynaecologist on call and reiterated the need for two consultants to be available given that Consultant Gynaecologist 2 anticipated difficulty in resolving the Patient's problem with just one consultant. The transfer of the Patient was accepted by the Tertiary Referrals Centre. Consultant Gynaecologist 2 commented "*Before the transfer, the vaginal bleeding was measured through the vaginal pack and showed a total of 360 ml. The observation chart of the ICU showed no clinical instability (the lowest Blood Pressure was 115/40 and Heart Rate at that moment was of 56)… I spoke to the Complainant and family again and apologised again, but explained that we thought it would be in the best interest of the Patient to be transferred at that point in time given that she was still in a stable situation. I also informed them that we had requested two consultant gynaecologists to be available*".

Consultant Gynaecologist 2 finally explained that given the time lapse of 2.5 hours from when the transfer was arranged to when the Patient's transfer actually began, the Patient's condition declined and the observations prior to transfer at 2.00 a.m. were, Blood Pressure 140/60 and Heart Rate, 90. She stated "*I do not know why it took 2,5 hours before the actual transfer took place and I also do not know what exactly happened at the Tertiary Referrals Centre since none of the consultants came back to me. Fortunately I did hear the next day via an unofficial route, that they did manage to stop the bleeding and that the Patient was in a stable situation. To learn that they managed the intervention within an hour confirms the fact that two consultants, see and, can do more than one*".

Consultant Gynaecologist 2 summarised her statement by explaining that vaginal bleeding after a vaginal procedure was a known complication which can often be solved without a second procedure, but this was not always the case. She stated "*In general, if a second procedure is necessary, sometimes the reason for the bleeding is found straight away but it is not always the case. The longer ago the original procedure happened, the more difficult it is to find the problem and to solve it. Additionally, any vaginal problem can be solved easier with two consultants than with one (the knowledge of the area, knowing how to assist, what to expect is superior with two)*". Commenting on the steps taken and her treatment of the Patient, she stated "*Knowing the above mentioned, I would follow the exact pathway as has been followed. Of course I would have preferred to have a colleague available, but that unfortunately is not the situation in Gibraltar*".

With regard to the comments made by the Complainant, that Consultant Gynaecologist 2 should have transferred the Patient to the Tertiary Referrals Centre prior to attempting the EUA single-handedly, Consultant Gynaecologist 2 reiterated the fact that had the Patient's problem been an "*easy to find*" one, she would not have made arrangements to transfer her at all and highlighted that it was a decision that she was only able to make during the EUA and "*not before*".

Consultant Gynaecologist 2 concluded her statement by stating "*Of course I never want to have any patient experience what this Patient experienced and I really wished it would have been different and I sincerely do apologise for that, but in my eyes, I never neglected the Patient and I did give her the best possible care I could give (including the transfer). I hope she will recover completely*".

Clinical Advice

Given that the matters being complained about were clinical in nature, the Ombudsman prepared a case file and dispatched it, together with a request for independent specialist medical advice to an Expert ("Expert") in the United Kingdom.

The questions presented by the Ombudsman to the Expert (a Consultant Gynaecologist and Urogynaecologist employed by the Oxford University Hospitals Foundation Trust who treats patients presenting with general gynaecological conditions, pelvic floor prolapse and urinary incontinence. The Expert specified that he also regularly carries out vaginal prolapse repair surgery and is a member of the Oxford University Hospital Urogynaecology Multi-Disciplinary Team and holds 5 operating lists and 3 Gynaecology Clinics per Week in the NHS and Private sector) and the replies received (which have been summarised for the purposes of this report) were as follows;

Ombudsman's Question 1 (a)

In the opinion of the expert, should the Patient's bleeding have been addressed at an earlier stage given that EUA was considered 9 days after the Procedure?

Expert Reply

The Expert explained by way of information the fact that the Patient had undergone a procedure known as Posterior Colphorraphy and noted that he was unable to find any notes in relation to the Procedure itself in the Patient's medical notes. The Expert further explained that subsequent to undergoing the Procedure, patients may experience vaginal bleeding for up to three weeks[13]. He stated that the Patient's medical notes documented light bleeding after the Procedure and commented that there was only a "*modest*" drop in her haemoglobin concentration during the time from 13.7 g/dl, preoperatively, to 11.5g/dl on Day 5 postoperatively. He stated "*When she was examined after re-admission, there was evidence of infection (offensive discharge/blood) and she was started on Co-amoxyclav and Metronidazole, broad-spectrum antibiotics which are the standard first-line treatments for post-operative gynaecological infections".* The Expert explained that Infection was a common cause of delayed bleeding and discharge after the Procedure and therefore it was appropriate not to perform the EUA until the bleeding increased on Day 9.

[13] Recovering Well. Information for you after a Pelvic Floor Repair Operation (https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/recovering-well/pelvic-floor-repair-operation.pdf)

Ombudsman's Question 1 (b)

Was it reasonable to wait as much as 9 days to address the Patient's bleeding? Are there any guidelines/ criteria in place?

Expert Reply

The Expert explained that in general, antibiotic treatment would address the *delayed post-operative bleeding and discharge*. He therefore concurred that since the Patient was started on antibiotics on Day 7, it was reasonable to wait for these to take effect, as they "*would be expected to resolve the offensive discharge and bleeding*".

The Expert further explained that there were no guidelines that specify when a further intervention should take place for women who bleed after pelvic floor surgery. He stated *"In this case the decision to perform EUA was made with respect to the heaviness of the vaginal bleeding and her overall clinical condition and appears appropriate*".

Ombudsman's Question 1 (c)

Was Consultant Gynaecologist 1's statement reasonable and to the required standard?

Expert Reply

The Expert explained that Consultant Gynaecologist 1's statement was a summary of the Patient's care, providing details of the clinical encounters throughout her admissions. He stated "*It explains the rationale for the management decisions that were taken and the statement is consistent with the written notes. Therefore in my opinion it is written to the required standard".*

Ombudsman's Question 2

The Complainant is of the opinion that the Patient's bleeding was aggravated by the vaginal "packing" which the Patient had on several occasions before the EUA was performed on the 24th March 2017. Can the Expert explain this process and confirm whether or not this was the right method to use under the circumstances?

Expert Reply

The Expert stated "*vaginal packs are lengths of gauze that are inserted into the vagina to create tamponade (pressure) on the vaginal walls and reduce bleeding by compressing small blood vessels"*. He commented that most clinicians believed that vaginal packing contributed to a reduction in haematoma formation, helped reduce bleeding and as such,

was a widespread practice used in patients who undergo pelvic floor surgery[14]. He stated, "*Packs are normally removed within the first 24-48 hours, as was the case for the Patient. A pack was re-inserted on the Patient's readmission on the 23rd March 2017(Day 8) to reduce bleeding and it was replaced after the EUA carried out by Consultant Gynaecologist 2. I consider that the use of vaginal packing was appropriate for the Patient.*

Ombudsman Question 3 (a)

Consultant Gynaecologist 2 explained that she needed the help of a colleague to identify the source of the bleeding. What is the set clinical standard for surgical procedures of this nature? Should Consultant Gynaecologist 2 have attempted the EUA without help?

Expert Reply

The Expert explained that when Consultant Gynaecologist 2 performed the EUA, "*it would be expected that she would have detected the source of bleeding and been able to treat by re-suturing. However, the procedure was technically more complex than anticipated and she was unable to identify the bleeding point. Consultant Gynaecologist 2 commented in her operation note that view of the operative field was compromised because the vagina was narrowed, making the procedure technically more complex. This procedure is routinely performed by one Consultant and an assistant and it was appropriate for Consultant Gynaecologist 2 to have undertaken the EUA without a second Consultant. She could not have anticipated the technical complexity that she encountered".*

Ombudsman Question 3 (b)

Given that Consultant Gynaecologist 1 was not able to assist in the EUA which took place on the 24th March 2017 and taking into consideration the condition of the Patient on the 23rd March 2017, does the Expert opine that transfer to the Tertiary Referrals Centre should have taken place earlier that day without undergoing the EUA?

Expert Reply

The Expert clarified that it was the increase in bleeding experienced by the Patient on the 23rd March 2017 which led to the Patient requiring the EUA immediately in order to ascertain and treat the source of bleeding. He commented "*At the time the decision was made to perform the EUA at St Bernard's Hospital, the expectation was that this would identify and treat the source of the bleeding and would not be expected to require two Consultants. The*

[14] Vaginal packing following pelvic floor surgery: an international survey. Int Urogynecol J. 2011; 22: S1769-S2008

degree of technical difficulty encountered during the EUA could not have been foreseen. It was therefore appropriate to have the EUA in St Bernard's Hospital by Consultant Gynaecologist 2, without Consultant Gynaecologist 1".

Ombudsman's Question 4

In the opinion of the expert, can any maladministration be identified in the procedure that has been followed as outlined by the Consultant Gynaecologist 2 in her statement?

Expert Reply

The Expert reviewed the notes and Consultant Gynaecologist 2's statement sent to the Ombudsman. He commented "*Consultant Gynaecologist 2 participated with Consultant Gynaecologist 1 in the Patient's care on the 24th March 2017 and later in the day took over care solely as the on-call Consultant. She made the appropriate management decision to take the Patient to the operating theatre (EUA) in a timely manner. She recognised that she was unable to surgically repair the vaginal tissue herself because of the technical complexity and she made the correct decision to transfer the patient to ITU and subsequently to the Tertiary Referrals Centre for further treatment. I can therefore find no evidence of maladministration*".

Ombudsman's Question 5

Would the expert advising conclude that the Patient received an acceptable/adequate level of care and that there has been no maladministration regarding the care afforded by the GHA to the Patient?

Expert Reply

The Expert acknowledged that the Patient had suffered "*serious*" and "*distressing*" complications following the Procedure and although he accepted that this must have been "*extremely frightening"* for both the Patient and the Complainant, he stated that "*these complications, though not common, are recognised*".

With regard to the general care provided by the GHA, he commented "*she was reviewed regularly by Consultant Gynaecologist 1 and the investigations and management decisions were appropriate. The working diagnosis for her secondary (delayed) post-operative haemorrhage was infection and she was commenced on the appropriate broad-spectrum antibiotics. The severity of her complication leading to her deterioration and need for re-operation could not have been predicted at an earlier stage and in the circumstance she was managed correctly. I therefore consider that she received a satisfactory standard of care"*.

Conclusions

The Ombudsman relied heavily on the advice provided by the Expert in order to deliver his findings on this case given that all matters complained about were clinical in nature.

As regards the delay in addressing the Patient's bleeding, although the Ombudsman considered the comments by the Patient and the Complainant in that the bleeding was much more abundant than Consultant Gynaecologist 1's account, the Ombudsman noted the Expert's comments in that the Patient's medical notes documented light bleeding after the Procedure and that there was only a "*modest drop in her haemoglobin concentration during the time from 13.7 g/dl, preoperatively, to 11.5g/dl on Day 5"* after the Procedure. The Ombudsman was therefore not able to sustain the complaint in relation to the care afforded to the Patient by Consultant Gynaecologist 1 following the Procedure.

With regards to the comments made by the Complainant in that Consultant Gynaecologist 2 should have made arrangements to transfer the Patient to the Tertiary Referrals Centre sooner without single-handedly attempting the EUA, the Ombudsman once again considered the Expert's opinion in that the Patient's source of bleeding on the 24th June 2017 needed to be identified and treated promptly and the fact that "*The degree of technical difficulty encountered during the second procedure could not have been foreseen".* The Expert summarised his position by stating *"It was therefore appropriate to have the EUA in St Bernard's Hospital by Consultant Gynaecologist 2, without Consultant Gynaecologist 1*". This led the Ombudsman to believe that although the steps taken by Consultant Gynaecologist 2 were distressing for the Patient and her family, the right pathway was followed and hence he was unable to sustain this limb of the complaint.

During the course of this investigation however, it came to light that according to Consultant Gynaecologist 1 and 2 and to the Expert delivering the advice that various medical notes were missing from the Patient's file. This the Ombudsman found to be concerning and wished to highlight the importance of proper record keeping to the GHA's Medical Director.

Classification

Aggrieved by the care received following a surgical procedure which led to the Patient being transferred to a Tertiary Referrals Centre in Spain due to excessive bleeding – Not Sustained

(Report extracted from Case No 58 - Health)

GIBRALTAR PORT AUTHORITY

Case 9

Complaint

The Complainant was aggrieved with the following:

1. Allegedly there was no mention of maximum dimensions for the mooring of a boat at the Mid-Harbour Small Boats Marina ("MHSBM") at the time of his application for a berth.

2. Vessels of the same size or larger are berthed there.

3. Unprofessional practice at the Gibraltar Port Authority ("Port Authority") in the manner that his request for a berth at the MHSBM had been dealt with and how it was subsequently revoked. As a result of such lack of professionalism the Complainant expended £16,000 on boat repairs and £5750 on legal fees.

4. Feels he should be allowed to return to the MHSBM for all the issues raised as well as the fact that Watergardens marina is unsafe.

Background

[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.*

The Complainant has written to us complaining that he is aggrieved with the alleged unprofessional behaviour he has had to endure from the Port Authority in relation to an application for a berth at the MHSBM. His complaint is four-fold and includes the fact that no mention was made at the time of application of the dimensions of acceptable vessels and of his boats' alleged unsuitability. The Complainant also informed the Ombudsman that there are boats of the same size or larger than his that are berthed at MHSBM, yet he has been made to return to Watergardens Marina where he was previously berthed. The Complainant contends that as a result of the malpractice with his application for a berth, he has spent £16,000 on boat repairs and a further £5,750 on legal fees. As a consequence and because he considers the Watergardens Marina is unsafe and not fit for purpose, the Complainant feels he should be allowed to return to the MHSBM.

Investigation

The Ombudsman wrote to the Port Authority setting out the Complainant's grievances. The letter explained how the Complainant's boat was registered in Gibraltar in 2008 with an official 'red book' bearing registration number and boat details. The vessel had been measured by the Port Authority and the details recorded accordingly. This red book is stamped on a yearly basis and carries a permit fee of £25.

In 2016 the new MHSBM was ready for allocation. It is alleged by the Complainant that he had priority for an allocation due to the fact that he was berthed at Watergardens and the standard of the pontoons were dangerous and had become a health and safety issue, yet he was not contacted by the Port Authority.

> *The Port Authority claimed that the Complainant was not contacted, due to the fact that he had used his boat to live on board and according to the law:*
>
> *Small Boats Mooring Control 2016*
> *11(1) "A vessel moored in a designated area shall not be used as a house boat or for storage or for any commercial activities or purposes".*

On 6th April 2016 the Complainant asked why he had not received a letter of allocation to the MHSBM. He was informed verbally that he was not entitled to it and according to the Complainant no reason was given for this decision. *The Port Authority on the other hand, stated to the Ombudsman that the reason cited above was given.*

On 12th April 2016 the Complainant, not being happy with this response, wrote to the then Captain of the Port, and on the 19th April he was called by the Port Authority and allocated a berth. He was allegedly asked to make some repairs to his boat so that it was up to an agreed standard. On the same day he paid £365 towards a commitment registration fee and was allocated berth K20. His application form was stamped and signed by the Port Authority. The Complainant subsequently emailed the Captain of the Port and thanked him for his assistance. The Captain replied congratulating him on his new berth.

During the course of the Ombudsman investigation, the current Captain of the Port commented that the previous office holder allocated the Complainant a berth, [but] should not have done so. Subsequent to his decision to allocate, he instructed the GPA officers to retrieve the berth. He also stated that there existed no such request for the Complainant to

improve his vessel. He alleged that the Complainant expended repairs because they were necessary because of the boat's state and not because they were imposed on him.

In order to upgrade his boat to the required standard and specification allegedly requested by the Port Authority (which the Port denies), the Complainant spent £16,000 on repairs. On 3rd May 2017 his boat was berthed at the MHSBM. The Complainant was also asked to pay his berthing fees in advance up to and including December 2017 (he was also asked to pay this in cash). This payment was settled accordingly.

However, according to the Port Authority, no such request would have been made "*as fees are collected by MHSBM Association".*

On 30th May 2017 the boat was taken to Spain for some repairs to its engine. On 3rd July 2017 the Port Authority called the Complainant and asked if they could go over to Spain to measure the boat. The Complainant agreed to this request believing it to be was common practice. However on 18th July 2017 he received a letter from the Port Authority stating that his boat was over the required length permitted for berthing at MHSBM and that he had one month to reduce the size of the boat or have his permit revoked. The Complainant stated that he was taken aback by the call and subsequently sought legal advice, particularly since he had been told that he would not be able to return to Watergardens where he was originally berthed but that he should instead seek "*alternative berthing*", something which he could never have afforded. It was as a result of engaging a solicitor to represent him on the issue that he was able to secure a place back at Watergardens but at a cost of £5750 in legal fees.

In his letter to the Port Authority, the Ombudsman sought comments in relation to the following:

1. Why the Complainant was not contacted in early 2016 for a berth when the MHSBM was ready for allocation? It is alleged that those berthed at the Watergardens Marina would be given priority.

2. Why, on enquiry in April 2016, was the Complainant verbally informed he was not entitled to an allocation?

3. Why was his request for a berth later accepted when he complained to the Captain of the Port?

4. Why was his boat not measured during the application process so as to verify the berthing requirements?

5. Bearing in mind that the berth was allocated on 19th April and that the boat was berthed in the MHSBM from 3rd May to 30th May before it was taken to Spain for repairs, why was contact not made with the Complainant until 3rd July for the boat to be measured, eleven weeks after the berth was allocated?

6. Confirmation that the vessel measurement requirement of 9.05m had been strictly adhered to by all boat owners.

A reply followed shortly thereafter. The CEO and Captain of the Port (new in post) replied chronologically to the questions out:

1. It was explained that the Complainant had been originally berthed at Sheppard's Marina. When that marina was sold and bought by Ocean Village, the Complainant was forced to move out of the marina as he was living on board his vessel with his disabled son. "*A concession was given to the Complainant by the then Minister of the Port for his vessel to berth at Watergardens, under humanitarian grounds only, with several other exceptional accommodations made". The letter confirmed that there "are other berth holders in Watergardens who have also been given berths under ministerial concession." It also stated that it was "correct that those berthed at Watergardens would be given priority for the new marina, however, this is not the case with [the Complainant] who was only given the concession to berth at Watergardens exclusively and was therefore not eligible for any other berth."*

2. As explained above.

3. As to why the request for a berth at MHSBM was accepted by the Captain of the Port, after the Complainant complained, the reply received was that "*under local legislation the powers of the Captain of the Port are **wide and varied** and exceptionally, under his discretion, he ordered that [the Complainant] be given a berth at MHSBM*:

"Small Vessels (Moorings Controls) Rules 2016

Powers of the Captain of the Port.

16(1) The Captain of the Port shall be entitled to issue such directions or orders as he may think necessary or expedient for the proper control and management of the designated areas and any act or omission which contravenes such directions or orders without reasonable excuse shall be deemed to constitute a contravention of these Rules."

