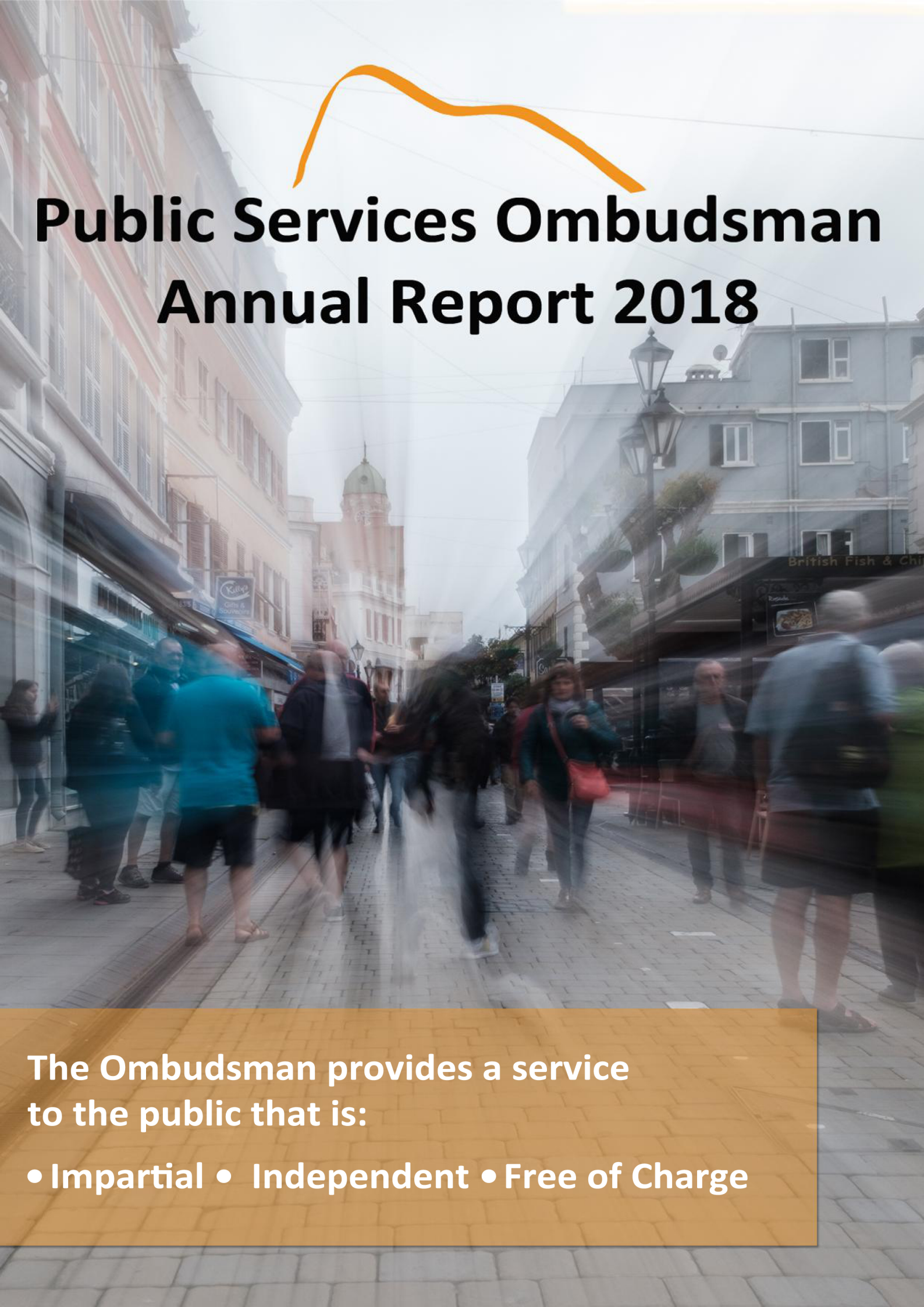

Public Services Ombudsman Annual Report 2018

The Ombudsman provides a service to the public that is:

• Impartial • Independent • Free of Charge

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Annual Report 2018

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Public Services Ombudsman

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Ombudsman's Introduction

This year marks the 20th Anniversary of the establishment of the Public Services Ombudsman's Office in Gibraltar. This is the Public Services Ombudsman's 19th Annual Report.

Ombudsman's Introduction

This year marks the 20th Anniversary of the establishment of the Public Services Ombudsman's Office in Gibraltar. This is the Public Services Ombudsman's 19th Annual Report.

The work of the Ombudsman's Office has developed significantly over the past 20 years. The Office is now firmly established as an institution that provides an important check on Government Departments and other Public Service Providers. 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 Ombudsman's Office provides an effective complaints service, which is free of charge to the public and without which many people in our community would have little opportunity to obtain redress or understanding of their grievances against the public administration. The Ombudsman's Office, therefore, makes a positive contribution to the delivery of administrative justice in Gibraltar.

The investigations carried out by the Ombudsman's Office and the many recommendations made by the Ombudsman, which are invariably respected and followed by Government Departments and Public Service Providers, have made a significant contribution towards the improvement of our public services over the years.

Today, the Ombudsman's Office has an increasingly important role to play in our community. The Ombudsman's Office 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 Thatnaas MBE, JP
Public Services Ombudsman
17th April 2019

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Highlights for 2018

2.1 Recommendations in previous Annual Reports - still pending a satisfactory resolution

Findings of maladministration are normally dealt with by the Ombudsman by way of formal recommendations being made to the Public Service Provider concerned. In some instances, however, the Ombudsman may address his recommendations directly to the Chief Secretary. This is usually the case where the Ombudsman's recommendations include proposed amendments to legislation, which may be considered necessary in order to avoid the continuation of maladministration or to minimise further injustices occurring of a similar type.

Although the Ombudsman does not currently have any power under the Public Services Ombudsman Act 1998 to compel the public administration to implement or act upon his recommendations, these recommendations are normally given careful consideration by the Public Service Provider and in most instances are taken on board.

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

The following are recommendations are still pending a satisfactory resolution by the relevant Public Service Provider:

2.1.1 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 and reserved their right to refuse to supply the Complainant with electricity at any future address, unless a historic debt, more than 22 years old, was settled by him within 21 days.

Recommendations and Outcome

The Ombudsman recommended that the Government should issue the Authority with revised conditions and procedures under section 19 (a) of the Gibraltar Electricity Authority Act, in order to prevent further injustices of this type, as follows:

Ombudsman's proposed revised conditions and procedures

Following the amendment to the Limitation Act on 27th July 2016, the conditions and procedures to be followed by the Authority when it considers to refuse or discontinue the supply of electricity to consumers because of the non-payment of arrears, should be 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) 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 was of the view that the Authority would have found it quite difficult to recover these historic arrears through legal proceedings. The amount reflected as due by this consumer on the inactive account in the Authority's computer system is over 22 years old and the Authority no longer has detailed records of what exactly the debt refers to.

In the circumstances, the Ombudsman also 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 of the Ombudsman's Annual Report 2017)

2.1.2 Housing Authority

Brief Outline of Complaint

The Complainant was removed from the tenancy of the flat in Gibraltar where he has lived, together with his parents, for all of his life. He requested the requested the Housing Authority to regularise the position as this 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 such '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, copy of his entry in the register of electors, and a copy of his car insurance – all these documents showed that his address was, beyond any doubt, the flat in question.

However, despite this required proof having been provided and despite the fact that the Housing Authority agreed that the Complainant meets the full eligibility criteria to be included in his parents tenancy, they have refused to do so on the grounds that he is married to a Spanish national whose main residence is currently in Spain.

Although his wife occasionally stays in the flat in Gibraltar, she currently resides in Manilva, Spain, together with her parents, so that she is able 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 submitted sufficient proof of his residence in Gibraltar, as required by the Housing Authority.

The Ombudsman 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 lives in Spain with her elderly parents, the Housing Authority refused to include him in the tenancy of his flat in Gibraltar.

The Ombudsman is of the view that the decision taken by the Housing Authority is clearly unreasonable and unfair and based on irrelevant grounds. The special family circumstances of this case were not taken into account and he recommended that the position be regularised.
(The full report can be found on pages 72 to 73 of the Ombudsman's Annual Report 2017)

2.1.3 Housing Authority

Brief Outline of Complaint

The Complainant was a single mother of three children who lived in Government rented accommodation ("her apartment") and was in receipt of social assistance benefits. The monthly house rent for her apartment was £63.54. The Complainant had applied for rent relief to the Housing Authority 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. Also provided were details of the formula 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 currently provide for a further deduction of £0.60 to be made for any children residing in the household. This allowance is not for each child but for the total number of children residing in the household.

The Ombudsman found that the total allowance deductible under the Rules for the Complainant was £57.60 per week in respect of herself as a single mother and just 60p per week for her three children. The Ombudsman was of the view that the allowance for the children seemed somewhat unrealistic and unfair when compared with the allowances 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 and pointed out that the correct formula should actually 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 amendment to Rules in order to make the necessary correction to the formula, as outlined above.

As regards the somewhat low level of allowance that was deductible in respect of children under the Rules, the Ombudsman suggested to the Housing Authority that they should perhaps consider proposing an amendment to the Rules in order to revise this allowance to a fairer and more realistic level.

(The full report can be found on pages 83 to 85 of the Ombudsman's Annual Report 2017)

2.1.4 Driver and Licencing Department

Brief Outline of Complaint

The Complainant had purchased a 'personalised number plate' for his daughter as a birthday present when she purchased her new car. The fee paid by the Complainant for the personalised number plate at the time was £200.

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

When the car loan had been fully repaid by the daughter and upon her request that the personalised number plate be now registered in her name, the Driver and Licencing Department ("the Department") demanded a further fee of £250 for the 'transfer' of the registration of the vehicle and the related personalised number from the loan company to the daughter's name.

Recommendations and Outcome

The Ombudsman was of the view that the transfer of the registered ownership from the loan company to the buyer upon the repayment of the car loan was not a case of a buyer 'disposing' of the 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 Licencing Department consider making an ex-gratia payment of £250 the Complainant's daughter in order to regularise the position.

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 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 again for the same personalised number plate, upon discharge of their loan.

Additionally, the Head of the Licensing Authority 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.

However, the Ombudsman continues to be of the view that the current practice by the Licencing Authority is unfair and should be reviewed.

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

2.1.5 Gibraltar Health Authority

Brief Outline of Complaint

A gold chain, with an estimated value of £200, belonging to a patient went missing whilst in the care of GHA staff.

The patient estimated that the gold chain that was lost by the GHA was valued at around £200. The GHA appears to have requested the patient to produce evidence of the cost of the item – in the form of receipts etc. – which were no longer available to the patient. The Ombudsman was of the view that it was quite unreasonable for the GHA to withhold a reimbursement to the patient on this basis - in this case, over 4 years have now elapsed since the item was lost by the GHA.

Recommendations and Outcome

In the Ombudsman's report on this case (included in the Ombudsman's Annual Report in 2016) two recommendations were made, as follows:

1. That a formal system be implemented by the GHA when accepting items from patients for safe-keeping. These items must be properly logged and recorded in a ledger by the GHA. Also, the patient, or authorised family member of the patient, should sign to confirm the relevant ledger entry upon the deposit of the items concerned;

2. That in case of loss of any item accepted by the GHA from a patient for safe-keeping, that the patient should by financially compensated for such loss by the GHA – the level of compensation should be based on the estimated replacement value of the item lost.

   With regard to point 2, the Ombudsman more recently also pointed out to the GHA that it would be useful for a note to be inserted in the ledger entry of the estimated value of the property taken. The GHA should also set a maximum value restriction on any item taken for safe-keeping.

In view that no receipts were available to establish the cost or replacement value, the Ombudsman suggested that what should have been done at the time by the GHA, or indeed should now been done, is to offer the patient a reasonable settlement for the item lost.

(The full report can be found on pages 78 and 79 of the Ombudsman's Annual Report 2016)

2.2 Review of Health Complaints Procedure

The Ombudsman's Office was given jurisdiction to investigate complaints against the Gibraltar Health Authority ("GHA") in April 2015. At the time, a Complaints Handling Scheme Office ("CHS") was established and housed at St Bernard's Hospital. Since inception, the CHS has operated at arms-length from the Ombudsman's Office.

The CHS deals with complaints made against the GHA, in the first instance, and a resolution to most of the complaints is normally arrived at effectively. However, where any complaints cannot be resolved following an investigation by the CHS, these are referred to the Ombudsman's Office for a more in-depth and exhaustive investigation. Some of these complaints are referred by the Ombudsman to clinical advisers in the United Kingdom for their opinion on the issues being investigated.

Following the setting up by the GHA of the 'Patients Advocacy and Liaison Service' ("PALS"), it became clear that there was an element of duplication and inefficiency in the way that complaints against the GHA were being dealt with. It was evident that many of the complaints being made at the CHS could be resolved more effectively and expeditiously by PALS. I therefore recommended that there should be a single office at the hospital for dealing with all such complaints.

In order to improve the service being provided to complainants, therefore, the services being provided by both the CHS and PALS have been merged. With effect from the beginning of 2018, there is a single office at the hospital dealing with GHA complaints, in the first instance. Of course, any complaints against the GHA that cannot be resolved by the CHS/PALS Office can be taken further by the Complainant to the Ombudsman's Office for a more in-depth and exhaustive investigation.

So far the revised procedures appear to be working well and complaints are being handled more efficiently by having a centralised complaints office at the hospital. The resources available to PALS have also been increased recently with the appointment of an officer responsible for clinical governance, with many years of experience in this field in the National Health Service. The revised complaints handling arrangements will, however, continue to be closely monitored by the Ombudsman's Office.

2.3 Issues highlighted in investigations carried out by the Ombudsman in 2018

Other than complaints received against the GHA, which are now being handled, in the first instance, by the CHS/PALS Office situated at the hospital, the main complaints received by the Ombudsman continue to be in respect of the Housing Authority and the Civil Status and Registration Office.

Some of the issues complained about during the year are as follows:

Housing Authority

- The lack of transparency in the administration of the approved Housing Allocation Scheme. In this respect, the Ombudsman has recommended that full details of the latest approved Housing Allocation Scheme be published. In fact, it is an important principle of good administration for a Public Authority, such as the Housing Authority, to be open and clear about policies and procedures and to ensure that any information and advice provided is clear, accurate and complete.

- Not providing applicants with reasons for their non-inclusion in the Housing Waiting List;.

- Not providing applicants with reasons for their decisions on the level of the award or non-award of housing social points;

- Removing persons from the Housing Waiting List without their knowledge, without informing them in writing and without providing a satisfactory reason for such removal from the Housing Waiting List;

- Unreasonable and unfair decisions taken when considering applications for inclusion in the Housing Waiting List;

- Delay in dealing with applications for inclusion in tenancy agreements;

- Delay in answering correspondence.

Civil Status and Registration Office

- Continuous deferrals (in some cases applicants have been waiting in excess four years) in 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 – I D cards. This includes issues regarding the required proof of residence in cases of applicants who have clearly been living in Gibraltar for many years. This has recently been compounded by the non-acceptance of Affidavits from long-term residents who may have been sharing accommodation for many years and where the landlord is now refusing to acknowledge their tenancy.

The main victims of such change in procedure/policy are many 'British Moroccans' (i.e. British citizens of Moroccan ethnic origin) who have lived in Gibraltar for many years in 'shared' accommodation with no formal tenancy agreements, as such. This was possibly the reason why the Government agreed in the past that Affidavits were to be accepted by CSRO as proof or residence in such cases.

Valid ID Cards are required by residents in order to have full access to medical treatment at the GHA and to enrol their children in Government schools.

Following the increase in the number of complaints received regarding this matter, the Ombudsman advised the Government that he was becoming increasingly concerned about the procedures being adopted by the CSRO and the Government 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 highlighted the fact that there had always been a reluctance by many private sector landlords to confirm, acknowledge or extend tenancies, even in the case of the spouse and children of their legal tenant. As regards tenants of Government-owned residential properties, the problem appeared to have been addressed, to a certain extent, by the Housing Authority issuing a 'licence' to confirm the residence requirement demanded by the CSRO.

The Ombudsman was 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 him 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 pointed out that there was ample case law regarding the rights under Article 8 to suggest 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.

For example, in the United Kingdom, the requirements for 'proof of income' or 'minimum income requirement' for eligibility to a Family Visa is published on their website (https:// www.gov.uk/).

The details published in this website includes the following:

Family visas: apply, extend or switch
Give proof of your income
You and your partner must have a combined income of at least £18,600 a year if:
• you're applying as a partner
• you want to settle in the UK (get 'indefinite leave to remain') within 5 years
You must prove you have extra money if you have children who are not:
• British citizens
• EEA nationals
• permanently settled
You'll need to earn an extra:
• £3,800 for your first child
• £2,400 for each child you have after your first child
This is the called the 'minimum income requirement'.
You may be able to use your savings instead of income.

In the opinion of the Ombudsman, the above example reflects the level of transparency in the criteria required to prove 'sufficiency of income' that should be given by the CSRO to applicants for Residence Permits;

- Delay in answering correspondence;

- Poor customer service by staff at the public counters;

Department of Social Security

One of the complaints received against the Department of Social Security (DSS) refers to the unsatisfactory systems and procedures at the DSS regarding the payment of old age pensions and dependant's benefits.

One particular aspect of this complaint, which the Ombudsman would like to highlight, refers to the refusal by the DSS to backdate the payment of a dependant's benefit (included as part of the old age pension) payable to a claimant upon his wife ceasing to be in gainful employment.

Section 22 of the Social Security (Open Long Term Benefits Scheme) Act 1997 provides that:-

> "*if a man is residing with or is wholly or mainly maintaining his wife or civil partner who is not over pensionable age and who is not engaged in any gainful occupation from which her monthly earnings exceed £231.95…….the monthly rate of an old age pension shall be increased by the amount set out in the third column……..*"

In this case, the claimant's wife was in full-time employment when his old age pension commenced to be paid by the DSS in 2007. Because of this, he was only entitled to receive a reduced old age pension – i.e. the dependant's benefit was not payable. However, when the claimant's wife ceased to be engaged in such gainful occupation, in 2011, the DSS failed to increase his old age pension by the element of the dependant's benefit.

The DSS maintained that they should have been notified of the wife's change of circumstances (when she terminated employment) in order to trigger the process of payment of the dependant's benefit.

It was clear to the Ombudsman following his investigation that the claimant's wife had called in to the offices of DSS in 2011 in order to claim her unemployment benefit and to seek further information about any other benefits that she may have been entitled to. However, because of the unsatisfactory systems and procedures in the DSS and the lack of effective communication between the different sections in the department, there was a failure to pick up on the fact that her husband was in receipt of an old age pension, which should have been increased as soon as she ceased to be in gainful employment.

However, the established procedure was that the onus remained with the claimant to inform the DSS of his wife's change of circumstances (i.e. when she terminated employment) in order to trigger the process of payment of the dependant's benefit. However, the Ombudsman pointed out that, in this case, the claimant had been diagnosed with vascular dementia in 2004 and because of this, his mental condition by 2011 was such that he was not able to notify the DSS of the change of circumstances.

The Ombudsman therefore recommended that, exceptionally the dependants benefit payable should be backdated to 2011 or that an ex-gratia payment should be made equivalent to the amount that would have been payable since the wife terminated her employment.

(The full report can be found on page ….under Chapter 8: Ombudsman's Case Book 2018.

2.4 Government Policy – v – Administrative Action

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. In this respect, there have been a number of cases of such decisions.

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.

The Ombudsman of British Columbia had a similar problem whilst investigating a complaint and the matter was eventually considered by the Supreme Court of Canada. (British Columbia Development Corporation v. Friedmann (Ombudsman), [1984] 2 S.C.R. 447).

In that case, which is considered to be one of the most important cases ever decided on the powers of the Ombudsman, Chief Justice Dickson said :-

> *"In my view, the phrase "A matter of administration" encompasses everything done by Government authorities in the implementation of Government policy. I would exclude only the activities of the legislature and the courts from the Ombudsman's scrutiny.*

Housing Authority – a matter of policy or administrative procedure?

One example of an Authority claiming that a decision had been made following Government policy and where the Ombudsman considered that it was a clear case of an administrative procedure that led to an injustice, was a case of a Complainant who 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. In the Ombudsman's view, all protocols and policies need to be made available to the public in order to ensure procedural transparency in public services.

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 policies, procedures and protocols upon request as well as providing an extract of the relevant section in writing when necessary.

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

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Ombudsman's Role & Function

3.1 Overview – The Ombudsman's Role and Function

The Office of the Ombudsman in Gibraltar first opened its doors to the public 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.

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

Initially appointed to carry out the functions of Ombudsman on an acting basis on 1st April 2017, Dilip's 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

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 - E*xecutive Investigating Officer*
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. This includes the Royal Gibraltar Police, the Gibraltar Health Authority, the Housing Works Agency and many other entities contracted by the Government to provide public services.

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 for 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 are 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 in 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;
- 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 there to;
    - ⇒ 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.

3.2 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.

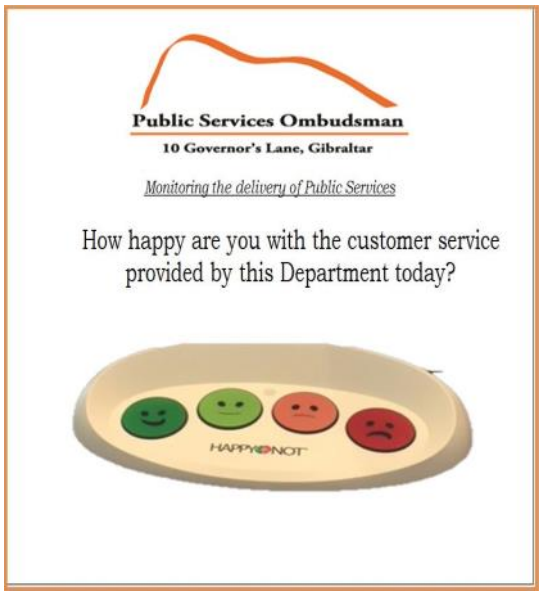
Strategic Objective (2) - To raise general standards in the delivery of public services

As mentioned above and in the Ombudsman's 2017 Annual Report, 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.

The provision of good customer service at our public counters has a vital role to play in the overall image of our public service. In this respect, a customer service monitoring system with the use of 'Happy or Not' machines is being introduced in some of the main public counters. One such machine has already been installed at the Ombudsman's Office itself and this will be extended, in the first instance, to Government Departments with public counters such as the Civil Status and Registration Office, the Department of Social Security and the Post Office.

The logo of the Public Services Ombudsman will also feature in the machines, along the following lines, in order to encourage people to submit feedback on their customer service experience at these public counters:



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 is currently reviewing all such in-house complaints procedures and following up those Public Service Providers that have still to set up an in-house complaints procedure.

The following is a list of the Public Service Providers that currently have a comprehensive and effective in-house complaints procedure in place and those that do not:

Do have a comprehensive and effective in-house complaints procedure in place	***Do not have a comprehensive and effective in-house complaints procedure in place***
AquaGib Ltd	Civil Status and Registration Office
Care Agency	Companies House
Chief Secretary's Office	Customs
Education Department	Environmental Agency
Gibtelecom Ltd	Gibraltar Broadcasting Corporation
Royal Gibraltar Police	Housing Authority
Port Authority	Income Tax Office
Office of Fair Trading	Tourist Office
Post Office	
Prison Services	
Treasury Department	
Department of Social Security	
Boarders & Coast Guard Agency	
Department of Culture	
Department of Employment	
Department of the Environment	
Fire and Rescue Service	
Gibraltar Electricity Authority	
Land Property Services Ltd	
Procurement Office	
Sports Authority	
Transport and Licensing Authority	

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.

The Ombudsman's Office recently asked all Public Service Providers to submit details of their in-house complaints procedures. The Ombudsman's Office is currently in the process of collating the information received in this respect and is providing specially designed posters, to be placed in all public counters, outlining the relevant internal complaints procedures that are in place and including details of when and how a complaint can be made to the Ombudsman. Further public awareness initiatives are planned for the coming year, including the publication of a quarterly newsletter, titled 'the Public Services Ombudsman'.

3.3 Principles for Remedy

Six Principles for Remedy, including an accompanying guide to these principles, have now been fully adopted by the Gibraltar Ombudsman's Office. These principles were approved and adopted by the following Public Services Ombudsmen:

Public Services Ombudsman - Northern Ireland;
Public Services Ombudsman - Wales;
Ombudsman and Information Commissioner - Ireland;
Public Services Ombudsman - Gibraltar;
Parliamentary Ombudsman – Malta
Parliamentary & Health Services Ombudsman – United Kingdom
LGO and Chair of the Commission for Local Administration - England; and
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) 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. 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.

The Principles

Principle 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.

Principle 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.

Principle 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.

Principle 4: To be fair, reasonable and 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.

Principle 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.

Principle 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.

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Diary of Events - 2018

4.1 Meetings and Seminars

Ombudsman Association's Casework Interest Group Meeting – held in Edinburgh on 11th May 2018

A meeting of the Ombudsman Association Casework Interest Group was held in Edinburgh on 11th May 2018.

Over 30 delegates attended the meeting and the Gibraltar Public Services Ombudsman was represented by our Senior Investigating Officer, Karen Calamaro.

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

Matters discussed at the meeting included the draft Service Standards Framework, which is due to be finalised and published by September 2018; guidance on the new General Data Protection Regulations; Proportionality in Decision Making; the proposed Ombudsman Association Newsletter; and the different Quality Assurance processes that are available to members.

The 25th Annual General Meeting and Conference of the Ombudsman Association - held in Edinburgh on 24th and 25th May 2018

The Ombudsman Association ("OA") 25th Annual General Meeting ("AGM") was held at the Hilton Carlton, Edinburgh on 24th and 25th May 2018. The Gibraltar Public Services Ombudsman is a fully participating voting member of the OA. I attended the AGM and the 2-day Conference the 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 'Proportionality in decision making'; GDPR; Reasonable adjustments vs Unreasonable behaviour; and Speaking truth to power.

Meeting of the Public Sector Ombudsman Group ("PSOG") held in Gibraltar on 10th and 11th December 2018

To mark the 20th anniversary of the of the establishment of the Public Services Ombudsman's Office, the Public Sector Ombudsman Group ("PSOG") held its bi-annual meeting in Gibraltar, on Monday 10th and Tuesday 11th December 2018. The PSOG meeting in Gibraltar was chaired by the Public Services Ombudsman of Gibraltar.

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 and the Parliamentary Ombudsman of Malta. The Director of the Ombudsman Association also attends these bi-annual meetings.

A reception was held at the Rock Hotel on 10th December 2108 to mark the occasion.


DILIP DAYARAM TIRATHDAS
PUBLIC SERVICES OMBUDSMAN
20th

Public Services Ombudsman

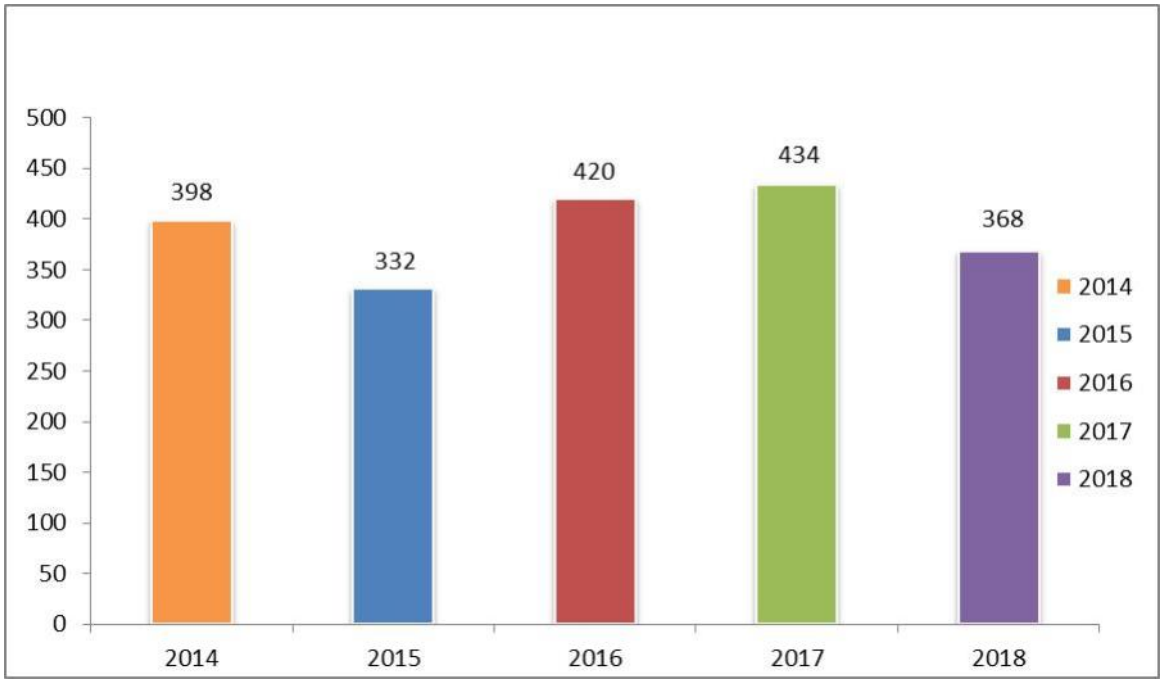
10 Governor's Lane, Gibraltar

Performance Review 2018

A total of 368 Complaints were received by the Public Services Ombudsman Office during 2018 and a total of 394 complaints were finalised during the year as follows:

Complaints not yet finalized – brought forward from 2017	94
Complaints received during 2018	368
Complaints finalized during the year 2018	394
Complaints not yet finalized – carried forward to 2019	68

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



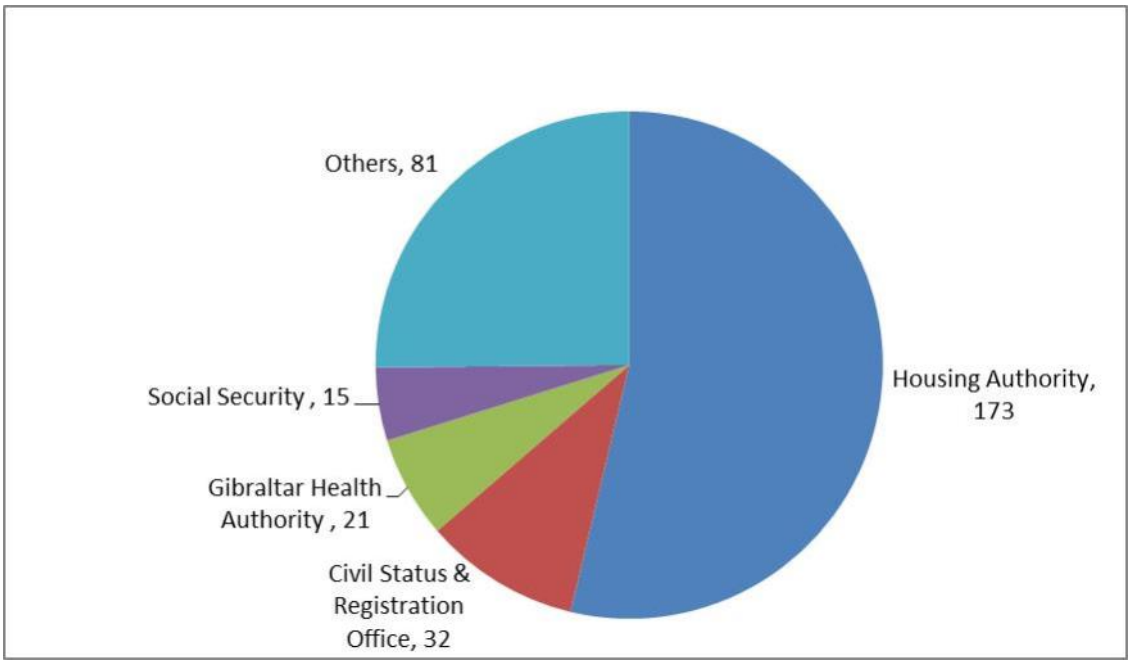
This year, the Public Services Ombudsman's Office ("PSO") received 368 Complaints. This represented a decrease of 66 compared to 2017. However, the number of complaints finalised during the year was 394 bringing the total number of complaints not yet finalised at the year-end down to 68 compared with 94 in the previous year.

From the 368 Complaints received, 46 related to private entities, such as private housing rent and repairs, legal issues and financial matters.

The remaining **322** Complaints related to Government departments, agencies and other entities within the Ombudsman's **jurisdiction.**

Complaints related to housing matters (Housing Authority, 173 - 54%) represented the highest number and type of complaint lodged at the Ombudsman's Office. These complaints include 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 reply to letters by members of the public.

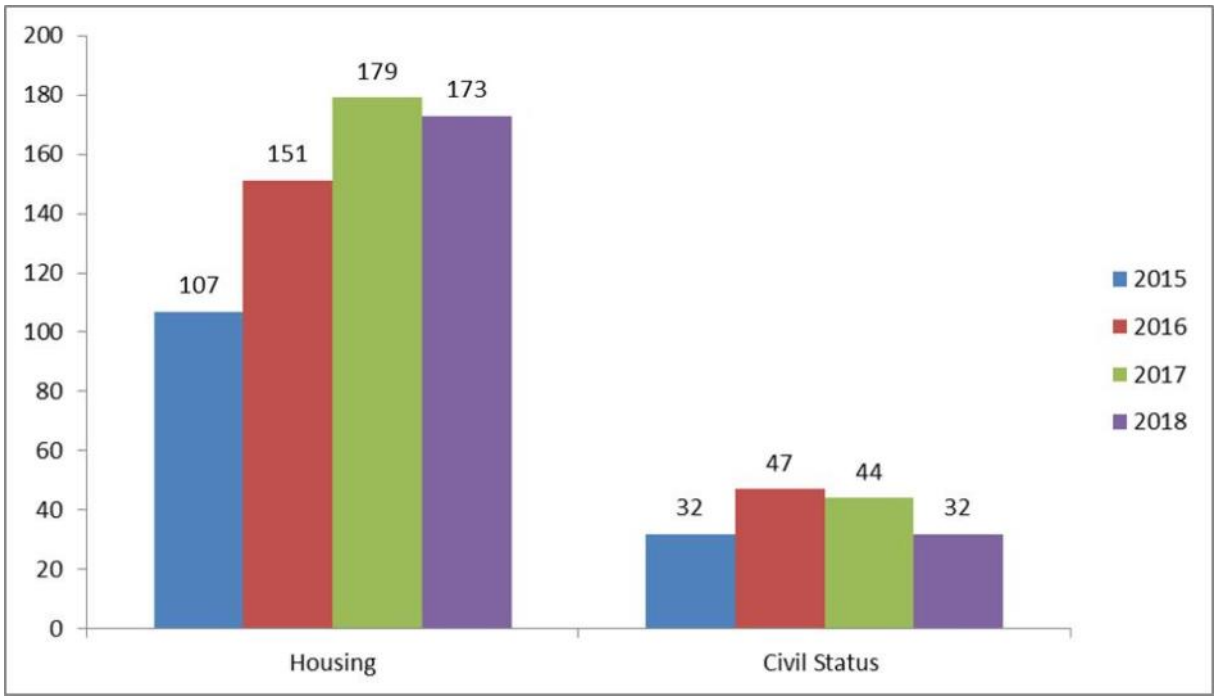
Analysis of the 322 Complaints received in 2018



The Complaints Handling Scheme Office (CHS), which was part of the Ombudsman's Office but has operated at arms-length from the Office during the past two years, has been merged with the 'Patients Advocacy and Liaison Service' ("PALS"), which has been set up by the Gibraltar Health Authority ("GHA"). The main reason for this was to improve the complaints handling service to the public by having a single office at the hospital to deal with complaints, in the first instance. It seems to be working well and there has been a reduction in the number of complaints received directly by the Ombudsman. A total of 21 complaints received by the Ombudsman's Office related to the GHA as the majority of health complaints (which used to be tackled in previous years by the CHS) are now being dealt with by PALS at the hospital.

This year there were 32 complaints received against the Civil Status and Registration Office. This represents a reduction in the number of complaints - 12 complaints less than in 2017. The delay in dealing with applications for naturalisation is still one of the most common complaints received by the Ombudsman against this Government department.

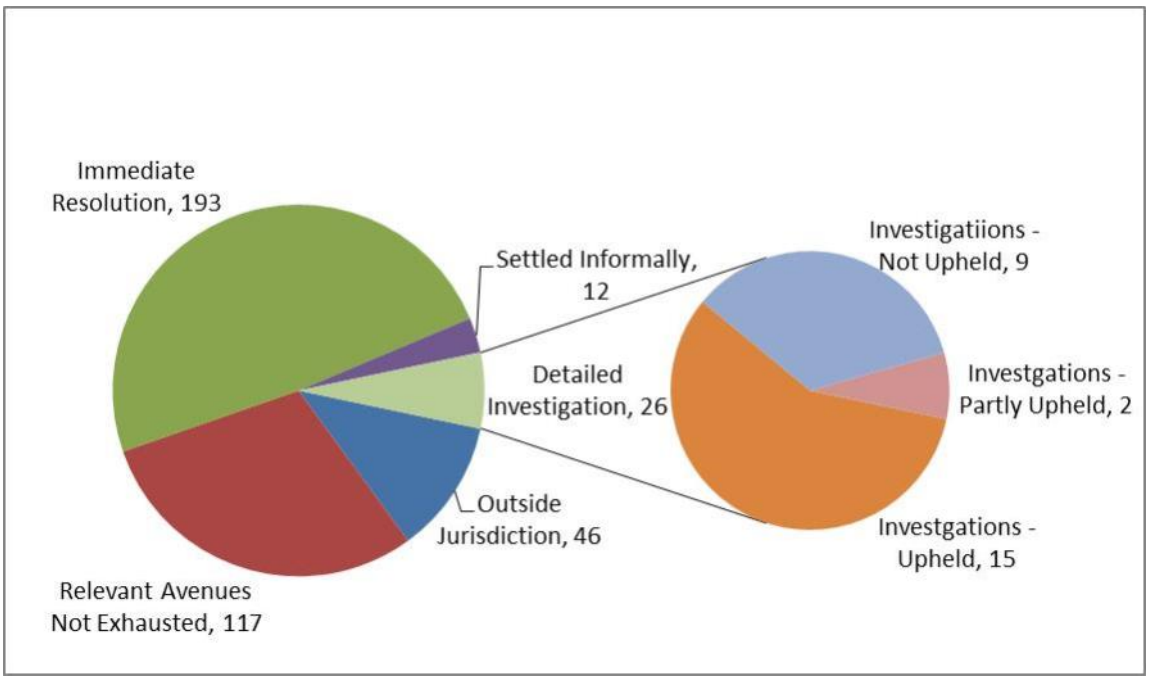
Number of complaints received against the Housing Authority (HA) and the Civil Status & Registration Office (CSRO) during the last four years.



The Housing Authority ("HA") has attracted a total of 610 Complaints at the Ombudsman's Office during the last four years. The average number of complaints received against the HA over the last four years was 152. This year although the number of complaints against the HA have decreased slightly from 179 received last year to 173, the number this year has surpassed the average over the last for years.

The CSRO has attracted 155 Complaints at the Ombudsman's Office during the last four years. This represents an average of 38 complaints per year. Complaints have decreased from 44 last year to 32, which is below the average over the last four years of 38 complaints. Complaints against the CSRO represent 10% of the total number of complaints received at the Ombudsman's Office against Public Service Providers.

Classification of Complaints Received at the Ombudsman's Office during 2018



There were 394 complaints finalised this year, as follows:

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

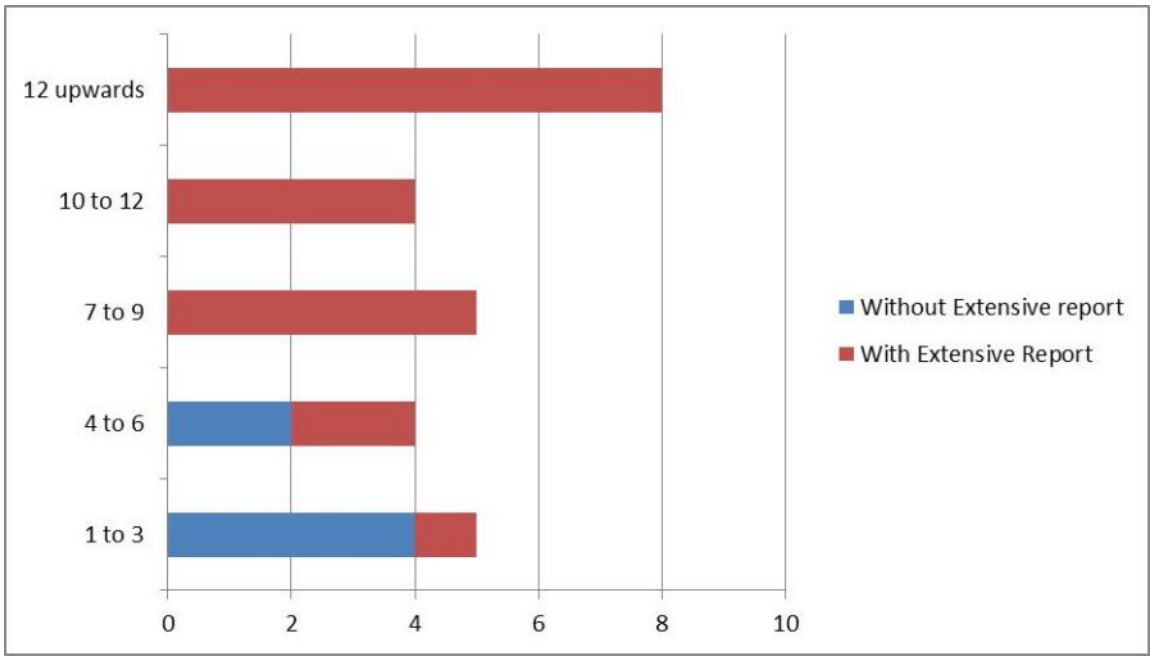
117 complaints were closed as it was considered that the Complainant(s) had not exhausted all their avenues of redress with the Public Service Provider concerned. These refer to complaints that are lodged at the Ombudsman's Office without the Complainant having formally submitted their complaint to the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

193 complaints were classified as dealt with by 'Immediate Resolution';

12 complaints were settled informally; and

26 complaints were followed up by the Ombudsman with 'Detailed Investigations', which were concluded by the end of the year. Out of these 26 Detailed Investigations,

DETAILED INVESTIGATIONS IN 2018
COMPLETION TIME CHART – In Months



A total of 20 cases, which warranted a full investigation and report (assigned to our Investigations Team), have been completed in 2018.

The average time taken by the Ombudsman's Investigations Team to complete a an investigation on a complaint requiring an extensive report has been 12 months.

A total of 6 cases which have been investigated without the need of writing an extensive report were completed in 2018. The average time to complete each of these investigations has been 2.5 months.

The average time taken to complete investigations on complaints (with or without an extensive report) has been 10 months.

Public Services Ombudsman

10 Governor's Lane, Gibraltar

20 Year Journey of the Gibraltar Public Services Ombudsman

2000, 2001, 2002, 2003, 2004 2005, 2006, 2007, 2008, 2009,

2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017 & 2018

1987-The Call for the Appointment of an Ombudsman

At the 1987 ceremony of the commencement of the legal year, the then leader of the Bar, Mr Samuel Benady Q.C. spoke on a matter of importance affecting the rights of the individual. Mr Benady pointed out that Gibraltar lacked the machinery to protect the individual against any act of maladministration by a Government Department. He explained how other jurisdictions had already established an Office of the Ombudsman and proposed that the time had come for the appointment of such an Ombudsman here in Gibraltar to act on behalf of the community. Mr Benady, on formulating what must have been a radical proposal, stated "The appointment of an Ombudsman would be a further assurance that those elected cannot, once in office, renege on their obligation to see justice done on behalf of every individual." Twelve years elapsed before Mr Benady's proposal materialised and the Office of the Ombudsman was finally established in April 1999.

1999-Appointment of Gibraltar's First Ombudsman

The appointment of Gibraltar's first Ombudsman, Henry Pinna, represented a challenge and a valuable opportunity for him and his staff to help create, in some measure, a more accountable Public Service, and thus help strengthen Gibraltar's democratic way of life.

During the first eighteen months there had been a growing awareness of the existence and operation of the Office and this was reflected in the high number of complaints received since the Office opened its doors to the public. The help and guidance given to the Ombudsman and his staff by the Ombudsman of Malta was of tremendous value to the Office and a key factor for it being able to operate efficiently and effectively with the handling of numerous complaints involving delay, indifference, arbitrary decisions, lack of replies, unfair decisions, etc.

2000-International Memberships

The Gibraltar Ombudsman's policy has always been to foster international relations with similar bodies in the United Kingdom and indeed worldwide and during its early years of serving the public, the Office of the Ombudsman in Gibraltar became a member of the International Ombudsman Institute, the British and Irish Ombudsman Association (BIOA), and the European Ombudsman Institute.

Apart from keeping the Office abreast of international developments in the Ombudsman field, the resulting cross transfer of experience and knowledge gained by these interchanges enhanced the local service that the Ombudsman provided to those persons who came to the Office seeking advice and assistance regarding their administrative complaints.

2001—Ombudsman's Recommendations

Deficiencies were addressed by the Ombudsman by way of making formal recommendations to the Public Service Provider concerned. Although the Ombudsman did not have any powers to compel the public administration to implement or act upon his recommendations, these recommendations were given careful consideration by the Government Departments or Public Entities concerned. In his second year in office the Ombudsman made a total of 46 formal recommendations. Most of them were accepted and implemented but of some concern to the Ombudsman was the length of time that the administration took in considering his recommendations.

2002—Ombudsman Powers - Same Powers as the Supreme Court

In 2002, an important case in the Supreme Court regarding the Ombudsman's powers arose when a member of the public complained to the Ombudsman about the manner in which the Social Services Agency had carried out an investigation into the ill-treatment of her grandchildren. She alleged that the Agency was guilty of maladministration in failing to consider her concerns. She also lodged a complaint with the Police in respect of the same matter. When the Ombudsman discovered that a police officer had made a report on the complaint, he sought the disclosure of the report but the Commissioner of Police refused to do so, on the ground of public interest immunity. The Ombudsman therefore applied to the Supreme Court, under Part 34 of the Civil Procedure Rules, for the assistance of the Court in obtaining the disclosure of the report.

The Ombudsman maintained that he had wide powers under the law to obtain any information that he required "from such persons and in such manner …. as he thinks fit….". (Section 16 of the Public Services Ombudsman Ordinance 1998). The Ombudsman also argued that Section 17 of the Ordinance gave him the same powers as the Supreme Court in respect of the production of documents and this gave the Ombudsman the right to be provided with this report from the Police as it was material to his investigation and the information contained within the report was not subject to public interest immunity.

The Supreme Court ruled that the Ombudsman could obtain the report and any other documents that he required, as Section 17 of the Ordinance gave him powers equivalent to the Supreme Court in this respect. He could therefore issue his own witness summons, which would have to be obeyed in the same way as a subpoena of the Supreme Court, without the assistance of the Supreme Court.

The Ombudsman could legitimately request Police records for his investigation, even though the main investigation was regarding another Authority. The Supreme Court also noted that the Police were specifically included within the ambit of the Ombudsman's investigatory powers under Part III of the Ordinance.

2002-Policy – v – Administrative Procedure

By the end of December 2002, a total of 2,135 complaints had been looked into by the Ombudsman and three 'Special Reports' had been submitted to the House of Assembly (the Parliament). One of these reports was against the Department of Transport for destroying a car, which had been towed away when found illegally parked. The Ombudsman pointed out that his special report intended to bring to the attention of the House of Assembly an issue which, in his mind, was an act of maladministration and which, regrettably, had not been remedied in accordance with his recommendation. The Authority concerned argued that the action taken by them was within the ambit of the Ombudsman's jurisdiction and power to review as it was a matter of policy and not administrative procedure.

The Ombudsman said that although the Department had acted within the remit of policy as set down by Government, he, the Ombudsman had taken the view that the measures taken by the Department had not been proportional or reasonable in the circumstances and therefore this amounted to maladministration. The Ombudsman explained that the Charter of Fundamental Rights of the European Union included as a fundamental right of citizenship, the right to good administration. The Ombudsman felt that, in this case, Government policy was applied in such a way that it constituted unfairness and that this therefore amounted to an act of maladministration, hence the issuing of his special report. This was laid by the then Chief Minister before the House of Assembly on 12 July 2002. The matter was debated in the House on 18 October 2002 and the Ombudsman's recommendation was duly accepted by the Government.

2003-Gibraltar's Second Ombudsman

Mario M. Hook was appointed as Public Services Ombudsman in 2003. Upon his appointment, one of the first things that he did was to announce an awareness campaign consisting of visiting the housing estates and the schools in order to meet as many people as possible, including schoolchildren, to explain the role of the Ombudsman.

Mario Hook believed that the Office of the Ombudsman was providing a service of the highest standard for those Complainants who called in with their grievances, but he was concerned that there was no procedure in place to obtain feedback. He therefore introduced a quality service and satisfaction survey that would involve all those who make use of the Ombudsman's services.

2004-The Ombudsman's Participation in International Events

The Ombudsman's aim was to take the Office of the Gibraltar Ombudsman into the international arena. He believed that by fostering of international relations and learning from the experiences of other jurisdictions, the Ombudsman and his staff would be able to enhance the service that they provided to those who called at the office seeking assistance and advice.

In 2004 the Ombudsman and his staff attended various International conferences and meetings in order to further their contact with colleagues from overseas. The Gibraltar Public Services Ombudsman met with his overseas counterparts, including the Public Sector Ombudsmen for England; Scotland; Wales; Northern Ireland; the Republic of Ireland and Malta. They met on three occasions, with the meetings being held in London, Edinburgh and Gibraltar. These three meetings proved to be very fruitful and the many items included in the agenda for discussion proved to be very beneficial for the Ombudsman, as he was able to further his understanding of the work of these Public Sector Ombudsmen.

The working meeting in Gibraltar was held at the Garrison Library, during which all participants were treated to a short talk on the history of the Library and Henry Pinna, Gibraltar's first Ombudsman, gave a talk on the development of the work of the Ombudsman in Gibraltar. It was also a busy year for complaints with 106 formal investigations being completed, out of which, 60% were sustained or partly sustained and 40% were not sustained. This reflected the Ombudsman's impartiality in investigating and classifying complaints.

