THE

DR GIRALDI HOME INQUIRY

An Inquiry under the Commissions of Inquiry Act into matters concerning the Dr Giraldi Home specified in Terms of Reference dated 22 October 2012

The Rt. Hon. Sir Jonathan Parker, Chairman

REPORT

VOLUME 1

THE DR GIRALDI HOME INQUIRY REPORT

AN INQUIRY COMMISSIONED UNDER THE PROVISIONS OF THE COMMISSIONS OF INQUIRY ACT

RT HON SIR JONATHAN PARKER

VOLUME 1

THE DR GIRALDI HOME INQUIRY

REPORT

Contents

Volume 1

Volume 2

Volume 3

Volume 4

THE DR GIRALDI HOME INQUIRY

REPORT

Volume 1: Contents

Introduction

Chapter 1: Factual and historical overview

Chapter 4: November 2000 to November 2004: evidence (3)

Chapter 5: November 2000 to November 2004: evidence (4)

Chapter 6: November 2000 to November 2004: evidence (5)

Chapter 7: November 2000 to November 2004: findings

DR GIRALDI HOME INQUIRY

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Chairman: The Rt. Hon. Sir Jonathan Parker

23 January 2015

The Hon. Fabian Picardo MP QC

Chief Minister

Her Majesty's Government of Gibraltar

6 Convent Place

Gibraltar

Dear Chief Minister

I enclose my Report herewith pursuant to the Inquiry's Terms of Reference.

The Report consists of four volumes. Volume 1 contains an introductory chapter which reviews the scope of the Inquiry and provides a procedural overview of the process followed. Chapter 1 (in Volume 1) provides a factual and historical introduction to the Dr Giraldi Home.

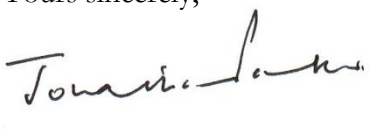
Chapters 2-15 of the Report span Volumes 1-3. They adopt a broadly chronological approach. The period 2000-2004 is reviewed in Chapters 2-7 (Volume 1). The period during which Joanna Hernandez was Manager of the Home is reviewed in Chapters 8-10 (Volume 2), with the specific allegation as to the existence of a punishment room being addressed in Chapter 9. Chapter 11 (Volume 2) considers staffing issues and Chapter 12 (Volume 2) considers the responses and the conduct of the relevant authorities and agencies in relation to allegations made in the Industrial Tribunal proceedings brought by Joanna Hernandez against the Social Services Agency. Chapters 13 and 14 (both in Volume 3) address specific allegations made in relation to the care provided to certain residents. Chapter 15 (Volume 3) reviews the care provided in the Home from 2006 to date.

Chapter 16 (Volume 3) sets out my conclusions and summarises my findings on the 22 specific issues considered by the Inquiry, as set out in the List of Issues annexed to the Report. The List of Issues was adopted, following public consultation, at preliminary hearings of the Inquiry at which represented parties and members of the public attending the hearings were afforded an opportunity to make representations. Volume 4 of the Report contains an Executive Summary.

A vast amount of documentation had to be considered by the Inquiry as a consequence of the numerous and diverse allegations contained in the witness statements filed on behalf of Joanna Hernandez in the Industrial Tribunal proceedings, and of a number of further allegations made in witness statements subsequently filed in the Inquiry itself. This in turn led to the Inquiry hearing oral evidence from in excess of 60 witnesses. The task of reviewing the documentary and oral evidence has inevitably been a very substantial one, which accounts for the length of the Report.

If I can be of any further assistance on any aspect of this Report, please let me know.

Yours sincerely,



Rt.Hon. Sir Jonathan Parker

INTRODUCTION

Contents

INTRODUCTION

The origin of the Inquiry

In November 2004 Joanna Hernandez was employed by the Social Services Agency ("SSA"), the predecessor of the Care Agency, as Manager of the Dr Giraldi Home, a residential home for individuals with learning difficulties situated in Smith Dorrien Avenue, Gibraltar ("the Home"). Her appointment was for one year. In the event, her contract was not renewed, and her employment as Manager of the Home accordingly ceased in November 2005.

In 2006 Joanna Hernandez commenced proceedings against the SSA in the Industrial Tribunal, claiming compensation for unfair dismissal. In support of her claim, she filed statements by a number of witnesses. Those witness statements contained allegations of mismanagement in the running of the Home, together with allegations of misconduct and malpractice (including abuse) by members of staff at the Home. The SSA initially defended the claim, but it later withdrew its defence and submitted to an order that it pay compensation to Joanna Hernandez for unfair dismissal. At the stage when the SSA withdrew its defence to the claim, the main hearing of the claim in the Industrial Tribunal had not yet taken place. In consequence the allegations in the witness statements have never been subjected to judicial investigation.

Over the years which followed there were repeated calls for a public Inquiry into the allegations, and into the circumstances in which the SSA's defence to Joanna Hernandez' claim came to be withdrawn. These calls led, in due course, to the establishment of this Inquiry by the present Government of Gibraltar.

The Inquiry's Terms of Reference

The Government took the view that the remit of the Inquiry, to be set out in its Terms of Reference, should extend beyond the allegations made in the witness statements filed by Joanna Hernandez in the Industrial Tribunal proceedings in 2006 and the withdrawal of the SSA's defence to Joanna Hernandez' unfair dismissal claim, so as to include such other matters relating to the Home as the Chairman of the Inquiry should, in his discretion, consider appropriate to be placed before the Inquiry for investigation.

In the event, the Inquiry's Terms of Reference are in the following terms:

> "1. To inquire into:
>
> a) allegations of mismanagement, misconduct and malpractice (including abuse) at the Dr. Giraldi Home contained in witness statements intended to be relied on by Ms Joanna

Hernandez in connection with her claim of unfair dismissal by the Social Services Agency; and

b) the conduct of the relevant authorities and agencies in response to, or otherwise in relation to, such allegations.

2. To inquire into such other matters relating to the Dr. Giraldi Home as the Chairman of the Inquiry shall, in his absolute discretion, consider appropriate.

3. To find the relevant facts.

4. To report on the above"[1].

The scope of the Terms of Reference

Attention is specifically drawn to two matters.

First, the Terms of Reference do not extend to an investigation of Joanna Hernandez' rights as an employee or former employee of the SSA. The only relevance of the Industrial Tribunal proceedings to the Inquiry's investigation lies in the fact that paragraph 1 of the Terms of Reference requires the Inquiry to inquire into allegations made in witness statements intended to be relied on by Joanna Hernandez in those proceedings, and into the conduct of the relevant authorities and agencies in response to, or otherwise in relation to, those allegations. It follows that the Inquiry is in no sense a re-run of the proceedings in the Industrial Tribunal.

Second, it is not the function of the Inquiry, under its Terms of Reference, to inquire into decisions taken by Government in relation to the allocation of public funds. By virtue of section 6 of the Social Services Agency Act (the Act which set up the SSA), the SSA's statutory duty was to carry out the functions conferred upon it by the Act only so far as practicable and "in so far as ... the Government provides sufficient resources therefor". Section 6 of the Care Agency Act (the Act which set up the Care Agency) is to similar effect[2]. These statutory provisions are of particular significance in the context of passages in this Report which identify aspects of the operation of the Home which could have benefited from additional funding. These passages are not to be read as implying that Government should have allocated additional funding for such purposes. It is in the nature of things that the provision of additional public funding will provide opportunities for improvements in public services; but that is not an area for this Inquiry to investigate, under its Terms of Reference. The allocation of public funds is a matter for Government, not for the Inquiry. The focus of the Inquiry, under its Terms of Reference, is on the manner in which the Home operated, given the financial resources available to it. So when, for example, the Report speaks of shortages of staff at the Home, it is speaking merely of the effect of those shortages on the operation of the Home and on the wellbeing of the staff and the service users: it does not seek to address, and must not be understood to be addressing, the question whether Government should have provided funding for additional staff.

[1] See Annex 1 to this Report.
[2] See Chapter 1 of this Report for further reference to these statutes.

The establishment of the Inquiry

On 22 October 2012 the Gibraltar Government announced the establishment of the Inquiry under the Commissions of Inquiry Act 1888, with the above Terms of Reference. My appointment as Chairman was announced at the same time. The issue of the formal Commission was published in the Gibraltar Gazette on 13 December 2012 pursuant to section 3 of the Commissions of Inquiry Act[3]. The engagement of counsel and solicitors to the Inquiry followed. Counsel to the Inquiry are Mr Robert Englehart QC and Mr Keith Azopardi QC. The solicitors to the Inquiry are Triay Stagnetto Neish. Mr Dennis Figueras MBE is the Secretary to the Inquiry. The Inquiry is grateful to Mr Figueras for undertaking this important role and for his work and assistance throughout the course of this Inquiry.

The initial work of the Inquiry team

(i) The "electronic platform"

One of the first tasks facing the Inquiry team was to undertake a very substantial exercise in relation to the extensive documentation made available (at the request of the Inquiry team) by the Care Agency, relevant Government departments, the Royal Gibraltar Police and the Attorney General's Chambers. Updates of that work were provided at the preliminary hearings of the Inquiry held in June and July 2013 (see below). Additionally, an electronic disclosure exercise was conducted on the Care Agency and Government servers.

After identification of relevant documents, an electronic database (described during the hearings as the "electronic platform") was established, onto which approximately 61,000 pages of documents were uploaded. From that mass of documentation a core set of documents was assembled and made available to legal representatives of parties represented at the Inquiry, and also to Yvette Del Agua (the former Minister for Social and Civic Affairs) who gave written and oral evidence to the Inquiry but who elected not to be represented.

The documentary exercise undertaken by the Inquiry team was as comprehensive as possible in the circumstances, given the historic record-keeping systems in place by the various agencies and relevant Government departments. Not all the documents uploaded onto the electronic platform were made available to the legal representatives of parties represented at the Inquiry. In deciding what documents should be made available to legal representatives, the Inquiry was conscious of the need to protect privacy and confidentiality so far as possible, consistently with the need to ensure a fair process for everyone involved in the Inquiry. Indeed, at the second preliminary hearing of the Inquiry counsel for the Gibraltar Disability Society stressed the need for the privacy of the residents and their families to be safeguarded wherever possible. To that

[3] Legal Notice 215/2012.

end, throughout the hearings residents at the Home (including respite users) have been referred to by letter rather than by name[4]. The same practice is adopted in this Report.

(ii) Public invitation

On 25 February 2013 the Inquiry issued a Press Release giving advance notice that it would shortly be issuing an invitation to members of the public to submit representations and evidence relevant to its work. The Press Release indicated that the invitation would explain the nature and scope of the matters on which the Inquiry wished to hear from members of the public, together with the procedure by which, and the time within which, representations and evidence relating to such matters should be submitted.

On 1 March 2013 the Inquiry duly published a notice in which it formally invited individuals and organisations to place before the Inquiry for consideration by the Chairman pursuant to paragraph 2 of the Inquiry's Terms of Reference any allegation which was critical of one or more of the following matters:

> "i) The operation of [the Home] during the period from November 2002[5] to date and/or
> ii) the conduct of any member of staff at [the Home] during that period and/or
> iii) the conduct of the relevant authorities and agencies in response to, or otherwise in relation to, allegations made against or in respect of [the Home] or members of its staff during that period."

The notice went on to request that evidence in support of any such allegation should also be supplied, and that responses should be received by no later than 27 March 2013. It went on to explain that should the Chairman of the Inquiry conclude in his discretion that it was appropriate that an allegation notified to the Inquiry in response to the public invitation should be included within the Inquiry's Terms of Reference that allegation would be investigated at a substantive hearing of the Inquiry and evidence relevant to it would be examined.

A further Press Release was issued on 20 March 2013 reminding members of the public that 27 March 2013 was the closing date for responses to the public invitation.

In the event, there were no responses to the public invitation.

(iii) Witnesses

As a separate exercise, the Inquiry team contacted a number of individuals who were thought likely to be in a position to provide the Inquiry with material evidence and assistance, and requested those individuals to indicate whether they would be willing to submit witness statements to the Inquiry and/or to attend to give oral evidence at subsequent hearings of the Inquiry.

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[4] See below, in the section of this Introduction entitled "Participation of Residents (including users of the respite service)".

[5] November 2002 was chosen as the starting-date for the period of the Inquiry's investigation on the basis that it was in November 2002 that the SSA took over responsibility for the running of the Home from Milbury Care Services Ltd ("Milbury"), a commercial organisation which had been running the Home for the previous four years.

Largely as a result of that process, no less than 63 witnesses gave oral evidence at the main hearing of the Inquiry (see below).[6]

Inquiry website

On 7 June 2013 the Inquiry launched its website (www.drgiraldihomeinquiry.gi) in order to keep the public informed of news relating to the Inquiry, forthcoming hearings and other information. Key documents, Press Releases and public notices were uploaded onto the website during the course of the Inquiry, together with other public information.

Preliminary hearings and the List of Issues

In early June 2013 the Inquiry announced that it intended to hold a preliminary hearing on 20 June 2013 to consider a provisional List of Issues to be investigated at the main hearing of the Inquiry, and to address various procedural and administrative matters in advance of the main hearing. The agenda for the preliminary hearing was posted on the website and was also sent individually to those who had indicated that they would be represented at the first preliminary hearing.

The Inquiry also indicated that it would hear representations relating to the matters to be dealt with at that preliminary hearing from any person, organisation or agency who wished to appear at that hearing, either in person or by a legal representative. Proposed representations were invited by 18 June 2013.

The first preliminary hearing of the Inquiry was duly held on 20 June 2013. At that hearing, the Inquiry heard representations as to the content of a proposed List of Issues which had earlier been circulated in draft. In the event, finalisation of the List of Issues was adjourned to a second preliminary hearing so as to allow any party who wished to make further submissions an opportunity to do so.

At the second preliminary hearing, which was held on 23 July 2013, the Chairman exercised his discretion under paragraph 2 of the Terms of Reference by adopting the List of Issues in its final form, after taking into account the submissions made[7].

The List of Issues defines the issues to be investigated by the Inquiry. It was arrived at following a full opportunity for public consultation and taking into account representations made by legally represented parties as well as members of the public present at the preliminary hearings. It

[6] See Annex 3 to this Report.
[7] See Annex 2 to this Report.

covers a number of broad areas in relation to staffing[8], physical facilities at the Home[9], care of residents[10], allegations of abuse of residents[11], and the conduct and response of public authorities, the Attorney General and Ministers[12].

Funding of legal representation

The Protocol on Funding issued by the Inquiry to provide legal assistance to eligible persons, together with the relevant application form, was uploaded onto the Inquiry's website. In addition, it was supplied directly to those individuals with whom the Inquiry was in contact.

Both before and after the first preliminary hearing, numerous applications for funding of legal representatives under the terms of the Protocol were considered by the Inquiry.

In the event 26 individuals, a representative body and an authority were granted funding under the terms of the Protocol.[13]

Participation of Residents (including users of the respite service)

An Annex to this Report describes the process followed by the Inquiry to seek to obtain evidence from residents[14]. In summary, all those residents who were capable of understanding were advised by Carlos Banderas (the Team Leader Disabilities (AG))) and his team of the establishment of the Inquiry. It was recognised that this might give rise to negative reactions on the part of residents, particularly as regards the publicity which would be directed towards the Home and thus towards them. Accordingly, Carlos Banderas and his team made every effort to respond to questions or concerns raised by residents.

The Inquiry has, from the outset, given the most careful and anxious consideration to the importance of obtaining evidence from residents where possible. Given the paramount need for the greatest sensitivity in the treatment of residents, the view was taken that the giving of

[8] The relations among members of the staff, conduct of staff towards residents, human resources, recruitment policy, support, training, supervision and appraisal of staff as well as organisation – Issues 1 to 5.
[9] Questions of adequacy of facilities, hygiene at the Home and safety – Issues 10, 12 and 14.
[10] Questions in respect of care pla**n**s, the interaction of staff and the provision of adequate care, arrangements for younger residents or residents of different genders, the level of care in relation to the mental and physical needs of residents and their social development and the custody of medication – Issues 6 to 9, 11 and 13.
[11] Under this broad heading, the List of Issues includes issues as to the existence or otherwise of cruelty, punishment, inappropriate behaviour, sexual misbehaviour, unlawful consumption of drugs, alcohol abuse, bullying of residents, misappropriation of medication, theft of petty cash and sleeping on duty – Issues 15 to 17.
[12] Including an examination of the complaints that were made to senior management and the relevant authorities and agencies as well as the disciplinary, investigative and other action taken by the authorities. The List of Issues also includes issues as to whether a code of conduct existed, and whether disciplinary procedures were adequate – Issues 18 to 22.
[13] See Annex 5 for the list of Counsel representing various parties in relation to the Inquiry. A majority of those received funding under the Protocol.
[14] Annex 7.

evidence by residents should not only be entirely voluntary but should also be subject to professional advice as to capacity; and that account should also be taken of the potential stress and anxiety on the part of residents to which the prospect of giving evidence to the Inquiry would be likely to give rise.

Following a number of meetings and discussions between the Inquiry team and the Care Agency, it was agreed that those residents who were considered by Giselle Carreras (the Care Agency psychologist) and Carlos Banderas to be capable of providing evidence to the Inquiry should be asked whether they wished to do so. In the result, one resident (Resident T) expressed a wish to provide written (but not oral) evidence to the Inquiry. Accordingly, following independent clinical advice taken by the Inquiry, the Inquiry team met Resident T informally at the Home, in the presence of her sister and of Carlos Banderas, and obtained a witness statement from her[15].

In addition, following the first preliminary hearing – and as a further protection for residents – the Inquiry team met the Gibraltar Disability Society (GDS) and (among other things) invited it to participate in the Inquiry in order to ensure that the interests of the residents were properly respected and protected. The GDS accepted this invitation and was duly represented by counsel at the second preliminary hearing and throughout the subsequent hearings of the Inquiry. The Inquiry is grateful to the GDS for undertaking this important task on behalf of the residents, and to its counsel for her assistance in discharging that task.

As noted above, at the second preliminary hearing counsel for the GDS stressed the need to protect the residents' right to privacy. In her written submissions for that hearing she referred to the impact of the Inquiry on the Home (describing the Inquiry as having caused an "upheaval" in the Home), and to the distress already caused to residents by media comment relating to the Home. She was concerned that further distress would be caused to residents were they to be referred to by name in the course of the Inquiry. The Inquiry fully recognised counsel's concerns, and accordingly at the further hearings of the Inquiry the practice was adopted of referring to residents by letter rather than by name (see above).