The Ombudsman found this reply to be insubstantial and unsatisfactory.

4. The boat was not measured during the application process because, according to the Captain of the Port in his written reply, when the ministerial decision was made to exceptionally grant a berth at Watergardens by special concession, the Port Authority measured the Complainant's boat to ensure that it would fit **that** berth and, for the subsequent issue of a "red book". Therefore, the current red book information was an accurate reflection of the vessels size at the time (2008).

"At the time of the MHSBM berth allocation process, coupled with the pertinent legislation having being updated, ***the Port Authority took for granted*** *that the paperwork and other documents held on file were correct as per our system, [as with] other official documents…. The craft belonging to the Complainant was deemed to meet the parameters set out in local legislation, namely, the Small Vessels (Mooring Controls) Rules 2016. Therefore, no comments were made to [the Complainant] of his now apparent oversized craft at that time."*

The Ombudsman view was that the issue of the "*paperwork and other documents held on file"*, notably the vessel's measurements, was far too significant for the Port Authority to have taken "*for-granted*" insofar as their accuracy was concerned. The Port Authority should have checked their validity at the MHSBM berth allocation stage or at the very least, should have stressed the importance of the accuracy of the information to the Complainant and indeed, to all other applicants, **prior** to allocation.

5. In reply to the Ombudsman's query as to why the delay in measuring the Complainant's vessel to July 2016, considering that the berth at MHSHBM was allocated on 16th April of that year and that the boat had been berthed there from 3rd to 30th May, it was stated that the Port Authority had gone through the expense of having surveyors measure a number of vessels, after having received information that there were vessels berthed at the marina which exceeded the measurement limitations. The Port Authority had tried to arrange with the Complainant a suitable date for the measurement but given the latter's work commitments that was not possible. As a result the instruction was given for the survey to be undertaken whilst the vessel was undergoing repairs in Spain. The result length was a measured hull

of 9.90m. "*the results were conclusive and therefore in breach of the Small Vessels (Mooring Controls) Rules 2016. Action was taken for the owner of the craft to meet the criteria, replace the craft in question or lose the permit to moor in a Government mooring.*"

6. The Ombudsman had asked whether the restriction of 9.05m vessel length had been adhered to by all berth holders. The reply stated that there were still several oversized crafts berthed at MHSBM but "*given the complexity of each case involving lawyers, government and non-governmental entities it will take time to resolve each case in order that legislation is complied with.*"

The Ombudsman found this reply to be vague.

The overall substantive reply provided by the Captain of the Port (for which the Ombudsman was grateful), raised further questions which the Ombudsman subsequently put. The first related to the criteria applied for the application of a berth at MHSBM. The Captain of the Port replied that the criteria was established by the legislation currently in force.

The following query was also raised: "*You state that the current red book information is "an accurate reading of the measurement that was conducted to verify the size of the boat in 2008. This information was subsequently used by the Complainant when he completed the "letter of commitment" information sheet requested by your Office. If the Red Book reflected an "accurate reading", was assume that the anomaly came about as a result of the different type of boat measurements that can be used, i.e., a "waterline" as opposed to a "centreline" measurement. Given this information, can you comment on why the letter of commitment did not specify the type of measurement required for the MHSBM? Is this type of measurement specified on the Small Vessels (Mooring Controls) Rules 2016 and Government Guidelines.*"

The reply received explained that applicants for berths are provided with various documents to fill out when they first attend Port Authority offices. One of those documents *"…is a diagram showing the length of the hull. The Complainant indicated his hull length as being under 9.05m, in accordance with the "red book". The legislation states that hull length must not exceed that amount for larger berths located at MHSBM".*

The final question posed by the Ombudsman was how many discrepancies with boat measurements came to light once the Port Authority became aware of the ambiguity regarding dimensions and from all of them, how many had lost their berth at MHSBM? According to the Port, there are eight cases including the Complainant's with some (five) having made amendments to their vessels and a further two either making changes or selling their craft. It was confirmed that "*only the Complainant has had his berth removed".*

Subsequent to all the exchanges in correspondence between the Ombudsman and the Port Authority, the Ombudsman met the Complainant to update him on matters.

Conclusions

The Complainant remained frustrated with the state of affairs over his vessel. He stated that there were still boats larger than his berthed at MHSBM yet he had been asked to move his after the survey had been commissioned. The Port Authority explained to the Ombudsman that larger vessels than those permitted are still being dealt with by the GPA and will be evicted. Although that may well be the case, the Ombudsman remained dissatisfied with that position, from an administrative standpoint. Indeed no action at all had been taken to remove larger vessels since this entire matter was investigated. Two years had elapsed for that to have occurred.

The Complainant's contention remained that the Port Authority had measured his boat and that he had done nothing wrong when he completed the paperwork for a berth, upon reliance on the measurement contained in the red book. He subsequently spent money on improvements as had been requested and was given an expectation vis-a-vis the new berth, which was then taken away. Although the Ombudsman has seen exchanges in correspondence by lawyers acting for the Port Authority and for the Complainant, each offering conflicting advice on this point, the Ombudsman agreed with the Complainant's view and stance insofar as the expectation was concerned. According to the Port Department however,… "*the Complainant was fully aware that he had declared the length of his boat was compliant according to the paperwork submitted, when in reality he knew it was not. Additionally, the Complainant had expended funds on his boat of his own accord- [since] there was no pressure to do so".* As a final point, it was pointed out to the Ombudsman that "*the advice provided by lawyers to the Port Authority was clear and concise*" on the legal position of the measurements/berthing occupancy.

The Complainant also explained how originally he had been told he could not apply for a berth, and it was only when he met the Captain of the Port that he was told he could apply, on the basis that he fulfilled the *"permanent residence in Gibraltar"* criterion.

In addition, at the time of the application, it was a requirement that all boats be no longer than 9.05m but it was never made clear whether that was a waterline or centreline mark. The measurement was allegedly later *"changed"* to 9.45m (*no proof seen of this*), the Complainant's vessel measuring 9.75m (only 30 cm over the maximum dimensions allowed). His contention was that the true measurement of the boat remained unknown until the surveyor (commissioned by the Port Authority) took measurements. Prior to this he relied on the not unreasonable assumption that the red book measurements were accurate, valid and a true reflection of the vessels size. It was as a result of the new measurement that he was asked to vacate the berth.

Alternately, as stated to the Ombudsman by the Captain of the Port, the Complainant *"was informed verbally and in writing as it is reflected in the application, that the measurement taken into account is the hull length. That is from the tip of the bow to the end of the stern without any appendages".*

The Captain of the Port added that in his view, "*the Complainant conveniently forgets to mention the fact that the measurement on the red book was put in place in order to be able to accommodate him and his boat into Watergardens when he was evicted from Sheppard's marina. He was further assisted by the previous administration as he claimed to have a very sick child living on board. He also fails to inform the Ombudsman the fact that his boat was the only one supplied with electricity and water in order to be able to live aboard".*

It is interesting to note that the Complainant sought the services of a local law firm to represent him on this matter. However, he claims not to have been aware that his lawyer who was in correspondence with the Port Authority had allegedly stated to them that the Complainant would not pursue a claim for compensation in exchange for being allowed to re- berth at Watergardens. He further stated that when he agreed to return to Watergardens it was on the understanding that the pontoons (which he considered unsafe and unfit for purpose) would be fixed. This improvement never materialised either. The version provided by the Port Authority was that the Complainant was indeed present with his lawyer when *"I the Captain of the Port told him verbally that we would allow him to go back to Water Gardens however no claims for compensation would be accepted as works carried out to his vessel was not as a result of the berth situation etc. [He} confirmed to me verbally that he would not claim and that he was extremely happy that he would go back".*

It was further confirmed to the Ombudsman that there are plans to refurbish the area *"although not as the result of any [agreement] or condition set by [the Complainant]."*

The Ombudsman sought a practical solution to the Complainant's complaint. He opined that the Complainant should be exceptionally allowed to re-berth at MHSBM based upon the following facts: (1), boats which were in excess of the permitted measurements still remain within the MHSBM, (2) the original vessel measurements which were inserted into the red book and upon which the Complainant relied upon when he submitted the application for the berth, had been taken by the Port Authority in 2008 (3) the Complainant was initially told by the previous Captain of the Port that he was not entitled to a berth (with no reasons given), but was later allocated one when he complained on the basis that he was a permanent Gibraltar resident (4) he signed an acceptance letter, paid a fee and was congratulated on the allocation (5) he expended a considerable amount of money on vessel upgrades as had been requested (6) the Complainant enjoyed use of the berth (albeit for a limited amount of time) (7) it later transpired that the Port Authority had taken the red book insertions for-granted as being correct and upon re-measurement, doubts were raised on the standard applied- (waterline or centreline) (8) the Complainants vessel exceeded the maximum measurement allowed by a not significant amount and to date, despite that fact, vessels larger than the Complainant's still continue to berth at MHSBM.

However, the not insignificant matter remains that although the Captain of the Port enjoys "*wide*" and "*varied"* powers, the statutory provisions (Small Vessel (Mooring Controls) Rules, would disallow him from inviting the Complainant to re-occupy a berth at MHSBM:

"*Notwithstanding the definition of "small vessel" in these Rules, an individual granted a permit under the Small Vessels (Moorings Controls) Rules, 1990 to moor a vessel with a hull length in excess of 9.05 metres but not exceeding 9.15 metres in the designated area specified in Part I of Schedule 1, may continue to moor the said vessel within the same designated area under the said permit in accordance with sub-rule (1) but may not be granted a permit by the Captain of the Port to moor the said vessel within the area of the Port waters known as the Mid-Harbour Small Boats Marina as specified in Part II of Schedule 1".*

The position therefor, is that despite the Ombudsman's recommendation that the Complainant be allowed to re-berth, the law is strict in its application and would not allow for this unless the Complainant made changes to reduce the hull length, or replaced his vessel with one fitting the legal parameters insofar as measurement is concerned.

Classification

1. Alleges that there was no mention of maximum dimensions for the mooring of a boat at MHSBM at the time of application- **Not Sustained** *(Diagrams were provided by Port Authority at an initial meeting although as mentioned above, the Complainant relied on previous measurements taken by the Port Authority and recorded in the vessels red book some years earlier. Accordingly, there was no mala fides or intention to deceive on the Complainant's part). Of significance to note and as mentioned in the body of this report, was that the importance of the accuracy of measurements should not have been "taken for granted" by the Port Authority and ought to have been stressed to applicants prior to the allocation stage and before upgrades to bring vessels up to standard, (at considerable expense to owners) were requested.*

2. Vessels of the same size or larger are berthed there - **Sustained.** The Ombudsman finds it unacceptable for the Port Authority to keep stating that Vessels over the permitted length will be evicted without further details being provided or proof of action in that regard being submitted. The matter has been ongoing since 2018. This constitutes an administrative failing and perhaps even a case of discrimination against the Complainant.

3. Alleged unprofessional practice at the Gibraltar Port Authority in the manner that his request for a berth at the MHSB marina had been dealt with and how it was subsequently revoked. As a result of such lack of professionalism the Complainant expended £16,000 on boat repairs and £5750 on legal fees -**Sustained** (*the fact that he was informed he was not eligible to apply, that he was later allocated a berth when he complained, invited to execute documentation and submit payment, and subsequently have the berth removed after considerable expense was expended, in reliance of the berth allocation, constituted an act of maladministration (irrespective of the results of the subsequently commissioned survey). The Ombudsman opined that the Captain of the Port should have taken a view and exercised his discretion in favour of the Complainant at that stage, given the special circumstances of this case.)*

4. Feels he should be allowed to return to the MHSB marina for all the issues raised as well as the fact that Watergardens marina is unsafe- **Sustained** *(as explained above)*

(Report extracted from Case No 1176)

Case 10

Complaint

The Complainant was unhappy that he had not been given permission to erect an extension to enclose an outside area of his property despite the fact that there were already similar extensions erected by his neighbours on either side of his property.

Background

[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]***

The Complaint had requested permission from Housing to extend the exterior of his ground floor government rented flat. His intention was to enclose an outside area, thus bringing the external boundary to his flat in line with his neighbours on either side, who had carried out similar extensions. The Complainant's application was refused on the basis that it was Government policy "not to allow any alterations to the structure and integrity of the building, as this will change the aesthetics of the building causing an encroachment of common areas that would lead to problems with the water drainage system. It would also restrict access to the passage which cannot be accepted for [reasons relating to] Health and Safety Regulations."

The Complainant appealed the decision on the following grounds: Firstly, he claimed that he required the extra space to hang his washing; (his flat was a bed-sitter) and secondly, he pointed out that there were already "numerous" extensions which had been built by other tenants.

His appeal was dismissed.

Dissatisfied with the state of affairs and what he perceived to be a discriminatory application of policy, the Complainant filed his complaint with the Office of the Ombudsman. The Complainant felt it was unfair and nonsensical to be told that the proposal would affect the aesthetics and structure of the building and that it would encroach on common areas, when Housing had "turned a blind eye" to all other existing extensions. Part of his argument was that he would only be aligning and encroaching on an area that already had extensions on either side. He would simply build a continuous wall in line with the extensions to the left and right of his flat. On the face of it and before embarking on any investigation, the Complainant's arguments did not appear to be unreasonable to the Ombudsman.

Investigation

The Ombudsman presented the Complaint to HA and requested their comments as per standard Ombudsman practice.

Following various chaser letters, the Ombudsman received a short reply from HA which stated that the Complainant's request had been forwarded to the Land & Works Panel where it was considered but not approved. The letter explained that new extensions within the named housing estate were not being approved, but that existing ones would remain. The Ombudsman questioned whether in fact, tenants of existing extensions had sought permission which was subsequently granted by HA and whether rental payments on those properties had been increased by the landlord (Government) to reflect the additional area of their rented property.

The reply received stated that "as far as HA was aware, no rent had been charged for such extensions…..only additional accommodation (extra rooms) are charged". No comments were received in reply to the question of whether existing extensions had been subject to the planning process.

The Ombudsman was aware of Government policy in relation to extensions (implemented by the previous administration) in January 1997. However, the Ombudsman was not informed on whether the same policy was in place or whether the current Government had implemented an alternative policy.

Irrespective of this, it appeared to the Ombudsman that those tenants who proceeded to build extensions without permission were "allowed" to remain (since admittedly, it was a subject which was difficult to police), whereas those who sought to do so via official means, were refused permission, in pursuance of legislation or Government policy in force.

Conclusion

Although the Ombudsman had no hard evidence to substantiate his view, it would seem a reasonable conclusion to reach, that any application (under the Town Planning Act) to build an extension onto common land or land which did not form part of the applicants demise, would not be granted since it would be against public policy to allow Government tenants to enjoy exclusive access to land which did not form part of their tenancy and for which they had paid no consideration by way of increased rent.

The Ombudsman opined that in order to ensure fairness among all its tenants, the landlord should consider each future application on its own merits. The reasons given for the refusal to grant the Complainant's application, namely, that it would constitute "a change in the aesthetics of the building causing an encroachment of common areas" was not reasonable and did not constitute a valid rationale in the circumstances given that the external areas of the flats to either side of the Complainant's had extensions built. Neither the aesthetics of the building or access to it would therefore be hampered. Indeed, the extension would in the Ombudsman's view serve to "unify" that section of the exterior (pavement) bordering it. On that basis, the Ombudsman would urge Housing to reconsider its decision.

As for the existing extensions which had not been subject to the planning process, HA should ask those tenants with "illegal" extensions to apply for retrospective planning permission thus regularising their position. An equitable solution could also be to proportionately increase the rent payable to Government by those tenants, as consideration for the additional space acquired/granted.

Classification

Partly sustained

Recommendations

1. That HA should consider each request for an extension on its own merits in order to ensure fairness among tenants in the practical application of Government policy in this regard.

2. In the case of the Complainant, Housing should reconsider its decision based on the fact that the extension would, in the Ombudsman's view, serve to "unify" the section of the exterior (pavement) bordering it.

Update

The Ombudsman received an update from HA after having drafted this report. It stated that their policy was not to allow the creation of extensions to properties which encroach on public footpaths or communal areas. Although the Housing was aware of extensions having been added without consent, the reply stated that they were actively removing all existing extensions once the flats were surrendered back to the housing stock by current tenancy holders. The letter also stated that HA were undertaking a survey of existing tenancies and any extensions built to ascertain whether these had been erected without consent after which , a view would be taken on how best to proceed. The Ombudsman will be following this up accordingly.

The Ombudsman was of the opinion that, in practice, if no action was taken by HA until tenants handed back their properties, it would be perfectly possible for tenants to erect extensions without consent and enjoy them for as long as they held an interest in the property that they occupied. That policy was in the Ombudsman's mind, not conducive to any applications being made. Additionally, it seemed disproportionately unfair on those tenants who chose to apply for consent for patio extensions, since all extensions would in fact "encroach on public footpaths or communal areas". Any applications made therefor, would be refused on that basis. The Ombudsman believed that instead of a "blanket policy", each case should be considered on its own merits.

(Report extracted from Case No 1152)

Case 11

Complaint

The Complainant was aggrieved because the Housing Authority had not categorised his Son's Application as urgent.

Background

[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].*

The Complainant explained that after his Son separated from his wife she remained in the matrimonial home (a Government rented property) with their two children. At that time (around 2004) he stated the Son made enquiries at the Housing Authority's offices for re-inclusion in the Housing Waiting List ("List") but claimed to have been informed that he was ineligible to apply. Unable to afford a private rental in Gibraltar due to his financial situation, the Son resorted to a rental in Spain. According to the Complainant, in the coming years, a number of factors contributed to the Son suffering from mental health issues, not least feeling isolated in Spain, and after two serious episodes and admission into a mental health facility for a period of time, the Complainant made arrangements for the Son to hand the rental back and return to Gibraltar to reside with him. Notwithstanding this, the Complainant lived in a one bedroom Government rented property, which was exclusively for pensioners (persons over 60) and he knew that the Son would not be authorised by the landlord, the Housing Authority, to reside in that property. The Complainant feared that in the event that anything happened to him, his vulnerable Son would be rendered homeless.

The Son applied for inclusion in the List in March 2017 with the Application accepted shortly thereafter, and the Complainant's address was allowed to be used as a forwarding address for application purposes only; the Son would not attain any rights to the property or overcrowding points [Ombudsman Note: The Application was subject to inclusion in a Pre-List for a period of one year and would not enter the List until March 2018]. In April 2017 the Complainant requested a meeting with the Housing Authority to discuss the Son's medical condition and subsequent to a meeting with the Housing Manager in June 2017, his case was considered by the Housing Allocation Committee ("HAC") for categorisation as a medical case which if agreed would result in the Son's Application being included in a medical housing waiting list which would prioritise an allocation. In August 2017 HAC

informed the Son that the Application had not been categorised as 'medical', for inclusion in the medical housing waiting list, but that the remaining time in the Pre-List would be waived.