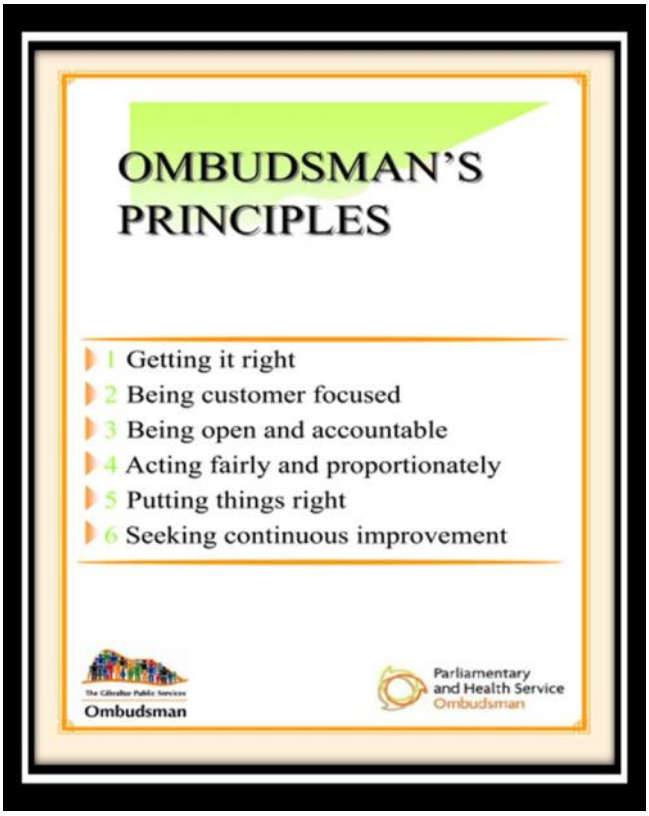
Gibraltar's Ombudsman, together with the visiting Ombudsmen at the Garrison Library

2005-A Change in Style

The Ombudsman believed that it was time to move on and depart from the original reporting methods and progress to a more dynamic reporting system. In order to achieve this new kind of reporting, the office had to undergo substantial changes to its working practices. The mapping of the changes was not easy, but the Ombudsman was driven by the desire to bring the work of the office in line with the international standards and he pointed out that, without the ability to produce reliable and sufficiently detailed information and statistics, it would be impossible to build the foundations required for successful reporting. The Ombudsman had to invest in IT equipment, and a new Case Management System that met the Office's requirements of flexibility and capability was introduced shortly after in 2005.

2006-Principles of Good Administration

The 'Principles of Good Administration' were first highlighted in the 2006 Ombudsman Annual Report. These Principles which had been compiled by Ms Ann Abraham, the United Kingdom Parliamentary and Health Service Ombudsman were reproduced and implemented in the Gibraltar Office with her kind permission.



The Ombudsman believed that these Principles were applicable in Gibraltar and he proposed to contact all entities within the Ombudsman's jurisdiction to explain them and to ensure that they were applied as widely as possible.

2007-Ombudsman made an Officer of the Parliament

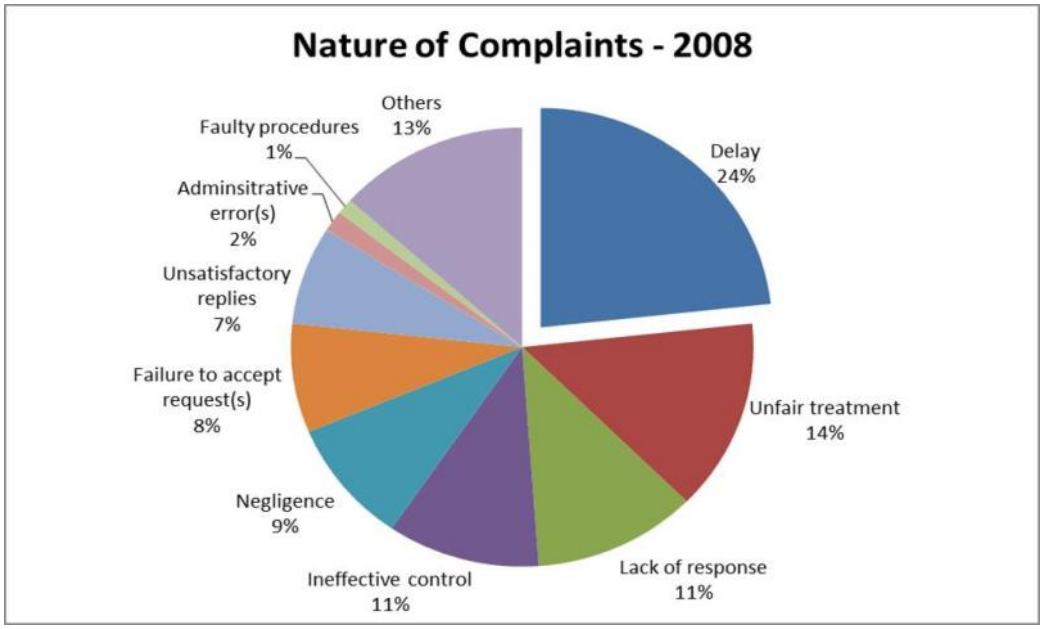
The new Constitution of Gibraltar made the Public Services Ombudsman an Officer of the Parliament. Following the coming into force of the Gibraltar Constitution Order 2006, section 25 (3) of the Constitution now specifically provides that the Ombudsman is an 'Officer of the Parliament'. Consequently, under Parliament's Standing Rules and Orders – Part IV Papers – Section 12 (3), the Ombudsman may now present the Annual Reports to the Parliament through the Clerk. The Speaker would therefore lay the Annual Report of the Ombudsman in Parliament.

2008-Report Writing

The improvement of the staff's investigative skills and report-writing skills were evident by 2008. The Ombudsman was of the opinion that, whilst investigations had, from the very first day that the Investigating Officers began their work, always been carried out in a conscientious manner and to the best of their ability, they were now being conducted in a more thorough manner and better quality reports were being produced at the conclusion of every investigation. The Ombudsman firmly believed that to some degree this was the result of the frequent attendances at international seminars, conferences and meetings.

2008-Nature of Complaints

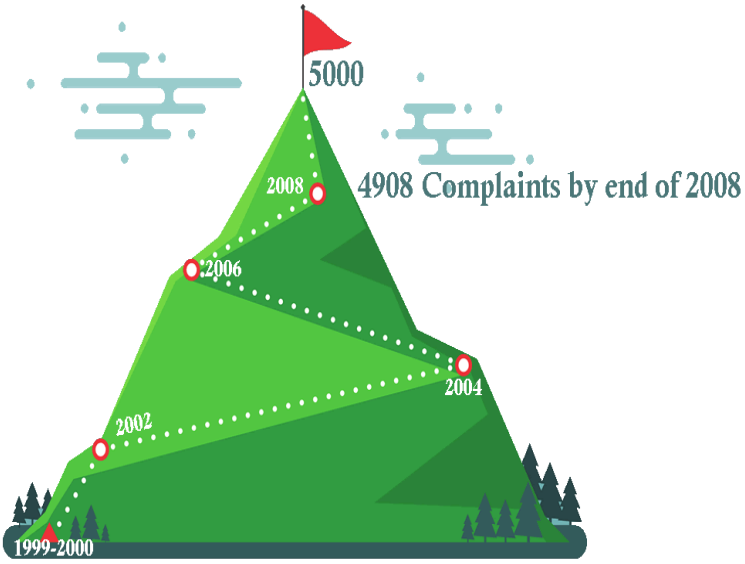
In 2008 the Ombudsman carried out a comprehensive analysis of the 263 complaints received at the Office in respect to the nature and description of the complaints.



The most common complaint that the office received was that of delay in dealing with matters. Nearly one quarter of all the complaints lodged in our office was about delay (24%). Common types of delay included excessive waiting time in having repair works carried out by the Buildings and Works Department; delay in having naturalisation applications processed by the Civil Status & Registration Office; delay in receiving social assistance payments from the Department of Social Security; and the irregular waiting time by the Housing Department in allocating flats. 14% of complaints were regarding unfair treatment, including matters such as unreasonable decisions made by the department concerned , and discriminatory or disrespectful attitude towards members of the public.

2009-Complaints received by the Ombudsman reach the 5,000 mark

The Ombudsman highlighted the fact that the Office would soon reach an important milestone by having handled more than 5,000 complaints since the Office opened its doors to the public in 1999.



As at the end of 2008, the total number of complaints that the Ombudsman dealt with stood at 4,902 plus a total of 1,137 enquiries. These figures are in themselves a testament to the wide recourse to the Ombudsman that is available by those members of the public who require assistance or who have some grievance as a result of a Public Service Provider's administrative action.

Tenth Anniversary of the Establishment of the Office of the Ombudsman

In 2009 the Public Services Ombudsman in Gibraltar celebrated its tenth anniversary.

On this occasion, the Ombudsman hosted an event to which the Heads of Government Departments and all Public Service Entities under his jurisdiction were invited. The Mayor, the Speaker, Members of Parliament and overseas Ombudsmen from the UK and Ireland were also invited.

The theme of the Ombudsman's presentation at the event was 'Complaints are Valuable Learning Tools'. Referring to those entities under the Ombudsman's jurisdiction, the Ombudsman highlighted that complaints received by Government Departments or other Public Service entities can contribute positively to the Ombudsman's work, if these complaints are used as learning tools to improve the public service.

2009-Data Protection

The Ombudsman carried out a review of the policy relating to the information held in respect of Complaints. It was decided to implement a clear policy that would comply with our obligations under the Data Protection Act. As such, the Ombudsman decided that all such information held that was three years or older would be destroyed.

2009-Professional Award in 'Ombudsman and Complaint Handling Practice'

The Professional Award & Certificate in 'Ombudsman and Complaint Handling Practice' was the first professional, validated course of its kind in the Ombudsman field. It was designed and delivered by Queen Margaret University, Edinburgh, Scotland, in association with the British and Irish Ombudsman Association.

Gibraltar was officially invited to form part of the intake of the pilot scheme. The course took place in October 2009 at Queen Margaret University over a period of four days. It encompassed issues such as Complaint Assessment & Standards; Law, Procedure & Investigation; Evidence Gathering; Communication and Interviewing; Decision-Making; and Recommendations and Report Writing.

2010-Growing Confidence between the Ombudsman and the users of Public Services

During the year 2010, the Ombudsman's Office dealt with a total of 399 Complaints and 132 Enquiries. The Ombudsman was pleased to note that the services provided by the Office were being used by those who felt that a Public Service Provider had not acted correctly and wished to complain about such action.

Complainants no longer needed to feel powerless to pursue a complaint against a public body, as the option to seek the services of the Ombudsman was always available to members of the public. The Ombudsman also highlighted the importance of meeting members of the public face-to-face. He conducted surveys in the main street of Gibraltar and listened to what the community thought about the service that the Ombudsman provided.

He was of the view that interacting with members of the public and listening to their comments and concerns would strengthen the trust and confidence between the Ombudsman and the users of the Ombudsman's services.

Distribution of Public Services Ombudsman Annual Report and interaction with the general public outside Parliament House

2011-Launch of New Ombudsman's Website

In line with the growing number of internet users in Gibraltar, a new Gibraltar Public Services Ombudsman Website was officially launched in 2011. The Ombudsman pointed out that he was committed to delivering the best possible service to those members of the public who sought his assistance and he encouraged people to browse through the new website.

The website would improve the Ombudsman's services to the general public as it was easy to use and, importantly, allowed complaints to be submitted electronically through an online complaint form. The Ombudsman hoped that a wider section of our community would now be able to avail itself of the services offered by the Ombudsman.

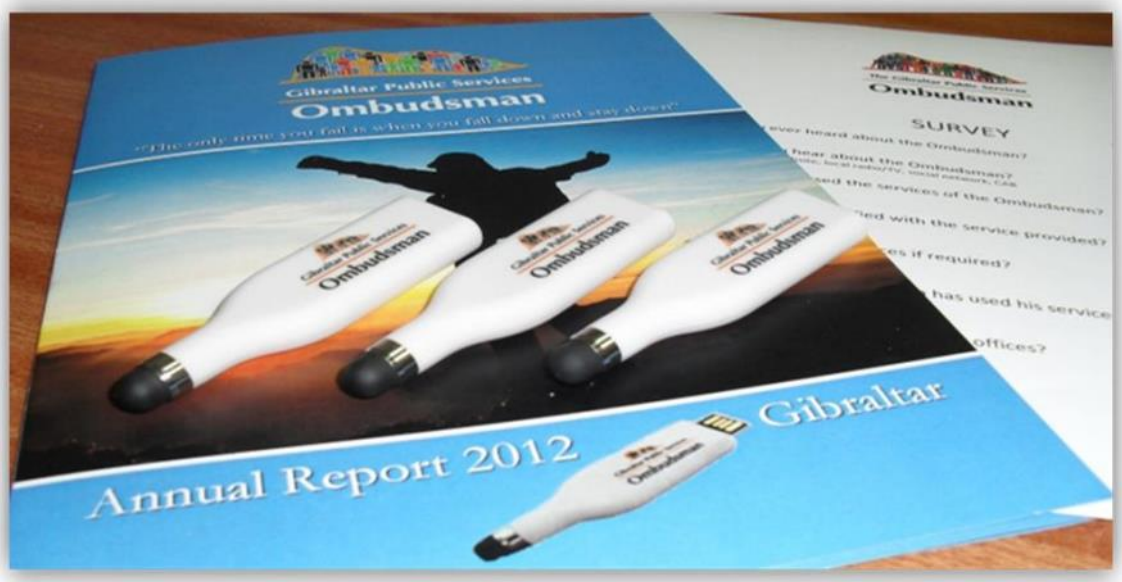
Gibraltar Public Services Ombudsman Website

2012-The Kirkham Report

In 2012, a Senior Law Lecturer from the School of Law at the University of Sheffield, Dr Richard Kirkham, came over to Gibraltar to conduct an evaluation and study of the work of the Office of the Public Services Ombudsman. Although there had been surprisingly little material that had been written on the topic, Dr Kirkham believed that his previous work on international ombudsman schemes provided him with the background knowledge and understanding necessary to put together a thorough review of the Gibraltar Public Services Ombudsman's Office. The exercise culminated in a report that contained many valuable comments and a total of 60 recommendations. Some of those recommendations were for the Ombudsman to implement and some were for consideration by the Government of Gibraltar. One of Dr Kirkham's most salient recommendations was that the Ombudsman should use his Annual Report to provide generic guidance on public administration to those entities falling under his jurisdiction.

2013-Distribution of Annual Reports

In 2013, the Ombudsman and his staff distributed copies of the Ombudsman's 13th Annual Report directly to the public in Gibraltar's Main Street. A significant change from previous years was the handing out of the Annual Report in USB pen drives rather than distributing the printed version to the public outside Parliament House. The Ombudsman believed this action to be more practical and environmentally friendly. The USB pen drives were presented to the members of the public together with an informational pamphlet containing additional information on the services provided by the Ombudsman.



The Ombudsman also considered that the innovation in presenting the Ombudsman's Annual Reports electronically would be a good way in promoting awareness and engaging with the community's younger generation. On a statistical note the Ombudsman announced that 57 investigations had been concluded by the end of 2013. Out of these 57, 35 were sustained or partly sustained whilst 22 had not been sustained. This continued to reflect the Ombudsman's impartiality with the investigation of cases.

2014-Complaints Handling Scheme (Health)

Throughout 2014, the Ombudsman had been busy developing a Complaint Handling Scheme and procedure to deal with complaints against the Gibraltar Health Authority (GHA).

It was envisaged that as from 1 April 2015 the Ombudsman would take over the handling of complaints against the GHA. In order to comply with Government policy and at the same time maintain the high standard of independence of the Gibraltar Public Services Ombudsman, it was necessary to develop a scheme that would be a separate entry portal for all complaints against the GHA. The Ombudsman therefore developed a GHA complaints portal to be known as the Complaints Handling Scheme (CHS). All complaints relating to the GHA would be lodged with the CHS whose aim would be for an early and speedy resolution of complaints by service users of the GHA.

Ombudsman staff discussing procedure to deal with complaints against the GHA

However, in cases where the CHS was not able to resolve a complaint, they would advise the Complainant to lodge a complaint with the Ombudsman for a formal investigation of that complaint.

2014-Mediation and Alternative Dispute Resolution

In July 2014 one of our Investigating Officers, attended a four-day mediation course delivered locally by UK Mediation Limited. In a mediation process, the affected parties enter the process voluntarily on a confidential and legally non-binding basis. They agree to the rules of the mediation process and with the choice of mediator. The mediator's basic role is to be impartial; to facilitate discussions between the parties and to provide a neutral setting for the discussions. If the parties reach a mutual agreement, the mediator is the person who would draft the outcome of such agreement but always maintaining impartiality and ensuring that the interests of both parties are balanced and represented in such agreement.

The Ombudsman pointed out that the purpose of his staff undertaking the course in Inter-personal mediation was not to provide mediation services within the Ombudsman Scheme but for staff to acquire skills that they could use in their role as Investigating Officers. On occasion, the Office of the Ombudsman serves to 'signpost' Complainants whose grievance does not come under the Ombudsman's remit or jurisdiction. The mediation course has familiarised the staff of the Ombudsman's Office with other methods and options available to Complainants for the resolution of such complaints.

Human Rights and the Ombudsman

The typical duties of an Ombudsman are to investigate complaints and attempt to resolve them, usually through recommendations made to Public Service Providers. The Ombudsmen also aims to identify systemic issues leading to poor service or breaches of people's rights, including their Human Rights. In his 2014 Annual Report, the Ombudsman highlighted the fact that that such basic rights and freedoms should be guaranteed as Human Rights are universal and are founded on the principle of dignity for every human being. In many parts of the world public services ombudsmen are seen as part of the wider system available to the public to ensure the protection of human rights and they often have the status of the National Human Rights Institute for UN accreditation purposes.

There is every reason, therefore, for all such ombudsmen to be increasingly self-conscious about their role in the protection of human rights within their community. The Public Services Ombudsman is committed to developing a human rights based approach to his investigations of maladministration and injustice by providers of public services in Gibraltar. In this respect it should be noted that the fundamental principles and rights under the European Convention of Human Rights are enshrined in the 2006 Constitution of Gibraltar.

The Ombudsman pointed out public bodies need to be mindful of the basic human rights of each individual that they come in contact with so that their human rights are not contravened in the delivery of the public services to the community.

2015-Complaints Handling Scheme (Health)

As from April 2015 the Ombudsman was given jurisdiction over the Gibraltar Health Authority (GHA), and for the purposes of providing a front-line service to the public a Complaints Handling Scheme (Health) Office (CHS) was created. The GHA is Gibraltar's largest public service provider and the vast majority of their services entail direct face-to-face contact with service-users. Consequently, it generated a considerable amount of complaints in respect of a very wide spectrum of issues.

There were a number of situations where the basic standards of healthcare were not met, at the very least at an administrative level, with excessive waiting times for appointments and treatment. Altogether, the CHS received 164 complaints and 79 enquiries since it opened its doors to the public (April 2015 to December 2015).

2016-Own Motion Investigations

The ability of the Ombudsman to investigate any issue of maladministration without having to rely on receiving a complaint from the public (Own Motion investigations) is a much desired and almost necessary tool for an Ombudsman to have.

The Ombudsman pointed out in his 2016 Annual Report that he could only investigate matters within his jurisdiction upon the receipt of a written complaint from a member of the public. This followed United Kingdom Ombudsmen who did not enjoy statutory Own Motion provisions. This contrasted sharply with the vast majority of Ombudsmen worldwide who enjoy the ability to conduct investigations without the need for a written complaint. By way of comment, the Ombudsmen and legislators of Scotland, Wales and Northern Ireland were reviewing the position in the UK and the Ombudsman's belief was that the Ombudsmen of those jurisdictions would soon enjoy the ability to initiate investigations of their Own Motion.

(Own Motion power is now enjoyed by Public Sector Ombudsmen in Scotland, Wales and Northern Ireland).

The Ombudsman emphasized that the reason why Own Motion was available to Ombudsmen was to allow the investigation of matters which are brought to their attention but where people may be reluctant to make written complaints for a variety of reasons.

To date, Own Motion investigations by the Ombudsman in Gibraltar are not permitted under the Public Services Ombudsman Act 1998. This is a matter that, in the opinion of the Ombudsman, should be regularised by the Government of Gibraltar and Parliament, as soon as possible.

2017-Appointment of 3rd Public Services Ombudsman

Dilip Dayaram Tirathdas MBE was appointed as Gibraltar's third Public Services Ombudsman on 1st April 2017. This followed the retirement of Mario Hook on 31st March 2017 after more than 14 years of dedicated service. The new Ombudsman publicly thanked Mario Hook for his outstanding work during his tenure and wished him a happy and well-earned retirement. The Ombudsman also placed on record the excellent work done by Henry Pinna during the initial years in setting up the Ombudsman's Office.

Review of Health Complaints Procedure

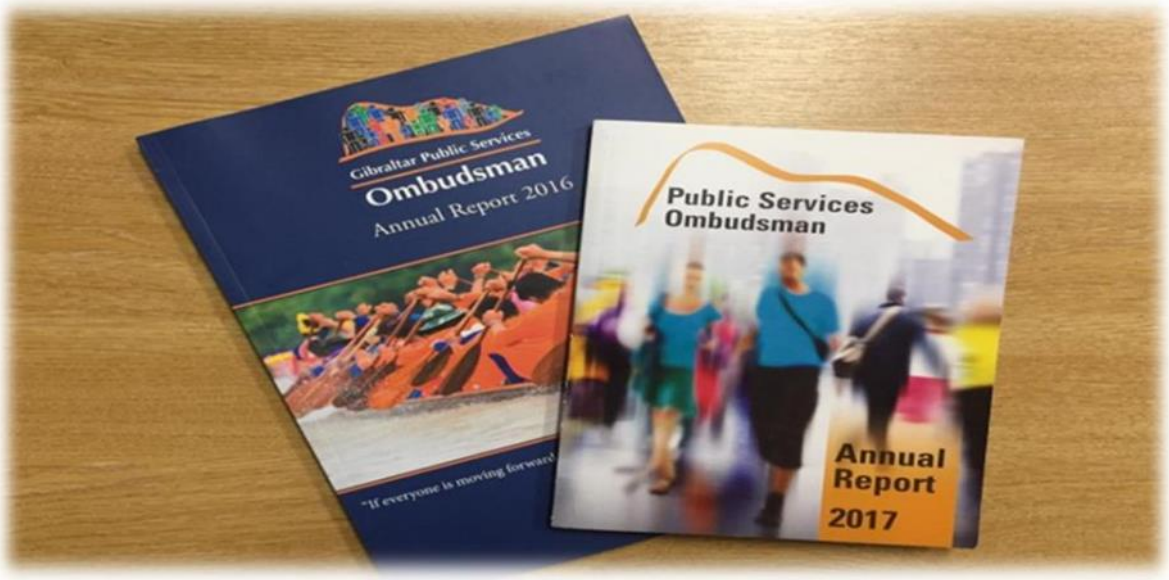
As mentioned above, the Gibraltar Ombudsman's Office was given jurisdiction to investigate complaints against the Gibraltar Health Authority (GHA) in April 2015. A Complaints Handling Scheme Office ("CHS") was established to operate at arms-length from the Ombudsman's Office. The CHS was based in the Hospital and dealt with all such complaints, in the first instance. Those complaints that could not be resolved following an investigation by the CHS were referred to the Ombudsman's Office for a more in-depth and exhaustive investigation. Some of these complaints were referred to clinical advisers in the United Kingdom for their opinion on the issues being investigated. More recently, in addition to the avenue that was available for making complaints to the Ombudsman at CHS, a Patients Advocacy and Liaison Service ("PALS"), was set up by the GHA as a further avenue for dealing with customer queries and complaints, in the first instance, with the PALS Office also based in the main GHA hospital building .

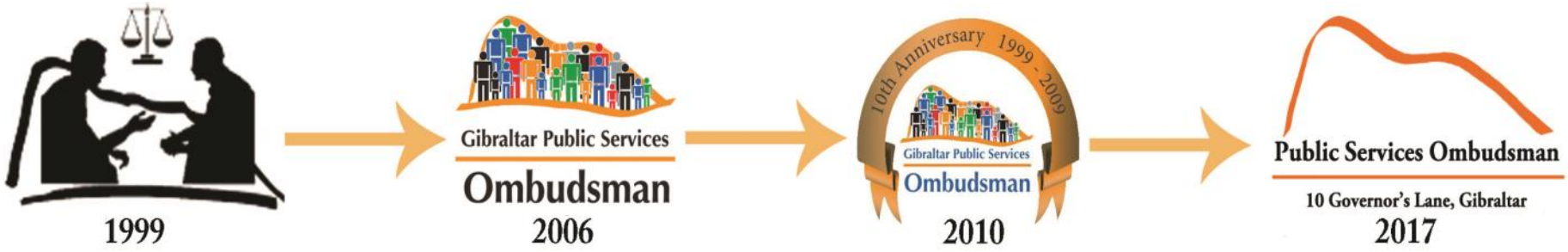
It became clear to the Ombudsman that there was room for improvement in the way that complaints at the GHA were dealt with. Many of the complaints received by the Ombudsman's Office could have been resolved easily and expeditiously by the GHA themselves. The Ombudsman therefore recommended that there should be a single office at the hospital for dealing with complaints, rather than two offices. It was his view, the service provided by the CHS should be merged with that of PALS and this would greatly improve the service being provided to its users.

The recommendation was taken on board and the new PALS/CHS Office opened its doors in a single office location at the hospital on 1st April 2018.

Presentation of Annual Report

In line with Annual Reports by Ombudsmen in other jurisdictions, the Gibraltar Public Services Ombudsman decided to change the presentation of his Annual Report with the aim of making this more user-friendly. In past years, the Ombudsman's Annual Report had been printed in an A4 format and contained full detailed reports of investigations. In the 2017 Annual Report, the printing size was reduced to an A3 format and the report included summaries, rather than full detailed reports, of the salient findings of the investigations carried out by the Ombudsman during the year. Full detailed reports continued to be available in the Ombudsman's website.





Evolution of Gibraltar Public Services Ombudsman's Office Logo

Change of Office Logo

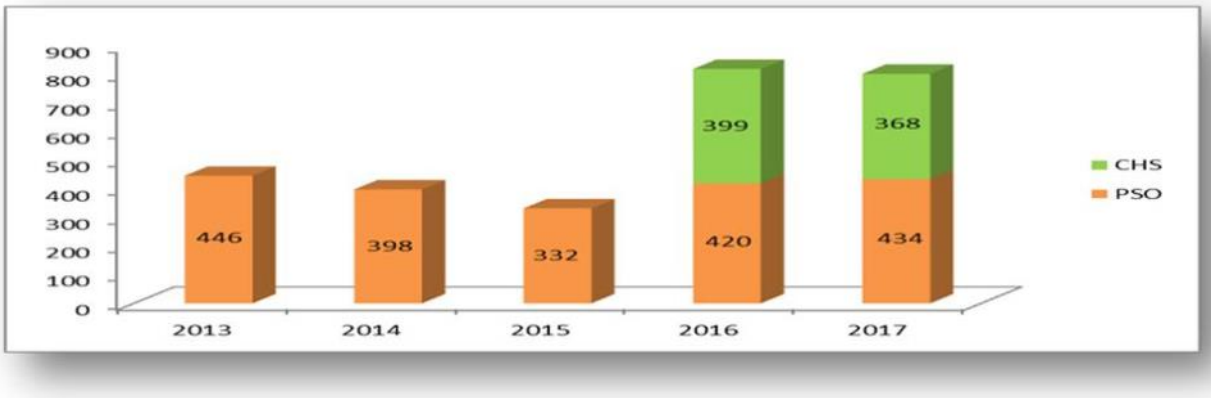
The Office of the Ombudsman was established in 1999. This was when the first office logo was introduced. Seven years later in 2006, during the 2nd Ombudsman's term, a second office logo was introduced and a further logo was introduced in 2010 to mark its 10th Anniversary of the establishment of the office of the Ombudsman.

In 2017, during the first months of the appointment of the current Public Services Ombudsman, the office logo was changed again. It was decided to simplify the logo by just having the silhouette of the Rock of Gibraltar above the title of Public Services Ombudsman, as shown above. This continues to be the current office logo.

Review of Complaints in 2017

A total of 434 Complaints were received by the Public Services Ombudsman' ("PSO") during 2017 and a total of 424 complaints were finalised during the year. In addition, a total of 368 complaints were received and dealt with directly by the Complaints Handling Scheme ("CHS"). Of the 424 Complaints that the Public Services Ombudsman finalised during the year, 383 complaints were dealt with in less than one month; 8 complaints were finalised within three months; 10 complaints were finalised between three and six months; 20 complaints were finalised between six and twelve months and 3 complaints took more than a year to finalise.

Complaints received for the Public Services Ombudsman Office from 2013-2017



2018-Ombudsman's Strategic Objectives

The Ombudsman outlined his views on the main strategic objectives of his office, as follows:

- To provide an efficient and effective mechanism for the public to be able to complain about any maladministration by Public Service Providers.

- To raise general standards in the delivery of public services; and

- To improve the in-house complaints handling procedures by public service providers.

Revised Principles of Remedy

Six revised Principles of Remedy were approved and fully adopted by the Gibraltar Ombudsman's Office. These covered the Ombudsmen's general approach to recommending a remedy for correcting an injustice or hardship caused by a public body's maladministration or poor service.

These Principles of Remedy, which are expanded upon in the Ombudsman's 2018 Annual Report, are as follows:

Principles:

1. to put things right;

2. to be open and accountable;

3. to be empowering;

4. to be fair, reasonable and consistent;

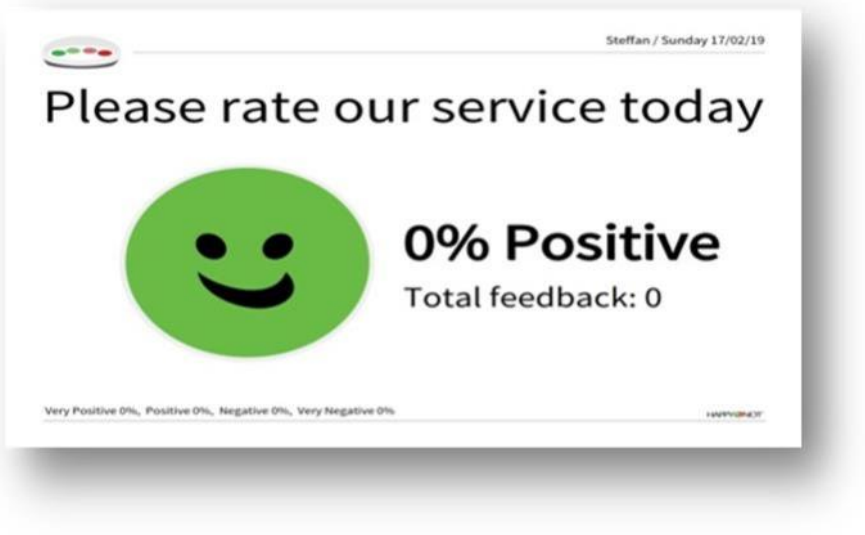
5. to be proportionate; and

6. to monitor and ensure compliance.

Monitoring of Customer Services at Public Counters

The Ombudsman was of the view that the provision of good customer service at public counters has a vital role to play in the overall image of our public services. In this respect, the Ombudsman decided that a customer service monitoring system with the use of 'Happy or Not' machines should be introduced in some of the main public counters.

A 'Happy or Not' machine was installed, in the first instance, at the Ombudsman's Office itself and the Ombudsman pointed out that the service of this machine will be extended to Government Departments with public counters, such as the Civil Status and Registration Office, the Department of Social Security and the Post Office.



Feedback of data from the Happy or Not Machine

The logo of the Public Services Ombudsman would also feature in the machines in order to encourage people to submit feedback for review by the Ombudsman on their customer service experience at these public counters.

Public Services Ombudsman
10 Governor's Lane, Gibraltar

Twentieth Anniversary of the enactment by Parliament of the Public Services Ombudsman Act 1998

On 10th December 2018 the Gibraltar Public Services Ombudsman it was 20 years to the day since the enactment by Parliament of the Public Services Ombudsman Act 1998.

The Three Gibraltar Public Services Ombudsmen—Past and Present

A special 20th Anniversary postage stamp was also issued to mark this important date in the Ombudsman's calendar.

To mark this significant date, the Public Services Ombudsman Group ("PSOG") semi-annual meeting was held in Gibraltar on 10th and 11th December 2018.

Ombudsmen and Staff - Past and Present – 1999 to 2018

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Appendixes

7.1 Delegation of duties and decision-making authority

7.2 Principles of Good Governance and Mission Statement

7.3 Financial Statements

7.4 Complaints about the service provided by the Office

7.5 Flow Chart on Handling of Investigations

7.1 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;

a) 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 Officer - Information Systems and Human Resources Manager *Steffan Sanchez*
Executive Investigating Officer *Sarah de Jesus El Haitali*
Executive Assistant to the Ombudsman and Public Relations Manager *Nadine Pardo-Zammit*

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:

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

7.2 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.

7.3 Ombudsman's Office - Receipts and Payments Account

For the years ended 31st March 2017 and 31st March 2018; and Approved Estimate for the year ending 31st March 2019

	Approved Estimate	Revised Estimate	Actual
	2018/2019	2017/2018	2016/2017
	£	£	£
Receipts			
Contribution from Government - Consolidated Fund Charges	475,000	427,000	405,068
Payments			
Salaries	351,000	333,000	318,358
Overtime	4,000	3,000	2,435
Allowances	4,000	5,000	249
Social Insurance Contributions	15,000	14,000	12,001
Pension Scheme Contributions	54,000	32,000	30,576
Relief Cover	1,000	0	0
Sub-total (Personal Emoluments)	429,000	387,000	363,619
General Expenses	3,000	3,000	3,195
Electricity and Water	2,000	2,000	1,240
Printing and Stationery	4,000	4,000	5,254
Telephone	5,000	4,000	4,085
Office Cleaning	5,000	4,000	3,711
Publications	1,000	1,000	825
Conferences, Training and Travelling Expenses	10,000	10,000	10,857
Computer and Office Equipment	4,000	4,000	4,050
Clinical Assessors	10,000	6,000	4,404
Office Expenses at St Bernard's Hospital	2,000	2,000	3,828
Total Payments	475,000	427,000	405,068

7.4 Complaints about the service provided by the Ombudsman's Office

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:

- failure to provide a service, or inadequate standard of service
- how we met your needs
- how we communicated with you
- how long we took to deal with your case
- treatment by or attitude of a member of staff
- failure to follow the appropriate administrative process.

WHAT IS NOT COVERED BY THE SERVICE 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?

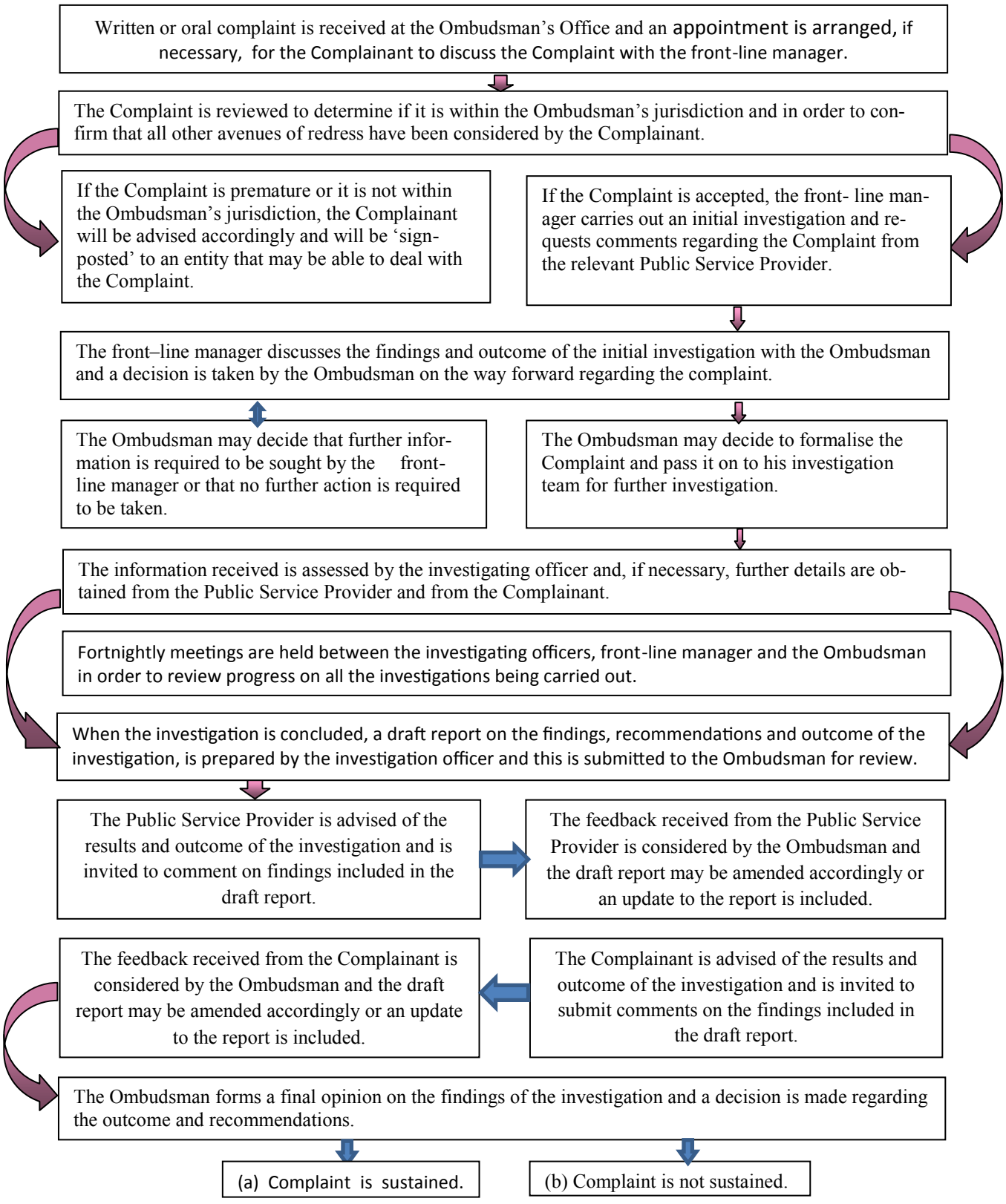
We aim to resolve complaints quickly. This could mean an on-the-spot apology and explanation if something has clearly gone wrong. We will try to take immediate action to resolve the problem whenever this is possible.

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 STILL 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.

7.5 Public Services Ombudsman Flow Chart—Handling of Investigations



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.

Public Services Ombudsman

10 Governor's Lane, Gibraltar

Ombudsman's Casebook

*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].

CIVIL STATUS AND REGISTRATION OFFICE

Case 1

Background

The complainant ("Complainant") complained that the the Civil Status and Registration Office ("CSRO") had not replied to correspondence he had addressed to them in relation to the renewal of his (and his wife's) id cards. On a point of principle, he felt it was unreasonable that the CSRO should keep requesting that he provide them with "three months'" worth of bank statements showing that he was in receipt of a pension, as a pre-condition to having the id card's renewed. He argued that state and occupational pensions had no expiry dates as long as the recipients were alive, thus he could not understand why CSRO required proof of receipt of pension. Consequently, he considered it a timely and costly affair to have to keep requesting bank statements to have his ID card renewed.

Investigation and Findings

The Ombudsman presented the complaint to CSRO and requested their comments. A reply was received some time later.

In the first instance, CSRO stated that they could find no record of the Complainant's letter which he claimed remained unanswered. They offered their apologies.

They further confirmed that they had checked the Complainant's (and his wife's) applications for civilian registration cards and residence permits and, by way of background for the Ombudsman's benefit, stated that they had applied for residency initially in April 2016 as "self -sufficient individuals/retired UK pensioners". At the time of the applications, they had provided CSRO with European Health Insurance Cards which were valid to November 2019. The applications were also supported with a one year tenancy agreement. CSRO also stated that there was a letter on file which confirmed that they had no objection to the renewal of the ID cards and permits being issued provided that the applicants were eligible for medical treatment under the "Group Practice Medical Scheme." As all criteria were satisfied, the residence permits were issued.

At the time of renewal a year later, CSRO had requested the bank statements given that it was *"…necessary as self -sufficient individuals to show that [they] were able to maintain [themselves] adequately in Gibraltar without recourse to Gibraltar public funds."*

As a significant and final point, CSRO informed the Ombudsman that they had asked the Gibraltar Health Authority ("GHA") for confirmation that the Complainant and his wife had transferred their UK pension rights to Gibraltar, thus enabling them to receive medical treatment locally. In relation to that latter point, CSRO was awaiting the GHA's reply before proceeding to authorise the issue of the ID cards and permits.

The Ombudsman also reviewed CSRO's published guidance notes readily available to the public from their counter, headed "Guidance Notes on Applying for Civilian Registration Cards." Under the "Self-Sufficient/ Pensioners" subheading. The notes stated that "*Proof of funds in the form of bank statements for six months prior to the application must be provided. European Union pensioners who are eligible to transfer their pension rights from their country of origin to Gibraltar must first register with the Primary care Centre (GHA).GHA card and proof of pension must be submitted with the application…."*

Despite the content of the latter part of the Guidance Notes which have been referred to, the Ombudsman learned from his investigation that in practice, GHA would advise applicants to attend CSRO **first** (since the GHA would ordinarily request ID cards in order to administer healthcare to individuals.) This, the Ombudsman opined, seemed to contradict the content of the Guidance Notes and could potentially cause confusion for applicants. There was in principle, no administrative failing as long as working practices were clearly explained to service users.

It did however became clear to the Ombudsman from respective telephone conversations held between his office, CSRO and the GHA, that there existed an element of confusion between the public entities involved as to the chronological steps each department was to follow, in order to properly process the applications in a diligent and expedient manner. The Permits and ID card renewals were eventually issued to the Complainant. It appeared that the GHA had in fact sent CSRO the necessary information some time earlier but it was misplaced. This led to delay.

Outcome

Although the Ombudsman accepted that the Complainant's unanswered letter may have been misplaced/misfiled by CSRO, he sustained the limb of the complaint where CSRO had failed to respond to the Complainant's queries in writing and that it constituted maladministration.

Insofar as the production of bank statements were concerned, although the Ombudsman noted that the Guidance Notes were clear that proof of funds needed to be provided and on that basis, he could not sustain that limb of the complaint, he would hope that the exercise would not have to be repeated by the Complainant (or other applicants) upon each renewal of their documentation (i.e., that proof of receipt of pension would only be required upon the initial and not subsequent renewals). From the Ombudsman's interpretation of the Guidance Notes, they appear to impose the production of bank statements and other criteria upon individuals when "applying " for civilian registration cards. There is no explicit mention of said proof having to be reproduced, upon "renewal". Perhaps the entities concerned could exercise an element of discretion when renewing documentation, in instances where the applicants were already in the system?

The Ombudsman also expressed the view that CSRO and GHA should communicate more clearly between them in order to facilitate the steps to be taken for the timely renewal of documentation (where applicants indeed met the qualification criteria).

(Report extracted from Case No 1121)

CIVIL STATUS AND REGISTRATION OFFICE

Case 2

Complaint

The complaint complained that the the Civil Status and Registration Office ("CSRO") had been inconsistent with the information provided on the issue of "id cards" and that allegedly, the complainant was lied to in respect of the requirement of a permit of residence. The complainant had applied for Civilian Registration Cards in February 2016.

Investigation and Findings

The Ombudsman presented the complaint to CSRO and requested their comments. Given the allegations, CSRO launched an investigation and replied to the Ombudsman shortly afterwards. They pointed out that the complainant was confused as to the application made and explained that persons who are entitled to hold Gibraltar id cards do not require permits of residence. Id cards are only issued to persons who are British nationals who are either registered Gibraltarians or have acquired British nationality by virtue of a connection with Gibraltar and, to those British nationals who have been issued with certificates of permanent residence. As a result, CSRO stated that the information provided by them to persons entitled to hold id cards, differs from applicants applying for a civilian registration card or permit of residence. "*Perhaps it is for this reason that the complainant considers that this department has lied to him in relation to the requirements.*" CSRO further commented that due to family issues of a financial nature (threshold and tenancy matters) and diverse nationalities (non EEA) also existing within the complainant's family, additional checks had to be undertaken by various Government departments. CSRO confirmed in later correspondence that after queries were satisfied and on production of the required documentation, Gibraltar Civilian Registration Cards were issued to the complainant and his family in August 2016.

Although the applications took six months to be processed, the Ombudsman was satisfied that the proper checks had been performed by CSRO and that the complainant had not been lied to. The Ombudsman however was unable to confirm whether or not the substantial and satisfactory explanations provided to him by CSRO, had in fact also been made to the complainant.

(Report extracted from Case No 1128)

DEPARTMENT OF EDUCATION

Case 3

Background

The Complaint had been verbally informed by the Department of Education that his two eldest children (of Moroccan origin) would not be allowed to continue their education at the Gibraltar College of Further Education. As a result he complained to Department of Education both verbally and in writing. The Complainant claimed he had not received a written reply to any of the three letters he had addressed to the Department.

The Complainant was of the view that he and his family should have been informed of the decision at the end of the last academic year. Some notice would have enabled them to make alternative educational arrangements for the continued education of the children, if this was necessary. As it stood, at the date of filing his complaint with the Office of the Ombudsman, the Complainant had only received verbal assurances from the Department that "the matter was in hand". The Complainant said that he felt that he was constantly being "fobbed off" by the Department.

By way of background, the Complainant explained that his daughter (who was of school leaving age at the time), had spent a year at the College of Further Education and had done well there. Despite this, however, she had not been allowed to continue with her studies in the following academic year. The Complainant's son (who was 17 years old) had also experienced a similar problem.

The Complainant was of the view that his children should have been given the option to continue with their studies at the College. He believed that they should have been permitted to continue in education until such time as that they found employment.

Investigation and Findings

The Ombudsman presented the Complaint to the Director of Education and requested his comments.

In his reply, the Director stated that the College of Further Education was an equal opportunities educational provider and that, as in previous years, they had continued to accept young adults of Moroccan origin, and indeed of other nationalities, to enrol on their courses. He explained that it was important to note that some of the students at the College of Further Education were actually beyond compulsory school age but that their view was that, in the current climate, it was not desirable to have young people out in the streets with no sense of purpose. As a result, language schemes (English literacy classes) had been implemented and were being delivered to those students who spoke little or no English. However, since those classes only amounted to a few hours a week, the development of language skills by such students was usually sufficient to enable them to enrol on to the mainstream courses being offered. As a result, more intense language courses were being devised in order to attempt to provide a solution to the problem.

The Director stated that he had offered the Complainant a half-hour meeting and that he went over the situation with the Complainant to reassure him that the matter was being given some thought. He stated that he had treated the Complainant with respect and genuine interest in his family's case and that when the Complainant left the premises he seemed "perfectly happy". He was, therefore, "completely perplexed by the accusations levied against the Department".

Recommendations and Outcome

The Ombudsman was grateful to the Director for the reply received and welcomed the inclusive view taken by the College of Further Education which, in effect, provided non-English native speakers the opportunity to enrol on their academic courses.

The Ombudsman did not consider that the Complainant had been "fobbed off". The Ombudsman noted, however, that despite having met with the Complainant, there was no mention in the Director's reply of the College of Further Education ever having written to him or replied to his letters formally addressing his concerns. There was also a lack of clarity as to how the decision to discontinue the education of the Complainant's children had been communicated to them by the College. The Complainant had claimed that they had been informed verbally and this was not rebutted by the Director.

Despite the best intentions by the College of Further Education (which the Ombudsman had no reason to doubt), in the Ombudsman's view, it would have been desirable, as a measure of good administrative practice, for decisions and/or updates to have been communicated to the Complainant in writing (even if the College of Further Education had taken the view that the courses could not continue to be delivered to the Complainant's children for whatever reason). The Complainant's correspondence should also have been formally replied to, despite the Director having offered the Complainant a meeting, as stated above.

From that perspective, the Ombudsman found that the College of Further Education and the Department of Education had failed administratively in the provision of their public service to the Complainant and his children.

(Report extracted from Case No 1144)

GIBRALTAR HEALTH AUTHORITY

Case 4

Complaint

The Complainant complained that the GHA had declined to reimburse/subsidise a foot operation which he felt obliged to arrange privately "as a necessity" since the GHA had allegedly been unable to schedule the procedure within a reasonable period.

Background

The Complainant explained that he first attended the GHA in April 2016 as a result of "*excruciating pain*" on the ball of his right foot. Suspected "*Morton's Neuroma*" was diagnosed and a scan requested. The scan results dismissed that diagnosis.

The Complainant was prescribed anti-inflammatories.

As the pain would not subside, the Complainant sought a second opinion privately, from a reputed podiatric surgeon in Marbella, Spain in June 2016. A metatarsal problem affecting both feet was diagnosed. The alternative solutions offered were surgery, at a cost of 2500 Euros, or the fitting of insoles, in an attempt to alleviate the problem. The Complainant chose the second option, at a cost of 250 Euros.

By August 2016, the insoles were no longer providing relief. As a result, the Complainant returned to the GHA for a consultation. The examining doctor referred him to the orthopaedic department ("Orthopaedics") on the basis that the pain was "affecting his quality of life".

In October, the Complainant made an enquiry about the date of his referral. He was allegedly informed that there was a two year waiting list as a result of consultant shortages.

In June 2017, at a subsequent consultation, the same examining doctor stated that Orthopaedics had employed another practitioner to accelerate assessments and that although waiting lists and times were being reduced, there was still considerable backlog.

The Complainant had previously had "*arthroscopies*" on both knees. He stated that the way he was walking was affecting his knees as well as his right hip (which had already been examined by the GHA- an x-ray confirmed signs of inflammation).

The Complainant sought another private opinion from a podiatric surgeon in La Linea, Spain, who confirmed the Marbella specialist's diagnosis, adding that the condition had deteriorated and that he would not operate the second toe without operating the first, which had become realigned. The collapse of the metatarsal bone was causing pain to the ball of the foot and by that stage, the second toe had developed into "*a full blown hammer toe*".

After two further consultations at the GHA and after having "*being told by staff that [he] was not anywhere near being called for the assessment*" the Complainant agreed to proceed with the operation, privately.

In August 2017 the Complainant wrote to the Hon Minister for Health, informing him of the situation and requesting funding/reimbursement for the operation he was due to undergo. The reply received stated that the request had been forwarded to the Medical Director ("MD"). A telephone call was subsequently received by the Complainant from the MD's office, stating that the GHA would not agree to the funding but that an accelerated appointment would be made for him at the GHA. A letter from the MD was issued on 1st September stating that it was not the policy of the GHA to fund treatments commissioned by individual patients and further advising that the GHA had appointed a foot and ankle Orthopaedic Surgeon whom they expected to take up post in the next three months.

A week later, the Complainant was seen by the doctor employed to "accelerate reviews". She apologised for the delay. She examined both his feet, knees and hip and requested x-rays which were taken there and then. The doctor agreed that surgery was required and offered a consultant referral for assessment. The Complainant replied that he did not wish to waste any more time and that he had already booked a private operation for the 6th October 2017. The doctor then offered post-operative reviews which the Complainant accepted. He was then given an appointment for December 2017.

The Complainant explained to the Ombudsman that the reason for not accepting the referral was threefold:

First, he was already committed to the private operation. Second, he was aware that the consultant he would be referred to was not a foot, but a knee/hip specialist. Finally, he had been informed that that consultant was away until October and he could ill afford further delays as a result of the progression of his condition.

The private operation was conducted successfully. At a GHA follow up that same month, the Complainant was allegedly told by the examiner "…..*Oh, you have already had surgery. Indeed, the wait was an undue wait*".