In paragraph 16 of his written closing submissions following the main hearing, counsel for Joanna Hernandez submitted that the Inquiry was not compliant with the European Convention on Human Rights and Fundamental Freedoms in that (among other things) the residents had been "shut out of the process". Responding to that submission, counsel for the Care Agency confirmed[16] that the Care Agency had been closely involved, together with the Inquiry team, in the process of considering the capability of residents to give evidence to the Inquiry and their willingness to do so. She went on to say that so far as the Care Agency was concerned, that process had been conducted appropriately, with sensitivity and care. Counsel for the GDS concurred with the submissions of counsel for the Care Agency. She agreed[17] that it could not possibly be in the best interests of residents to subject them to the ordeal of giving evidence to the Inquiry unless they were both able and willing to do so. It is to be noted that no relative of

[15] See Chapter 13 of this Report.
[16] See Day 18 page 151 line 24ff.
[17] See Day 19 page 10 lines 24-25.

a resident or respite user has at any stage expressed support for the views expressed by Counsel for Joanna Hernandez in this regard or asked that the Inquiry take evidence from their relative without regard to their unwillingness or incapacity.

In the concluding paragraph of her third witness statement to the Inquiry (paragraph 558) [**E/67/143**], Joanna Hernandez urged the Inquiry to keep at the forefront of its considerations the vulnerability of the residents and their inability to speak up for themselves. She went on to ask the Inquiry to give them a voice.

The welfare of the residents is indeed at the heart of this Inquiry; hence the presence of counsel for the GDS throughout the Inquiry to represent their interests and to speak on their behalf. As counsel for the GDS rightly put it in her closing submissions[18]:

> "The [GDS] ... represent people who, regardless of whether the failings were due to [failures of management], lack of support, lack of training, ... are still going to be there; they are still going to be in need of the service. .... Ministers have come and gone but the residents still remain, and they are in fact the ones who will be most affected by your Report."

Participation of relatives

In the course of the Inquiry process, the relatives of (in total) 40 service users were contacted by the solicitors to the Inquiry. Of those, 37 relatives responded, either by letter or telephone, or in some cases by personally attending a meeting with the solicitors to the Inquiry. Some of them did not wish to give evidence to the Inquiry. In the event, the solicitors to the Inquiry assisted in the preparation of witness statements for 12 relatives. Three further relatives, having initially contacted the Inquiry team, instructed counsel for the GDS to draft witness statements and represent them at hearings of the Inquiry.

Final preparation for the main hearing

Following the second preliminary hearing, the Inquiry team finalised its preparations for the main hearing, which was scheduled to commence on 30 September 2013. These preparations included the timetabling of witnesses and final consideration of additional documents and statements submitted by various entities.

In addition, copies of all the witness statements filed in the Industrial Tribunal proceedings, together with copies of witness statements provided to the Inquiry, were made available to all parties.

On 24 September 2013 the Inquiry issued a Press Release updating the public in relation to the forthcoming main hearing. The Press Release reminded the public that the main hearing would

[18] See Day 19 page 11 line 1ff.

take place in public, and it advised the public of the date, venue and time of commencement of the hearing.

The main hearing

The main hearing commenced on 30 September 2013 and took place over 17 days, during which (as noted earlier) 63 witnesses gave oral evidence[19]. 25 individuals were legally represented at the main hearing. In addition, the Care Agency, the Gibraltar Disability Society, the Royal Gibraltar Police and the Attorney-General's Chambers were each separately represented by counsel[20].

Witness statements were also made by relatives of five residents, in which they say that they have no complaints as to the care provided to their family member[21].

Closing submissions

At the conclusion of the main hearing, the Inquiry adjourned to 10 December 2013 to hear closing submissions from counsel (including counsel to the Inquiry). This hearing took place over two days, and was also held in public. At its conclusion, the Inquiry was adjourned generally for the preparation of this Report.

Further Representations

At the conclusion of the hearing of closing submissions the Inquiry Chairman indicated that once the Report had been prepared in draft anyone who had provided evidence to the Inquiry:

> "and who is the subject of adverse criticism in the draft report will have an opportunity to respond to or otherwise to comment on such adverse criticism before the report is finally signed off. I will of course carefully consider any such responses or comments, and I'll take them into account when finalising the report. That said, I should make two things absolutely clear. First, any such responses or comments must relate only to the adverse criticism of the individual concerned. It is most emphatically not an opportunity for any individual or their legal representative, if they have one, to comment on any other aspect of the draft report. Secondly, I do not envisage that there will be any further hearings of the Inquiry following receipt of any such comments."[22]

[19] A list of witnesses is Annex 3 to this Report.
[20] Details of the representation are set out in Annex 5 to this Report.
[21] The residents in question are Residents A, D, M, P and Q. Residents A, D, M and P have been permanent or respite residents of the Home throughout the period with which the Inquiry is concerned. Resident Q became a respite resident in 2010.
[22] Day 19 page 90 lines 14ff.

At the end of September 2014, nine letters issued from the Inquiry to various parties with accompanying extracts of the draft Report inviting comment on proposed intended adverse criticism of those particular individuals. Recipients were reminded that they were receiving these extracts in the context of strict confidentiality and that there should be no publication or dissemination to any third party. Replies were requested by 31 October 2014. A number of requests for extensions of time were received and granted with the last of the representations received on 17 November 2014. The Inquiry has carefully considered those representations.

In representations received from Counsel for Joanna Hernandez, he made certain criticisms of the process followed by the Inquiry some of which had already been raised in his closing submissions for the December 2013 hearings.[23]. Those criticisms and other similar observations received fell wholly outside the process envisaged by the letters inviting representations from particular individuals. Even so and given the seriousness of some of the assertions advanced by Counsel for Joanna Hernandez (which had been copied to His Excellency the Governor and the Chief Minister[24]) the Inquiry responded by letter on 4 December 2014 rejecting those criticisms.

None of the views expressed on behalf of Joanna Hernandez in these submissions have been made at any stage by any other party. As has already been indicated in this Introduction, the Inquiry has adopted a consultative and inclusive approach in inviting evidence and comment on the issues to be investigated. The List of Issues to be investigated and the procedures to be followed were settled after public comment was invited and following two preliminary hearings at which all parties represented (and any member of the public) had an opportunity to express an opinion. The Inquiry is satisfied that the procedures adopted have allowed a full investigation of the issues and a fair hearing within the scope of its Terms of Reference.

The evidence on which this Report is based

For the purposes of this Report, statements contained in witness statements made in the Industrial Tribunal proceedings, and documents exhibited to such witness statements, are taken into account to the extent that they are relevant to the Inquiry's investigations and were referred to in the course of the main hearing. This applies whether or not the maker of a witness statement in the Industrial Tribunal gave evidence to the Inquiry (save that no account is taken of statements contained in the witness statements of John Harris, Robert Tavares and Susan Ignacio in the Industrial Tribunal proceedings, each of whom informed the Inquiry team that the contents of his/her witness statement is to be treated as withdrawn). It also applies to

[23] The main process points made in the November 2014 representations were - (1) that there had been a failure to involve the residents of the Home (including respite users) in the Inquiry process; that this was somehow in breach of their rights; and that as a result the Inquiry was fatally flawed; (2) that the draft report contained findings made in the absence of key witnesses; (3) that the report when finalised would be unsafe and the Inquiry tainted; (4) that the Chairman evinced a pre-determined view on issues arising in the course of the Inquiry and a reluctance to examine allegations; (5) that the Inquiry had investigated matters outside its remit in that it had engaged in a re-run of Joanna Hernandez' claim of unfair dismissal by the Social Services Agency.

[24] In the letter to the Chief Minister, Counsel for Joanna Hernandez also criticised the Inquiry for taking too narrow a view of the scope of its Terms of Reference.

statements referred to (directly or indirectly) in witness statements made in the Industrial Tribunal or in documents exhibited to such witness statements.

For obvious reasons, it is not practicable for this Report to review or refer to every piece of evidence (whether written, oral or documentary) which was presented to the Inquiry in the course of the main hearing. However, the findings and conclusions expressed in this Report are based on the totality of the evidence presented to the Inquiry at the main hearing.

'Dramatis personae'

Annexed to this Report is a list of the names of every individual mentioned in the Report, together with a brief description of each such individual[25].

References

References in this Report to documents on the electronic platform (including witness statements) are shown in square brackets and in bold type, using the lettering and numbering on the electronic platform: e.g. [**E/73/49**]. References to the daily transcript of the oral evidence appear in footnotes (the abbreviation "ff" meaning "and following"): e.g. Day 14 page 7 line 15ff.

Structure of this Report

Given the length of this Report it is set out over a series of four volumes. The first three volumes contain an introductory chapter as to the Inquiry's work (this Introduction), the factual and historical overview of the Home (Chapter 1) and the detailed consideration of the evidence and findings of the Inquiry (Chapters 2-16). The Report also contains an Executive Summary as Volume 4. This Executive Summary is intended to be no more than a convenient resume of findings made and conclusions reached in volumes 1-3 of this Report. It should not be regarded as a substitute for reading those volumes. In particular it is strongly recommended that those intending to read this summary should first read the Introduction and Chapter 1 of the Report (within Volume 1). A Summary of the findings made in relation to the 22 Issues investigated by the Inquiry is set out in Chapter 16 (within Volume 3).

[25] The 'Dramatis personae' is Annex 8 to this Report.

ANNEXURES

Annex 1: Terms of Reference

Annex 2: List of Issues

Annex 3: List of Witnesses and Timetable

Annex 4: Process followed in respect of evidence to be obtained from residents

Annex 5: Details of legal representation

Annex 6: List of Residents and Staff Organograms

Annex 7: Tables of numbers of residents and staffing numbers

Annex 8: 'Dramatis personae'

Annex 9: 1990/1 Plans of the DGH

Annex 10: 2014 Plans of the DGH

CHAPTER 1: Factual and Historical Overview

Contents

CHAPTER 1: *Factual and Historical Overview*

The premises

The Home is a residential home the principal location of which is on Smith Dorrien Avenue, Gibraltar. It currently houses thirteen permanent residents in five flats[26] as follows:

1. Flat 1 accommodates six residents[27];
2. Flat 2 accommodates four residents[28];
3. Flat 3 is primarily used for a respite sitting service, but also houses one permanent resident[29];
4. Flat 4 accommodates one resident[30]; and
5. Flat 5 which also accommodates one resident[31].

In addition to those five flats, which physically form part of the Home itself, there is a flat in the community, Goole House (see below), which falls under the responsibility of management of the Home[32].

The Home has not always had its present configuration. Initially it consisted of open-plan premises with a number of bedrooms, and for a period it was operated as such[33]. The partitioning of the Home into separate units (flats) took place some time later, during the Milbury era.

Nor is it the case that residents have resided at the Home continuously since its establishment. As was made clear in evidence before the Inquiry, there have been periods when, because of either programmed refurbishment works or, for example, urgent repair works or other operational reasons (e.g. flooding, in 2002), residents have had to be relocated temporarily or housed in other premises[34].

Other such premises which featured in the evidence before the Inquiry included: Bishop Healy Home, Merlot House and a flat at Flat Bastion Road.

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[26] See the first witness statement of Carlos Banderas, paragraph 12 **[J1/124/3]**.
[27] Residents N, T, K, B, U and F.
[28] Residents J, AI, E and AA.
[29] Resident I.
[30] Resident AD.
[31] Resident AE.
[32] See the first witness statement of Carlos Banderas, paragraph 5 **[J1/124/2]**.
[33] See for example the plans prepared by the Public Works Department in January 1991 which provided for 16 single bedrooms, 2 bedrooms for twin occupancy and a large bedroom/"quiet room" [**A/20-27**].
[34] To either the Bishop Healy Home or flats at Merlot House.

The Goole House flat is situated within Goole House, Glacis Estate. For all practical and administrative purposes it is part of the Home. It was identified in 2004 as a suitable location for the encouragement of independent living. It was most recently refurbished in 2013, when a new kitchen, bathroom, stairway and air-conditioning system were installed. It is used by vulnerable adults who have a learning disability or have been diagnosed with autism. As of late 2013, there were two permanent residents (Residents A and X) living there. Care is provided at all times, day and night. The staff currently consists of a Unit Manager, five full-time care workers and one part-time care worker.

Bishop Healy Home was originally a children's home, but in 2003 it was also used by the Dr Giraldi Home, in order to meet the increasing number of adults with learning difficulties who required care. In 2003/4 alterations were made to the premises in order to accommodate Resident I and Resident L as permanent residents. It was described in evidence as being old and having limited facilities, with an unsatisfactory standard of hygiene[35].

In 2003 the use of four flats at Merlot House was introduced as an addition to the Home, on a temporary basis, to provide residential services for adults with learning difficulties. The flats were described as being in need of improvement, as the atmosphere there was dull and depressing. Two of the four flats were used by Residents AE and Z following flooding at the Home. The other two flats were used by the Children's Residential Service following a dramatic increase in the number of children requiring care. Hygiene at Merlot House has been described as substandard.

Use of a flat at Flat Bastion Road was introduced in 2009, following the creation of the Care Agency, as part of the Care Agency's policy of integrating children with learning difficulties into society[36]. The flat was administered not by the Home but by the Children's Residential Service. Resident L (who was previously a resident at the Home) was resident in the flat for a time. The flat comprises a bedroom (with a large wardrobe area), living room, kitchen, utility room, bathroom and separate toilet. There is a second bedroom which serves as a playroom.

Historical background

The witness statement of Albert Bruzon (currently the acting CEO of the Care Agency) sets out the uncontroversial historical background of the Home, including details of staffing arrangements, line management/reporting structures, structural/managerial changes and major refurbishments.

There are four clearly identifiable periods during which the Home was under different operational management.

[35] See para 4.14 of the witness statement of Mandy Vallender [**E/65/6**] and her oral evidence at Day 10 page 149 line 17- page 150 line 11, where she says she once saw a rat there, and that the bathrooms were "terrible".
[36] See generally Chapter 14.

Period 1: 1994-7

The earliest plans for the establishment of the Home supplied to the Inquiry date back to late 1990 and early 1991[37]. The Gibraltar Disability Society[38] ("the Society") had approached the then Government with a request that a residential home for persons with "mental and/or learning disabilities" be built[39]. The new building was to provide "a residential home for the disabled and the existing St Bernadette's Occupational Therapy Centre" and was to be operational by late 1993[40].

Before construction was complete discussions ensued between Government, the Catholic Church and the Society as to the running of the Home. A decision was taken that the then Mgr Charles Caruana[41] should take the lead in the arrangements for the running of the Home[42]. A trust was set up for that purpose called "The Dr Giraldi Home Trust". The trustees of the Trust were Mgr Caruana, AV Stagnetto QC, Louis Lombard, Father Paul Bear and Mrs Maruchi Risso[43]. The Trust appointed Mrs Risso as the first Manager of the Home[44].

The Home was opened in January 1994. It was initially run by the Trust with the benefit of Government grants. The grants were initially quite modest – approximately £18,000 in 1994 rising to approximately £156,000 in 1996/7[45]. The Trust was also active in fund-raising for the Home[46]. The Home was, at first, a fairly small scale operation servicing only a small number of permanent and respite residents. Mrs Risso was initially assisted by volunteers and a handful of staff.

The purpose of the Home was set out in an initial document entitled *Aims and Objectives of the Dr Giraldi Home Guidelines*[47]. This document defined the object of the Home as the provision of "home-care facilities for the persons with disabilities from birth, where in such cases there are no parents or members of their respective families who can provide natural home-care for these disabled persons"[48]. For this purpose the Home employed "key workers", whose prime responsibility was to ensure the well-being of residents and who were to act as "advocate and friend" [49]. The Home's "top priority" was said to be to "provide the same loving care and attention which would be given by parents in a natural home within a homely and family

[37] See the plans at [**A/20—27]** and Annex 9.
[38] Then called the Society for the Handicapped.
[39] Witness statement of Albert Bruzon, para 9 [**J1/1/3**].
[40] According to a statement in Parliament on 26 May 1993 by the then Minister responsible: the Hon. R Mor.
[41] Subsequently Bishop of Gibraltar.
[42] See the witness statement of Albert Bruzon para 9 [**J1/1/3**].
[43] See the witness statement of Albert Bruzon para 10 [**J1/1/3**].
[44] Ibid.
[45] See the witness statement of Albert Bruzon para 11 [**J1/1/3**].
[46] Ibid.
[47] Undated – at [**J1/3/2**].
[48] Para 1.
[49] Para 6 **[J1/3/3]**.

atmosphere, thus minimising the effects on quality of life consequent on disabled persons ending up with no parents or families to care for them"[50]. The document also emphasised that the Home was not to be considered "an extension of the professional and specialized services provided by other agencies"[51].

Given the issues to be investigated by the Inquiry (as set out in the List of Issues[52]), it is to be noted that the document also emphasised:

1. that residents' rooms were private, and that members of staff were to ask "permission before entering", on the basis that the "residents have rights to dignity and privacy at all times[53]";
2. that the "Handicapped Allowance[54] paid by the DLSS[55] to the residents via the Home was for the personal use of the residents, and that a Post Office account would be opened for each resident on arrival at the Home with the Manager acting as trustee of such accounts" [56];
3. that residents were to be treated as adults and had rights to complain about the care they received[57];
4. that residents' files were to be "kept in the filing cabinet in the Office [at the Home]. These are confidential and must not leave the House" [58];
5. that a high standard of hygiene was to be maintained at all times[59]; and
6. that the Manager was to discuss all issues concerning a resident's needs and health with his or her next of kin, with decisions being made in partnership between management and next of kin if the resident was not able to take such decisions[60].

In January 1995 the Home had five permanent residents, rising to seven permanent residents and three long-term respite residents in 1996[61]. It appears that a weekly respite service was introduced at the Home in 1995[62].

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[50] Para 3 **[J1/3/2]**.
[51] Para 2 **J1/3/2]**. Indeed it appears that residents did not initially have access to social workers – see Bruzon para 12.
[52] See Annex 2 to this Report.
[53] Para 7 **[J1/3/3]**.
[54] Now Disability Allowance.
[55] Department of Labour and Social Security – as it was then.
[56] Para 10 **[J1/3/3]**.
[57] Para 11 **[J1/3/4]**.
[58] Para 12 **[J1/3/4]**.
[59] Para 13 **[J1/3/4]**.
[60] Para 14 **[J1/3/4]**.
[61] Letter from Mgr Caruana to the then Chief Minister, The Hon. Joe Bossano MP, undated but apparently sent during January 1996 [**J1/104/2**]. In his letter Mgr Caruana talks about the introduction of the respite service and excursions for residents, training in Makaton sign language and finances. It appears that the main purpose of the letter was to update Government of the Trust's work in the context of seeking slightly additional funding for the following year – see the enclosed estimates for 1996/7 at [**J1/104/4**].
[62] Evident from the same letter.

Period 2: 1997-2002

In 1997 the Government commissioned a review of social services in Gibraltar ("the Review"). The Review was conducted by Milbury Care Services Limited ("Milbury")[63]. Milbury was a company which specialised in the field of social services in the United Kingdom. From the Review it appears that Milbury had made recommendations in 1993 to the previous administration. The 1997 review noted a number of concerns in relation to the Home although it recognised that the Trust had done its best to "hold the fort"[64]. The main issue noted by Milbury in its Review was that "staff do not have the professional skills, knowledge or experience to meet the varied and demanding needs of Gibraltarians with Learning Disabilities"[65]. Additionally, concerns were expressed about an institutionalised approach[66], the physical layout of the Home[67], the mixing of adults, children, respite residents and persons with challenging behaviour[68], the lack of professional or clinical skills[69], the lack of written procedures and UK statutory quality standards[70] and the management style of the Home[71]. At that stage the total approximate annual cost of the service was £250,000[72].