Distressed by the manner in which the Son's situation had been dealt with by the Housing Authority, the Complainant lodged his complaint with the Ombudsman.

Investigation

In September 2017, the Ombudsman presented the complaint to the Housing Authority. They confirmed that at HAC's meeting in August 2017 there had been no medical categorisation of the Son's case because medical professionals (part of HAC) deemed that his condition did not merit it. The Housing Authority advised that in looking at the Son's case they had noted that he had no fixed abode and suggested that he attend the Housing Authority's offices for a social interview to be undertaken and the case to be considered by HAC (for consideration of social categorisation) at their next meeting. The Ombudsman requested a copy of the minutes of HAC's meeting in August 2017 and a copy of the minutes of the June 2017 meeting between the Son and the Housing Manager. In respect to the August 2017 minutes, when those were received the Ombudsman noted that there was no written record of the decision process, there was only reference to a medial letter received (no date or detail provided) and the record of the decision that HAC had not made any medical recommendation and had agreed to waive the one year qualifying period (the remainder). The Ombudsman wrote to the Housing Authority putting to them his concerns that the minutes should include more detail as to the reasons that lead to a decision. No response was received from the Housing Authority.

Regarding the June 2017 minutes, the Ombudsman noted that at that meeting, the Son had raised the fact that he was living with the Complainant in the pensioners flat and was not authorised to reside there. He also informed the Housing Manager about his medical condition and that he had been admitted to a mental facility on a number of occasions. The Housing Manager requested an up-to-date letter from the Son's doctor for it to be passed to HAC for consideration. The Son was asked why he had not applied to the List earlier and he responded that he had tried at the time when he separated from his wife but was told by the Housing Authority at one of their counters that he would not be able to apply. The Housing Manager responded that there must have been a misunderstanding.

In December 2017, the Son received a letter from the Housing Authority informing him that HAC had recommended social categorisation and he would therefore be placed on the Social A List (priority list). Months later (April 2018) the Son notified the Housing Authority that the Complainant had sadly passed away and asked them to urgently review a solution to his situation. The response received from the Housing Authority on the 18th May 2018 offered the Son their condolences but requested that the keys to the Complainant's flat be returned by the 18th June 2018. They stated that they understood that it was a very sensitive and difficult time for the family but that their cooperation would be greatly appreciated. Distraught, the Complainant brought the letter to the Ombudsman. The latter suggested that the Son write to the Housing Authority to request a meeting. In the interim, on the 29th May 2018, the Ombudsman met with the Housing Authority to discuss a number of cases and also referred them to the Son's situation. The Housing Authority explained that the letter was a formality that had to be complied with. The Ombudsman pointed out that notwithstanding the fact that they were looking into his case, they had not contacted the Son, especially in view of his mental health condition, to reassure him that he would not be rendered homeless.

The Ombudsman updated the Complainant with the information provided by the Housing Authority and reassured him that he would not be left without a home. On the 11th July 2018, the Complainant was made an offer of allocation which he accepted.

Conclusions

The allegation raised by the Complainant that around 2004, the time when he and his wife separated, the Son made enquiries at the Housing Authority's offices for inclusion in the List and was told that he could not apply, cannot be investigated by the Ombudsman due to the fourteen year period elapsed.

On the matter of non-categorisation of the Son's case as urgent, the Ombudsman cannot comment on the merits of the decision taken by HAC, in this case not to categorise the Son's situation as a medical one, but pointed out to the Housing Authority that the minutes of those meetings should have provided more details on the reason/s for the decision that was taken; upon reviewing a copy of HAC's minutes it was noted that at present, these only record documents submitted by the applicants, and then without providing any detail (no date) and the decision taken.

Notwithstanding the above, the Ombudsman finds maladministration in this case as the Housing Authority, despite having full knowledge of the Son's situation, both health and housing issues, failed to provide him proper advice on the correct course of action to follow;

i.e. failing medical categorisation, the Housing Authority should have contacted the Son and informed him that due to his circumstances, he could request that his case be considered for social categorisation. That did not happen automatically. It was only when looking into the Son's case as a result of the Ombudsman's enquiries in September 2017 that the Housing Authority noted that the Son had no fixed address and suggested that he apply for social categorisation. Had the Complainant not lodged his complaint with the Ombudsman nothing would have happened.

Regarding the letter sent by the Housing Authority to the Son, after the Complainant passed away, for the repossession of the flat, the Ombudsman was critical about the insensitive manner in which this matter was handled. It was only as a result of a meeting between the Housing Authority and the Ombudsman and when discussing the letter sent to the Son, that the Ombudsman learned it was a formality that had to be complied with but that the Housing Authority were looking into the Son's case. It was the Ombudsman's view that in similar cases in the future, the Housing Authority should meet with the person to discuss all issues.

Classification

Sustained - Housing Authority had not categorised the Son's Government Housing Application ("Application") as urgent.

Update

Further to reading this report, the Housing Authority advised that although they did not accept the Ombudsman's classification they agreed that they could have referred the Son to HAC for social recommendation, following the outcome of his application under medical grounds. The Housing Authority further advised that the letter sent to the Son, following the Complainant's demise, was sent as a formality, and that subsequently, the Son met with the Housing Manger who reassured him of the Housing Authority's willingness to assist him with his application and he would not be made homeless.

(Report extracted from Case No 1159)

Case 12

Complaint

The Complainant was aggrieved because the HA had not provided written replies to letters she had sent to them in October, November and December 2017. She was further aggrieved because despite having submitted a copy of the divorce 'decree absolute' the HA had refused to activate her Application until her Former Partner submitted the Form, excluding her and her son from the tenancy of the matrimonial home.

Background

[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].*

The Complainant, a British national, explained that she and her Former Partner had married in 2009. The Complainant and her son from a previous relationship (three years old at the time) resided with the Former Partner at his mother's home until they were allocated the Flat. The Complainant explained how she and her Former Partner had experienced marital difficulties to the extent that by the end of 2016, the relationship was acrimonious and at breaking point. According to the Complainant, in January 2017, upon returning with her son from a short holiday, she was unable to gain access to the Flat because he had changed the lock.

The Complainant stated she contacted a lawyer who advised her that forced entry to the Flat was not lawful and that the matter would have to be resolved in Court. The Complainant approached the HA about her situation and claimed to have been told by a clerk at one of the office counters that the Former Partner had the right to the Flat because the tenancy agreement was in his name. The Complainant claimed to have voiced her disagreement about this as she was already married at the time of allocation and highlighted that whereas she and her son had nowhere to live, her Former Partner owned a property in Spain. According to the Complainant, the clerk was adamant that the Flat was his. The Complainant stated that if the HA had told her she had a right to the Flat she would have fought for it. By way of further information, the Complainant explained to the Ombudsman that she had engaged the services of a lawyer but that she did not pursue obtaining the tenancy of the Flat via the legal route.

In February 2017, the Complainant submitted her Application to the HA. In June 2017 she obtained the divorce 'decree absolute' and provided a copy of said document to the HA in support of her Application. In October 2017, not having had any news from the HA in respect of her Application, the Complainant hand delivered a letter to them along with a second copy of the divorce document (HA issued a receipt for that dated 30th October 2017). In that letter, the Complainant explained their circumstances; that she and her son were homeless and had to rely on charity from friends for a roof over their heads. She also conveyed to the HA the information provided by the clerk at the HA offices regarding the right of tenancy of the Flat and the fact that as a result, she had not pursued that avenue. The Complainant stated that her son was suffering as a result of their situation and that it was inevitably affecting all aspects of their lives. In order to prioritise their Application, the Complainant requested that the HA include them in the Social A List (a priority housing waiting list) as from the date of Application.

Due to the severity and desperate nature of their circumstances, the Complainant sent a chaser letter to the HA on the 17th November 2017 and also phoned and visited their offices. Despite being informed that her case was being considered, the Complainant claimed she was told in December 2017 that the HA did not have her October 2017 letter and that her Application could not be activated until her Former Partner submitted the pertinent exclusion form ("Form") to remove her and her son from the tenancy. The Complainant explained that the divorce had been acrimonious and as such she did not think he would sign the Form so she asked that the HA take the divorce document as proof that the relationship had broken down and they no longer resided together in the Flat. The Complainant resubmitted the October 2017 documentation on the 6th December 2017, accompanied by a letter of complaint in which she noted that the documentation she had handed in in October 2017 had been lost. The Complainant stated that it was unjust that such important documentation had been lost, moreso, considering their situation plus the fact that when she had visited the HA's offices for an update (subsequent to the October 2017 documentation having been handed in) she had been informed that her case was being considered.

By February 2018 due to there having been no developments or contact from the HA with regard to her Application, the Complainant lodged her complaints with the Ombudsman.

Investigation

The Ombudsman presented the complaints to the Housing Manager ("HM"). The latter's response to the Ombudsman was received on the 14th February 2018 and noted that the processing of the Application was pending the Former Partner's submission of the Form and that he had been informed of this by way of letter on the 11th January 2018. The HM advised that the Complainant could submit an affidavit to the effect that her Former Partner was unwilling to cooperate in signing the Form and that would be considered by the Housing Allocation Committee ("HAC").

On the 15th February 2018, the Ombudsman enquired as to whether the Complainant had been notified of the above in writing, considering she had sent three letters to the HA, and further enquired as to the need for an affidavit when the HA had in their possession a copy of the divorce decree absolute in which the judge had stated that the couple had lived apart for a continuous period.

The HA wrote to the Complainant on the 19th February 2018 and informed her that her Application was not being processed because they were waiting for the Former Partner to sign the Form. As the latter had not been signed, the HA advised that to remove the Complainant from the tenancy, so that she would be able to apply for Government housing, they required that she submit an affidavit stating that they were no longer in a relationship and detailing that the Former Partner was unwilling to sign the Form. HA noted that once all the documentation was received her Application would be considered.

On the 13th April 2018, further to the Ombudsman pursuing the matter, the HA reverted and advised that the Former Partner had signed the Form and there was no need to put the matter to HAC. The Application would be activated as from the date of submission, once the Complainant provided an address [Ombudsman Note: The Complainant had provided the address of a close family friend who lived in a male workers' hostel in which the HA was the landlord. Owing to the particular criteria required to be able to reside at the hostel, the HA could not agree to the Complainant using that address. In June 2018 the Complainant was subsequently able to provide a relative's address as an alternative which was accepted by HA. Further to that, the Complainant and her son were given accommodation at the women's refuge]. For completeness of records, the Ombudsman requested the details of the date on which the Form was submitted by the Former Partner as well as a copy of said Form and enquired as to whether the Complainant had been updated accordingly. In that same letter, the Ombudsman referred the HA to the Complainant's request to be considered as a social case due to her and her son's homelessness and enquired if HAC would be considering that aspect of her case. The HA responded that the case would be discussed

by HAC on the 23rd April 2018 and a letter informing her of the outcome sent to her once the minutes of that meeting were approved. Regarding the Form, HA now advised that was being prepared for the Former Partner to sign [Ombudsman Note: The HA had advised on the 13th April 2018 that the Form had been signed].

On the 27th April 2018, the HA informed the Complainant that HAC had requested a 'Social Inquiry Report' which would be carried out by a social worker and that she would be contacted by the latter directly. Once the report was completed, HAC would review her case.

The Ombudsman met with the PHO on the 29th May 2018 to discuss some of the issues that had arisen in this case. Regarding HA's request for an affidavit in the Complainant's particular case where there was a divorce decree absolute in place which stated that the Complainant and Former Partner lived apart, the PHO was of the opinion that HA staff had acted incorrectly by requesting an affidavit. On the issue of counter staff at the HA having advised the Complainant that the Former Partner had the right to the tenancy, the PHO responded that due to the period of time elapsed there was now no access to the CCTV footage of that conversation and what was said could not be established.

The Ombudsman sought further information from the HA as to procedures in place for similar cases. HA advised that standard procedure was for the parties to decide who stayed in the property and that the remaining person would sign the exclusion form to submit to HA to effect the change of name in the tenancy, if warranted. Once that had been undertaken, the person excluded from the tenancy could apply for Government housing (if eligible). In the Complainant's case, the tenancy was in the Former Partner's name rather than in the name of both parties because they had never requested the joint tenancy.

On the 2nd July 2018, HAC notified the Complainant by letter that further to the Social Inquiry Report, HAC had discussed her case and recommended that she be placed on the Social A List.

Conclusions

Complaint (i): Non-reply to letters – Sustained

The Ombudsman sustained the complaint of non-reply by HA to the Complainant's letters to them in June, October and December 2017. Despite the severity of the Complainant's

and her son's situation, the only communication up until February 2018 (after the Ombudsman's involvement in the case) from the HA was at counter level at the HA's offices, and then only when approached by the Complainant who visited their offices to enquire if there were any updates on her Application.

In the course of an investigation, the Ombudsman establishes what happened and what should have happened. In this case, when the Complainant handed in a second copy of the divorce 'decree absolute' in October 2017 and requested social categorisation, the HA should have written to her and informed her of the process thereon. That did not happen so in November 2017 the Complainant chased a reply to her October letter. Again no written reply was received. Finally, in December 2017 she wrote a letter of complaint to the HA which was also not replied to nor were the serious issues of documents having been lost addressed or an explanation and apology provided.

Complaint (ii): Complainant submitted a copy of the divorce 'decree absolute' to the Housing Authority ("HA") but they refused to activate her application for public housing ("Application") until her ex-husband ("Former Partner") submitted a signed exclusion form ("Form") excluding her and her son from the tenancy of the matrimonial home, a Government rented flat ("Flat") - Sustained

According to the Complainant, as a result of the relationship having broken down, her Former Partner changed the lock to the Flat and she and her son were left homeless. Upon enquiring at the HA offices about her entitlement to the tenancy she claimed to have been informed that because the tenancy was in the Former Partner's name he had the right to the Flat. Notwithstanding this information which cannot be corroborated by the HA, the Complainant had engaged the services of a lawyer for the purpose of divorce proceedings and should have pursued the tenancy of the Flat via the legal route but opted not to.

The Ombudsman's investigation found that the Flat was in the Former Partner's name because the couple had never requested a joint tenancy. The Ombudsman takes this opportunity to highlight that a recommendation was made in Case No. 918 where the circumstances of the case were similar to this one. The recommendation is as follows:

"In light of the infringements in respect of the Complainant's basic rights and the vulnerable position that the Complainant and her child have been left in, the Ombudsman recommends that the Housing Authority re-issues or issues (as the case may be) tenancies as joint tenancies whenever the family composition is one of unmarried couple with children in common".

[Ombudsman Note: For the purposes of clarification, although the case above was that of an unmarried couple with a child in common whereas the case in hand is that of a married couple, the same recommendation would apply].

It was both the PHO's and the Ombudsman's view that under the circumstances of this case, there was no requirement for an affidavit as the HA had in their possession a copy of the divorce 'decree absolute' which stated that the parties lived apart, and that legal document was the proof required by the HA to process the Application. Furthermore, considering that break up of relationships can in many cases be acrimonious, the Ombudsman considers that the HA should have a procedure in place to prevent a recurrence of the non-signing of the exclusion form by the tenant by putting measures in place which tenants have a requirement to abide by and not put the onus, as happened in the Complainant's case, for her to produce an affidavit stating that the Former Partner did not want to sign the Form.

The Ombudsman is very critical of the contradictory information provided by the HA with respect to the signing of the Form. Whilst on the 13th April 2018 the Ombudsman was informed that the Complainant's case did not require consideration by HAC because the Former Partner had signed the Form, the HA's response to the Ombudsman's request days later for a copy of said Form stated that the Form was still being prepared for the Former Partner to sign. It is clear from this response that no Form had been signed but rather, that further to the Ombudsman's and PHO's involvement, the HA had taken the divorce 'decree absolute' as the proof required to proceed with the Application.

The Ombudsman takes issue with the fact that the HA stated that there was no need to present the Complainant's case to HAC because the Form had been signed and therefore appeared to disregard the Complainant's request for social categorisation. This was despite the severity of her and her son's situation, which required HAC's recommendation and consideration of her case for inclusion in a priority list, Social A. It was due to the Ombudsman's reminder in an email of the 10th April 2018 that the Complainant's case was put to HAC.

Classification

Complaint (i):Non-reply to letters – Sustained

Complaint (ii): Complainant submitted a copy of the divorce 'decree absolute' to the Housing Authority ("HA") but they refused to activate her application for public housing ("Application")

until her ex-husband ("Former Partner") submitted a signed exclusion form ("Form") excluding her and her son from the tenancy of the matrimonial home, a Government rented flat ("Flat") – Sustained

Recommendations

In cases similar to that of the Complainant's, where the tenancy holder fails to sign the HA's exclusion form and there is documentation from the Courts attesting to the fact that there has been a divorce/separation and the parties are not residing together, that the HA should take said document/s to substantiate the exclusion of the tenancy of the person/s no longer residing in the property.

The Ombudsman further recommended that in order to avoid a recurrence of similar circumstances, the staff at the Housing Authority be properly briefed on the issues arising from this complaint.

(Report extracted from Case No 1163)

HOUSING AUTHORITY (HA)

Case 13

Complaint

The Complainant stated that the HA had allowed the Flat to remain vacant for seven years and when she enquired as to the reasons why, was not offered a reasonable explanation.

Background

[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].***

The Complainant and her husband resided in a one bedroom Government rented flat since 2011/12. According to the Complainant, in 2012 she identified the Flat (a two bedroom property) was vacant and she approached the HA to request that they exchange their property for the Flat. The Complainant claimed to have pursued the matter with the HA throughout a four year period with no success. In December 2016 she put her request for the exchange to the HA in writing setting out her case to them. She explained that she was aware that she and her husband were not eligible for a two bedroom property but had been told by the Ministry for Housing that if they identified a property (private exchange) comprised of a maximum of two bedrooms, the exchange would be allowed. In that same letter, the Complainant informed the HA that there was a squatter in the Flat and asked them to take action to resolve the situation.

In January 2017, the HA informed the Complainant that they were looking into the issues she had raised and that necessary action was being taken but regretted that they were unable to accede to her request to exchange her property for the Flat because vacant flats returned to public housing stock were allocated via the housing waiting lists. They further advised the Complainant to re-apply for larger accommodation if their family composition had increased. The Complainant wrote back to the HA thanking them for the information provided and enquired about the reasons why the Flat had been allowed to remain vacant for seven years.

The HA responded that due to the Data Protection Act they were unable to disclose information as to why the Flat was unoccupied but they reiterated that they were dealing with the matter and that correct methods and procedures were in place.

Dissatisfied with the response, the Complainant brought her complaint to the Ombudsman.

Investigation

The Ombudsman put his initial enquiries to the HA and was provided with a timeline with respect to the Flat.