The Complainant made further requests for reimbursement after his operation, which were denied. The GHA was of the view that the surgery was considered "*elective and not urgent*". This view was expressed in writing by the MD and by one of the practitioners who had been involved in the Complainant's care. The Minister himself wrote to the Complainant in reply to his October 2017 letter, stating that although he was sympathetic, he had sought clinical expert opinions on his pre-operative condition and based upon those views, the path elected by the Complainant was indeed determined to have been elective and not as a result of urgency, particularly since the Complainant could have waited for the foot and ankle specialist to have begun employment in December 2017. As a result, the Complainant's request was not considered justified in the circumstances.

According to the Complainant, the GHA's stance that it was against their policy to fund private operations was "not altogether true", since he was aware of at least two cases where costs had been reimbursed.

As a result of his grievance, the Complainant brought his complaint to the Office of the Ombudsman.

Investigation

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

The MD provided the Ombudsman with a substantial reply.

He began by stating that the GHA had no set standards for the time from initial referral to hospital, to in clinic reviews leading to the provision of definitive treatment. Waiting times were based on available existing resources and clinical urgency.

He also advised that waiting times for orthopaedic surgery had been quite long over the last few years and that extra resources had been put in place to deal with the backlog in mid and late 2017 (namely the doctor employed to accelerate referrals). Furthermore, that department had been restructured to include a foot and ankle specialist who started in December 2017. Foot problems had previously been dealt with by general orthopaedic surgeons and referred elsewhere if expertise was required.

The MD stated that he appreciated that the Complainant had to wait more than he would have liked to be seen and treated. He explained how the Complainant did bring the issue of the private operation to the GHA's attention before he had the surgery, for GHA approval/ funding. At the time, the MD sought specialist advice from the orthopaedic team on the clinical urgency of the case. The ensuing advice was that the matter was considered "*routine"* and "*not urgent".* The Complainant nonetheless opted to have private treatment in October, even though he had been informed that the GHA would not reimburse him and that a specialist review could be arranged for December 2017 at the GHA.

The existing criteria was therefore applied, namely, that private fees incurred by patients are not routinely reimbursed. The MD stated that the GHA endeavours to help patients with concerns about treatment waiting times or worsening symptoms and where possible will expedite in-house treatment. In the event that treatment is clinically urgent and the treatment cannot be provided in-house, the GHA may refer to an external provider.

The MD further advised that it would have been unlikely that the Complainant would have been seen sooner by an external provider than by the specialist who commenced in December 2017. It was in fact the GHA's intention to expedite his GHA treatment so it would have been likely carried out in December (delay of two months compared to his private provider).

In conclusion, the MD informed the Ombudsman that since he started as MD in June 2016, he had not personally approved any reimbursement of private treatment undertaken by patients on their own initiative. He further confirmed that a formal GHA policy was being drafted on the issue of reimbursements for small claims/expenses and that once finalised, a copy would be forwarded to us.

Conclusions

The Ombudsman was sympathetic and fully understood the Complainant's position. He appreciated that there had existed delays and what on the face of it appeared to be an unreasonable waiting time for the necessary treatment to have been carried out at the GHA. The Ombudsman was also aware of the fact that the Complainant must have been suffering pain.

However, based upon the Ombudsman's investigation, his review of matters and a thorough analysis of the MD's comprehensive reply, the Ombudsman was of the view that the GHA decision taken in this case was reasonable; both (i) from an administrative perspective (in line with GHA established policy) and (ii) based upon the clinical opinion sought on the urgency or otherwise of the Complainant's condition. The Ombudsman opined that the GHA acted appropriately administratively, in seeking in-house Orthopaedic opinion before issuing the Complainant with a written reply to his request.

Given that the condition was not classed as "medically urgent", the Ombudsman had no alternative but to concur with the GHA's view that the private procedure opted for by the Complainant, constituted "elective" and not "urgent" surgery.

The added fact that the Complainant had been made aware before the surgery that he would not be reimbursed and that attempts had been made to expedite his treatment were also determining issues which the Ombudsman carefully considered when reaching his decision.

Classification

Complainant aggrieved with the GHA's decision and subsequent lack of funding/ reimbursement for private surgery- **not sustained**.

Ombudsman Note

The Ombudsman was unable to opine on the Complainant's view that he was aware of two other instances where patients were allegedly reimbursed, given that that issue was not central to this investigation. The Ombudsman was solely concerned with the decision taken in the Complainant's case (and the application of administrative criteria/policy) which in this instance, was appropriately followed on the evidence presented and examined. It was further supported by clinical opinion of the Complainant's condition. The Ombudsman assumed that based upon the information received in this investigation, independent cases/claims made would be assessed on their own merits and on individual bases, applying the criteria set out in the MD's written reply.

(Report extracted from Case No 1172)

GIBRALTAR HEALTH AUTHORITY

Case 5

Complaint

The Complainant was aggrieved as a result of an alleged lack of follow up care after the Patient had undergone surgery to remove part of a tumour.

The Complainant explained that the Patient had been diagnosed with a "meningioma" brain tumour in 2002. A partial extraction of it was successfully undertaken in Cadiz followed by radiotherapy in Malaga, Spain in 2003. It was further explained that as a result of the latter procedure, the remaining area of the surrounding tumour was able to be "burnt off" but not fully removed. The Complainant further stated that at that point, the Spanish radio-surgeon ("Radio Surgeon") advised that the Patient should have yearly MRI scans and that he would arrange the annual consultations to be conducted at a nearby Spanish clinic (Radon) to review and compare the MRI's. The Complainant stated that these check-ups ceased two/three years prior to the Ombudsman complaint being filed, at a time when a GHA consultant ("the Consultant") advised that no further MRI's should be undertaken. The Complainant informed the Complaints Handling Scheme ("CHS") that the Patient started to complain of headaches and a tingling sensation on the right side of his head sometime in February 2016. She stated that the Patient visited a general practitioner at the Primary care Centre ("PCC GP") who she alleged "immediately sent an email to the relevant department at the GHA advising them that an MRI should be taken as soon as possible. In the meantime, he prescribed some anti- inflammatory tablets…. A couple of weeks later the Patient was contacted by the PCC GP who advised that the MRI report confirmed a variation from the last MRI taken 2/3 years previously. The PCC GP explained that he could not advise on the variation as that was not his area of expertise and that he would refer this to the relevant department." The Complainant explained that the PCC GP wrote to the GHA's Neurosurgical Department. As next-of- kin, the Complainant was contacted towards the end of March 2016, informing her that they (the GHA) had made unsuccessful attempts to contact the Complainant. She stated how it was confirmed that the Patient had a scheduled appointment for April 2016 with the neurologist but that the appointment was later cancelled since it was deemed that the appropriate consultant to discuss the MRI findings was a UK neurosurgeon (who was due to visit the GHA in May 2016) and not the neurologist.

Towards the end of April 2016, the Patient was hospitalised since he could "no longer feel the side of his face and was having difficulty speaking." As a result, the GHA dispatched the Patient's medical records and MRI scans to Xanit Hospital in Spain for an urgent consultation with the resident neurosurgical team who since then, have taken over the Patient's care.

The Complainant subsequently lodged her complaint with the Office of the Ombudsman seeking answers to the following questions:

1. Why did the Consultant stop the yearly MRI scans and consultations with the PCC GP given that only part of the tumour had been extracted? If these check-ups had been continued there may have been an earlier detection of the variation and the Patient would have been examined sooner before any symptoms would have manifested themselves?

2. When the MRI taken in February 2016 confirmed that there existed a variation, why was the MRI not sent to the neurosurgical team at Xanit Hospital as soon as possible and where was the letter sent by the GP in February 2016?

3. Why did the Patient have to wait from February until May for a neurosurgical consultation if the GHA has been utilising Xanit's services for a number of years?

Investigation

The CHS presented the complaint to the GHA in writing setting out the facts as alleged by the Complainant and requesting their comments. Given the nature of the complaint, the CHS took the view that the complaint would be more appropriately served if formally investigated by the Office of the Ombudsman.

The Ombudsman wrote to the GHA. The initial reply received from the Consultant was that according to his recollection and front desk record, he had never been involved in the Patient's care. He stated that it was unusual that he would have stopped the Patient from receiving further scans without knowing him. The Consultant confirmed that he had requested the Patient's notes after which he would provide a more substantive reply.

Two weeks later the Consultant reverted. He stated that for the benefit of all concerned he would provide a summary of clinical episodes in chronological order.

The Consultant explained how the Patient was diagnosed with a "left frontotemporal meningioma" in 2002 at the age of 38. He was operated in July 2002 at the Neurosurgical Unit, Cadiz University. Actual tumour size at the time of diagnosis was 6cm in diameter. According to medical notes available, he had two further follow up episodes in Gibraltar by a consultant physician and by a medical NCHD in January and February 2003. His repeat MRI scan according to the letter dictated on behalf of the consultant physician to the PCC GP, showed some evidence of residual tumour, perhaps recurrence. He was sent back to his neurosurgeons in Cadiz for a review. On 2 July 2003, he was seen by the Radio Surgeon in Malaga, whose impression was that there was a small residual tumour which needed further treatment. He subsequently received stereotactic radiotherapy and was asked to return for a review in three months' time with a repeat MRI scan.

He had another review in December 2003. That MRI scan showed no evidence of recurrence. He saw the Radio Surgeon again in January 2004 who advised a repeat MRI scan in six months and a review in June 2004. MRI scan again showed no alterations or significant pathology. His next appointment with the Radio Surgeon took place in September 2004. Another MRI scan and a review in six months was recommended.

The next entry in the Patient notes is from April 2005. The Radio surgeon was satisfied with the repeat MRI scan and gave him another appointment in six months with another follow up scan. The subsequent entry is October 2005 when the Patient is offered another six month appointment and MRI. The next entry is June 2006 and again, an appointment and scan are undertaken. Satisfied with the results, another scan is not performed until August 2009.

In January 2010, the Radio- Surgeon attended the Patient in Algeciras, Spain and post examination concluded that "although there is a slight increase of a few millimetres in the last year, the finding is difficult to assess. The Patient is asymptomatic, however I would like to suggest another MRI scan in April/May 2010."

The latest correspondence the GHA had received from the Radio- Surgeon (as contained within the Patient's file) was dated 29 June 2010 where he suggested another review in a year- February/March 2011 and another MRI. At that time, he observed a "*reduction of the lesion with a decrease in uptake of the contrast with the previous MRI scan… there is no further growth and the Patient remains asymptomatic*." The GHA received no report on the outcome of the February/March 2011 MRI although a subsequent scan conducted in May 2012 showed no significant change in the appearances of the left sided frontotemporal meningioma.

The Consultant providing the chronology to the Ombudsman stated that the Patient had alleged he did not have any local follow up after May 2003. "*as a matter of fact he was making his own appointments with his consultants in Spain and his wife was requesting MRI scans through medical secretaries."* The Consultant confirmed that his involvement started after August 2006 when he joined the GHA and was limited to requesting MRI scans on his or his wife's advice. The Consultant did not recall any direct interaction with the Patient or his wife. "*there was no referral to me by his GP or even a request made by the Patient. I have checked with my medical secretary who has been dealing with my clinic related matters and has received external correspondences since July 2012 and also my clinic nurse, who has been organising my clinics since 2007; they both have no recollection of any request for repeat scans and have not received any correspondence from Clinica Radon after June 2010."*

The Consultant further stated that cases such as the Patient's where an annual examination needs to be performed pose a significant difficulty as the appointments system does not allow appointments to be scheduled at a year's interval. "*in other such cases, it remains the responsibility of the patient or the family to remind the doctors to arrange these investigations before their next appointment with a centre outside Gibraltar. Because the Patient's care was transferred to the Radio- Surgeon by the GHA consultant physician,* ***clearly there was an understanding for the patient to have follow up with the Radio- Surgeon"*** (as the Ombudsman noted, that appeared to have been the case from the information received and reviewed.)

The Consultant further explained that "with regard to the meningioma, in general after complete removal recurrence is between 8-20% over ten years and in residual tumours the rate of recurrence is 29-55% over a ten year period. It is impossible for any doctor to refuse interval scans."

The Consultant concluded by stating that he was sad to hear that the Patient's disease had returned but considering the benign nature of the tumour, he was confident that the Patient would recover and wished him well in his future treatment. He also confirmed he had passed on copies of the complaint to other practitioners involved for them to address points 2 and 3 which related to a more recent episode.

The second statement received by the Ombudsman was drafted by a GHA NCHD (identified) ("the NCHD"). The statement relates to the latter limbs of the Complainant's complaint.

The NCHD commenced by defining his role which included helping co-ordinate the neurology clinics with the visiting neurologist. He explained how he also attended upon patients in a rapid access clinic for follow up after migraines etc- said function being carried out with the backup of medical consultants/neurologist. The NCHD explained how he came across the Patient's referral whilst he was in the records department checking through neurology referrals to ensure that people had not been missed.

He went on to state how an administrative officer asked for his advice regarding the Patient's referral letter (the letter is the one alluded to at point 2 of the complaint). The letter contained a request for a **routine neurosurgical clinic outpatient appointment.** The NCHD explained to the administrative officer that neurosurgery was a different speciality to neurology and was under the management of the surgical team. The NCHD read the letter to ensure that the clinician had documented that there was no neurological deficit and to verify that the referral had indeed been for a routine neurosurgical appointment. He also explained to the Ombudsman how he checked with the front desk to ensure that the Patient had an appointment booked and it was then, when he noticed that he had had an appointment cancelled. The NCHD assumed that the Patient had been inadvertently booked into a neurology clinic by administrative staff for April and was then subsequently booked to see the visiting neurosurgeon in May.

In terms of the Complainant's specific concerns, the NCHD could not explain how the letter ended up in the neurology pile of letters. He repeated that he assumed that an administrative error had occurred and he helped correct it. The appointment for the 5th April had been mistakenly made with the neurologist by staff when they had assumed that neurosurgery formed part of the neurology clinic. In terms of the cancelling and rebooking of said appointment that would have been carried out by GHA staff.

Regarding the letter being redirected to surgical referrals, again, the NCHD could only guess that once he had corrected the administrative officer's understanding, the letter was correctly triaged to surgery. He added by stating that all medical referrals were and continue to be triaged by the medical consultants each Friday.

The NCHD in his conclusion, stated that he was concerned regarding suggestions that he had made decisions regarding when or where a patient may be followed up. He explained he was clear in his role and that the consultants were the practitioners who made the decisions regarding triaging of patients. He ended by stating that he understood that the Patient did see the neurosurgeon and that the outcome had been satisfactory.

Conclusions

The Ombudsman carefully examined the statements received from the GHA. He will provide his conclusions numerically as they appear in the complaint:

1. Why did the Consultant stop the yearly MRI scans and consultations with the PCC GP given that only part of the tumour had been extracted? If these check-ups had been continued there may have been an earlier detection of the variation and the Patient would have been examined sooner before any symptoms would have manifested themselves?

The Ombudsman accepted the Consultant's explanations in relation to the fact that he had never been directly involved with the Patient and that it was the understanding that the local consultant physician had discharged the Patient's care to the specialist Radio Surgeon. This can be evidenced by the fact that indeed, it was the Radio Surgeon who suggested follow up appointments in the manner he deemed appropriate and of most benefit to the Patient. In accordance with GHA practice at the time relating to follow up appointments of this nature, it was the Patient "who was making his own appointments with his consultants in Spain and his wife was requesting MRI scans through medical secretaries."

It appeared to the Ombudsman that no further MRI's were sought by the Radio Surgeon after May 2012 since the Patient appeared to remain asymptomatic after various MRI's and examinations had shown over time.

Unfortunately the Patient begun to suffer symptoms in 2016. In the Ombudsman's view, the Patient owed a responsibility to himself to have sought further reviews from 2012-2016 to address any concerns you may have had. Clearly, the Radio Surgeon appeared to have seen no need to keep repeating tests, although it would have been desirable to have seen some evidence of a final report or discharge letter signed off by him.

2. When the MRI taken in February 2016 confirmed that there existed a variation, why was the MRI not sent to the neurosurgical team at Xanit Hospital as soon as possible and where was the letter sent by the GP in February 2016?

3. Why did the Patient have to wait from February until May for a neurosurgical consultation if the GHA has been utilising Xanit's services for a number of years?

The Ombudsman considered it appropriate to address points 2 and 3 under the same limb. From the statements reviewed, it was clear that the PCC GP's referral letter requested a **routine neurosurgical clinic appointment**, despite the variation in the Patient's condition as shown in the 2016 MRI scan. There was no explicit or implicit sense of "urgency" contained within the referral.

It was for that reason that the Ombudsman could only assume that the consultants who triaged the referral did not consider it an appropriate case to outsource to either Xanit or to any other external provider. Furthermore, since a visiting neurosurgeon would be attending the GHA to examine patients in May, they considered that that was the most desirable route to follow. The Ombudsman did not consider this approach to have constituted any unreasonableness, neglect or a lack of a duty of care towards the Patient. It should be noted that the administrative error made by staff which mistakenly led to the referral letter ending up at neurology instead of neurosurgery should not have occurred. Despite that, the mistake was corrected, and fortunately, did not make an important contribution to any significant delay in the Patient's examination or subsequent treatment, or to any worsening of the Patient's state of health. For the above reasons, the Ombudsman, based upon all the material before him, was unable to sustain this complaint in part or as a whole.

(Report extracted from HEALTH CS 2016-27)

GIBRALTAR HEALTH AUTHORITY

Case 6

Complaint

The Complainant was aggrieved as a result of the following allegations:

(i) Lack of support in relation to breastfeeding.
(ii) Lack of care towards the baby´s weight problem.
(iii) Discrepancy in treatment during ward stay.
(iv) Unnecessary involvement of the Royal Gibraltar Police ("RGP") & the Care Agency.

The Complainant stated that her baby who was born the 14th January 2016 at St Bernard´s Hospital, had recorded a weight loss of 9% from the original birth weight three days after her birth. This concerned the midwives and led to the baby being closely monitored.

The midwives discussed the baby's weight loss with the paediatricians who offered advice in relation to breastfeeding. The Complainant was discharged from Maternity Ward on the 17th January 2016 and was advised to continue breastfeeding. However, the baby continued to lose weight.

The baby was eventually referred to the Consultant Paediatrician on the 29th January 2016 who advised the Complainant to top up with Formula Milk after each breastfeed and who also allegedly "reminded" her that she had had the same problem with her other child who had also lost weight at birth. The Complainant was unhappy with these remarks since she felt that this was a separate issue altogether and she recalled her other child having suffered from a Urinary Tract Infection, which had contributed to the weight loss.

The Complainant further explained that although she offered Formula Milk top ups after each breastfeed, she did not find them helpful since according to her, the baby threw up after each feed. The Complainant suspected that this was caused by the excess intake of milk. She informed the GHA of the baby's constant throwing up during her visits with the midwives and Child Welfare Department at the Primary Care Centre thereafter.

On the 25th February 2016 the Complainant attended the baby´s weekly weight check at the Child Welfare Department. After examining the baby, the health visitor ("Health Visitor"), informed the Complainant that the baby needed to be referred to the paediatrician at Rainbow Ward in St Bernard´s Hospital due to her constant weight loss. The Complainant agreed to attend Rainbow Ward but informed the Health Visitor that she would do so after she had collected her other three children from school. The Complainant further commented that she informed her husband of the advice given by the Health Visitor and he expressed his wish to attend Rainbow Ward with the Complainant and the baby after he finished work that day.

Upon arrival at Rainbow Ward that afternoon at approximately 17:20, the couple were met by two RGP officers and two social workers as well as the Consultant Paediatrician. At this stage, the Complainant was informed that the baby was in a very poor state in that she was cold, dehydrated and severely malnourished. The Complainant could not understand however, why the RGP and the Care Agency were called even before the doctor had had a chance to examine the baby.

The baby was immediately admitted to Rainbow Ward and the family subsequently subjected to an investigation by the Care Agency. This the Complainant stated, only added strain to an already stressful situation. Moreover, she was also of the opinion that the baby's care did not follow a set path during her admission to Rainbow Ward since the Complainant was not allowed to breastfeed the baby first and subsequently top up with Formula Milk, as per the advice she was given previously.

The Complainant was aggrieved and she lodged her complaint with the Ombudsman. She felt that the situation she and her family found themselves in February 2016 could have been avoided if the various professionals involved in the baby's care had addressed her weight loss at an earlier stage. She was also of the opinion that the Health Visitor should have alerted her of the seriousness of the baby's condition on the 25th February 2016 and, if necessary, called an ambulance to transport the baby to St Bernard's Hospital if indeed she had felt that the baby needed to be seen urgently.

Investigation

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

Postnatal Midwifery Care – (Medical Notes)

From the entries made in the baby's postnatal notes and specifically in relation to her feeding plan, the Ombudsman was able to ascertain the following:

14th January 2016 – Weight at birth 2805g. The Complainant's choice of feeding method was breastfeeding. Baby "on the breast with minimal assistance. Suckling rhythmically….not interested and again suckling well, good amounts".

15th January 2016 – Baby became "mucosy". Did not breastfeed for a total of fourteen hours. Complainant encouraged to breastfeed every 3-4 hours. Blood Glucose Monitoring test performed to monitor the Complainant's Gestational Diabetes and found within normal range.

16th January 2016 – New-borns not weighed on Day 2. Observed breastfeeding and "suckling well" at 02:30, 05:15, 06:30, 07:00 and again at 11:00 "good suck and attachment".

17th January 2016 – Weight 2550g. It was however documented that she "looked fine" and had "good muscle tone". The Complainant was discharged from Maternity Ward and advised to return in two days to repeat checking of the baby's weight.

19th January 2016 - Weight 2520g, dropped a further 30g. Referred to the on-call paediatrician who advised the Complainant to 'persist on breastfeeding' for an extra two days and return to Maternity Ward for a further weight check.

21st January 2016 – Weight 2440g. Baby found to have lost a further 80g. The paediatrician was once again contacted and advised the Complainant to top up with Expressed Breast Milk (EBM) after each feed to help increase the baby s' intake.

23rd January 2016 – Weight 2500g. She had gained 60g, had "*good colour*" and was "*alert".* On this occasion it was documented that she had "*breastfed well from both breasts"* and that *"mum offered EBM top up of 30 ml after feed but baby couldn't tolerate it (vomited all)".* There was a further note stating that the plan was *"to be seen in 3 days to weigh again and discharge"* from midwifery care to the Health Visitors.

26th January 2016 – Weight 2480g. She had lost 20g in the preceding three days. It was documented that the Complainant had informed the midwives that the baby had breastfed well the day before but did not tolerate top-ups as per previous plan. It was also noted that she "*appeared alert, pink, warm, good tone….weight static and still below normal weight loss threshold".* The midwives documented that on this occasion there had been "*no paediatrician on site to review"* and informed the Complainant that if the baby didn't gain weight by the following day, *"she may need to be admitted to Rainbow Ward".*

27th January 2016 – No weight was noted on this occasion although the entry stated "*Attended the ward as planned for weight…baby pink and warm*". An appointment was given for the 29th January at 3:30 p.m. for a further check-up with the midwives.

29th January 2016 – Baby s' weight - 2470g. "*Has lost 10g*…baby *now at loss of >10%".* The baby was seen by the paediatrician on ward who advised that the Baby's feeding plan was to change from solely breastfeeding to topping up with formula milk. It was further documented that advice was given about the severity of the Baby's weight loss and the need for admission to Rainbow Ward if this continued. A further appointment for re-weight was given for the 31st January 2016.

1st February 2016 – The baby was not brought for re-weight on the 31st January 2016. On this occasion it was documented that the Complainant was not contactable at home or mobile and it further noted "*husband contacted – he will pass a message for her to come to ward tomorrow at 4p.m. (will not come any earlier) - To be seen on ward and paediatrician review".*

2nd February 2016 – *Weight 2550g. The Baby had now gained 70g and the midwives documented that the baby looked healthy, had good colour and muscular tone. It was further documented that the Baby was discharged from midwifery care that same day due to her "gaining weight and health visitors will see baby on Thursday 4th February 2016".*

The Health Visitors

The Ombudsman requested a statement from the health visitors who routinely take over the care of new-borns upon discharge from Midwifery Care. The health visitors provided a detailed report of their involvement leading up to the baby´s admission at Rainbow Ward on the 25th February 2016, (summarised below in chronological order for the purposes of this report).

27th January 2016 - The health visitors visited the Complainant's home after the birth of the baby at 13 days of age. At this point, given the baby's weight loss, she had not been discharged from midwifery care and her weight was 2480g. During the visit, the Complainant was therefore advised that her next encounter with the health visitors depended on the outcome of her next visit with the midwives. This was due to take place that same afternoon.

28th January 2016 - The following day, the Complainant received a call from the health visitors who invited her to take the baby to the Child Welfare Department on the 4th February 2016 given that the baby was due to be seen by the midwives once again on the 31st January 2016.

4th February 2016 – A week later, the health visitors noted that the baby weighed 2480g (the same weight as they had noted on the 27th January). They commented "*the baby had not gained any weight in the previous week despite mother stating she was giving top ups of Aptamil formula 1-1.5 oz, 4 times daily*". The Ombudsman however noted from the entries made by the midwives to the baby's Postnatal Notes (summarised above) that the baby had in fact lost 10g on the 29th January and gained 70g on the 2nd February which had prompted her discharge from Midwifery Care. It is also important to note at this stage that there were no entries to the baby's Child Welfare Department notes indicating that there had been a discussion between the midwives and health visitors.

The health visitors informed the Ombudsman that as a result of the 'lack' of weight gain noted, they contacted the paediatric dietician ("Paediatric Dietician") immediately and asked for the Baby to be assessed. The assessment took place that same afternoon where advice was given for the Complainant to fortify her EBM with a high energy formula and a review date was given for the 8th February, four days later.

The health visitors also informed the Ombudsman that the baby was not brought in for review by the Paediatric Dietician as previously agreed and although attempts were made to reach the Complainant both at home and mobile phone, they did not manage to speak to her. The Complainant on the other hand refuted this allegation by stating that she had not been given an appointment with the Paediatric Dietician, but that she had been advised to attend the following week to the Child Welfare Department to repeat the check of the baby's weight.

In an attempt to obtain some clarity, the Ombudsman contacted the Primary Care Manager who provided a breakdown of the electronic appointment system used at the Primary Care Centre. From this, the Ombudsman was able to peruse the entries made by the Paediatric Dietician and ascertained that on the 4th February 2016 she had indeed documented "Agreed for weekly weight, at health centre, for weight check on Monday. To follow up in 2 weeks, Health Visitors to update with weight check".

11th February 2016 - The health visitors continued their account by stating that the baby was taken to the Child Welfare Department on the Thursday as opposed to Monday (three days after) where she was found to have gained only 85g. At this point the Complainant was advised to increase the amount of high calorie supplement added to her expressed breast milk and the Paediatric Dietician was informed of the baby's poor weight gain. The health visitors highlighted that the Complainant did not take the baby for a further check-up the following week despite being asked to do so. Nevertheless, the Ombudsman noted that the baby had received immunisation for Tuberculosis the following day (12th February 2016). The Complainant informed Ombudsman that this also contributed to the baby s' lack of interest in feeding for the subsequent two/three days and, in her opinion, she felt that she should have been counselled better in that regard and advised to offer immunisation at a later stage, once the Baby had reached the desired weight. The baby's next encounter with the health visitors was thirteen days later on the 25th February 2016.

25th February 2016 - According to the health visitors, the nurse who weighed the baby on the day was concerned about her "appearance, lack of interest and general subdued behaviour".

The Health Visitor was subsequently asked to examine the baby and found that she weighed 2540g (she had lost 25g since the last time that she had been weighed 14 days earlier).

The Health Visitor found that the baby looked *"pale, thin and dehydrated*". She immediately called the Consultant Paediatrician expressing the need for urgent admission to hospital. He agreed to this and had a long discussion with the Complainant who according to the Health Visitor was "*upset*", "*crying*" and commenting that she did not want to go to hospital. The Complainant informed the Health Visitor that she needed to go home first as her school age children were coming home for lunch. Seeing that the Complainant became "*extremely stressed"*, the Health Visitor agreed that she should go home first given that her children were expected for lunch and highlighted the importance of her attendance to Rainbow Ward after attending to her other children. The Complainant agreed to this and went home.

The Health Visitor was aware that the Complainant's children were arriving home at noon and would be returning to school approximately an hour later. She therefore called Rainbow Ward at 14:15 p.m. to see if she had arrived and once again at 15:30 p.m. She subsequently attempted to call the Complainant on three consecutive occasions. She stated "*Her mobile recorded: 1. No reply, 2. Engaged, 3. No reply. Her landline was called three times with no reply".*

Given that she had been unable to make contact with the Complainant, the Health Visitor once again contacted the Consultant Paediatrician with concerns over the baby's wellbeing. As a result, it was agreed that she would contact the duty social workers at the Care Agency in order to arrange a joint visit to the Complainant's home. The Health Visitor was however unable to arrange this given that the duty social worker was alone in the office while his colleagues were already out on a visit. She informed the Ombudsman that, as a result, the duty social worker contacted his team leader to discuss the situation and subsequently a strategy meeting was arranged which took place at 16:45 p.m. in Rainbow Ward. During the meeting it was agreed that the police and a social worker would carry out the home visit that same evening. This, however was unnecessary as by 17:20 p.m. the family including the baby arrived at the ward where the baby was immediately examined by the Consultant Paediatrician who after performing blood tests, found her to be suffering from dehydration and malnourishment.

The Health Visitor concluded her account of the events by stating that she had not called for an ambulance to transport the baby from the Child Welfare Department to St Bernard´s Hospital because she believed that the Complainant was capable of complying with her instructions to take the baby into hospital after attending to the rest of her children.

Meeting with Health Visitor

Subsequent to receiving a statement from the Child Welfare Department, the Ombudsman met with the Health Visitor on the 8th December 2016 in order to find out which protocols were in place for babies with excessive weight loss at the Child Welfare Department. This query was especially significant given that it had become apparent from the various correspondence and from the review of the medical notes that the baby had been closely monitored and had been referred to a paediatrician every time that she had lost, or failed to gain weight from birth up until she was discharged to the Child Welfare Department.

The Health Visitor explained that at the time, there were no formal protocols for referring babies with excessive weight loss and hence the referral to the Paediatric Dietician. The Health Visitor further commented, that as a result of the baby's admission she had made representations to the paediatricians at St Bernard's Hospital for the creation of a protocol for a paediatric referral for babies who had not reached their birth weight by week three. This however had not materialised.

Rainbow Ward

The Ombudsman was also able to revise a statement provided by the ward sister ("Ward Sister") at Rainbow Ward who answered several questions pertaining to the nursing staff and their involvement upon the baby's admission on the 25th February 2016.

The Ward Sister explained that on the 25th February 2016, the health visitors repeatedly called the ward asking whether the Complainant had arrived. She explained that during the telephone exchanges, Rainbow Ward was not informed that the Complainant would be collecting her children from school first and commented that "*Given the medical state of the baby on admission I feel the mother is correct in raising concerns as to why the child was not sent via ambulance".* The Ward Sister further explained that at the time of the baby's admission, there was no formal policy or guidelines on breast or bottle feeding. She commented "Treatment is mainly consultant led and sometimes there are inconsistencies between consultants. There is no formal training on breastfeeding for Rainbow Ward nurses despite this being requested. We rely on support from the midwives".

The Ward Sister informed the Ombudsman that at the time the complaint was lodged, the GHA were exploring the possibility of standardised training by a Senior Nurse who had significant experience in the subject.

In reply to the allegations made about the inconsistencies in the baby's care plan ("Care Plan") throughout her admission, the Ward Sister explained that Care Plan changes were made depending on the "*success*" or "*failure*" of the existing plan, the Complainant's wish to breastfeed, nursing observations, episodes of vomiting and weight loss or gain. She commented "*Plans are reviewed daily on the ward rounds and new opinions expressed when the consultants hand over".* The Ward Sister emphasised that when admitted to Rainbow Ward, the nursing staff actively encouraged breastfeeding and EBM top-ups "*within the constraints"* of the Care Plan. She added "*Nursing staff expressed concerns to medical staff and asked for the rationale as to why the baby was not breastfed first and then offered top-ups. Eventually this plan was implemented but the baby lost weight so it continued with defined 'top-up' amounts.* She further commented "*Nursing staff advocated for breastfeeding when mum felt she couldn't express her views with the consultant*".

The Consultant Paediatrician

The Ombudsman requested comments from the Consultant Paediatrician with regard to the events which transpired on the 25th February 2016 where an investigation into the baby s' family ensued on the part of the Care Agency.

He explained that on the day of the events, at approximately 11a.m. he had received a call from the Health Visitor who was "very concerned" about the state of the baby. Given the baby s' weight and the clinical condition, as described to him, he advised that the baby be admitted to Rainbow Ward for assessment and "urgent" treatment. He further stated that he had kept in touch with the Health Visitor and had become increasingly concerned as the hours went by and the baby had not been taken to Rainbow Ward. Given that the Complainant was not contactable via telephone, and it was already late afternoon, the Consultant Paediatrician explained that the Care Agency was contacted as the GHA now "had serious concerns and this had become a child safeguarding issue". He stated "A strategy meeting was called by the Care Agency and held in Rainbow Ward.

During this meeting it was decided that the social worker and police would visit the home and bring the baby to Rainbow ward. At the end of the meeting at approximately 5.30pm the baby arrived on the ward with her parents". The family attended Rainbow Ward before the plan was put in place.

The Consultant Paediatrician described the Baby's clinical condition as being "*very poor*" on admission. He further stated "*she looked severely malnourished".* The initial diagnosis of Failure to Thrive ("FTT") was substantiated by blood, urine and stool tests as well as by an abdominal ultrasound, performed upon admission.

In reply to the Ombudsman's questions with regard to the procedures in place for bottle fed and breastfed babies, the Consultant Paediatrician explained that FFT was a condition with many possible causes and when faced with the situation, a full assessment is carried out to establish the underlying cause. He further explained that there were no formal written guidelines for the treatment of FFT and that paediatricians are consulted on a case by case basis where a joint plan is agreed with the midwives/health visitors and parents.

The Consultant Paediatrician informed the Ombudsman that there were many possible tests that could be carried out while treating babies with FTT which may involve blood tests, urine tests, x-rays, stool tests, abdominal ultrasound and therapeutic trials of specialised formulas/ medications. Nonetheless, the initial assessment involves ascertaining if the intake of milk is sufficient and whether this alone accounts for the FTT. He emphasised that this was particularly difficult to assess in breastfed babies such as was in this baby's case during the period leading up to her admission. Once she had been admitted, his main priority had been to feed her normal quantities of milk in order to assess whether or not there was an underlying medical condition or if the lack of weight gain was purely caused by a reduced intake of milk. He explained that the baby was therefore fed every three hours where her intake of milk was measured "*so that there would be no doubt after a few days if there was an issue with milk intake. I encouraged the Complainant to express her breast milk and we planned to give the Baby the expressed breast milk and top-up any deficit with formula…. On 27th Feb 2016, I noted a huge improvement in the baby s' clinical condition as a result of regular feeding. Her weight had increased by 5%.She no longer had signs of dehydration. She was much more active and able to feed better...This confirmed that the FTT was likely caused by a reduced quantity of milk intake rather than because of an underlying medical condition".*

The Consultant Paediatrician stressed in his reply to the Ombudsman the fact that all paediatricians within the GHA were pro-breastfeeding and encouraging of breastfeeding in preference to formula feeding. He also refuted the allegations made against him that he had told the Complainant that breast milk lacked nutrition as a result of a woman's age. He stated "*I have not heard this being said by any of my colleagues (nursing or medical) and I certainly would not say this myself"*. He concluded his statement by stating that he did not believe that the care provided to the Baby was inconsistent. He commented *"We managed to make her better quickly, which was our main objective".*

Clinical Advice

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 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 Senior Midwife with 37 years' experience of working within the NHS as well as being a named Midwife for Safeguarding Children.) and the replies received (which have been summarised for the purposes of this report) were as follows:

Ombudsman's Question 1

Does the expert consider from the medical notes provided that the baby was given adequate or acceptable care in relation to her weight problem?

Expert's Reply

"I consider from the medical notes provided that the baby was given adequate or acceptable care from the midwifery services in relation to her weight problem."

The expert reviewed the postnatal notes and highlighted that the following was in keeping with good practise:

- The baby was observed feeding for the first time after she was born for over thirty minutes. This indicated "*good position and attachment".* It was documented that the Complainant was provided with breast feeding support at 22.00 on 14 January and again at 00.45 where it was documented that *"no support was needed for breast feeding*".

- On the 17th January 2016, it was documented that the baby was '*mucosy*', this she stated was "*common in new born babies*" and that her Blood Glucose Monitoring which was being routinely monitored as the Complainant was a gestational diabetic, were within the normal range. She stated "*It is documented at 17.10 on 15 January 2016 that the baby was suckling well with good amounts of colostrum seen when the Complainant expressed. She was advised to feed her baby every 4 hours if she did not demand a feed which is normal routine practice for a baby who has not fed regularly. It is documented at 22.30 that the baby had been on the breast for 35 minutes and was observed to be in a good position and there is further documentation at 23.10, 02.30. 05.15, 06.30, 07.00, 08.30 and 11.00 regarding breast feeding with no concerns identified*."

- The Complainant and the baby were appropriately discharged from Maternity Ward on the 17th January 2016 since there had been no concerns identified with *"feeding*" or with the "*general well-being*" of the baby.

- The baby was routinely seen the day following discharge by the midwife who documented that the she had lost 9% of her birth weight and carried out a full assessment of well-being with no concerns. It was noted at this review that the baby showed signs of jaundice (a yellow colouring of the skin when bilirubin levels rise due to the breakdown of red blood cells). The adviser stated "*The midwife appropriately undertook a bilirubin monitoring which demonstrated it was within normal limits and in accordance with National Institute for Health and Clinical Excellence (NICE) clinical guidance 98, Neonatal jaundice May 2010. High levels of bilirubin can make a new-born lethargic and interfere with feeding. The midwife appropriately made a plan to re-weigh the baby in 2 days' time*".

- The baby was re-weighed the 19th January 2016 and had lost a further 30g which was 10% loss from birth weight. The adviser commented "*It is documented that the Complainant reported that her baby was feeding every 3 hours for up to 20 minutes. The midwife appropriately discussed this with the on-call paediatrician who advised that the Complainant continue with regular feeding and to attend the hospital for weight check in 2 days' time unless the baby's condition deteriorated.*"

- A paediatrician was appropriately notified on the 21st January 2016 when the baby was found to have lost 13% from her birth weight and advice was given for topping up with 30mls of EBM after breast feeding every 3 hours and for a weight review in two days' time.

- On the 23rd January 2016, the Baby's weight increased to 2500g and a plan was put in place to re-weigh the baby in three days' time given that the Complainant reported that the baby was feeding from both breasts for 30-45 minutes but vomited after top-up was given. She was reviewed on the 26th and again on the 27th January 2016 and asked to return on the 29th January for a further re-weight.

- On the 29th January 2016, the baby was appropriately referred to a paediatrician who advised that the Baby had to change from exclusive breast feeding, given that she was losing weight. A plan for re-weight in three days' time was appropriately put in place. The Complainant failed to attend this appointment and, given that she was not contactable, her husband was contacted instead.

- On the 2nd February 2016, the Baby was appropriately discharged to the health visitors, given that she had gained weight, looked "*healthy*" with "*good colour*" and the Complainant had reported that she was taking 45ml formula top-ups with "*some*" feeds.

The expert concluded her reply to the Ombudsman's question by stating "It is evident from the documentation that the midwifery services provided appropriate breast feeding support whilst the Complainant was in the maternity unit following the birth of her baby. There is also documentary evidence that the midwives were closely monitoring the baby weight and appropriately referred their concerns to the paediatric services in a timely way on 19th January 2016 when the baby had lost greater than 10% of her birth weight and again on 21st and 29th January 2016 when the baby failed to maintain any weight gain".

Ombudsman's Question 2

(a) Should the baby have been referred to the Paediatricians for failure to thrive at an earlier stage by the Child Health Visitors? (b) Or indeed should care have reverted back to the midwives upon noticing that discharge from Midwifery Care had taken place when baby was still under 10% of her original birth weight?

Expert's Reply

(a) "*The Child Health Visiting Services would need to respond to this question in relation to referral to the Paediatricians at an earlier stage".*

(b) "*There is no national guidance relating to whether a baby should be back to its birth weight prior to transfer and it is routine normal practice for babies to be transferred to the Health Visiting Services if they are gaining weight. Once care has been discharged from Midwifery Care to Child Health Visitors it is not normal practice for care to be reverted back. The baby had gained 70gms in weight prior to discharge to the health visitors and a clear plan was in place for the Baby's feeding regime. Health Visitors provide feeding/nutritional support for all babies from day 10 and should have the appropriate training and competencies to appropriately monitor and refer appropriately".*

Ombudsman's Question *3*

Is the expert of the view that the baby was discharged from Maternity Ward and Midwifery Care too early considering she had not regained her birth weight?

Expert's Reply

"Please see response to question 1 and 2. I consider that the baby was not discharged from Maternity Ward and Midwifery Care too early given she had not regained her birth weight".

Ombudsman's Question 4

Are there any UK established guidelines in existence in relation to procedures or tests which should have been applied or conducted given the baby's symptoms or upon discharge?

Expert Reply

"I consider that given the baby's history on discharge that there were no procedures or tests which should have been applied or conducted given the Baby 's symptoms or upon discharge from a midwifery perspective".

Ombudsman's Question 5

(a) Does the expert opine that more should have been done to support the mother's wish to breastfeed the baby considering the mother's comments that the baby was constantly *'bringing up'* after *'top ups'* were provided?

(b) The Complainant is of the view that the NICE guidance CG 37 appears not to have been followed. Does the adviser opine that this was indeed the case? And if so, was it reasonable not to have done so?

Expert Reply

(a) The expert opined that there was nothing else that should have been done to support the Complainant's wish to breastfeed the baby. She commented "There is no documentary evidence to prove that the Complainant was not supported to breast feed her baby even when she reported that her baby was not tolerating top-ups. The initial advice to breast feed 3 hourly and top-up with expressed breast milk should have supported the increased production of breast milk. The introduction of formula feed top-ups was appropriately introduced when the baby continued to lose weight, however breast feeding continued to be supported at this time…... It is evident from the documentation that the Complainant was not keen to introduce formula feed top-ups. However the health and nutrition of the baby was paramount at this stage due to her failure to gain weight following a plan of solely providing breast milk…….It is also noted that following the admission of the baby, when staff were either feeding baby or observing feeds, there is no documentation of her vomiting large amounts following feeds, although there is documentation of small possets and [that she] gained 70gms of weight [after] 2 days of admission… and regained her birth weight within 5 days of admission.

(b) "I have reviewed my original advice report, the midwifery clinical notes and the NICE Clinical Guideline 37 (Routine postnatal care of women and their babies July 2006). The NICE guidance does not provide guidance for new-born babies with excessive weight loss which was the case for the baby. Maternity Units have Infant Feeding Guidelines which include the care of babies with excessive weight loss. Excessive weight loss is routinely identified when a baby loses greater than 10% of its birth weight.

* *After receiving the initial advice, the Ombudsman contacted the Expert a second time and posed Question 5 (b).*

The NICE guidance provides generic advice for a supportive environment for breastfeeding, starting successful breastfeeding and continued successful breastfeeding which was followed by the midwives. The midwifery advice given by the midwives, which is in my original report, was appropriate in supporting the Complainant to exclusively breast feed her baby when it was identified that she had lost 9% of her birth weight as it was documented that the baby was reportedly feeding regularly and no other concerns were identified.

Again when the baby was weighed 2 days later and noted to have lost 10% of her birth weight, the midwife appropriately discussed this with a paediatrician and the Complainant advised to continue to feed her baby every 3 hours as reported and for the baby to be re-weighed in 2 days at the hospital, as per my original report. Advising regular breast feeding is routine best practice as this stimulates the production of prolactin and hopefully increase the milk supply, and support exclusive breast feeding.

As per my original report, when the baby was weighed 2 days later, she had lost 13% and the Complainant was recommended to top up with expressed breast milk every 3 hours which supports the increase in breast milk and exclusive breast feeding.

In my original report, an individualised plan remained in place in order to monitor the baby's weight and support an increase in breast milk and continue exclusive breast feeding, however the baby failed to continue to gain weight and the paediatricians recommended that the baby be given formula top up feeds.

NICE 1.3.6 states 'Formula milk should not be given to breastfed babies unless medically indicated'. It was the paediatricians who made the recommendation to top up the baby with formula feeds. The baby continued to lose weight and was eventually admitted as per my original report.

I consider that the midwives followed NICE general principles of supporting the mother to breast feed her baby, however the baby continued to lose weight even when an individualised plan was put in place and regularly reviewed. I also consider that the advice provided by the midwives, and documented in my original report was appropriate and ensured that the mother was supported to exclusively breastfeed her baby before medical advice was appropriately sought".

Ombudsman's Question 6

Is the expert of the opinion that the Royal Gibraltar Police and the Care Agency were contacted prematurely? Do there exist any welfare guidelines in this regard?

Expert Reply

"*I do not consider that the police and social services were contacted prematurely, and in this case they were appropriately informed of the professionals' concerns for the safety of the baby.* ***HM Government Working Together to Safeguard Children, March 2013*** *(https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) identifies statutory guidance for all relevant professionals to read and follow so that they can respond to individual children's needs appropriately. The document states the following;*

Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone's responsibility. Everyone who comes into contact with children and families has a role to play. Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- *Protecting children from maltreatment;*
- *Preventing impairment of children's health or development;*
- *Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and*
- *Taking action to enable all children to have the best outcomes.*

It is documented that the Complainant was advised by a Health Visitor on the morning of 25 February 2016 to take the baby immediately to the hospital for a paediatric review due to failure to regain birth weight, the baby being generally unwell and some failure of the Complainant to engage with health professionals. The Complainant did not attend the hospital when expected and there is documentary evidence that the Health Visitor tried to make contact with the complainant by phone that afternoon but without success. The Health Visitor documented that she made contact with the duty social worker to discuss her concerns.

It is documented that a strategy meeting was later held between the police and social services and an agreed plan was to visit the family and admit the baby to hospital. The Family attended the hospital at 17.30, before this plan was put into place.

Professionals had a responsibility to ensure the safety of the baby and they did not know whether the Complainant was going to attend the hospital as they had not been able to make contact……. The police would have been involved as they are the only service who have the power to remove a child in the event that parents refuse treatment for a child/baby who is at significant risk".

Conclusions

(i) The Ombudsman considered the advice provided by the Expert in relation to the alleged lack of support regarding breastfeeding. The expert summarised the position by stating that according to the medical notes "*the baby was given adequate or acceptable care".*

(ii) In relation to the complaint of lack of care by the Child Welfare Department regarding the baby´s weight problem, the Ombudsman sustained this limb of the complaint. Although he took into consideration the Health Visitor's explanations as to why the baby had not been referred to the Paediatricians at an earlier stage, the Ombudsman was very critical of the way in which the baby's weight problem appeared to have lost importance after the baby's care was transferred to the Child Welfare Department. The baby had previously been referred to a paediatrician once she had lost over 10% of her birth weight and subsequently every time she had lost or failed to gain weight under the care of the midwives, something which did not happen when weight loss was noted by the health visitors who appeared not to be aware of the fluctuations in weight the baby had had previously under the care of the midwives. It was in the Ombudsman's view that this lack of awareness adversely affected the continuation of the baby's treatment.

Additionally, the Ombudsman wished to highlight the proactive approach taken by the midwife who contacted the Complainant and called her husband's mobile phone (when unable to reach her on the 1st February 2016) in order to remind her that she had missed an appointment to re-weigh the baby the previous day.

The Ombudsman was of the view that in contrast, the Child Welfare Department did not appear to show concern at the lack of attendance to the Child Welfare Department despite the time that transpired from the 11th February to the 25th February 2016 (thirteen days) where the Complainant had not attended to have the baby weighed. This in the Ombudsman's opinion could have proven fatal had the Complainant not attended the Child Welfare Department on the 25th February 2016. However, the Ombudsman noted that as a responsible adult and mother who was fully aware of the struggles that the baby had endured with her weight since birth, the Complainant had a responsibility to take the baby to the weight clinic so that she could be weighed and monitored regularly yet this in the Ombudsman's view in no way absolved the GHA from its prime responsibility to monitor the baby's progress.

(iii) With regards to the alleged discrepancy in treatment during the baby's stay at the ward, the Ombudsman accepted the explanations offered by the Consultant Paediatrician and the comments from the Ward Sister that Care Plan changes were made depending on the "*success*" or "*failure*" of the existing plan. The Ombudsman also considered the Expert's clarification of the NICE guidance regarding to breastfeeding and noted how these would cease to apply in the presence of a tailored medical plan.

(iv) Finally, in relation to the allegation that the RGP & Social Services were unnecessarily and prematurely involved in the afternoon of the 25th February 2016, the Ombudsman did not sustain this limb of the complaint given that, the medical professionals had a duty to inform both the RGP and Social Services as they are the two entities empowered to intervene in situations where children are involved.

Classifications

(i) Alleged lack of support in relation to breastfeeding – Not Sustained

(ii) Alleged lack of care towards the Baby´s weight problem – Sustained

(iii) Alleged discrepancy in treatment during ward stay – Not Sustained

(iv) Alleged unnecessary involvement of the RGP & Social Services – Not Sustained.

Recommendations

(i) The establishment of a clear discharge plan for babies who have not regained their birth weight before being discharged to the Child Welfare Department.

(ii) The creation of a protocol for a paediatric assessment of babies who fail to gain their birth weight by week three as suggested by the Health Visitor.

Update

Subsequent to the drafting of this report, the Ombudsman received an email from the Child Welfare Department stating that they had not offered any immunisation on the 12th February 2016 as stated in the Ombudsman's report (Page 5). They explained that the Baby had not been administered vaccinations at the Child Welfare Department until April 2016 after her discharge from St Bernard's Hospital. The Ombudsman therefore asked the Medical Director for clarification in order to ascertain which medical professional had administered the Baby with the BCG immunisation on the 12th February 2016. The Medical Director explained that it was indeed the midwives who administered the BCG immunisation in St Bernard's Hospital and commented that the midwives would have been limited to administering the BCG immunisation and would not have had any input into weight issues after the handover to the Child Welfare Department. The information received, in the Ombudsman's opinion, only substantiated the above recommendations in view of the lack of communication between both departments.

(Report extracted from HEALTH CS 2016-29)

GIBRALTAR HEALTH AUTHORITY

Case 7

Complaint

The Complainant was aggrieved as a result of the following allegations:

(i) In June 2016 the Complainant contacted the Community Mental Health Team ("CMHT" about a change she noted in the Patient and was informed of Patient's weight loss. Complains that CMHT did not contact her to notify her of the Patient's weight loss;

(ii) CMHT did not visit the Patient or contact her during the ensuing week;

(iii) CMHT did not carry out regular visits to the Patient's home;

(iv) Delay on the part of CMHT in arranging an appointment for the Patient with a General Practitioner ("GP");

(v) Further to GP appointment, Complainant states CMHT did not contact her to provide feedback;

(vi) Complainant contacted CMHT for assistance but complains about the way in which they handled the situation, considering how sick the Patient was;

(vii) Complains that the Patient's psychiatrist was prescribing oral antipsychotic drugs which the Patient could not swallow because he had been diagnosed with Metastatic Advanced Oesophageal Cancer. As a result, the Complainant states the Patient's mental condition was being left untreated.