Following the Review, a four-year contract was entered into between the Government and Milbury on 13 November 1997, whereby Milbury took over the running of the Home. The contract with Milbury was much more extensive than the provision of management of the Home, as it required Milbury to establish and manage a single coordinated Social Services Agency, to include the Home, the Bishop Healy Children's Home, the St Bernadette's Day Centre, a home care service, Social Work and Probation, as well as identify training and development needs[73]. In so far as the Home was concerned, the objective of the contract was that Milbury should manage the Home, advise "on the further development of learning disability services for the restructuring and unitisation" of the Home and identify training needs[74].

Schedules 3 and 4 to the Milbury contract provided an overview of policies in respect of residential services for people with learning disabilities[75] and residential services for children[76]. They set out broad principles as to the basic philosophy of the Home, the aims of the service which it offered, admission and discharge arrangements, conditions of residence, individual plans, reviews, pastoral care, procedures, estate management and visitors. Care plans were to be

[63] Review of Community Care in Gibraltar by Milbury Care Services [**J1/106/1**].
[64] See the witness statement of Albert Bruzon para 13 [**J1/1/4**].
[65] [**J1/106/2**].
[66] Para 1.2(i) and (v) [**J1/106/2&3**].
[67] Para 1.2 (ii) and (v) [**J1/106/2&3**].
[68] Para 1.2 (iii) [**J1/106/2**].
[69] Para 1.2 (vi) [**J1/106/3**].
[70] Para 1.2 (vii) [**J1/106/3**].
[71] Para 1.2 (viii) [**J1/106/3**].
[72] Para 1.2 (xiii) [**J1/106/4**].
[73] **[J1/107/11-12 & 36]**
[74] **[J1/107/11]**
[75] Schedule 3 [**J1/107/14-16**].
[76] Schedule 4 [**J1/107/17-19**].

designed for both adult and child residents and reviewed every six months[77]. As to the procedures to be adopted in running the Home, it was provided that "all staff will be conversant with the Milbury Operational Procedure Manual. … In particular staff will be aware of the policy relating to Appropriate Risk Taking when individual Care Plans are being formulated"[78].

The aim of the *Operational Policy* dated 7 November 1997[79] was to inform staff, relatives and other bodies of "the broad framework of service quality that will be achieved within the Home". Carers and staff were asked to sign the document in acknowledgment of having read it[80]. It was the declared "responsibility of the Home Manager to ensure that all carers and staff read the contents of this Operational Policy. This must occur within the Induction Check-list timescale"[81].

The overall objective of the Home was described as being to "provide a pro-active and responsive needs led service leading to demonstrable outcomes for the individuals living within their own home"; and the Home was to "provide a warm caring environment, to facilitate the growth of each individual, spiritually, emotionally and physically at all times"[82].

The policy document provided for a respite and sitting service[83].

It also made clear that there were a number of highlighted procedures "to ensure that specific basic rights are adhered to"[84]. The procedures themselves are set out in a document entitled *Milbury Procedure Manual*[85]. That document spans some 500 pages and incorporates a number of policies in relation to residents' rights[86], accidents within the Home[87], "Use of Physical Intervention"[88], complaints procedures[89], risk-taking by persons with learning disabilities[90], safety and issue of drugs[91], residents' monies[92], whistle-blowing[93], disciplinary procedures[94], inventories[95] and petty cash[96].

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[77] In relation to adults see para 6 at [**J1/107/15**] and in relation to children paras 5 and 6 at [**J1/107/18**].
[78] [**J1/107/15**].
[79] [**J1/5/1**].
[80] [**J1/5/2**].
[81] [**J1/5/21**].
[82] [**J1/5/3**].
[83] [**J1/1/12**].
[84] [**J1/5/12**].
[85] While the opening page of the copy supplied to the Inquiry is dated 15 January 2001 [**J1/111/2**] it annexes policies that are dated 1999 and were then updated in 2002.
[86] B2 [**J1/111/15**].
[87] B3 [**J1/111/17**].
[88] B10 [**J1/111/53**].
[89] B11 [**J1/111/69**].
[90] B13 [**J1/111/80**].
[91] B14 [**J1/111/89**].
[92] B16A [**J1/111/117**].
[93] B30 [**J1/111/195**].
[94] C10 [**J1/111/321**].
[95] D1 [**J1/111/467**].
[96] D3 [**J1/111/473**].

Service Audit Meetings were held on a monthly basis to discuss issues affecting the service. On 9 March 1999 one of these was used to set the standards for the Home[97]. These were then set out in a document dated February 2000 entitled *Social Services Agency, Procedures and Standards*. The aims and principles of the residential service and of the respite service were summarised in that document[98]. On admission to the Home, every resident/service-user (or an appropriate adult relative or guardian on their behalf) would sign a *Lifestyle Agreement* setting out the respective rights and obligations of Milbury and of the service-user[99]. Although the Home was stated to be used for the purposes of persons with learning disabilities, at a meeting held with parents in June 1999 it was confirmed that individuals who would qualify to make use of the Home might also suffer from mental health issues[100].

In an Individual Planning Review of October 1998 it is noted that the Home was then one large unit comprising fourteen beds, two respite beds, two separate apartments, a main dining area, two lounges, a kitchen, an office, a playroom, laundry facilities, six bathrooms and a garden[101]. Milbury informed parents of its policy of unitisation in June 1999. A tender for the works was issued in July 1999. The plan was to divide the Home into three flats[102]. Works were delayed as a result of the original contractor going into liquidation, but by the end of 2000 works were almost complete.

Period 3: 2002-2009

The SSA, which had been established some years earlier, was placed on a statutory footing by the Social Services Agency Act 2002. The contract with Milbury, which had been extended by one year, came to an end in 2002. All the former local Milbury staff at the Home were offered continuing employment by the SSA, and as from 10 November 2002 the SSA assumed direct responsibility for social services, including responsibility for the management of the Home.

On that date, the then CEO of the SSA (Douglas Rodriguez) issued Employment Directions 2002 ("the 2002 Directions") [**J1/57/2**] and, subsequently, a number of other procedures and policies. The Introduction to the 2002 Directions stated that all employees were to make themselves thoroughly acquainted with the contents of the Directions, and that Managers should ensure that copies of the Directions were accessible to all employees at their place of work.

For the purposes of this Report, it is unnecessary to refer to the provisions of the 2002 Directions in any detail. However, two sections of the 2002 Directions are worth noting at this stage as they form part of the background to what follows in this Report.

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[97] See the witness statement of Albert Bruzon para 16 [**J1/1/5**].
[98] See the witness statement of Albert Bruzon paras 16-17 [**J1/1/5**] and also [**J1/7/4**] to [**J1/7/10**].
[99] [**J1/8/1**].
[100] See the witness statement of Albert Bruzon para 19 [**J1/1/7**].
[101] See the witness statement of Albert Bruzon para 94 [**J1/1/22**].
[102] See the witness statement of Albert Bruzon para 95 [**J1/1/22**]. A plan of the proposed unitisation is at [**J1/87/1**].

The first is section 3, which is headed "Probationary Period" **[J1/57/6]**. Subsection 3.1.1 provided as follows:

> "The first 12 months of employment with the Agency will be treated as a probationary period and notwithstanding any other provision to the contrary in these Employment Directions the employment may be terminated by the Agency or the employee at any time during that period without notice."

The second is section 15, which related to "Discipline" **[J1/57/51]**. Subsection 15.1.1 provided that the section applied to all SSA employees. Section 15.2 is headed "Interdiction from Duty". Subsections 15.2.1 and 15.2.2 provided as follows:

> "15.2.1 An employee of the agency may at any time be interdicted from duty if that course is considered to be a necessary precaution in the general interest of the agency pending the outcome of criminal or disciplinary investigations, and no alternative course, e.g. transfer to other duties, is appropriate.
> 15.2.2 Interdiction in these circumstances, as distinct from suspension as a disciplinary penalty, does not imply any decision about the case, and this important distinction should be kept in mind wherever any record or report of the period of absence is necessary."

Subsection 15.3.5 **[J1/57/55]** provided that an employee against whom disciplinary proceedings are instituted should be given "a written statement defining the charge and setting out the details of the case which the employee has to answer". Subsection 15.3.6 gave the employee a right of reply to the charge against him. Subsection 15.3.11 gave the employee a right of appeal. Subsection 15.4.2 **[J1/57/ 58]** listed the available penalties, ranging from a written reprimand to dismissal.

Notwithstanding the exhortations in the Introduction to the 2002 Directions, there appears to have been a degree of lack of awareness of their contents in certain quarters[103]. The same applies to other policies and procedures relating to the operation of the Home. I return to this aspect in due course.

A Report was prepared into the first few months of the SSA's operations spanning the period 10 November 2002 to 31 March 2003[104]. In so far as the Home is concerned, the Report noted that the Home provided a residential service for 13 permanent residents in two flats. At that stage the service was led by "a Manager and a Deputy Manager with overall responsibility for the area held by the Team Leader (Adults). Each flat has a Senior Support Worker in charge of daily operations." The Report also noted that respite services were used on average by 15 residents[105].

In October 2002 severe flooding at the Home led to the respite unit being declared unusable until repair works were carried out to the roof of the Home. This caused the temporary relocation of residents and ceasing of respite facilities[106]. The offices of the acting Manager (Sharon Berini) and of the deputy manager (Sean Matto) were moved to Bishop Healy Home.

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[103] See the witness statement of Albert Bruzon paras 76-78 **[J1/1/19]** and [**J1/57/2**].
[104] [**J1/13/1**].
[105] [**J1/13/4**].
[106] See the witness statement of Albert Bruzon para 98 [**J1/1/23**].

In 2004 there was a review of the Learning Disability Service and a flat was identified at Goole House for the purposes of an independent living scheme[107]. A review was carried out in December 2005, aimed at improving respite services – although staffing shortages led to the respite service being temporarily cancelled in March 2006. In January 2008 a review of the entirety of the services provided by the SSA was carried out.

Period 4: 2009 to date

In 2009 the Care Agency was formed as an amalgam statutory agency, representing the merger of the Elderly Care Agency, the SSA and Bruce's Farm (a drug rehabilitation centre which had been run by the New Hope Trust).

The statutory context since 2002

(i) The Social Services Agency Act 2002 ("SSAA")

The SSAA provided that the SSA would consist of the Minister with responsibility for Social Affairs, the Chief Executive Officer (CEO) of the SSA, and at least four other persons appointed by the Minister (SSAA s3(1)). The SSA was to meet at least once every quarter (the quorum at all meetings of the SSA being three members in addition to the chairman or other person presiding) (SSAA s5).

Section 6 of the SSAA is in the following terms:

> "6(1) It shall be the principal duty of the Agency to carry out the functions conferred upon it by this or any Act so far as practicable.
>
> (2) Without prejudice to the generality of the provisions of subsection (1), it shall be the duty of the Agency to do the following things in so far as it is mandated to do so by Government and the Government provides sufficient resources therefor –
>
> (a) to provide a comprehensive social service for the community generally,
>
> (b) with the prior consent of the Chief Secretary of the Government to employ
>
> (i) a chief executive officer,
>
> (ii) such appropriate staff as are considered necessary,
>
> (iii) a finance officer,
>
> (c) with the prior consent of the Chief Secretary of the Government to employ such persons (including advisors and consultants) as the Agency thinks fit for the proper discharge by the Agency of its functions;
>
> (d) to publish codes for regulating the terms of service, discipline and training of all persons employed by the Agency;
>
> (e) to administer and inspect all facilities provided by the Agency so as to ensure the effective and efficient operation of such facilities;
>
> (f) to ensure that all complaints made against the Agency or any employee or contractor of the Agency are properly investigated without delay;
>
> (g) to provide on request an advisory service to the Government of Gibraltar;
>
> (h) to prepare and implement schemes providing policies and plans designed to meet the present and anticipated future needs of social service provision in Gibraltar and to secure continued services in the event of an emergency;

[107] See the witness statement of Albert Bruzon para 24 [**J1/1/8**].

(i) to carry out such other duties as the Minister may from time to time direct."

The SSA was obliged to appoint a Management Board consisting of the CEO, the Finance Officer, the Team Leader (Adults), the Team Leader (Children and Families) and such other member of the staff of the SSA as the Minister might designate (SSAA s11(1)). The function of the Management Board was to advise and assist the CEO in the execution of his functions (SSAA s11(2)). It was required to meet at least once a month, and to forward a copy of the minutes of its meetings to the Minister (SSAA s11(3)).

The SSA had power to establish any other advisory committee to provide professional or technical advice as necessary (SSAA s12). It was required to keep proper books of account, which were to be audited and certified by the Principal Auditor, submitted to the Chief Minister and laid before Parliament (SSAA s15). Complaints about maladministration could be made to the Public Services Ombudsman (SSAA s23).

(ii) The Care Agency Act 2009 ("CAA")

Under the CAA the SSA's assets, liabilities and employees were transferred to the Care Agency. The statutory framework of the CAA was similar to the SSAA save that since it merged three different agencies the composition of the Management Board became the CEO, the Finance and Human Resources Director, the Services Safety and Standards Director and such other employees as might be appointed by the Minister (CAA s11).

The duties of the Care Agency were also wider than those of the SSA under the SSAA, to reflect the fact that the Care Agency also catered for care for the elderly (CAA s6(2)(b)). However, as in the case of the SSA, the statutory duty of the Care Agency, as set out in s6(1) of the CAA, is to carry out its stipulated functions "so far as practicable within the financial and other resources provided or available to it".

Residents at the Home 1994-2013

Nine of the fifteen[108] permanent residents of the Home were admitted during the period of 1994 to 1997. Of those, five were admitted in 1994[109]. The majority of the residents are of long standing, a number of them having been resident at the Home since the time when it was run by the Trust. Only one new resident has been admitted to the Home in the last ten years. A table showing the numbers of residents at various times during the relevant period is annexed to this Report[110].

A useful pencil-sketch of residents was prepared by the Care Agency and was exhibited to the first witness statement of Albert Bruzon at **[J1/112/3]**. That document summarises the diagnosed disabilities of the particular residents, from which it is clear that many residents suffer

[108] Taking into account the thirteen permanent residents at the Dr Giraldi Home and two at Goole House.
[109] Information provided by the Care Agency to the Inquiry.
[110] See Table A in Annex 7 to this Report. See also Annex 6.

significant learning and mental disabilities (and sometimes consequential physical disabilities) of a wide-ranging nature. Some of these are very severe in extent.[111]

Staffing levels

The Home, which began as a relatively modest enterprise, underwent a gradual but steady increase in numbers of staff. Records indicate that in 1999 there were approximately 30 employees of the SSA working at the Home, rising to around 45 to 50 by 2002. By the time Joanna Hernandez became the Manager of the Home (November 2004) there were around 60 members of staff working there. By 2009 that figure had risen to more than 80, despite the fact that the number of residents at the Home has remained relatively constant since November 2004. A table showing staffing numbers from 1999 to 2010 is annexed to this Report[112].

The gradual growth in staffing levels over the period after 1994 was punctuated by frequent complaints of staff shortages especially during the years 2003-06[113]. A letter was sent by staff to the Minister in October 2004 on the issue[114]. A couple of days later, the Acting Manager of the Home, Sharon Berini, sent a Memo to Isabella Tosso – then Acting Team Leader of the SSA – expressing concerns for the safety of residents as a result of staff shortages. The Minister acknowledged the letter and asked the acting CEO of the SSA to investigate the issues and consult the staff representatives[115]. This is an issue to which I shall return later in this Report[116].

Key managerial changes: 2000 to date

(i) CEOs of the SSA

In 2002, Douglas Rodriguez was appointed CEO of the newly created SSA. He remained in post until September 2004. Marie Gomez assumed the post of Acting CEO from October 2004 until Isabella Tosso took over as CEO in April 2005. Isabella Tosso continued as CEO until January 2007. She was succeeded as CEO in February 2007 by Chris Wilson, who was in turn succeeded by Carmen Maskill in March 2009. In June 2009 the Care Agency took over responsibility for the Home from the SSA, pursuant to the CAA. In March 2012 Carmen Maskill was succeeded by Jennifer Allison, who took the post of Acting CEO until Albert Bruzon was appointed CEO in October 2012, a post he continues to hold.

(ii) Managers and Deputy Managers of the Home

From November 2000 until November 2002 (that is to say during the last two years of the Milbury era) the Manager of the Home was Mandy Spencer, under her then name Mandy

[111] A description is also set out in Annex 8.
[112] See Table B in Annex 7 to this Report.
[113] For a description of these, see the witness statement of Albert Bruzon paras 47-68 [**J1/1/14**].
[114] See the witness statement of Albert Bruzon para 48 [**J1/1/14**].
[115] See the witness statement of Albert Bruzon para 49 [**J1/1/15**]
[116] See Chapters 8 and 11.

Spencer Ball. She was succeeded as Manager by Morag Jack, who held that post until she resigned on 31 January 2004. Following her resignation, Sharon Berini (who had been Deputy Manager since 2002) was appointed Acting Manager, with Sean Matto as Acting Deputy Manager. On 22 November 2004 Joanna Hernandez was appointed Manager. She held that post until 22 November 2005, when her one-year contract expired and was not renewed. During her tenure as Manager, Sharon Berini was the Deputy Manager. Joanna Hernandez was succeeded as Manager by Iain McNeil, who held that post until 2009. Sharon Berini left the service in 2006. She was succeeded as Deputy Manager by Liz Gallagher. Liz Gallagher held that post until June 2012. At that point, the post of Deputy Manager was discontinued. In the meantime, in January 2010 Mary De Santos was appointed Manager. In September 2011 she was succeeded by Sarah McDonagh, who held the post until September 2012, when Sean Matto was appointed Acting Manager, a post he continues to hold.

(iii) Other key staff changes – Agency Adult Team Leaders

Following the departure of Milbury in November 2002, Duncan Jones became Adult Team Leader. He held that post until 31 January 2004[117], when he was succeeded by Marie Gomez in an acting capacity. Marie Gomez was formally appointed Adult Team Leader in June 2004. She continued in that post until October 2004 when she was appointed Acting CEO of the SSA following the retirement of Douglas Rodriguez. In the meantime, she had been replaced as Adult Team Leader by Isabella Tosso. In April 2005 Marie Gomez resumed her post as Adult Team Leader, and Isabella Tosso became CEO. In 2009 the Disability Services Team was established. Marie Gomez became the Disability Team Leader, and Debbie Guinn, a senior social worker, assumed the role of Adult Team Leader.