DATE	DESCRIPTION
2011	Flat returned to HA
2011 – 2015	Flat was under the control of the Housing Works Agency ("HWA") because it was in a very poor condition and whilst a decision on whether repairs should be undertaken was made, squatters entered the Flat
2015	Request to HWA/Gibraltar General Construction Company ("GGCC")for Flat to undergo complete repairs and refurbishment
31ST JANUARY 2017	Flat sent for cleaning (refurbishment completed)
9TH FEBRUARY 2017	Flat ready for allocation
27TH APRIL 2017	Flat allocated

Further to receiving the above information, the Ombudsman requested details from the HA as to:

(i) The period of time the squatters had remained in the Flat;

(ii) The HA's procedure to remove squatters from Government owned properties; and

(iii) The turnaround period from the date on which a Government-owned property returns to housing stock right through to the property being allocated to a new tenant.

The HA responded that in most cases with respect to squatters, the HA relied on reports from the public. Further to those reports, HA inspectors would undertake an inspection at the pertinent property and if the reports were substantiated, the Royal Gibraltar Police ("RGP") would be informed and legal action taken if required. Once the HA regained access to the property it was secured to prevent a repetition. Regarding the squatters in the Flat, the HA stated that there was no evidence that a report had been made and noted that the senior member of HWA staff who had been dealing with the Flat had retired.

Regarding the turnaround period for Government properties this was as follows:

- Property returned to the HA;
- HWA inspectors undertake an inspection;
- Property is sent to be cleaned;
- Site visit arranged with a prospective new tenant (this can occur a number of times until the property is accepted);
- Once property is accepted by a new tenant, the latter decides on whether he/she will take it on a self-repair basis or sent for refurbishment via HWA;
- If via HWA, estimators arrange a visit with the tenant to the property to establish the extent of the refurbishment;
- HWA pass the estimate on to Gibraltar General Construction Company Limited ("GGCC") for the works to be contracted out;
- When works are completed, GGCC inspect the property and ensure works have been carried out satisfactorily; if not sent back to the contractor;
- Once works are completed the property is returned to HWA who then return it to the HA.

The Ombudsman also directed his enquiries to the HWA and requested the following information:

1. Why it took a period of four years for the HWA to make a decision on whether repairs could be carried out in the Flat;

2. Whether any works were in fact undertaken during that period;

3. A timeline from the date on which the Flat was passed by the HA to HWA (further to the removal of the squatters) through to the completion of the refurbishment and return of the Flat to the HA.

HWA explained that the now retired senior member of HWA staff was tasked with providing solutions to rainwater penetration experienced in the Flat. HWA stated that had been a massive undertaking and had taken time; from the problem being identified through the external repairs being undertaken and subsequent refurbishment of the Flat which HWA believed had been carried out separately. The Flat was allocated in April 2017.

Conclusions

HA in their timeline refer to squatters having entered the Flat at some point between 2011 and 2015 but subsequently state that there is no record of a report having been made [Ombudsman Note: The Complainant's email to the HA denouncing the presence of squatters in the Flat was sent in December 2016 and in January 2017 the refurbishment works had been completed so that would point to no squatters in the Flat by that point]. Furthermore, no information can be obtained from the HWA's senior member of staff who dealt with the Flat as he had retired. The Ombudsman is critical that the HA have no record of the squatters having gained entry to the Flat despite this being a fact which is substantiated by both the HA and the Complainant. Due to the lack of information in this respect, it is unclear as to what impact the squatters had with regard to any delay/s in works to the Flat. The extent of the refurbishment works in the Flat is unknown but the period for those works is stated as being between 2015 (no date provided) up to the 31st January 2017, anything between one and two years, a period of time which would appear to a layperson to be undoubtedly excessive and costly (the cost of workers in a property for such a lengthy period of time as well as the much needed property not being in a rentable state until the works were completed). The HA or HWA have not provided any reasons as to why the internal refurbishment works in the Flat took such a lengthy period of time.

The Ombudsman notes that the HA have a protocol in place to deal with squatters and that they rely mainly on the public to make these reports.

The HA's response to the Complainant upon enquiring as to the reasons why the Flat was left vacant for so many years was that they could not disclose any information due to the Data Protection Act. The Ombudsman's investigation found that the Flat had remained vacant from 2011 to 2017, approximately six years. It was clear that during the four year period, 2011 to 2015, the Flat was under the jurisdiction of HWA and there was a further two year period during which internal refurbishment was carried out in the Flat. The Ombudsman

does not find that disclosing the aforementioned reasons would constitute a breach of Data Protection legislation and as such is information that could have been provided to the Complainant and would have prevented this investigation.

The Ombudsman therefore sustains this complaint.

Classification

Sustained – Complaint that the Flat had been left vacant for seven years and when she enquired as to the reasons why, was not offered a reasonable explanation

(Report extracted from Case No 1173)

Case 14

Complaint

The Complainant was aggrieved because the Housing Authority had cancelled her Permit until rent arrears for her Government rented flat ("Flat") were settled. Furthermore, due to the rent arrears, the Complainant claimed that the Housing Authority had refused to include her new-born grandson in the tenancy.

Background

[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].*

The Complainant explained that for the past twelve years she had struggled financially as a single mother and that had led to rent arrears accumulating on her Flat. The Complainant pointed out that the Housing Authority had not chased the payment of those arrears until 2016 at which point she had to sign an agreement with them to make monthly payments to settle those, which she stated she was honouring. Under the circumstances, the Complainant felt that the Housing Authority had treated her unjustly as, despite the agreement being in place, the Permit which allowed her to park her car in an assigned parking space within the estate in which she resided had been cancelled and would only be reissued upon settlement of 50% of the rent arrears, an amount which the Complainant claimed she could not afford. Furthermore, the Complainant stated that the Housing Authority had refused the inclusion in the tenancy of her daughter's new-born baby (her daughter was a single mother who resided in the Flat) until the rent arrears were settled.

The Complainant wrote to the Housing Authority putting her grievances across and asking them to reconsider their position but was informed that the rent arrears should be settled before they could proceed with inclusion of the new-born baby in the tenancy. In respect of the Permit, 50% of the rent arrears had to be settled for it to be reactivated.

The Complainant lodged her complaints with the Ombudsman in April 2018.

Investigation

By way of background information, the Ombudsman was aware that the Government had implemented a rent arrears recovery exercise in 2016, at which point the outstanding rentals for Government rented properties stood at just over £6- million accumulated throughout a twenty year period (source: Gibraltar Chronicle 23rd June 2017).

In May 2018 the Ombudsman held an initial meeting with the Principal Housing Officer ("PHO") and Housing Manager ("HM"). At said meeting, the PHO informed the Ombudsman that there had been a change in policy in relation to inclusion of children in Government tenancies (who would ordinarily be authorised to reside in said Government tenancy) with arrears of rent and stated that the inclusion would now no longer be affected by this.

Regarding the cancellation of the Permit, the Housing Authority provided the Ombudsman with the minutes of a meeting the HM had had with the Complainant in January 2018 at which amongst discussing other issues, she had informed them of the parking problems she was experiencing since the cancellation of the Permit. The HM explained to the Complainant that in January 2017, a policy had been put in place by Government with respect to rent arrears. Notwithstanding, the HM said that exceptions could be made in certain cases for the Permit to be reissued if the tenant immediately settled 50% of the rent arrears and informed her that her case would be put to senior management for consideration. The Complainant stated that due to her financial circumstances she would be unable to accept that option and could not afford to pay more towards the agreement in place. The Housing Authority noted that the Complainant had made regular payments towards the agreement but identified that she had defaulted in the past.

By way of further clarification on the above, the HM informed the Ombudsman that further to the meeting with the Complainant, her case was referred to senior management and after careful review of the case it was agreed that if the Complainant immediately paid a 50% lump sum of the existing rent arrears balance, the Permit would be reissued. The HM added that was standard practice at the present time and was only offered to tenants who had a longstanding agreement and had not defaulted on it. In January 2016 when the Housing Authority started its arrears recovery process, the policy was that for the renewal or issue of a Permit, the rent balance had to be nil. Tenants who entered into an agreement for the repayment of rent arrears or had a prior agreement on which they had never defaulted did not have the parking permits revoked. In the Complainant's case, she had entered into an

agreement in 2016 and had the Permit cancelled because she subsequently defaulted on the agreement but was allowed to keep the Permit upon signing the agreement.

Conclusions

(i) Cancellation of Complainant's parking permit ("Permit") until rent arrears were settled - Not Sustained

In view that the level of arrears of rent of Government residential properties continued to increase over the past years, in 2016, the Housing Authority introduced a more effective procedure for the recovery of those rent arrears. Whilst it is understandable that tenants with rent arrears could consider the Housing Authority's revised rent arrears recovery procedure to be harsh and demanding, particularly in view that rent arrears had not been effectively followed up in the recent past, it is undoubtedly the case that the Housing Authority have a duty to pursue those rental arrears and that they were using the leverage they had on tenants, in this case the revocation of parking permits, rather than the repossession of the Government tenancies, in order to press for payment.

The Complainant stated that she had struggled with her finances since becoming a single parent years earlier, and that she could ill afford the repayments on the agreement she had entered into, which was the reason why she had defaulted. Furthermore, she was unable to accede to the Housing Authority's offer of immediate payment of 50% of the outstanding rent arrears in order to have the Permit reissued.

It is the Ombudsman's view that there has not been maladministration on the part of the Housing Authority in respect of this issue. In reminding public service users of rights and responsibilities, it is clear that the Complainant exercised her right to reside in the tenancy but failed in her responsibility to pay the rent due and considering her financial circumstances failed to make arrangements with the Housing Authority for a rent repayment plan prior to them chasing the debt.

(ii) Refusal to include Complainant's new-born grandson in the tenancy due to rent arrears – Sustained

The Ombudsman sustains this complaint of maladministration. Although the Housing Authority state that the action of not including the new-born grandson in the tenancy was the result of the policy in place of not including new tenants in tenancies where there were rent arrears, again to be used as leverage for payment of those monies, it is clear that this policy had resulted in an injustice. The effect of the non-inclusion in the tenancy rendered

the new-born homeless, which would mean that the Civil Status & Registration Office ("CSRO") would not be able to issue a Gibraltar Identity Card ("ID") to the child nor would he/she be eligible for a health card. The Ombudsman is satisfied that the unjust policy has now been rescinded and no recommendation is therefore warranted.

Classification

(i) Cancellation of Complainant's parking permit ("Permit") until rent arrears were settled - Not Sustained

(ii) Refusal to include Complainant's new-born grandson in the tenancy due to rent arrears - Sustained

(Report extracted from Case No 1174)

Case 15

Complaint(s)

The Complainants complaint to the Ombudsman was threefold:

1) Alleged discriminatory interpretation of the housing allocation rules.

2) HA refused the Complainant inclusion on the housing waiting list. The Complainant was of the view she was entitled to be included under Schedule 4(b) of the Housing Allocation Scheme.

3) Non reply to emails sent requesting information on the issue of entitlement and interpretation of Housing Allocation Scheme.

Background

[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.***

The Complainant complained to the Ombudsman on the basis that she believed that the HA were misinterpreting the Housing Allocation Scheme and that she was being refused inclusion on the housing waiting list as a result.

The Complainant was aggrieved by the alleged misinterpretation and misapplication of the rules because not only was she unable to join the housing waiting list but also, ineligible from applying to purchase a Government property from the affordable housing scheme or to tender for any available MOD property. She had been informed that she would only be eligible to join the list once she had proof of ten years' continuous residence in Gibraltar. The Complainant was of the opinion that this was discriminatory, considering that Gibraltarian nationals may be included on the list after having resided continuously for a period of one year. The Complainant, as a British national, believes that this application by the Government of Gibraltar was an infringement of her rights as an EU permanent resident and that she was being discriminated against for **not** being Gibraltarian. She argued that she had worked and resided in Gibraltar for over eight years and further possessed a Gibraltar (red) ID card and had permanent EU resident status.

The Complainant stated that she has not been afforded the courtesy of a reply from Housing over the issue she raised. She has also requested formal clarification of the housing allocation rules from the HA to no avail. They had also allegedly stopped replying to her letters altogether.

The Complainant rightly highlighted the fact that under the current Housing Allocation Scheme (Revised 1994), persons eligible for Government Housing are:

4 (a) Gibraltarians registered under the Gibraltarian Status Act

(b) Those not registered as Gibraltarians but who have the right of permanent residence

(c) British Dependent Territories citizens by virtue of a connection with Gibraltar.

Accordingly, the Complainant believed she was an entitled person as she has permanent residency as an EEA national under the Immigration, Asylum and Refugee Act and further, did not understand how as a British Citizen in a British Territory, she should have to provide ten years proof of residency to qualify, when she satisfied the Housing Allocation Scheme provisions.

Investigation

The Ombudsman concurred fully with the Complainants view. The alleged misinterpretation and application of the Housing Allocation Scheme had attracted numerous other complaints, also on the basis of discrimination.

In accordance with the Ombudsman Investigative process, a letter was issued presenting the complaint to the HA setting out the Complainant's grievance and requesting their comments. A reply followed shortly afterwards.

To the Ombudsman's surprise, the reply cited sections of the Public Services Ombudsman Act 1998 (the statutory provision which created the office of the Ombudsman in Gibraltar and under which it operates), stating (albeit erroneously) that complaints 1 and 2 being investigated by the Ombudsman were "***outside the scope of the remit of the Ombudsman's powers of investigation."***

The Ombudsman replied to that letter substantively, setting out the statutory position in relation to his office and the legal position in relation to the Complainant's rights, as follows:

"Regarding complaints one and two as per above, you have responded that these are outside the scope of the Ombudsman's remit in relation to his powers of investigation, and you refer to Sections 13 and 18 (5) of the Public Services Ombudsman Act 1998 which we have set out below for ease of reference.

Power to investigate

13.(1) Subject to the provisions of this Part, the Ombudsman may investigate any administrative action taken by or on behalf of any Authority to which this Part applies in any case where –

(a)a written complaint is duly made to the Ombudsman by a member of the public who claims to have sustained injustice in consequence of maladministration in connection with the action so taken; and

(b) the Ombudsman considers that it is right and proper to conduct an investigation in respect of such complaint.

(2) In determining whether to initiate, continue or discontinue an investigation, the Ombudsman shall, subject to the provisions of this Part, act in accordance with his own discretion; and any question whether a complaint is duly made under this Act shall be determined by the Ombudsman.

(3)(1)(a) the reference to an "administrative action" shall be read as a reference to an "action" as defined in section 2;

(b) the words "maladministration in connection with" shall not apply where the action is not of an administrative nature.

Powers in relation to Ministers or officers of the Crown

18 (5) It is hereby declared that nothing in this Act authorises or requires the Ombudsman to question the merits of Government policy or a decision taken without maladministration by any Authority in the exercise of a discretion vested in that Authority".

The Ombudsman clarified that "…complaint one above alleges that the Housing Authority has acted in a discriminatory manner in their interpretation of the housing allocation rules in

the Complainant's case. The allegation stems from information obtained by the Complainant (further substantiated by a case investigated by the Ombudsman in 2011 CS 921) that under Section 55N (1)(a) of the Immigration, Asylum and Refugee Act she is entitled to reside permanently in Gibraltar and would therefore make her eligible for Government housing under Clause 4 (b) of the Housing Allocation Scheme (Revised 1994)".

In his letter, the Ombudsman addressed the HA on the relevant and applicable law:

"Right of Permanent Residence

55N (1) The following persons are entitled to reside permanently in Gibraltar–

(a) an EEA national who has resided in Gibraltar in accordance with this Part for a continuous period of five years;

(b) a non-EEA family member of an EEA national, who has resided in Gibraltar with the EEA national in accordance with this Part for a continuous period of five years;

(c) a person who–

(i) has resided in Gibraltar in accordance with this Part for a continuous period of five years; and

(ii) was, at the end of that period, a family member who has retained the right of residence.

The Housing Allocation Scheme (Revised 1994) in clause 4 states:

4. PERSONS ELIGIBLE TO APPLY FOR GOVERNMENT HOUSING

The following persons are eligible to apply for Government housing:-

(a) Persons who are registered in the Register of Gibraltarians;

(b) Persons who are not registered Gibraltarians, but who at the time of application, have a right of permanent residence;

(c) Persons who are British Dependent Territories citizens by virtue of a connection with Gibraltar, as defined by the British Nationality Act 1991.

This is further substantiated by directive 2004/38/EC of the European Parliament and of the Council, 29th April 2004 in clause 20, on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States, as follows:

(20) In accordance with the prohibition of discrimination on grounds of nationality, all Union citizens and their family members residing in a Member State on the basis of this Directive should enjoy, in that Member State, equal treatment with nationals in areas covered by the Treaty, subject to such specific provisions as are expressly provided for in the Treaty and secondary law.

The Complainant's allegation of discrimination in the Housing Authority's application of the housing allocation rules in her case results from the fact that an EEA national would be required to reside in Gibraltar for a period of five years in order to obtain permanent residence and be eligible for inclusion in the Government's Housing Waiting List whereas a ten year residence requirement as a result of Government policy, is being applied to her case because she is a British national. In effect, that the Housing Authority's policy and procedures being applied in this case, are over and not in accordance with the legal rights of the Complainant.

Regarding complaint two, a similar reasoning as set out above applies.

Please note that the Ombudsman is not questioning Government policy (Section 18(5) Public Services Ombudsman Act 1998) but the apparent maladministration in the application of legal rights in the Complainant's case. This is therefore certainly not a case of the Ombudsman acting outside the remit of the Act in relation to his powers of investigation under the Act.

It is unclear as to why you are referring to Section 13 of the Public Services Ombudsman Act 1998".

Pursuant to and in conclusion to his reply, the Ombudsman sought clarification from the HA on the issues and suggestions raised in their previous letter. No further written reply was received.

The Ombudsman subsequently attended a meeting at the relevant Ministry. Again the matter of "policy" was raised. The Ombudsman replied that although it was not within his

power or inclination to investigate policy, he would do so if any application of policy was in direct contravention of laws currently in place.

Conclusions

It was clearly the position insofar as this complaint was concerned, that a British national would have to reside in Gibraltar for ten years before he or she became eligible to apply for permanent residence and be eligible to be included in the Government housing waiting list, whereas an EU national was only required a period of five years residence to apply for permanent residence. In this case, the Complainant was both a British and EU national. She was being penalised (in that the ten, as opposed to the five year policy), was being applied.

Classification

1 Alleged discriminatory interpretation of the housing allocation rules- Sustained

2 HA refused the Complainant inclusion on the housing waiting list. The Complainant was of the view she was entitled to be included under Schedule 4(b) of the Housing Allocation Scheme- Sustained

3 Non reply to emails sent requesting information on the issue of entitlement and interpretation of Housing Allocation Scheme- Sustained

Recommendations

Given the seriousness of the administrative failing and the human rights issues being infringed, the Ombudsman recommended that the Government address the issue and amend the Housing Allocation Scheme in order to properly reflect the law and clarify the position on Government Housing eligibility.