(viii) Complainant states during the Patient's time in hospital there was little or no communication between CMHT and the hospital.

(ix) GP did not request urgent ultrasound despite considerable unexplained weight loss; Patient's condition worsened and Complainant's husband ("Husband") called for an ambulance. According to the Husband, ambulance crew refused to attend to the call because of the Patient's mental condition;

(x) Patient's condition worsened and Complainant's husband ("Husband") called for an ambulance. According to the Husband, ambulance crew refused to attend to the call because of the Patient's mental condition;

(xi) Complainant called for an ambulance a second time and claimed she had to convince them to attend to the call;

(xii) Complainant claimed that the ambulance crew handled the Patient in a rough and insensitive manner;

(xiii) Complainant stated that ambulance crew did not offer her the option to accompany the Patient in the ambulance transfer;

(xiv) Patient not examined by the GHA's Accident & Emergency ("A&E") Doctor on duty ("Doctor");

(xv) Patient discharged from A&E and sent home in a taxi, shortly after Complainant left A&E with the object of the Patient's admission into hospital;

(xvi) Complainant not notified of the A&E discharge of the Patient;

The Complainant explained to the Ombudsman that the Patient had suffered from paranoid schizophrenia for the past thirty years and that he had passed away in September 2016 at the age of 58 from metastatic advanced oesophageal cancer. The Complainant was aggrieved because of the GHA's alleged failure to identify how sick the Patient was and for the treatment afforded to him in the last months of his life.

She explained that the Patient had lived with their mother until she was hospitalised in early 2015 and shortly after admitted into long term care. The Complainant lived in an apartment in a block of flats and the Patient lived in the apartment block adjacent to hers. According to the Complainant she took great care of the Patient, ensuring that he attended to his daily hygiene, took his medication, the flat was clean, etc. and provided him with cooked meals daily. The Complainant stated that the Patient was a very nice man but very much a loner.

In June 2016, in one of her daily visits, the Complainant noticed a change in the Patient's facial expression. Feeling there was something wrong with him she contacted staff at the CMHT with her concerns. She spoke to a male nurse and claimed he responded that he doubted it was a mental problem as the Patient had been to the CMHT the week before and blood test results were fine (Ombudsman Note: Statement by CMHT Staff under 'Investigation' expands on this statement) . The nurse informed her that the difference she had seen in the Patient was that he had lost 6kgs. The Complainant was aghast at the fact that CMHT had not informed her of the weight loss and alleged the nurse responded that they were there to deal with mental health problems and not physical ones. The Complainant was surprised to hear that comment from a nurse, especially because for many psychiatric patients, CMHT was the only point of contact with the health service.

Subsequent to the above, the Complainant was shocked that CMHT neither contacted her or visited the Patient to check up on him during the following week.

Shortly after the telephone conversation and because of the Patient's alarming weight loss, the Complainant contacted CMHT on two more occasions, in desperation that there was something very wrong with the Patient and it was not being addressed (by way of background information, the Complainant stated she had been a nurse for forty years and so had her Husband) and requested and later demanded that someone at CMHT take him to see a General Practitioner ("GP"). The Complainant explained to CMHT she had offered to accompany the Patient to a GP but he had declined her offer; she felt that if CMHT tried to convince him to go to a GP he would cooperate with them. They agreed to arrange the appointment but the Complainant stated that by the time that was done, the Patient had lost another 4kgs. In a six week period he had lost 10kgs and there was a sunken look in his eyes; he looked very sick.

A member of CMHT accompanied the Patient to the GP appointment at the end of July but no one contacted the Complainant with the outcome and so she telephoned CMHT and was told that the diagnosis had been that he had a 'bug' (virus or infection) and the GP had prescribed antibiotics and a stomach acid secretion reduction medication. The GP had requested an ultrasound examination but no urgency had been given to the request. The Complainant was frustrated and felt impotent that no one was seeing how sick the Patient was.

Due to personal medical reasons, the Complainant was away from Gibraltar for two weeks (around end July beginning August 2016) and when she returned, claimed the Patient was suffering from constant vomiting and diarrhoea; he was mentally disturbed and the flat was in a complete mess. The Complainant pointed out that CMHT had not visited the Patient during that two week period. On the 8th August 2016, considering the Patient's medical situation to be very serious, she asked her Husband to call for an ambulance whilst she attended to the Patient. According to the Complainant, the ambulance crew refused to attend to the callout because of the Patient's mental condition, despite the Husband having informed them of the seriousness of the Patient's physical condition. The Complainant herself then called for the ambulance and claimed to have been further interrogated before she was able to convince them to dispatch an ambulance. When the ambulance crew arrived, the Complainant was appalled at the fact that they had not brought a chair or stretcher but rather "...grabbed him from under the armpits...and carried him away dragging his feet on the floor...". Furthermore, she claimed they did not ask her if she had transport or wanted to accompany the Patient considering his mental condition [Ombudsman Note: Subsequently, the Complainant stated that as she was leaving the Patient's home and was about to lock the main door, the key broke inside the lock and that delayed her departure]. The Complainant alleged that throughout her nursing career she had never seen a patient handled in such a rough and insensitive manner.

Once at A&E, the Complainant claimed the Doctor did not examine the Patient but rather decided after he was administered with intravenous medication (stomach acid secretion reduction and hydration) that all he required was a hydration drink and could be discharged. Aware of how sick he was and the fact that he lived alone, the Complainant, in order to force the Patient's admittance into hospital refused to take him home and left the hospital in order to force the Patient's admission. It transpired that shortly after she left, A&E staff put the Patient into a taxi and sent him home without informing her.

The following day, the Patient was still feeling very sick. The Complainant contacted CMHT in desperation and it was agreed that the psychiatrist would see the Patient. The Complainant once again felt that the system had failed because CMHT contacted the Patient directly and did not notify her. As such, the extremely sick Patient was made to go to CMHT on his own where he was seen and urgently sent to A&E unaccompanied and without the Complainant being informed.

The Patient was admitted on the 10th August 2016 and six days later diagnosed with metastatic advanced oesophageal cancer. This diagnosis explained to the Complainant the reason for the dramatic weight loss and the deterioration in his mental state; he was unable to swallow so could neither eat nor have his medication (the Complainant claims to have found three months supply of Clozapine (drug administered for schizophrenia) at home). According to the Complainant, Clozapine was only available in oral form and in view of the Patient's condition, the Complainant asked the ward staff to contact the psychiatrist for a substitute drug. Under the circumstances, the Complainant could not understand how she could have been informed that the 'blood Clozapine levels' were within normal range.

The Complainant stated that on the 29th August 2016 when she arrived in hospital she found the Patient very agitated, vomiting, screaming, somewhat aggressive and threatening to kill himself. Once again the Complainant approached ward staff to ask the psychiatrist to prescribe medication to calm him down and she was dismayed that he prescribed crushed Diazepam to someone who suffered with occlusion of the oesophagus. The Complainant asked the ward charge nurse to call for a multidisciplinary meeting for a plan of care to be put in place for the Patient. The Complainant felt there was little or no communication between the various GHA departments. When she returned home, the Complainant contacted CMHT and asked that the psychiatrist treating the Patient be replaced by another. The Complainant claimed CMHT acceded to the request and assigned another.

On the 31st August 2016, the Patient was sent to a tertiary referral unit and had an oesophageal stent inserted as a palliative procedure for his condition. The Patient passed away on the 24th September 2016.

Investigation

Complaints against CMHT

(i) In June 2016 the Complainant contacted CMHT about a change she noted in the Patient and was informed of Patient's weight loss. Complains that CMHT did not contact her to notify her of the Patient's weight loss;

(ii) CMHT did not visit the Patient or contact her during the ensuing week;

(iii) CMHT did not carry out regular visits to the Patient's home;

(iv) Delay on the part of CMHT in arranging an appointment for the Patient with a General Practitioner ("GP");

(v) Further to GP appointment, Complainant states CMHT did not contact her to provide feedback;

(vi) Complainant contacted CMHT for assistance but complains about the way in which they handled the situation, considering how sick the Patient was;

(vii) Complains that the Patient's psychiatrist was prescribing oral antipsychotic drugs which the Patient could not swallow because he had been diagnosed with Metastatic Advanced Oesophageal Cancer. As a result, the Complainant states the Patient's mental condition was being left untreated.

(viii) Complainant states during the Patient's time in hospital there was little or no communication between CMHT and the hospital.

The Ombudsman sought statements from CMHT nursing staff and the consultant psychiatrist ("Psychiatrist") in respect of the Complainant's allegations.

CMHT NURSING STAFF

Nursing staff provided the Ombudsman with background information on the Patient's medical history. He was diagnosed with paranoid schizophrenia approximately thirty years ago and eventually maintained on 'Clozapine' (an atypical antipsychotic medication mainly used for schizophrenia that does not improve following the use of other antipsychotic medications). They explained that it is a requirement when treated with Clozapine that there is strict monitoring to ensure that the benefits of the drug outweigh the risk of severe neutropenia (an abnormally low level of neutrophils which are a common type of white blood cell important in fighting off infections). The monitoring involves regular blood tests (usually monthly) and identifying possible side effects including weight gain, appetite increase, drowsiness, high blood pressure, breathing difficulty, confusion, constipation, temperature and joint weaknesses.

The Patient was reviewed on a regular basis by the consultant psychiatrist and a nurse at the Clozapine Clinic. According to the nursing staff, the Patient remained mentally stable throughout the last few years with full capacity to make decisions regarding his wellbeing. He was a private person who resisted any attempt to involve his family in his care as he chose to do that for himself and respecting that decision, no contact was made by CMHT with his family over the last few years. Neither was there contact from the family with CMHT during that time. CMHT stated that the Patient resisted advice and attempts from them encouraging him to visit his GP. At his review on the 20th June 2016 it was recorded that he was losing weight and he was strenuously advised to visit a GP for a check up to which the Patient agreed. According to nursing staff, the Complainant contacted CMHT about a week after the last review, voicing her concerns about the Patient's health. She was informed that he had been reviewed and there was no concern for his mental health and that he had been advised to consult his GP for a physical check up regarding his weight loss. Two weeks later, the Complainant again contacted CMHT concerned about the weight loss and informed them that she had offered to take the Patient to see a doctor but he had refused. She was informed that a member of the CMHT would contact the Patient and implore him to see a GP. The Patient initially refused the intervention but was eventually persuaded and agreed to attend an appointment with a GP at which an ultrasound scan appointment was requested. CMHT later learned that the Patient's physical health had deteriorated and he had attended A&E and remained unwell. The Patient was contacted and asked to attend CMHT to be assessed by the consultant psychiatrist where it was found that his mental state was stable. As the weight loss continued he was sent to the hospital with a recommendation that he be admitted for further assessment of his physical state. He was taken to A&E by ambulance accompanied by a CMHT nurse and was admitted later that same day (10th August 2016).

PSYCHIATRIST

The Psychiatrist stated he had looked after the Patient since 2007 except for brief periods when other colleagues had attended to him and they had always maintained a friendly and respectful relationship. The Psychiatrist added that the Patient was a pleasant and polite gentleman whom he was really fond of and it was very sad for him and his team to have learned about the Patient's diagnosis and death. He explained that the Patient had suffered from 'treatment resistant paranoid schizophrenia' but had responded well to Clozapine which is indicated in treatment resistant cases.

The Patient had been free of psychotic symptoms for most of the time although he presented frequently with very mild thought disorder which manifested as hesitance in speech and difficulties in organising and expressing his thoughts. Despite that residual symptom, most of the time, the Patient had insight and maintained capability to make his own decisions except for very brief periods of relapses when he had had to stop Clozapine, and at the last stage of his life when he was diagnosed with metastatic oesophageal carcinoma.

The Psychiatrist highlighted that when a patient stops Clozapine their mental health condition is affected within 48 hours. When the Clozapine is reintroduced this is done by slowly increasing the dosage. In the Patient's case, the schizophrenia was in remission because of the Clozapine.

By way of insight into the Patient's relationship with his family, the Psychiatrist provided information on several of the Patient's past admissions to both the psychiatric and general hospital and described how in a 2011 admission, the Patient had been initially paranoid with his family until his mental state improved. According to the Psychiatrist, the Patient admitted to feeling over-controlled by his family and becoming frustrated as a result. Although the Patient generally maintained a good relationship with his family he was very private and independent and was not willing to involve his family in his care; as such, he always attended the Clozapine clinic on his own. The Patient resided with his mother for most of his life until she was put into long term care around March 2015.

The Psychiatrist provided a summary of notes dating back to January 2015 of the Patient's monitoring in the Clozapine clinic since January 2015. The first weight loss of 4.2 kg in the course of two months was recorded in March 2015, coinciding with the Patient's mother's admission to long term care. The Patient told the Psychiatrist he had started a diet and increased exercise. In May 2015 he lost 1.4kg in two months and up to March 2016 lost slight amounts of weight. It was on the 20th May 2016 when a loss of 6.5 kg in two months was recorded. The Psychiatrist's notes stated that the Patient claimed to be eating well but doing more exercise and that was the reason for the weight loss. Notwithstanding, the Psychiatrist requested extensive blood tests.

On the 15th June 2016, the Complainant called CMHT and was informed of the blood test results and the recommendation made for the Patient to see a GP. The Complainant was unhappy and expressed that someone should take the Patient to see the GP. She was told that CMHT could not force the Patient to go and see the GP but he had been advised and was being encouraged to do so. An appointment was made at the CMHT for the **22nd June 2016** for the Patient's mental state to be reviewed. At that appointment which the Patient attended alone as always, he told the Psychiatrist that he had had an upper airways infection (Psychiatrist stated there was no sign of current infection) had been eating well and denied gastrointestinal symptoms other than heartburn. He had lost **10.65kg** in one month which might be explained by the infection and loss of appetite as a result. The Psychiatrist noted that progress would be monitored and the Patient would be reviewed on the **15th July 2016**. At that appointment a further weight loss of **5.9kg** was noted which the Patient attributed to doing more exercise and the recent infection. The Patient appeared much thinner but still well kempt and told the Psychiatrist he felt physically strong. The Psychiatrist stated that the Patient had no psychotic or affective symptoms and was stable in his mental state. The Clozapine dose was reduced and the Psychiatrist requested that the CMHT arrange an appointment with the Patient's GP in the course of the coming week, accompanied by a nurse, for the investigation of significant weight loss, anaemia and possible infection. A blood test was requested. A week later, the Complainant contacted CMHT to complain that they were not affording her brother enough care and was unable to go and see a GP on his own. She also stated that the Patient was refusing for her to accompany him to the GP. She was informed that a CMHT nurse had tried to organise an appointment with the GP but because the health card had expired he was not given an appointment.

The Complainant was asked to assist with the renewal of the health card (this coincided with the Complainant leaving Gibraltar for two weeks) and it was CMHT who finally managed to arrange the appointment. On the 28th July 2016 the Patient visited the GP accompanied by a CMHT nurse. An ultrasound scan was requested and antibiotics and increased stomach protection medication prescribed. He was described as being well and appropriate during that visit. The Psychiatrist stated that the Patient had the capacity to make his own decisions and tell the Complainant or not about what he had been told at the GP visit.

On the 9th August 2016, CMHT received a call from the Complainant raising concerns that the Patient lived on his own and might not have been eating well and not taking his medication appropriately. She explained that he had been to A&E the previous day and sent home but she believed he was ill and should be in hospital. CMHT nurse immediately discussed the case with the Psychiatrist and an urgent review arranged for the next day. The Psychiatrist reviewed the Patient and noted that the current main problem was that the Patient was unable to tolerate food and was vomiting, he had difficulty swallowing, was feeling weak and pale and had lost 11.9kg in the last month. The Patient had a history of subacute intestinal occlusions secondary to intestinal adherences and incisional hernia. The Patient was sent to A&E by ambulance accompanied by a CMHT member of staff for investigations to be carried out. Mental state was stable. The Patient was admitted to the general hospital.

The Psychiatrist explained that the powers under the Mental Health Act can only come into effect if a patient is a risk to himself or/and others and that was not the Patient's case. The latter had valid excuses for the weight loss which started around the time of his mother's admittance into long term care. Furthermore, the Psychiatrist stated that because one of the side effects of Clozapine can be weight increase, they encourage patients to lose weight. It was after the Psychiatrist noted significant weight loss in a relatively short period of time without a convincing explanation that he advised the Patient to go and see his GP and offered a CMHT member of staff to accompany him but clarified they could not force a patient to visit a GP.

He also pointed out that their field of expertise is quite defined in the context of mental health vis a vis physical health and gave the example of a mental health patient with high blood pressure in which case they could not prescribe blood pressure medication because that came under the GP's remit. The Psychiatrist pointed out that it was important to understand that the Patient had insight and capacity until after he was admitted to the general hospital near the end of his life. He was a very independent and proud man and even though he maintained a good relationship with his family most of the time, he wanted to maintain his independence and did so for most of his life excepting the periods when he relapsed in his mental illness. The Patient had always attended appointments alone and was always informed of the recommendations and findings at those attendances; as an adult person with full capacity it was his decision on whether to inform his family or not.

The Psychiatrist further added that families have expectations, patient groups pressure for patients rights and patients undoubtedly have their rights and he explained that mental health services have to abide by the rules; they have to respect the autonomy and independence of patients. In the Patient's case, despite being close and loving his family he always kept them away from his mental health care. No family member ever accompanied him to a review because he did not want them to. In cases where the family accompanies a patient they are naturally involved and included in the patient's consultation but that was not the Patient's case.

The Psychiatrist provided detailed notes of the Patient's psychiatric and physical reviews undertaken by psychiatrists and doctors throughout his stay at the general hospital (from 10th August to 24th September 2016 when the Patient passed away). The Psychiatrist stated that during the length of his admission at the general hospital, the Patient was on a liquid diet. He was taking liquid nutritional supplements prescribed by a dietician and took liquid medication as he did not have complete occlusion of the oesophagus. He could not tolerate solid food but it was reported that at some points he managed to obtain and ingest solid food which resulted in an obstruction being caused and more intense episodes of vomiting.

On the 18th August 2016, diagnosis of "...poorly differentiated carcinoma of oesophagus.." was confirmed, as a result of which the Patient was referred to a tertiary referral unit for a stent to be inserted by way of palliative procedure which was undertaken on the 30th August 2016 with the Patient returning to the general hospital on the 31st August 2016. The successive medical notes report the problems the Patient suffered with regards to swallowing and liquid diet due to the cancer and the fact that the medication, Clozapine, which had for many years been effective in stabilising his schizophrenia was not being absorbed appropriately and was making the Patient distressed and paranoid. According to the Psychiatrist, Clozapine was the only treatment for 'treatment resistant schizophrenia' and was not available in either liquid form or injection only oral so the Clozapine tablets were being crushed, mixed in liquid and administered orally. In the course of the ensuing weeks, the Patient stabilised and on the 22nd September 2016 the medical staff considered transferring the Patient to the mental health hospital with a view to eventually going home. Sadly, the Patient deteriorated the following day and passed away on the 24th September 2016.

Regarding the Complainant's allegation that she had found three months supply of Clozapine in the Patient's home, the Psychiatrist stated he could not comment on the amount of medication she claimed to have found or the level of supervision she had on him. He stated that the Patient always claimed to have been concordant with medication and that is substantiated by the fact that his mental state had been preserved until his final admission to the general hospital; i.e. a highly indicative sign that he must have been taking and being able to swallow the medication although struggling with solid food for some time.

In response to the Complainant's statement that she had contacted the CMHT and asked that the Psychiatrist be replaced with another to which CMHT acceded, the Psychiatrist explained that even though he had been the Patient's consultant, there were arrangements for distribution of work within the psychiatric department, with each consultant having areas of special interest and responsibility. By the time the Patient was admitted to the general hospital it was P2 who had responsibility for liaison psychiatry which mainly involves the care of patients admitted to the general hospital who also present with mental health problems. As such, P2 was the psychiatrist involved in the Patient's care throughout his admission except for interventions by the consultant on call outside normal working hours or periods when P2 was on leave.

Regarding the complaint that the Patient was prescribed oral antipsychotic drugs which he could not swallow, resulting in the mental condition being left untreated, the Psychiatrist stated he was called into the general hospital on the 29th August 2016 to assess the Patient. According to the Psychiatrist he had threatened with self harm, had collapsed when walking out to smoke, had been vomiting and was suspicious and paranoid but not suicidal. He was very angry about not being allowed solid food and being given regular injections of Haloperidol (antipsychotic medication) twice a day. He had no insight and no capacity. In view of the irritation with the regular injections, the Psychiatrist advised to discontinue those on a daily basis and to administer them only as required. The Patient was being given Haloperidol Decanoate (long acting antipsychotic) every two weeks which was not discontinued. The Psychiatrist prescribed Olanzapine Velotab (an antipsychotic that dissolves in the mouth) 20mg at night and regular doses of Clozapine, crushed and dissolved in liquid (as there is no liquid form of this medication). He also prescribed Diazepan liquid 5mg three times a day and Lorazepam 1 mg intramuscular up to three times a day as required for agitation.

The Psychiatrist also recommended that the Patient be placed on one to one care by a nurse assistant, have his weight checked weekly and get his oesophageal transit resolved with palliative stent or via a PEG (Percutaneous endoscopic gastrostomy – surgical procedure for placing a feeding tube) as a priority in respect of diet and the absorption of medication, particularly as Clozapine was the best option to control his mental illness and could only be administered orally.

On the issue of house visits to the Patient by CMHT, the Psychiatrist stated that the circumstances of his case did not warrant house visits as he had full capacity to manage on his own and had family support.

Complaints against the Ambulance Service

(x) Patient's condition worsened and Complainant's husband ("Husband") called for an ambulance. According to the Husband, ambulance crew refused to attend to the call because of the Patient's mental condition;

(xi) Complainant called for an ambulance a second time and claimed she had to convince them to attend to the call;

(xii) Complainant claimed that the ambulance crew handled the Patient in a rough and in sensitive manner;

(xiii) Complainant stated that ambulance crew did not offer her the option to accompany the Patient in the ambulance transfer;

In relation to the complaints above, the Ombudsman sought statements from the GHA's Chief Ambulance Officer ("CAO"), ambulance staff involved in the transfer of the Patient, recordings of the calls made by the Complainant and her husband to the Gibraltar Fire & Rescue Service ("GFRS") (tasked at the time with receiving telephone calls to request ambulance services) and statements from the GFRS operators.

CHIEF AMBULANCE OFFICER ("CAO")

The Ombudsman met with the CAO in relation to the complaints made against the ambulance service ("AS").

The CAO, in order to provide some insight on how the system works, stated that there were three different telephone numbers via which an ambulance could be requested:

(I) 190 call would be answered by the GFRS (and calls recorded);

(ii) 112 in which case the call would be answered by the Royal Gibraltar Police;

(iii) GHA call centre and call transferred to the AS.

The Complainant and her husband could not recall what number they had contacted but the CAO nevertheless asked GFRS to check if the call had been made to them and whether the recording was available (Ombudsman Note: The call had been made to 190 and the recording was provided).

Regarding procedure followed by the AS in cases of mental health patients requiring assistance, the CAO stated they followed JRCALC Guidelines (Joint Royal Colleges Ambulance Liaison Committee - the same as are followed in the United Kingdom). Ambulance crews attend a call and it is after examination that they decide if the patient requires to be taken to A&E in which case the patient is transferred. In cases where the patient resists and desperately needs medical attention, the Mental Welfare Officer is contacted for advice and attendance on the scene if required.

About the manner in which the Complainant alleged the Patient was taken to the ambulance, the CAO stated he would make arrangements for the Ombudsman to meet with ambulance crew involved. Regarding not having taken the Patient down in either a stretcher or wheelchair, the CAO stated that ambulance crew usually assess a situation and decide if the patient can walk to the ambulance or needs to be taken. In the Patient's case, the CAO referred to the emergency ambulance's patient clinical record which noted that the Patient was fully mobile and walked to the ambulance aided by ambulance crew.

MEETING WITH AMBULANCE CREW

The Ombudsman met with one of the two ambulance crew members ("AC") who transferred the Patient on the 8th August 2016.

The AC stated that at that attendance an assessment of the Patient was carried out and recorded. The Patient stated he felt dizzy but AC assisted him to the ambulance as he was fully mobile. To further substantiate the Patient's mobility, AC pointed the Ombudsman to the fact that the Complainant had informed them (denoted in Patient's emergency ambulance medical record) that she had stopped the Patient from going to hospital on his own as he was feeling dizzy. AC added that there are always two persons in the AC and in situations such as the aforementioned there has to be consensus on decisions.

Regarding AS attendance to patients who suffer from mental health problems, the AC stated that was dependent on the patient's history. In cases where the patient was violent or aggressive and known to AS they would be escorted by the Royal Gibraltar Police.

TELEPHONE CALLS TO GFRS FOR AMBULANCE

The Ombudsman heard the recordings provided by the GFRS in respect of the two phone calls made; one by the Husband and the other from the Complainant. The duration of the first call was one minute forty five seconds. The Husband explained that his wife (the Patient's sister) was with the Patient in his house (address provided but no name). He then informed the GFRS that the Patient was schizophrenic but that was not what he was suffering from presently. He explained they had been trying for a long time for him to go to hospital and see a doctor but that in the last few weeks had lost a lot of weight. They had called a GP to discuss the situation and she had told them he needed to be admitted to hospital as she could not do anything for him. The Husband added that the Patient "...looked like death warmed up". The GFRS responded that he was calling the emergency ambulance and they could not force anyone to go to hospital. The Husband responded that it was an emergency as he thought the Patient was going to die as he was feeling so ill. Again GFRS responded they could not force anyone to go to hospital and then asked the age of the Patient. The Husband responded he was around fifty years old and GFRS reiterated their earlier response now also taking into account the Patient's age and the fact that he was a mental health patient.

The GFRS voiced their concern that the AC would attend and find that the Patient was experiencing a psychological problem and did not want to be taken to hospital. The Husband stated the problem was physical and he was dying and GFRS asked the Husband for the telephone number. The Husband provided his telephone number but when asked who was with the Patient and told it was the Complainant, GFRS asked for her number. The Husband provided the number but GFRS asked that he repeat it a little slower. The Husband repeated the number at the same speed stating that he had lost his patience and telling GFRS not to worry and hung up.

The duration of the Complainant's call to GFRS was one minute thirty three seconds. She stated her name and the fact she was calling on behalf of the Patient (name and address provided) to request an ambulance. GFRS asked what was wrong and she informed them that he was very sick, had lost a lot of weight and been vomiting and suffering from diarrhoea and appeared to have an obstruction. GFRS asked what doctor had seen him and the Complainant stated he had been seen by a GP a week ago but his condition had worsened and when she called the duty GP, because she knew the Patient, she had been advised he needed to go to hospital. GFRS enquired about any other ailments and the Complainant responded he was dizzy and very sick, adding that she had been a nurse for forty years. GFRS again asked for the Complainant's name which she repeated and asked GFRS for his which he provided. Complainant told GFRS that they were wasting too much time to which GFRS replied that they had to note the details down. She provided address and phone number and then told that the ambulance was being dispatched.

A&E ATTENDANCE & DISHCARGE

(xiv) Patient not examined by the GHA's Accident & Emergency ("A&E") Doctor on duty ("Doctor");

(xv) Patient discharged from A&E and sent home in a taxi, shortly after Complainant left A&E with the object of the Patient's admission into hospital;

(xvi) Complainant not notified of the A&E discharge of the Patient;

The Doctor provided a detailed account of the Patient's attendance at A&E on the 8th August 2016. He was brought in at 18:30hours, triaged and placed in one of the observation cubicles and assessed by the Doctor thirty minutes later. According to the Doctor all observations were within normal limits except pulse which was around 100bpm. The Patient's general condition was acceptable although he was very slim, mildly dehydrated and pale. The differential diagnosis was infectious gastroenteritis and mild acute renal failure likely due to dehydration. The Patient felt better after intravenous medication was administered (fluids, antiemetic, painkillers and antibiotic) and wanted to go home. He was no longer vomiting, oral tolerance was good as evidenced by oral juice but Complainant was demanding admission for him to recover in hospital which he refused. The Complainant and Patient had a big argument after which she left A&E. The Patient was prescribed medication and discharged to follow up treatment by his GP. He was given verbal advice and told to return if there were any further problems. A taxi approval form was completed and the Patient left A&E around 21:30hours.

In response to the Complainant's allegations, the Doctor clarified that hydration was not the only thing the Patient needed but it was a very important part of the treatment which patients frequently forgot. The Patient was already on antibiotics prescribed by the GP and at A&E he was given intravenous medication and prescribed a second antibiotic and an antiemetic (a drug effective against vomiting and nausea) to complete the treatment and palliate his symptoms.

In respect of the Complainant's refusal to take the Patient home, the Doctor stated she did not doubt the Complainant was acting in the Patient's best interest but there was no criteria for admission at that moment as his examination was acceptable, there was no fever, no surgical abdomen, bloods were not bad and the Patient was feeling better and tolerating fluids after treatment. Furthermore, the Patient did not want to stay in hospital and he was in full possession of mental capacity to make decisions and he decided to try and recover at home and see his GP to review progress and continue further investigations. A&E offered to arrange for a taxi to take him home; the Complainant had left after an argument between them and the Patient had no money on him at that time. Regarding not having informed the Complainant of the Patient's discharge, the Doctor reiterated the Patient was a capable adult and A&E had no reason to contact the Complainant about anything related to his A&E attendance. More so, the Doctor stated they could have incurred in a legal fault in violating patients rights in relation to data protection.

GP

GP did not request urgent ultrasound despite considerable unexplained weight loss

The GP provided a statement to the Ombudsman in respect of the Patient's visit on the 28th July 2016. The appointment was requested by the mental welfare officer as a check on the Patient's general health and concern about some weight loss. The Patient complained of heartburn, abdominal bloating for the past six weeks and some diarrhoea, and it was only after close questioning that he found out the Patient had lost 10kgs because he was not eating as he did not feel like it. The Patient did not mention any vomiting. The GP stated that the abdominal examination was unremarkable and the Patient did not look clinically unwell or cachectic (relating to or having the symptoms of cachexia which is weakness and wasting of the body due to severe chronic illness). The GP prescribed antibiotics on the basis that the most likely diagnosis was gastroenteritis due to not eating and diarrhoea, but advised that the weight loss was enough for an ultrasound of the abdomen to be requested to ensure nothing else was going on. The GP routinely advised the Patient to return to see him if he did not get better. The GP stated that the reason for the ultrasound was a safety netting investigation and not because the Patient presented clinically unwell; the ultrasound was therefore requested as routine investigation (appointment made for the 12th September 2016) as the presentation did not warrant an urgent ultrasound. The GP stated that the Patient did not request that the GP discuss the results of the consultation with anyone else.

According to the GP, the only red flag was the weight loss; the other symptoms warranted the appropriate treatment. He stated that was the first time he had met the Patient so he had no comparison with previous attendances that could indicate weight loss. Additionally, he highlighted that he was unable to discuss the Patient's case with a family member or anyone else without the Patient's express permission. The GP confirmed that the Patient attended the appointment unaccompanied.

Conclusions

(i) <u>In June 2016 the Complainant contacted CMHT about a change she noted in the Patient and was informed of Patient's weight loss. Complains that CMHT did not contact her to notify her of the Patient's weight loss</u>

From the information provided by the various parties it can be established that the Patient's schizophrenia was in remission and he was deemed to be mentally stable with full capacity to make decisions. Under those circumstances, medical professionals had no authority or obligation to contact the Complainant to discuss the Patient's case and it would therefore have been up to the Patient to inform relatives of his medical situation if he chose to.

Furthermore, the Psychiatrist who regularly attended to the Patient and had done so for approximately nine years stated that it was the Patient's decision not to involve his family in his care. As such, no family member ever accompanied him to a review. The Psychiatrist stated that in cases where the family accompanies a patient they are naturally involved and included in the patient's consultation but that was not the Patient's case.

(ii) CMHT did not visit the Patient or contact her during the ensuing week

(iii) CMHT did not carry out regular visits to the Patient's home

The Psychiatrist's evaluation of the Patient's circumstances deemed that his case did not warrant house visits as he had full capacity to manage on his own and had family support. Furthermore, the Ombudsman found no evidence in the Patient's CMHT/GHA records of any requests made by the Patient, family or any other party to the effect that due to the Patient's mother's hospitalisation, house visits were required.

(iv) Delay on the part of CMHT in arranging an appointment for the Patient with a General Practitioner ("GP")

(v) Complainant contacted CMHT for assistance but complains about the way in which they handled the situation, considering how sick the Patient was

In June 2016, after the second consecutive substantial weight loss, the Psychiatrist told the Patient that he should see a GP and in July 2016 after further weight loss finally convinced the Patient to see a GP and an appointment made. The delay on the part of CMHT in arranging the GP appointment was due to the Patient's health card having expired but a GP appointment was finally made and the Patient seen on the 28th July 2016 (thirteen days after seeing the Psychiatrist).

The Ombudsman does not find that CMHT failed in their duty of care to the Patient but rather, considering the circumstances of the Patient's condition whereby he was deemed to be a capable adult who could make his own decisions, provided advise to the effect that he should see a GP in respect of the weight loss and the possible infection detected in June 2016 blood tests. How CMHT handled the situation is similar to how the Complainant tried to convince the Patient to see a GP but the decision ultimately rested with him as no one could force him to do so.

(vi) Further to GP appointment, Complainant states CMHT did not contact her to provide feedback

It was the Patient's decision not to involve his family in his care as he chose to do that for himself and in keeping with his decision, CMHT did not consider contacting the Complainant.

The Ombudsman's investigation established that despite the diagnosis of paranoid schizophrenia, the Patient's condition was in remission as a result of medication. As such, the Patient was deemed by medical professionals to be a capable adult who was able to make his own decisions. Starting from this position, CMHT could not force the Patient to see a GP. Notwithstanding, the Patient was being regularly monitored by CMHT due to the Clozapine medication and it was at those reviews that the weight loss of 6.5kg in the course of two months was recorded; 20th May 2016, 10.65kg on the 22nd June 2016 and 5.9kg on the 15th July 2016. The Patient explained the May weight loss as being due to increased exercise and eating well and the June one as due to an infection which made him lose his appetite. In June, urgent blood tests were requested by the Psychiatrist subsequent to the Complainant's call, and those suggested a possible infection. It was in July 2016, after a third substantial weight loss that the Psychiatrist pushed for and the Patient finally agreed to seeing a GP. When CMHT attempted to make the GP appointment they were informed that the Complainant's health card was expired and this led to a delay (15th July 2016 Psychiatrist appointment & 28th July 2016 GP appointment) but ended with the matter finally being resolved by CMHT.

Throughout the timeframe set out above, the Psychiatrist stated that the Patient's mental state remained stable.

(vii) Complains that the Patient's psychiatrist was prescribing oral antipsychotic drugs which the Patient could not swallow because he had been diagnosed with Metastatic Advanced Oesophageal Cancer. As a result, the Complainant states the Patient's mental condition was being left untreated

The Psychiatrist's account of the medication given to the Patient to manage the paranoid schizophrenia attests to the fact that because of the oesophageal cancer and vomiting, the Clozapine, given in cases of 'treatment resistant paranoid schizophrenia' was not being absorbed appropriately. Clozapine is only manufactured in oral form and as such, in order that the Patient could continue to have the medication, the tablets were crushed and mixed in liquid. The Patient was on a liquid diet. Other antipsychotic drugs were administered but in liquid form and via intramuscular injections.

(viii) Complainant states during the Patient's time in hospital there was little or no communication between CMHT and the hospital

In the course of the investigation, the Ombudsman found that there is a 'liaison psychiatrist' whose main role is the care of patients admitted to the general hospital who also present with mental health problems. Periods outside normal working hours or when the 'liaison psychiatrist' is on leave are covered by a consultant psychiatrist.

Notwithstanding the above, the Patient's situation was difficult to manage due to the poor absorption of the only medication that could keep his mental condition stable and the serious physical disease he was suffering from. It was only once the palliative stent procedure was undertaken that the Patient was stabilised.

(ix) GP did not request urgent ultrasound despite considerable unexplained weight loss;

The GP's statement attests to the fact that he did not know the Patient and from the examination he undertook and the information provided by the Patient that he had lost 10kgs decided on a routine ultrasound of the abdomen, i.e. to determine or discard any other condition. The Patient did not present clinically unwell and the abdominal examination undertaken was unremarkable. The GP prescribed antibiotics on the basis that the most likely diagnosis was gastroenteritis and told the Patient to return if he did not get better.

The Ombudsman is critical about the fact that the Psychiatrist's instruction for a CMHT nurse to accompany the Patient was not complied with. CMHT knew the Patient and would have been able to relay important information to the GP, like the fact that the Patient had in fact lost in excess of 20kgs in two months, which in all probability would have triggered the urgent request for an ultrasound. Notwithstanding the aforementioned, the period of time elapsed between the Patient having visited the GP and the hospital admission was thirteen days, which would not constitute a substantial delay; in the event that an urgent ultrasound had been carried out the cancer would have been detected earlier and possibly palliative treatment accelerated which may have gone some way in sparing the Patient some of the suffering he endured.

(x) Patient's condition worsened and Complainant's husband ("Husband") called for an ambulance. According to the Husband, ambulance crew refused to attend to the call because of the Patient's mental condition

The Ombudsman obtained recordings of the Husband's call to the GFRS. The Husband did not make clear to GFRS the reason for requesting an ambulance until nearing the end of the call by which point he was exasperated and hung up the phone. The Husband provided details on the Patient's mental condition and the fact that he had lost a lot of weight and they had been trying for a long time to get him to go to hospital. Under those circumstances, it was not wrong for GFRS to have raised their concerns that they could not force anyone to go to hospital.

The GFRS did not refuse to attend to the call because of the Patient's mental condition.

(xi) Complainant called for an ambulance a second time and claimed she had to convince them to attend to the call

The Complainant's call to GFRS requesting an ambulance lasted one minute thirty three seconds which may have seemed like an eternity to the Complainant but in reality was not. The Ombudsman did not find maladministration in the manner in which GFRS handled the call. The Complainant provided the reasons for the ambulance request and GFRS after taking the pertinent details dispatched the ambulance.

(xii) Complainant claimed that the ambulance crew handled the Patient in a rough and insensitive manner

The Complainant alleges that the Patient was treated in a rough and insensitive manner by AC whereas the latter alleged that the Patient's case did not warrant that he be carried down to the ambulance by either stretcher or chair as he was mobile. There is no evidence to the effect that the AC mistreated the Patient or failed in their duty of care to the Patient.

(xiii) Complainant stated that ambulance crew did not offer her the option to accompany the Patient in the ambulance transfer

From information provided by the Complainant throughout the course of the investigation it transpired that as she was about to lock the door of the Patient's home as AC were taking the Patient to the ambulance, the key broke inside the lock and the Complainant had to attend to that incident. AC could not have delayed the Patient transfer in wait for the Complainant to resolve the lock issue.

(xiv) Patient not examined by the GHA's Accident & Emergency ("A&E") Doctor on duty ("Doctor")

The Doctor examined the Patient, made a diagnosis and prescribed intravenous medication. As the Patient responded positively to the treatment he was discharged.

(xv) Patient discharged from A&E and sent home in a taxi, shortly after Complainant left A&E with the object of the Patient's admission into hospital;

The Complainant's objective for leaving the Patient on his own at A&E was so that he would be admitted to hospital. As the results of tests conducted, (evidenced by the Doctor's statement), there was no criteria for admission, and this was further strengthened by the Patient's decision not to stay in hospital. A&E offered to get him a taxi to take him home upon discharge, since he had no alternative means of transport.

Complainant not notified of the A&E discharge of the Patient

A&E had no obligation to inform the Complainant of the Patient's discharge and as stated by the Doctor, they could have been in breach of data protection laws in disclosing to a third party, medical information pertaining to his case. The Patient was a capable adult, able to have informed the Complainant of A&E's findings.

Classification

Further to the exhaustive investigation conducted by the Ombudsman which included meetings with the pertinent GHA staff, review of statements, documentation and other material, the Ombudsman was unable to sustain the complaints filed in this case.

(Report extracted from HEALTH CS 2017-42)

GIBRALTAR HEALTH AUTHORITY

Case 8

Complaint

The Complainant was aggrieved by the aftercare experienced following a shoulder injection. He complained he was subjected to a delay of three months to be examined by Physio, post infiltration.

By way of background, the Complainant explained that he had been referred by the GHA to a Consultant Orthopaedic Surgeon in the UK who saw him on the 5th November 2014 and addressed a medical problem to his right shoulder. He stated that he had recently started to suffer similar symptoms, including pain and restriction of movement on his left shoulder. As a result, he made a doctor's ("GP") appointment.

The Complainant informed the CHS that on the 27th September 2016, he was 'infiltrated' by his GP on the left shoulder. He explained that the GP instructed him to carry out rotating exercises for a few days and at the same time, he referred him to Physio for follow up by a physiotherapist.

The Complainant stated that on 28th September 2016, he made his way to Physio and handed in the referral letter. He was informed that there existed a 6 to 8 week waiting time for new patients. The Receptionist allegedly told the Complainant that they would call him that same afternoon with an appointment date once Physio had assessed his referral letter.

The Complainant also explained that on 29th Sept 2016, he made a telephone enquiry given that he had not received a call from the Physio. He was advised that they would call him with an appointment date nearer the time when he was due to be seen. The Complainant questioned why he could not have a date for his appointment since it was necessary that he plan work commitments but was told that "that was the way it was". He subsequently lodged his complaint with the CHS.

The Complainant stated that between the date of the referral and the time of filing his complaint with the CHS; (a period in excess of two months):

(a) He had not been seen by any Physio staff member,

(b) He had not undergone an evaluation on the possible extent of his problem,

(c) He had not been provided with information on any exercises he could possibly do at home in the meantime.

The Complainant questioned if the waiting time was standard procedure introduced by the GHA or whether it was a Physio matter. He also questioned the efficiency of the GHA appointment system since he had already been given a date for another non associated issue over which he had also been referred.

The Complainant explained how in November 2016, he gave Physio a further call. According to him, his call was returned that same day and the appointment system explained to him by the Physiotherapist herself. He was additionally informed by her that if he really wanted an appointment date in order to enable him to schedule work matters, she would give him one. This meant however that he would not be eligible to be contacted in the event of any cancellation which would have otherwise brought his appointment forward.

The Complainant stated that he did not understand how he could be treated in such a way when no one from Physio had even examined or evaluated him. How could they give him an appointment date for the 13th January 2017 and at the same time make it a condition that he would not be eligible to be called at short notice if there was a cancellation? He was also unhappy with the fact that he had not been provided with any information on how he could self-treat in the meantime.

The Complainant stated that he believed that a patient under pain and restrictions, having undergone a medical procedure such as an infiltration and with a referral from a GP to Physio, should at least be initially triaged within a reasonable time (i.e. “within the week”). This could prevent his condition worsening and through proper examination; they would be in a position to ascertain the urgency that the condition may require in respect of a follow up appointment. Advice could also be given to patients on how best to self-manage their condition while waiting to be seen by the Physio for further treatment.

Investigation

The CHS presented the complaint to the GHA in writing setting out the facts as alleged by the Complainant and requesting their comments.

A written reply was received from the Physiotherapist approximately one month later.

The reply stated that since summer 2016, the Physio waiting list for appointments was between three and four months *"so I can only assume that the [Complainant] was informed incorrectly or misunderstood."*

The content of the letter went on to explain how referrals were taken directly from patients and how they would be telephoned if their symptoms had existed for less than six weeks to assess if the appointment would be classed as "*routine"* or otherwise. *"It would be impossible to phone [in order to arrange] approximately twenty referrals a day."*

The process was then subsequently explained. This process consisted of referral letters being triaged and placed on the waiting list. After that, patients would be sent a letter to contact the clinic for an appointment if it was still required. The reasons presented by Physio on working appointments were as follows: "Appointments are not issued at the time due to (1*) waiting times may change according to external factors (2) we contact patients when patients are unable to attend last minute (3) it has reduced our "did not attend" rate by not issuing appointments three to four months in advance."*

The reply also stated that the Physiotherapist spoke to the Complainant and explained to him how patients would be issued with a letter providing them one month to telephone for a planned appointment. However, it was also explained to the Complainant that the said window of one month would allow him the opportunity to schedule his work or other commitments if necessary. The Physiotherapist also informed the CHS that she had explained to the Complainant that they could of course give him a fixed appointment for four months' time but that would mean that he would be taken off the cancelation list. As to the Complainant's complaint that he had not been "*examined*", the reply stated that he had obviously not been examined because he was "on the list". Note was also taken on the comment that injections are usually administered once physiotherapy had failed and not vice-versa.

A footnote was appended to the Physiotherapists reply, by the Primary care Centre ("PCC") manager. It stated that *"I am informed that all patients with such injections are not routinely referred to Physio. I am [further] informed that it is not a medical indication as in a fixed pathway, that once a person has been injected* ***they must be treated*** *by Physio. Physio did consider this man's condition referral and did follow through in accordance to present prioritization criteria and slot availability."*

Given the reply received, the CHS deemed this complaint fit for transfer to the Office of the Ombudsman for further investigation. The Complainant consented to the transfer.

The Ombudsman sought independent expert clinical advice, the Ombudsman made copies of the Complainant's case file and dispatched it to the United Kingdom for an expert view on the Complainant's grievance.

Expert Opinion

Advice was provided by a "*senior outpatient physiotherapist*" based in England ("the Expert"). The Expert had "*vast experience in assessing and treating shoulder injuries."*

The case file was reviewed by him in its entirety.

Background and Chronology (as cited by the Expert).

"[The Complainant] received a steroid injection for left shoulder pain from his GP on 27th September 2016. His GP also referred him to the outpatient physiotherapy department based in St Bernard's hospital on the day of the injection for follow up care. [The Complainant] was not given an appointment with a physiotherapist until the 10th January 2017. As a result, he has complained to the Ombudsman due to a lack of follow up care post injection." He went on to state that "Physiotherapists are autonomous clinicians, which means that they are in charge of running their departments how they see fit, as long as local procedures are followed by the department and they meet the standards set by the governing Trust/Health Authority [in this case the GHA]. As long as clinical or administrative decisions are made based on locally referred standards, then physiotherapists are not obliged to follow GP requests/referrals."

Ombudsman Question

Given the treatment administered by the GP at the primary care stage, was it reasonable that the Complainant was not seen by a member of Physio until the 10th January 2017?

Expert Reply

"*Under the NHS Constitution, "patients have the right to access services commissioned by NHS/ public bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible." The NHS Constitution states patients should wait no longer than 18 weeks from GP referral to treatment. The Complainant waited just over 14 weeks."*

The Expert opined that from a clinical perspective there was no *"gold standard pathway"* to be followed post shoulder injection. He explained how some GP's will organise follow up physiotherapy treatment after administering an injection whereas others will not do so. "***No definitive clinical guidelines will state that follow up physiotherapy is needed post injection because there is no such guideline. His GP also did not specifically mark "urgent" on the referral".***

Ombudsman Question

Was it reasonable/acceptable that no physiotherapist had evaluated the extent of the Complainant's problem prior to issuing him an appointment for 10th January 2017?

Expert Reply

"All physiotherapy units in the UK will follow a locally set up triage process. Once a referral is received from a GP, a process is followed to process the referral appropriately."

The Complainant's GP referral stated he had shoulder pain for less than two weeks and according to Physio they would phone patients if "they had their symptoms for less than six weeks to assess if they are routine or not." "According to the Complainant, Physio did not call him".

The Expert opined that if that was indeed the case, ***"they have failed to follow their triage process."*** The Expert further stated that the Physio form clearly states*, "patients' will be assessed by physiotherapy telephone triage."* He went on to say that normally acute pain/symptoms (less than a few weeks) is assessed fairly quickly by most physiotherapy departments and that problems such as those could be treated fairly early resulting in good outcomes generally. However, chronic pain lasting several months or longer is more difficult to treat also less susceptible to sudden change or deterioration *"… hence those problems are not usually assessed or treated urgently."* The Expert clearly stated that "*if [the Complainant] had the telephone triage consultation as per procedure then he may have been assessed sooner. But I cannot say if this would have reduced his pain or improved his shoulder function. Some patients seen quickly still struggle and need specialist opinion anyway."*

Ombudsman Question

Was it reasonable for the Complainant not to be provided with information/exercises that he could carry out at home while waiting to be given physiotherapy treatment?

Expert Reply

"Yes and no depending on the local procedures of where the service is located." He explained that in England operational physiotherapy services differ depending on local service level agreements and commissioning requirements. Some services provide telephone triage and others just provide an appointment and no advice prior to the initial assessment. *"The key thing which can result in a patient being seen very quickly is the presence of red flags, which are sinister symptoms requiring urgent investigation or treatment. Normally the GP would screen for these red flags prior to making a referral. These symptoms are written on a referral and would be flagged as urgent.* ***[The Patient] had no red flags requiring urgent attention."***

Ombudsman Question

Should the Complainant not have been administered the shoulder injection infiltration without having an already established pathway for post-injection aftercare? Are the PCC manager's comments reasonable and to the required standard in this regard?

Expert Reply

"*If the GP had the necessary experience and qualifications to do a shoulder injection, then I see no issue with an injection being administered. The GP would discuss benefits and risks associated with an injection. Informed consent would also be gained from the patient prior to injection. As said earlier, as far as I know there are no NICE or NHS guidelines specifically on what to do post injection for shoulder pain. The manager is also correct. Physiotherapists are NOT obliged to follow their locally set procedures and standards, which are normally audited by the Governing Trust/health authority.*"

Ombudsman Question

Would the Expert advising conclude that the Patient received an acceptable/adequate level of care?

Expert Reply

"*The Patient should have had a physiotherapy telephone triage as per local procedure. This may have altered the care he received. But as written earlier, even if he was seen sooner as a result of a telephone assessment, his pain may not have decreased and his shoulder function may not have improved. We will never know what may have happened if he did have that telephone consultation.*"

Expert Conclusion

"One failure. Local triage process not followed which possibly delayed assessment and treatment."

Conclusion

As is the case in all complaints where reliance is placed by the Ombudsman on expert clinical judgement, the Expert's views were noted and endorsed. The Ombudsman opined that the following points were of particular relevance and assistance in the investigation of this complaint:

1. That under the NHS Constitution, patients should wait no longer than 18 weeks and in the Complainant's case, he was seen after 14 weeks.

2. From a clinical perspective there was no "*gold standard pathway"* or clinical guidelines stating that physiotherapy was needed post shoulder infiltration/injection.

3. Significantly and in direct correlation to 2 above, that the Complainant's GP did not mark the referral as "*urgent"*. As a result, no *"red flags"* were present indicating sinister symptoms requiring urgent investigation.

4. That although Physiotherapists were autonomous they had to follow local procedures.

5. Local procedure established a telephone triage process which in the Complainant's case, was not adhered to.

Although the Expert could not state whether had the telephone triage been carried out, the Complainant's condition and/or treatment would have been any different, it was indeed clear that "*The Patient should have had a physiotherapy telephone triage as per local procedure."*

Based that upon that sole factor, the Ombudsman was of the opinion that the GHA failed the Complainant, purely on that administrative perspective.