Carlos Banderas worked in the Elderly Care Services section of the Care Agency until March 2011, when he was asked to take over the management of the nursing team at the Home. In December 2011 he was appointed Acting Team Leader of the Care Agency's Disability Services. Thereafter he returned for a time to Elderly Services, until, in July 2012, he was again asked to manage Disability Services, with particular regard to the introduction and implementation of new policies designed to improve the services provided by the Home. It is a pleasure to report that there was general agreement amongst the witnesses who gave evidence to the Inquiry that he has done that with conspicuous success.

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[117] Duncan Jones tendered his resignation in November 2003 but offered to continue in post until 31 January 2004.

CHAPTER 2: November 2000 to November 2004: evidence (1)

Contents

CHAPTER 2: *November 2000 to November 2004: evidence (1)*

Introduction

As stated in paragraph 2 of the List of Issues (Annex 2 to this Report), the Inquiry is concerned to investigate the listed issues in respect of the period from November 2002 (when the SSA took over operational management of the Home) to date, save that it is also concerned to investigate specific allegations made by Mandy Spencer (formerly Spencer-Ball) in respect of the period when she was Manager of the Home (November 2000 to November 2002). However, in order to set her allegations in context, brief references are made to evidence relating to the operation of the Home before she became Manager.

Equally, some of the evidence reviewed in this Chapter contains references to the period since November 2004, but I have nevertheless included that evidence at this stage in the interests of presenting as coherent a picture of the Home as possible. That said, evidence relating to specific incidents alleged to have occurred after November 2004 is not reviewed at this stage; nor is evidence relating to alleged incidents involving Resident T and to the repercussions of such allegations[118]. That evidence is reviewed later in this Report[119].

As explained in the final section of the Introduction to this Report, in conducting this review I take into account: (a) statements contained in witness statements made in the Industrial Tribunal proceedings (including witness statements the makers of which have either failed to respond to an invitation to assist the Inquiry or declined such an invitation, apart from the three cases where the makers of witness statements have asked the Inquiry to treat them as withdrawn[120]) and (b) statements referred to (directly or indirectly) in witness statements made in the Industrial Tribunal proceedings or in documents exhibited to such witness statements.

On that basis, and subject to the above qualifications, in this Chapter and the following four Chapters I review the evidence presented to the Inquiry relevant to the period from January 2000 (when Mandy Spencer became Manager of the Home) until November 2004 (when Joanna Hernandez became Manager). My findings based on that evidence are set out in Chapter 7 of this Report.

For the purposes of this review, the witnesses (that is to say those who have given evidence to the Inquiry or who have made statements – whether or not in the form of witness statements – which are to be treated as evidence presented to the Inquiry) are divided into five groups.

Group 1 consists of those members (or former members) of staff at the Home who made witness statements in the Industrial Tribunal proceedings in support of Joanna Hernandez' claim

[118] The evidence relating to the alleged incident involving Resident T is reviewed in Chapter 13 of this Report.
[119] See Chapter 8 onwards.
[120] As stated in the Introduction to this Report, the makers of the three witness statements in question are John Harris, Robert Tavares and Susan Ignacio.

of unfair dismissal and whose evidence is directed in whole or in part to the period currently under review, together with three other employees (or former employees) of the SSA who did not make witness statements in the Industrial Tribunal but whose evidence to the Inquiry includes criticisms and/or allegations relating to the conduct of members of staff at the Home in that period[121]. (NOTE: Witness statements were made in the Industrial Tribunal in support of Joanna Hernandez' claim of unfair dismissal by *Simy Herbert* [**C1/10/1**], *Stuart Borastero* [**C1/19/1**], *Dean Joseph Lopez* [**C1/20/1**], *Denielle Gomez* [**C1/21/1**] and *Nicole Viagas* [**C1/22/1**], but none of those witness statements contains material relating to the period currently under review. These witnesses are accordingly not included in Group 1).

Group 2 consists of those additional members or former members of staff who made statements which, although not in the form of witness statements, are nevertheless to be taken into account for the purposes of the Inquiry (see above).

Group 3 consists of those relatives of residents or respite users who made witness statements in the Industrial Tribunal proceedings and whose evidence is directed in whole or in part to the period currently under review.

Group 4 consists of those additional members (or former members) of staff in respect of whose conduct in the period currently under review criticisms and/or allegations are made.

Group 5 consists of other witnesses whose evidence covers the period currently under review and who are not included in any of the other Groups.

This Chapter reviews the evidence of the witnesses in Group 1, that is to say:

Mandy Spencer

Gayle Everest

Denise Hassan

Elizabeth Harrison

Ave Gonzalez

Douglas Rodriguez

Jordan Davis[122].

Chapter 3 reviews the statements of the individuals in Group 2, that it to say:

Jonathan Dalrymple

Christian Santos

[121] The three witnesses in question are Gayle Everest, Denise Hassan and Elizabeth Harrison.
[122] Ave Gonzalez, Douglas Rodriguez and Jordan Davis made witness statements in the Industrial Tribunal proceedings, but did not give either written or oral evidence to the Inquiry.

Rose Seruya

Jackie Palma

Gabrielle Llambias

Emily Dempsey

Maria Gonzalez

Nicholas Hassan

Nicola Paine

Stacey McKay.

Chapter 4 reviews the evidence of the witnesses in Group 3, that is to say:

Gina Llanelo

Elizabeth Featherstone

Violet Sullivan

Maurice Valarino

Frederick Becerra

Emilia Bruzon and Denise Evaristo

Moira Elmer

Carmen Dixon-Pritchet

M. A. Beiso[123].

Chapter 5 reviews the evidence of the witnesses in Group 4, that is to say:

Marie Gomez

Sharon Berini

Sean Matto

Nigel Bassadone

[123] M. A. Beiso informed the Inquiry team that she did not wish to participate in the Inquiry. Carmen Dixon-Pritchet informed the Inquiry team that while she was willing to assist she could not commit to do so because of medical reasons and in the event did not do so.

Richard Muscat

Jennifer Garrett

Michelle Garro

Yvette Borastero

Kirushka Compson

Manuela Adamberry

Angelica Williams

Yvette Del Agua.

Chapter 6 reviews the evidence of the witnesses in Group 5, that is to say:

Matthew Turnock

Mandy Vallender

Natalie Fortuna.

GROUP 1 Witnesses

Mandy Spencer

Mandy Spencer was the Manager of the Home under Milbury from November 2000 to November 2002. She made a witness statement in the Industrial Tribunal in support of Joanna Hernandez' claim of unfair dismissal (I will refer to that witness statement as her "2006 witness statement") [**C1/2/1**]; and in 2013 she made a witness statement in this Inquiry (I will refer to that witness statement as her "2013 witness statement") [**E/63/1**]. She also gave oral evidence to the Inquiry.

In her 2006 witness statement she gives examples of what she characterises as incidents of "intimidation and bullying" during her two years as Manager.

In paragraph 2 of her 2006 witness statement [**C1/2/1**], she describes how, in December 2000 (i.e. shortly after she had taken up her post as Manager), her passport went missing from her bag, which she had left in a flat at the Home. She says that some six months later she was told by a member of staff that three other members of staff had taken it and disposed of it, in order to prevent her attending the staff Christmas dinner in Spain. She says that she was told that Richard Muscat "threw it up in the loft with the help of Nigel Bassadone, and then Nigel

Bassadone burnt it in the bin" [**C1/2/2**]. She goes on to say that she was not in a position to do anything about this incident, as she had no proof.

In paragraph 3 of her 2006 witness statement [**C1/2/2**], she says that she was told by a Spanish-speaking member of staff that in April 2001[124] several members of staff had accompanied some residents on a trip to Lourdes, and that "three members of staff were involved in some kind of sexual incident in a bunk bed above a resident on the train to Lourdes". The three members of staff were said to be Nigel Bassadone, Jennifer Garrett and another member of staff who has since left the Home. Mandy Spencer goes on to say that she was unable to do anything about that alleged incident either, as she had no proof.

In paragraph 4 of her 2006 witness statement [**C1/2/3**], Mandy Spencer says that "whenever [she] tried to put policy in place, [she] would get opposition". She continues [**C1/2/3**]:

> "To get anything done was an uphill struggle and even to implement care plans, get care plans written, to get professionalism in report writing, was difficult because it was a struggle to get past people. Trying to get training, epilepsy training, medication training, they would say: "[W]ell, why [do] we need that?". It was impossible on occasions."

In paragraph 5 of her 2006 witness statement [**C1/2/3**], Mandy Spencer describes an incident which occurred on 27 January 2002 when she saw Nigel Bassadone "pinning a very frightened Jenny Garrett up against the kitchen wall and Angelica [Williams] was in tears trying to get people out of the kitchen and to a safe environment, away from Nigel Bassadone, and Nigel was screaming ...". She goes on [**C1/2/3-4**]:

> "... [M]y instinct was to shout "What the hell is going on here" he then flew across the kitchen at me, out onto the balcony, so fast that I thought I was going to fall backwards out of the balcony. When I clung to ... the balcony he was shouting and pointing in my face, very close to my face. His eyes were all over the place, and saying "Who do you think you are to tell me what to do, you know nothing". And I said "Nigel come in and calm down", and he said "[D]on't tell me what to do", and I was really concerned and I told him he really need[ed] to go home and he had a choice, like he could either go and lie down and see if he felt better in a couple of hours, because at the time I was not entirely sure what was wrong. In my own personal opinion he was either drunk or stoned. From the look in his eyes he was stoned, but I could smell alcohol. He had a choice that he could either go or lie down, until lunchtime, in a room in respite, and I would see how I felt once he woke up again, or, if he didn't calm down, I would send him home. And he would then be suspended. He totally calmed down, eventually, of his own accord, but I did call Duncan [Jones], and we did eventually suspend him. And it went to a disciplinary. At which point I had to be called as a witness and I did say that I was very frightened, but he got off with a written warning which was a surprise to myself, although it did not seem to [be] a surprise to Duncan and to Rod [i.e. Rod Campbell: a Milbury employee who presided at the disciplinary hearing], because I was told that their hands had been pretty much tied over this. We were only allowed to give him a written warning over that because, technically, it was his first offence."

Mandy Spencer provided a report to the disciplinary hearing [**E/2/20**], which took place on 6 February 2002. The report, which is dated 27 January 2002 and timed at 11.40am, includes the following:

[124] She confirmed this date in her oral evidence to the Inquiry: see Day 15 page 46 line 22.

> "While working in respite [i.e. Flat 3], cleaning out the store room, I heard loud shouting coming from flat 2. I was concerned that there was a problem so [I] went to investigate. Upon my arrival in flat 2's kitchen, I asked if there was a problem, I was greeted by N. Bassadone shouting abuse in [S]panish at the other staff, and he then started shouting at me. I asked him to explain in [E]nglish but he just became more abusive and threatening to report everyone. J. Garrett and S. Berini were trying to encourage him to go home, as they felt that he was not safe to be on duty. I managed to remove N. Bassadone from the situation down to the office in respite. The only way I could get him to go to the office was to state that if he went home without explaining to me what was going on[,] I would not allow him back. He shouted that I had no right to tell him what to do, to which I replied: "[M]y office now, PLEASE! I don't want to lose my temper." .... He was verbally hostile throughout. I then asked him to explain his actions, and the incident. At this point I noticed that N. Bassadone smelt faintly of alcohol and I made him aware of this. Although he smelt of alcohol I don't think he was actually still drunk – though I can't be certain. He explained that he had had a large amount to drink last night, but he was OK. I stated that I didn't feel the same. He said that the staff in flat two had told him that they were unhappy with him being in that condition and they didn't want him to drive the van. I explained that I was also unhappy with his behaviour, and that I also felt that he should not drive the van. I asked him to go and have a coffee whilst I spoke to the other staff. I also told him that I found it unacceptable that he displayed this behaviour in front of service users, and that if he wished to remain on shift he was to apologise to service users, and sort his temper out. At this point I explained to N. Bassadone that I didn't wish to be nasty but I was within my rights to take action if I felt necessary – and that I didn't want him to lose his job or anything. N. Bassadone was still very tense and stressed and how much he was taking in I was not sure as I was having difficulties getting him to calm down."

In paragraphs 6 and 7 of her 2006 witness statement [**C1/2/4**], Mandy Spencer refers to an incident following which her Deputy Manager[125] was sacked for being drunk. She says that he "almost overdosed [Resident L] on Ritalin"; and that he had "misread the chart, because he was so drunk he couldn't read the drug sheet".

In paragraph 8 of her 2006 witness statement [**C1/2/5**], she says that:

> "... time sheets would go missing; Policies or procedure[s] would go missing from the office".

In paragraph 9 of her 2006 witness statement [**C1/2/5**], she says that members of staff were "very split into distinct groupings". She goes on:

> "You had the group that is influential, manipulative and bullying which mainly consisted of the ringleaders were [sic] Sharon [Berini], Nigel [Bassadone], and Richard Muscat and others, and their ego followers, weak minded people who thought they would get far by following them like [among others,] Sean Matto ... and people like that. Then there were the people who would go out of their way to try and help you ..."

In paragraph 10 of her 2006 witness statement [**C1/2/6**], she says that lots of different things "wore you down", giving as an example being called out at 4am "for ridiculous things that you would feel they would be able to cope with". She goes on:

> "Then you would get people who would put barriers in your way."

[125] In the course of her oral evidence (see Day 14 page 137 line 2) she gave his first name as Steve: she could not recall his last name.

In paragraph 11 of her 2006 witness statement [**C1/2/6-7**], she refers to an occasion when a number of Ritalin tablets went missing. There was a police investigation, but it came to nothing. She goes on:

> "We never found out whether they found anything and nothing ever came of the investigation other than we had to tighten up our procedures. Two members of staff had to count [the Ritalin tablets] in and out. The key to the cupboard had to be opened and closed by a senior member of staff on duty to try and stop it."

In paragraph 12 of her 2006 witness statement [**C1/2/7-8**], she describes an occasion when she went to collect Resident C from respite (his mother was abroad at the time):

> "... to find he was asleep on the sofa with a large lump, approximately the size of a golf ball, on his head, and when I asked Sean [Matto] what had happened, he explained the night staff had heard a thump in the night, and they had gone into his room to find him tripped over the mattress that was on the side [of the] bed. When I asked him why there was a mattress on the side of the bed, he told me it was in case he falls out of the bed having a fit. So I then went on to explain to Sean that I had never known [Resident C] to fall out of the bed while he was having a seizure. I don't know why they started doing that and if this happened at four or five [in] the morning had he been cleaned of spittle and had he been checked over. To which Sean said "No, no we were waiting till you got here". [Resident C] had not eaten all day. He had hardly drank all day. He was clearly lethargic and I was concerned about him. I was very cross. I was quite angry with Sean really, and I said to him "Why the hell haven't you taken him to be checked out, he could have head injuries. He is showing signs of head injury", to which I got the reply "Well you can take him now if you like Mandy", and I said "[W]hat, [on] the back of my moped, I don't think so". I was planning on walking [Resident C] home because it was a nice evening, and I now had to call a cab. But they had not bothered to have his head injury checked out."

In paragraph 13 of her 2006 witness statement [**C1/2/8**], she refers to another incident involving Resident C, as follows:

> "13. Another one with [Resident C] was I had gone somewhere and I phoned to say that I was going to be running late, and if they could hang on to him, and was told that he was in the hospital. I asked why he was in hospital, and they said he had fallen over and had cut his chin open. I immediately went down to respite where Sean was again and asked Sean what had happened and I was told he had accidentally given him [too] much Epelim and he was a bit unstable on his feet and a member of staff turned their back on him for five minutes, and he fell over. When I asked him how the hell they had managed to over-medicate him, Sean said "I mistook his Epelim tablets, I gave him two 200 Epelim instead of two 100 Epelim". When I pointed out that that was not good enough because at the time the Epelim 200 hundred was purple, and the 100 Epelim he was taking were white, so to make a mistake like that really was not acceptable to me and I would then have to phone his mother in Seville, [who was] on a business trip, to tell her he had four stitches in his chin and I was not happy with that. Things didn't seem as if very much care or attention was taken."

In paragraph 14 of her 2006 witness statement [**C1/2/9-10**], she refers to rotas and to small amounts of petty cash going missing. She goes on:

> "14. .... The proper receipts weren't always given in when received, which is handwritten receipts. I would receive receipts back that were from some of the cafes in Casemates for lagers, and when I questioned them … would get back "Well [it's] alcohol free lager". And I used to stipulate, "I don't want to see this, because I will question it, and people will question it. If you cannot get a receipt stating "alcohol free lager" on it I don't want to see it on there. It has got to be soft drink, juice. Things like that, and it is not always acceptable to be sitting in a bar,

> especially if you are supervising children". Because some of our service users, you know, we did have a couple of complaints from people that they had seen our staff out sitting at bars like the Royal Calpe and they were sitting with their friends chatting away, while they were supposed to be supervising a nine year old and they were just running around, a bar is not the perfect place for children to be, and to try and get them to do activities that was interesting to the service user, not just to themselves. During the summer we don't want them sitting just watching TV, thank you very much. Go out and do something, and try and implement changes and implement care plans, where we go out and do things with the service users rather than just sitting there and looking at them. It was a very difficult uphill struggle."

In paragraph 15 of her 2006 witness statement [**C1/2/10**], she recounts an occasion when her then husband, Kelvin Ball, who was a supply worker at the Home, told her that a senior support worker with responsibility for Resident AE (a male resident who displayed challenging behaviour, and who had a weight problem) had told the other carers on Resident AE's team that "if he wanted a burger, he could have a burger", which, said Kelvin Ball, was "undermining his behaviour plans".

In paragraph 17 of her 2006 witness statement [**C1/2/11**], she says this:

> "17. The bullying that went on, people wouldn't come forward. They really wouldn't, because they had been told that I would make it difficult. They would be unwilling to come forward and say that this happened, and that happened[.] I would want them to put it in writing, and they would say ["]No no I would rather not, because I don't want my life to be made difficult["]. It was just a regime and your bullies Sean, Sharon, Nigel, Richard, etc ... your bullies, they would manipulate people how they wanted to get what they wanted, and power, basically, was what they wanted. Their own way most of the time."

In paragraph 18 of her 2006 witness statement [**C1/2/11-12**], she recounts how she was told by "a very good [male] member of staff" that he had found Resident Z (then a young child) fitting very badly, and when he went to give him his evening medication there was no medication. According to Mandy Spencer, he went on to tell her that when he inquired where the medication was, he was told that Resident Z had been taken off medication as he was "not epileptic". Mandy Spencer continues:

> "He [i.e. the carer] then went mad and asked which doctor did this, and apparently there had not been a doctor involvement. They had decided that he wasn't epileptic because he wasn't fitting, so he wouldn't need his medication, and he was extremely concerned and he wanted to know what we could do about it, for that person who made the judgement."

In paragraph 19 of her 2006 witness statement[**C1/2/12**], she goes on to say:

> "It turned out that the person who made the judgment was Sharon; she just decided he did not need the medication."