Until such a time, the Ombudsman recommended that the Complainant and all similar complainants who were both British and EU citizens should have the five year residence criteria imposed and not the ten year rule, on the reasoning that as long as we continue to remain in the EU, it is well established jurisprudence that EU law will supersede domestic law.

Additional Complaints received

At the time of drafting this report the Ombudsman received two further complaints bearing an almost identical factual background to this case. For that reason, the Ombudsman thought it practicable to include those complaints as an addendum to this report:

1) The first complainant stated that she felt it wrong that the HA had not accepted her application for housing in light of her family's special social needs. In addition, the family (composed of the Complainant, her husband and two sons), were all British nationals who had resided in Gibraltar for a continuous period of seven years and were relying on the argument that EU nationals were entitled to apply for Gibraltar Government Housing after 5 years continuous residence. They were also saddened and frustrated to note that the HA had not applied any discretion considering her sons special medical needs (medical evidence had been provided setting out the young man's mental health issues, which were being treated).

2) The second complainant who was a single mother and who had suffered from a continuously violent relationship with her ex-partner, also complained that she had been disallowed from applying for Government housing despite having continuously resided in Gibraltar since 2010. The Complainant had unsuccessfully challenged the decision, based upon the permanent residency criterion and her difficult personal circumstances. Arguments had been submitted to the HA on behalf of the Complainant which *inter alia* stated:

"… I understand that the Housing Department must strictly apply the policy set but I make two points that I do not think have been considered:

1) That the amendment to the 1994 rules (housing allocation rules) already allowed leeway to waive the qualifying period in deserving circumstances. We are saying this is such case.

2) That even if the Housing Department did not have a discretion [which for the reasons in point 1 I do not think is right] because this is a policy issue set by Government, the HA does have a discretion to waive this as is appropriate or to establish a policy that allows [the Minister] some discretion in appropriate cases."

The Ombudsman fully concurred with the view expressed and also sustained the complaints.

(Report extracted from Case No 1182)

HOUSING AUTHORITY (HA)

Case 16

Complaint

Complainant believed that the Housing Authority's ("HA") decision to withdraw the offer of allocation of a Government rented property ("Flat") and the cancellation of her application ("Application") for Government rented accommodation were unjust

Background

[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]***

The Complainant stated that she was a British national who in 2001 moved with her husband and two daughters from the United Kingdom to reside and work in Gibraltar. The Complainant explained that since their arrival in Gibraltar they had resided in her aunt's house until in September 2017 she rented a bedsit (in Gibraltar) with her daughters. She explained they felt the need to move out because her aunt was unwell and needed her space. The monthly rental for the bedsit was £580-. The Complainant explained that as a single mother she struggled to make ends meet. By this point, the Complainant and her husband had separated and their younger daughter was in university. As such, when in February 2018 the HA made the offer of allocation of the Flat she claimed that she enquired at their offices whether she could vacate the private rental and claimed to have been told that she could. [Ombudsman Note: The Complainant had opted for works to be carried out to the Flat under the 'Government of Gibraltar Refurbishment Programme' and that would result in the Complainant not being able to move in until the works had been completed.]. The Ombudsman is not aware of what the Complainant's living arrangements for the interim period were.

The Complainant signed the HA's declaration form ("Declaration") on the 22nd February 2018 accepting the Flat and on the 20th March 2018 received a letter from the HA confirming the allocation. She stated that she presented the letter to the Civil Status & Registration Office ("CSRO") in order that they could update the address in her and her daughters civilian registration cards ("Cards"). According to the Complainant she then received a call from the CSRO to inform her that the Cards had been cancelled because she had left the rental. The Complainant explained the reasons for having vacated but stated that CSRO responded

that was not the way it worked. It was on the 20th April 2018 that she received the letter from the HA informing her that the offer of accommodation had been withdrawn because they had noted that she had provided false information relating to proof of residence. The HA referred her to the Declaration which stated:

"The Housing Allocation Committee ("HAC") may withdraw an offer of accommodation even if an acceptance has been signed by the applicant, if it has reason to believe that false or misleading information has been supplied by the applicant or the circumstances which lead to an offer being made have changed as declared in the housing application and the applicant has not informed Housing Allocation Unit."

The HA requested that in order to maintain her Application on the Government housing waiting list ("List") she needed to submit proof of continuous residence for herself and her children and informed the Complainant that her Application would be suspended pending submission of that proof and cancelled if not submitted within one month. The HA advised that as proof of residence she could provide payslips, employment contract, utility bills, rental agreement, etc. The Complainant submitted electricity and water bills for November 2017, December 2017, January 2018 and February 2018 and the rental agreement of the bedsit she had been renting. The Ombudsman was able to inspect the Complainant's utility bills as part of his investigation which established that the Complainant's average monthly consumption for the period October 2017 to March 2019 was: £2.96 for electricity and £0.17 for water.

Further to consideration of the above, the Complainant stated that she met with the Housing Manager and was told that the consumption of electricity and water was too low, which indicated she had not been residing in the bedsit. The Complainant justified the low consumption to the fact that she only slept in the bedsit. She explained that she spent the rest of the time between work and supporting her mother who resided in Spain. The Complainant requested that her Application be reinstated. The matter was put to HAC who after consideration informed her in November 2018 that her request had been denied because she had not provided proof of twelve months continuous residence in Gibraltar. HAC advised her that she could submit an application for 'Re-accommodation'. When the Complainant made enquiries as to what would be required for this she claimed to have been told that if she was included in the 'Register of Gibraltarians' she would have to provide one year's proof of continuous residence in Gibraltar and if she was not, she would have to provide ten years proof of continuous residence in Gibraltar. As the Complainant was a UK national it was the HA's position that it was the latter that applied. [Ombudsman Note: The Complainant had entered the List in 2011, after meeting the ten year residency requirement

for a UK national to enter the List. This contrasted with the five year period of residence required by EEA nationals under Section 55N(1)(a) of the Immigration, Asylum and Refugee Act, which made provision for entitlement to their right to permanent residence, and who under the said Act are deemed to be "qualified persons"; Section 55E(1) by virtue of being in Gibraltar under one of the following categories: job-seekers, workers, self-employed persons, self-sufficient persons or students and having resided in Gibraltar for a continuous period of five years. Please refer to Ombudsman's Report 921].

Desperate about her situation, the Complainant lodged her complaint with the Ombudsman.

Investigation

The Ombudsman presented the complaint to the HA and made a number of enquiries on various issues.

The HA provided their responses, as follows:

With respect to clarification on the alleged false information provided by the Complainant, the HA stated that on the 16th April 2018 they were informed by CSRO that following an investigation undertaken by the Royal Gibraltar Police ("RGP") they had found that the Complainant and her daughters' locally issued permits of residence and Cards had been obtained by providing false information (details of the alleged false information are set out overleaf) and that had resulted in the HA initiating their own investigation, which included reviewing other documentation submitted by the Complainant (utility bills). That information was subsequently considered by HAC and the decision of allocation of the Flat was revised. The HA advised that the withdrawal of an allocation offer was an extraordinary decision and not something they could have pre-empted.

The Ombudsman also enquired about the two occasions in which the Complainant stated that she had spoken to clerks at HA's offices regarding leaving her private rental after allocation of the Flat and her claim that she had been told that she could do so. The Ombudsman also pointed out that the withdrawal of the offer of allocation and her having vacated the private rental now left the Complainant with no accommodation. The HA responded that if those conversations had in fact taken place it would have been around February 2018, which was before their investigations were carried out. The HA referred the Ombudsman to the Declaration signed by the Complainant, which stated that HAC could

withdraw an offer of allocation if there was reason to believe that false or misleading information had been provided.

The Ombudsman requested the HA to provide a copy of the letter of 16th April 2018 that was sent to them by CSRO [Ombudsman Note: By way of background information as to the reason why CSRO made contact with the HA, it was because in March 2018 CSRO had carried out an address check at the Complainant's bedsit rental and found that she had handed in the keys to said property. This resulted in the Cards being cancelled by CSRO and a letter sent to the Complainant informing her of the cancellation (as she was deemed to no longer be residing in Gibraltar) as well as details on the requirements for her to re-apply for residence documentation. The Complainant subsequently contacted the CSRO and informed them of the allocation of the Flat and the fact that in the interim she was living in Spain].

CSRO's letter to the HA noted that they were rather surprised to learn that the Complainant and her daughters had been allocated Government rented accommodation, given that they had been obtaining permits of residence and Cards by providing CSRO with false information. CSRO stated that in 2014, after an address check by RGP, it had come to their notice that the Complainant and her daughters were not residing in Gibraltar at the aunt's address. A subsequent address check carried out in 2017 revealed that they were still not residing at the given relative's address and the permits and Cards were cancelled. They then applied under a different address (bedsit rental) and again, a recent address check (March 2018) proved that the Complainant had handed in the keys to the rental once she had obtained the permits and Cards. On the 12th April 2018, further to the latest address check, CSRO emailed a number of public service departments notifying them, for the purpose of any action they considered necessary, that the Complainant and daughters did not reside at the address they had on record (bedsit rental).

The Ombudsman contacted the Complainant to enquire when she had handed in the bedsit rental and was informed that this was in February 2018, due to the allocation of the Flat.

The Ombudsman met with CSRO to enquire further into the false information CSRO stated had been provided to them by the Complainant. CSRO advised that the Complainant and her husband originally applied for residence permits in June 2001. A letter from the Complainant's relative (aunt) stated that the couple resided with her in her privately owned property and permits of residence and Cards were issued to the couple and renewed annually on the strength of that letter. CSRO confirmed that no address checks were carried out during the ensuing nine years. Then in 2011, when the Complainant applied for the

renewal of her Card, she submitted first-time applications for her two daughters who were 12 and 16 years old at the time. CSRO noted that when the Complainant and her husband applied in 2001 from the relative's address there was no mention of the two daughters. The fact they were included in the 2011 applications raised questions. This resulted in CSRO requesting an address check. The results of the check were somewhat questionable as it appeared that there had been simultaneous use of a property in Spain and CSRO requested a further check. Before that second check, the Complainant attended CSRO offices and spoke to a member of staff to explain her situation. CSRO informed her that the Cards had not been issued as they had reason to believe that she was not residing in Gibraltar. CSRO asked the Complainant to write a letter to the Head explaining her situation so that her case could be considered. The Head looked into the Complainant's case with CSRO staff and was informed that the issue of the Cards was on hold pending the outcome of the second house check. The Head's enquiries determined that from an early age, the daughters had been registered with the Department of Education as well as the Gibraltar Health Authority, possibly due to an oversight as the girls had never been issued with a Card. Further to a discussion between the Head and other senior members of CSRO staff it was decided that there was no reason to delay the issue of the Cards on the following grounds:

(i) The Complainant was eligible to reside under Section 55M(1) of the Immigration, Asylum & Refugee Act ("Act") qualifying under Section 55E(1)(b) of the Act as she was and had been working and residing in Gibraltar for an extended period of time;

(ii) The daughters were entitled to residency under Section 55M(2) of the Act, qualifying under Section 55F(1) as dependants of an EEA national.

The Head requested that the Cards be issued without further delay and from then on these continued to be renewed on an annual basis. In August 2014 the Complainant applied for permanent residence which if granted would have extended the Card renewal period to ten years. CSRO informed the Ombudsman that the application was not approved on the basis of an address check undertaken by the RGP in July 2014. The RGP's report concluded that the Complainant and her daughters stayed at the relative's house on regular occasions but were not living there permanently and spent much of their time at an address in Spain. The report stated that there was a sofa bed which they used when they stayed at the relative's address but there were no clothes or personal belongings evident. According to CSRO, back in 2014 the application for permanent residence was dealt with by a separate section

of the CSRO and the pertinent documentation kept in a different file. As such, the CSRO section which dealt with the annual renewal of Cards was not aware of the outcome of the RGP's address check and the refusal of the permanent residence and therefore continued to renew the Cards on an annual basis [Ombudsman Note: The Ombudsman opined that this was an administrative failing by the CSRO but the Head advised that this issue had now been addressed and there was now only one file per person].

In August 2017, when the Complainant applied for renewal of the Cards, she handed in a letter to CSRO signed by her cousin, which stated that the Complainant and her daughters indeed resided in the aunt's flat. CSRO contacted Borders & Coastguards ("B&C") (entity undertaking address checks at that time) to request that they carry out an address check and received a call from a senior member of B&C staff stating that the letter that had been sent to the CSRO was fraudulent and that the Complainant's cousin (a B&C member of staff) had been suspended as a result of the letter and was pending a disciplinary hearing. Based on that information, CSRO stopped the issuing of the Cards.

In September 2017, the cousin wrote to CSRO to inform them that the Complainant and her daughters no longer resided at the aunt's address and shortly after, the Complainant applied for the renewal of the Cards from the address of the bedsit rental [Ombudsman Note: The information provided by the Complainant to the Ombudsman as to the reason for having moved out of her aunt's flat was that her aunt was unwell and needed her space]. CSRO renewed the Cards with the new address and made a note to undertake a further address check in the coming months. A number of address checks were carried out during March 2018 but CSRO stated that there was no one in the property on those occasions and that when B&C approached the estate manager of the estate, he informed the officers that the Complainant had handed in the keys to the flat [Ombudsman Note: The Complainant states that she handed in the private rental in February 2018 when she was allocated the Flat].

On the 12th April 2018 CSRO wrote to the Complainant and informed her of their findings. CSRO noted with concern that although it may have been an oversight on her part in not having notified CSRO of her change in living arrangements, it was noted that was not the first time that had been brought to her attention. CSRO reminded the Complainant of her obligations and informed her that it was an offence to knowingly and recklessly provide false information in order to obtain residency documentation. CSRO advised that the Cards had been electronically cancelled in their system and other relevant Government departments had been informed accordingly for the purpose of taking whatever action they deemed appropriate. CSRO further advised that if she continued to reside in Gibraltar she should make arrangements to re-apply for residence documentation at her new address. It was at

that point that the Complainant informed CSRO that she had been allocated the Flat, as a result of which CSRO contacted the HA and the allocation was ultimately withdrawn; the reason cited as being that she had provided false information relating to the proof of residence. In September 2018, after having the allocation of the Flat withdrawn, the Complainant found another private rental in Gibraltar and provided the new address details to CSRO; Cards were issued to her and her daughters. CSRO requested an address check in February 2019 and B&C officers found a young couple with a baby in the rental. B&C officers enquired about the Complainant and were told that they did not know where she was. B&C asked to enter the property but that was refused. The Complainant had informed the Ombudsman that as she was going to be away from Gibraltar for a number of days she had allowed her daughter's friend to stay at the rental. The Ombudsman asked CSRO if a further check had been carried out since, and if Cards had been cancelled, but CSRO advised that B&C were presently not undertaking the address checks due to operational reasons and that the Cards remained active.

The Ombudsman reverted to the HA and requested further information on the Complainant's case. A copy of her Application was provided as well as confirmation from the HA that this had been accepted based on ten years proof of residence having been provided.

A copy of the minutes of the meeting between the Complainant and the HA in June 2018 was also provided to the Ombudsman. The salient points of the meeting were:

- The Complainant had explained to the HA that she had been renting private accommodation and that she had been struggling financially;
- HA informed the Complainant that there was no issue with providing the HA with an address in Spain if that was her situation;
- HA informed the Complainant that a consumption report (electricity and water) proved that she was not residing at the bedsit rental. HA had estimates of how many electrical units are consumed by electrical appliances in a flat and noted that the consumption in the bedsit rental was not even enough for a fridge;
- The Complainant explained the reasons for the low consumption as being due to her having recently been staying with her mother in the latter's property in Spain and her daughter sometimes staying in her partner's flat;
- The HA informed the Complainant that her Application had been suspended and she would have to re-apply and provide proof of residence.

The Ombudsman requested clarification on the information the HA had provided to the Complainant with respect to being eligible to continue to be on the List if she resided in Spain. The HA reverted and advised that subsequent to a person becoming an applicant, circumstances could be such that the applicant could decide to reside in Spain (the main reason being the difference in rental prices between Gibraltar and Spain). In the case of applicants who had the right of abode in Gibraltar, the HA would continue to accept the application. It must be highlighted that the disadvantage to the Complainant in this case would have been that if they were not residing in Gibraltar, her daughters would not have been eligible to education or healthcare in Gibraltar.

The Ombudsman provided an initial draft of his report to the CSRO and HA. A number of issues were raised by CSRO, the main one being that they were not aware that the HA's policy was that certain applicants in the List could continue to be eligible for Government rented housing whilst residing in Spain. The Ombudsman arranged a meeting between CSRO and HA in order that the issues could be discussed and addressed.

CSRO's main concern was that for a non-Gibraltarian to obtain a Card they needed to be a resident in Gibraltar. In the Complainant's case, because she had been residing in Spain she was forfeiting her residency in Gibraltar and therefore eligibility for the Card and for the purposes of immigration, she no longer resided in Gibraltar. In light of that information, the HA noted that they would have to revisit their policy in relation to certain applicants with a Card who resided in Spain being eligible to remain on the List. The position was clarified as follows: Those persons who have a right of abode in Gibraltar did not lose their right to their ID Card nor to their right to apply for Government housing whilst residing in Spain. However, they would not receive any points on their housing application in relation to their living conditions in Spain, given that an Environmental health report could not be conducted in a different jurisdiction. In order to have a Civilian Registration Card a person must reside in Gibraltar.

By way of further evidence to substantiate that the Complainant did not reside in Gibraltar, CSRO disclosed in the course of the meeting a copy of the 2004 divorce agreement provided to them by the Complainant, which stated that she resided in a property the couple owned in Spain.

Regarding the false information provided by the Complainant in respect of residing in Gibraltar, the HA referred to CSRO's 2011, 2014, 2017 and 2018 address checks as well as to the investigation they had carried out with regards consumption of electricity and water in the bedsit rental. In respect of the allocation of the Flat in February 2018, the HA pointed

out that the Complainant was allocated the Flat due to the number of points accumulated in the Application, which had been acquired for reasons of overcrowding at the aunt's address. As this had proven to be false information, the HA had withdrawn the allocation.

Conclusions

In 2001, the Complainant, a UK national, arrived in Gibraltar with her husband and two daughters and claimed to have resided at the Complainant's aunt's house until August 2017. The reason for having left the aunt's address was ultimately found to be due to B&C having identified, further to an address check requested by CSRO, that the letter submitted by the Complainant's cousin attesting that she was resident in the aunt's address was fraudulent. The Complainant found alternative accommodation in Gibraltar in September 2017 which she left in February 2018 when she was allocated the Flat. In March 2018 CSRO requested an address check and found that the Complainant no longer resided there. This led to CSRO cancelling the Cards and sending a letter to the Complainant, and her contacting CSRO informing them that she had been allocated the Flat. CSRO acted on this information by notifying the HA that the Complainant had been obtaining permits of residence and civilian registration cards by providing CSRO with false information. This resulted in the HA withdrawing the allocation, informing the Complainant accordingly, and subsequently undertaking their own investigation, by way of reviewing electricity and water consumption in the bedsit rental and establishing that the Complainant did not reside in the Flat. The Complainant appealed the decision by stating that the low consumption was because she only slept in the Flat as her time was split in between working and looking after her mother who lived in Spain but the HA maintained their decision.