Ombudsman note: The Ombudsman wished to clarify that this complaint had been sustained solely on the failure to have triaged the Complainant via telephone, in accordance with local practice. The Ombudsman additionally concurred with the Expert that the level of care afforded to the Complainant was otherwise adequate and acceptable.

Recommendation

That Physio ensure that the triage system be followed appropriately. It appeared to the Ombudsman that Physio generally performed a highly successful albeit an overloaded practice and that the error committed in relation to this complainant could easily be avoided in future.

(Report extracted from HEALTH CS 2017-44)

GIBRALTAR HEALTH AUTHORITY

Case 9

Complaint

The Complainant was aggrieved at the manner in which the Psychiatrist had dealt with the Patient, and allegedly, incorrectly diagnosed Alzheimer's Disease.

She was further aggrieved because she had been told by two private doctors that the Spanish to English translation of reports of medical imaging were inaccurate.

The Complainant stated that she and the Patient's wife ("Wife") raised concerns with the Patient's General Practitioner ("GP") about changes in the Patient in the past year; namely, frequent headaches and changes in his speech. The GP referred the Patient to the Psychiatrist's memory clinic. According to the Complainant, on the 8th August 2016, the Wife accompanied the Patient to that first appointment at which the Psychiatrist put two tests to the Patient. He was asked to draw a house which he did correctly and a clock in which he omitted the number '3'. According to the Complainant, from that moment on, the Psychiatrist ignored the Patient and addressed the Wife to tell her that she was quite sure that he had Alzheimer's (a progressive disease of the brain that slowly causes impairment in memory and cognitive function.). The Complainant stated the Patient left the room whilst the Wife, distressed and overwhelmed, asked the Psychiatrist about the severity of the condition. The Psychiatrist allegedly responded that from her medical experience, it was at an advanced stage and he had probably had it for two years but that would be confirmed with a blood test, an electrocardiogram and a CT scan. (Note: An MRI was also performed as the CT scan was not very clear).

On the 8th September 2016, the Patient, accompanied by the Wife and the Complainant, returned to see the Psychiatrist. The Complainant stated that the Patient waited outside whilst they spoke to the Psychiatrist who confirmed that he had Alzheimer's and that it was at a more advanced stage than she thought. The Psychiatrist informed them that:

- His vision would quickly deteriorate;
- He would live about seven years;
- He was no longer fit to drive (the Psychiatrist wrote a letter at that consultation stating he was no longer fit to drive);
- He should not be trusted with money or credit cards;
- He should be spoken to like a seven year old child.

The Psychiatrist prescribed medication, 'Exelon', for one month and issued a second prescription for a higher dose for the following month, which the Complainant stated the Patient fortunately never took considering the many side effects.

Dissatisfied with the diagnosis and the decision to stop him from driving, the family took the Patient to an optician for an eye test and stated that he assured them that his vision was fine. They returned to see the Psychiatrist with the optician's results in the hope that she would reconsider her decision in respect of the Patient not being allowed to drive but the Psychiatrist responded that the optician's test had nothing to do with Alzheimer's which was a condition that rapidly deteriorated the brain. According to the Complainant, the Psychiatrist informed them at that point that if they were not satisfied with her diagnosis they could get a second opinion from another GHA consultant ("Consultant") but if that opinion determined that the Patient could drive, she would not be able to see him again. The Complainant responded that they did not want her to see the Patient again.

Confused, scared and uncertain about the Psychiatrist's diagnosis, the family took the Patient to see three private doctors who all concurred that more tests had to be carried out to confirm that the Patient was suffering from Alzheimer's. Furthermore, two of the doctors alerted her to the fact that the Spanish to English translations of the MRI scans were inaccurate and could lead to misdiagnosis [Ombudsman Note: Both the Psychiatrist and the GHA Consultant's first language was Spanish, therefore the Spanish to English translation issue was not significant in this particular case].

On the 17th November 2016, the Patient had his first appointment with the GHA Consultant who after posing general questions repeated the same tests as the Psychiatrist. According to the Complainant, the Consultant informed them the MRI scan did not match the Patient's mental state and ruled out that he had Alzheimer's but could have dementia (an overall term used to describe symptoms that impact memory, performance of daily activities, and communication abilities). The Consultant stated that a neuropsychology test and a PET scan (Positron Emission Tomography scan) would be required to confirm this.

At the Patient's appointment with the Consultant on the 23rd January 2017, the latter informed them that the Patient's condition could not be classified as dementia because of his lifestyle and the tasks he was able to carry out (volunteer ambulance mechanic) and that the neuropsychologist at the referral unit where the tests were performed was in agreement with this opinion. The Consultant's diagnosis was that the Patient had a learning disability and brain lesion on the memory side of the brain from an early age. He would review the Patient in six months and informed them that the dementia day care centre was in the process of commencing workshops and he would be made an offer to join those. At the conclusion of the consultation, the Consultant informed the Patient that he could continue to drive.

The Complainant lodged the complaints with the Ombudsman.

Investigation

Complaint (i) - Aggrieved at the manner in which the Psychiatrist dealt with the Patient and with the premature diagnosis of Alzheimer's made

The Patient's medical notes confirmed that as a result of concerns expressed by the Wife at a GP consultation with the Patient, the GP referred the latter to the Psychiatrist at the GHA's Memory Clinic. Based on the Wife's concerns and after examination, the GP suspected that the Patient was suffering from early dementia and noted this in the referral letter.

The Ombudsman sought a statement from the Psychiatrist.

PSYCHIATRIST

The Psychiatrist expanded on the reasons for the GP's referral of the Patient and stated that the family had noted a change in character. He was becoming confused and sometimes aggressive; he was very argumentative and was continuously forgetting things. The Psychiatrist highlighted there was no mention of headaches or changes in speech [Ombudsman Note: The Ombudsman had sight of the GP referral letter and corroborates the Psychiatrist's statement in this respect].

The Psychiatrist stated that amongst other things, she had performed the standard Mini Mental State Examination ("MMSE") which any patient at the memory clinic would complete, and explained that it contains eleven items and not two. The Patient scored 15/30 and was also asked to complete the clock face test.

During the assessment, the Psychiatrist identified the Patient was unable to respond to her questions and so as *'...not to put him on the spot...'* and obtain as much information as possible, addressed the questions to the family.

The Psychiatrist stated that the report of the CT brain scan performed on the 10th August 2016 had findings in keeping with dementia and an MRI was therefore recommended. The MRI was performed on the 12th August 2016 by a different radiologist whose report noted the Patient had an 'encephalic atrophy' and ischaemic lesions of white matter in relation to degenerative ischemia; these changes in keeping with dementia. The Psychiatrist concluded that it was her duty to stop the Patient from driving as she had serious concerns about him driving not only his car but also an ambulance on a volunteer basis [Ombudsman Note: The Complainant advised that the Patient was a volunteer ambulance mechanic and not a volunteer ambulance driver]. According to the Psychiatrist, she methodically followed every step she was supposed to when there is a diagnosis of dementia. Furthermore, she stated that she told the Patient's family to seek a second opinion if they were not happy with the diagnosis and an appointment was made for the Patient to see the Consultant. The Psychiatrist added that although the situation was very disappointing for both patients and their relatives, she had no option but to act responsibly as per the General Medical Council's code of conduct.

CONSULTANT

The Consultant provided a statement to the Ombudsman. He explained he was asked by the Psychiatrist to see the Patient for a second opinion as the Patient's family were not happy with the diagnosis. The Consultant stated the Patient's case was a very difficult one in which he required support from external resources due to the limited ones available at the GHA. He stated the Patient definitely had some cognitive impairment as shown by the results of the MMSE and some vascular disease as shown on the scan but noted that going through the details of the Patient's history with his family, he was made aware of information not given to the Psychiatrist in terms of learning difficulties when the Patient was young. In light of that information and in order to have a full report, the Consultant requested a neuropsychology assessment. The conclusion of that investigation was that the Patient had some cognitive deficit which could be explained by his lack of schooling as a child. The Consultant explained he requested a PET scan which did not show any evidence of dementia at that stage although the Patient was definitely in high risk of developing it in the near future.

The Consultant stated that making a diagnosis of dementia was not simple and added that at times, the diagnosis is made but depending on progression of the disease, the diagnosis can be changed. The Consultant concluded his statement by saying that the Psychiatrist was giving a good support to the services.

CLINICAL ADVISER ("CA")

In view of the difference in diagnoses between the Psychiatrist and the Consultant, the Ombudsman sought clinical advice from an independent source, a consultant 'old age' psychiatrist.

The CA stated that based on the history outlined in the Psychiatrist's letter after examination on the 8th August 2016, in which she remarked that there was insidious onset (an insidious disease comes on slowly and does not have obvious symptoms at first so the person is not aware of this developing) of short term memory impairment over the last few years and on the results of cognitive testing using the MMSE, he was of the opinion that it was reasonable for the Psychiatrist to conclude that the Patient had Alzheimer's Disease.

The CA explained that Alzheimer's disease is essentially a clinical diagnosis based on careful exploration of the history where one normally sees progressive cognitive decline over time with an insidious onset. The diagnosis is supplemented by cognitive testing such as the MMSE which is scored out of 30, higher scores indicating better performance and a conventional cut off point of below 24 is indicative of cognitive disorder. A score of 15/30 (Patient's score) was well below that cut off point.

The CA stated that in some individuals, further investigation such as neuro- imaging would be unnecessary given the history and cognitive test result but due to the relative youth of the Patient (61) thought it would be important to proceed to neuroimaging. The CT scan is reported to show medial temporal lobe atrophy bilaterally, predominantly on the left lobe. The CA reviewed the neuroimaging results and confirmed that was indeed his impression of the neuroimaging. He stated medial temporal atrophy was one of the early signs of Alzheimer's disease and even in the absence of significant cerebral atrophy elsewhere, it could help to support the diagnosis.

The CA advised he was of the opinion that it is imprudent to diagnose dementia, purely on the results of neuroimaging but that was not the case with the Psychiatrist who, as evidenced in her letter of the 8th August 2016, made the diagnosis based on the history, the cognitive test and the neuroimaging results.

The CA notes that at a later stage it emerged that the Patient may have had some longstanding neurocognitive difficulties but the history outlined in the Psychiatrist's letter suggests she did deduce a history of impairment, progressive over the past few years. In the CA's opinion, the pre-existing neurocognitive impairment which may well be developmental and account for some decrease in the score of the MMSE should not have diverted the Psychiatrist from her opinion of probable Alzheimer's disease. Indeed, there is evidence that people with developmental delay are more at risk of developing Alzheimer's disease.

The Ombudsman referred the CA to a score of 22/30 in a later MMSE undertaken as part of the neuropsychology assessment (January 2017) i.e. 7 points more than the score on the MMSE. The CA explained that any cognitive test is only supplemental to the diagnosis of dementia, including Alzheimer's disease, and the diagnosis is essentially a clinical one based on a history of a patient's decline as described by the Patient's family.

The CA stated that although the use of MMSE is very widespread, it is really a poor instrument in terms of diagnostic utility and highlighted a case where he had accurately diagnosed dementia in a person with a score of 30/30. Furthermore, he pointed out that a score of 22/30 was still below the cut off for dementia (24/30) and added that scores can fluctuate for two main reasons; plasticity of the disease and inter rater variability. The CA concluded from the medical records available, that the Psychiatrist's diagnosis of Alzheimer's disease was reasonable.

The Ombudsman asked the CA if it was reasonable for the Psychiatrist to decide the Patient could no longer drive and inform the family of the Patient's imminent deterioration. The CA responded that it was important for a doctor making a diagnosis of Alzheimer's disease to advise patients not to drive, at least until the licensing authorities agreed driving was permissible. The CA stated there was a definite association between developing dementia and increasing the risk of road traffic accidents. In Gibraltar, paragraph 65 of the Gibraltar Highway Code mandates drivers to inform the Licensing Authority of any medical condition/s that may affect their driving.

Regarding the Psychiatrist having told the family about the Patient's imminent deterioration, the CA stated there was significant disparity between the Psychiatrist's record of the meeting and the family's account of it. The CA pointed out the Psychiatrist did not record the content of the conversation with the family in detail but added it was usual practice to be open about the diagnosis of dementia when one is made, and to inform the patient and the family of the likely course of the condition. The CA highlighted that the Psychiatrist's record keeping was a little sparse and a more comprehensive record of the discussion between her and the family at the meetings of the 8th August and 8th September 2016 would have been appropriate.

The CA's opinion was that the appropriate tests were undertaken in this case and there was possibly an excessive amount of neuroimaging as it is unusual for someone to have a CT scan, an MRI scan and PET imaging. He stated it could be argued that the Psychiatrist could have ordered neuropsychometry earlier in the course of the investigation but that would have been unusual when someone scored 15/30 on the MMSE. According to the CA, the score was so far removed from the conventional cut off that it would not normally provoke a more in depth neuropsychometric evaluation, especially when the MRI imaging supports the diagnosis.

The CA added that he would go so far as to say that the Psychiatrist's investigation of the Patient was exemplary.

The Ombudsman further enquired about the Psychiatrist's and Consultant's diverging diagnoses. The CA responded that there was no absolute certainty in making a dementia diagnosis; either doctor could be correct. Notwithstanding this, the CA reiterated that it was reasonable and in keeping with accepted practice for the Psychiatrist to have diagnosed Alzheimer's disease, given her assessment at the time. In the CA's view, neuropsychometry did not prevail over a clinical assessment. The CA added that only time would tell who was correct.

GHA

The Ombudsman was concerned due to the clinical advice received, that two doctors now concurred with the diagnosis of Alzheimer's disease which would in effect mean that the Patient should not drive (as per Psychiatrist statement above) until the Licensing Authority agreed driving was permissible. The Ombudsman contacted the GHA's medical director ("MD") with his concerns about the matter, making available a copy of the clinical advice received.

The MD responded that the Gibraltar system for informing the Licensing Authority of medical conditions and medical assessment for driving licences was not effective. He stated that he had asked the Director of Public Health and the Consultant Psychiatrist to engage with the Licensing Authority and agree an effective system for dealing with drivers with medical conditions. The MD stated that this complaint would be a catalyst for ensuring a robust system at the Licensing Authority which might involve them having their own doctor or even outsourcing medical advice to the UK's Licensing Authority.

The MD was of the view that in light of the external advice received, and in the public interest, the Licensing Authority should be informed of this particular case. Based on the above, and the fact that at present, the onus is on the driver (Patient in this case) to notify the Licensing Authority if a doctor has advised they cannot drive, the Ombudsman contacted the Complainant to read through the clinical advice and also to highlight the concerns raised about the Patient continuing to drive.

COMPLAINANT

The Ombudsman met with the Complainant.

By way of update on the Patient's condition, the Complainant stated that at the present time, his speech had deteriorated. According to the Complainant, the Consultant was confounded with the Patient's condition and had referred him to a UK neurologist for further tests amongst which was a lumbar puncture. They are presently awaiting details of that appointment. The Consultant suspects the Patient suffers from 'primary progressive aphasia' (a neurological syndrome in which language capabilities become slowly and progressively impaired and which is caused by neurodegenerative diseases like Alzheimer's or Frontotemporal Lobar Degeneration).

The Complainant stated that an MRI has been performed and sent to the neurologist in the UK and this will be compared to the 2016 MRI. According to the Complainant, there are no other symptoms that the Patient suffers from at present. On the matter of the Patient continuing to drive, the Complainant stated that she was very aware of the dangers that could arise if a person who was not fit to drive did so, but stated that was not the Patient's case.

LICENSING AUTHORITY ("LA")

The Ombudsman contacted the LA for information on the procedure they have in place in cases where drivers are deemed by a medical professional as being unable to drive due to a medical condition.

The LA explained that in those cases, the onus is on the driver to inform the LA. When that situation arose, the latter would give the driver a form and send him to a doctor (registered in Gibraltar). When the doctor examined the driver and completed the form, it could be the case that the doctor would decide that the person could drive. In cases where the driver suffered from a degenerative disease, the doctor would need to state the timeframe for which the licence could be issued.

If there were diverging medical opinions, the LA would send the report to the GHA's occupational therapist who would make the final decision. The LA added that there had been cases where, in the interest of safety, the driver had also been asked to undertake a driving test.

OMBUDSMAN NOTE

The Ombudsman, in the course of the investigation, found that the Gibraltar Highway Code under section 65 states:

*"Make sure that you are fit to drive. You **MUST** report to the Licensing Authority any condition likely to affect your driving."*

Based on the above, in the Patient's case, it was his duty to notify the Licensing Authority that the Psychiatrist had deemed he could not drive due to his medical condition. The Ombudsman, in order to identify if any other entity had the duty to notify the Licensing Authority, referred to the Traffic Act 2005 and to Traffic (Licensing and Registration) Regulations and noted that under the former Act, under Section 36 it states:

> ***Suspension of Licences***
>
> ***36.(1) If it appears to the Licensing Authority that the holder of a driving licence is suffering from any physical or mental disease or disability as is likely to cause the driving by him of a motor vehicle a source of danger to the public, he may, by notice in writing to such person, suspend the licence.***

What would trigger the LA's action as described above is unclear as there is at present no duty on any other entity to notify the LA.

The current position is that the Gibraltar Highway Code mandates that it is the driver who has to inform the Licensing Authority of any medical condition/s that may affect their driving. The Ombudsman therefore welcomes the MD's proactive approach in this issue and has asked to be kept updated on developments.

On the basis of:

(i) The Consultant's ongoing investigations on the Patient's suspected condition of 'primary progressive aphasia' and the standing diagnosis of Mild Cognitive Impairment; and

(ii) The CA's statement that there was no absolute certainty about making a dementia diagnosis; either doctor could be correct;

the Ombudsman's concerns about the Patient continuing to drive were abated.

Complaint (ii) - Inaccurate Spanish to English translations of medical imaging reports

The Ombudsman asked the CA to review the imaging and reports in relation to the complaint lodged by the Complainant. Although highlighting he was not a neuroradiologist, the CA confirmed that he had reviewed the imaging and there was clear asymmetrical hippocampal atrophy which corresponded with the English reports and the CT and MRI imaging.

Conclusions

Complaint (i) - Aggrieved at the manner in which the Psychiatrist dealt with the Patient and with the premature diagnosis of Alzheimer's made – Not Sustained

Based on the advice and explanations provided by the Clinical Adviser, the Ombudsman did not uphold this complaint.

In respect to the Psychiatrist having made a premature diagnosis of Alzheimer's disease vis-a-vis the Consultant's diagnosis of Mild Cognitive Impairment, the Clinical Adviser concluded that only time would tell who was correct. Notwithstanding this, the Psychiatrist's diagnosis given her assessment at the time was reasonable and in keeping with accepted practice. The Clinical Adviser pointed out that neuropsychometry did not prevail over a clinical assessment, effectively stating that the tests requested by the Psychiatrist did not fall short of what would have been required to give a diagnosis.

Regarding the manner in which the Psychiatrist dealt with the Patient, this could not be determined by the Psychiatrist's record keeping. As stated by the Clinical Adviser, the record keeping was a little sparse and a more comprehensive record of the discussion between her and the family at the meetings would have been appropriate.

Notwithstanding, it is clear from the complaint brought to the Ombudsman that the Patient's family were upset and distressed about the manner in which the Psychiatrist delivered the diagnosis and then appeared to be dismissive of the Patient, addressing questions to the family. From the statement provided by the Psychiatrist, the reason for addressing the questions to the family after giving her diagnosis was so as not to continue to put the Patient on the spot, considering he had not been able to reply to her earlier questions, and to obtain as much information as possible.

Complaint (ii) - Inaccurate Spanish to English translations of medical imaging reports – Not Sustained

Based on the clinical advice from the CA who after comparing the medical imaging to the English reports stated they corresponded, the Ombudsman does not sustain this complaint.

(Report extracted from HEALTH CS 2017-45)

GIBRALTAR HEALTH AUTHORITY

Case 10

Complaint

The Complainant (Patient's son) was aggrieved because he believed the GHA had not afforded the Patient the due care he required; the pertinent issues are set out below:

(i) Was there any maladministration on the part of the GHA in the Patient's case?

(ii) If the Patient showed signs of having suffered a stroke when he arrived at the GHA's St Bernard's Hospital ("Hospital") was he given appropriate treatment?

(iii) If the scan results showed the Patient suffered a stroke and not a brain haemorrhage why was the vital anti coagulant injection not administered?

(iv) During the subsequent four days spent in Hospital before the second stroke, were there further tests that could have been performed or medication given to prevent a further stroke?

(v) Was the Patient prematurely transferred from the Hospital's Intensive Care Unit ("ICU") to the medical ward ("Ward")?

(vi) Should an urgent MRI scan have been performed?

(vii) Was the tracheostomy too big and could that have damaged the Patient's vocal chords or was the damage as a result of the stroke?

The Complainant explained that on the 22nd September 2012 he received a call from a family member to inform him that the Patient had fainted and had been taken to Hospital. Upon arrival at the Hospital's Accident & Emergency ("A&E"), the Complainant stated that he was informed by doctors and nurses that the Patient was in a critical state and his stats poor. A CT scan (computed tomography scan) was performed and several hours into that A&E attendance, the Patient's condition improved and he was admitted to the ICU for the night and later transferred to the Ward.

According to the Complainant, doctors informed him they had not given the Patient an anti-coagulant injection because they did not know if the Patient had suffered a brain haemorrhage in which case the injection would have made him bleed to death.

On the 26th September 2012, the Patient's condition worsened. He was in the ICU and was unresponsive and dazed. The Complainant stated that he rushed out to speak to nursing staff and was told that they were not sure if he had suffered another stroke or a brain haemorrhage. According to the Complainant he asked if they were going to perform a brain scan and when he was told it would be done the following day he demanded that it be carried out immediately.

When the Complainant next saw the Patient he was connected to breathing apparatus. He had no physical movement and his eyes were staring at one fixed point. He was put into a medically induced coma and a tracheostomy (surgical procedure to create an airway in the cervical trachea) performed to help him breathe. The Complainant stated that the Patient spent one month hospitalised with 'locked in syndrome'; he was aware of his surroundings but could neither move nor communicate due to paralysis of all his voluntary muscles except his eyelids. According to the Complainant, they asked the Patient to blink if he could hear them and that served as the only means of communication between them. After much pleading on the part of the Patient's family to medical staff, the Patient was transferred to a hospital in the United Kingdom ("UK") where he spent approximately three months being treated and as a result of which, the Complainant claimed the Patient's condition improved slightly. The Complainant stated that it was doctors at that UK hospital who informed them that the tracheostomy was very big compared to what it should have been.

After the three month admission at the UK hospital, the Patient was transferred back to the Hospital as nothing further could be done for him there.

The Complainant approached the Ombudsman in August 2016 (approximately three years after the Patient's first admission to Hospital) out of desperation that the Patient had zero quality of life and was in permanent care in a Ward at the Hospital.

He suffers from paralysis of the legs, arms, hands, torso, neck and vocal chords, has no swallowing reflex, is fed via a PEG (percutaneous endoscopic gastrostomy, a surgical procedure for placing a feeding tube) inserted in his stomach and breathes through a hole in his throat but is fully aware and can make decisions. The Complainant asked the Ombudsman to undertake an investigation into the case and the Ombudsman exercised his discretion to accept the complaint, considering the timeframe elapsed of notice of the matter alleged (Ombudsman Note: Section 12.(2) of the Public Services Ombudsman Act 1998 refers).

Investigation

The first part of the Ombudsman's investigation focused on establishing the treatment afforded to the Patient (what happened), whereas the second part focused on establishing whether appropriate treatment had been provided (what should have happened); the latter information obtained through independent clinical advice from medical professionals.

The Ombudsman requested statements from the medical team at the Hospital. There was a very lengthy delay in obtaining the information in respect of the treatment afforded by the consultant physician to the Patient as he no longer worked for the GHA and it was left to another consultant physician ("Consultant") to provide this. The Consultant's statement was received in August 2017.

PART 1 OF THE INVESTIGATION

CONSULTANT

The Consultant's statement was based on the information available in the Patient's medical notes. He stated that the Patient was admitted to the ICU on the 22nd September 2012 under the care of the consultant physician. He was experiencing sudden onset dizziness and vomiting and was being treated for a chest infection suffered a few days prior to admission but was previously a fit and healthy gentleman. According to the admission notes, the Patient felt unwell whilst shopping and was taken to A&E where he had an episode of confusion and jerky movement of his legs and was unable to focus at one point with his eyes. He had full mobility of four limbs and his speech was coherent.

The Consultant stated that the Patient's neurological examination was consistent with an acute cerebrovascular event i.e. a stroke. The CT head scan carried out that same day at 15:47 hours showed a subtle area of low density in the right posterior parietal lobe consistent with early infarction (stroke). The conclusion was probable right parietal infarct (stroke). He was reviewed by the consultant physician and started on anti-platelet medication twice daily and Heparin (Clexane) (medication used to stop blood clots from getting bigger and helping the body to break them down and to stop blood clots from forming in the blood).

Further investigations were recommended including an echocardiogram and a carotid Doppler (an imaging test that examines the 'carotid' arteries located in the neck). He was reviewed again the following day by the consultant physician and was noted to have improved to some extent and allowed to be transferred to the medical ward. He had a carotid Doppler on 25th September 2012 which showed normal flow bilaterally with no evidence of stenosis (abnormal narrowing of a body channel).

The notes revealed that the Patient's condition deteriorated on 26th September 2012; his conscious level reduced. He had a CT head scan that same day at 16:00 hours which showed marked progression in appearance with low density in the right posterior parietal lobe as well as the right occipital and right posterior temporal lobes. In addition there was a focal area of low density in the right cerebellar hemisphere. There was no evidence of haemorrhage. The Patient was transferred back to ICU at 18:30 hours and subsequently put on the ventilator to assist his breathing. In the meantime, his scans had been discussed with a neuroradiologist in the UK and the overall feeling was that it was due to stroke. For further clarity he had an MRI scan at a tertiary referral centre on the 28th September 2012 which showed basilar artery thrombosis[1] with multiple secondary infarcts[2] with no evidence of space occupying lesion[3]. The Patient subsequently developed 'locked in syndrome' and was transferred to a UK hospital for intensive neuro rehabilitation.

On the matter of whether upon admission to Hospital the Patient showed immediate signs of stroke and whether he was given appropriate treatment, the Consultant stated that the Patient exhibited signs of an acute stroke but the picture was confusing as to whether it was mid brain or posterior circulation stroke. Notwithstanding that, the initial treatment was appropriate.

The CT scan showed an established area of infarct and the basilar artery appeared dense. The CT angiogram[4] performed did not show any filling defect within the basilar artery. According to the Consultant, there is no documentation on whether there was any discussion about offering thrombolysis[5] to the Patient or transferring him to the nearest centre for thrombolysis and he believed that this was due to the lack of clear evidence of basilar arterial thrombosis on the CT angiography whereby a conservative approach was adopted to treat the Patient with dual anti-platelet therapy[6].

Regarding the question on whether during the four days in Hospital after the first stroke, further tests could have been performed or medication given to prevent a further stroke, the Consultant responded that the Patient had a carotid Doppler which was unremarkable and he had been given oral antiplatelet therapy and a cholesterol lowering drug.

On the question of whether the Patient had been prematurely transferred to the ICU, the Consultant stated that decision is often made by the consultant physician and his team depending on the stability of the patient. In this case, the Patient showed signs of improvement and the only remaining symptom was dizziness. According to the Consultant, the consultant physician must have felt satisfied that there was no reason for further cardiac monitoring or intensive care nursing. General periodic neurological observations are what he required and that is offered in a medical ward.

In relation to the query of whether a scan should have been performed on the same day when the second stroke occurred, the Consultant stated the first sign of deterioration was noted at 15:00hours on the 26th September 2012 and a repeat CT scan of head performed about an hour later. According to the Consultant, the appearances were suggestive of an ischaemic[7] event, however, inflammatory or neoplastic process could not be ruled out. For that reason an MRI scan was suggested by the reporting radiologist (Ombudsman note: The Ombudsman reviewed the medical notes and found that the MRI was requested on the 24th September 2012). As the Patient's condition deteriorated further, he was transferred to the ICU where he was intubated and put on the ventilator. The notes reveal that the MRI of his head was planned for 27th September 2012. However, it was performed on 28th September 2012 and this confirmed basilar artery thrombosis with multiple secondary infarcts (strokes).

The Consultant felt that it was important to mention that the Patient had a repeat MRI scan and MR angiogram performed on 14th November 2012 at the UK hospital which showed dissection of the left distal vertebral artery extending to the basilar confluence. The proximal basilar artery remained occluded, which was likely from the extension of the thrombus but there were no particular features to support dissection of the basilar artery itself. The Consultant pointed out that on the basis of this information it was probably the right decision not to thrombolyse (vital anti-coagulant injection) the Patient in the first place as he was at a high risk of catastrophic haemorrhage.

In respect of the tracheostomy, the Consultant stated the tracheostomy tube is inserted below the vocal chords and is unlikely to have affected the vocal chords. He did point out that the tracheal tube (intubation) can damage vocal chords and stroke can affect the speech but is less likely to affect the voice.

The Consultant reiterated that the information he had provided was based on the notes available and added that any attempt on his part to explain the actions of the doctors five years earlier would be inappropriate.

CONSULTANT ANAESTHESIST ("CA")

The CA explained that he had reviewed his notes and found his involvement to have been quite limited, and only relevant to the question about the timing of the MRI scan following the Patient's deterioration. The CA stated that from the initial admission, the Patient had been under the sole care of the consultant physician's medical team until he deteriorated with a decreasing level of consciousness on the 26th September 2012. The Patient had a repeat CT scan on that day, confirming the extent of the previously suspected stroke. The CA stated he had looked after the Patient on the 27th September 2012 further to the Patient having been intubated the evening before, following his deterioration. The CA noted he had tried to arrange an MRI scan for the Patient for that same day but only succeeded in getting one at a tertiary referral unit for the following day; the tertiary referral unit's MRI scan was broken down that day and a second option at a Cadiz (Spain) hospital was unavailable because they did not have any ICU beds and did not want to accept the Patient for an 'outpatient' MRI scan.

The CA stated that he had informed the Patient's family about the unavailability of an MRI scanner until the following day and noted that they were adamant that the MRI should be performed immediately. The CA recalled and noted a discussion with the consultant physician which centred around the fact that a scan would provide additional information as to a differential diagnosis of tumour or vasculitis but would not alter treatment at that stage.

CLINICAL DIRECTOR ANAESTHESIA & CRITICAL CARE ("CDA")

The CA referred the CDA to the Patient's case with regard to the tracheostomy. The CDA stated that he could not comment on the size of the tracheostomy as that was a surgical procedure undertaken by the Ear Nose & Throat Surgeon ("ENT") and explained that the norm is for percutaneous tracheostomies to be performed in the ICU by anaesthetists. However, if the neck is not suitable (short, obese) large thyroid, coagulation disorder or prominent vessels in the midline, the tracheostomy is referred to the ENT for surgical tracheostomy. From the Patient's medical notes, the CDA identified that the Patient had a large thyroid that took considerable time for the surgeon to divide.

EAR NOSE & THROAT SURGEON ("ENT")

In his statement, the ENT explained that he was asked to perform a tracheostomy for the Patient who was suffering from a stroke and needed long term ventilation. He explained that during long term ventilations, the tracheostoma (permanent opening into the trachea through the neck) tends to shrink and can make the changing of the tracheostomy tube very difficult for medical staff; the re-insertion of the tube can cause severe problems and can be very uncomfortable and painful for the patient. To prevent the shrinking of the tracheostoma with all the complications, the ENT decided to perform a percutaneous tracheostomy but use a different technique, Björk Flap (U shaped flap). The ENT explained that this type of trachestoma is usually bigger than a percutaneous stoma but tends not to narrow so much.

The ENT stated that no matter what technique is used, a tracheostomy cannot damage the vocal chords as these are located significantly higher and also protected by the thyroid cartilage.

PART 2 OF THE INVESTIGATION

CLINICAL ADVICE

The Ombudsman requested clinical advice from three UK medical professionals in the pertinent medical fields.

EAR NOSE & THROAT SURGEON CLINICAL ADVISER ("ENT ADVISER")

The ENT Adviser explained that patients who require a ventilator to assist their breathing, need a secure airway, and a tracheostomy is an effective method of achieving that objective. He stated that a tracheostomy is one of the life saving procedures in the medical practice and is mostly performed on patients who have difficulty in weaning off a ventilator, followed by those who have suffered trauma or a catastrophic neurologic injury. He added that tracheostomies may also be performed to provide a long term route for mechanical ventilation, in cases of respiratory failure or to provide a pulmonary toilet and that the *'Council of Critical Care of the American College of Chest Physicians'* recommends tracheostomy on patients who are expected to require mechanical ventilation for more than seven days. Notwithstanding this, he advised that the final decision is made on an individual basis, depending on the associated co-morbidities and the patient's current condition.

The ENT Adviser stated that there are many surgical methods to perform tracheostomy but the final technique depends on the individual patient's condition, the surgeon's experience and the guidelines of the facility where the procedure is to be performed. The ENT Adviser noted that it is acknowledged that the percutaneous technique is not the preferred technique in patients who suffer from obesity; abnormal or poorly palpable midline neck anatomy; patients who need emergency airways; have coagulopathy; enlarged thyroids; paediatric patients. He stated that the Björk Flap tracheostomy technique is one of the modifications of incisional tracheostomy with lesser complication rates.

In response to the Ombudsman's question on whether the ENT Adviser concurred with the ENT on the chosen procedure for the tracheostomy, the ENT concluded that after considering the review of medical literature and the Patient's medical records he agreed with the decision taken by the ENT.

The ENT Adviser highlighted that it is usual practice to discuss with the patient and or relatives the details of the surgical procedure, side effects, long term plan for follow up, complications, etc. as well as the post operative recovery period and this should be documented in medical records. The ENT Adviser reviewed the medical notes and found that information was not documented in the Patient's medical notes other than some hand written words which were illegible. The ENT Adviser did not find any consent forms that should have explained the possible risks of the tracheostomy.

On the question of whether the Patient's vocal chords could have been affected by the tracheostomy, the ENT Adviser stated that was very unlikely. The tracheostomy is making a portal opening in tracheal rings and those are located far down from the level of the vocal chords. The ENT Adviser stated that it is well acknowledged that damage to the vocal chords is not one of the known complications of tracheostomy.

By way of further information, the ENT Adviser stated that the tracheal intubation (ventilation tube) can harm the vocal chords and that harmful effect of the stroke on the vocal chords function cannot be entirely excluded, depending on the stroke location in the brain.

CONSULTANT STROKE PHYSICIAN CLINICAL ADVISER ("CS CLINICAL ADVISER")

The CS Clinical Adviser had been a consultant stroke physician for over fifteen years. He stated that the symptoms of a posterior circulation stroke (quite rightly suspected at A&E) can be very subtle and difficult to diagnose even by experienced clinicians but explained that the assessment at the Hospital was thorough and had identified several important signs. The CS Clinical Adviser confirmed that the necessary tests, i.e. a CT brain scan and even a CT angiogram were performed in a timely manner and in keeping with current good practice.

Notwithstanding this, the CS Clincal Adviser stated that it was possible the Patient was seen within the time window for thrombolysis (clot busting treatment which would be administered within four and a half hours from onset of the stroke although many authorities would treat basilar artery occlusion even after that timeframe) which in 2012 was a well established treatment in the UK and Europe. The CS Clinical Adviser stated that it is clear that the Hospital did not have a stroke unit and did not thrombolyse patients routinely, but added that what was not clear due to lack of documentation, is whether there where policies in place to transfer potential thrombolysis patients to stroke centres and whether those policies were followed. He added that patients with acute stroke are best managed by a specialist stroke team in a stroke unit, in keeping with established good practice and guidelines in 2012. The CS Clincal Adviser further stated that patients presenting within the time window for thrombolysis should be considered for that treatment unless there are contraindications or reasons not to proceed in which case, those reasons should have been documented. According to the CS Clincal Adviser, there were a few potential reasons why thrombolysis could have been difficult in the Patient's case and not have produced the desired result:

(i) The time of onset of the stroke is not documented either in the medical notes or the ambulance sheet and it is possible that the precise onset time was not known. The thrombolytic drug would have to be administered within 4.5 hours of onset to be in keeping with established good practice.

(ii) The CT head scan on the 22nd September 2012 at 15:47 hours showed a small area of visible infarction in the right parietal, suggesting that the actual onset of the stroke may have been earlier than when the Patient collapsed; it takes several hours for the changes of infarction on a CT head scan to appear.

(iii) The cause of the basilar artery occlusion was the dissection of the extracranial (V3) and intracranial (V4) portions of the vertebral artery. Intracranial dissection has a 10% risk of bleeding in the brain and this could have been made worse by thrombolysis. However, dissection of an artery is not an official contraindication to thrombolysis and in most instances, dissection is diagnosed after the thrombolysis has been given.

The CS Clinical Adviser stated that the Patient had suffered a rare and very severe stroke (basilar artery occlusion caused by dissection of the intracranial and extracranial part of the left vertebral artery) which can be difficult to diagnose and treat, even by experienced stroke specialists. The prognosis of the basilar artery occlusion can be very poor with almost 60% of sufferers progressing to severe deficits, including the 'locked in state'. The CS Clinical Adviser stated that the onset can be atypical and stuttering and many unusual symptoms can occur which makes diagnosis difficult. He added that although a proportion of patients can improve spontaneously and not have very disabling strokes, the only effective treatment which could reduce death and disability is to restore circulation to the blocked basilar artery by either intravenous thrombolysis and intra arterial thrombolysis/ clot retrieval (procedures not widely available in 2012).

The CS Clinical Adviser explained that he has no way of knowing if the outcome would have been different if the Patient had been treated by an experienced stroke team in a centre with a stroke unit. He also noted that thrombolysis was not considered as a treatment option, and if considered, there was no documentation as to why it was discounted. He stated that was not in keeping with established good practice or guidelines in place in 2012.

Regarding the Ombudsman's question of whether the Patient's second stroke could have been prevented, the CS Clinical Adviser stated that the Patient had been started on adequate secondary prevention (aspirin and dipyridamole tablets). He explained that a proportion of patients with iscahemic strokes, including basilar artery strokes, can progressively get worse or have recurrent strokes, in spite of secondary prevention. The CS Clinical Adviser concluded that the second stroke could not have been foreseen or prevented.

In respect of whether having an MRI undertaken on the same day of the second stroke would have made any difference, the CS Clinical Adviser concluded that this would not have made any difference as no change in treatment would have resulted. There is no effective treatment to undo the damage at that stage of a stroke.

CONSULTANT DIAGNOSTIC & INTERVENTIONAL RADIOLOGIST CLINICAL ADVISER ("Radiologist CA")

The Radiologist CA reviewed the images of the CT scan and the CT angiogram performed on the 22nd September 2012. He noted from the CT scan that there was subtle hyper density in the lower basilar artery (slice 126.79mm) and there was evidence of mild small vessel ischaemic change in the white matter and some established cortical volume loss and subcortical low density change in the posterior watershed region (old infarct). The Radiologist CA stated he could not see clear evidence of acute infarct in the anterior or posterior circulation. On the CT angiogram, the Radiologist CA noted there was a low density filling defect in the distal left vertebral artery/lower basilar artery. The appearance was consistent with an occlusive thrombus blocking the dominant left vertebral artery and lower basilar artery. The distal basilar circulation is filled (enhancing with contrast) from collateral circulation via the circle of Willis (the left posterior communicating vessel).

The Radiologist CA noted that the clinical information provided in the CT request included dizziness, confusion, vomiting, nystagmus (vision condition), leg twitching and was consistent with a posterior circulation event (affecting posterior circulation supplying one side of the brain).

The GHA radiologist noted hyper density in the basilar artery on the CT scan study and performed a CT angiogram to look for basilar artery occlusion but did not detect the occlusive thrombus on the CT angiogram images. The Radiologist CA concluded that the GHA radiologist had missed imaging evidence of left vertebral and lower basilar occlusion on the CT angiogram. He had misinterpreted mature ischaemic changes in the posterior watershed as evidence of acute parietal infarct (this would indicate an anterior circulation stroke pattern). In respect of the CT performed on the 26th September 2012, the Radiologist CA stated that the GHA radiologist described the changes inaccurately but correctly attributed them to stroke as the most likely diagnosis and noted that an MRI was booked for the following day. The Radiologist CA explained that at that point, the Patient's clinical deterioration was most likely due to progressive basilar artery thrombosis.

An opportunity was missed to appreciate the significance of the change in CT scan appearances (images from 22nd September 2012) and to identify the likely cause of progressive posterior circulation stroke, either by reviewing the previous imaging and detecting the thrombus or by proposing further immediate imaging (repeat CT angiogram or urgent MRI) to identify the cause of deterioration and potentially consider treatment options.

On the MRI report performed on the 28th September 2012, the Radiologist CA advised that he agreed with it and that at that point there was established bilateral brainstem infarction.

In response to the Ombudsman's question on whether the second stroke on the 26th September 2012 could have been prevented, the Radiologist CA stated that unfortunately it could have been prevented. The opportunity to detect the location of the arterial clot was missed on the CT scan and CT angiogram and at that point there was no convincing evidence of acute stroke on CT in any arterial territory. Had the clot been identified on the admission CT scan it is possible that a treatment may have been instituted at the time and might have prevented the clot extending to involve the mid basilar artery and right posterior cerebral artery. Treatment may have resulted in a favourable modification of the Patient's clinical course. Detection of the clot would have provided the clinical team with a clear diagnosis and would have enabled consideration of management options either within the GHA (if able to administer intravenous thrombolysis) or in the regional neuroscience centre (Radiologist CA not aware what arrangements were in place in 2012 to manage patients with acute stroke due to large vessel occlusion). The Radiologist CA added that process was prior to clear evidence of the benefit of mechanical thrombectomy for patients with anterior circulation stroke due to occlusion of a large cerebral vessel [Goyal M HERMES Collaboration. Lancet 2016:387:1723-1731].

The Radiologist CA stated that it was also possible that early detection of the vertebral clot and treatment by whatever method may not have altered the outcome for the Patient. Basilar artery thrombosis can be a difficult condition to diagnose, particularly in a district hospital setting, and while good outcomes are unlikely without early diagnosis and treatment, overall management outcomes are variable and often poor, whatever treatment is provided.

The Radiologist CA further added that detection of arterial occlusion on plain CT scans can be difficult and all radiologists make mistakes but notwithstanding this, it is hard to explain how the thrombus was missed in this case where the GHA radiologist performed at CT angiogram to specifically look for evidence of thrombus in the basilar artery, suspected from CT before contrast. One possible explanation offered by the Radiologist CA relates to the timing of the contrast arrival on the CT angiogram study, as the lower carotids (arteries supplying blood to the brain), left vertebral and lower basilar are not opacified on the largest data set and it is not clear from the images provided on disc how many acquisitions were in the study, i.e. it is possible that the GHA radiologist did not look at all of the images.

According to the Radiologist CA, even at the later stage on the 26th September 2012 when the Patient's clinical situation was deteriorating, appreciation of the diagnosis might have altered patient management. At that point, IV thrombolysis was contraindicated and the Radiologist CA stated he would not argue that an interventional procedure would definitely have altered the outcome but the intervention might have been considered as the Patient did not have imaging evidence of brain stem infarction on the CT (26.09.12). However, had the diagnosis been appreciated after the second CT, a referral for intervention may have been declined for a number of reasons including, service availability and factors related to prognosis for patients with basilar artery occlusion.

In response to the Ombudsman's enquiry on whether an MRI should have been performed on the same day after the second stroke and if so, how that would have benefited the Patient in the treatment, the Radiologist CA stated that an MRI was requested on the 24th September 2012 and had that service been available locally, basilar artery occlusion might have been detected prior to the Patient's deterioration on the 26th September 2012.

By way of further information, the Radiologist CA highlighted that though the admission CT was incorrectly reported as showing an acute parietal infarction, there is subsequent documentation in the medical notes that the Patient's clinical signs did not correlate with a parietal stroke. He further added that it is well recognised that basilar artery occlusion can be difficult to detect and is often missed and regardless of treatment, may have a poor outcome.

Moving forward, the Radiologist CA suggested that the GHA inform the Patient and his family that there was an error in the original CT and CT angiogram report and discuss the possible implications of the error with them. He also suggested that the GHA discuss the reporting error at the radiology discrepancy meeting and review the case for team learning.

GHA RADIOLOGIST STATEMENT

Further to the Radiologist CA's clinical advice, the Ombudsman contacted the GHA's Medical Director to request the GHA's Radiologist's comments. The salient points from the latter's response have been set out below.

The Radiologist highlighted that the Radiologist CA was a specialist neuroradiologist who was too specialised to provide a fair assessment of a general radiologist in a centre that lacked a stroke unit.

The GHA Radiologist noted the time of the initial scan, 15:50 hours, which he reported on, and does not think that his opinion was extraordinarily different to that offered by the Radiologist CA. They both described an 'infarct' but the Radiologist CA stated that it was 'old' rather than 'acute'. The GHA Radiologist states that in the absence of previous imaging, this distinction in such a subtle finding can be difficult on CT. Nonetheless, he appreciated and respected the expert's opinion and stated he would bear this diagnosis in mind in future cases with similar patterns of imaging abnormalities.

The Radiologist stated he performed the initial CT Scan on the 22nd Sept 2012 at 15:50 hrs (referred to by Radiologist CA as being performed at 15:47; note there are two times "saved on the CT image" and the GHA Radiologist states his is the correct one) was reported by him as also showing *"The basilar appears dense..."* and is the reason why he asked the on-call Radiographer to perform a CT angiogram.

The CT angiogram was performed at 16:42 hrs. The GHA Radiologist stated he has reviewed his report (which clearly relates to this 16:42 hours CT angiogram) with three consultant radiologist colleagues who concur with his report.

The GHA Radiologist notes he made comment to the contrast dynamics being suboptimal and to the lack of evidence of filling defect within the basilar artery, both true to this specific study. The Ombudsman sought information from the GHA Radiologist on whether it would have been common practice for him to have requested another scan if the contrast dynamics were 'suboptimal' and asked for clarification on what the 'lack of evidence of filling defect' meant. The Radiologist explained that the request for another scan depended on many factors. Possible scenarios would be if the blood vessel in question did not contain any contrast; then it would be repeated. In this case, it was partially opacified rather than not opacified at all and it is unlikely that a repeat scan was requested. Radiologists usually make comment on whether contrast dynamics are suboptimal (in CT angiographic studies) so that the requesting clinician is aware that the study has not been perfect. There are times when the examination is repeated if the clinical suspicion is high (usually after discussion with Consultant clinician in charge) but when that is done it is often 24 hours after the original scan as there can be clinical consequences to giving too much IV contrast to a patient. There are occasions when the benefit of repeating a study would be discussed with the consultant physician in charge as they would take into account the patient's clinical condition and the benefit of repeating such a study but the GHA Radiologist could not recall if he had a conversation with the referring clinician about this specific matter in this case. He stated that if he had requested a second scan, it would have been his normal practice to have made it clear in the report that the study was repeated for a given reason. There is no reference to this on the report. Given the timeframe, the radiographer does not recall what happened in this particular case. Regarding the 'lack of evidence of filling defect', the GHA Radiologist stated it meant that on that specific study that he reported, he did not see definite evidence of thrombus in the artery (filling defect usually = thrombus). Regarding the timeframe for reporting after imaging is obtained, the GHA Radiologist advised that for an out-of-hours CT scan, most scans are reported within the hour after the scan is done and he usually reported these even sooner.

The GHA Radiologist pointed out that the Radiologist CA refers to 16:13 for the CT angiogram images and notes that there are two times recorded on the CT scans and the Radiologist CA refers to the wrong time, especially from a chronological point of view.

On review of all the imaging, the GHA Radiologist states it is apparent that a *second* CT scan was performed some minutes later at 16:47 hours and is the image set which the Radiologist CA refers to and where he concludes the *"...appearance is consistent with an occlusive thrombus, blocking the dominant left vertebral artery and the lower basilar artery."* The Radiologist agrees with this interpretation. He is not sure why this CT scan was performed and the imaging parameters, as confirmed with the CT lead radiographer, are of a CT head and not of a CT angiogram. The GHA Radiologist discussed this with the radiographer on-call that day and they are not sure why this was the case either as this happened six years ago. The CT radiographer lead has checked the paper records of the scan to check for any comments from the radiographer at the time but unfortunately these are not available from 2012. In addition, the Radiology Services Manager has checked the "CT fault" records book but that goes back to 2013 only. The GHA Radiologist stated it would be fair to say that they experienced regular faults with the old CT Scanner which was one of the reasons for replacing it in 2015 and with the new CT Scanner and software there is a more comprehensive way of automatically transferring required imaging and making this situation less likely to occur.

The GHA Radiologist interprets that the Radiologist CA believes that the CT angiogram and another image set are part of the same CT scan but they are separate studies. The GHA Radiologist believes he provided his report for the CT angiogram performed at 16:42 hours. He did not know that the second scan had been performed at 16:47hours nor did he have those images. The most likely reason given by him is that the second CT images did not transfer to the Picture Archiving and Communication System ("PACS") at the time as a result of a technical fault with the CT Scanner (the faults referred to above by GHA Radiologist). The GHA Radiologist stated that when that had happened in the past, the images sometimes transferred over onto PACS the next time the scanner was used or switched off and on again; on occasions the images need to actively be "pushed" onto PACS when someone noted they had not been transferred successfully. However, the GHA Radiologist stated that he couldnot know that images had not been transferred onto PACS if he was not aware that those images had been taken.

The GHA Radiologist stated that the statement by the Radiologist CA: *"A possible explanation relates to timing of the contrast arrival on the CTA study as the lower carotids…and it is not clear from the images provided on disc how many acquisitions were in this study (it is possible that the radiologist did not look at all of the images)"* supports his report of the first CT angiogram (16:42 hours), supports the fact that there was more than one CT scan done, as explained above, and supports his belief that he did not look at all the images *as they were not available to him* at the time of reporting and it was not known to him that a further acquisition of any sort had been obtained.

The GHA Radiologist noted that this case has heightened his awareness for the need for smooth communication with colleague radiographers on whether there were any technical issues with a scan and whether any steps were taken to remedy these. He stated that with the purchase of the new CT scanner (2015), it would be fair to say that workflow had improved, with less technical glitches of this type.

With respect to the subsequent CT performed on 26/9/2012, the GHA Radiologist feels that his findings generally correlate with the Radiologist CA's interpretation and the conclusion agrees with stroke.

The GHA Radiologist refutes the statement by the Radiologist CA: "An opportunity was missed to appreciate the significance of the change in CT scan appearances (compared with 22/9/2012)…" He refers to his report which clearly states that "There has been marked progression in the appearances with low density now seen…" and thinks the wording reflects a significant change in appearances from the previous CT, as also interpreted by the Radiologist CA.

The GHA Radiologist agreed that there could have been an opportunity to perform an urgent MRI sooner but does not recall, nor has any documentation on the radiology records, of any discussion for the MRI to be arranged out of hours which in 2012 would have meant travelling to a tertiary referral centre. Out of hours (as in this case), this would have involved a hospital transfer and referral to a receiving team elsewhere, which Radiology are usually not involved in. During normal working hours, the Radiology department facilitate appointments in nearby imaging centres.