In the same paragraph, she recounts an occasion when Debbie Guinn (an SSA social worker with responsibility for Resident Z) had reported to her that Resident Z's mother:

> ".... had just made a formal complaint that she had been there visiting with [Resident Z] and [Resident Z] had misbehaved, or that sort of thing, to which the carer then made him stand facing the wall, with books, quite heavy books, from what I can account for, on both his arms, and his mum was told that she could not do anything. And I went mad, absolutely mad. I then found

> out which member of staff it was, and I had him in the office and wanted to know what the hell they thought they were doing. That this was not an acceptable form of punishment to which they said that they had been told, by a senior person on duty, that that was ok. They had been told by Nigel that that was ok because he was the most senior person on duty. Because I was on a day off, and he had been an extremely junior member of staff at the time, he had not been with us very long, and he was in tears when I finished speaking to him, I gave him quite a severe reprimand. He then went straight to [Resident Z's mother] and Debbie [Guinn] and [Resident Z] ... and apologised and I know he did not do it again, because he was told that this was the acceptable form of behaviour and modification to use with [Resident Z], which it wasn't. .... [We] were trying to teach his Mum strategies on how to deal with him as well. But then all these guidelines were written down, I spent months and months and months with Stuart [Sinclair (Deputy Manager)] with care plans and behaviour guidelines together, basic information on how to deal with [Resident Z] and they went missing."

In paragraph 20 of her 2006 witness statement [**C1/2/13**], she continues on the theme of missing files, saying this:

> "20. Shortly after I left [in November 2002] I went to take [Resident C] in and there was a new member of staff who knew nothing about him, and I said that all his information is in his file, and she took his file out and it was empty. Not a piece of paper in [it], not one piece, and there wasn't any information in any file. The only file that they had that has got any information in [it] is [Resident L's]. There was nothing on anybody else in any of the files that I had spent months with Stuart Sinclair putting the information together. It had all disappeared. I don't think the other manager Morag [Morag Jack, her successor] found it either. She certainly did not find it."

In paragraphs 21 and 22 of her 2006 witness statement [**C1/2/13-14**], she returns to the subject of bullying, saying this about Sharon Berini:

> "21. Sharon has a background of bullying and being bullied and she is manipulated grossly by Nigel[126]. He threatens her with taking [their] children away and taking her home away, and in turn she then bullies people as well, and she will make their life difficult and they will never get anywhere. This will happen quite often, that if you either don't play along or you don't do this, or you do this, to progress her career.
>
> 22. I've been told by her, even though indirectly, when I wanted to implement the strategy, then she said "Oh no I wouldn't do that because your life would be very difficult". And I used to say "Are you threatening me or are you just whingeing". She is very good at playing the victim to get her own way. She manipulated me for a long long while. It took me a long while ... to see through it. It took various things, that didn't quite add up, for me to see through it. It was quite frightening when I did manage to catch on, thinking, what have I missed here, what have I been playing along with, and what have I been a party to. And you know it is quite frightening because they manipulate people to their own ends. To get things she wants, or to get things to stay the way she wants. And I think that a lot of things that I wanted to implement would mean that her and her other bullies would no longer be safe, because they would be uncovered. Things like the petty cash and the drugs, and things like Nigel taking tablets and other things going missing, would be uncovered. And they did not want to be discovered."

In paragraph 23 of her 2006 witness statement [**C1/2/14-15**], she turns again to Nigel Bassadone and Sean Matto, saying this:

> "23. Nigel is very manipulative and hostile. He has threatened members of the staff that they are too frightened to say anything because of what he has threatened. Sean is very manipulative.

[126] Sharon Berini and Nigel Bassadone lived together for some 17 years, until late 2000. They have two children. They never married.

> He is very clever with what he does. Extremely clever. I think he thinks because he has a degree he is above it. And he will stack all less knowledgeable members of staff with the paper work as well. Nigel is a dangerous human being. He went through drug rehabilitation in the UK for four weeks while I was there, and the only people who were allowed to know he was in rehab, was Sharon, and because of the children, and he told Duncan [Jones] that he was given four weeks unpaid leave to go. We had to lie and cover for him and say he had gone on holiday for four weeks because his father was not well in UK. But we knew that he was in rehab. It is just something that was not publicly mentioned. When I asked management I was told that we were not allowed to sack him when he was ill. That is what we got told. So we weren't able to do anything. When we tried after the incident in Flat two [i.e. the incident on 27 January 2002 which she referred to in paragraph 5] what we got was its his first offence and he gets a final written warning, that is all we can do. What do we do? What can we do?"

Mandy Spencer concludes her 2006 witness statement by saying (in paragraph 25 [**C1/2/15**]):

> "25. I worked at [the Home] under Milbury Care Services who managed it until November 2002 when Government took over. My contract then expired. I applied for the post as Manager, but was relieved when I didn't get it. I only applied out of a feeling of duty to try and help those I was leaving [behind]."

Much of Mandy Spencer's 2013 witness statement [**E/63/1**] is taken up with responding to allegations made against her by other witnesses who made witness statements in the Industrial Tribunal proceedings.

In her 2013 witness statement, she turns first to the witness statement of Susan Ignacio. However, as noted earlier, when contacted by the Inquiry team Susan Ignacio requested that the contents of that witness statement be treated as withdrawn[127]. I accordingly pass over Mandy Spencer's responses to that witness statement.

The other witness statement to which Mandy Spencer refers in her 2013 witness statement is the joint witness statement of Emilia Bruzon and Denise Evaristo (the grandmother and mother of Resident Z) [**C1/4/10**]. In paragraph 3 of their joint witness statement [**C1/4/10**], they describe the occasion (described in paragraph 19 of Mandy Spencer's 2006 witness statement) when they arrived at the Home to find that a carer had "got hold of" Resident Z, and "put him in a room and placed books on his hands for more than one hour". In paragraph 5 of that witness statement, they say that Mandy Spencer and another carer "put [Resident Z's] head in the freezer and he shouted like an animal", and that "they put him on a motor ski, something could have happened to him"[128]. In paragraph 33 [**C1/4/14**] they allege that Resident Z was "given cold showers".

As to that evidence, Mandy Spencer says (in paragraph 6 of her 2013 witness statement [**E/63/3**]):

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[127] See Day 19 page 52 line 16.

[128] Emilia Bruzon said in evidence that Resident Z was born on 17 July 1996: see Day 3 page 29 line 23. Denise Hassan said in evidence that this alleged incident occurred when Resident Z was "three, nearly four": see Day 7 page 104 line 23. That would put the date of it at around 1999/2000.

- that Resident Z would shout and swear from the day he arrived in respite; that that was a behaviour the carers were trying to deal with;
- that she had never received any reports of Resident Z's head being placed in a freezer (which, in any event, she doubted was physically possible);
- that she had ascertained from the carers involved that Resident Z had been allowed to sit on a stationary jet ski, accompanied by the carers;
- that she had told the carers involved that although they had done that with the best of intentions this was risky for Resident Z, and that proper procedure had not been followed;
- that a risk assessment should have been undertaken, and parental consent sought;
- that to her knowledge there have been no recurrence of such an incident;
- that she had not been on duty when Resident Z had been made to stand with books on his hands;
- that she gave the "extremely junior" member of staff responsible "a really severe reprimand";
- that he told her that he had been instructed to treat Resident Z in that way by "the most senior member of staff on duty at the time" (a reference to Nigel Bassadone);
- that she could not recall receiving any report from Emilia Bruzon or Denise Evaristo about Resident Z being given cold showers;
- that carers would sometimes take Resident Z to the beach during the summer and use the (cold salt water) showers there;
- that she had also on occasion given Resident Z a tepid bath (but not a cold bath) in order to bring his temperature down;
- that tepid baths or cool showers are a recognised treatment for regulating the internal body temperature of individuals suffering from epilepsy; and
- that on occasion a group of members of staff and service users would put the hose on in the garden in the summer and play water games involving paddling pools, buckets, water pistols etc. – an activity which Resident Z enjoyed.

In paragraphs 1 to 6 of her 2013 witness statement [**E/63/7**], Mandy Spencer summarises the evidence in paragraph 2 of her 2006 witness statement relating to the occasion in December 2000 when her passport went missing.

In paragraphs 10 to 12 of her 2013 witness statement [**E/63/8**], she summarises her evidence as to the incident involving Nigel Bassadone which occurred on 27 January 2002 (as described in paragraph 5 of her 2006 witness statement).

Paragraphs 13 and 14 of her 2013 witness statement [**E/63/9**] refer to the sacking of the Deputy Manager called Stephen, as described in paragraphs 6 and 7 of her 2006 witness statement.
In paragraphs 15 to 21 of her 2013 witness statement [**E/63/9-10**], she summarises the evidence in her 2006 witness statement relating to missing medication and paperwork.

Finally, so far as her 2013 witness statement is concerned, in the last four paragraphs of that witness statement[129] [**E/63/10**] she summarises the evidence in her 2006 witness statement as to the missing paperwork relating to Resident C post-2002.

In her oral evidence, Mandy Spencer told the Inquiry that prior to becoming Manager of the Home she had worked for Milbury in England[130]; that after she left the Home in November 2002 she worked for about a year in a different care environment; but that since then she has worked in a completely unrelated field[131].

Asked by counsel to the Inquiry about a lengthy manual prepared by Milbury [**J1/111/2**], she confirmed that the policies and disciplinary procedures contained in that manual would have been those which were implemented at the Home from 2001 until Milbury left[132]. When asked by counsel to the Inquiry about the policy in relation to whistleblowing, she said that she "would hope" that members of staff at the time were aware of it[133]. She went on to say that she operated "an open door policy", and that she encouraged staff to be open with her and to come and see her if they had any problems[134], although she felt on occasion that members of staff were reluctant to do so as they feared that if they did so "their life would be made difficult"[135]. She said that when Milbury's contract came to an end on 10 November 2002 (after having been extended for an extra year) – that is to say, shortly before her own term as Manager came to an end – she "did sort of a handover" to her successor as Manager (Morag Jack)[136]. She later referred to "a handover period" before she left on 30 November 2002[137], explaining that Morag Jack's contract started in mid-November 2002, so the handover period lasted some two to three weeks. She said that following the sacking of her Deputy Manager he was not replaced, so that at the time when she left the position of Deputy Manager was also vacant[138].

Asked by counsel to the Inquiry about a document [**J1/57/51**] which indicated that on taking over responsibility for the running of the Home the SSA introduced some new policies and disciplinary procedures, she said that she did not know about them[139].
Counsel to the Inquiry then asked her about the specific incidents described in her witness statements.

As to the missing passport, she accepted that she could not help the Inquiry on the question whether her passport was taken by another member of staff since she had no direct knowledge as to whether the allegation was true or not.[140].

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[129] The four paragraphs are numbered (out of sequence) 8 to 11.1.
[130] See Day 14 page 123 line 9.
[131] See Day 14 page 121 line 19ff.
[132] See Day 14 page 124 line 16.
[133] See Day 14 page 129 line 11.
[134] See Day 14 page 130 line 7.
[135] See Day 14 page 130 line 19.
[136] See Day 14 page 131 line 11.
[137] See Day 14 page 132 line 3.
[138] See Day 14 page 137 line 17.
[139] See Day 14 page 133 line 19.

The same applied, she said, to the allegation relating to the trip to Lourdes[141]. All she knew about that, she said, was that the three staff members had denied that anything untoward occurred on that trip[142]. In response to a question from her own counsel, she said this[143]:

> "A staff member came to me and they [sic] outlined the incident at Lourdes which is in my statement. They also said there were photographs. .... I asked them where these were, they couldn't/wouldn't tell me. I asked them – I felt what they were telling me was quite serious – again, would they write it down for me or come with me to my manager to express this. Again, they said no they wouldn't, because they basically were worried about repercussions if it was found out that they had spoken to me about it."

Asked by counsel to the Inquiry about her evidence in paragraph 4 of her 2006 witness statement [**C1/2/3**] that whenever she tried to implement a policy she met with opposition from some members of staff, she said this[144]:

> "Some people within the staff team couldn't understand why we were trying to change this as it had worked like this for years, trying to establish that we were just trying to enhance professionalism and to bring the standard up, like proper epilepsy training so people would understand what epilepsy is, how we treat it, how we deal with it. Things like medication training, how we store medication. But it wasn't just them. It was a real struggle for us to get anything from above as well, to get them to buy a lockable medication cabinet that we could bolt on the wall, we got told no because there was no budget for it, you would have to wait until the new financial year. To me that wasn't a luxury, it was something that was essential and we needed to improve standards. So it kind of came from both directions."

Mandy Spencer went on to say that she never had any direct dealings with the Government; that all her correspondence was with her (Milbury) line managers[145]; and that she never questioned "the upper structure", because she had been taught not to question the people in charge[146].

Returning to the existence of opposition to change, Mandy Spencer said this[147]:

> "I think it was reluctance to change because ... I was trying to sort of raise professional standards, bringing in proper report writing, bringing in proper drug sheets, drug medication, because they weren't used to that, and they were like "OK we have been doing it this way for a couple of, you know, for years. Why are we changing it now?", kind of thing. ... It's to a degree fairly natural in some aspects, and just trying to get them to understand that we are trying to improve the professionalism of the service we are trying to provide."

Asked whether there were language difficulties when she was working at the Home, Mandy Spencer said this[148]:

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[140] See Day 14 page 134 line 21.
[141] See Day 14 page 135 line 6.
[142] See Day 14 page 135 line 12.
[143] See Day 15 page 48 line 7ff.
[144] See Day 14 page 137 line 21ff.
[145] See Day 14 page 140 line 8ff.
[146] See Day 14 page 141 line 13.
[147] See Day 14 page 143 line 3.
[148] See Day 14 page 143 line 21.

> "Not when I was there. Towards the end we had a few supply workers who were Spanish but initially when I started there most of the care workers that I had working with me spoke English with the exception of a couple who only spoke a little bit of English, [they spoke] mainly Spanish but they understood English. So communication on some fronts was a little difficult."

She went on to say that the difference in culture was very difficult to get to grips with. Asked to explain what she meant by that, she replied[149]:

> "The difference in culture for me was ... really hard to quantify, but it's the culture that people go into bars, you take children into bars and restaurants. Where I come from you don't take children into bars and restaurants ... It's a much more open family oriented culture. It's quite an expressive culture, which I'm not used to. The switching between the languages I found a little bit difficult to get to grips with initially, until I started to learn a little bit of Spanish. But you know it was different, very different to what I was expecting."

She said that there had to be give and take on each side, so as to reconcile the two cultures and to ensure that a professional standard was maintained[150].
Asked whether there was a forum for discussion with members of staff while she was Manager, she replied[151]:

> "We would try and arrange management meetings, [but it was] not always easy to keep [to] those arrangements due to issues [that] would crop up, staff shortages, but we would try. And also there was support and supervisions, which again we would try and organise to discuss things as well. I would try and have a weekly meeting with my deputy; likewise my manager would try and have a weekly meeting with me to sort of catch up on how things were, if there were things we needed to look at, and things like that. Not always easy due to [the] conditions we were working in."

Asked about resistance to change on the part of some members of staff, she said that with hindsight the instances of such resistance seemed "quite small". She went on[152]:

> "When you are in that situation it is quite an uphill struggle to try and say: "I'm not doing this to be awkward. I'm doing this to try and improve our life." And it just seemed a fairly sort of steady barrage of: "Why do we need to do that? What do we need that for?" .... I felt after a few months that we were very much a Cinderella, particularly the respite end, we are very much a Cinderella service, and if you ignore us long enough we will go away. We had a lot of issues going on down there with the general environment and that. And you try and do the best you can with what you have. And all admiration to everybody, we all did that, and it was really hard. But you are then trying to bring that up with people who are already fairly sort of in difficult conditions, and they are like: "OK, why do we need to do that now?". And it's trying to maintain that status quo without sort of unlevelling [sic] it, but trying to improve the professional standards so we are taken seriously."

Asked whether there were specific members of staff who were resistant to change, or whether it was more of a general feeling, she said this[153]:

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[149] See Day 14 page 144 line 6.
[150] See Day 14 page 145 line 3.
[151] See Day 14 page 145 line 17.
[152] See Day 14 page 146 line 6ff.
[153] See Day 14 page 147 line 16.

> "It was an initially fairly general feeling. People didn't know me; I didn't know them. Perhaps they felt I was trying to do too much too soon, I don't know. But there was sort of a general unease around the place."

She went on to explain that the policies she was trying to implement were new policies, which had not previously been operated by Milbury. She said that when she started working at the Home "there wasn't a great deal there". She went on[154]:

> "There were no care plans; they had all gone. It seemed to be that there were [care plans], but they had gone missing. Likewise when I left the care plans were vanished again. This seemed to be a constant theme. So it's having to almost start over and redo things. .... It's like moving and handling legislation [that] had just come in in the UK when I came over, so we were trying to implement moving and handling techniques and policies to safeguard the staff, to bring [the Home] up to a UK standard, which was a new thing for staff. .... Maintaining and hanging onto the records didn't seem to be very good at that point in the respite end. Care plans and things in Flat 1 and Flat 2 were fine: they had those in place. They were far more settled units."

She went on to confirm that the missing care plans related only to respite users[155].

Counsel to the Inquiry then referred her to her description (in paragraph 5 of her 2006 witness statement [**C1/2/3**]) of the incident involving Nigel Bassadone on 27 January 2002, and to his being "either drunk or stoned". Counsel put it to her that in her report to the subsequent disciplinary hearing relating to this incident she had not mentioned the possibility that Nigel Bassadone might have taken drugs; and that in that report she had said that although he smelt of alcohol she did not think that he was drunk, although she could not be sure. He also put it to her that in her report there was no mention of Jennifer Garrett. He then referred to the minutes of the disciplinary hearing [**M15/4/4**], in which her oral evidence is set out, pointing out that once again there is no reference in those minutes to Nigel Bassadone being "stoned", or to Jennifer Garrett being pinned up against the kitchen wall (although Jennifer Garrett is mentioned in the first paragraph of the relevant part of the minutes [**M15/4/4**]).

As to whether or not Nigel Bassadone was "stoned" (an allegation which he denies), Mandy Spencer said this[156]:

> "His eyes when he was very close to me sort of shouting in my face were – his pupils were very wide and dilated and he had a very vacant look. Bearing in mind that I had been out with Nigel in a group socially on a few occasions, I had seen Nigel under the influence of alcohol, and his behaviour on the balcony was not what one would associate – it wasn't normal for Nigel, having had a couple of drinks. .... It was very, very different, and there was something not right about it. His eyes were very, very wide and starey and he was shouting in my face, and that to me was very – and there was only a faint smell of alcohol. It didn't feel right that his behaviour matched the amount that I could smell on his breath."