The Ombudsman reviewed the information available regarding the dates on which CSRO had requested address checks between 2001 and 2018 and the outcome of these requests, as well as other information that the CSRO had provided to support their claim that the Complainant had obtained Cards under false pretences.

The Ombudsman found that:

- Between 2001 and April 2011 - no address checks were undertaken;
- The Complainant and her husband divorced in June 2004 in Spain, the marriage having taken place in the United Kingdom. The Complainant provided a copy of the divorce document to CSRO in which the Complainant and her husband's address are stated as being a property in Spain;

- Around April 2011, the results of the address check undertaken were somewhat questionable and a second check was requested;
- In May 2011, further to a meeting of senior CSRO staff, the decision was taken to issue the Cards;
- In July 2014, as a result of the Complainant requesting permanent residence (which was ultimately refused) an address check was undertaken. The check determined that the application for permanent residence was not *bona fide*. The applicants stayed at the aunt's address on regular occasions but were not living there permanently and spent much of their time at an address in Spain. No clothes or personal belongings were evident and they used a sofa bed when they stayed there;
- Permanent residence was refused by the CSRO;
- An address check in March 2018 determined that the Complainant had handed in the keys to the bedsit rental and therefore was deemed by CSRO not to be resident in Gibraltar;
- After the withdrawal of the Flat allocation, the Complainant rented private accommodation. B&C undertook an address check at that property in February 2019 but the Complainant was not in the premises at that time. A couple and their baby were in the property at the time and entry to the premises by B&C was refused.

The above was provided by CSRO as proof that the Complainant obtained Cards and Permits under false pretences. Despite the evidence, CSRO continued to renew the Cards and residence permits of the Complainant and her daughters, by which they were continuing to accept that they resided in Gibraltar. Residency made the Complainant and her daughters eligible to the benefits that came hand in hand with it, including university education abroad and eligibility to Government rented accommodation.

The Ombudsman was highly critical of CSRO having continued to issue Permits and Cards to persons who they deemed did not reside in Gibraltar. He recommended that in similar cases, CSRO should pursue and conclude investigations in order to determine if those persons are permanently residing in Gibraltar and therefore entitled to residence permits and Civilian Registration Cards before issuing them.

Regarding the HA's action of withdrawing the allocation based on the information provided by CSRO, **the Ombudsman found that there was no maladministration in this instance**. The HA had acted both on the evidence provided by CSRO as well as on the evidence found in their investigation. In light of the CSRO evidence, it was the HA's position that the

Complainant entered the List in 2011, after falsely claiming to have permanently resided in Gibraltar for ten years, and withdrew their offer of allocation.

Classification

Not Sustained

Recommendation

Regarding the carrying out of address checks, the Ombudsman is concerned that there is currently no system or entity in place to carry out this important task for the pertinent Government departments and public services. These address checks are **CRUCIAL** to ensure that persons who are not permanently resident in Gibraltar cannot avail themselves of or reap the benefits that they would otherwise not be entitled to.

That in similar cases, CSRO should pursue and conclude investigations in order to determine if those persons are permanently residing in Gibraltar and therefore entitled to residence permits and Civilian Registration Cards before issuing these documents.

(Report extracted from Case No 1186)

Case 17

Complaint

The Complainant was aggrieved because the Housing Authority had not socially categorised her Application even though she alleged that she had been homeless for three years. She was further aggrieved because when she requested the reason/s for the decision, none were provided.

Background

[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].*

The Complainant explained that she and her partner had owned a property which was repossessed after their relationship terminated. She explained that after the breakup she became depressed and turned to narcotics and alcohol and went for rehabilitation to the United Kingdom ("UK") in 2009/2010. According to the Complainant, when she returned from the UK she rented a place in Spain because she could not afford the rental prices in Gibraltar and she lived there until in 2015 the rent in Spain was increased to the point that she could no longer afford it and had to leave. At that stage she wrote to the HA asking for help. She explained that she had a son ("Son") who was living with his father ("Father") in her old Government rented accommodation ("Flat"), which he had kept after they separated, but she highlighted that they both had custody of the Son.

According to the Complainant, after leaving the rental in Spain she had to put her belongings in storage and was living off a suitcase as well as using her car as a base. She slept on a sofa in her grandmother's small flat except when her Son stayed with her, at which point they stayed at her brother's house.

In December 2015, the HA wrote to the Complainant and informed her that the Housing Allocation Committee ("HAC") had agreed to accept her Application but in order to process it, they required a residential address. They also informed her that in order to include her Son in the Application, she needed to provide the 'Residence Order' as well as his birth certificate and Identity Card ("ID"). The Complainant provided her grandmother's address for the purpose of the Application and after consideration by the HA this was ultimately accepted for application purposes only.

In February 2016, the HA informed the Complainant that she had entered the Pre-List for the General Housing Waiting List ("List"); she would remain in the Pre-List for one year, after which the Application would enter the List. In March 2016 the HA informed her that the Pre-List period had been waived further to HAC having considered a 'Social Inquiry Report' ("SIR") undertaken by Social Services. In June 2016, the HA, further to documentation provided by the Complainant, agreed to include her Son in her Application. However, after giving further consideration of her case, HAC decided not to socially categorise the Application [Ombudsman Note: Applicants for social housing can request that HAC consider the circumstances of their case with the objective of having their application socially categorised. Housing applications considered by HAC and deemed to be in urgent need of Government rented accommodation are placed in the Social A List via which such applicants would be allocated a property within a shorter time frame than through the general housing waiting list]. The Complainant continued to pursue through the HA the urgent allocation of a property for her and for her Son who she stated was being very much affected by all that was going on in her life. In March 2017 she informed the HA that her grandmother had gone into long-term care and that she could no longer use that address for the purpose of her Application and she provided her parents address in its place. In order for the HA to update her Application they requested that she provide a rental agreement or a letter from the owners of that property authorising the use of that address. According to the Complainant the relationship with her parents was strained and they did not want her to use their address so in July 2018, the Complainant provided them with her cousin's address for the purpose of the Application. She explained that she was homeless and was sleeping in her car, staying at her cousin's house at times, sleeping on the beach and when she could afford to staying at a campsite in Spain.

Since she applied for social housing the Complainant had communicated frequently with the HA. She had pursued both medical and social categorisation but stated that the HA had failed to see the reality of her situation; i.e. her homelessness and the impact this was having on her and her Son's psychological and physical health. Finding herself in such a desperate situation, the Complainant brought her complaints to the Ombudsman in December 2018.

Investigation

The Ombudsman presented the complaints to the HA. Whilst awaiting a detailed response, the Complainant's case was raised at a meeting with the HA on the 23rd January 2019. As a result, the HA proposed to approach HAC for a review of the Application and of the

decision taken, as well as to consider the option of awarding social/medical points if the Application did not fully merit a categorisation.

In February 2019, the HA provided their detailed response to the Ombudsman. In respect of the non-social categorisation, the HA stated that when taking the decision, HAC had taken into account social media posts from the Complainant that she was residing in Spain as well as information provided by the Complainant to the Housing Manager at a meeting in which she had informed him that she was staying in her cousin's flat.

Regarding their proposal to approach HAC for a review of the Complainant's Application and the decision taken not to categorise her case, the HA advised that HAC had met and had requested an updated SIR.

The SIR was carried out on the 18th March 2019. The Ombudsman reviewed a copy of the document and noted that it reflected that in December 2018, the Complainant's cousin had asked the Complainant to leave and she had since slept in the car and when she could afford it, stayed in a campsite in Spain. She had lost her job at the end of January 2019. The Complainant explained that she now had limited support from family and friends due to having had to ask for favours and support, which had caused tensions in the relationships. The Complainant had relapsed and wanted to seek support from a local rehabilitation centre. The social worker undertaking the SIR noted that Social Services Department would be supporting the Complainant to enter the programme.

On the 25th March 2019 HAC considered the SIR in the Complainant's case and recommended that she be placed on the Social A List.

The Ombudsman requested copies of minutes of HAC meetings and documentation pertinent to the Complainant's case. The Ombudsman extracted the following information:

November 2015: Application submitted.
Complainant submitted 'Homeless Report' detailing where she had slept between 16th to 30th November 2015 (on her grandmother's sofa on some days and in her car on others);

December 2015: HAC agreed to accept the Application but needed a forwarding residential address to process the Application and documentation in respect to Son to include him in the Application;

January 2016:	HAC accept her grandmother's address for application purposes only but required pertinent documentation to include Son in Application. SIR undertaken;
March 2016:	HAC reviewed SIR and Complainant's case and waived one year Pre-List period. Requested documentation to include Son in Application;
May 2016	HAC unable to accept sworn affidavit from Father as it did not specify times and dates that each parent spent with Son;
June 2016	HAC were referred to the Complainant's meeting with the Housing Manager in which she requested an explanation for HAC's conclusion not to socially categorise her Application and appealed their decision. At the meeting with the Housing Manager, the Complainant informed her that she was homeless, occasionally slept at a friend's house or at her grandmother's;
July 2018	The Complainant carried out a social interview in which she explained she had been homeless for four years, sleeping in the car and on sofas in different houses. She had just lost her job and was on antidepressants. HAC agreed to consider request for social categorisation. An SIR requested;
August 2018	A medical letter was received in support of medical categorisation of the Complainant's Application due to depression and life stresses. HAC made no medical recommendation;
September 2018	A medical letter was received in support of medical categorisation of the Complainant's Application. HAC agreed to leave the case, pending further information on the Complainant's mental health issues;
October 2018	HAC agreed that a meeting should be arranged for the Complainant to meet with the Housing Manager;
December 2018	HAC discussed the outcome of the meeting between the Housing Manager and the Complainant on the 6th November 2018 where the

latter stated that she was sleeping on a mattress in the living room of her cousin's home and that she could not stay there for long as her cousin's daughters were complaining about her staying there. HAC made no social recommendation and agreed that the Complainant should wait her turn on the waiting list;

February 2019 HAC's minutes stated that a complaint from the Ombudsman had been received and an updated SIR had been requested;

March 2019 HAC agreed to socially categorise the Complainant.

The Ombudsman enquired as to what the HA's definition of 'homeless' was. The HA's response stated that their definition of 'homeless' was: "When someone has nowhere to go and is typically living on the street or sleeping rough".

For completeness of the records and clarity of the timeline for the purpose of this report in relation to the various properties that the Complainant had resided in since 2001, the Ombudsman found that the Flat was allocated to the Complainant in 2001 and her partner was authorised to reside there with their Son. In 2005 the Complainant filed a termination of tenancy of the Flat because she purchased a private property (affordable housing) and consent to purchase was granted subject to her signing the termination before the completion of the sale. The minutes of HAC's meeting of the 18th January 2016 (in relation to the Complainant's request for her Son to be included in her Application) reflected the following information:

- That in 2006 HAC had requested legal advice in relation to the Flat as the termination was signed but the Flat was never returned to the HA.
- The Partner, who had previously left the Flat, moved back in and claimed that he looked after the Son and requested to keep it.

- The Ministry for Housing, identifying that a young child would be made homeless if the Flat was repossessed, agreed in May 2006 that the Partner would become the tenant so that he could remain in the Flat with his Son.

- In 2006 the Complainant sold the affordable property, bought an open market property and that was repossessed in 2010 (as explained in the background section of this report).

The Ombudsman noted from documentation provided to him by both the Complainant and the HA that the first c/o address on record for the Application was given in 2015 as being the grandmother's flat through to March 2017. When her grandmother went into care, the Complainant requested that the HA take her parents address as the c/o address. The HA requested that the Complainant provide authorisation from the property owners (by way of rental agreement or other documentation) for the address to be used but that never materialised, according to the Complainant because the relationship with her parents was strained and they did not want her to use that address. In July 2018 the Complainant submitted to the HA an email providing her cousin's address as a c/o address. In December 2018, a copy of the cousin's letter to the HA stated that the Complainant and her Son had been sleeping on a sofa in her home since the Complainant's grandmother was taken into care but that she had now asked them to leave. The Complainant claimed to have been staying at a campsite in Spain since then as well as sleeping in her car. In March 2019, the Application was socially categorised, further to the case being reviewed by HAC after a request from the HA further to the meeting with the Ombudsman in which they were advised of the Complainant's change in circumstances.

By way of update, the Complainant was allocated a flat in July 2019. The Complainant's Application had been placed in the 3RKB list due to her Son being included in said Application.

Conclusions

Having had to leave a private rental in Spain in 2015 due to financial reasons, the Complainant applied for Government housing on the basis that she was homeless. The Complainant requested that her Son be included in her Application as she and the Son's father shared custody and the HA acceded to this, further to the Complainant submitting pertinent documentation. The Complainant entered the pre-list of the housing waiting list in February 2016, the pre-list period was waived in March 2016 and the Son was included in the Application in June 2016. The Complainant pressed HAC for the Application to be socially categorised, claiming that she was homeless. Based on the HA's definition of homeless, HAC considered her case on a number of occasions and requested several SIRs and also considered information from two meetings the Complainant had with the Housing Managers. HAC, further to considering the information, did not consider that the Complainant was homeless. From documentation provided it is noted that the Complainant had been able to stay in her grandmother's flat and when the latter was put into care, had been able to stay in her cousin's flat. Despite not having a home of her own, the

Complainant had been able to depend on relatives until in December 2018 the Complainant's cousin asked her to leave. It was from then on that HAC requested the updated SIR (further to HA's meeting with the Ombudsman) and finally decided to categorise her case.

The Ombudsman noted and accepted that the HA's role is to manage public housing as well as the numerous waiting lists in order that allocations are made fairly and in cases of social categorisation, that these are in fact legitimate. It is HAC's role to assist in this exercise and be vigilant and cautious, which includes reviewing information provided to them by the HA. The ultimate goal is to manage public housing via a fair allocation system. If cases similar to that of the Complainant were not meticulously investigated through various channels, including social media posts available to the HA, social categorisation could be identified by applicants as being a means of fast tracking their application and the allocation system would no longer be a fair one.

So, on analysis of the findings of the investigation including the HA's definition of homelessness, it is clear that this was not the Complainant's case until December 2018 when she had to leave her cousin's flat.

The Ombudsman does not therefore sustain the Complaint of not being categorised as a social case despite the Complainant's claim of being homeless since 2015.

However, the Ombudsman does sustain the complaint brought regarding the fact that no reasons were provided as to why the HA did not recognize the Complainant as a social case. The HA should have considered awarding social points to the Complainant due to her circumstances; i.e. the fact that she did not have a home of her own.

Classification

Complaint (i) - Complainant's Application was not socially categorised even though she alleged she had been homeless for three years – Not Sustained

Complaint (ii) - Complainant requested reason/s for the non-social categorisation but these were not provided - Sustained

(Report extracted from Case No 1190)

HOUSING AUTHORITY (HA)

Case 18

Complaint

The Complainant was aggrieved because despite being homeless since 2014, the HA had not categorised her as a social case. Furthermore, the Complainant claimed that the HA had not provided reasons as to why they had refused her social categorisation.

Background

[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]*

The Complainant, a young woman in her twenties, explained to the Ombudsman that throughout her life, her 'living conditions' had not been what would be considered standard. Her parents' relationship had broken down when she was a baby and for the first eight years of her life she had lived mainly with her paternal grandparents. Since then to date (2019), due to difficulties in her relationships with her parents, she claimed to have moved from living with one family member to another, staying at friends' houses, sleeping in the car, renting private accommodation (which she could ill afford and had to give up) and taking up a room at the Women's Refuge ("Refuge") [Ombudsman Note: By way of further background, the Complainant undertook a university degree in the United Kingdom between the period September 2013 to June 2016 and a further one year course between September 2017 through to June/July 2018].

The Complainant explained that in 2009 (at the age of 16) she moved back in with her mother (after living temporarily with her older sister) but that situation was unsustainable and so she moved in with her grandparents for a short time but they could not support her so they asked her to leave. Around 2010, the Complainant stated that her close male friend ("Friend") offered that she stay at his parents flat (without the parents' consent). The Complainant claimed she was so desperate that without asking the parents she gradually moved her belongings in, hoping not to be confronted. According to the Complainant, the parents were nice enough not to say anything but knew something was up. The Complainant stated that during the two years she lived there (2012), she and her Friend formed a very close relationship. Around that time, the Complainant re-established contact with her father and asked him if she could have the keys to his rented flat, as he was living

with his partner in her flat. The father agreed but around April 2014 asked her to leave as he had broken up with his partner and had to move back in. The Complainant was at that time completing her first year at university and was devastated. She pleaded with her father to allow her to stay but was ultimately forced out of the property. In April 2014, the Complainant contacted the HA about her situation but stated that they did not categorise her case as a social one.

She contacted her mother to ask if she could keep her belongings in a small store (rented by her mother) and stayed with her sister until she was allocated a room at the Refuge (around April 2014).

The Complainant explained that she experienced problems at the Refuge to the point that she could not reside there and resorted to sleeping in her car or in her mother's store. When around that time her maternal grandmother moved in temporarily with her mum due to ill health, she asked her mother if she could stay in the grandmother's flat and her mother agreed. She moved out of the Refuge in June 2014 and was able to stay there until she left for the new university year (September 2014) at which point her mother asked her to move her belongings back into the store in order that her grandmother could move back in if she recovered.

Due to the desperate situation she was in, her Friend once again offered that she stay in his parent's home (on this occasion with his parents' consent) during the university breaks. The Complainant took him up on the offer and stayed there during the holidays until summer 2015 when her Friend's parents needed her to leave because their daughter and children were moving back in for a period of time. The Complainant claimed she was desperate and asked her mother if she could move back into her grandmother's flat. The Complainant moved her belongings into the flat in December 2015. Her grandmother passed away in March 2016 and the Complainant pleaded with the HA to be able to remain in the property but they did not agree and the flat subsequently reverted to the HA. Between 2016 and 2017 the Complainant claimed to have stayed between her sister's house and her Friend's home as well as in UK attending interviews for further education there. Between 2017 and 2018 she continued her studies abroad and when she returned to Gibraltar in summer 2018 she rented a flat with financial support from her Friend, which she ultimately had to give up in January 2019 due to financial circumstances and return to the Refuge [Ombudsman Note: Since completing her studies, the Complainant pursued her career but at the present time was only offered supply work].

In respect of the Complainant's communications with the HA, she explained that she wrote to them in 2014, after she left her father's flat, informing them that she was homeless. According to the Complainant this resulted in the HA arranging for a 'Social Interview' and 'Social Inquiry Reports' ("SIR") between a social worker and herself but stated that her case was considered by the HA and she was not socially categorised [Ombudsman Note: Categorisation of housing applications considered by the Housing Allocation Committee ("HAC") and deemed to be in urgent need of Government rented accommodation are placed in the Social A List via which said applicants will be allocated a property within a shorter period of time than through the general housing waiting list].