He noted that the Patient demonstrated a slight clinical improvement "the following day" (i.e. 23rd Sept 2012) when he was transferred to the ward and suspects that this would have contributed to the decision making on the timing of the MRI by the attending clinical team.

Had a local MRI Scanner been available, then it is quite likely that the Patient would have undergone an in-patient MRI study which may well have led to the diagnosis sooner than obtained in this instance. However, to assess whether this would have altered the outcome the lack of a local thrombolysis service needs to be taken into account. The Radiologist points to the CS Clinical Adviser's statement that the second stroke could not have been foreseen or prevented and does not feel best placed or confident in making either statement but feel the CS Clinical Adviser is best placed to offer such a view.

The GHA Radiologist agreed with the Radiologist CA that the GHA inform the Patient and his family that there was an error in the reporting of the CT angiogram for the reasons explained above. He also agreed with the Radiologist CA's suggestion to discuss the case at the Radiology discrepancy meeting and review for team learning. The case had already been listed for that and informally discussed with colleagues.

The GHA Radiologist concluded that the context of his radiological reports should be taken in the context of his scope of work, which is that of a general radiologist in a small district general hospital setting, a member of a team of three Radiologists (at the time). Apart from breast radiology and a few other minor specifics, he states he is responsible for interpreting and reporting a wide variety of imaging procedures and techniques and did not and does not have access to "emergency" tertiary opinions. This should be contrasted with the Radiologist CA's opinion and his scope of work which is of a Consultant diagnostic and interventional neuroradiologist in a large UK Regional Neuroscience Unit. This implies that he spends 100% of his time dealing with neuroimaging alone.

The GHA Radiologist agreed with the general opinion (by the Radiologist CA and CS Clinical Adviser) that these rare types of strokes can be difficult to diagnose and treat, with a generally poor prognosis in basilar artery occlusion.

From a radiology-specific perspective in this case however, the GHA Radiologist stated that the explanation for missing the diagnosis on the CT angiogram, as explained above, was not for lack of trying or considering the diagnosis, but rather a technical glitch which resulted in images which he did not know had been acquired not being available to him as the reporting radiologist.

The Ombudsman enquired further on the CT scan faults and was informed by the GHA Radiologist that the previous CT scanner gave regular technical errors but he could not give specific dates. The faults were dealt with as and when they occurred and would be dealt with either locally or by a visiting technical team, depending on the problem. The same would be the case with the present new scanner.

The GHA Radiologist explained that there are many types of errors as it is complex machinery as well as software. If an error rendered the CT scanner not usable, as occurred occasionally, patients would then have to go to a tertiary referral centre for scans. Another member of the Radiology team stated that there were many different issues over a very long period of time with not much that could be done other than to report the faults.

GHA RESPONSE IN RESPECT OF THROMBOLYSIS TREATMENT

Further to clinical advice provided, the Ombudsman contacted the GHA to enquire whether thrombolysis treatment was available in 2012 when the Patient suffered the stroke. The Consultant responded that the GHA did not have thrombolysis in stroke service in 2012 and still do not have that service. He explained that embolic strokes had been managed conservatively and in recent years, some patients had been referred for clot retrieval to tertiary referral centres in Spain. In 2012 there was no nearby centre to refer patients for thrombolysis after stroke within the recommended timeframe. In respect of the treatment guidelines followed in Gibraltar, the Consultant stated that the GHA follows UK/NICE (National Institute for Health & Care Excellence) guidance as much as possible but added that there are some geographical constraints.

Conclusions

In respect of what happened to the Patient, it is both the CS Clinical Adviser's and the Radiologist Clinical Adviser's opinion, that the Patient suffered a rare and very severe stroke which can be difficult to diagnose and treat, and regardless of treatment, may have a poor outcome.

Regarding treatment for basilar artery occlusion, the CS Clinical Adviser stated that the only effective treatment which could reduce death and disability in those cases is to restore circulation to the blocked basilar artery by either intravenous thrombolysis and intra arterial thrombolysis/clot retrieval (the latter, procedures not widely available in 2012). The CS Clinical Adviser explained that he has no way of knowing if the outcome would have been different if the Patient had been treated by an experienced stroke team in a centre with a stroke unit. He noted that thrombolysis was not considered as a treatment option, and if considered, there was no documentation as to why it was discounted. The CS Clinical Adviser stated that was not in keeping with established good practice or guidelines in place in 2012.

The Radiologist Clinical Adviser stated that had the clot been identified on the admission CT scan it is possible that a treatment may have been instituted at the time which might have prevented the clot extending to involve the mid basilar artery and right posterior cerebral artery. Treatment may have resulted in a favourable modification of the Patient's clinical course. Detection of the clot would have provided the clinical team with a clear diagnosis and would have enabled consideration of management options either within the GHA (if able to administer intravenous thrombolysis) or in the regional neuroscience centre (Radiologist CA not aware what arrangements were in place in 2012 to manage patients with acute stroke due to large vessel occlusion).

The GHA's response to the Ombudsman's enquiry in relation to the above was that in 2012, and still to date, there is no thrombolysis in stroke service and that embolic strokes were and are managed conservatively. The GHA stated that in recent years, some patients have been referred for clot retrieval to tertiary referral centres in Spain but that in 2012 there was no nearby centre to refer patients to, for thrombolysis after stroke, within the recommended timeframe.

In respect of whether having an MRI undertaken on the same day of the second stroke would have made any difference, the CS Clinical Adviser concluded that it would not have, as no change in treatment would have resulted as there is no effective treatment to undo the damage at that stage of a stroke. Notwithstanding, the Radiologist CA's opinion was that had an MRI which was requested on the 24th September 2012 been performed before the Patient's deterioration on the 26th September 2012, the basilar artery occlusion would have been detected.

The CS Clinical Adviser concluded that the second stroke could not have been foreseen or prevented.

The Radiologist CA concluded that the GHA radiologist had missed imaging evidence of left vertebral and lower basilar occlusion on the CT angiogram. He had misinterpreted mature ischaemic changes in the posterior watershed as evidence of acute parietal infarct (this would indicate an anterior circulation stroke pattern). The Radiologist CA further added that detection of arterial occlusion on plain CT scans can be difficult and all radiologists make mistakes but notwithstanding this, it is hard to explain how the thrombus was missed in this case where the GHA radiologist performed at CT angiogram to specifically look for evidence of thrombus in the basilar artery, suspected from CT before contrast.

From the GHA Radiologist's statement, the main issue identified is that the CT scan in use at the GHA in 2012 experienced occasional technical glitches. In this case, the glitch resulted in images which the GHA Radiologist did not know had been acquired by the radiographer, not being available to him as the reporting radiologist at that time. From the images of the CT scan the GHA Radiologist reported on, he did not see definitive evidence of thrombus in the artery, and he noted the contrast dynamics were suboptimal. The second CT scan which the Radiologist CA reviewed but which the GHA Radiologist was not aware of, did show the thrombus.

[Ombudsman Note: It was only when the Ombudsman requested that radiology provide a copy of the Patient's imaging for the purpose of clinical advice that the second CT scan images came to light.].

The above raises issues of concern. Firstly, that GHA management who undoubtedly must have been aware of the CT scan's technical glitches, allowed that machine to continue in use until 2015, regardless of the potential consequences this could have had on patients. Secondly, that although the GHA were aware of the technical issues of images being retained in the system by the CT scan, they failed to introduce fool proof measures and procedures to mitigate those. A system of additional checks should have been implemented and a more effective system of communication between radiographers and radiologists should have been in place. Had the aforementioned systems been in place, the GHA Radiologist would have been able to report on the second CT scan instead of on the suboptimal images which led to the basilar artery occlusion being missed.

Complaint (i)

Was there any maladministration on the part of the GHA in the Patient's case? - **Sustained**

Complaint (ii)

If the Patient showed signs of having suffered a stroke when he arrived at the Hospital was he given appropriate treatment? – **Not Sustained**

Complaint (iii)

If the scan results showed the Patient suffered a stroke and not a brain haemorrhage why was the vital anti coagulant injection not administered? – **Not Sustained**

Complaint (iv)

During the subsequent four days spent in Hospital before the second stroke, were there further tests that could have been performed or medication given to prevent a further stroke? – **Sustained**

The salient matter identified by the Ombudsman in the investigation into this case is the fact that the GHA radiologist failed to identify the evidence of thrombus in the basilar artery, despite having undertaken a CT angiogram because of the suspected thrombus, further to the Patient's initial CT. Notwithstanding the fact that the treatment given to the Patient may not have altered, as there was no thrombolysis service available to the GHA in 2012, the appropriate course of action should have been to inform the Patient and relatives of the situation which would have placed them in a better position to consider options of their own.

However, the GHA Radiologist provided a counter argument to this view, namely, that the CT Scanner suffered technical difficulties for a considerable period of time and in some cases retained images (as was the case with the Patient). Although the Ombudsman took this factor into account when drafting this report, he also opined that since the non production of images in some cases was a fact which the radiology team was already well aware of, this "technical glitch" could have therefore been addressed/ identified by simply having established an effective line of communication between radiographers and radiologists.

Of concern is the fact that reporting on sub-optimal imaging in this case, led to the basilar artery occlusion not being identified.

Based on this analysis, the Ombudsman considers there was maladministration in the manner in which the GHA treated the Patient and concurred with the Radiologist CA's suggestion that the GHA should discuss the circumstances leading to the radiological misdiagnosis and its implication to the Patient and family. The Ombudsman, in keeping with the fact that complaints can serve as valuable learning tools, further concurred with the Radiologist CA's suggestion that the GHA should discuss the CT and CT angiogram's reporting misdiagnosis and review the case for team learning.

Complaint (v)

Was the Patient prematurely transferred from the ICU to the Ward? – **Not Sustained**

The Consultant explained in his statement that the decision to transfer a patient from the ICU to the medical ward is often made by the consultant physician and his team depending on the stability of the patient. The Patient showed signs of improvement and the only symptom remaining was dizziness so the consultant physician must have felt satisfied that there was no reason for further cardiac monitoring or intensive care nursing. Periodic neurological observations required were offered in the medical ward.

The clinical advisers did not raise an issue in respect of the Patient's transfer from the ICU to the medical ward.

Based on the findings of this investigation, the Ombudsman was of the view that there was no maladministration in this regard and the Patient was not prematurely transferred from the ICU to the Ward.

Complaint (vi)

Should an urgent MRI scan have been performed? - **Sustained**

An MRI undertaken on the same day of the second stroke would not have made any difference as no change in treatment would have resulted as there is no effective treatment to undo the damage at that stage of a stroke. Notwithstanding this, the Radiologist Clinical Adviser's opinion was that had an MRI which was requested on the 24th September 2012 been performed before the Patient's deterioration on the 26th September 2012, the basilar artery occlusion would have been detected. This was a second missed opportunity by the GHA to have detected the thrombus and informed the family and despite the GHA not having a thrombolysis service available in 2012, as detailed in the conclusion to complaints (i) to (iv) above, would have put the Patient and relatives in a position to consider options of their own.

The Ombudsman finds maladministration with regards to the lack of urgency placed in obtaining an MRI scan appointment.

Complaint (vii)

Was the tracheostomy too big and could that have damaged the Patient's vocal chords or was the damage as a result of the stroke? – **Not Sustained**

Both the ENT and the ENT Adviser concurred that it was very unlikely that the Patient's vocal chords could have been affected by the tracheostomy. The ENT Adviser further stated that the tracheostomy makes a portal opening in tracheal rings located far down from the level of the vocal chords and that therefore, damage to the vocal chords is not one of the known complications of tracheostomy.

By way of further information, the ENT Adviser stated that the tracheal intubation (ventilation tube) can harm the vocal chords and that harmful effect of the stroke on the vocal chords function cannot be entirely excluded, depending on the stroke location in the brain.

The ENT Adviser highlighted that there was no information documented in the Patient's medical notes with regard to having discussed with the Patient and/or relatives, all issues related to the tracheostomy and potential post operative complications. The ENT Adviser did not find any consent forms that should have explained the possible risks of the tracheostomy.

Further to having analysed the information gathered in relation to the investigation, the Ombudsman concluded that the ENT had made an informed decision as regards the chosen tracheostomy technique carried out on the Patient.

The Ombudsman did find, as a result of the investigation, that there was no medical documentation and no consent forms related to the tracheostomy in the Patient's medical files. It is therefore clear that the ENT did not provide pertinent information to the family and/or the Patient on the tracheostomy procedure, which would have gone some way in allaying their concerns regarding the procedure and possibly prevented this particular complaint. The Ombudsman proposed that in future cases, medical staff should communicate effectively with relatives and/or patients to prevent further hardship and that medical staff should document this information accordingly in patients medical notes.

Classification

Partly Sustained

Recommendations

The Ombudsman recommends that GHA management address the two main issues in this complaint which are (i) the circumstances leading to the radiological misdiagnosis and its implication to the Patient and family and (ii) the lack of communication between the ENT and Patient/family in respect of the tracheostomy and possible complications resulting from the procedure.

The Ombudsman further recommends that in future, pertinent documentation be recorded in patients' medical notes.

Furthermore, the Ombudsman is very concerned at the fact that the GHA took at least three years to replace a faulty CT scan which must have no doubt impacted on the diagnosis of other patients conditions and would recommend that lessons are learned from this case.

(Report extracted from HEALTH CS 2017-47)

GIBRALTAR HEALTH AUTHORITY

Case 11

Complaint

The Complainant was aggrieved by the GHA in respect of the management of his cancer diagnosis from his first attendance to the Accident & Emergency Department at St Bernard's Hospital ("A&E") to the point when it was decided not to perform resecting surgery. The Complainant believed that had the time-lapse between one point and the other been shorter, he might have had a better chance of survival.

The Complainant stated that on Sunday 22nd May 2016 he attended A&E as he was experiencing chest pains, and given that he has a stent in the heart, he was worried that something was wrong.

The Complainant explained that after various tests were carried out he was admitted to the Intensive Care Unit ("ICU") where he was given a blood transfusion due to his haemoglobin count being very low.

He stated that he remained in the ICU for a week where further tests were carried out including an endoscopy. The Complainant was eventually informed by the Surgical Consultant ("Surgical Consultant 1") that a biopsy should be carried out as he was certain that the Complainant had "some type of cancer". He was told not to worry however, given that the treatment consisted of a simple surgical procedure.

The Complainant explained that it was not until August/September 2016 that he began treatment in Xanit Hospital, Benalmadena, Spain. He explained that prior to commencing treatment, every time he inquired about what was happening with his condition, he was informed that they [the GHA] were working on it. The Complainant explained that after several "Biopsies, Pet scans, Cat scans, various Endoscopies", he was finally administered chemotherapy at Xanit Hospital for 9 consecutive weeks during the months of August/ September 2016.

After the chemotherapy sessions were complete, the Complainant was referred to the Oncologist at Xanit Hospital who contrary to what Surgical Consultant 1 had explained in May 2016 (5 months earlier), informed him that his stomach and 'part if not all" of his oesophagus needed to be removed. The Complainant stated that although this came as a shock to him, he agreed with the doctors as he had no other option. However, to his dismay, after the surgery, he found out that the surgeons in Xanit Hospital had only been able to perform an exploratory procedure where it was decided not to remove his stomach or oesophagus.

On his return to Gibraltar, the Complainant was seen by a second Surgical Consultant ("Surgical Consultant 2") who took over his care as a result of Surgical Consultant 1's departure. Surgical Consultant 2 informed him that his condition was now inoperable and incurable and advised him to retire from work to enjoy the time he had left.

The Complainant was aggrieved and lodged his complaint with the Ombudsman as he felt that had he started his chemotherapy sessions shortly after May 2016 rather than in August/ September 2016, his cancer may still have been operable.

Investigation

The Ombudsman wrote to the Medical Director and requested information from the various medical professionals involved in the Complainant's care. The Ombudsman also obtained a copy of the Complainant's medical notes and reviewed them.

The Medical Director

In his reply to the Ombudsman's request for information, the Medical Director informed the Ombudsman that Surgical Consultants 1 and 2 had since left the GHA. He explained that as a result of the two consultants' departure he had requested the information from the Cancer Services Coordinator and the GHA's newly appointed Surgical Consultant with a speciality in Upper Gastrointestinal surgery ("Surgical Consultant 3"). The Medical Director specifically asked Surgical Consultant 3 to review the Complainant's medical notes with the purpose of identifying whether there had been any significant delays in addressing the Complainant's cancer diagnosis from May 2016 up until it was decided that the surgery could not be performed.

Cancer Services Coordinator – Timeline

The Cancer Services Coordinator presented the Ombudsman with the following timeline of events regarding the Complainant's medical interventions;

22nd May 2016 – *Complainant attended A&E with chest pain & anaemia. Portable X-ray of chest normal: Heart size at the upper limit of normal. No lung consolidation. No pleural effusion.*

23rd May 2016 - *Admitted to Dudley Toomey Ward to investigate cardiac condition. Hx (Medical History taken). An Oesophago-Gastro-Duodenoscopy carried out. Which showed that the stomach looked malignant at 38cm. Samples sent to Pathology. CT scan requested.*

24th May 2016 – *CT scan performed.*

26th May 2016 – *CT of Thorax, Abdomen and Pelvis performed. Report stated "locally advanced gastric CA with suggested spread of tumour limiting potential resection". Surgical Consultant 1 reviewed the Complainant and requested a PET scan.*

30th May 2016 – *Pathology results from Gastroscopy showed "Gastric cardia-focal atypia, suggesting high grade dysplasia but adenocarcinoma cannot be excluded. The Gastroscopy also revealed there was a presence of oesophageal mucosa, in keeping with Barrett's disease, with intestinal metaplasia. Additionally, the GHA sent Samples obtained from the Gastroscopy for a second opinion to the Royal Marsden Hospital in the United Kingdom)"*

31st May 2016 – Complainant was discharged from St Bernard's Hospital.

2nd June 2016 – *Letter from Surgical Consultant 1 to Xanit Hospital's Oncologist & Upper Gastroenterology Surgeon requesting an urgent assessment of whether the Complainant was suitable for surgery or Chemotherapy only.*

3rd June 2016 – Complainant had outpatient appointment at Xanit Hospital with the Oncologist. Since pathology was not clear, the Oncologist wrote to Surgical Consultant 1 explaining that a further gastroscopy with biopsy was required. The Complainant was informed that after PET-CT the following week, he was to return to see the Oncologist.

9th June 2016 – *PET-CT carried out.*

14th June 2016 – *PET-CT Report stated "increased (pathological) tracer uptake in the gastro -oesophageal junction, gastric cardia and proximal segment of the lesser curvature of the stomach compatible with known cancer.*

15th June 2016 – *Royal Marsden Hospital second opinion of pathology received. Report stated "…features are best regarded as at least intra-mucosal invasive adenocarcinoma…if radiological features do not fit with invasive adenocarcinoma then re-biopsy should be considered…"*

16th June 2016 – *Surgical Consultant 1 wrote to the Oncologist in Xanit Hospital explaining that the 1st Gastroscopy showed a carcinoma of the stomach, but biopsies were not positive. He therefore requested an urgent repeat Gastroscopy at Xanit Hospital.*

20th June 2016 – A*ppointment at Xanit Hospital for repeat Gastroscopy under sedation with biopsies taken and pulmonary auscultation. X-ray also carried out.*

21st June 2016 – *Gastroscopy report from Xanit Hospital received stating: "Echo-Endoscopy showed that lesion invaded all sides of the oesophagus & stomach. In the cardia we can appreciate the destruction of the muscular layer and the invasion out of the stomach.*

25th June 2016 – *Xanit Hospital Oncology Multidisciplinary Team meeting- Surgeons aware that Complainant may have surgery there after review post-chemo, they recommend Neoadjuvant Chemotherapy.*

4th July 2016 – *Complainant attended Outpatient appointment with Surgical Consultant 1. On this occasion, Surgical Consultant 1 wrote to the Oncologist in Xanit Hospital requesting for Neoadjuvant Chemotherapy treatment to start as soon as possible. He also wrote to the Complainant's GP about the repeat Gastroscopy & PET scan.*

11th July 2016 – *The Complainant was admitted to St Bernard's Hospital as an in-patient.*

18th July 2016 – *The Complainant attended appointment at Xanit Hospital with Oncologist.*

19th July 2016 – *Surgical Consultant 1 spoke to Oncologist over the phone and wrote asking for surgical arrangements to be made as soon as possible.*

20th July 2016 – *Complainant attended appointment in Xanit Hospital with 'digestive' team.*

26th July 2016 – *Complainant attended appointment in Xanit Hospital with Gastroenterologist for an endoscopic ultrasound.*

2nd August 2016 – *Complainant attended appointment in Xanit Hospital with the Oncologist. Neoadjuvant Chemotherapy planned. Complainant signed consent form to start Chemo in 3 weeks' time.*

4th August 2016 – *Blood results back from Xanit Hospital.*

8th August 2016 – *Complainant had first Neoadjuvant Chemotherapy session at Xanit Hospital and was seen by the Oncologist.*

29th August 2016 – *Complainant had second Neoadjuvant Chemotherapy session at Xanit Hospital and was seen by the Oncologist.*

9th September 2016 – *Complainant attended outpatient appointment with Surgical Consultant 1 at St Bernard's Hospital.*

19th September 2016 – *Complainant underwent last Neoadjuvant Chemotherapy session at Xanit Hospital. Was seen by the Oncologist and advised to continue with oral chemotherapy for a further three weeks. CT scan requested for possibility of surgery post-chemotherapy.*

10th October 2016 – *Xanit Hospital requested CT and bloods. Oral chemotherapy ends.*

11th October 2016 – *CT Thorax, Abdomen & Pelvis report stated: "no substantial change since May CT".*

19th October 2016 – *Complainant attended outpatient appointment with Surgical Consultant 2 at St Bernard's Hospital. Multidisciplinary Team discussion set to take place at St Bernard's Hospital on the 25th October 2016 to discuss whether surgery is possible.*

24th October 2016 – *Complainant attends outpatient appointment with Surgical Consultant 2.*

25th October 2016 – *Complainant's case discussed during GHA Oncology Multidisciplinary Meeting. Complainant had requested surgery at Royal Marsden Hospital in the United Kingdom rather than Xanit Hospital. GHA decided to refer the Complainant for surgery in either Xanit Hospital, Spain or the Royal Marsden Hospital, United Kingdom.*

2nd November 2016 – *Complainant attended appointment at Xanit Hospital with Specialist in General Surgery and the Digestive System ("Specialist Surgeon")*

8th November 2016 – *Complainant attended appointment at Xanit Hospital with Specialist Surgeon. Chest CT performed (oral & I/V contrast). CT report stated "no significant changes".*

11th November 2016 – *MRI of the abdomen performed. Report stated "organs normal, parietal thickening of proximal slope of stomach in relationship with filiated neoproliferative process".*

16th November 2016 – *Admitted to Xanit Hospital for resecting surgery the following day.*

17th November 2016 – *Specialist Surgeon unable to perform resecting surgery. Complainants' tumour found to be "inoperable". "Intraoperative" biopsy taken. Biopsy report stated "diagnosis: peritoneal Carcinomatosis".*

24th November 2016 – *Complainant discharged from Xanit Hospital with Jejunostomy.*

25th November 2016 – *Complainant attends outpatient appointment with Surgical Consultant 2 in St Bernard's Hospital.*

30th November 2016 – *Surgical Consultant 2 wrote to Complainant's General Practitioner stating that Complainant's cancer was inoperable.*

6th December 2016 – *Complainant had blood tests carried out and was seen by the Medical Oncologist, in GHA's Chemotherapy Unit.*

14th December 2016 – *Complainant had Porta Cath inserted for receipt of Palliative Chemotherapy every two weeks. Chest X-ray & portable chest X-ray carried out.*

3rd January 2017 – *Complainant started Palliative Chemotherapy treatment in St Bernard's Hospital.*

Clinical Advice

The Ombudsman reviewed all the correspondence and documentary evidence contained within the Complainant's GHA medical notes. Given that the complaint was 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 Clinical Oncologist of 24 years standing) and the replies received (which have been summarised for the purposes of this report) were as follows;

Ombudsman Question 1

Based on the various procedures undertaken since his first attendance to A&E on the 22nd May 2016, was the management of the Complainant's tumour reasonable to the required standard in this regard?

Expert Reply

The Expert explained that the Complainant was found to have stomach cancer on the 23rd May 2016 by way of endoscopy. He further stated that in general, the initial diagnosis of cancer is made through endoscopy and biopsy and clarified that there were International guidelines available for the management of stomach cancer. He commented "For example ESMO guidelines (2016) are relevant:

- *"Staging and risk assessment Recommendation: Initial staging and risk assessment should include physical examination, blood count and differential, liver and renal function tests, endoscopy and contrast-enhanced computed tomography (CT) scan of the thorax, abdomen ± pelvis (Table 1) [V, A].*

- *Laparoscopy is recommended for patients with resectable gastric cancer [III, B].*

- *Multidisciplinary treatment planning before any treatment is mandatory [IV, C]"*

The Expert further explained that from reviewing the Complainant's medical notes, he was able to ascertain that the Complainant's case was discussed by a Tumour Committee *"but no staging Laparoscopy (an inspection of the abdominal cavity by a telescope under anaesthetic)"*had been performed. The Expert's opinion was that if this procedure had been carried out subsequent to the CT scan and the Endoscopy, the Complainant's cancer would have been found to be "*widespread at that time (by July 2016)".* He continued to explain that this would have meant that the Complainant would have been *"correctly told he was incurable at that time before chemotherapy".* The Expert clarified that the Complainant would still have been offered Chemotherapy *"but the intent would have been palliative ie to prolong quantity and quality of life rather than neo-adjuvant where given to improve chance of cure".*

Ombudsman Question 2

Was there any element of delay from then up to the point when it was decided not to operate?

Expert Reply

"A diagnosis of cancer was not made by biopsy until June 2016. I would have expected treatment to start by early August 2016 which it did. Thus it was not delays that resulted in this man being incurable. I am afraid he was incurable at presentation but not correctly staged prior to chemotherapy treatment starting".

Conclusions

Based upon the expert medical opinion, the Ombudsman reached the view that although there had been no apparent delay in treating the Complainant's tumour, an important step in the management of the Complainant's cancer had been missed which in turn would have managed the Complainant's expectations and given him and his family a more accurate picture of the advanced stage of his disease, which according to the Expert was, unfortunately, incurable at the presentation stage.

The Complainant was subjected to Neo-Adjuvant treatment for a total of eight weeks when the Chemotherapy offered should have been Palliative from the outset. As mentioned above, although the GHA's management of the Complainant's treatment was not a contributing factor to the advancement of the disease, an "incurable diagnosis" ab initio, would have at the very least, managed the Complainant's expectations insofar as the possibility of a recovery or improvement in his condition was concerned.

Classification

That the time-lapse between diagnosis and treatment had the consequence of the Complainant's cancer being inoperable – **Not Sustained**

(Report extracted from HEALTH CS 2017-50)

GIBRALTAR HEALTH AUTHORITY

Case 12

Complaint

The Complainants were aggrieved due to the fact that the newly established GHA Tertiary Referrals Board ("TRB") had not approved their upcoming scheduled appointments with their United Kingdom consultants.

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

Complainant 1

Complainant 1 complained on behalf of her husband ("the Patient") and explained by way of background that the Patient had been diagnosed with prostate cancer back in 2013 and after receiving unsuccessful radiotherapy in a Tertiary Referrals Centre in Spain, he was referred to a Tertiary Referrals Centre in the United Kingdom ("Tertiary Referrals Centre") where he was seen as from February 2016. Complainant 1 stated that the Patient remained under the care of the Tertiary Referrals Centre where he underwent a Salvage Robotic Radical Prostatectomy procedure in July 2016. She further explained that in April 2017, nine months post-surgery, she attended the GHA's Sponsored Patients Department to make arrangements for the Patient's upcoming appointment at the Tertiary Referrals Centre in May 2017.

Complainant 1 stated it was at that point when she was informed that the system for sponsored patients had recently changed. She was advised that the Patient was now required to see the local consultant who would write to the TRB who would in turn consider the merits of the 'referral' and only then would the Sponsored Patients Department be able to proceed with the necessary arrangements for the Patient's upcoming appointment at the Tertiary Referrals Centre.

Complainant 1 explained that she did not understand why the Patient's case had to be discussed by the TRB given that he was an "ongoing patient" already receiving care at the Tertiary Referrals Centre and relayed her concerns to the Sponsored Patients Department clerk who assured her that this was merely a formality that had arisen further to the new system in place for sponsored patients. Complainant 1 accepted the explanations given by the clerk and accompanied the Patient to see the local consultant. Complainant 1 explained that during that visit which took place the same month, the local consultant informed them that he would write to the TRB and recommend that the Patient remain under the care of the Tertiary Referrals Centre given that he was unable to find any information relating to the Patient's Tertiary Referrals Centre interventions and treatment in the Patients medical file. However, to Complainant 1's surprise, approximately a week later, she received a call from the Sponsored Patients Manager who informed her that the TRB had not approved the Patient's upcoming appointment at the Tertiary Referrals Centre.

In order to expedite matters for the Patient, and given that Complainant 1 had been unable to obtain any explanations for the TRB's non approval of the Patient's appointment at the Tertiary Referrals Centre, Complainant 1 contacted the Medical Director via email on the 29th April 2017 to set out her grievance and urged him for a favourable outcome. The Medical Director replied to her queries on the 4th May 2017 and explained that the TRB had reconsidered the case and given that the local consultant had not "*had the opportunity to get to know the Patient until recently and had not had any formal communication/reports from the Tertiary Referrals Centre*", the TRB had recommended that the Patient be seen one last time at the Tertiary Referrals Centre in order to allow for a "*formal transfer of care to take place between the Urology Team at the Tertiary Referrals Centre and the local consultant before the local consultant took over the Patient's care locally*". The Medical Director further stated that the May 2017 appointment would be the Patient's *"last follow-up*" to the Tertiary Referral Centre and where the GHA *"expected a formal handover to take place in the near future so that subsequent follow-ups were carried out in Gibraltar"*.

Complainant 1 informed the Ombudsman that notwithstanding the approval of the TRB, upon arriving at the Tertiary Referrals Centre on the 16th May 2017, the Patient was informed that his appointment had been cancelled by the GHA. Nonetheless, the Patient's needs were prioritised and he was seen by the Tertiary Referrals Centre consultant.

Complainant 1 further stated that during this appointment, the Patient was informed that his condition had slightly deteriorated. He was given some advice to carry out during the ensuing three months after which he was advised that he would be seen again by the Tertiary Referrals Centre consultant where if no improvement was noted, further surgery would be considered. Complainant 1 informed the Medical Director of this state of affairs via email dated 21st June 2017 upon their return to Gibraltar and attached a letter to this effect from the Tertiary Referrals Centre consultant.

Additionally, Complainant 1 informed the Ombudsman that the Patient was seen again by the local consultant on the 17th July 2017, where he was able to peruse the Patient's report from the Tertiary Referrals Centre and agreed on the fact that the Patient should once again see his consultant at the Tertiary Referrals Centre in August 2017 and informed the Patient that he would be writing to the TRB informing them of this.

To their disappointment, the Patient received a letter from the TRB on the 27th July 2017 informing him that the TRB had discussed his case and they had not approved his upcoming August 2017 appointment at the Tertiary Referrals Centre. In their letter, a copy of which was provided to the Ombudsman, the TRB stated that the reason for the non-approval was that a board of senior clinicians had considered the information provided in the referral letter and after having reviewed the Patient's case, had determined that the referral did not provide the optimal treatment for the Patient's condition. As a result, the TRB had asked the local consultant to review the Patient's treatment plan in partnership with the Patient. The letter further stated that an appointment had been arranged for the Patient to see the local consultant yet contrary to this, Complainant 1 informed the Ombudsman that they had been to inquire about the date of the appointment and had been informed by the local consultant's nurse on the 27th July 2017 that no appointment had been scheduled or requested in respect of the Patient.

The TRB concluded its letter by stating “Finally, I wish to assure you, that whereas this may not be the decision you wished to receive, the board has carefully considered this matter with your very best interest at heart.”

Aggrieved by the above, Complainant 1 lodged her complaint with the Ombudsman.

Complainant 2

By way of background, Complainant 2 explained that for a a number of years he had suffered from EosinophilicAsthma (a subtype of asthma causing elevated levels of eosinophils, white blood cells that typically fight off infection but can cause inflammation when built up in excess). He stated that due to this condition s he had been referred to a Difficult Asthma Clinic at a Tertiary Referral Centre in the United Kingdom. He further explained that in March 2017 he attended the Tertiary Referral Centre and saw his consultant who prescribed him a new medication and offered him a follow-up appointment to review the effects of the new medication, six months later in September 2017. Complainant 2 stated that on the 29thAugust 2017 he received a letter from the Tertiary Referral Centre notifying him of an appointment on the 6th September 2017. As per usual, Complainant 2 attended the Sponsored Patients Department and handed in the appointment letter for his flight arrangements to be made. It was at that stage when he was informed that before making any arrangements, his appointment had to be approved by the TRB with the input from his local consultant. Complainant 2 stated that he was asked to return in a few days. On Thursday 31stAugust 2017, Complainant 2 stated he contacted Sponsored Patients via telephone and was informed that they had been unable to contact the local consultant as he was on annual leave. He was informed that the matter had been passed to the TRB’s secretary and suggested that the appointment in the Tertiary Referrals Centre be postponed to a later date. Complainant 2 explained that he was dissatisfied with this option given that his condition had deteriorated since his medication was changed six months earlier. As a result, Sponsored Patients agreed to see him again on the 5th September 2017 (a day before the appointment and also the day the local consultant was expected back from annual leave).

Complainant 2 did as advised yet when he returned to the Sponsored Patients Department on the 5th September 2017, the local consultant had not been able to address his case given that he was conducting surgical procedures that morning. Complainant 2 therefore had no choice but to have his appointment rescheduled for a later date and to his disappointment, the date he was given was the 24th January 2018.

Dissatisfied with the service received from the GHA which he described as "an extremely stressful experience", Complainant 2 lodged his complaint with the Ombudsman hopingfor a "proper mechanism to be implemented so that patients who have to visit the UK for treatment do not have to suffer the torment that I (he) went through".

Investigation

The Medical Director

Given that the Ombudsman had received two similar complaints in the preceding months which had been resolved through informal action, the Ombudsman saw it fit to explore these issues further as in his opinion, these matters had now become of public interest. The Ombudsman contacted the Medical Director on the 20th September 2017 and requested his comments on whether there had been a change in policy with regards to sponsored patients. The Medical Director met with the Ombudsman on the 16th October 2017 and explained that the GHA were indeed reviewing all services offered abroad with the aim of repatriating the care of all of those patients who had previously been referred to Tertiary Referrals Centres given the recent recruitment of specialised local consultants. For example in the case of Complainant 1, he explained that the Patient had been previously referred by a Consultant General Surgeon in November 2015 to a Consultant Urological Surgeon at the Tertiary Referrals Centre and since then, a Consultant Urological Surgeon had been employed by the GHA around early 2017.

During the meeting with the Medical Director and in relation to Complainant 1's grievance, the Ombudsman pointed out a referral letter dated 7th September 2017 from the local consultant to the Tertiary Referrals Centre consultant and a reply to this letter dated 19th September 2017 sent to the attention of the GHA Medical Director by the Tertiary Referrals Centre consultant where he confirmed that up until September 2017, he had received no communication from the GHA with regards to the Patient. This appeared to be contrary to the plan of action set out in the Medical Director's correspondence on behalf of the TRB dated 4th May 2017, (a copy of which was provided to the Ombudsman). In his letter, the Tertiary Referrals Centre consultant further stated "*As you know, he (the Patient) is in the early stages of his follow-up, and we are still managing his survivorship issues. I have been informed by the patient that you have unfortunately cancelled his ongoing treatment at the Tertiary Referrals Centre*, *I believe due to financial pressures. I am not clear of the process for this decision, but I certainly have not had the opportunity to input. I today have received a new referral for this patient from the local urologist (local consultant) asking for me to see him. This is rather unfortunate as the patient had an appointment last week which he did not attend, because his visit was not supported locally. This is all rather confusing as I'm sure you would appreciate, and I would be grateful for some clarification from you so we can best support this patient during his ongoing treatment"*

During his meeting with the Ombudsman, the Medical Director explained that he had not seen either the referral letter dated 7th September 2017 or the letter from the Tertiary Referrals Centre Consultant dated 19th September 2017 and hence why no reply had been issued. He agreed to discuss this with the local consultant and reply to the Ombudsman's queries. He subsequently contacted the Ombudsman on the 27th October 2017 and explained that the local consultant had indeed sent a letter dated 7th September 2017 to the Tertiary Referrals Centre Consultant and clarified that this had not been a referral but rather a request for the Tertiary Referrals Centre consultant's opinion with regards to the Patient. He clarified that this is why the letter did not go through the TRB process.

Notwithstanding this, the Ombudsman noted the Tertiary Referrals Centre consultant's letter and his comments requesting clarification from the Medical Director and the last paragraph in the local consultants' letter dated 7th September 2017 stating "*An estimated quote of treatment cost should be emailed to xxxx.xxxx@gha.gi when the appointment or admission date is given. The patient's treatment will be funded by the Gibraltar Health Authority and the patient will be a Government of Gibraltar Sponsored Patient".*

On the 6th November 2017, the Ombudsman wrote to the Medical Director once again inquiring whether the GHA was now in possession of the Patient's medical records from the Tertiary Referral Centre and whether or not a reply had now been sent to the Tertiary Referrals Centre consultant's letter dated 19th September 2017. A reply to the Ombudsman's inquiry was received on the same day from one of the GHA clinical directors ("Clinical Director") who informed the Ombudsman that arrangements were being made for the Patient to travel to the Tertiary Referrals Centre to see the consultant who would "make the final decision on immediate surgery and if the plan is to delay, then we have agreed to follow-up here". The Ombudsman was happy to note that the Patient's care was now at hand.

With regards to Complainant 2, during his meeting with the Ombudsman on the 16th October 2017, the Medical Director explained that the events leading up to Complainant 2's grievance had been an unfortunate circumstance and to avoid a repetition, the GHA was appointing duty consultants to cover for these situations should a patient's local consultant be unavailable due to annual or sick leave in the future. He furthermore explained that given the number of patients suffering from difficult asthma, the GHA was arranging for a Difficult Asthma Team to visit Gibraltar every six months to see patients locally.

Conclusions

Complainant 1

Aggrieved due to the fact that the newly established TRB had not approved the Patient's upcoming scheduled follow up appointment at the Tertiary Referrals Centre – **Sustained**

The Ombudsman was very critical of the TRB given that they had initially considered the Patient's case in April 2017 in the absence of the Patient's medical records from the Tertiary Referrals Centre. This in the Ombudsman's opinion amounted to maladministration and gave rise to his concerns given that the TRB had made a decision on the Patient's medical condition in the absence of his full medical records. Furthermore, the Ombudsman was also of the opinion that the TRB had once again failed the Patient in July 2017 by not taking into consideration the Tertiary Referrals Centre consultant's letter dated May 2017 where he stated that the Patient's condition had deteriorated and recommended seeing him in August 2017 to decide on whether further surgery was needed. The TRB simultaneously appeared to have ignored the local consultant's support of this visit.

The Ombudsman was also critical of the fact that the GHA's local consultant did not appear to have requested the Patient's full medical reports from the Tertiary Referrals Centre shortly after the decision taken in May 2017 not to allow the Patient to travel to the Tertiary Referrals Centre for any more follow-ups after his May 2017 appointment. It was only until the 7th September 2017, four months after this decision was taken that an attempt was made to contact the Tertiary Referrals Centre consultant.

Taking into consideration all of the above and the stress the Patient and Complainant 1 went through dealing with the situation while simultaneously trying to deal with the obvious stress that comes with"sequela" such as the ones suffered by the Patient post prostate cancer, the Ombudsman sustained this complaint.

Complainant 2

Aggrieved due to the fact that the newly established TRB had not approved his upcoming scheduled follow up appointment at the Tertiary Referrals Centre – **Sustained**

With regards to Complainant 2, the Ombudsman could not understand why the TRB discussed and reached a decision, i.e., not approved his case in the absence of the local consultant's input.

The Ombudsman felt that the TRB should have requested another local consultant's input prior to considering the merits of the Complainant's appointment at the Tertiary Referrals Centre or alternatively noted the fact that Complainant 2 was under the care of a specialist whose specialty was not offered locally and he had been started on a new trial medication six months earlier where follow-up was required. Based on the above, the Ombudsman saw it fit to sustain Complainant 2's complaint. The Ombudsman was however happy to note that Complainant 2's plight was swiftly picked up on by the GHA and a plan B promptly implemented.

Classification

Aggrieved due to the fact that the newly established TRB had not approved their upcoming scheduled follow up appointments at the Tertiary Referrals Centre – **Sustained**

Update & Additional Information from the Medical Director

In March 2019, further to reading a draft of this report, the Medical Director provided further information and clarification regarding the TRB process in a written statement to the Ombudsman. In his statement, he explained that the TRB's role was to simply confirm that a referral (or review) complied with GHA policies and stated that no clinical decisions were made during the TRB's discussions. He explained that during TRB meetings, board members discussed matters such as, "is the correct patient referred to the correct place for the condition suffered? Is there a clear reason for referring the patient to a tertiary referrals centre?". The Medical Director reiterated that it was the local consultants who were responsible for providing to the TRB the relevant information regarding their patients and subsequently the TRB took a decision on the information provided to ensure that the referral/appointment was in line with the GHA's policy, i.e. appropriate referral centre/no ability to repatriate. The Medical Director commented "The TRB cannot chase up additional, relevant information. This information must be provided by the local consultant. That consultant may be asked for additional information if this is lacking. Not providing all the relevant information may result in a delay in the decision making and that delay is the responsibility of the local consultant".

Additionally, the Medical Director clarified that the TRB ordinarily reviewed all new referrals and only selected cases of "follow-up" patients at the request of the Sponsored Patients Manager. He stated "*The complaints highlight the challenges of setting up the TRB vetting process. The theme for both complaints was that both cases were follow up appointments brought to the TRB by the Sponsored Patients Manager (they were not new referrals), the main issue related to poor communication...The GHA certainly learned from the feedback we received and have made adjustments over the last 2 years so that we now have a more streamlined process. The process will need to be continuously reviewed and improved".*

The Medical Director provided the Ombudsman with an update in respect of both patients in Complaint 1 and 2. He stated that the Patient in Complaint 1 had had his last review at the Tertiary Referrals Centre in the UK in March 2018 and had recently received pelvic floor exercises in a tertiary referrals centre in Spain.

With regards to Complainant 2, the Medical Director explained that his last attendance to the Tertiary Referrals Centre in the UK had been in December 2018. Finally, the Medical Director provided further specific comments on the Ombudsman's report with regards to Complainant 1's case which have been included in chronological order below:

Comment 1

With regards to the call received from the Sponsored Patients Manager in April 2017 where Complainant 1 was verbally informed that the Patient's appointment in May 2017 had not been approved by the TRB, the Medical Director commented "This was a miscommunication for which the GHA apologises unreservedly. At this point in time the Sponsored Patients' Manager had contacted the Medical Director and the local consultant asking about the need for further follow-up. Whilst the Medical Director was awaiting a reply from the local consultant, the Sponsored Patients Manager assumed that the visit would not be sanctioned by the TRB on the basis that follow up could be carried out locally. The Patients' appointment was cancelled by the local consultant's secretary on instructions from the Sponsored Patients' manager. This is what was communicated to Complainant 1 by telephone. The TRB had not yet considered this patient's circumstances at this stage".

Comment 2

The Medical Director explained that as a result of Complainant 1's email of the 29th April 2017, he acknowledged receipt of her request and explained the TRB process on the 30th April 2017 and that he would communicate the outcome of the TRB's decision on the Patient's case which he did on the 4th May 2017 as stated in Complainant 1's account.

Comment 3

The GHA had cancelled the Patient's appointment in May 2017 on instructions from the Sponsored Patients Manager as explained by the Medical Director. Complainant 1 explained that notwithstanding this, the Patient was seen by the Tertiary Referrals Consultant upon their travel to the United Kingdom. The Medical Director commented "*Again the GHA apologise for the miscommunication. The Sponsored Patients department and the urology team (local consultant's secretary) were made aware of the TRB's decision to approve the Patient's appointment. The appointment should have been reinstated at the time. We were very grateful that the patient was nevertheless seen at the Tertiary Referrals Centre*".

Comment 4

The Medical Director explained that further to the receipt of Complainant 1's email dated 21st June 2017 with attached letter from the Tertiary Referrals Centre consultant suggesting that the Patient return to the Tertiary Referrals Centre in August 2017, the TRB met and discussed the Patient's case and decided not to approve the Patient's follow up appointment. He commented "*The TRB specifically asked the local consultant to discuss the case with the Tertiary Referrals Centre consultant and agree further management with the Patient and the Tertiary Referrals Centre consultant. It seems that neither the patient was informed of the outcome of the TRB's meeting nor did the local consultant contact the Tertiary Referrals Centre consultant*".

Comment 5

Regarding the TRB meeting dated 27th July 2017, the Medical Director stated "*The TRB made another determination on 27th July 2017 and commented "Patient advised to discuss monitoring/follow-up options with local Urology team. Further referrals to the UK will follow if clinically necessary".*In relation to the their decision making based on the local consultants' recommendations, the Medical Director stated "*The Medical notes made by the local consultant were as follows. "….He has an appointment in August. We should talk with the Tertiary Referrals Centre consultant".*

With regards to the fact that the letter dated 27th July from the TRB stated that an appointment had been arranged for the Patient to see the local consultant yet contrary to this, Complainant 1 had been informed by the local consultant's nurse on the 27th July 2017 that no appointment had been scheduled or requested in respect of the Patient, the Medical Director explained that the appointment for the Patient was created on the 7th August 2017 (a week after the letter was provided to the Patient). He also informed the Ombudsman that the appointment with the local consultant was scheduled for the 7th September 2017.

Comment 6

With regard to the fact that no contact had been made with the Tertiary Referrals Centre consultant from May 2017 to September 2017 (4 months) for a transfer of care of the Patient as stated by the Medical Director in his email to Complainant 1 on the 4th May 2017, the Medical Director stated "*This is true. It is important to note that the patient's responsible local consultant is responsible for carrying out the instructions of the TRB. The local consultant should have called or written to his Tertiary Referrals Centre colleague shortly after the initial TRB determination in April and planned the Patient's repatriation of care to the GHA if at all possible. If it was not possible he should have resubmitted a request to the TRB advocating for further UK reviews and giving valid clinical reasons for this".*

Comment 7

With regard to the email dated 6th November 2017 sent to the Ombudsman by the Clinical Director informing him that arrangements were being made for the Patient to travel to the Tertiary Referrals Centre to see the consultant who would "*make the final decision on immediate surgery and if the plan is to delay, then we have agreed to follow-up here*". The Medical Director stated "*The TRB had been newly constituted in May 2017 and the process at the time was not yet mature and robust. As a result of patient feedback and complaints we have improved our processes and communication. One of our actions was to assign complex cases that required more detailed discussions and liaison to one of the clinical directors. In this case, the Clinical Director personally contacted the Tertiary Referrals Centre and liaised with the Patient directly. This significantly improved communication and is now part of the standard process for the TRB".*

.....

The Ombudsman reviewed the update and additional comments and information provided by the Medical Director. Despite the different version of events outlined by the Medical Director, after consideration of the additional information, the Ombudsman concluded that this did not change the outcome of the conclusions and classification of these complaints, as outlined in the report.

(Report extracted from HEALTH CS 2017-54)

GIBRALTAR HEALTH AUTHORITY

Case 13

Complaint

The Complainant was aggrieved due to the following:

(i) The administrative procedures being applied at the Radiology Department in relation to an Ultrasound Doppler investigation which the Complainant required prior to seeing a Consultant Vascular Surgeon.

(ii) Lack of urgency applied by the GHA in addressing the Complainant's health problem given her medical background.

The Complainant explained by way of background that she had suffered a heart attack in 2006 at the age of forty four caused by a clot which was provoked by her undiagnosed diabetes and untreated atherosclerosis. Therefore, as a result of her newly diagnosed ailments, she was given medication and started her recovery.

In early 2012 the Complainant suffered another heart attack, where she had to have five coronary stents inserted. From then on she was closely monitored by a General Practitioner ("GP") and the Diabetes Nurse.

Four years later, in the summer of 2016, the Complainant explained that she began to have difficulty walking and for this she visited the Diabetes Nurse at the Primary Care Centre ("PCC") on 28th July 2016. The Diabetes Nurse booked the Complainant for a Doppler APBI (a simple non-invasive method of identifying arterial insufficiency within a limb). This procedure took place on 23rd August 2016 where no readings could be obtained on both the right and left leg. As a result, according to the Complainant, the Diabetes Nurse requested that the Department of Radiology ("Radiology") offer the Complainant an Ultrasound Doppler (a non-invasive test that can be used to estimate the blood flow through your blood vessels by bouncing high-frequency sound waves (ultrasound) off circulating red blood cells) and simultaneously referred her to be seen by the Consultant Vascular Surgeon.

The Complainant eventually received an appointment to be seen by the Consultant Vascular Surgeon on 13th October 2016 and an appointment from Radiology for an Ultrasound Doppler on 27th October 2016 (fourteen days after the appointment with the Consultant Vascular Surgeon). The Complainant therefore contacted Radiology, explained her situation and requested that her Ultrasound Doppler be brought forward given that she required the procedure to be performed prior to seeing the Consultant Vascular Surgeon. The request was declined by Radiology on the grounds that the Chief Radiographer had applied protocol when considering her referral letter. She was advised at this point that consideration for her procedure to be brought forward would only be given upon receipt of a new referral from the Complainant's GP.

The Complainant explained that at this point she felt hopeless given that her life had been on hold for most of September 2016, worried that she may have a thrombosis, having to wear surgical stockings in the heat and elevating her legs as much as possible as well as missing out on her exercise which was crucial for her weight loss and sugar control programme. She further explained that by October, (almost 2.5 months since her symptoms started) her legs were in so much pain that she could not even walk to the PCC to see the GP. According to the Complainant, her husband attended the PCC on her behalf and saw the GP's nurse who passed on the message and assured him that the GP would email the Radiology Department and request that they provide her with an earlier appointment for the Ultrasound Doppler so that results would be available for the Consultant Vascular Surgeon on 13th October 2016. The Complainant's husband was allegedly advised by the GP's nurse to go to the Radiology Department that same day to pick up the appointment slip to avoid a misunderstanding on the day of her appointment. However, to the Complainant's disappointment, upon attending the Radiology Department, her husband was informed that the GP's request had been received and the appointment would be rescheduled but that this had to be vetted by a Consultant Radiologist before informing the Complainant of her new appointment date and time.

The Complainant waited another week, and given that she had not received any notification of her appointment, she once again attended the Radiology Department and to her dismay she was told that her new appointment date was for the 31st of October 2016.

The Complainant therefore lodged her first complaint with the Complaints Handling Scheme at St Bernard's Hospital as she was aggrieved with the stance adopted by Radiology and felt that Radiology were not taking into consideration the fact that she required the Ultrasound Doppler performed prior to seeing the Consultant Vascular Surgeon.