In response to questioning by counsel for Nigel Bassadone, she said this[157]:

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[154] See Day 14 page 148 line 9ff.
[155] See Day 14 page 150 line 11. She later qualified this evidence by saying that the care plan for Resident AE, (who lived permanently in the respite flat) also went missing: see Day 14 page 188 line 11.
[156] See Day 14 page 153 line 16ff.
[157] See Day 15 page 40 line 21.

> "It's a long time ago. I didn't know he was on prescription medication[158], if that's what you're asking. I didn't. If I had have done, I would have looked at things very differently."

As to her earlier evidence that Jennifer Garrett had been pinned up against the wall of the kitchen, in response to questions from counsel to the Inquiry she described her report as "a very quick, very brief statement to get down very quickly"[159]. As to her oral evidence at the disciplinary hearing, she said that the minutes contained only a very brief summary of her evidence. She confirmed that when she referred to Jennifer Garrett being pinned up against the kitchen wall, what she intended to convey was that Jennifer Garrett had her back to the wall, and that Nigel Bassadone was shouting at her from close range[160].

She said she had only recently discovered that Nigel Bassadone was given a first and final written warning for the incident (she had previously thought that it was merely a first written warning). She felt that he should have been dealt with more severely[161].

She went on to describe Nigel Bassadone as follows[162]:

> "He was a very reliable member of staff. He would turn up on time. He would do his work: he wouldn't go off sick. .... But he was very unpredictable on occasions as to what mood he was going to be in when either he arrived or if something happened during the day his mood would change quite drastically. .... [You were] never quite sure what you were going to get with Nigel. You know, he loved his job, he turned up, he worked very hard, but sometimes there would just be this anger, which was very hard to work with. So that's my reservation. He was a good member of staff, if I could have that one all the time, but we got these flashes of anger which made him very difficult to work with and very difficult to manage. So it was like two people for the price of one ... . It was very difficult to manage, to the point sometimes I felt it could be potentially dangerous to try and manage, because although it never bubbled over onto the residents, you know, would it bubble over and cause a situation? Thankfully while I was there no, it never did, apart from the one incident we had, but that unpredictability was very unstable to work with. .... You were never quite sure how to handle Nigel, to what kind of mood he was going to be in, to, you know, to keep that compassionate hardworking person you had got, without the explosions every now and then."

This evidence is consistent with her evidence to the February 2002 disciplinary hearing, where (according to the minutes [**M15/4/5**]) she said this about Nigel Bassadone:

> "[She] has worked with NB now for 15 months and [he] works hard, is efficient and extremely reliable. [She] said she'd rather have 2 or 3 people like NB. He also has a good relationship with Service Users. He shows anger when things are unfair for Service Users or himself."

When this passage was put to her by counsel for Nigel Bassadone, she replied[163]:

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[158] Nigel Bassadone's evidence is to this effect (see below). See also the minutes of the disciplinary hearing [**M15/4/5**].
[159] See Day 14 page 154 line 15.
[160] See Day 14 page 156 lines 6-11.
[161] See Day 14 page 158 line 15.
[162] See Day 14 page 160 line 6ff.
[163] See Day 15 page 28 line 16ff.

> "He did work hard, he did work hard, and I could have done with two or three people who had the same work ethic of turning up on time and working hard. His anger was what I found extremely hard to deal with. .... Things are unfair for people, but they don't express it in the aggressively angry way he did. That was extremely frightening for me."

She went on to say[164] that no one had complained to her about Nigel Bassadone's behaviour or temperament, although "you could see people shrink away from it". She said that she spoke to him about his anger, in particular on the occasion of the incident on 27 January 2002; and that she had mentioned his anger to management, but the response she was given was that everyone was very passionate, and that it was a "cultural thing". She said that she tried to work with it as best she could, and that she did not feel he was a danger to residents.

In response to further questions from counsel for Nigel Bassadone, she confirmed that she had never given him a verbal warning[165]. Asked by counsel whether possibly Nigel Bassadone was not as bad as she had described in her 2006 witness statement, she said this[166]:

> "I felt he was – possibly just towards me. I don't know. I felt it was towards me, because it was directed at Milbury. .... I saw the shrinking back in staff meetings, I saw, you know, people sort of being quiet when he got verbal. That's difficult to quantify when you want to speak to somebody about it. .... I'm sure other people did see it. They are probably unwilling to say they saw it. I know what I saw."

As to the incident itself, she said[167] that she was completely taken aback by it; that it took her by surprise; and that she had no idea how to deal with it, bearing in mind that she had only recently arrived in Gibraltar.

In response to questioning by counsel to the Inquiry, she confirmed her written evidence about the sacking of the carer called "Steve" who was drunk on duty, following a disciplinary hearing. She confirmed that this occurred during the Milbury era[168]. She said that she recalled another occasion when that same carer was "out cold in his flat and smelt heavily of alcohol"[169]. She confirmed that there were no other incidents of which she was aware during the period of her managership involving the consumption of alcohol by members of staff[170].

She went on to say this, about consumption of alcohol by members of staff[171] when out with residents:

> "No. I'm not saying they [i.e. members of staff] would consume it. They would bring back receipts. We had to take back receipts for everything, and a receipt would come back from a restaurant with "beer" on it. I would immediately look at this and say: "Who had the beer?", you know, was it a resident? Because obviously they don't itemise as to who had what, so I would want to know why there was beer on the receipt. Some of our residents in Flat 1 and Flat 2 were

[164] See Day 15 page 29 line 7ff.
[165] See Day 15 page 41 line 14.
[166] See Day 15 page 41 line 17ff.
[167] See Day 15 page 31 line 18ff.
[168] See Day 14 page 163 line 18.
[169] See Day 14 page 164 line 23.
[170] See Day 14 page 166 line 8.
[171] See Day 14 page 166 line 14ff.

> permitted alcohol, you know, they are adults, you know, if they are not on medication and they are adults, if they want half a lager, then they are within their rights to have half a lager. So I would ask who had the beer, and if the staff would say: "Well, I had a beer, but it was an alcohol free lager", it doesn't always state on the receipt it was alcohol free. So I had to trust them to a point that they were telling me the truth."

Mandy Spencer confirmed that when she referred to missing policies and procedures she was referring to missing care plans[172].

As to her reference in paragraph 9 of her 2006 witness statement [**C1/2/5**] to people being "split into distinct groupings", she said[173] that to her recollection:

> "... there seemed to be sort of different groups of staff sort of in little cliques or whatever."

As to her reference in that paragraph to "the group that is influential, manipulative and bullying, [the ringleaders of which] were Sharon, Nigel, Richard Muscat and others, with their ego followers, weak-minded people ... [etc.]" (quoted above), she said that possibly she had expressed herself a little too strongly[174]. She went on[175]:

> "What I meant ... was that you had people who were quite verbal, and you had those people who were possibly slightly less verbal [who] would go along with these people. .... Then you have got the other people, another group of people who seemed to want to distance themselves from that, who were willing to help. … They would ... really ... bend over backwards to cover your shortfalls in shifts and things like that, but they didn't seem to be [as] obstructive or verbal as the other group. And I think there were certain people in sort of the more verbal group who would take advantage of the fact that some members of staff were quieter, possibly less educated, and use that to their advantage."

When counsel to the Inquiry suggested to her that that would be normal in any workplace, she responded[176]:

> "It is, but I had never met it to the degree that I had met it there. Of course it's normal, it's normal where I work now, but it seemed much more distinct. I had never come across [it to] the degree that I met [in the Home]."

When it was put to her that the language which she was using in her oral evidence was much more moderate than the language she had used in her written evidence, she explained that in her written evidence she had expressed what she felt at the time (i.e. in 2002). She went on[177]:

> "I felt very strongly at the time: I don't feel as strongly now. .... I had been faced with working [in] increasingly difficult circumstances in a very problematic environment, and I just felt I was getting help from one side and objection from another side and that people were being dragged to one side or another. That's how I felt. I can't adequately describe it. You had to

[172] See Day 14 page 168 line 18 and page 169 line 19.
[173] See Day 14 page 170 line 7.
[174] See Day 14 page 170 line 16.
[175] See Day 14 page 170 line 19.
[176] See Day 14 page 171 line 12ff.
[177] See Day 14 page 172 line 6ff.

> be there to experience it. It's the only thing I can say. But that's how I felt in 2002."

Asked whether, if she had been satisfied that there had literally been bullying of one member of staff by another, she would have taken any action, she responded[178]:

> "If I could have obtained proof that I felt would sustain [sic] in a disciplinary I would have done, but a lot of it I felt ... was very subjective to picking up on people's strengths and weaknesses and playing to that, and there seemed to be ... almost a fear culture that people were unwilling to come forward... I did try to voice this concern to my managers, and I didn't get very far."

She went on to say that the stress of the job had made her ill, saying this[179]:

> "I had a constant feeling I was kind of swimming against the tide, trying to not even make things better, but keep things on an even keel .... and it was just the constant uphill struggle [that] was making me very tired, it was making me very stressed, and ... it was making me ill."

Mandy Spencer was then asked about the incident which she describes in paragraph 11 of her 2006 witness statement [**C1/2/6-7**], and in particular about the police investigation into missing medication at the Home. She said this[180]:

> "I think it was either myself or Sharon had collected the Ritalin prescription, and we had a procedure where when we got the new prescription we would count them in and make sure we had the correct amount. .... We had to make sure we had the correct amount for that sort of prescription worth of dose and the date [it] would go up to. It would be recorded. .... At that point the tablets were locked inside ... the little metal money tins you can get; they were locked inside that, inside the medication cupboard. So it was like a double lock procedure. When we went to check the tablets, ... we discovered there were some missing. So we did the double count again, and we still came to the same conclusion. There were some missing. So I then telephoned Duncan [Jones] and said we had discovered there were tablets missing. He came down and he double-checked. He came and did a double count with us and he came to the same conclusion. He then contacted Rod [Campbell] and we went through the procedure; implementing a formal investigation, which would start the next morning. Before we had a chance for that to take place, basically the police turned up on the doorstep at 9 o'clock the next morning saying that they had had an anonymous phone call saying that drugs had been going missing and they had suspicions that someone within staff had been taking them. The staff on duty were all sort of quite shocked and upset, and we were like: "Yes, I've reported to my manager that we had discovered some had gone missing yesterday", and they are like: "Well, can we come and chat to the staff that are on duty now ...? .... They asked us if they could have an informal chat with each of us, within the Home. I was interrogated for nearly two hours. I wasn't happy with that, because they said it was an informal chat. I wasn't cautioned; I wasn't told I was being investigated; I wasn't asked if I wanted ... any legal representation, et cetera. .... I was extremely upset when I got out of there, and I think it upset the other staff that were questioned by the police that day. We were all very upset by it. .... I have no idea what happened [subsequently]; they just left the building and we never heard anything since. We didn't even know if there was a follow-up for anything. They literally came in, made us all feel like rubbish, and left."

Asked whether they had improved medication procedures as a result, she replied[181]:

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[178] See Day 14 page 176 line 15ff.
[179] See Day 14 page 177 line 15ff.
[180] See Day 14 page 178 line 18.
[181] See Day 14 page 181 line 14.

> "We did. As a result of it, before that it was two people counting the medication in and out; after that it was only senior staff – i.e. a manager, a deputy or a senior support worker – and two of them had to count them in and out at each administration. So every time we gave the tablets they had to be counted how many there were before we administered, how many we took, how many there were, to make sure that [they] tallied up each time."

She was then asked about the incidents relating to Resident C, as described in paragraphs 12 and 13 of her 2006 witness statement [**C1/2/7-8**]. She said she was "quite disappointed" with Sean Matto's account of what had happened[182], and that she thought he should have done more than he did[183]. She went on[184]:

> "Common sense would tell me that if a large lump comes up on somebody's head and they look slightly lethargic, you would take them to get checked out."

As to paragraph 13 of her 2006 witness statement, she confirmed that the incident described in that paragraph happened in about 2003, after she had ceased to be Manager of the Home[185]. Asked whether she had lodged a complaint with management about this incident, she said[186]:

> "I didn't. I spoke to his mum. I spoke to Sean directly and sort of said ... : "I am not really happy with what you are telling me and I will need to tell his mum." So I spoke to his mum when she phoned that evening from Seville, and I told her. I don't know what his mum did after that."

As to paragraph 14 of her 2006 witness statement (in which she refers to missing rotas and missing petty cash), she confirmed that she was referring to the time when she was Manager[187]. Asked whether she had discussed the matter of missing documents with senior members of staff, she said this[188]:

> "Possibly. I couldn't recollect. I don't know. They would sort of go missing; they would turn up; they would go missing.... I am not sure whether they would drop down the back of things or whether they had been taken. I don't know. They would go missing for a couple of days and then turn up."

As to missing amounts of petty cash (she described them in paragraph 14 of her 2006 witness statement – quoted above – as "small amounts"), she said this[189]:

> "Oh, not huge amounts. It's very difficult to keep track of residents' petty cash. We would try and do our best. Obviously getting receipts for things is not always easy. Asking for a receipt from an ice-cream van at the beach is not something ... considered to be normal living. But small amounts. We had a man come in once a month to audit the respite books. He would check over them and make sure things tallied up, and he would point out to me that that they didn't always tally or that the sheet seemed to be rewritten all in one handwriting, and ask me why was

[182] See Day 14 page 182 line 7.
[183] See Day 14 page 183 line 9.
[184] See Day 14 page 183 line 11.
[185] See Day 14 page 184 lines 14 and 17.
[186] See Day 14 page 185 line 16.
[187] See Day 14 page 185 line 25.
[188] See Day 14 page 186 line 8.
[189] See Day 14 page 186 line 16.

> that. .... I would sort of say I don't know but I will try and find out. I would ask sort of if I recognised the handwriting of the rewritten sheet why it had been rewritten. They would normally say, the usual one was: "Well, it got a bit messy with mistakes on it, so we rewrote it out neatly. And no, the amounts of money were not large. It was sort of small, pounds, 50ps here and there, so it wasn't something you would notice on a grand scale, as it were."

She went on to say that this did not necessarily happen every week or every month[190].

Asked about paragraph 15 of her 2006 witness statement, she described Resident AE as follows[191]:

> "... Resident AE, he was quite overweight, and we had him on a fairly – not strict, strict diet but trying to reduce his weight for his own health benefits really; and as part of his behaviour he would demand, and part of his demanding is if he didn't get, he would then start thumping, break windows, break furniture. So we had a management strategy in place [which] was if he did his jobs without banging or destroying, then he would earn extra treats in addition to his sort of other bits and pieces during the day. So one of his things was he would, if you drove past Burger King or MacDonalds he would go "burger, burger" and start thumping the windows of the van. This is not an ideal way – if you were to give him the burger that's rewarding and reinforcing his behaviour. So he would earn a burger if he completed his Special Olympics swimming training, things like that. .... He had a balanced, varied diet according to his weight needs, with occasional treats. So a burger would be an occasional treat."

Asked about her reference to "bullying" in paragraph 17 of her 2006 witness statement [**C1/2/11**], she said she felt bullied on occasions, and that she was not used to being shouted at[192]. The example she gave was that of Nigel Bassadone, as to which she said this[193]:

> "Nigel had shouted at me. I had seen him shout at other people in staff meetings. I was not used to that. I felt quite intimidated by that on occasions. .... I don't think it was directed at me personally, ... but I still found that quite intimidating."

Counsel for Sharon Berini, Sean Matto and Richard Muscat put to her that she was the person in authority in the Home, and yet she said that she felt bullied. She replied that perhaps she was "just a sensitive person"[194].

Asked to explain what she would describe as "bullying", she said this[195]:

> "Bullying is a very personal thing and it's a perceptive thing. If you say something to me, you may not think you are being bullying, but it's how I perceive it. .... It's my perception of it. I may feel bullied by that though it may not be your intention. .... It may not be a conscious thing on that party, but it's how you perceive something as to how it makes you feel. It doesn't have to be a specific word or act, it's how something makes you feel, as to whether it's bullying."

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[190] See Day 14 page 187 lines 19 and 23.
[191] See Day 14 page 189 line 3ff.
[192] See Day 14 page 191 line 14.
[193] See Day 14 page 191 line 17ff.
[194] See Day 15 page 12 line 21.
[195] See Day 15 page 19 line 18ff.

Asked about staff meetings, she explained that staff meetings were voluntary, and that if members of staff were on duty on the day in question they would try to hold the meeting at a time when they would be able to attend. She said that the staff turnout was usually fairly good[196].

Asked about her reference to bullying in the context of staff meetings, she said[197]:

> "I would say [they were] aggressively putting [their] point. I have had staff meetings where people will put their point across assertively: I can put my point across assertively. [But] there is a line between aggressive and assertive."

Counsel for Sharon Berini, Sean Matto and Richard Muscat then asked her whether she thought that, in putting their points across in the way they did, his clients were "undermining the Home or trying to make it better" (echoing an allegation made by Joanna Hernandez in paragraphs 313 and 314 of her third witness statement to the Inquiry [**E/67/85-87**] – an allegation which I shall address later in this Report[198]). She replied[199]:

> "I think we were all trying to make it better, I just felt that they were undermining the way we were trying to do it. There were things that I had to do that I didn't like doing. I had to implement quite strict budgets. I didn't like doing it: they didn't like it. .... I didn't feel it was going to make the Home better, but I had no choice. ... I was made to feel like it was my personal decision to do that, and the backlash I had from that ... They weren't willing or able to accept that this was not my personal decision. I didn't like the decisions, some of them, I had to make. I still had to work with them. I didn't like them [i.e. the decisions she had to make]. And I agreed with them on that, but it didn't make it any easier."

She went on to agree with counsel for Sharon Berini, Sean Matto and Richard Muscat that, notwithstanding these difficulties, their hearts were in the right place[200]: i.e. that they had the interests of the Home at heart. She later described this as "the bottom line", saying[201]:

> "We were all out to try and improve the Home, at the bottom line."

As to Sean Matto, she said this[202]:

> "I'm not very good at explaining – to find words that fit what's in my head is very difficult. Sean had the knack of being manipulative and using large words ... with people who didn't necessarily understand the large words that he was fortunate enough to learn in his education. .... I don't discredit his education; some people aren't as fortunate to have that education. I felt that was quite manipulative. But in the sense that he would then go along with other people if he felt it would further his cause, so he could ... progress his career."

Asked by counsel to the Inquiry whether, during the time that she was Manager, any member of staff had complained of bullying by another member of staff, she said this[203]:

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196 See Day 14 page 192 line 8ff.
197 See Day 15 page 13 line 5ff.
198 See Chapter 8.
199 See Day 15 page 13 line 12ff.
200 See Day 15 page 14 line 11.
201 See Day 15 page 16 line 18.
202 See Day 15 page 16 line 5ff.

> "Not direct bullying. .... No. If I can clarify, it just seemed to be very much an undercurrent. ... In staff meetings, if certain people started sort of putting ... you could see people shrinking back. It's extremely difficult to quantify; you really had to be there to feel it."