Notwithstanding the above, the Complainant continued to pursue social categorisation. Her case was considered by HAC in March 2016 and again refused with the reason stated as being: '...it has come to the Committee's attention that you are not homeless.'

In April 2016, the Complainant wrote to the HA requesting details of the information that had led to that decision, in order to challenge it, but states that to date that information has not been forthcoming.

The Complainant lodged her complaints with the Ombudsman in January 2019.

Investigation

The Ombudsman presented the complaints to the HA and whilst awaiting a detailed response, raised the Complainant's case at a meeting with the HA on the 23rd January 2019 and informed the HA that the Complainant was now residing at the Refuge.

The HA reverted on the 25th February 2019 and advised that in light of the information received at that meeting they had approached HAC and asked them to review the Complainant's housing application and their decision not to socially categorise her application. The HA explained that when HAC considered the Complainant's case they understood the Complainant had not been homeless as she was residing alternatively between the Refuge and her Friend's family home and that information was put to HAC. Furthermore, the HA stated that at a meeting in December 2014 between the Complainant, the Housing Manager and the Principal Housing Officer, the Complainant had confirmed that information as being correct.

The HA stated that on this occasion they had also asked HAC to consider awarding social points to the Complainant's application if they felt the Complainant's case did not fully merit social categorisation as they recognized that there was a social element in it [Ombudsman Note: The General Housing Waiting List is points based and as such, the awarding of social points would raise the Complainant's position in said list]. In preparation for HAC's consideration of the Complainant's case, the HA had requested an updated SIR which was presented at HAC's meeting of the 28th January 2019. HAC requested that the Complainant should provide confirmation that she was residing at the Refuge and would await the outcome of her meeting with the Principal Housing Officer. In February 2019, HAC agreed to socially categorise the Complainant's application.

As part of his investigation, the Ombudsman requested further information from the HA which included the date of the Complainant's housing application, copies of SIRs and copies of minutes of HAC's meetings in which the Complainant's case had been discussed. The Ombudsman also enquired as to what the HA's definition of 'homeless' was.

The HA's response stated that their definition of 'homeless' was: "When someone has nowhere to go and is typically living on the street or sleeping rough".

Regarding the Complainant's application, the HA stated that it was activated on the 25th November 2015 (the date on which the Complainant provided to the HA her father's address as a c/o address for application purposes only). The Ombudsman noted the year and a half elapsed between the Complainant's initial contact with the HA in April 2014 and the date on which the application was finally accepted. The investigation established that in April 2014, HAC had requested a SIR after which her case would be reviewed. The SIR carried out on the 10th June 2014 recorded that the Complainant was residing at the Refuge but after considering her case on the 30th June 2014 made no social recommendation and agreed that she should submit an application for social housing [Ombudsman Note: The HA, further to the Ombudsman's enquiry, advised that until this point, the Complainant was not in their records as she must have been using her mother's address which was a privately owned property]. The application was handed in on the 17th April 2015. HAC considered the application and reverted that an updated SIR was required (the first SIR had been compiled in June 2014) and she would be contacted by a social worker. The SIR was undertaken on the 9th June 2015 and it concluded that since June 2014, the Complainant had been living in the house of her Friend's parents. The SIR stated that the Complainant was unable to allow the social worker to carry out a house visit as she claimed she was there against the wishes of the home owners; she was at the point of being asked to leave and the visit could expedite that. At their 24th June 2015 meeting, HAC made no social recommendation as the

Complainant had not allowed a home visit, but would be willing to reconsider the case if the social worker achieved this. At that meeting, HAC requested that the Complainant provide a local residential address in order to activate her application. A letter was sent to the Complainant on the 29th June 2015 communicating the outcome of that meeting.

In August 2015 a further SIR was undertaken. The SIR reflected that the Complainant's circumstances had changed in that she had been asked to leave her Friend's parents' home and stated she was sleeping at different friends' houses and storing items she needed on a daily basis in the boot of her car whilst the rest of her belongings were in her mother's small store room. The SIR denoted that the Complainant alleged she had been so desperate recently that she had spent the night in the store and that she showered in the public changing rooms at the beach. The SIR noted that she would be continuing her university studies in the UK in September 2015 but that her current situation was inevitably impacting her studies. HAC considered the case again in October 2015 (updated SIR) and once again made no social recommendation and reiterated that she needed to provide a local residential address in order to activate her application.

The minutes of HAC's meeting of the 21st March 2016 denoted that the Complainant had provided her father's address for application purposes and that was accepted by HAC. The application had been temporarily suspended pending an address. At that same meeting, HAC noted that the Complainant had written a letter requesting to learn why HAC did not socially categorise her application if she was homeless. HAC considered her case and concluded that she should be informed that she had not been socially categorised as it had come to HAC's attention, through social media, that she was living with her Friend. A further item of discussion in the Complainant's case was a request for an extension of time on the deadline set by the HA (15th April 2016) with regards handing back her late grandmother's flat (her grandmother passed away in March 2016) in which she was storing personal belongings. The Complainant had requested that the date be put back to May 2016 when she would return from university. HAC concluded that the request for an extension was outside their remit and would be referred to the HA. The letter sent to the Complainant by the HA dated the 29th March 2016 informed her that: "The Committee would also like to inform you that they have not socially categorised you as it has come to the Committee's attention that you are not homeless". The reason for the decision was not communicated to the Complainant, in breach of what HAC had requested. The Complainant once again enquired about the reason why they believed she was not homeless but the explanation was never provided.

In the course of the investigation, the Ombudsman enquired as to what information the HA had come across in social media. The HA advised that they had seen photos on social media of the Complainant's engagement to her Friend as well as noting that she resided in her Friend's parents flat [Ombudsman Note: The Complainant clarified that she had been engaged to her Friend for a short period of time (one month or so) in summer 2018 but that they broke off the engagement. She explained that during that period she was not living in her Friend's flat but in the private rental].

The Complainant resumed contact with the HA in December 2018 and lodged her complaints with the Ombudsman in January 2019. The Ombudsman raised her case with the HA as a result of which the Complainant met with the PHO and that resulted in them asking HAC to review the Complainant's case, due to her becoming a resident at the Refuge, and a meeting between her and the PHO. She was socially categorised and entered the Social A List in February 2019.

Update

In the course of the investigation, the HA provided copies of the minutes of the two most recent meetings between the Complainant and the HA held in January and July 2019. The January 2019 meeting denoted the Complainant informing the HA that she did not know where she was going to live when her private rental contract expired in May 2019 (this was precipitated due to the Complainant's financial situation). The HA raised the option of the Refuge but she responded she had not had a good experience there on a previous occasion and would be her last option. The HA advised that flats are allocated through the different waiting lists and that even if she were to be socially categorised she would have to wait her turn as there was no emergency housing. Regarding her financial situation due to working on a supply basis, the HA suggested she could seek other employment to be able to afford a private rental until she was allocated a flat and the Complainant responded that she had studied to follow her chosen career and that was what she would do.

In the July 2019 meeting, it was the HA who had requested to meet the Complainant as they had been notified by the company ("Company") tasked with selling properties for the Government's affordable housing scheme, that the Complainant had applied with her Friend to purchase a property jointly as a couple. Due to the Complainant's social categorisation, the HA had to discuss with her if there had been any changes which might affect the categorisation. At the meeting, the Complainant confirmed she was no longer in a relationship with her Friend but they remained good friends. After applying for the property they broke up and asked the Company to cancel the application but claimed to have been told it could not be cancelled. The HA requested that once they received notification from

the Company that the purchase application had been cancelled, her housing application would continue as standard. The Complainant informed the HA that she was two months pregnant but was no longer in the relationship.

Conclusions

The issues brought to the Ombudsman by the Complainant undoubtedly brought to the surface the very private and personal circumstances in respect of the Complainant's turbulent relationship with her parents, the apparent root cause of her 'homelessness'.

When the Complainant sought assistance from the HA in 2014 she was not an applicant for Government rented accommodation and so when HAC considered her case, concluded that she had to apply. The application was activated in November 2015 with her father's address used as a c/o address for application purposes only. Parallel to the application being accepted, SIRs and HAC meetings took place.

In reconciling the information from the SIRs and that provided by the Complainant, the following timeline was established:

In April 2014, the Complainant's father asked her to leave his flat which triggered that the Complainant turned to the HA for assistance. In parallel, she contacted her mother to ask if she could keep her belongings in a small store (rented by her mother) and stayed with her sister until she was allocated a room at the Refuge (April 2014). She claimed not to have had a good experience at the Refuge and left after a short period and moved during that summer into her grandmother's flat (June 2014). In September 2014 she left for the new university year and up to September 2015 when she returned to Gibraltar during the university breaks stayed at her Friend's parent's house. In December 2015 she stayed in her grandmother's flat with the flat reverting back to the HA in April 2016 after the Complainant's grandmother passed away. From June 2016 through to September 2017, the time when she returned for further education to the United Kingdom, she stayed between her sister's home and a friend's house in the United Kingdom. Then some time in 2018 she rented private accommodation which had to be given up in January 2019 due to financial issues and she moved into the Refuge. In February 2019 she is socially categorised by the HA. In July 2019 the Complainant is summoned by the HA to enquire if there had been any changes which could affect her social categorisation, as a result of the Company having notified them that they had a joint application for the purchase of affordable housing from the Complainant and her Friend, and the Complainant states that there is no change, that

she is no longer in a relationship and the application will be cancelled. The Complainant also informs the HA that she is pregnant.

The HA's role is to manage public housing as well as the numerous waiting lists in order that allocations are made fairly and in cases of social categorisation, that these are in fact legitimate. It is HAC's role to assist in this exercise and be vigilant and cautious which includes reviewing information provided to them by the HA, like in the Complainant's case with regards social media posts. The ultimate goal is to manage public housing via a fair allocation system. If cases similar to that of the Complainant were not meticulously investigated through various channels available to the HA, social categorisation could be identified by applicants as being a means of fast tracking their application and the allocation system would no longer be a fair one.

So, on analysis of the findings of the investigation including the HA's definition of homelessness, it is clear that was not the Complainant's case until February 2019 when she had to leave the private rental due to financial issues and take a room up at the Refuge where she still resides at the time of writing this report.

The Ombudsman does not sustain the Complaint of not being categorised as a social case despite the Complainant's claim of being homeless since 2014.

The Ombudsman does sustain the complaint brought regarding the fact that no reasons were provided as to why the HA did not recognize the Complainant as a social case. At HAC's meeting in March 2016 they had concluded that the Complainant should be informed that she had not been socially categorised because it had come to HAC's attention through social media that she was living with her Friend. The letter from the HA to the Complainant failed to provide the reason.

Classification

Not categorised as a social case despite being homeless since 2014 – Not Sustained

No reasons provided as to why HA did not recognize her as a social case – Sustained

(Report extracted from Case No 1191)

HOUSING AUTHORITY

Case 19

Complaint

The Complainant brought to the Ombudsman, the five complaints listed below.

(i) Informed in August 2017 that parking plan in the Estate was being finalised but to date (February 2020) that has not been implemented;

(ii) Feels that it is excessive for the Housing Works Agency and Gibraltar Joinery & Building Services ("GJBS") to have nine designated parking spaces in the Estate;

(iii) Unhappy that only cars displaying parking permits ("Permit") denoting vehicle licence number, are allowed to use parking bays in Estate, whereas in other Government estates this policy is not applicable;

(iv) Issued one Permit denoting the licence numbers of vehicles permitted to park in the Estate instead of issuing one Permit for each authorised vehicle;

(v) Complainant states that vehicles without Permits, park with impunity on pavements and on the side of the road in the Estate;

Background

[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].***

Complaint (i)

The Complainant stated that there was no visitors' parking area in the Estate and that she had raised this issue in a letter to the Housing Authority in August 2017 whilst pointing out that the estate adjacent to hers had visitors' parkings.

The Housing Authority responded to the Complainant and confirmed that subsequent to the parking spaces in the adjacent estate having been allocated, there were a number of surplus spaces and those were designated as visitors parking. Parking in those bays required the display of visitors permits and time restrictions applied. Regarding visitors parking in the

Estate, the Housing Authority advised that they were currently (August 2017) finalising the parking plan within the Estate and if possible, visitors parking would be implemented in future.

Complaint (ii)

The Complainant believed that under the circumstances, the fact that there was no visitors' car park, it was excessive for the Housing Works Agency and GJBS to have nine parking bays designated for use.

Complaint (iii)

The Complainant explained that at the time of allocation of the flat in the Estate she was allocated a designated parking bay. According to the Complainant, she had always been able to park different vehicles in that bay (she sometimes used her son's or daughter's cars) until a policy was implemented by the Housing Authority in 2017 whereby all vehicles parked in the parking spaces in the Estate had to display the Permit denoting the licence number of the vehicle/s authorised to park in said parking space. Permits would only be issued to vehicles registered under the name of the tenancy holder or those persons authorised to reside in the property, and would be issued conditional to any arrears of rent being settled.

In order for the Permits to be issued, the Housing Authority in conjunction with Gibraltar Car Parks Limited ("GPCL") had requested, by way of letter, that tenants submit the following documents:

1. Valid MOT (Ministry of Transport) certificate;
2. Valid driving licence;
3. Vehicle registration book.

The Complainant wrote to the Housing Authority, further to the Permits policy implementation, putting across her dissatisfaction that only cars displaying Permits would be allowed to use parking bays in the Estate and referred the Housing Authority to the fact that the policy was not applicable in other Government estates. In her letter, the Complainant enquired as to the reasons for the vehicle documentation having to be submitted and put her concerns about what would happen with regards to parking in the designated bay if she used one of her relative's vehicles.

The Housing Authority responded to the Complainant and explained that they had set guidelines with respect to the issue of Permits. All vehicles parked within the Estate had to be deemed roadworthy and the MOT certificate substantiated that. Regarding the vehicle registration book, the Housing Authority explained that only tenants registered within the household could apply for the Permits and the registration book would, for the purpose of this exercise, serve as an address check. The Housing Authority reiterated in their letter that only vehicles of authorised tenants were allowed to park within designated parking bays and the Permit had to be displayed, as failure to do so could result in the vehicle being clamped.

Complaint (iv)

The Complainant was issued with one Permit denoting the licence numbers of the two vehicles registered at the address instead of being issued with two Permits, one for each vehicle. The Complainant claimed to have asked the reason for this and was informed that it was to prevent them from using the Permit in another parking bay. According to the Complainant she asked other tenants about this issue and claims to have been told that they had a Permit for each vehicle.

Complaint (v)

According to the Complainant, the Permit policy in the Estate was partly implemented so that the Housing Authority would have some leverage with respect to recovery of rent arrears by way of removal of Permits from those tenants who owed rent. The Complainant claimed that it was in fact the law abiding tenants that were being punished through the application of the policy as permitted vehicles not displaying a Permit when parked in their designated bay would be clamped, whereas vehicles of residents who had had their Permits revoked, vehicles of non-residents and commercial vehicles were allowed to park with impunity on pavements and on the side of the road inside the Estate.

By 2019 there had been no developments and so the Complainant lodged her complaints with the Ombudsman.

Investigation

The Ombudsman put the initial complaints to the Housing Authority in March and May 2019. For ease of reference we shall continue this report by setting out each complaint separately.

Complaint (i)

The Housing Authority confirmed to the Ombudsman that the Complainant had been correctly informed (in 2017) that a reviewed parking plan within the Estate was being undertaken at that time and was in its final stages. Notwithstanding, they explained that the input from the Estate's Tenants Association ("Association") had been taken into account with respect to the elaborate comprehensive review and works would have to be undertaken in order to implement said plan. It was therefore decided that the revised parking plan would be implemented once the general embellishment of the Estate was carried out and they were awaiting financial approval in order to proceed. According to the Housing Authority it was envisaged that once works were completed, the Estate would enjoy more parking facilities. At the time of writing this report (February 2020) the Ombudsman requested an update from the Housing Authority. The latter provided a copy of the Government's press release dated September 2019 of a major refurbishment plan for housing estates. The Estate was included in the first phase of a two phase plan to be rolled out over a ten year period and amongst the items listed for the Estate was the creation of further parking spaces, particularly motorcycle spaces. No information was provided in the press release on the start date.

[Ombudsman Note: The Association, approached by the Complainant, wrote to the Ombudsman in March 2019 in support of the Complainant's grievances. They explained that they did not claim to have a mandate from residents as two meetings that they had called had been attended by a very small number of residents and that they had decided to continue as concerned residents under the banner of Association. According to them, in November 2016 they met with the Housing Authority and submitted a plan which they stated would increase parking in the Estate from 25% to 45%. They stated that Housing were not supportive of their proposal but agreed to carry out a survey. There were no developments and in August 2017 the Housing Authority sent letters to residents informing them of the Permit scheme. The Association stated that they were not involved in the planning or implementation of the Permit scheme. They added that they were asked to a further meeting with the Housing Authority in January 2018 where they were informed of the imminent enforcement of the scheme but stated that they were not provided with a copy of said scheme beforehand. The Association raised the fact that on the 2nd March 2018, the Housing Authority's press release on the new Permit scheme stated that they had met with the Association before implementing the strategy. They did not want this statement to be misinterpreted and reacted with a press release of their own which stated that they did not support the scheme or manner of implementation and clarified that they had not been involved in the preparation of said scheme nor provided with details beforehand].

Regarding visitors parking in the adjacent estate, the Housing Authority confirmed that there was a designated area for visitors to park in as there were a surplus number of parking spaces in that estate, but stated those were diminishing as new residents moved in and requested a parking space.

Complaint (ii)

The Housing Authority stated that GJBS and the Housing Works Agency have their onsite facilities management office in the Estate and have allocated parking spaces.

Complaint (iii)

The Housing Authority advised that the Permits policy had been successfully implemented in order to ensure that parking bays were being used fairly and in accordance with the terms set out in the tenancy agreement and confirmed that this was the same policy as that in place in the adjacent estate. The Housing Authority explained that the policy allowed for Permits to be issued to authorised vehicles and that those vehicles had to be registered under the name of the tenant and/or authorised tenants of a household, provided they held a driving licence.

Complaint (iv)

The Housing Authority informed the Ombudsman that it was usual practice in all Government estates with parking permits for one permit to be issued for all authorised vehicles allowed to park in a designated bay.

Complaint (v)

The Housing Authority advised that they contracted the services of a private company to ensure compliance with the Permits policy by residents but stated that the issue of cars parked on pavements and on the side of the road in the Estate was a traffic enforcement matter beyond their remit.

The Ombudsman contacted Gibraltar Car Parks Limited ("GCPL") and was informed that he should approach Gibraltar Parking Management Services Limited ("GPMSL"). A meeting was convened with GPMSL.