The Complaints Handling Scheme contacted the Hospital Services General Manager with responsibility over Radiology and as a result of this, the Complainant's appointment to have the Ultrasound Doppler was brought forward to 17th October 2016 and her appointment to see the Consultant postponed to take place on 20th October 2016.During her appointment with the Consultant Vascular Surgeon, the Complainant was informed that she had a 2.5 cm partial blockage (identified by the Ultrasound Doppler). At this point, the Consultant Vascular Surgeon ordered a CT scan and listed her for an angioplasty to take place at a Tertiary Referral Unit in Spain on 13th December 2016 which was unsuccessful. Instead, the Complainant required a Femoro-femoral bypass (A procedure which entails connecting the two femoral arteries in the groin together with a bypass graft running under the skin of the lower abdomen. If one iliac artery in the pelvis is blocked the blood supply to a leg can be restored by taking the bypass from the good femoral artery on the other side.

The Complainant informed the Ombudsman that she underwent the procedure on 21st December 2016 as her blockage was found to be of 10cm. as opposed to 2.5cm. The Complainant was aggrieved and she lodged her two-fold complaint with the Ombudsman as she felt that Radiology should have been more accommodating of her need to have her Ultrasound Doppler prior to seeing the Consultant Vascular Surgeon. The Complainant was also of the opinion that given her past medical history, all departments involved should have addressed her ailment sooner and with more urgency.

Investigation

The Ombudsman requested information from the Radiology Department, the Medical Director, and the Diabetes Nurse. The Ombudsman also reviewed the medical notes.

Radiology

In his replies to the Ombudsman's queries, the Clinical Director of Radiology explained that the standard procedure at the Radiology Department was that all requests were vetted as either routine or urgent on a clinical basis. He further explained that there were no formal arrangements for Radiology performing investigations prior to patients' next appointments, yet the department informally accommodated for these situations when given due notice of follow up appointments. Contrary to what the Complainant believed, the Consultant Radiologist informed the Ombudsman that the Ultrasound Doppler was requested on 16th September 2016 as opposed to 23rd August 2016 and that in the case of the Complainant, the request fell into the clinically 'routine' category. The Radiologist informed the Ombudsman that *"unfortunately"* the routine waiting list for ultrasounds was at the time of the events, 6-7 weeks. He stated *"of note, the requester made this request as a "routine" one. He then informed us of the clinic appointment and asked whether it could be brought forward. However, this was not possible as we have to go on a clinical basis. I wondered however whether her appointment with the Vascular Consultant could be postponed to ensure she was seen after her scan".*

The Clinical Director of Radiology concluded his statement by stating that in order to avoid a repetition of the same events, the Radiology Services Manager circulated an email to all doctors informing them of the waiting times for the different modalities offered by the Radiology Department.

The Diabetes Nurse

Based on the comments received from the Radiologist and given that the Complainant had all along been under the impression that she had been urgently referred to Radiology for an Ultrasound Doppler by the Diabetes Nurse on 23rd August 2016, the Ombudsman contacted the Diabetes Nurse in order to obtain clarity. In her reply to the Ombudsman, the Diabetes Nurse explained that in fact she was not able to refer patients to Radiology in her scope of practice. She clarified that she was indeed able to refer patients for an ABPI Doppler at the PCC and subsequently based on the score obtained, she was able to refer them to the Consultant Vascular Surgeon as she did in the Complainant's case on 23rd August 2016.

Clinical Advice

Given that some of 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 Vascular Surgeon) and the replies received (which have been summarised for the purposes of this report) were as follows;

Question 1

Based on the findings from the Doppler ABPI performed on the 23rd August 2016 was the Radiology Department reasonable in not prioritising the patient's Ultrasound Doppler?

The Expert explained by way of information that it was not unusual and often wise, that the ordering of specialist tests were undertaken by the vascular surgeons as opposed to the GP as this meant that the specialist was able to decide on how to further investigate the patient's peripheral vascular disease. He commented:

"*On the strength of the clinical consultation a number of options are available to the specialist:*

i. Firstly, no investigation if intervention was not appropriate,

ii. Secondly, an ultrasound scan if only the legs were to be involved

iii. Thirdly, go directly to a CTA scan if the patient had a raised body mass index and an intra-abdominal blockage or an artery is suspected.

Therefore, arranging a duplex ultrasound scan after the consultant consultation would be wise and good practice."

The Expert summarised his position by explaining that from the history outlined by the Diabetes Nurse and from the history detailed by the Consultant Vascular Surgeon, the complainant had peripheral vascular disease presenting as "*intermittent claudication (i.e. calf pain on walking that stops after a few minutes, settles quickly but returns when patient starts to walk again*)….*The patient did not have critical ischaemic rest pain or ulcers."* This therefore meant that in his opinion, there was no indication to consider an *"urgent"* appointment with the Consultant Vascular Surgeon or an "*urgent*" appointment to consider intervention as the peripheral vascular disease was such that the limb was not threatened.

Question 2

Does the Expert concur that the Patient was treated within the required standard given her past medical history? If not, can the Expert offer advice on what should have happened as opposed to what happened in the Complainant's case from her first attendance to see the Diabetes Nurse on 28th July 2016 up until she was seen by the Consultant Vascular Surgeon and an angioplasty was attempted?

The Expert explained that in a patient with "*intermittent claudication*" and without "*ischaemic*" rest pain or foot ulcer, who had significant co-morbidities (The Complainant was a diabetic, significantly overweight and an ex-smoker with a history of unstable angina requiring stents) the management undertaken by the vascular team at the Tertiary Referral Unit would be considered, by a reasonable body of vascular surgeons in the United Kingdom as too aggressive.

He further explained that "intermittent claudication" could significantly improve with exercise and loss of weight and very often did not require invasive intervention. He stated, "The risk of subsequent limb loss is not significantly reduced by undertaking early intervention….Despite these comments, in Europe there is often a more aggressive approach to peripheral vascular disease intermittent claudication management than in the United Kingdom. Nevertheless, this patient did have very extensive arterial intervention".

The Expert commented that in the Complainant's case, there was no suggestion of initially attempting to lose weight and there was no suggestion of an exercise programme prior to considering extensive invasive intervention. The Expert was of the opinion that an exercise regime could have ideally started by the Diabetes Nurse prior to seeing the Consultant Vascular Surgeon and once the Complainant had seen the Consultant, the regime could have been continued for several months before considering an invasive investigation such as was the case.

The Expert summarised his position by stating that the Complainant was indeed treated within the required standards and commented that "*if anything the treatment was too invasive too early*".

Question 3

Does the adviser concur that the Patient was treated within the required standard given her past medical history? If not, can the expert offer advice on what should have happened as opposed to what happened in the Complainant's case from her first attendance to see the Diabetes Nurse on the 28th July 2016 up until she was seen by the Consultant Vascular Surgeon and an angioplasty was attempted?

The Expert explained that the increased length of the occlusion in the Complainant's right iliac vessels (blockage) could have been due to the lapse of time between investigations and interventions, however, there could have also been a miss-match between CT angiogram findings and intra-arterial angiography at the time of intervention, i.e. that the extent of the blockage was actually larger than initially shown by the CT scan.

The Expert finalised his report by stating that once the decision to treat the Complainant had been made, the plan of initially attempting "*iliac angioplasty and stenting*" was correct. And once this procedure had failed to be successful, which does occur, a bypass was an "*optimum decision*".

Conclusions

(i) The administrative procedures being applied at the Radiology Department in relation to an Ultrasound Doppler which the Complainant required prior to seeing a Consultant Vascular Surgeon. – **Not Sustained**

The Ombudsman was not able to sustain this part of the complaint given that the Expert summarised his position by stating that 1. There was no indication for the Ultrasound Doppler to be undertaken urgently and 2. There was a good clinical precedent that only a specialist should order specialist investigations based on the clinical findings.

Notwithstanding this, the Ombudsman noted the stress the Complainant and her husband went through while trying to arrange for the Ultrasound Doppler prior to seeing the Consultant Vascular Surgeon. The Complainant was under the impression that the Diabetes Nurse had referred her for the Ultrasound Doppler on the 23rd August 2016 (three weeks before she was in fact referred by the GP on the 16th September 2016). The Complainant received an appointment for the Ultrasound Doppler for after her appointment with the Consultant Vascular Surgeon and subsequently advised by Radiology to obtain a re-referral from the GP to reflect the need for the Ultrasound Doppler to be brought forward to take place prior to the appointment with the Consultant Vascular Surgeon and this in the Ombudsman's view only added to the Complainant's frustration once the request was declined. As a result the Complainant saw herself obliged to lodge a complaint with the Complaints Handling Scheme where as a result, the Complainant's appointment with the Consultant Vascular Surgeon was delayed for a further seven days to accommodate for the Ultrasound Doppler. The Complainant's expectations in the Ombudsman's view should have ideally been managed by the GP and or the Diabetes Nurse.

(ii) Lack of urgency applied by the GHA in addressing the Complainant's health problem given her medical background. - **Not Sustained**

The root of this complaint is a clinical issue and as such, the conclusion arrived at by the Ombudsman has to largely take into account, the clinical advice provided for the purpose of this investigation. Therefore, the Ombudsman saw it fit not to sustain this part of the complaint given that the Expert opined that there was no indication to consider an *"urgent"* appointment with the Consultant Vascular Surgeon or an "*urgent*" appointment to consider intervention as the Complainant's peripheral vascular disease was such that the leg was not threatened.

Classification

(i) The administrative procedures being applied at the Radiology Department in relation to an Ultrasound Doppler which the Complainant required prior to seeing a Consultant Vascular Surgeon. – **Not Sustained**

(ii) Lack of urgency applied by the GHA in addressing the Complainant's health problem given her medical background. – **Not Sustained**

Update

The Complainant

The Complainant informed the Ombudsman that after having her first yearly follow-up appointment with the Consultant Vascular Surgeon, it was confirmed to her that the bypass procedure had indeed failed and that due to her exercise regime, her body had instead grown peripheral veins to supply the area with oxygen. This outcome, was in line with the advice received from the Expert.

The Medical Director

The Medical Director informed the Ombudsman in early 2019 that GHA Management were working with the Radiology Department to map capacity/demand to ensure that waiting times for investigations were minimised.

(Report extracted from HEALTH CS 2017-56)

HOUSING AUTHORITY

Case 14

Complaint

The Complainant explained that the Government rented flat ("Flat") she and her family resided in had experienced water ingress problems through the light fixtures since 2008. According to the Complainant, despite some repairs undertaken in 2010, the problems persisted and no other repairs had been carried out since. The Complainant claimed that in February and May 2017 she had written to the Housing Authority ("HA") regarding her plight but had not received a reply. The Complainant was very concerned because she claimed this was affecting the Flat's electrical installation and the situation posed a fire hazard.

The Complainant stated that the water ingress problems originated in the building's communal duct and dated back to 2008. The water ingress had filtered into the Flat's electrical installation which had resulted in frequent incidents of light bulbs exploding as well as other dampness related issues throughout the Flat. The Complainant stated that in one of those incidents in 2016, hot glass from one of the bulbs fell on her son's arm and caused burns to his skin.

The Complainant explained that she had met with the HA in July 2010 to discuss the water ingress problems. As a result of that meeting, the Ministry for Housing requested that the Buildings & Works Department expedite pending repairs in the Flat and asked for a copy of the electricity inspector's report in order to make the necessary arrangements for repairs to be carried out (copy of letter setting out the aforementioned provided by the Complainant dated 9th September 2010 which denotes that by that time, they believed the works had already been undertaken).

Thereafter, the Complainant met with the Ministry for Housing in 2013 and also wrote to them in September and November 2016 but claimed that nothing was done. In February 2017 she wrote to the HA after which she was contacted by the Reporting Office Manager and informed that her case would be dealt with. By May 2017 as no repairs had materialised, the Complainant chased the matter. No reply was received and she lodged her complaints with the Ombudsman.

Investigation

In September 2017, further to preliminary enquiries, the Ombudsman requested copies from the Reporting Office of any pending reports relating to water ingress problems. The Reporting Office stated that there were no pending reports as the Complainant had refused repairs related to works order report 270123 raised on the 12th December 2016 (further to a meeting between the Complainant and the HA on the 9th December 2016) and the works order report had been cancelled.

The details of the works order report 270123 denoted: *"Water ingress affecting bathroom and kitchen. Please treat as urgent as electrics have been affected."*

The works requested were:

"Repair all cosmetic defects to wall and ceiling to kitchen and bathroom ceiling with approved filler, sand down to existing surfaces. Apply two coats of emulsion paint to match existing approximately 50m²."

The Ombudsman sought the Housing Manager's comments as to how they considered that the water ingress problems could be resolved with aesthetic repairs which did not address the root cause of the ingress and pointed out that was the reason being given by the Complainant for refusing the repairs.

The Housing Manager provided copies of an exchange of emails in March 2017 between the Reporting Office Manager and the HWA concluding with a decision to amend the scope of works which did not occur at that point, as the copy of works order report 270123 provided to the Ombudsman in September 2017 still showed the original scope of works (as denoted above) which was cancelled in August 2017 when the Complainant refused the aesthetic repairs. According to HWA this was because at the time of responding to the report, no leak was found and as such, the only action that could be taken was for repairs to be carried out in the Complainant's Flat which she refused.

At a later stage in the Ombudsman's investigation, the Ombudsman met with HWA and was informed that works order report 270123 had been reopened in September 2017 and the scope of works amended to include the repair of cracked waste pipes in the duct and a leak in a soil pipe. HWA stated that the report had been reopened when they found out through Gibraltar General Construction Company Limited ("GGCCL") [Ombudsman Note: GGCCL is a wholly owned Government company tasked with outsourcing to private contractors, works/ contracts to public housing stock] that the Complainant did not want aesthetic repairs to the Flat before the leak was identified. That report was marked as completed in May 2018.

The Housing Manager advised that two other reports dated 29th March 2012 and 4th March 2013 had been marked as completed and that based on the scope of works for Report 270123, no fire hazard had been identified.

The Housing Manager provided a copy of the minutes of the meeting held on the 9th December 2016 between the Reporting Office Manager and the Complainant which noted that further to the Flat having been affected by water ingress in 2008, false ceilings had been installed. The Ombudsman was provided with a list of reports pertaining to the Flat and identified that the false ceilings in the kitchen and bathroom were installed in 2014. The Complainant was now concerned that those false ceilings would collapse due to the persistent water ingress. Regarding the electrics, the Complainant stated that exploding light bulbs were a regular occurrence and that the Gibraltar Electricity Authority had disconnected some of the light fittings until the water ingress issue was resolved. The minutes mentioned that the Complainant and her husband were in arrears of rent but they had confirmed they would sign a repayment agreement once the works were completed. The Reporting Office Manager informed them that no reports were processed if tenants were in arrears of rent but because this case related to water ingress affecting the electrics, a report would be raised.

Regarding non-reply to the letters sent by the Complainant, the Housing Manager stated that the letters were passed on to the Reporting Office and the Reporting Office Manager contacted the Complainant by telephone.

In January 2018, the Ombudsman undertook a site visit to the Flat. According to the Complainant the last episode of water ingress had occurred about a month earlier. The Complainant pointed out a wall in the kitchen, behind which was the communal duct where damp patches were emerging. In the bathroom was an electric extractor fan attached to the tiled wall (also behind which was the duct) which appeared to have been disconnected as it had been affected by water ingress (Report 233193 refers to relocating extractor fan and kitchen/bathroom lights and marked as completed). The Complainant pointed out the false ceilings installed in the kitchen and bathroom to conceal the damage caused by water ingress to the original ceilings and showed the Ombudsman photos of the state of the original ceilings.

The day after the site visit, the Ombudsman met with the Housing Manager and the Reporting Office Manager to discuss the case as a result of which it was concluded that HWA would be contacted for an inspection to be undertaken. The Reporting Office Manager opened a new works order, 284604.

In April 2018, further to a request for an update from the Ombudsman's Office, HWA staff inspected the Flat and in order to mitigate the water ingress to the Flat, applied waterproof paint to the service duct walls. HWA advised that they would monitor the situation to identify if those works prevented the water ingress to the Flat. HWA further advised that the Flat's kitchen walls and ceiling would also be plastered and painted. At a meeting with the Ombudsman in August 2018, HWA stated that further to the works they had contacted the Complainant on three different occasions for access to the Flat to assess these but to date the Complainant had not been able to agree on a date and time.

HWA looked into all reports of water ingress by the Complainant and noted that these begun in 2009 and not in 2008 as was claimed by the Complainant. HWA further stated that all reports of leaks had been attended to and repaired and that these had occurred in 2011, 2012, 2013 and 2014 (one report a year) and false ceilings fitted as a result of the last leak. All leaks originated from the flat above. In respect of the electrical installation being affected, HWA explained that Gibraltar Electricity Authority staff had attended to reports at the Flat on two occasions. The ceiling rose had been disconnected in order that it would not pose a fire hazard. HWA categorically stated that there was no fire hazard in the Flat from the electrical installation.

Conclusions

Complaint (i) - Not Sustained—Water ingress problems through light fixtures being experienced since 2008 and despite works in 2010, problem persists but no other repairs undertaken since

The Ombudsman did not sustain this Complaint. The findings of the investigation substantiate that reports made by the Complainant between 2008 and 2014 were attended to, the leaks identified and repairs undertaken as well as the fitting of a false ceiling in the Flat's kitchen and bathroom in 2014. The crux of the water ingress problems is that leaks originating from flats above, as well as from waste and soil pipes in the communal ducts, have resulted in water ingress to the Flat. The latest works undertaken, waterproofing the duct wall adjacent to the Flat, aims to prevent water ingress to the Flat when leaks in the communal duct occur but HWA are presently waiting for access to the Flat to be granted by the Complainant to assess if these works have been successful.

Notwithstanding the above, it was only as a result of the Ombudsman's intervention in the matter and investigation into the complaints that report 270123 was reopened in September 2017 and the scope of works changed to include the repair of a cracked waste pipe and soil pipe in the duct. It was also as a result of the Ombudsman's meeting with the Housing Manager and Reporting Office Manager in January 2018 that a new report was raised in which the scope of works included the waterproofing of the Flat's duct wall.

Complaint (ii) - Sustained—No replies to letters sent by the Complainant to the Housing Manager & Principal Housing Officer on the 8th February and 16th May 2017

The Ombudsman notes that further to the Complainant's February 2017 letter, both the HA and the Complainant acknowledge that the Reporting Office contacted the Complainant by phone. The action taken by the Reporting Office Manager further to the Complainant's February 2017 call was to contact HWA (as evidenced by the email thread in March 2017) and the latter agreeing to change the scope of works which did not materialise.

Notwithstanding, the Ombudsman sustains the complaint of non-reply to the 16th May 2017 letter as no action was taken either by way of a reply or further contact with HWA, resulting in the report being closed in August 2017 without the scope of works having been amended.

Complaint (iii) – Unable to classify—Concerned that the situation posed a fire hazard

The HWA attests to the fact that qualified staff from the Gibraltar Electricity Authority attended to two reports at the Flat due to the electrical installation having been affected by water ingress and state that the disconnection of the ceiling rose removed any possibility of a fire hazard.

The Ombudsman does not have the expertise available to contrast this information and thus verify or refute the above and as such cannot classify this complaint.

The HA through this report is well aware of past water ingress problems experienced in the Flat, as well as of the injury caused to the Complainant's son due to a light bulb having exploded and the Complainant's claim that light bulbs exploding is a daily occurrence, and as such should make arrangements for the Flat's electrical installation to be checked and a clean bill of health issued in this respect.

Classification

Complaint (i) Not Sustained
Complaint (ii) Sustained
Complaint (iii) Unable to classify

Recommendations

HWA should make arrangements for the Flat's electrical installation to be checked and a clean bill of health given in this respect.

(Report extracted from Case No 1155)

HOUSING AUTHORITY

Case 15

Complaint

The Complainant was aggrieved because a year after having been notified by the Housing Authority that an offer for allocation of a Flat would be made imminently, the offer had not materialised.

The Complainant explained she had applied for Government rented accommodation a number of years ago and was included in the general housing waiting list. In October 2016 she was categorised as a social case and was included in the Housing Authority's Social A List [Ombudsman Note: Categorisation of cases considered by the Housing Allocation Committee ("HAC") and deemed to be in urgent and dire need of accommodation are included in the Social A List, with the objective of housing these applicants within a shorter period of time than through the general housing waiting list].

The Complainant claimed she lived in a houseboat which was in a very bad condition and had already been saved from sinking on two occasions. She further stated that she had suffered a number of injuries from getting on and off the houseboat during periods of bad weather and on those occasions had been left with no choice but to resort to the goodwill of friends to provide a roof over her head. The Complainant had submitted documentation to HAC in support of these claims.

On the 30th November 2016, the Housing Authority's Housing Manager ("HM") responded to an email query in relation to the Complainant's case from a member of Action for Housing ("AH") (a local pressure group who was assisting the Complainant with her situation) stating that the Housing Authority had discussed her case and that they would be making *"…an offer of allocation imminently…"*. The Housing Authority informed AH that they had already made the Complainant aware of this information and added that they did not presently have the details of the property to be offered. By October 2017, the offer of allocation had still not materialised. Throughout that period of time, AH continued to make representations to the Ministry for Housing about the Complainant's case.

In November 2017, the Complainant lodged her complaint with the Ombudsman.

Investigation

The Ombudsman presented the complaint to the Housing Authority. After a lengthy three month delay, a response was received on the 14th February 2018. The response was that all applicants in the Social A List are deemed to be urgent cases and that, although the Housing Authority endeavoured to attend immediately to all cases, it had to be understood that priority was always dependent on availability of properties and applicants included in the Social A list at an earlier date being allocated a property. The Housing Authority advised that the Complainant was in 23rd position and there were therefore twenty two other applicants on the Social A list who had been categorised prior to October 2016 (the date on which the Complainant was categorised).

To corroborate the above statement, the Ombudsman requested a copy of the Social A list allocations between November 2016 to May 2018 (date on which request was made by the Ombudsman was 2nd May 2018). Once again a lengthy three month delay ensued for the information to be provided. The details were received on the 3rd August 2018. The Ombudsman analysed the information provided and identified two cases where allocations had been made to applicants who had entered the Social A list after the Complainant. One case entered the Social A list on the 20th February 2017 and was allocated a property on the 25th April 2017 and the other entered the list on the 25th September 2017 and was allocated a property on the 24th November 2017. The entitlement of those applicants was similar to that of the Complainant's, i.e. a one bedroom property. Based on the earlier information provided by the Housing Authority with regard to the chronological order of allocation, the Ombudsman reverted to the Housing Authority. On this occasion, the latter's response was received a day after the enquiry was made. The Housing Authority explained that the February 2017 applicant had in fact been socially categorised on the 9th February 2015 but due to the file having been cancelled and subsequently reinstated on the 20th February 2017, the later date appeared on the Social A listing when in fact the date listed should have been the original date of categorisation, i.e. February 2015. In respect of the September 2017 case, the Housing Authority stated that this was a case involving a child who had left care (Social Services).

Upon further analysis of the Social A list allocations, the Ombudsman found that the time taken for allocations from the time of categorisation for the Complainant's entitlement ranged from between one year and ten months to four years and seven months – other than the two cases identified by the Ombudsman above. The reason given for this timeframe was that the Housing Authority were dependent on properties being released and vacated by previous tenants in order for allocations to be made.

The Ombudsman probed the Housing Authority on the matter of the email sent in November 2016 to AH in relation to *'an imminent offer of allocation'* to the Complainant. The Ombudsman noted that the Principal Housing Officer and the Housing Minister's office had also been copied into this email.

The Housing Authority stated that the then Housing Manager should not have used that wording as Social A list allocations are made in chronological order of applications and the Complainant had to wait her turn.

At the time of writing this report - November 2018 - the Complainant continued to wait her turn in the Social A list for an offer of allocation to materialise and was in sixth position.

Conclusions

In the course of this investigation, the Housing Authority informed the Ombudsman about the established procedure regarding allocations to applicants on the Social A list - i.e. that allocations are dependent on chronological order of entry into said list and the availability of properties. The Ombudsman has no doubt that the circumstances of all applicants in the Social A list are considered to be urgent in relation to their housing needs and that the procedure followed by the Housing Authority is therefore an appropriate one. Notwithstanding this, the communication sent to the Complainant in November 2016 stated that an offer of allocation was imminent, a statement which the Complainant had no reason to doubt considering her desperate situation, especially not being aware of the inner workings of the Housing Authority. It has become clear, two years later, that the Housing Authority have indeed applied the established procedure for allocation in the Complainant's case but that they have failed to inform her that the November 2016 email should never have been sent to her.

The Housing Authority have also failed to apologise to the Complainant for this.

The Ombudsman found maladministration in the manner in which the Housing Authority dealt with the Complainant's case. Due care needs to be taken by the Housing Authority in order to avoid erroneous information being provided to applicants as well as in their management of expectations.

Classification

Sustained

Recommendations

The Ombudsman recommends that the Housing Authority should apologise to the Complainant. He further recommends that the Housing Authority should implement a system to prevent a recurrence of this situation in similar cases.

(Report extracted from Case No 1164)

HOUSING AUTHORITY

Case 16

Complaint

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

The Complainant stated that in 2002, she and her husband ("Husband") separated after over twenty years of marriage. As a result of the break up, the family home ("Property") was sold and the Complainant moved in with her sister-in law (Husband's sister) whilst her Husband moved into alternative rented accommodation. The divorce was finalised in March 2014. The Complainant explained that she went through a very difficult time after the separation and was unable to face dealing with the legalities of the situation until years later, hence the twelve year gap between the time when the marriage broke up and obtaining the divorce. Expanding on this issue, the Complainant stated that neither she nor her Husband wanted to marry anyone else at that point nor were they in a financial position to incur the legal expenses of a divorce.

The Complainant noted she had contacted the Housing Authority prior to obtaining the divorce in 2014 with the objective of applying to the List and had been informed that this would have to be finalised before she could proceed to apply. The Complainant submitted the application on the 8th August 2014. A long process ensued whereby the Housing Authority requested substantial documentation dating back to the date of the sale of the Property in 2002, some of which she found impossible to produce due to the time that had elapsed. In April 2016, the Housing Authority informed the Complainant that the Housing Allocation Committee ("HAC") had considered her case and had denied her application. The reason given for the refusal was that the financial assessment undertaken, showed a positive computation at the time of sale of the Property, which established that she was financially able to afford the 'monthly payments' for the Property. The Housing Authority referred the Complainant to Government policy introduced in September 2005 known as the '5d Clause' which stated the following:

> [1]*"People who have been home owners and have chosen to sell their homes shall not be entitled to go on the public waiting list unless, in the judgement of the Housing Allocation Committee, the sale was genuinely necessary or there is some justification for being admitted. No other person shall be allowed to earn "overcrowding" points when people move into his home after having sold their own home, unless the Housing Allocation Committee rule that the sale was genuinely necessary."*

By way of further explanation in relation to the eligibility procedure in this case, where the applicant had been a homeowner, the Housing Authority stated that a financial assessment at the time of sale of the Property had to be undertaken. If the outcome of the assessment demonstrated financial hardship at the time of the sale, then the 5d Clause would be waived. In the Complainant's case, the assessment deemed that she could afford the Property and as such disqualified her from eligibility for an application to the List.

The Complainant challenged the decision and explained to the Housing Authority that there was a genuine reason for the sale of the Property which was due to the breakdown of the marriage; she would have been unable to obtain a mortgage based on her sole income in order to buy her Husband's 50% share in the Property. Furthermore, the Complainant noted in her letter that her Husband's application to the List had been accepted and he had been allocated accommodation, despite the fact that his annual income was higher than hers, whereas her application had been declined. The Complainant asked the Housing Authority to review her case as under the circumstances there had to be some misunderstanding.

The Housing Authority reconsidered the case but reverted that the decision was upheld. In respect of the Husband's case, she was informed that they could not provide any details on why his application had been accepted due to the restrictions in this respect under the Data Protection Act 2004.

The Complainant once again appealed the decision but the Housing Authority upheld this. In July 2017, the Complainant lodged her complaint with the Ombudsman.

Investigation

The Ombudsman presented the complaint to the Housing Authority. The latter's initial response in December 2017 stated that the financial assessment was based solely on the information provided by the Complainant pertaining to the time of the sale of the Property in 2002 and that the divorce was not taken into account as this proceeding was not effected until June 2014. The outcome of the computation of the financial assessment proved that the Complainant was not struggling to meet payments at the time of the sale of the Property. HAC refused her application based on Clause 5d (as per [1] above).

Regarding the Husband (at the time of writing this report, the Husband had passed away and the General Data Protection Regulations (GDPR) and the Data Protection Act 2004 no longer apply to identifiable data that relates to a person once they have died) the Housing Authority in their initial response in December 2017 explained that his application was presented to HAC and that due to his serious medical condition and the fact that he had shown an interest in purchasing a property from the affordable housing scheme ("Scheme") (criteria for application to this scheme is the applicant has to be eligible for inclusion in the List) HAC agreed to forward his case to the Housing Authority. The application was accepted on the grounds that once an allocation (of social housing) was made he would have to sign a licence agreement stating that once he purchased from the Scheme he would surrender any social housing.

The above information raised enquiries from the Ombudsman as follows:

1. The Husband's date of entry in the List;
2. Whether the Housing Authority were aware that at the time of application the Complainant had been a home owner;
3. That the Husband was possibly still legally married to the Complainant (dependent on date of entry in the List).

In February 2018, in response to the above, the Housing Authority informed the Ombudsman that the Husband's application had been erroneously accepted and that this had only come to light as a result of the Complainant's application in 2014. At that point it was decided that discretion would be applied in respect of the Husband's application based on medical and humane grounds. By way of further information to substantiate the decision, the Housing Authority advised the Ombudsman that the owners of the building in which the Husband had a rented flat , had applied for demolition (Ombudsman Note: The Ombudsman asked the Housing Authority for documentation to substantiate this information and he was provided with a copy of the demolition application dated 24th March 2016). Regarding the Husband's medical condition, the Housing Authority provided a copy of a doctor's letter the Husband had sent to them in July 2015 when he was diagnosed with cancer. The Husband passed away towards the end of 2017. Notwithstanding the aforementioned, it was the Housing Authority's position that accepting the Complainant's application on the basis of the error made in accepting the Husband's application had never been entertained.

Regarding the Housing Authority's policy in respect of entitlement for application to the List in cases of marital breakdown in which the parties were homeowners, they responded that in those cases, applicants were requested to submit property deeds of completion or transfer, and either, a legal separation agreement, divorce agreement or a signed affidavit from both parties stating that they were separated.

The Ombudsman was provided with a copy of the Husband's application dated the 29th March 2012 which was considered at HAC's meeting of the 25th June 2012 and at which it was agreed to accept the application. The Ombudsman noted from the Husband's application form that he had in fact disclosed he had previously been a homeowner. Furthermore, from the minutes of HAC's meeting provided to the Ombudsman it is also noted that HAC were duly aware of this and the fact that he resided in privately rented accommodation with his partner and a daughter in common.

The Ombudsman was informed that the Husband's application was cancelled on the 23rd November 2016 due to the purchase of a property from the Scheme.

Conclusions

The Ombudsman found that there has been maladministration in the manner in which the Housing Authority have acted in relation to this complaint.

When arriving at his conclusions on the findings of an investigation, the Ombudsman always starts from the premise of 'what should have happened'.

What has been established in the course of the investigation is that it was in March 2012 that the Husband applied for inclusion in the List. Despite having informed the Housing Authority in his application form that he had been a homeowner, the Housing Authority failed in this instance to request the pertinent documentation from the Husband. The HAC were also fully aware of the fact that the Husband had been a homeowner but nevertheless proceeded to recommend his inclusion in the List. The Housing Authority informed the Ombudsman that the application had been erroneously accepted and that this only came to light in 2014 when the Complainant applied. The Housing Authority decided to apply discretion in relation to the Husband's application based on medical and humane grounds. The Ombudsman has found in his investigation that the Husband was not medically diagnosed until July 2015 (letter from Husband's doctor refers) and that an application for demolition of the building in which the Husband's rented flat was contained was filed in March 2016. Both these events occurring a year and two years respectively, after the Housing Authority's purported 'error' came to light (2014). This does not therefore justify that the discretion was applied on the basis of medical and humane grounds. Furthermore, the fact that the Husband and the Complainant had in 2012 not divorced never came to light.

Regarding the Housing Authority's refusal of the Complainant's application to the List, the Ombudsman is of the opinion that Clause 5d was inappropriately applied. Although the outcome of the financial assessment undertaken showed a positive computation to the effect that the sale of the Property was not necessary because the Complainant could afford the payments towards the Property, the fact that the Complainant would have had to buy out her Husband's 50% stake in the Property was not taken into account.

It was this factor that would have in all probability changed the outcome to a negative computation deeming the sale of the Property to be genuinely necessary as per Clause 5d referred to by the Housing Authority. Under these circumstances, it would possibly be the case that both the Complainant and the Husband would have been eligible for inclusion in the List. Even though in this case the sale of the Property took place in 2002, whereas no official document of the marriage breakdown was produced until 2014 (the time when divorce proceedings were executed due to circumstances explained by the Complainant in this report), the facts remain that:

I. The couple ultimately divorced deeming the sale genuine as the Complainant could not have afforded to pay the Husband off for his 50% stake in the Property, something which was not taken into account by the Housing Authority;
II. The Housing Authority at the time of the Complainant's application agreed to a revised financial assessment taking only her income into consideration which would point to the Housing Authority neither doubting or questioning the facts presented by the Complainant;
III. At the time when the Husband applied for inclusion in the List (2012) his daughter from his partner was already four years old.

Regarding the Housing Allocation Scheme from which Clause 5d is quoted by the Housing Authority, the Ombudsman is critical that these policy guidelines are not published and this makes it impossible for applicants to the List to identify the full requirements for eligibility. In the Ombudsman's view, all protocols and policies need to be made available to the public in order to ensure procedural transparency in public services.

Recommendations

The Ombudsman recommends that the Housing Authority undertake a fresh financial assessment in respect of the Complainant's application, on this occasion taking into account settlement of the Husband's 50% share in the Property. The Ombudsman recommends that the Housing Authority make available to the public, its protocols and policies in order to ensure procedural transparency in public services.

(Report extracted from Case No 1166)

HOUSING AUTHORITY

Case 17

Complaint

The Complainant was aggrieved over the non reply to letters dated 5th and 29th January 2018; the Housing Authority's December 2017 letter requesting him to hand back vacant possession of the Flat was inaccurate and alarming and was received during a holiday period when the offices were closed; non reply to letters dated 1st and 23rd November 2017 complaining about the status of his housing application and numerous requests to have his tenancy in the Flat recognised, had been ignored or delayed.

The Complainant explained to the Ombudsman that he resided in the Flat with his mother ("Mother") and father ("Father"). The Flat was a Government rented property and the tenancy was held in his Father's name with his Mother and he listed as authorised tenants. The Complainant claimed that this information was provided to him by a clerk at the HA offices when in October 2016 he made enquiries with respect to submitting his application for inclusion in the Government housing waiting list for rented accommodation ("List") [Ombudsman Note: The Complainant was applying with the objective of being allocated a property in his own right]. The Complainant claimed the clerk confirmed from the HA's electronic records that he resided in the Flat and had the legal right to reside there. The Complainant further claimed that this same information was confirmed to him by the Ministry for Housing on the 31st May 2017 (when he contacted them in an attempt to have his tenancy confirmed in order to have utility bills changed to his and his Mother's name further to his Father having passed away).

By way of background, the Complainant informed the Ombudsman that he had lived in the United Kingdom ("UK") between 1981 and 2003 after which he returned to Gibraltar and had ever since resided in the Flat (which had always been the family home). He claimed that upon his return to Gibraltar in 2003 his Father submitted the pertinent application to the HA for his re-inclusion as an authorised tenant in the Flat which was accepted.

The Complainant's Father passed away in November 2016 and in March 2017, the Complainant submitted an application to the HA for the Flat's tenancy to be transferred to his and his Mother's names; joint tenancy. In April 2017, the Complainant enquired on progress and was asked by the HA to provide a copy of his identity card and proof of residency in Gibraltar. The Complainant complied and as proof of residence, presented a copy of his motor vehicle insurance policy which covered the period commencing 10th February 2017 to 9th February 2018. In May 2017 the HA asked the Complainant to provide proof of continuous residency twelve months prior to the date on which the transfer of tenancy application was requested (March 2017). In July 2017, the Complainant submitted a number of electricity and water bills dating back to June 2016. The bills were for consumption in the Flat and were addressed c/o (care of) the Complainant and his Mother with the account holder shown to be his late Father. According to the Complainant, in order for the utility company to change the account name they required a copy of the HA's tenancy agreement in his and his Mother's name but that could not be provided until the tenancy was transferred; the c/o names had been included in the bill by the utility company, Aquagib, as an interim measure.

In September 2017, the Complainant's Mother passed away and the Complainant submitted to the HA, a new application for the transfer of the tenancy of the Flat to his name. On the 18th December 2017, the Complainant presented to the HA electricity and water bills in which he was now shown as the account holder. The bills dated back to November 2016. According to the Complainant, the utility company, Aquagib ("Aquagib") had finally, after months of him complaining about the continued distress caused in having the account in his late Father's name, changed the account name. The Complainant believed the account name was changed because Aquagib had contacted the Ministry for Housing who confirmed he had the legal right to reside in the Flat.

On the 24th December 2017 the Complainant received a letter from the HA dated 18th December 2017, requesting that he hand in the keys to the Flat by the 29th January 2018 for the HA to obtain vacant possession. The HA stated that the transfer of tenancy had been refused as the proof submitted by the Complainant of continuous residence in Gibraltar were Aquagib bills under the Father's name

(Ombudsman Note: Although by this point in time the account had been changed by Aquagib to the Complainant's name, the Complainant's submission of these bills on the 18th December 2017 intersected with the HA's letter of the same date). Furthermore, the HA added that he had been excluded from the tenancy of the Flat because he had left for the UK.

The Complainant could not reconcile the HA's request for vacant possession with the fact that he was an authorised tenant in the Flat as per the information in HA's electronic record. He also noted the erroneous reason given by the HA in relation to the utility bills as the account was now in his name.

The Complainant stated that on the 5th January 2018, after an anxious Christmas period during which the HA's offices were closed, he handed in a lengthy letter to the HA expressing his discontent and setting out the reasons why he felt the request to vacate the Flat were unfounded. By the 29th January 2018 he had not received a response and he submitted a second letter explaining everything again and requesting that the tenancy of the Flat be transferred to his name. On the 26th February 2018 he received an acknowledgement letter advising that '...a further communication would be sent to you [Complainant] shortly'.

On a separate issue, the Complainant stated that on the 20th July 2017 he had handed in an application to the HA for inclusion in the List, together with supporting documentation: motor vehicle insurance policy dated 10th February 2017 and electricity and water bills dating back to June 2016 (bill showed the Complainant as a c/o recipient). By November 2017 the application had not been processed and the Complainant sent letters of complaint to the HA on the 1st and 23rd November 2017 to which he received acknowledgements but no substantive replies. In mid March 2018, the Complainant lodged his complaints with the Ombudsman.

Investigation

The Ombudsman presented the complaints to the HA in March 2018. [Ombudsman Note: Parallel to the submission of complaints to the Ombudsman, the Complainant had submitted a complaint to the Gibraltar Regulatory Authority ("GRA") against the HA.

The Complainant had presented 'subject access requests' to the HA under the Data Protection Act 2004 for the disclosure of personal data held by them. The complaint arose because HA had not provided the documentation within the prescribed 28 day period. The GRA's investigation found that notwithstanding a delay beyond the prescribed 28 day period, HA eventually provided the Complainant with the information he was entitled to].
The Ombudsman received an initial response from the HA in April 2018.

In relation to the non-reply to the 5th and 29th January 2018 letters, the HA stated both were acknowledged on the 26th February 2018 and the Complainant advised that his case was being considered. The Ombudsman was provided with a copy of said letter in which apart from the acknowledgement, the HA informed the Complainant there would be a further communication shortly.

Regarding the letter requesting vacant possession, the HA stated that the case was very complex and they had had to rely on advice from several entities such as Land Property Services Limited ("LPS") and the Land Management Committee ("LMC"). The letter was sent out on the 18th December 2017 when all the necessary information had been compiled. The HA stated that the Complainant could have asked for an extension of the deadline.

[Ombudsman Note: The Ombudsman was made aware that LPS' and LMC's involvement in this case had been due to an expression of interest from one of the Complainant's siblings to purchase the Flat (years before the Father's death). The Ombudsman contacted the Complainant to enquire about this situation and was informed that the purchase had not materialised. Notwithstanding, he (the Complainant) had discussed with LPS the possibility of purchasing the Flat, after his Father passed away in November 2016. In March 2018, after further discussions, LPS offered to sell the Flat to the Complainant and his four siblings for £120,000 - with completion required by May 2018. The Complainant refused the offer on the basis that the Flat should have been offered at a discounted price to the sitting tenant and asked LPS and LMC to reconsider the sale price and the Flat to be sold solely to him.. At the time of writing this report, the Complainant was awaiting a decision on this issue. The Complainant stated his preferred option was to remain a tenant in the Flat due to the financial stress that purchasing the Flat would put on him.

The HA stated that they provided a response to the Complainant's letters of the 1st and 23rd November 2017 on their 18th December 2017 letter, but noted that in said letter, they only made reference to the 1st November 2017 letter.

The Complainant contacted the Ombudsman and provided copies of the documentation sent to him by the HA on the 10th April 2018, further to his 'subject access request' under the Data Protection Act 2004 amongst which were the following:

I. **12.01.07-** *A form from the Ministry for Housing dated 12.01.07 approving the Complainant's inclusion in the Flat's tenancy;*

II. **22.01.??** - *A 'Housing Information Form' in which the Complainant's name had been crossed out (thereby revoking his tenancy in the Flat). [Ombudsman Note: The date on the form was unclear and the Ombudsman requested to see the Complainant's file held by HA to examine the original document].* [The Ombudsman requested access to the Complainant's file to check the original exclusion form's date which was not clear from the copy provided by the HA to the Complainant. The Ombudsman met with the HA in October 2018 and after examination of the document on file, concluded that the date was in all probability '07'. For avoidance of doubt, the Ombudsman enquired about the form format in 2000 and noted that those forms appeared as an older version than the form being queried].

III. **04.04.17**- Request for a change of name of tenancy in the Flat to include the Complainant's and Mother's name, approved for the latter but Identity card and proof of residence noted on the form as being required from the Complainant;

IV. **04.04.17**- Request for a change of name of tenancy in the Flat to include the Complainant's name is denied stating the Complainant is not authorised;

V. **20.09.17**- Request for a change of name in the tenancy to the Complainant's name (further to his Mother having passed away) is denied stating son (Complainant) not authorised.

Accompanying the documentation was a letter from the HA in which a response to a letter from the Complainant dated 1st February 2018, in which he had requested details of his exclusion from the tenancy of the Flat, were addressed.

HA responded that the only records held by them on this issue related to an application in 2005 requesting authorisation for him to reside in the Flat which was approved and subsequent records which showed that some time after the 22nd January 2007 his name was removed as a person authorised to reside in the Flat. HA stated that regrettably there was no record of the reasoning for that decision but noted that subsequent correspondence in the file indicated that it was due to him not residing in Gibraltar.

The Complainant maintained that despite the hard copy records denoting that he had been excluded from the tenancy, the computer records showed he was an authorised tenant in the Flat. [Ombudsman Note: At a subsequent meeting between the Ombudsman and the HA, the latter corroborated this information, adding that had been due to an oversight; i.e. the hard copy record had been update but not the electronic record].

Regarding the documents requested by the HA from the Complainant as proof of one year's continuous residency in Gibraltar prior to his Mother's death (as from September 2016) the Complainant stated that the HA had asked for:

1. An employment contract: The Complainant stated he had retired on medical grounds in 2003 when he returned to Gibraltar, so he was unable to provide this;

2. A motor vehicle insurance: The Complainant stated that the car he drove was owned by his Father and Mother and that this remained in their names until after his Father passed away. Until that point he was insured under the clause 'any driver over 25';

3. Utility Bills: The telephone bill was not acceptable to the HA as proof of address. For the electricity/water bill to be changed to his name, Aquagib (water company) required a copy of the tenancy agreement with his name. The Complainant was finally able to provide a copy of the bill in his name dating back to August 2016.

The Ombudsman queried how it had been possible for the Complainant to have the electricity and water account changed to his name and the Complainant believed it was because Aquagib must have contacted HA and the Ministry for Housing and been informed that he was an authorised tenant in the Flat, as per electronic records.

The Ombudsman directed his enquiries to Aquagib and found that the account name was changed to the Complainant's name when he registered his Mother's death at one of Civil Status & Registration's Offices ("CSRO") (a branch office of CSRO set up for the purpose of assisting next of kin of deceased persons to register the person's death, to apply for pertinent death benefit, update/cancel utility services, Government tenancies, etc.). CSRO had emailed the change of name application form to Aquagib with relevant documents, stating that they would let them know if the HA approved the change of name in the tenancy agreement. Regarding the need for a tenancy agreement for the account name to be changed, Aquagib responded that they had acted on the CSRO's email request and applied the change of name; they would await for CSRO to, at a later date, confirm or deny the approval from the HA (Ombudsman Note: Aquagib provided a copy of the email). If it was denied, the account name would revert to the original format. Furthermore, Aquagib advised that as from June 2018 due to GDPR (General Data Protection Regulation) in order to minimise the data collected from customers, they would no longer request to see copies of deeds, rental agreements, housing contracts, etc (Aquagib advised that they had sent an information leaflet to all their customers informing them of this in June 2018). The 'tick box' in Aquagib's application for service form required applicants to have a legal right to the property they were requesting service to and this would now serve as a check to Aquagib as well as verification at the time of connection of supply that the person applying had access to the property. Aquagib stated that their utility bills should no longer be used as proof of address although that remained at the discretion of the Government department/entity concerned.

The Ombudsman met with CSRO to discuss the above. CSRO highlighted that the objective of the branch office was to provide assistance to next of kin of deceased persons (for the purposes explained above) and it should not have informed Aquagib that they would contact them if and when the HA approved, or not, the Complainant's tenancy. That was a matter for the HA.

To further clarify a number of issues in the investigation, the Ombudsman met with the HA's Principal Housing Officer ("PHO") and a representative from the Ministry for Housing.

The PHO confirmed that the Complainant's application for re-inclusion in the Flat's tenancy was signed in March 2005. This was submitted to the HA in December 2006 and was approved on the 12th January 2007 as denoted by a copy of the pertinent form and subsequently removed from the tenancy on the 22nd January 2007. The hard copy file had been updated in 2007 when the Complainant was removed from the tenancy of the Flat but, due to an oversight, the electronic records were not updated accordingly. By way of further explanation, HA stated that as there had been no further changes in the tenancy in the ensuing years, the electronic record had not been accessed and therefore not updated accordingly. The PHO stated that to date, the electronic record still showed the Complainant as being included in the tenancy. PHO stated that no changes have been made to the Complainant's record since the matter came to the HA's attention, due to the matter being an ongoing Ombudsman investigation. Nevertheless, a note has been attached to the electronic record, denoting that the Complainant was not included in the tenancy. PHO stated that this case has triggered an internal exercise in which all tenancies were being updated/checked. PHO confirmed that the reason/s for the decision to exclude the Complainant from the tenancy were not documented.

Regarding the request by the Complainant for a transfer of tenancy to his and his Mother's name, the PHO stated that the tenancy was transferred to his Mother in April 2017 (after the Father had passed away) but the new tenancy agreement was never signed by her. In September 2017, after his Mother passed away, there was a second request by the Complainant for the tenancy transfer to his name. For that purpose, the HA required that the Complainant submit proof of residency in Gibraltar, one year prior to his Mother having passed away, i.e. September 2016 and the PHO stated that to date he had been unable to provide this proof, a requirement for both the transfer of the Flat's tenancy and Government housing application. PHO informed the Ombudsman that the Complainant was aware as from April 2017 that his inclusion in the tenancy had been denied.

The PHO referred the Ombudsman to the fact that the Flat had been with the LMC for many years as the Complainant's family had shown an interest in purchasing it. PHO was aware that in March 2018 an offer had been made by the LMC for all five siblings to purchase the Flat but that appeared to have fallen through. The current situation was that the matter was now in the remit of the LMC who were studying the possibility of selling the Flat to the Complainant at the 'sitting tenant' price.

Regarding the letter sent by the HA to obtain vacant possession of the Flat, the PHO stated that the Mother had been admitted into permanent care in June 2017. Ordinarily, the HA would have pursued the vacant possession of the Flat, a month after admission but explained that because LMC were considering the sale, HA were not in a position to make the request until December 2017.

PHO stated the utility bills could not serve as proof of the Complainant having resided in Gibraltar since September 2016, only as proof of responsibility for payment of bills.

The Ombudsman met with the Complainant to update him on the investigation and at that meeting suggested that he provide other means of proof of residency in Gibraltar for the period required by HA like bank statements, which should serve to establish his whereabouts in given periods of time. The Complainant stated he had thought of that option but felt that the HA would not accept this as they had been stringent in their requests of what would be acceptable proof and were not deviating from the standard documentation requested which was an employment contract, motor vehicle insurance and/or utility bill.

At the time of writing this report, for the purpose of proof of continuous residence in Gibraltar for the period September 2016 to September 2017, the Complainant submitted to the HA (copy to the Ombudsman) bank statements denoting his expenses and the location where those transactions had taken place during that period. The Ombudsman noted that apart from twenty three days in October/November 2016 and three days in March 2017, most of the transactions were for purchases in Gibraltar establishments. The HA advised that they had received the documents and were reviewing the case.

Conclusions

The Complainant had resided in the Flat from birth until 1981 when he left Gibraltar to reside in the United Kingdom at which point it appears he was excluded from the tenancy but there is no documentation held by the HA to this effect. According to the Complainant he returned to reside in Gibraltar and to the Flat in 2003.

The HA presented the Ombudsman with copies of the application form for the Complainant's inclusion in the tenancy, which was signed in 2005 This has been submitted to the HA in December 2006 and approved on the 12th January 2007. The HA submitted as evidence of the Complainant's removal from the tenancy of the Flat, a copy of a form dated 22.01.07 in which the Complainant's name had been crossed out from the tenancy by the stroke of a pen. There are no reason/s for the exclusion recorded on file and this is because, according to the HA, at that time reasons for those decisions were not recorded. In contrast, to date, the Complainant continues to show in the HA's electronic records as an authorised tenant in the Flat. The HA stated the reason for this was an oversight at the time when he was excluded from the Flat.

In relation to inclusions and exclusions in tenancies by the HA, the Ombudsman notes that the HA do not write to the tenancy holder and/or the subject of the inclusion/exclusion to inform him/her of the decisions taken by the HA in this respect. The HA appear not to consider the impact that an exclusion from a tenancy would have on a person more so if this is concealed from them as was the Complainant's case who only became aware of the situation further to an enquiry. The HA are, in effect, deeming people homeless without the person's knowledge and in doing so, denying them a timely right of appeal.