As to paragraph 18 of her 2006 witness statement, she confirmed that the evidence in that paragraph is entirely based on hearsay, but she was unwilling to divulge to the Inquiry the identity of her informer[204].

As to paragraph 19 of her 2006 witness statement, she said that her evidence that it was Sharon Berini who had taken the decision that Resident Z did not need medication was likewise based on hearsay[205]. Later in her evidence, she said that she had told her informer that she could not get involved as she no longer worked at the Home[206], and that she was surprised to be told that it was Sharon who had taken the decision, as "it didn't seem like her at all, in all fairness to her"[207]

She went on to say that, having heard about the other incident described in that paragraph (involving Resident Z), she had taken Jordan Davis (whom she described as "a very, very inexperienced member of staff on duty"[208]) into her office and asked him about the incident in question[209]. She had heard of the incident from Debbie Guinn (an SSA carer, later the senior SSA carer) who had been telephoned by Resident Z's mother (Denise Evaristo). Denise Evaristo had complained to Debbie Guinn about it. Mandy Spencer continued[210]:

> "So I then spoke to Jordan and Jordan said that he had been given this advice, information, to put the books on by Nigel."

Asked by counsel to the Inquiry whether she had spoken to Nigel Bassadone about it at the time, she said that she had not[211]. Asked why not, she said[212]:

> "After I spoke to Jordan, he was deeply upset that it had occurred. Like I say, he had only been with us a couple of months, he went and apologised to Denise [Evaristo] and to the child and to the child's [grand]mother [Emilia Bruzon], and I went and spoke to Denise and asked her if she wanted me to take any further action, and she was happy with the apology so I took no further action."

Asked whether it had occurred to her that if Jordan Davis had been instructed to take the action he did by a senior care worker like Nigel Bassadone, she should speak to Nigel Bassadone about it, she replied[213]:

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[203] See Day 14 page 192 line 19ff.
[204] See Day 14 page 194 line 6.
[205] See Day 14 page 195 line 12.
[206] See Day 15 page 24 line 24.
[207] See Day 15 page 25 line 2.
[208] See Day 14 page 194 line 19.
[209] See Day 14 page 195 line 2ff.
[210] See Day 14 page 195 line 8.
[211] See Day 14 page 195 line 20.
[212] See Day 14 page 195 line 22.
[213] See Day 14 page 196 line 7.

> "Possibly, I possibly got distracted and didn't, I don't know why."

Asked whether, in retrospect, she thought she should have spoken to Nigel Bassadone, she replied[214]:

> "Quite possibly, yes. But Denise was happy that it wouldn't happen again, Jordan was adamant it would never happen again. I showed Jordan the care plan. I had never seen Nigel do anything like that prior. So perhaps I should have done, yes, but for some reason, whatever, I don't know, I didn't."

Asked by counsel to the Inquiry about her statement in paragraph 21 of her 2006 witness statement that Sharon Berini had a background of bullying and being "manipulated grossly" by Nigel Bassadone, she said this[215]:

> "I felt she was being manipulated by Nigel at the time. They were going through quite a difficult break up[216], and on occasions she would come in quite upset, and feel that he was trying to manipulate her, or using their children."

Asked whether she was suggesting that Sharon herself was guilty of bullying, she said this[217]:

> "'Bully' is not the right word. She would ... try and manipulate. I think it was possibly self-preservation, I don't know. .... Again, it's so difficult. You had to be there to feel it. .... There was the undercurrent of trying to bring people round to her way of thinking, or to Nigel's way of thinking, for – I don't know – a quiet life to make her life easier because she was going through quite a difficult break-up."

Asked whether Sharon Berini made her job of managing the Home more difficult, she replied[218]:

> "Towards the end, a little bit. She used to be really, really supportive and helpful, we got on really well. But I felt sort of the last six to eight months things became ... a bit more strained. There was less support there. There was more questioning when I went to do things, whereas she would be supportive before. But it was more ... sort of ... more questioning, more obstruction there. So I just felt it had deteriorated."

As to her reference (in paragraph 22 of her 2006 witness statement [**C1/2/14**]) to Nigel Bassadone "taking tablets", she said this[219]:

> "That stems from the incident on the balcony when I felt he was not just drunk. I felt ... something caused that behaviour and that look that I saw in him, and the only thing I could think of was tablets or drugs of some description. I wouldn't know what. That's what I meant by that."

When it was put to her that (as was the fact) there was evidence at the subsequent disciplinary hearing that Nigel Bassadone had taken prescribed medication, she said that no one had ever

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[214] See Day 14 page 196 line 7ff.
[215] See Day 14 page 196 line 21ff.
[216] They ceased living together in 2002.
[217] See Day 14 page 197 line 3ff.
[218] See Day 14 page 197 line 18ff.
[219] See Day 14 page 198 line 11ff.

told her that; that she wished they had; and that had they done so she would not have suggested that he had been taking drugs unlawfully[220].

Asked about her statement (in paragraph 23 of her 2006 witness statement) that Nigel Bassadone "went through drug rehabilitation in UK for four weeks", she said that that was what she was told by Duncan Jones. She went on[221]:

> "Duncan said to me: "You will need to cover Nigel's shifts for four weeks". Naturally, I went: "Oh, why?" We were short staffed as it was. .... He said: "He is going to the UK for drug rehab for four weeks. This is highly confidential information; no one must know. If they ask, he has gone to visit his dad in the UK who is ill. The only people that will know are you and Sharon.". .... That's the information I was given."

When counsel to the Inquiry told her that (as was the fact) there was nothing about drug rehabilitation in Nigel Bassadone's personnel file (which was kept at SSA's Head Office in Governor's Parade), she said that that did not surprise her[222].

Asked by counsel for Nigel Bassadone about her statement (in paragraph 23 of her 2006 witness statement) that Nigel Bassadone had threatened members of staff and that they were "too frightened to say anything because of what he had threatened", she confirmed that this was what she had been told by the members of staff in question[223]. She went on[224]:

> "They gave me the information regarding the two incidents [i.e. the alleged misbehaviour on the trip to Lourdes in April 2001 and the incident on 27 January 2002]. .... I asked would they write it down, were they prepared to come to my manager with me, and they said no, if anybody found out, or if they found out (I am assuming they meant the people had named) found out that they had told me, they would make their life very difficult. .... That's what I meant."

In response to further questions from counsel for Nigel Bassadone, she said that she understood her informers to be implying that they had been threatened: that "they felt threatened" by him[225]. She agreed with counsel that in the circumstances her statement that Nigel Bassadone had threatened members of staff was a little "too hard"[226].

As to her statement (also in paragraph 23 of her 2006 witness statement) that Nigel Bassadone "is a dangerous human being", she said that that was how she felt at the time. She went on[227]:

> "I thought that he was dangerous on that one incident [i.e. the incident on 27 January 2002], but his anger was unpredictable. It was difficult to work with, and that was dangerous to me. The unpredictability of his moods to me made him dangerous because you never knew what you were going to get. .... It made it difficult to manage ... That, to me, was a danger. .... I felt he was potentially dangerous".

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[220] See Day 14 page 198 line 21.
[221] See Day 14 page 200 line 2ff.
[222] See Day 14 page 201 line 9.
[223] See Day 15 page 33 line 10.
[224] See Day 15 page 33 line 1.
[225] See Day 15 page 33 line 23.
[226] See Day 15 page 33 line 25.
[227] See Day 15 page 34 line 14.

In response to further questions from counsel for Nigel Bassadone, she accepted that to describe Nigel Bassadone as "a dangerous human being" was "possibly a little loose". She went on[228]:

> "I think there were dangers there with his moods. Is that a better way of phrasing it? I don't know. .... I would prefer to have two or three of the hard-working calm Nigel; not the aggressive shouty Nigel."

Asked by counsel to the Inquiry about her statement (also in paragraph 23 of her 2006 witness statement) that "Sean [Matto] is very manipulative", she confirmed that that remained her view[229]. She went on[230]:

> "From my experiences with the residents, with the two incidents, he was quite – I don't know – blasé over the two incidents. Prior to that, when I used to work with him, he would like to use large words and terminology in describing things to members of staff who weren't as fortunate to have an education [like] he did, which I felt was a little intimidating and manipulative, because people don't like to own up that they feel daft that they don't understand, and that I felt to me was a little manipulative."

Asked whether she could rely on the senior members of staff, she said initially she relied on Sharon Berini, whom she described as "very good", but that during the last six to eight months of her time as Manager she felt that "things deteriorated"[231]. She went on to say that she felt that Richard Muscat was "there for himself", but that she could rely on Michelle Garro[232].

Gayle Everest

Gayle Everest started working in the Home on 19 November 2003 as a supply Support Care Worker. On 19 May 2006 she was employed full-time by the SSA as a Support Care Worker. She ceased working at the Home in about 2010[233], and went to work at the Jewish Home.

Gayle Everest made a signed statement in June 2005 at the request of Joanna Hernandez [**E/47/3**][234]. I will refer to this statement as her "June 2005 statement".

Her June 2005 statement began:

> "Re Complaints
> As per your instructions on Saturday 11th June 2005, please see below a list of complaints from myself regarding Miss Sharon Berini."

[228] See Day 15 page 36 line 2ff.
[229] See Day 14 page 201 line 13.
[230] See Day 14 page 201 line 15.
[231] See Day 14 page 202 line 14.
[232] See Day 14 page 202 lines 21 – 23.
[233] See Day 11 page 5 line 12. She was not entirely sure of the date.
[234] As related in Chapter 10.

She went on to say that on 21 July 2004 Sharon Berini had made a comment regarding her employment, saying: "We knew you were a Duo, but we never thought you'd be this much trouble"; and that on 30 March 2004 Sharon Berini had said to her, referring to an earlier conversation between Sharon Berini and another carer who had asked if she could work some shift on Resident Z's team: "God, I don't know how I didn't laugh in her face". She went on to describe (among other things) alleged occasions when Sean Matto changed her shift at short notice and without explanation, and to an alleged occasion when she was told by Kirushka Compson that Nigel Bassadone had retrieved a resident's passport saying that he was going to use it for another resident.

I turn next to Gayle Everest's witness statement to the Inquiry [**E/13/1**].

In paragraphs 7 to 10 of that witness statement [**E/13/2**] she says this:

> "7. At the outset of my employment, I perhaps did not set off on the best start, as I refused to tolerate poor or inadequate treatment of the Service Users and did make my position clear to staff and management alike and confirmed that I would make complaints about staff who acted unprofessionally or inappropriately with Service Users.
>
> 8. It was apparent that there was a segregation of staff and Service Users and a complete lack of care plans and strategies for assisting and progressing Service Users to allow them to progress. I also considered many of the ways staff treated the Service Users was institutional, draconian, degrading and denied them one of their basic human rights, being the right to dignity.
>
> 9. I would like to express that my concern throughout my employment has at all times been to act in the best interests of the Service Users, rather than to form friendship or alliances with staff members. I perceive that my job is to be a good employee within a team, however [to] act impartially, effectively and professionally. Nevertheless, it seemed that management appeared to encourage or condone friendship among staff, with some staff members dating others and being good friends outside the workplace, which I considered inhibits the necessary impartially and professionalism within the Care Agency/SSA. As a result of this, I did bring many issues to the attention of management where I considered this was causing harm or detriment to Service Users.
>
> 10. Unfortunately, this has caused me detriment in my career with the SSA, as I am considered to be outspoken and not a team player. Whilst this would not necessarily concern me provided it caused no harm to the Service Users, it has provoked many staff complaints against me personally, rather than my professional abilities."

Gayle Everest exhibits a number of documents to her witness statement, including documents relating to an incident which occurred on 8 October 2004, where she is alleged to have pushed a female resident, Resident AB, to the floor. The incident was apparently reported to Michelle Garro (a witness in Group 4) by another carer. Michelle Garro in turn discussed the incident with Gayle Everest. In her written note of this meeting with Gayle Everest [**E/13/13**], Michelle Garro quoted Gayle Everest's own account of the incident, as described by her in Resident AB's Report Diary. In the Report Diary, Gayle Everest describes the incident as one where Resident AB had been hitting Resident AA (a male resident) several times during the day, and Resident AB had "thrown herself to the floor". According to the entry in the Report Diary, Gayle Everest then fetched a chair for Resident AB to help herself get up from the floor. Michelle Garro's note of her meeting with Gayle Everest concludes:

> "I also mention[ed] to Gayle that she seemed to be detaching from teamwork and looked angry most of the time for the past few weeks as [the] following changes [sic] had been complained of i.e.: not joining in house chores, not communicating much with carers and ... [At this point some words are missing from the text of the photocopy provided to the Inquiry] ... could do more for themselves and was also very concerned [about] a client residing in flat 1 that was not respecting carers as he was swearing most of the time and this was of great concern to her. I did not totally agree with this comment [about] clients not doing house chores as clients do help around eg: Ironing, Sweeping, Baking, cleaning the table after meals and putting away dishes in the dishwasher and clearing the dishwasher when ready. But I told Gayle that with other chores they need a lot of support and development is slow."

Also exhibited to Gayle Everest's witness statement is a letter dated 22 November 2004 from Sharon Berini to Isabella Tosso, copied to Marie Gomez [**E/13/16**]. According to that letter, following her meeting with Michelle Garro, Gayle Everest telephoned Sharon Berini to tell her of the allegation that she had pushed Resident AB to the floor, and how upset she was at having been accused of such conduct. In her letter, Sharon Berini reports that Gayle Everest had come to see her that day about the allegation. The letter goes on:

> "I informed GE [Gayle Everest] that I did not know what the situation was as I had not received the allegation or any other report in writing and I could not do anything until I had all of these reports. GE expressed to me the fact that she felt very angry and vulnerable due to this situation and that she wanted to continue to work in Flat 2 but she did not want to be left alone with anyone. I informed GE that it would not be possible for her to work and not be left alone at some point with the residents. GE decided to cancel her shift that day on the 09.11.04 and her further shifts as she wanted to seek legal advice and did not want to work until the matter was resolved.
>
> Today when I spoke to GE she informed me that she did not want all of her shifts cancelled and demanded to know why I had done so[.] I replied that I had complied with her previous request[.] [S]he then became agitated. I further explained that her shifts with [Resident Z] had not been cancelled as she had again requested[.] [S]he then threatened me with legal action saying that she wanted me to put this in writing so that she could take this to her lawyer as she had had her shifts cancelled. I explained that this had been done due to her own expressed vulnerability at the above situation. I could not reason with her as she was angry and continuously challenged my position accusing me of lying. I feel that I acted in a professional and courteous manner and deemed her behaviour as inappropriate and I am raising my concerns to you for your consideration and recommendation. Joanna witnessed the conversation above and I confirmed with Joanna that I did not need to put anything in writing to GE to which she agreed."

Returning to Gayle Everest's witness statement, in paragraphs 15 to 18 [**E/13/3**] she says this:

> "15. .... I can confirm that on 8 October 2004, I was working in Flat 2, I believe on the day shift. In terms of the Service [Users] there are often times when the Service User[s] bicker amongst each other and this is more likely to occur when they are bored. In 2004 there was very little in the way of activities to prevent this amongst Service Users.
>
> 16. .... [T]he Service User, [Resident AB], had been bickering and hitting another Service User, [Resident AA], throughout the day. At the time of the incident, I re-directed [Resident AB] to her room ... to prevent another incident with [Resident AA], and in an act of defiance she threw herself on the floor. At this point [the other carer present, who reported the incident to Michelle Garro] attempted to intervene and offered to help [Resident AB] get up. I advised [the carer] that her assistance was not required as [Resident AB] was quite capable of getting herself up.
>
> 17. In circumstances such as this many staff often simply hoisted Service Users from the floor, causing pain to both themselves and the Service User.

> 18. I instructed [Resident AB] how to get up from the floor by following a known technique that is widely used throughout the UK in Manual Handling Procedures. .... Using this technique I aided [Resident AB] to get to her feet by placing a chair in front of her and showing her how to get herself up, which she did quite easily and without incident. I recorded this in [Resident AB's] diary, rather than the accident book, as this was not an accident and [Resident AB] was not hurt. It is likely that this information was also explained when the handover of staff took place."

On 25 November 2004 Marie Carmen Santos, the Human Resources Manager at the SSA, wrote to Gayle Everest informing her that her services were no longer required by the SSA and giving her one month's notice of termination of employment with effect from 27 November 2004 [**E/13/28**].

Gayle Everest duly carried out her threat to take legal advice. This led to a letter from Nunez & Co to Marie Gomez dated 29 November 2004 [**E/13/25**] complaining that on 22 November 2004 Sharon Berini had informed Gayle Everest that she had cancelled all her shifts and that she was no longer required to work at the Home, an act which Nunez & Co described as "tantamount to the unfair dismissal of our client". Nunez & Co asked for an explanation.

However, events overtook Nunez & Co's request, in that by letter dated 16 December 2004 Johann Fernandez, Crown Counsel, wrote to Marie Gomez [**E/13/37**] informing her that the SSA had not followed proper procedures in terminating Gayle Everest's employment, and recommending that she be reinstated. Marie Gomez accepted that recommendation, and by letter dated 22 December 2004 [**E/13/40**] she informed Gayle Everest that the SSA would not be seeking to enforce the notice of termination.

In paragraph 25 of her witness statement [**E/13/5**], Gayle Everest says that the incident has never subsequently been discussed with her, nor has it ever been formally investigated.

In paragraphs 26 to 29 of her witness statement [**E/13/5**], Gayle Everest turns to a written diary entry which she made on 14 July 2005 relating to Resident E (an adult female resident) The last sentence of the diary entry was drawn to her attention by the Inquiry team in the course of preparing for this Inquiry. It reads as follows [**M14/35/1**]:

> "[Resident E] also consumed x4 beers".

In her witness statement, Gayle Everest says:

- that it was not her role as a care worker to make decisions regarding the consumption of alcohol by residents;
- that the diary entry related to a group evening when residents and staff were present; and
- that she could not recall whether the beers which Resident E consumed were alcoholic or non-alcoholic.

She goes on to say this (in paragraphs 28 and 29 of her witness statement **[E/13/5]**):

> "28. However, [Resident E] is an adult Service User who has Downs Syndrome. Whilst we do monitor her and other Service Users[']drinking, we do not and should not prevent a Service User from making certain decisions, which they are free and able to make.
>
> 29. Whilst alcohol is permitted to be consumed by Service Users, I do not recall being informed or advised that this was not permitted. There were and are occasions when Service Users cannot use alcohol, such as in the event they are in receipt of medication for which alcohol is not compatible."

In paragraph 32 of her witness statement, Gayle Everest says this [**E/13/6**]:

> "32. Unfortunately, many staff members consider simply attending during their shift to be a completion of their work. Many, who either by virtue of the lack of systems or lack of training do not treat Service Users appropriately or indeed attempt to improve upon the Service Users[']quality of life. There is a complete lack of care about the dignity of the Service Users, this can be seen from the way in which the flats at the [Home] are set up. The Service Users have no privacy, or independence and this is not encouraged by staff or management."