GPMSL explained that they were a privately owned company which had been contracted by GCPL to take over the assets and responsibilities of the day to day running and management of GCPL and that GPMSL followed instructions from, and reported directly to,

GCPL directors and the Ministry of Transport. GPMSL stated that they had responsibility for the issue of fixed penalty notices, clamping and towing of vehicles stationed in contravention of parking signs or causing obstructions to the public or traffic flow in public roads. GPMSL stated that in some Government owned residential estates, as was the case with the Estate, private companies were contracted directly by the Housing Authority with respect to compliance with the Permit policy in relation to designated parking bays (as explained above) which did not fall under the public highway (within these estates). In respect to designated parking bays, GPMSL stated that they would only intervene if they received a specific request for assistance from the Housing Authority with prior consent from the Ministry of Transport. Notwithstanding, GPMSL were the responsible authority for enforcement of the law in public highways within those estates. GPMSL explained that the Estate boasted extremely wide pavements, some of which were partially being utilised as parkings. GPMSL stated that in a similar manner to the Royal Gibraltar Police ("RGP") they used discretion to enforce the law when vehicles parked on the wide pavements had allowed sufficient access for pedestrians, wheelchairs and prams, given that there was limited parking availability in the Estate to cater for demand.

The Ombudsman requested information from GPMSL with regards to the section in the Traffic Act which provided discretion with respect to enforcement of the law for cars parked on pavements or on the side of the road within the Estate. GPMSL referred the Ombudsman to Section 83C.(1) of the Traffic Act as follows:

Obstruction of pavement or verge.
83C.(1) No device or equipment may be installed on a pavement or verge if it obstructs the passage of pedestrians, in particular the passage of elderly or disabled persons.

GPMSL informed the Ombudsman that they had enforced the law with respect to cars parked on pavements and that a number of cases had been challenged in Court with the vehicle owner arguing that he/she was not causing an obstruction because the pavements were very wide. According to GPMSL, the Court had ruled in favour of the vehicle owner.

GPMSL reiterated that the Ministry of Transport and the Ministry of Housing were working together on a plan which would increase parking availability.

Conclusions

(i) Informed in August 2017 that parking plan in the Estate was being finalised but to date (February 2020) that has not been implemented – Sustained

The Ombudsman sustained this complaint. Aware of the Complainant's concerns, some of which were shared with the Association, the Housing Authority should have communicated to the parties the fact that the implementation of the reviewed parking plan for the Estate which had in August 2017 been in its final stages, was delayed and would be implemented once the general embellishment of the Estate was undertaken. The lack of communication by the Housing Authority is further substantiated by the fact that the Association were not aware that the Housing Authority had taken into account their input when arriving at that decision.

(ii) Feels that it is excessive for the Housing Authority and their contractor GJBS to have nine designated parking spaces in the Estate – Not Sustained

The Housing Authority's position on this issue was that the Housing Works Agency and GJBS have their onsite facilities management office in the Estate, and as such, have allocated parking spaces there.

Considering the shortage of parking spaces for residents in the Estate, the Ombudsman suggested that the Housing Authority review the current allocation to those contractors' vehicles and establish whether it is necessary for the nine vehicles to park in the Estate or whether some of those parkings could be released by relocating some of the vehicles to the contractors depots.

(iii) Unhappy that only cars displaying parking permits ("Permit") denoting vehicle licence number, are allowed to use parking bays in Estate, whereas in other Government estates this policy is not applicable – Not Sustained

The Ombudsman did not sustain this complaint. The Housing Authority, in their capacity as landlord, rent out parking spaces to residents. For the purpose of ensuring that only authorised vehicles are parked in a designated parking bay, the Housing Authority have implemented a Permit system whereby a Permit needs to be displayed on the authorised vehicle, as failure to do so would result in the vehicle being clamped or towed away. Permits would only be issued to vehicles registered at the address in the Estate and said vehicles

registered under the name of the tenancy holder or those persons authorised to reside in the property, and would be issued conditional to any arrears of rent being settled.

The Housing Authority have confirmed that the same policy is applicable in all Government estates where the Permit system has been implemented.

(iv) Issued one Permit denoting the licence numbers of vehicles permitted to park in the Estate instead of issuing one Permit for each authorised vehicle – Not Sustained

Based on the information provided by the Housing Authority that their policy is to issue one Permit for any number of vehicles authorised to park in a designated bay, the Ombudsman did not sustain this complaint.

Notwithstanding, the Ombudsman believes that it would be more practical for residents to have a Permit issued for each vehicle which can be displayed at all times and remain in the vehicle, rather than have the current situation of having to change the one Permit from one vehicle which maximises the chances of an error and thereby having the vehicle clamped.

(v) Complainant states that vehicles without Permits, park with impunity on pavements and on the side of the road in the Estate – Sustained

The complaint brought to the Ombudsman by a resident in the Estate was that whilst Permit holders had to comply with specific requirements set by the Housing Authority to be able to park in designated bays, other vehicle owners parked on pavements and on the side of the road in the Estate were getting away unpunished whilst seemingly breaking the law.

GPMSL confirmed that at the present time, only vehicles causing an obstruction whilst parked in those areas were being towed away. The reason given by GPMSL was that because the Estate boasted extremely wide pavements and given that there was limited parking availability in the Estate to cater for demand they used discretion to enforce the law when vehicles parked on said pavements had allowed sufficient access for pedestrians, wheelchairs and prams. Furthermore, GPMSL referred the Ombudsman to a number of cases that had been challenged in Court by vehicle owners who had their cars clamped/fined/towed and had resulted in the Court ruling in favour of the vehicle owner.

Whilst there is no discretion in relation to the enforcement by the private company with regards to vehicles parked in designated bays not displaying a Permit being clamped, the opposite is the case when it comes to vehicles parked on pavements and on the side of the

road, the enforcement of which comes under the remit of GPMSL. As stated by the Complainant, law abiding tenants are being penalised in the event that they inadvertently fail to display the Permit.

In order to establish a 'level playing field' with regards to parking on pavements and on the side of the road, GPMSL and the Housing Authority should make the general public aware of the discretionary approach being taken due to shortage of parkings, for the purpose of making everyone aware that they can avail themselves of the 'parking opportunities' in the Estate. At present it would appear that only those persons in the know of this discretionary approach, or those who take the chance of parking in areas not designated as such, thereby running the risk of having their vehicle fined, clamped or towed, are availing themselves of those areas.

Classification

(i) Informed in August 2017 that parking plan in the Estate was being finalised but to date (February 2020) that has not been implemented – Sustained

(ii) Feels that it is excessive for the Housing Authority and their contractor GJBS to have nine designated parking spaces in the Estate – Not Sustained

(iii) Unhappy that only cars displaying Permits denoting vehicle licence number, are allowed to use parking bays in Estate, whereas in other Government estates this policy is not applicable – Not Sustained

(iv) Issued one Permit denoting the licence numbers of vehicles permitted to park in the Estate instead of issuing one Permit for each authorised vehicle – Not Sustained

(v) Complainant states that vehicles without Permits park with impunity on pavements and on the side of the road in the Estate – Sustained

(Report extracted from Case No 1210)

Case 20

Complaint

The Complainant was aggrieved against the Royal Gibraltar Police (RGP) due to the following:

(i) Non reply from RGP to letter of the 28th November 2018;
(ii) Non reply from RGP to letter of the 10th January 2019;
(iii) Claim for main door to Complainant's Government rented flat ("Flat") due to damages caused by RGP in November 2018 remains outstanding;
(iv) No written apology from the RGP.

Background

[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].***

The Complainant explained to the Ombudsman that the execution of a search warrant in his Flat (on the 26th November 2018) which was shared with his wife and family, had resulted in extensive damages to the Flat's front door, security lock and frame. The Complainant stated that RGP officers failed to knock and identify themselves and instead used unnecessary force and broke into the Flat. The only person at home at that time was the Complainant's daughter (adult over 18) who the Complainant claimed was left traumatised and distressed by the incident.

The Complainant wrote to the RGP Commissioner ("Commissioner") on the 28th November 2018 setting out what had happened and the effect of the RGP's actions. The Complainant attached to the letter receipts of expenses incurred (£15 for two keys, £3.50 for photos of the damaged door) and a quote for the replacement of the door amounting to £2,243.70 [Ombudsman Note: The Complainant informed the Ombudsman that a number of years ago he had replaced the standard front door of the Flat with a sturdier and more secure door, frame and lock].

On the 10th January 2019 the Complainant wrote to the RGP, on this occasion to two inspectors, and informed them that he had been told by the Police Complaints Board ("PCB") that the inspectors involved had requested a meeting with him and his daughter in order that

they could provide an oral apology. The Complainant argued that was not what had been agreed between him and the inspectors at a meeting at RGP Headquarters. The Complainant stated that what had been agreed with the RGP was that a written apology would be made to his daughter and other house residents. Regarding the compensation for the damages, the Complainant asked the RGP to settle the payment as soon as possible; he and his family did not feel safe in the Flat as after the forced entry the door had only been partially fixed as a temporary measure (by a local contractor sent by the RGP) but was in a very bad state.

On the 20th February 2019 the Complainant lodged his complaints with the Ombudsman.

Investigation

The Ombudsman wrote to the RGP and a reply was received on the 7th March 2019. RGP explained that Drug Squad officers had executed a search warrant at the Flat and that forced entry was made because the officers had a reasonable belief that Class A drugs (the reason for the warrant having been obtained) were being disposed of. The RGP confirmed that the forced entry had caused damage to the door. The Complainant was not at home at the time and no drugs were found. The only person in the Flat was the Complainant's daughter.

RGP advised that on the 28th November 2018, the Complainant went to the PCB to lodge a complaint about the search. According to RGP, given that the Complainant was complimentary about the conduct of the officers who executed the search warrant and that his complaint was about the damage to the door of the Flat and compensation for said damage, the Complainant was referred by the PCB to the RGP and no complaint was lodged at that stage.

The Complainant met with two inspectors later that same day and handed over his letter of complaint dated 28th November 2018 as well as the quote for damages. According to the RGP, in the course of that meeting, the Complainant asked the officers for a written apology to be offered to his daughter. The inspectors undertook to look into both issues. The RGP stated that the matter was discussed internally at a later stage and it was decided to progress the claim and to offer the daughter a verbal apology for any distress caused.

The RGP stated that the Complainant spoke to one of the inspectors on the 10th and 13th December 2018 to enquire about the status of the claim for damages but that no mention was made about the apology by either party. On the 8th January 2019, at a meeting between

RGP and PCB it was agreed that the latter would inform the Complainant that there was no basis for a complaint to be lodged and that RGP officers would meet with the Complainant and his daughter to offer the verbal apology as described above. PCB communicated the aforementioned to the Complainant and this resulted in the Complainant's letter of the 10th January 2019 (RGP clarified that the letter was addressed to them but was handed over to PCB). Upon receipt of the letter, one of the inspectors contacted the Complainant and informed him that no written apology would be provided for the damage to the door. Noting that the Complainant and his daughter did not want to meet RGP officers, the matter was considered closed. Regarding the claim for damages, the Complainant was informed that this was being processed. On the 29th January 2019, the Complainant attended the PCB offices for an update on the claim and was informed that there was none. Again, no mention was made of the apology on that occasion. Similar updates were sought by the Complainant on the 6th and 11th February 2019 with the same outcome.

RGP stated that the latest position with regard to the claim was that it would be submitted for consideration to the Financial Secretary. The delay in doing so had been due to internal issues collating documentation to support the claim and communications with the Housing Authority with regard to the type of door installed at the Flat.

RGP advised that they had had frequent contact with the Complainant on the matter but acknowledged that they had not sent a written reply to his two letters. RGP stated that the fact that both letters were channelled through PCB may have had a bearing on this. RGP reiterated that the offer to meet with the Complainant and his daughter to offer the daughter a verbal apology for the distress caused still stood but pointed out that they were confident that no mistakes were made, either of judgement or in law in the execution of the search warrant and they would not offer an apology in that respect. RGP concluded that they would write to the Complainant within the next seven days to provide an update on the claim and offer a meeting. The letter was sent to the Complainant on the 8th March 2019 (copy provided to the Ombudsman).

The Ombudsman contacted the Housing Authority in their capacity as landlord to enquire what their policy was with regard to the replacement of a fixture, in this case the Flat's front door, in cases where the RGP had executed a search warrant and caused damage as a result of forced entry. The Housing Authority stated that they had been in communication with the RGP on this matter and informed them that their policy in similar cases was for the RGP to replace the front door with a standard door (works undertaken either by the Housing Works Agency or an appointed subcontractor). By way of further information, the Housing Authority advised that they had notified the RGP that the Complainant had not sought nor

received permission from them for the replacement of the standard front door with a security door. By way of background information, the Housing Authority explained that in past years, as landlord, they had taken responsibility for damages caused by the RGP but that this had changed and it was now the latter's responsibility to make good any damages that they caused when executing search warrants in Government-owned properties.

The Ombudsman met with the RGP to clarify a number of aspects of the complaint and establish the current position vis-a-vis the apology and compensation. At the meeting, the RGP reiterated that they had carried out the search in the Flat on the strength of a search warrant, obtained from information received. RGP stated that the team executing the search warrant must have heard a noise which led them to believe that drugs were being disposed of and that was what must have triggered the forced entry. Regarding the length of time taken for the door to be replaced, the RGP stated that they had sought advice from the Housing Works Agency and that had resulted in substantial delay. The Ombudsman enquired as to whether the RGP had dealt with a similar case in the past and the RGP responded that, in the past, where forced entry into a Government rented flat had been required during the execution of a search warrant, damages to the front door had either been repaired or the front door replaced with a standard one.

The Ombudsman informed the RGP that he was aware of the Housing Authority's policy in similar cases but noted that the Complainant would not be satisfied with a standard door being fitted in view that a number of years ago he had replaced a similar standard one with a security door, frame and lock.

The Ombudsman suggested that under the circumstances and in order to manage resources effectively, the RGP should credit the Complainant with the cost of the standard door and the cost of installation and that the Complainant should be permitted to apply the credit either towards the cost of a new security door or towards the cost of repairs to the one in place. RGP stated that because the Complainant did not have permission from the Housing Authority for the replacement of the door they could not proceed with the Ombudsman's proposal.

The Ombudsman advised the Complainant of the above and suggested that he write to the Housing Authority explaining the circumstances of his case and going forward, request formal permission for the security door to remain installed. The Ombudsman also informed the Complainant of the Housing Authority's policy regarding replacement of fixtures and

advised that if the Ombudsman's suggestion was agreed to, the RGP's liability would be limited to the cost and the fitting of a standard door.

By way of further information, the Ombudsman brought to the Complainant's attention the following RGP's Code of Practice in relation to the legal liability or otherwise for the payment of compensation where a search was lawful, and the force used can be shown to be reasonable, proportionate and necessary to effect entry.

Criminal Procedure and Evidence – Notice of Publication of Codes of Practice – Subsidiary Legislation made under s. 690(3)(a), Code B - Code of practice for searches of premises by police officers and the seizure of property found by police officers on persons or premises – Notes for Guidance - Section 6A:

6A. Whether compensation is appropriate depends on the circumstances in each case. Compensation for damage caused when effecting entry is unlikely to be appropriate if the search was lawful, and the force used can be shown to be reasonable, proportionate and necessary to effect entry. If the wrong premises are searched by mistake, everything possible should be done at the earliest opportunity to allay any sense of grievance and there will normally be a strong presumption in favour of paying compensation.

The Ombudsman further informed the Complainant that if he felt that the force used in carrying out the search by the RGP had been unreasonable, he would have to engage the services of a lawyer as this was outside the Ombudsman's remit; RGP operational procedures and not matters of maladministration.

The Complainant wrote to the Housing Authority on the 10th May 2019 asking for their approval for the Flat to have a security door. The Ombudsman informed the RGP accordingly who noted the positive development.

At the time of closing this report (20th May 2019) the Complainant was awaiting a response from the Housing Authority.

Conclusions

(i) Non reply from RGP to his letter of the 28th November 2018 – Not sustained

The RGP confirmed that they had not replied to the Complainant's letters of the 28th November 2018 but noted that there had been a number of meetings and communications between RGP inspectors and the Complainant on the 28th November 2018, 10th and 13th

December 2018. Considering that there had been communication between the two parties after the letter, the Ombudsman did not sustain this complaint.

(ii) Non reply from RGP to his letter of the 10th January 2019 – Sustained

The RGP stated that further to a meeting between the RGP and the PCB on the 8th January 2019 it was resolved that the PCB would notify the Complainant that there was no basis for a complaint to be lodged and that RGP officers would meet with the Complainant and his daughter to offer the verbal apology as described above. It was further to having been given this verbal information that the Complainant wrote the 10th January 2019 letter which remained unanswered until the 8th March 2019, the date on which further to the Ombudsman's investigation, the RGP sent a reply to the Complainant. The Ombudsman notes that further to his letter, the Complainant had sought verbal updates on the 29th January, 6th and 11th February 2019 through the PCB and on each occasion was informed that there were no developments. The Ombudsman therefore sustains this complaint.

(iii) Claim for main door to Complainant's Government rented flat ("Flat") due to damages caused by RGP in November 2018 remains outstanding – Sustained

The Ombudsman sustains this complaint. Considering that similar cases of damages to the front door of Government rented flats had occurred in the past during the execution of search warrants and that the RGP had responsibility for repairs or replacement of damage caused to fixtures in those properties, the RGP should have had a procedure in place to deal with the Complainant's request for compensation. The RGP should have been clear with the Complainant from the onset as to the limit of their liability.

In respect to the Housing Authority's procedure in place for tenants of Government rented properties who want to make changes to fixtures, the Ombudsman notes that permission has to be sought from the Housing Authority and approval given by them before tenants can proceed. It would have been in the course of that process that the Housing Authority would have informed the tenant of what their replacement policy was in the event of damages to the door; i.e. that it would be replaced by a standard door.

(iv) No written apology from the RGP – Not sustained

The Ombudsman does not sustain this complaint. There was no maladministration in respect of the search as there was a lawful search warrant in place for the Flat. The distress caused to the Complainant's daughter was unfortunate but that was the result of the RGP's operational procedure which is outside the Ombudsman's remit. The RGP's stance is that no mistakes were made, either of judgement or in law in the execution of the search warrant and they would not normally offer an apology in that respect but as a courtesy, would provide a verbal apology to the daughter for the distress caused.

Classification

(i) Non reply from RGP to his letter of the 28th November 2018 – Not sustained;

(ii) Non reply from RGP to his letter of the 10th January 2019 – Sustained;

(iii) Claim for main door to Complainant's Government rented flat ("Flat") due to damages caused by RGP in November 2018 remains outstanding – Sustained;

(iv) No written apology from the RGP – Not sustained.

Recommendation

The Ombudsman recommends that the RGP should have a clear procedure in place with regard to their policy for repair or replacement of fixtures damaged as a result of a forced entry when executing a search warrant, particularly in Government rented properties that are managed by the Housing Authority.

(Report extracted from Case No 1192)

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