On the basis of what happened in the Complainant's case vis-a-vis what should have happened, the Ombudsman found maladministration on the part of the HA by having excluded the Complainant from the tenancy without having the evidence to substantiate that action. Furthermore, the evidence now submitted by the Complainant and required by the HA for inclusion in both the Flat's tenancy and application to the Government housing list proves that he has been in Gibraltar for the period required to meet the HA's criteria for the aforementioned transfer of the tenancy to his sole name.

None of the complaints brought to the Ombudsman would have arisen had it not been for the maladministration on the part of the HA in having excluded the Complainant from the tenancy without having informed the affected parties (tenancy holder and Complainant) - an action which the Complainant was only made aware of when he requested the transfer of the tenancy to his and his Mother's name.

In this respect, the Ombudsman was reminded of Lord Denning's words in R V Local Commissioner for Administration for the North and East Area of England ex parte City of Bradford Metropolitan Council, (1979):

> *"In the nature of things, a complainant only knows that he has suffered injustice. He cannot know what was the cause of the injustice. It may have been due to an erroneous decision on the merits or it may have been due to maladministration somewhere along the line leading to the decision. If the Commissioner looking at the case – with all his experience can say: "It looks to me as if there was maladministration somewhere along the line – and not merely an erroneous decision" – then he is entitled to investigate it. It would be putting too heavy a burden on the complainant to make him specify the maladministration: since he has no knowledge of what took place behind the closed doors of the administrators' offices."*

In consideration of the fact that the Complainant has been able to provide evidence of continuous residency in Gibraltar for the period September 2016 to September 2017, a year prior to his fresh application for the tenancy to be transferred from his Mother's name to his, the Ombudsman recommends that the HA transfer the tenancy of the Flat to the Complainant. This recommendation is further strengthened by the fact that the HA's only reasoning for the Complainant's exclusion from the tenancy of the Flat was a form in which the Complainant's name had been crossed out manually and no reasons recorded to substantiate such a decision. Furthermore, despite the HA's assertion in their letter of the 10th April 2018 to the Complainant, that subsequent correspondence in his file indicated the exclusion was because he was not residing in Gibraltar, no such evidence has been provided to the Ombudsman, in this regard

The Ombudsman further recommends that in such cases where persons are either included or excluded from a tenancy, the HA write to tenancy holders as well as to the person who is the subject of the exclusion/inclusion notifying them of the decision.

The Ombudsman has not expressed a view with regard to the proposed purchase of the Flat, as that was a separate avenue being pursued by the Complainant and his family.

Classification

Sustained on the basis of the HA's maladministration in having excluded the Complainant from the tenancy.

Recommendations

The Ombudsman recommends that the HA transfer the tenancy of the Flat to the Complainant.

The Ombudsman further recommends that in cases where persons are either included or excluded from a tenancy, the HA write to tenancy holders as well as to the persons who are the subject of the exclusion/inclusion notifying them of the decision.

Update

At the time of completion of this report, the Complainant submitted to the HA (copy to the Ombudsman) as proof of twelve months continuous residency in Gibraltar (for the period September 2016 to September 2017 (September 2017 being the date on which the Mother passed away)) bank statements denoting his expenses and the location where those transactions had taken place during that period. The Ombudsman noted that apart from twenty three days in October/November 2016 and three days in March 2017, most of the transactions were for purchases in Gibraltar establishments. The HA advised that they had received the documents and were reviewing the case.

After consideration of the above documentation, the HA nevertheless informed the Complainant that he did not meet the eligibility criteria for either a change of tenancy name in the Flat or for a housing application (submitted July 2017). They informed the Complainant that to meet the eligibility criteria, they required evidence that he had been a resident in Gibraltar for a continuous period of twelve months (as from March 2016) whereas the proof he had submitted only proved residence since September 2016. The HA further stated that even then it was 'clear that was not continuous (residence since September 2016) and that he had been returning to the United Kingdom regularly'.

The Complainant brought a copy of the response to the Ombudsman who wrote to the HA requesting clarification as to the relevance of requesting proof of residence from March 2016 when the application for the transfer of tenancy of the Flat submitted by the Complainant on that date had already previously been refused by HAC. He had submitted a new transfer of tenancy application in September 2017 (after his mother passed away) and this was the reason why he had submitted proof of residence for a year prior from that date. The Ombudsman also sought clarification on the statement made by the HA that in their view it was clear from the evidence submitted by the Complainant, that his residence in the tenancy since September 2016 was not continuous as he had been returning to the United Kingdom regularly. [Ombudsman Note: The Ombudsman had already reviewed the documentation submitted by the Complainant and had found from the evidence presented that the Complainant had been in the United Kingdom for a total of twenty six days in the course of the twelve months]. The Ombudsman put it to the HA that their statement implied that for an applicant to prove continuous residence for a period of one year, he/she would not be able to travel outside Gibraltar during that time.

The HA's response stated:

> *'Essentially, the right to apply for a transfer of tenancy on the grounds of succession only accrues as a result of a 'tenant' having since deceased and is conditional on proof of residence for a continuous period of 12 months prior to the date of the application.'*

The HA further stated that it was important to note that the Complainant's Mother (the tenant) ceased to reside in the Flat in March 2017 when she was admitted to the Elderly Residential Service and subsequently passed away in September 2017. The HA clarified that once the Mother ceased to reside in the Flat, the Complainant no longer had a right to acquire a transfer of tenancy on the grounds of succession and the Flat should have been handed back to the HA shortly after that date. The HA stated that further to HAC's consideration, his September 2017 application for the transfer of the tenancy was refused on the same grounds as the March 2017 application which was due to lack of proof that he had resided in Gibraltar for a continuous period of twelve months prior to the date when his late Mother ceased to reside in the Flat.

The HA advised that until such time as the Complainant submitted proof of one year continuous residence as from March 2016, any subsequent application would be refused as that time frame was a prerequisite for the right of succession to accrue.

The Ombudsman contacted the Complainant to update him on the HA's response. The Complainant's maintained that his Mother did not cease to be a tenant in the Flat until the date on which she passed away. Although she had been admitted into the elderly care residential service, the Complainant maintained it was always his intention for her to return to the Flat and be cared for at home.

The Ombudsman noted from the findings of his investigation that whilst the HA stated that the Mother ceased to be a tenant in March 2017, HAC had actually approved the transfer of tenancy to the Complainant's Mother on the 4th April 2017. The Ombudsman further noted that there is no documentation to the effect that the Mother was removed from the tenancy whilst she was in the care of the Elderly Residential Services.

Having considered the further information provided in this update, the Ombudsman concluded that his finding of maladministration by the HA and his recommendations, as outlined above, remain unchanged.

(Report extracted from Case No 1168)

SOCIAL SECURITY (DEPARTMENT OF)

Case 18

Complaint

The Complainant was aggrieved because the DSS had failed to record Contributions he had made which resulted in the Complainant being unable to receive a Pension until he submitted proof of having made those Contributions. The Complainant was further aggrieved because when he obtained his Pension he considered that the DSS should have made retrospective payments dating back to the date when he attained pensionable age, rather than the six month backdated payment he received. The Complainant claimed he was not offered an explanation or apology as to why his Contributions were not recorded by the DSS.

The Complainant alleged that in August 2011, upon having attained retirement age (65), he attended the DSS offices to apply for his Pension. According to the Complainant, at that visit he was informed by a clerk at the counter that he was not entitled to a Pension because he had not paid sufficient Contributions. The Complainant stated he was shocked at receiving that information and that throughout the ensuing years he searched for evidence (sieving through documentation he held) to prove that he had in fact made substantial Contributions to be entitled to a Pension. He stated that it took him four years to find pertinent receipts and that upon informing the DSS that he had found these, was directed to the Income Tax Office's Contributions Section ("ITOCS"). The Complainant claimed that he left copies of those receipts with the ITOCS and a week later (February 2016) when he contacted the DSS, he was told that he was now entitled to a Pension and that a six month retrospective payment would be made from the date on which the Pension was awarded i.e. payment of the Pension would be backdated to August 2015. [Ombudsman Note: The Ombudsman delved further into why it had taken the Complainant four years to find the receipts and he explained that when he made payment of Contributions he did not think it was important to file the receipts as he trusted that the payments would be recorded by the DSS. As such, it was difficult to find those receipts and the reason why the search took such a long time to do so].

Subsequent to the above, the Complainant was dissatisfied that the payment of the Pension had not been backdated to the date on which he became entitled to such (August 2011) and arranged a meeting with DSS officers and the Director of the DSS ("Director") to discuss the issue. According to the Complainant, the DSS' position was that he was not entitled to retrospection dating back to August 2011. At a later stage, a letter dated April 2017 from the DSS to the Complainant on the matter, stated that the DSS had no record of him having submitted an old age pension claim form in 2011; that an old age pension claim form was submitted in February 2016. The DSS went on to explain that under Section 7 of the Social Security (Open Long-Term Benefits) (Claims and Payments) Regulations 1997, if a person fails to make a claim six months from the date on which he/she becomes entitled to the benefit, he/she shall be disqualified from receiving benefit for any period more than six months before the date on which the claim was made (i.e. the DSS take the claim form as the date on which a person makes a claim). In May 2017, the Complainant wrote to the Director putting across his grievance and the fact that he did not agree with the DSS' decision with regard to the retrospective payment date of the Pension. He stated that the DSS had failed in 2011 to provide him with an old age pension claim form when they informed him he did not have enough Contributions and as such he could not produce a copy of a claim form dating back to 2011 as proof of having attended the offices of the DSS. The Complainant considered that the root cause of the problem was that the DSS had not recorded all his Contributions in his social insurance record. He found the DSS' decision and reason for non-payment of full retrospection of the Pension unjust and requested:

- An explanation as to why the Contributions had not been recorded appropriately;

- An apology;

- Payment of Pension retrospective to the date of entitlement, i.e. the date on which he attained the age of 65 (August 2011).

Not having received the above, the Complainant brought his complaints to the Ombudsman in November 2017 accompanied by relevant documentation.

Investigation

The Ombudsman sieved through the documentation submitted by the Complainant and noted the following:

- March 2016 letter from the DSS to the Complainant informing him that his claim to a Pension had been approved with effect from the 15th August 2015;

- March 2017 letter from the DSS to the Complainant informing him that his Pension had been recalculated to include pre-entry credits and contributions made in 2007/08 which were not accounted for at the time when his Pension was calculated. The DSS provided details of the amount and advised of retrospection of the new Pension to August 2015;

- Certificate of Contributions from the Income Tax Office dated 9th February 2016 with Contributions recorded between 1976 to 1984, 1986, 2004 to 2008;

- New Certificate of Contributions from the Income Tax Office (undated) with Contributions recorded as above but on this certificate, Contributions from 1999 to 2003 included;

- 27 copies of receipts (dated between 2006 and 2008) of arrears of Contributions made by the Complainant.

The Ombudsman wrote to the Director presenting the complaints.

The Director informed the Ombudsman that there was a general misconception by the public that the DSS had responsibility to record social insurance contributions. He explained that had been the case until in 2007, responsibility and function was transferred to the Income Tax Office where the Contributions Section continues to be housed.

The Director stated that if the Complainant had a grievance in respect of the late posting of some Contributions, he should direct his enquiries to the Income Tax Office.

The Director rejected there had been an error on the part of the DSS; they had acted correctly at all times as set out in the law. He stated the DSS could only pay an old age pension once it received a duly completed application which satisfied the required contribution conditions.

Regarding the Complainant's request for an apology from the DSS as to why the Contributions were not recorded appropriately at the time when they were made, the Director stated that the Complainant had been informed on numerous occasions that the DSS did not have responsibility for recording social insurance contributions and that his grievance should be directed to another department. The Director highlighted he had met with the Complainant on the 5th June 2017 and had at that meeting provided him with explanations. The Director stated there had been no failure in the DSS' administrative process that would warrant an apology. On the matter of the Complainant's allegation that he had not been provided with an old age pension claim form in 2011, the Director stated that was impossible to verify due to the period of time elapsed. Notwithstanding this, the Director noted that a pension application form is always given to members of the public who request it and added that forms have been available on the Government website for a number of years.

By way of further background, the Director explained that the Complainant had a number of gaps in his Contributions history. He added that in 2011 when the Complainant went to the DSS his record showed that he did not have sufficient Contributions to be entitled to an old age pension and was asked to contact the ITOCS to regularise his position, given that he claimed that there were Contributions he had paid which were missing from his record. The Director stated that over four years had elapsed before the evidence was produced by the Complainant and the ITOCS then posted the corresponding Contributions. The Director reiterated that at no time was the DSS at fault for failure to record the Complainant's Contributions correctly.

Regarding the six month time period for retrospection of payment of benefits, the Director referred the Ombudsman to Section 7 of the Social Security (Open Long-Term Benefits) (Claims and Payments) Regulations 1997 (referred to in the 'Background' section of this report). The Director pointed out that the regulations did not provide for discretion for the time period to be waived. As such, although very sympathetic to the Complainant's predicament, the Director stated that there was nothing further they could do. He explained that they had paid out the correct Pension from the date of application and six month arrears as allowed by law.

Further to the information provided by the Director, the Ombudsman directed his enquiries to the Income Tax Office, particularly in relation to the failure in recording Contributions made by the Complainant.

The Commissioner of Income Tax ("Commissioner") responded to the Ombudsman. Regarding the Complainant's claim that he had visited the DSS' offices in 2011 and been advised that he had made insufficient Contributions and was not entitled to a pension, the Commissioner stated that they were unable to comment on the administrative practice at the time but confirmed that under current working practices, the DSS referred such shortfalls in contributions affecting an individual's pensions entitlement to the ITOCS for regularisation, thereby minimising the delay for the individual concerned. The Commissioner stated that a search of their files had not revealed any contemporaneous record of a referral in the Complainant's case. The Complainant's Contributions consequently remained un-rectified until he located and submitted the relevant evidence in relation to payment of contributions.

The Commissioner explained that in order to assist in this investigation, they had examined the shortfall in Contributions and the Complainant's non-entitlement to a Pension in August 2011. An analysis of the transaction history of the Complainant's Contributions confirmed that Contributions pertaining to pre-2001 together with those extending from 2004 to 2007 were allocated on the system and thereby visible to the DSS in August 2011. Similarly, Contributions pertaining to 2001 up to and including 2003, together with those for 2007/2008 were allocated on the system later and thereby not visible to the DSS at that time.

The Commissioner highlighted that the reference to the Contributions for the period 2007/2008 related to the period after 1st April 2007 when ITOCS assumed responsibility for the collection of social insurance contributions.

The Commissioner explained the reason why ITOCS allocated some of the Contributions made by the Complainant after the date of payment. ITOCS required a self-employed contribution schedule (as was the Complainant's case) to accompany all payments of social insurance contributions made by self-employed persons. The schedule indicated the weeks covered by the payment and specified the value of the individual contributions paid. The requirement to submit the schedule with the payment enables ITOCS to facilitate the correct allocation of payments onto the system. Payments not accompanied by a schedule cannot be correctly allocated to the respective self-employed individual and therefore remain on the system in 'suspense' until either the corresponding schedule is submitted, or the 'suspense entry' is regularised subject to workload capacity. According to the ITOCS records, the Complainant never submitted schedules for the period 2001 up to and including 2003, together with those for 2007/2008. An internal initiative by ITOCS aiming to minimise the 'suspense entries' on the system resulted in those payments being allocated accordingly.

The Commissioner did not have any objection to the DSS retrospectively applying the Complainant's pension payments but clarified there had been no error on the part of the ITOCS, rather, in his view, this had been a case of lack of communication between departments. The Commissioner stated that the matter would have been addressed immediately had the Complainant complied with the requirements to submit the schedules. Additionally, the Commissioner advised that had the DSS referred the matter to the ITOCS when they identified that the Complainant was not eligible to a pension, the matter would have been regularised and resolved without delay.

The Ombudsman reverted to the Commissioner for clarification on a number of issues raised in his letter. The questions are set out below followed by the Commissioner's response.

1. Why were the Complainant's Contribution payments accepted by the ITOCS without the schedule?

Reply: The Commissioner confirmed that payments for social insurance contributions would not be rejected if not accompanied by the schedule. They would be processed by ITOCS but remained as a 'suspense' credit entry within the system. They would be allocated to the person's record but not in relation to specifically defined contribution periods.

2. Subsequent to the Contribution payments being accepted by ITOCS without the schedule, was the Complainant notified that in order to allocate payments to Contributions he had to submit the schedule?

Reply: The Commissioner explained that schedules for payment of self-employed social insurance contributions are due after the end of the year of assessment (1st July to 30th June). Under administrative practice at the time, ITOCS followed up the non-submission of schedules bi-annually in November and March and as such, ITOCS would have communicated to the Complainant in November 2008 and March 2009, the need to submit schedules. The follow up function is presently undertaken by the Central Arrears Unit. The Commissioner stated that a thorough search had been conducted in their files but they had been unable to locate any evidence of that communication due to the time elapsed and the ongoing requirement to 'weed out' files to efficiently use limited storage capacity available.

3. In view of the fact that the Complainant did not submit the schedules, how were ITOCS ultimately able to allocate the 'suspense entries'?

Reply: The Commissioner responded that if no schedule is submitted, ITOCS estimate the number of social insurance contributions and the period covered by the payment, using both the amount of the payment and the unit contribution as a point of reference. The Commissioner pointed out that this was a timely exercise and could only be undertaken when the daily workload capacity allowed. The Commissioner explained that they had conducted a thorough search in their files but had been unable to obtain any evidence of schedules having been submitted by the Complainant. Notwithstanding this, the Commissioner stated that the possibility remained that the Complainant had submitted the schedules at a later date but that those had been 'weeded out' for the reasons explained in (2) above.

4. On what date were the 'suspense entries' allocated to the Complainant's social insurance contributions record?

Reply: The Contributions for the year of assessment 2007/2008 were allocated within the system in March 2017.

Prior to compiling his report, the Ombudsman met with the Director. The findings of the investigation were discussed and the Ombudsman put it to the Director that he would be recommending that retrospective payment of the Pension be made to the Complainant. The Ombudsman enquired on whether the DSS was able to connect and have access to the ITOCS system in order to see social insurance contributions payments when persons apply for benefits. The DSS officer explained that they had access to the system but explained that they could only see those contributions that had been allocated, not suspense entries. The DSS stated that aware of suspense entries, they often contact the ITOCS and enquire in order to have the complete information of all payments made by claimants before a decision is taken on whether a person is eligible for said benefit.

Conclusions

Complaint 1: Failure by the DSS to record Contributions made by the Complainant, resulted in the Complainant being unable to receive a Pension until he submitted proof of having made those Contributions

It is clear from the findings of this investigation that as from the 1st April 2007, it was the ITOCS that had assumed responsibility for the collection of social insurance contributions whilst the DSS continued to be the entity tasked with dealing with claims for benefits derived, on the basis of social insurance contributions paid. The Complainant's allegation that he visited the DSS offices in August 2011 is confirmed by the Director. The difference in the versions between the two parties is that whilst the Complainant states that he left the DSS offices and took over four years to find copies of receipts of Contributions he had made, the Director states that the Complainant was asked to contact the ITOCS to regularise his position, given that he claimed that there were Contributions he had paid which were missing from his social insurance contributions record.

In his analysis, the Ombudsman starts from the premise of 'what should have happened'; that is that in August 2011, the Complainant should have been signposted by the DSS to the ITOCS where it would have been identified that he had actually made payments of Contributions without submitting the pertinent schedule resulting in those payments being allocated to his record in general but not in relation to specifically defined contribution periods. This would have triggered the ITOCS to have undertaken the exercise of allocating the 'suspense entries' to update the Complainant's social insurance record which would have confirmed his eligibility for a Pension. It is clear that did not happen; furthermore it is the Ombudsman's view that the Complainant was not signposted by the DSS to go to ITOCS in 2011 as there is no doubt that he would have visited those offices and any other that would have been able to assist him in his plight. The alternative was that throughout a four year period the Complainant undertook an exercise of finding receipts to be able to provide proof of payment of Contributions. Undoubtedly, had he been given any other avenue through which he could have pursued being eligible for a Pension, he would have availed himself of the opportunity which would have saved him much hardship and anxiety. The Ombudsman notes that current day practice when persons make a claim for benefits at the DSS is for the latter to contact the ITOCS in order to obtain all information on payment of social insurance contributions made by the claimant, to include suspense entries.

The Ombudsman sustains this complaint but not as it is set out. The Ombudsman sustains the complaint against the DSS because of their failure to signpost the Complainant to the ITOCS in August 2011 or indeed, to have contacted the ITOCS at that time to ensure that the Complainant's social insurance contributions were fully recorded, including any suspense entries. The Ombudsman is satisfied that when they become aware of suspense entries, it is the DSS' present day practice to contact the ITOCS to enquire, in cases similar to that of the Complainant, in order to have the complete information of all payments made by claimants before a decision is taken on whether a person is eligible for said benefit.

In relation to the non-allocation of suspense entries by the ITOCS, in the Complainant's case, the Ombudsman notes that this situation stemmed from the failure on the part of the Complainant to have submitted a schedule accompanying the payments.

Notwithstanding this, in consideration of the fact that the ITOCS accepted those payments, the Ombudsman is very concerned that they had remained in 'suspense' for an inordinate period of time; the payments were originally made in 2007/2008 and not allocated until February 2016 when the Complainant submitted copies of receipts of Contributions and not, as the Commissioner stated in his letter to the Ombudsman, that this had been due to an internal initiative by the ITOCS aimed to minimise suspense entries on the system. The exercise the Commissioner is referring to was the one carried out in March 2017 as a result of which the Complainant's Pension was recalculated and the Complainant informed accordingly. The Ombudsman cannot reconcile how in the Complainant's case, 'suspense entries' remained unallocated after February 2016 when the ITOCS should have undertaken the complete exercise of allocating all payments in order to regularise the Complainant's position vis a vis obtaining his Pension.

In consideration of the aforementioned facts, the Ombudsman finds that the ITOCS has an obligation to maintain accurate and up-to-date records of contributions received. The ITOCS cannot therefore continue to allocate 'suspense entries' to the pertinent social insurance contributions when 'workload allows'. The ITOCS has to maintain working practice to ensure that, at the end of each financial year, any suspense entries in individual's social insurance contributions records are allocated accordingly, in order to maintain a true and accurate record with the objective of avoiding a recurrence of the problem suffered by the Complainant.

The Ombudsman sustains this complaint against the ITOCS for the inordinate delay in allocating Contributions made by the Complainant.

<u>Complaint 2: The Complainant considered that when he received his Pension, the DSS should have made retrospective payments dating back to the date when he attained pensionable age rather than the six month backdated payment he received</u>

Considering that the Director corroborates the Complainant's statement that he attended the DSS offices in August 2011, the time when the Complainant attained pensionable age, the Ombudsman finds that it has been established that he did go to the DSS but was deemed not to qualify for a Pension because he did not have enough Contributions.

The Ombudsman's investigation has established the reasons why the Complainant's record did not reflect substantial Contributions thereby deeming the Complainant ineligible for a Pension and on the basis of those findings sustains this complaint.

The Ombudsman notes the Director's reference to Section 7 of the Social Security (Open Long-Term Benefits) (Claims and Payments) Regulations 1997 but is of the view that under the circumstance of this case, this section is not applicable in this case.

The Ombudsman therefore recommends the fully retrospective payment of the Pension to the Complainant as from August 2011.

Complaint 3: The Complainant was not offered an explanation or apology as to why his Contributions were not recorded by the DSS

The Ombudsman is aware that in June 2017, the Complainant met with the Director and other officers of the DSS and that amongst other information offered at that meeting, the Director told the Complainant that the recording of social insurance contributions was the responsibility of another department which is where he should direct his grievance. The Director stated that there had been no failure in the DSS' administrative process which would warrant an apology.

It is clear that the Complainant did not understand the explanation offered by the Director as he clearly blamed the DSS for his problem without understanding that the ITOCS had been responsible for the collection of social insurance contributions from April 2007.

The Ombudsman is confident that this report will provide the Complainant with the explanations he sought with regards what happened and the reasons why in his case the system failed to keep a true record of the Contributions he had paid which resulted in non -payment of his Pension. The investigation has also identified the failures in the overall system and the lack of effective communication between the two departments; one charged with the maintenance of up-to-date records of social insurance contributions, the other reliant on that information for eligibility or not of benefits to individuals.

Classification

Sustained

Recommendations

1. The ITOCS has to establish a working practice to ensure that at the end of each financial year, any suspense entries in individual's social insurance contributions records are allocated accordingly, in order to maintain a true and accurate record with the objective of avoiding a recurrence of the problem suffered by the Complainant.

2. The Ombudsman recommends retrospective payment of the Pension to the Complainant as from August 2011.

3. The Ombudsman recommends that the DSS continue to check social insurance contributions with ITOCS to ensure that all social insurance contributions made, including suspense entries, are taken into account before the DSS make a decision on whether a person is eligible to a benefit or claim.

Update

Further to having read the final draft report, the Commissioner and the Director commented as follows on the recommendations:

Recommendation 1

The ITOCS has to establish a working practice to ensure that at the end of each financial year, any suspense entries in individual's social insurance contributions records are allocated accordingly, in order to maintain a true and accurate record with the objective of avoiding a recurrence of the problem suffered by the Complainant.

Director

The Director stated that this recommendation was specific to the Income Tax Office and it was for them to respond.

Commissioner

The Commissioner explained that the allocation of payments held in suspense by ITOCS could only be correctly allocated on the basis of available documentation, essentially, the social insurance returns showing what periods the contributions paid referred to. He explained that since 2018, the compliance function regarding the follow up of the non submission of social insurance contribution returns was performed by the Treasury's Central Arrears Unit ("CAU"). Although there was an established working practice, the Commissioner explained that the successful clearance of all suspense entries was entirely dependent on the level of compliance generated by the CAU. Notwithstanding, the Commissioner stated that ITOCS ensured at the end of each financial year end that suspense entries were cleared to the extent possible, on the basis of information available.

Recommendation 2

The Ombudsman recommends retrospective payment of the Pension to the Complainant as from August 2011.

Commissioner

The Commissioner commented that no opinion could be expressed regarding the above recommendation as that was not within the Income Tax Office's remit.

Director

The Director accepted the recommendation.

Recommendation 3

The Ombudsman recommends that the DSS continue to check social insurance contributions with ITOCS to ensure that all social insurance contributions made, including suspense entries, are taken into account before the DSS make a decision on whether a person is eligible to a benefit or claim.

Commissioner

The Commissioner explained that the present system allowed the DSS to view social insurance contributions declared but not payments made which had not yet been allocated and held in suspense. This system had been in place since it was first introduced in 2001.

The Commissioner advised that in order to adopt the recommendation made and allow the DSS to remotely check contributions with ITOCS in determining eligibility to a benefit or claim, system access permissions would need to be granted to the DSS in order for them to view the pertinent data contained in the tax system. Such a change would require liaison with both the Information Technology & Logistics Department ("ITLD") regarding operational matters and HM Government's Data Protection Officer in relation to any General Data Protection Regulation ("GDPR") implications arising from the granting of system access across departments.

Director

The Director accepted the recommendation subject to the following:

1. That system access permission is given by the Income Tax Office to the DSS to view relevant data contained in the tax system.

2. That there were no GDPR implications from accessing the system.

(Report extracted from Case No 1171)

SOCIAL SECURITY (DEPARTMENT OF)

Case 19

Complaint

The Complainant was aggrieved because she claimed the DSS do not effectively inform persons attaining pensionable age about their old age pension benefits. She was further aggrieved because in 2011 she had enquired at the DSS' offices about entitlement to benefits and because of erroneous advice provided, she and her husband ("Husband") lost out on dependant's benefit.

The Complainant had asked the DSS to backdate those benefits to 2011 but DSS refused.

The Complainant explained that her Husband had retired on medical grounds in 2003 and that ever since, they had been in financial dire straits. She stated that at that time, she enquired at the DSS' offices on whether they and their eight year old daughter would be entitled to any benefits (as her Husband had been the main bread winner and was now only in receipt of a small occupational pension) but claimed she was told that they did not qualify for any social benefit.

The Complainant continued in her job as a supply worker until in 2011 her contract was not renewed and she became unemployed. Due to her supply worker status, the Complainant could not apply for unemployment benefit but stated she attended the DSS offices to once again enquire and get advice on what benefits/income if any, she and her Husband were eligible to, considering that she was now unemployed. According to the Complainant she was verbally informed that she would have to wait to attain pensionable age (60) (the Complainant was 53 at the time and would attain pensionable age in October 2018) to receive the state pension and that because her Husband was in receipt of an occupational pension they did not qualify for further income from the DSS (the Husband was aged 69).

The DSS contacted the Complainant at that point and informed her that they had looked into her case carefully and identified that at the time when she applied for a pension forecast there had been an oversight by the pensions section in not having realised that the Husband was in receipt of an old age pension and therefore entitled to receive the dependant's rate as she was no longer in employment (Ombudsman Note: The Complainant was sixteen years younger than her Husband and would have been entitled to that benefit if she remained unemployed until she attained pensionable age, 60). The DSS explained that the Director had taken the decision to backdate payments to the 3rd February 2016 (date of pension forecast) [Ombudsman Note: The pension forecast request form was the tangible proof to the DSS that the Complainant had contacted them] plus a further six months backdated payment commencing on the 4th August 2015. Subsequent to the aforementioned information, the Complainant contacted the DSS to request that the payment be backdated to 2011, the date when she enquired at the DSS offices about any benefits she was entitled to as a result of having become unemployed. The DSS responded that they did not have substantial proof that she had attended the DSS counter in 2011 and were therefore unable to backdate payments to that date. The Complainant believed that the DSS had been very unjust in the manner in which they had dealt with their situation and lodged her complaints with the Ombudsman.

Investigation

The Ombudsman presented the complaints to the Director of the DSS ("Director"). For ease of reference, the response is set out below addressing the individual complaints. The Ombudsman's investigation follows that format.

i. DSS do not effectively inform persons attaining pensionable age abouttheir old age pension benefits

The Director disagreed that persons attaining pensionable age are not effectively informed of their pension entitlement and referred the Ombudsman to the Gibraltar Government's website ("Website") which contained information on statutory benefits paid by the DSS and in particular on pension eligibility conditions, and to a booklet available at the DSS' office counters which sets out statutory benefits.

The Director noted that the information had been on the Website for a number of years. The Director stated that the onus was on individuals and not the DSS to inform themselves on what benefits they were entitled to.

The Ombudsman noted the Director's response and checked on the Website, the information he had referred to. The Ombudsman found that the 'Guide to Social Security Benefits' ("Guide") under the 'Department of Social Security' Section is the same as the booklet at the DSS' offices. Amongst other information, the Guide included details related to old age pension as follows:

- The period of time an old age pension is payable for;
- social insurance contributions conditions;
- pension forecast request;
- how and when to claim an old age pension.

The Ombudsman inspected the old age pension claim form (also found on the Website) and noted section 11 on the first page of the form stated:

> *11. If any change of circumstances occur which may affect your entitlement to payments, you must notify the Department of Social Security immediately.*

The Ombudsman did not find any information in the Guide or the old age pension claim form which made reference to old age pensioners being entitled to dependant's benefits. He enquired at the DSS and was directed to Section 22A under the Social Security (Open Long Term Benefits Scheme) Act 1997 which states the following:

Increase of old age pension

22. The monthly rate of an old age pension shall be increased by the amount set out in the third column of either Parts I, II or III of Schedule 2 (depending on which rate of benefit in those Parts is paid to the beneficiary) for any period during which the beneficiary–

a) if a man is residing with or is wholly or mainly maintaining his wife or civil partner who is not over pensionable age and who is not engaged in any gainful occupation from which her monthly earnings exceed £231.95; or

b) if a woman is residing with and is and has been for not less than ten years wholly or mainly maintaining her husband or civil partner who is not over pensionable age and who is and has been during this period permanently incapable of self-support.

It was the DSS' position that they should have been notified (as stated in the old age pension claim form) of the Complainant's change of circumstances (when she terminated employment) to trigger the process of payment of the dependants benefit. The Ombudsman requested the DSS to check the Husband's claim form which would have been submitted in 2007 (to confirm if section 11 was included in the form at that time) but was advised that that information was included in a separate letter. The DSS checked the Husband's file but the copy of the letter on file did not include any information to the effect that the Husband should notify the DSS of any change of circumstances which could affect entitlement to payments.

Furthermore, the Complainant provided evidence to the Ombudsman that her Husband had been diagnosed with vascular dementia in 2004 and because of this would not have been able to notify the DSS of any change of circumstances in relation to his entitlement to a dependant's benefit.

<u>Ii. In 2011 when the Complainant enquired about entitlement to social benefits at the DSS they provided erroneous advice which resulted in loss of income</u>

The Director stated that the DSS had no record that the Complainant attended the DSS office counters in 2011 and noted that she was unable to provide evidence of those enquiries. The Director explained that given the time that had elapsed, it was impossible to verify whether the Complainant's assertions were correct.

Iii. DSS refused to backdate payments of those monies to the Complainant

The Director explained that the DSS had paid the monies due to the Complainant, namely, six months arrears from the date on which she applied for the pension forecast, and referred the Ombudsman to Regulation 7 of the Social Security (Open Long-Term Benefits) (Claims and Payments) Regulations 1997 (see below) which allowed for six months retrospective payment of benefit from the date on which apart from satisfying the condition of making a claim, the claimant became entitled to the benefit. He explained that in 2016, there was a genuine oversight in that the DSS officer who prepared the forecast did not realise that the Husband was already in receipt of an old age pension and that she was entitled to be included in his payments; the Director apologised for that issue on behalf of the DSS. Notwithstanding this, he added that was immediately remedied when it was brought to the DSS' notice (when the Complainant submitted her old age pension claim form in April 2018).

Social Security (Open Long-Term Benefits) (Claims and Payments) Regulations 1997

Time for claiming

7. (1) The time for claiming benefit (not being an old age pension for a widow, widower or surviving civil partner by virtue of the insurance of a spouse or civil partner in respect of whose death the beneficiary was immediately before attaining pensionable age entitled to survivor's benefit) is six months from the date on which, apart from satisfying the condition of making a claim, the claimant becomes entitled to the benefit.

(2) If a person fails to make a claim within that time he shall be disqualified for receiving benefit for any period more than six months before the date on which the claim is made.

(2) A claim to old age pension may be made at any time not more than four months before the date on which the claimant will, subject to the fulfilment of the necessary conditions, become entitled to such a pension.

Conclusions

(1) DSS do not effectively inform persons attaining pensionable age about their old age pension benefits - Sustained

(ii) In 2011 when the Complainant enquired about entitlement to social benefits at the DSS they provided erroneous advice which resulted in loss of income – Sustained

(iii) DSS refused to backdate payments of those monies to the Complainant – Sustained

The Director's stance with regard to benefits is that the onus is on individuals to inform themselves on what benefits they are entitled to. In the Complainant's specific case, the Ombudsman perused the information available in the Guide and the Website but found no reference to dependant's benefit. It was the DSS' position that the Husband, being in receipt of an old age pension, would have had to notify them of any change in circumstances and that would have resulted in the payment of the dependant's benefit. The DSS stated that information was contained in the old age pension claim form and in 2007, the time when the Husband claimed his pension, this was instead purported to have been included in a separate letter. Further to checking the Husband's file, the DSS did not find that information included in the copy of the letter sent to him. Furthermore, even if the Husband had been aware of this benefit, the fact that he suffered from vascular dementia would have precluded him from reporting the nature of the changes to the DSS.

On the balance of probability, and because of the dire financial situation they were in, it is the Ombudsman's view that the Complainant did attend the DSS offices in 2011 to enquire about any benefits she would be entitled to and the officer that attended to her failed to identify that her Husband was already in receipt of an old age pension; a failure which may have been due to the fact that there was a sixteen year age difference between the Complainant and her Husband; the Complainant being the younger party. Furthermore, the fact that the onus would have been on the Husband to report the change of circumstance and he was neither made aware of this when he claimed his old age pension nor was he in a position to do so in 2011 due to his condition, strengthens the Ombudsman's argument.

The Ombudsman sustains this complaint and recommends that due to the Husband's condition, the dependants benefit should be backdated to 2011 or an ex-gratia payment should be made, equivalent to the amount that would have been payable; the precise date could easily be ascertained from the DSS records as the first week when the Complainant ceased social insurance contributions at the time when she terminated employment.

Regarding information on benefits that social insurance contributors are entitled to, and not disputing the fact that the onus appears to be on individuals to inform themselves on what benefits they are entitled to, the Ombudsman recommends that the Guide be reviewed and information on dependant's benefits be included in the old age pension section of the Guide. The Ombudsman further recommends that the DSS should provide a copy of the Guide to individuals, both at the time when they commence payment of social insurance contributions and on the month when the contributors attain old age pensionable age.

The Ombudsman sustained this complaint.

Ombudsman Note

In the course of this investigation, the Ombudsman noted that Section 22A of the Social Security (Open Long Term Benefits Scheme) Act 1997 provides the following:

> **Increase of old age pension**
>
> 22. The monthly rate of an old age pension shall be increased by the amount set out in the third column of either Parts I, II or III of Schedule 2 (depending on which rate of benefit in those Parts is paid to the beneficiary) for any period during which the beneficiary–
>
> (a) if a man is residing with or is wholly or mainly maintaining his wife or civil partner who is not over pensionable age and who is not engaged in any gainful occupation from which her monthly earnings exceed £231.95; or

(b) if a woman is residing with and is and has been for not less than ten years wholly or mainly maintaining her husband or civil partner who is not over pensionable age and who is and has been during this period permanently incapable of self- support.

The Ombudsman noted that there is a clear element of discrimination in the above section of the legislation and suggested that the DSS look into the matter and bring this to the attention of the Government, so that any amendment to the legislation that may be required can be looked into, as soon as possible.

Classification

Sustained

Recommendations

1. The Ombudsman sustains this complaint and recommends that due to the Husband's condition, the dependant's benefit be backdated to 2011 or an ex-gratia payment should be made accordingly; the precise date to be determined by the DSS records as the first week when the Complainant ceased social insurance contributions at the time when she terminated employment.

2. The Ombudsman recommends that the Guide be reviewed and information on dependant's benefits be included in the old age pension section of the Guide.

3. The Ombudsman further recommends that the DSS provide a copy of the Guide to individuals both at the time when they commence payment of social insurance contributions and on the month when the contributors attain old age pensionable age.

Update

Further to having read the final draft report, the Director commented as follows on the conclusions and recommendations:

DSS do not effectively inform persons attaining pensionable age about their old age pension benefits – Sustained

The Director stated that the onus is on individuals to inform themselves on what benefits they are entitled to, including old age pension. The DSS had no way of knowing when someone had attained pensionable age as that information was held by the Contributions Section of the Income Tax Office, the department responsible for the collection of social insurance contributions.

The Director noted the Ombudsman's observations that the Guide did not include information on old age pension – adult dependant and advised that the Guide would be updated to include that information. Notwithstanding, he informed the Ombudsman that the Guide was printed as a general guidance to the public and could not be treated as a complete and authoritative statement of the law on any particular case.

In 2011 when the Complainant enquired about entitlement to social benefits at the DSS they provided erroneous advice which resulted in loss of income – Sustained

The Director stated that there was no evidence to suggest that the Complainant was given erroneous evidence. He noted that the Complainant worked as a supply worker and that in 2011 when her contract was not renewed she became unemployed. She claimed to have attended the DSS offices and been informed that she was not eligible for unemployment benefit and the Director stated that would have been the correct advice. However, the Complainant then claimed that she enquired on what benefits or income if any, she and her Husband were eligible to, considering she was unemployed and that she was verbally informed that she would have to wait to attain pensionable age to receive the state pension and that because her Husband was in receipt of an occupational pension they did not qualify for further income from the DSS.

The Director stated that it was highly unlikely that the clerk dealing with her claim for unemployment benefit would have told her that she was not eligible for other benefit/s as the clerk would only have dealt with the unemployment benefit. The fact that the Husband was in receipt of an occupational pension was not relevant for the purposes of her eligibility for unemployment benefit.

The Director stated that on the balance of probability, the clerk at the unemployment benefit counter would have directed the Complainant to enquire at the counter which deals with social assistance benefit. The Husband's income would have been relevant for the purpose of eligibility to receive social assistance and would have been taken into consideration when calculating entitlement to the benefit. The Director explained that in assessing the Husband's income it would have been clear that the Husband was in receipt of an old age pension and the entitlement to the dependant rate would have been apparent. The Director explained that there was no evidence that the Complainant enquired as to what other benefits she was entitled to and reiterated that on the balance of probability her attendance at the DSS would have been to claim unemployment benefit.

<u>DSS refused to backdate payments of those monies to the Complainant – Sustained</u>

The Director noted the information provided by the Ombudsman that the Husband had been diagnosed with vascular dementia in 2004 and that due to his medical condition he was unable to inform the DSS of the Complainant's termination of employment. In contrast, the Director pointed out that in 2007 the Husband applied for an old age pension and in 2010 signed a change of bank details form and there had not been any medical evidence produced to show that the Husband was unable to provide information to the DSS. Notwithstanding, the Director stated that whether the Husband was able to or not able to inform the DSS was not the determining factor as the Complainant could do that. The Complainant contended she did inform the DSS. However, the Ombudsman's view was that the Husband's condition and inability to inform the DSS strengthened the argument that the Complainant be made an ex-gratia payment equivalent to the amount payable in the form of the dependant's benefit and the Director disagreed with this. He stated the Complainant had been paid the correct amount in arrears she was entitled to and there was no evidence to suggest she was provided with erroneous advice. Due to the explanations provided, the Director could not support a claim for an ex-gratia payment.

Update from Complainant in March 2019

Further to having read the final draft report which contained the Director's update, the Complainant provided her comments which specifically related to the DSS counters she had been to in 2011 and in the two subsequent years up to 2013. The Complainant stated that she had been to the Social Assistance Counter at her visit to the DSS in 2011 and been told by the clerk there that because her Husband was in receipt of an occupational pension they were not entitled to social assistance.

The Complainant further stated that in 2011, her young daughter, 15 years old at that time, had a baby and was in receipt of social assistance for two years after which she went into employment and the assistance ceased. During those two years, the Complainant claimed that on a number of occasions on which she accompanied her daughter to the DSS Social Assistance counter she continued to enquire if she was entitled to any benefits and the response was always the same; her Husband was in receipt of an occupational pension and they were not entitled to any benefits until she attained pensionable age at 60.

[Ombudsman Note: Based on the Director's update, what should have happened at that time was that the Social Assistance clerk who assessed the Husband's income should have identified that the Husband was also in receipt of an old age pension and that he was therefore entitled to an increase in his old age pension to include the dependant rate. It is clear that this never happened.]

.....

Having considered the response received from the Director, the Ombudsman was of the view that his original findings and recommendations, as outlined above in his report still stand.

The position is as follows:

Recommendation 1

The Ombudsman sustains this complaint and recommends that due to the Husband's condition, the dependant's benefit be backdated to 2011 or an ex-gratia payment should be made accordingly; the precise date to be determined by the DSS records as the first week when the Complainant ceased social insurance contributions at the time when she terminated employment.

Director

The Director did not accept this recommendation for the reasons explained above.

Recommendation 2

The Ombudsman recommends that the Guide be reviewed and information on dependant's benefits be included in the old age pension section of the Guide.

Director

The Director stated that the DSS accepted this recommendation.

Recommendation 3

The Ombudsman further recommends that the DSS provide a copy of the Guide to individuals both at the time when they commence payment of social insurance contributions and on the month when the contributors attain old age pensionable age.

Director

The Director did not accept this recommendation because the DSS did not have records of the commencement dates and similarly, of dates when contributors attained pensionable age. That information was held by the Income Tax Office. [Ombudsman Note: The Ombudsman would refer this recommendation to the Income Tax Office].

(Report extracted from Case No 1177)

TREASURY DEPARTMENT

Case 20

Complaint

The Complainant was aggrieved because neither the Pensions Section nor the Treasury Department had contacted him to notify him that part of his pension settlement had been sent and been received at the GSB. The Complainant claimed that as a result, he had lost out on the interest payable on those monies for a period of seventeen days.

The Complainant, an ex-civil servant, explained that prior to his retirement date, 18th December 2017, he met with officers of the Pensions Section to discuss arrangements for settlement of his pension fund. According to the Complainant, at the conclusion of that meeting they informed him that he would be contacted prior to the 18th December 2017 in order that the transfer of funds and the various investments options available to him could be discussed. The Complainant stated that he signed a form ("Form") at that meeting in which he authorised part of the pension fund to be transferred to the GSB to be invested in debentures. The Complainant highlighted he was not given a copy of the Form.

By the 4th January 2018, not having been contacted by either the Pensions Department or the Treasury Department, the Complainant stated that he went to the offices of the GSB but claimed to have been told that they could not assist him. As the amount involved was substantial, the Complainant pressed for information which resulted in GSB staff checking an internal 'suspense account' and finding that the funds had been in that account for seventeen days (transferred on the 18th December 2017). [Ombudsman Note: Public services offices were closed for the Christmas period from the 23rd December 2017 to the 1st January 2018 (inclusive)]. The Complainant considered that someone should have contacted him upon receipt of the funds by GSB and wrote a letter of complaint to the Treasury Department. The latter resulted in a meeting on the 15th January 2018 in which Treasury Department officials informed him that in the Form he signed at the meeting with the Pensions Section there was a clause which stated that funds would not be invested in debentures until the pertinent documentation and application form had been handed in by the Complainant to the GSB.

The Complainant stated he was not provided with a copy of the Form and as such did not recall the clause; notwithstanding this, he had expected to have been notified prior to the funds being transferred to GSB at which point he would have been informed of what he needed to do. The Complainant asked that the Treasury Department review their procedures to prevent a recurrence of this incident and requested payment of interest for the seventeen day period in which the monies had remained in a 'suspense account'. According to the Complainant, at the conclusion of the meeting, the Treasury Department assured him that they would contact him in due course with their decision. Not having received any communication by the 3rd April 2018, the Complainant wrote to the Treasury Department. On the 12th April 2018 he received a reply in which they apologised for the delay in reverting. They reiterated what had been discussed at the January 2018 meeting and enclosed a copy of the Form where the following clause stated:

TRANSFER TO GIBRALTAR SAVINGS BANK (PURCHASE OF DEBENTURES

Amount:-_____

We will make arrangements to transfer the funds requested to the Gibraltar Savings Bank, however you will need to take all the relevant documentation and signed forms to the Gibraltar Savings Bank counter situated at 206-210 Main Street.
(For any information on debentures please contact telephone number 200.....

FUNDS WILL NOT BE INVESTED IN DEBENTURES UNTIL THE APPLICATION FORM AND THE PERTINENT DOCUMENTATION HAS BEEN HANDED IN TO THE GIBRALTAR SAVINGS BANK.

The Treasury Department informed the Complainant that they had forwarded his request for payment of interest to the Treasury Department's Accounting Standard's Section for their consideration.

Dissatisfied with the situation, the Complainant lodged his complaint with the Ombudsman.

Investigation

The Ombudsman contacted the Treasury Department with the complaint. In their initial response they stated that in the Form the Complainant had signed in November 2017 it was clearly stated that the purchase of debentures would not be processed until the client contacted the GSB. As such, they did not believe they were at fault and pointed the Ombudsman to address the complaint to the Pensions Section for their failure to contact the Complainant. The Ombudsman complied.

The Pensions Section response referred the Ombudsman to the clause in the Form which they stated was very clear and would also have been pointed out verbally at the meeting with the Complainant, i.e. that the money would not be invested in debentures until the client went to the GSB to sign and submit the pertinent documentation instructing them of his preferred investment option/s. The Pensions Section stated that everyone is contacted by telephone once the monies are ready to be sent to GSB but that they could not verify that the call had been made in this case because no notes are made on file in this regard. Notwithstanding this, the Pensions Section stated that the telephone call was not a must. [Ombudsman Note: The Complainant was adamant that no phone call was made because he had an answering machine and no message had been left there].

The Ombudsman made further enquiries from the Treasury Department as to why they had not attempted to identify the recipient of the monies deposited in the suspense account. Despite the closure of the GSB offices over the Christmas holidays, the monies were received in the suspense account on the 18th December 2017, four full working days before the holiday period commenced. The Treasury Department maintained that it was the Complainant's responsibility to submit the necessary documents to enable the investment.

The Ombudsman put his concerns to the Accountant General at the Treasury Department. In her response, the Accountant General informed the Ombudsman that the facts he had presented in the letter (based on the information provided by the Complainant) setting out the complaint, were not entirely correct. The Accountant General stated that prospective civil servant retirees are given a retirement pack by the Human Resources Department, normally through their Head of Department. The pack includes information and all the relevant forms that need to be completed in connection with the retirement process. Once the forms are duly completed and submitted to the Human Resources Department, these are then sent to the Treasury Department's Pension Section, including the gratuity payment instruction form, for computation of the pension. It was the Accountant General's view that the Complainant would therefore have had ample time to read through all the documentation and forms and even had the chance of making copies before returning them to the Human Resources Department.

In relation to the Complainant's claim that he had not been contacted prior to the transfer of funds to the GSB, the Accountant General stated that the Pensions Section should have contacted the Complainant prior to his retirement date to remind him that he had to complete the debenture application form and noted that had been the established procedure in place for some time now. As there was no official record of a call having been made, it was the Accountant General's view that the Complainant should be given the benefit of the doubt and as a gesture of goodwill, payment of interest lost should be made. The value date of the investment would be the Complainant's retirement date.

The GSB reviews the suspense account regularly and liaises with the Pensions Section allowing for proper follow up.

The Accountant General informed the Ombudsman that earlier that year (2018) the processes had been strengthened as follows:

- A reminder letter was sent to all prospective clients of the GSB just before their retirement date;

- The reminder letter was followed by a telephone call if the debenture application forms had not been delivered to the GSB by the retirement date;

- The GSB reviews the suspense account regularly and liaises with the Pensions Section allowing for proper follow up.

Conclusions

At the conclusion of his investigation, the Ombudsman found that the root cause of this complaint lay with the failure on the part of the Pensions Section in not having contacted the Complainant prior to the pension funds being transferred to the GSB. That communication would have provided the Complainant with timely information whereby he would have been notified of the date on which the GSB would receive the funds and would have triggered that he attend the GSB offices to submit the documentation required for the funds to be invested in debentures without any delays.

In the course of the investigation, the Pensions Section informed the Ombudsman that a telephone call to the prospective retiree, prior to the transfer of pension funds to the GSB, was not a must. From the information provided to the Ombudsman by the Accountant General it is clear that the telephone call had been established procedure for some time. Due to the diverging positions, the Ombudsman is satisfied that with the strengthening of procedures resulted from this complaint, the Pensions Section is now clear on the process they need to follow in similar situations. The Ombudsman would suggest that the reminder telephone call to the prospective retiree also be recorded on file.

Regarding the suspense account at the GSB, the Ombudsman was of the view that the GSB should have followed up the receipt of these funds promptly in order to identify the sender of the funds but instead allowed the monies to remain in said suspense account until the Complainant's enquiries. In this respect, however, the Ombudsman is satisfied that the Treasury Department have now implemented regular checks on the suspense account in order to prevent a recurrence of a similar situation.

Classification

Sustained

Recommendations

None made as the Treasury Department paid the Complainant the element of lost interest claimed and identified and strengthened procedures in order to prevent a recurrence of a similar situation.

(Report extracted from Case No 1179)