In paragraphs 4 and 5 of her witness statement [**E/13/1**], Gayle Everest also refers to other matters which, in response to questioning by counsel to the Inquiry, she agreed had nothing to do with the Home[235]. I accordingly pass over that part of her evidence.

Asked by counsel to the Inquiry whether Michelle Garro's comment (in her note of her meeting with Gayle Everest, referred to above) that Gayle Everest "seemed to be detaching from teamwork and looked angry most of the time" was a justifiable comment, she said that she could not change the way she looked[236] (i.e. that the comment was not justified). She went on to deny that she was "a bit of a loner", albeit she described herself as "a bit stern, ... a bit maybe forthright"[237].

Asked by counsel to the Inquiry about the final paragraph of Sharon Berini's letter to Isabella Tosso dated 22 November 2004 (quoted above), in which Sharon Berini said that she felt she had acted in a professional and courteous manner, Gayle Everest denied that[238]. Asked about her decision to take legal advice, she said that she wanted to protect herself from further allegations[239].

Asked by counsel to the Inquiry about the reference in the diary entry for 14 July 2005 to Resident E's consumption of four beers, she confirmed that she could remember the occasion[240]. Asked whether she regarded four beers as excessive for Resident E, she said[241]:

> "For this service user, no. .... I probably should have been a bit more clear and classified it, whether it was just beer or a mixture of beer and non-alcoholic. .... The receipt would tell me what exactly type of alcohol it was. .... For this particular service user, I think today she still consumes alcohol. She is an adult, and she's entitled to drink. .... We're probably talking about

[235] See Day 11 page 5 line 8ff.
[236] See Day 11 page 8 line 1.
[237] See Day 11 page 8 line 3.
[238] See Day 11 page 9 line 23.
[239] See Day 11 page 11 line 1.
[240] See Day 11 page 14 line 16.
[241] See Day 11 page 15 line 10ff.

> ... the small bottles of beer, because she would like to walk around with it, and that's how she conked me on the head, and that brought the evening to a close!"

Asked what was the policy in the Home about consumption of alcohol by residents, she replied that "there wasn't one"[242], adding that it was "possibly" a matter of discretion for the carer. She said that, absent a policy, it was down to her judgment; and that she would "play it by ear"[243]. Asked whether residents could help themselves to alcohol when she was working in the Home, she said[244]:

> "When I was last there ... it was kept in the fridge. So if you wanted to, yes, you could technically go up and if you needed to open it, you would hand it to me, and I would quite happily open it for you."

She went on to clarify that statement by saying that[245]:

> "... if there [are] things like medication crossovers and stuff like that, ... you are advised or you know not to give too much."

Gayle Everest's evidence that when she worked at the Home there was no policy in place in relation to consumption of alcohol by residents prompted the recall of Carlos Banderas to clarify the current position in that respect. I will consider his evidence later in this Report[246].

Counsel to the Inquiry then referred Gayle Everest to an email dated 16 July 2009 from Maurice Valarino (the father of Resident X) to Iain McNeil [**O8/192/1**] complaining about Gayle Everest's abrupt manner and curt tone when dealing with him in front of his son. Counsel to the Inquiry asked her whether it would be fair to say that she could be a little abrupt on occasion, to which she replied[247]:

> "I am sure anyone can, so I would say yes, of course."

She went on to say that she had been criticised "constantly" for being abrupt[248].

Asked whether she was still maintaining the serious allegations which she makes in paragraph 32 of her witness statement (quoted above), and if so why, she said this[249]:

> "I think because of the structure, the way that the system is set [up], there is no ability for the service user to maintain or to be able to have a ... normal kind of existence, ... be able to go out to work, how do they get their money, how do they spend their money and how do they go about making friends, having a life that is worth living."

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[242] See Day 11 page 16 line 10.
[243] See Day 11 page 17 line 18.
[244] See Day 11 page 18 line 3ff.
[245] See Day 11 page 18 line 16.
[246] See Chapter 15.
[247] See Day 11 page 19 line 22.
[248] See Day 11 page 19 line 25ff.
[249] See Day 11 page 31 line 6ff.

She went on to make it clear that she was complaining about the management structure, rather than particular members of staff[250]. As she put it[251]:

> "It's not the workers. The workers are doing the best they can with the tools they have."

She went on to say that she did not accept that some degree of restraint or restriction in relation to the conduct of residents was inevitable in their own best interests[252].

She confirmed that she had no direct experience of the current situation at the Home[253].

Asked by counsel for Sharon Berini about the incident when she was alleged to have pushed Resident AB to the floor, she agreed that no written report of the alleged incident had been made to Sharon Berini, and described the allegation as "just gossip"[254]. Counsel then asked her what she expected Sharon Berini to do about it in those circumstances. She replied[255]:

> "To be able to stamp out gossip. Part of the problem is when you are working with different people who have different perspectives, they can say: "Oh, Gayle's done this, Gayle's done that". I don't want that. I want people to be able to say ... unless you've got proof, then you need to shush [i.e. keep quiet]."

Counsel then referred Gayle Everest to Sharon Berini's letter dated 22 November 2004 to Isabella Tosso (quoted above) and suggested to her that Sharon Berini's decision to, as he put it, "take [her] out of that environment" was a good management decision. Gayle Everest agreed that[256];

> "There could be an argument to say, yes."

Counsel for the Gibraltar Disability Society referred her to her statement that residents tended to be grouped together and invited her to give examples of what she meant. She gave as an example the fact that towels and shower products were not assigned to particular residents[257]. Counsel then suggested that another example might be an occasion when a resident might wish to go on a particular outing and there were difficulties in providing staff for that. Gayle Everest replied[258]:

> "Again, that's a form of structural institutionalisation. You don't have the bodies [i.e. the staff] to be able to do that activity, so the service user suffers."

[250] See Day 11 page 32 line 21.
[251] See Day 11 page 34 line 6.
[252] See Day 11 page 33 line 10ff.
[253] See Day 11 page 34 line 23.
[254] See Day 11 page 36 line 5.
[255] See Day 11 page 36 line 9.
[256] See Day 11 page 36 line 24.
[257] See Day 11 page 37 line 18.
[258] See Day 11 page 38 line 10.

Counsel for the Gibraltar Disability Society then asked her, with reference to the incident when she allegedly pushed Resident AB to the floor, whether Resident AB had a problem with communication. She replied[259]:

> "No, not at that time. She spoke mainly in Spanish. The problem would have been me. I don't speak Spanish."

Denise Hassan

Denise Hassan worked at the Home from 1999 to 2005 as a support worker. She gave written and oral evidence to the Inquiry.

She made a signed statement dated 13 June 2005 at the request of Joanna Hernandez [**F/23/7-11**][260]. I will refer to this statement as her "June 2005 statement". She did not make a witness statement in the Industrial Tribunal proceedings, but she made a witness statement to the Inquiry [**F/23/1**]. She also gave oral evidence.

Her June 2005 statement began as follows [**F/23/7**]:

> "As you requested after our conversation, here is a report on some of the instances of mal practice [sic] that I have unfortunately either witnessed [or] been involuntarily involved in."

She went on to describe how her "outgoing personality" had changed due to the "situations and stresses" which she had had to endure in her work, saying that this change had "mostly been provoked by the behaviour and practices of the present Deputy Manager" (i.e. Sharon Berini). She said that "an accumulation of years of being belittled and made to feel as if [she was] worthless and unworthy that [had] brought [her] to [a] moment of desperation and frustration". She went on to refer in general terms to staff being "victimized and marginalized". She then listed a number of instances which, she said, showed the "inconsistent approach of the Deputy Manager when dealing with unacceptable behavior [sic]". She went on:

> "It also proves how she tends to protect certain employees whilst being really strict with others. It proves how she has a few allies (mainly 3) who she always defends makes sure they always get what they want in exchange for their support and their loyalty."

The first such instance was an alleged occasion when Sean Matto left his shift, when he should have been caring for Resident AE. Denise Hassan said that when she told Sharon Berini about this, Sharon Berini advised her "not to tell anybody" as she would be speaking to Sean Matto later about it.

The second such instance was an alleged occasion when Nigel Bassadone asked her to leave Flat 3 as he had arranged for a lady friend (not a member of staff) to visit him in the flat. She said

[259] See Day 11 page 38 line 24.
[260] As related in Chapter 10.

that she did as he asked, as he was "not the kind of person that you challenge". She said that she decided not to report the incident, as Nigel Bassadone "always gets away with everything as he is protected by Sharon". She went on to say that she was scared to report it, in case she was victimised "for having told on the senior's partner".

The third such incident was the incident on 27 January 2002 described in paragraph 5 of Mandy Spencer's 2006 witness statement (see above). Denise Hassan described it as follows [**M24/1/2**]:

> "I was working a night shift (sleep-in) with Yvette Gonzalez at Flat 2 one night; when at about 7am Nigel Bassadone popped his head through Flat two's kitchen window. He looked under the influence and was quite eager to come in to the flat. Yvette Gonzalez let him in. He took off his clothes, covered himself with a quilt and went to sleep in Flat two's sitting room. At that stage I left for Flat Three as I preferred not to be part of that kind of practice or [behaviour]. I remained at Flat Three for the remainder of my shift. However, at about 9.00am Sharon [Berini] arrived at Flat Three. Shortly after she informed me that she had to rush to Flat 2 as Nigel was there and she had to attend to an incident involving him. A few minutes later I received a call on my mobile from Sharon who told me to try and keep Mandy [Spencer] (manager at the time) occupied by speaking to her and to not let her come into Flat 2 as she was having big problems with Nigel at the Flat and she didn't want Mandy to see it. I tried to do as my senior requested but I think Mandy sensed that there was something going on and she left for Flat 2. I am not able to give a first hand account of what happened at Flat 2, but I witnessed how after a while, Nigel left Flat 2 via the kitchen exit followed by Mandy who was advising him that he could not work in the state he was in. Mandy asked Nigel to leave the premises and return the following day. Nigel then turned and shouted verbal abuse to Mandy (manager) and then left. Although I was not present in ... Flat 2 when all this happened, the people involved in the incident, mainly Yvette Gonzalez and Angelica Williams told me that Nigel had been helped into [Resident E's] bed ... by Sharon Berini and Yvette Gonzalez. In order to do this [Resident E] had been dragged out of bed. Further to this, what I found quite disturbing was the fact that Yvette said that between herself and Sharon Berini they had had to dispose of some cocaine down the toilet that Nigel had left [in] the sitting room beside the sofa where he had been sleeping Yvette also spoke about how Nigel was verbally and physically abusive towards Sharon. According to Yvette, Nigel seemed to be high on drugs, jumping on top of kitchen tops and kitchen furniture shouting and using abusive and offensive language. I am unsure of how that incident was dealt with after that. But I can assure you that no one expected Nigel to return to work after that incident. It was quite surprising that Nigel continued to work without any kind of disciplinary [action] taken against him. I can also add that it was common knowledge that the people involved in the incident openly said that they had helped to cover for Nigel when they were asked for the report."

The fourth such incident was an alleged occasion when Sharon Berini asked her to go on night shifts because her sister Angelica Williams preferred day shifts. Denise Hassan went on [**F/23/8**]:

> "I felt powerless to argue this point as Sharon and Sean seemed to act together in what seemed like little plots to help some and cause distress for others."

She went on to describe a similar alleged incident when Nigel Bassadone was advised by his doctor to take a break and was given special leave to go to the UK. On his return, Sharon Berini told her to go on night shifts once again "as Nigel wanted to do the day shifts".

Denise Hassan went on to complain that there was "an imaginary black list and another with people who seemingly always get all the benefits", and that she had "learnt first hand what bullying means". She continued [**F/23/9**]:

> "Fortunately, all of my insecurities and anxiety improved when we had a change of Manager. I was able to sit down with Joanna Hernandez (Manager) and get the support from her that I had lacked for so long. Joanna told me that although she could not comment on what had happened to me in the past ... she reassured me that under her management everybody would be treated equally and fairly. She told me that I had to start afresh with Sharon, and that I should give her another chance. This I did willingly as I felt extremely reassured and supported by her."

However, she went on to say that whenever Joanna Hernandez was away, Sharon Berini would become the same "cold, abrupt person who we all knew her to be", and to give examples of this. She described Sharon Berini as creating "animosity". She also complained of staff shortages [**F/23/10**].

She went on to list six more incidents [**F/23/11**], saying that Sharon Berini had lied when she said that she had not given her permission to escort Resident AA to Cadiz Hospital; that Sharon Berini had given preferential treatment in relation to shifts to her sister Angelica Williams; that Sean Matto had insisted on her (Denise Hassan) coming in to carry out her shift when her aunt was dying; that there were "major money discrepancies" in Flat 3, with money missing"; that Sharon Berini "showed total indifference" when told about that; that Sharon Berini had "orchestrated" changes in the rotas "seemingly to create chaos"; and that Sharon Berini had shown favouritism towards Nigel Bassadone when it was proposed that he join Resident AE's team in Flat 3.

She ended her June 2005 statement by saying that her list was not exhaustive.

I turn next to Denise Hassan's witness statement to the Inquiry [**F/23/1**].

In paragraph 6 of her witness statement, she says that she has no additional information to add to her June 2005 statement. Notwithstanding that confirmation, however, she goes on to address a number of further matters.

Referring to the List of Issues (Annex 2 to this Report), she says this (in paragraphs 10 to 19 of her witness statement [**F/23/2**]):

> "10. Issue 1 & 2 – Management did not provide sufficient support for the care workers in general.
>
> 11. Issue 3 – When I was employed by the [SSA] to work at the [Home] I felt that I was not prepared to take on the job. At the beginning, I was not provided with any training. ....
>
> 12. In relation to issue 4, I felt that the staff at the Home were not sufficiently trained, organized, supervised nor appraised.
>
> 13. Issue 5 – I recall that some pages used to go missing in the daily reports and they used to be ripped out. This however did not happen regularly.

> 14. Issue 6 – I do not recall many seniors using care plans. When management changed, Morag Jack started to implement care plans.
>
> 15. Issue 10 – The physical facilities in the Home such as bathrooms at the beginning of my employment were not satisfactory but they did improve.
>
> 16. When Joanna Hernandez started in the Home, I felt that she implemented many procedures which improved the Home.
>
> 17. Issue 13 – I recall that everyone used to distribute the medication to the residents, when we were not trained for it. It was my responsibility to do this, even though we requested that a nurse be employed to do it. On numerous occasions controlled drugs used to go missing, such as valium and [Ritalin]. When medication used to go missing, there was no procedure to report it.
>
> 18. Issue 14 – In so far as respite and Merlot House were concerned, the conditions of hygiene were disgusting. This was even reported to Sharon Berini and nothing was done.
>
> 19. Issue 15 – I was aware that [Resident AE] had a time out room with a little light bulb and a small window. In his bedroom there was only a mattress on the floor and there was no other furniture in the room. The time out room had a lock and they would lock him in. Kelvin Ball used to have the key and was in charge of the room. [Resident AE] would remain in the time-out room until he calmed down, for roughly 20 minutes."

In paragraph 20 of her witness statement [**F/23/3**], Denise Hassan makes a serious allegation of abuse of a resident (Resident N: a male resident), saying this:

> "20. In Christmas 2003, I recall seeing Manolita Adamberry and Yvette Borastero Gonzalez trying to arouse [Resident N] and used [sic] to grab his bottom. Also, Manolita went into his room and lay on top of [Resident N]."

In paragraph 21 of her witness statement [**F/23/3**], Denise Hassan describes an incident when another resident (Resident Y: a male resident) suffered scalding on his foot when the carer, Karinda Durante (Denise Hassan gives her name as Karinda Duarte), ran a bath in which the water was too hot and then (according to Denise Hassan's account) tried to cover up her mistake. It appears that she was reprimanded following a disciplinary hearing.

In paragraph 22 of her witness statement [**F/23/4**], Denise Hassan recalls an occasion when she overheard two carers "joking" with Resident Z, saying that if he continued to misbehave they would "stick his head in the freezer".

In paragraphs 23 to 26 of her witness statement (the concluding paragraphs) [**F/23/4**], she says this:

> "23. Regarding all the above incidents I would say that senior management was well aware but would not deal with these incidents. On the contrary, they would tell us to write a report which would then go missing. When we would want to speak out we were told to keep quiet for fear of repercussions.
>
> 24. As a recurring theme, petty cash would never balance. Receipts would go missing, there was an imbalance in the distribution of petty cash to different residents and no explanation was given. In some of the residents[']flats, when money was required for any outing the residents[']

> personal funds would be used as opposed to petty cash. This was more common with the residents and staff members of flat 2.
>
> 25. I recall that some care workers used to come to the Home drunk and on occasions came a couple of hours before to their shift to sleep until their shift started. I cannot recall who this was[261]."

In paragraph 26 of her witness statement [**F/23/4**], she describes an occasion when Sean Matto was absent from his night shift. However, in oral evidence she said that this occurred some time during 1999[262]. That being so, I need not investigate that matter. The same applies to her allegation (in her June 2005 statement) that Nigel Bassadone arranged for a lady friend to visit him in the Home. In oral evidence she said that that occurred some time during 2000[263].
As to the level of support provided by managers, she said[264]:

> "We couldn't go to them and say anything."

As to her comment on Issue 15 (see paragraph 19 of her witness statement [**F/23/3**]), she confirmed that her evidence about Resident AE's time-out room related to a time prior to 2002.
In the course of her oral evidence, Denise Hassan accepted that she had no direct knowledge of the incident on 27 January 2002 involving Nigel Bassadone[265].

In answer to counsel to the Inquiry, she said that when the incident occurred she was working in Flat 3[266].

In answer to counsel for Nigel Bassadone she explained that on the night of 26/27 January 2002 she was "on nights" (i.e. 9pm to 9am)[267], but that on that particular night she was in Flat 2 on a "sleep-in" (i.e. she was available to assist if required) which ended at 9am[268]. She went on to say that Nigel Bassadone arrived at the Home at about 7am, took off his clothes and went to sleep in the sitting room in Flat 2[269]. As to her statement (in her June 2005 statement quoted above) that "at that stage [she] left for Flat 3", she said that she "had to go to Flat 3 to work", as she getting ready to start a day shift (i.e. 9am to 9pm) in Flat 3. She said she went to Flat 3 at 7am and stayed there[270].

Counsel for Nigel Bassadone then put to her the passage in Mandy Spencer's report dated 27 January 2002 [**E/2/20**] (quoted above) where Mandy Spencer reported that she "managed to

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[261] This may be a reference to the incident on 27 January 2002 involving Nigel Bassadone, referred to elsewhere in this Chapter. At all events, the only other reference to a "drunk" care worker in the evidence before the Inquiry is to be found in the Mandy Spencer's evidence about her Deputy Manager called "Steve" who was found drunk on duty, subjected to a disciplinary process and sacked (see above).
[262] See Day 7 page 59 line 9ff.
[263] See Day 7 page 59 line 20.
[264] See Day 7 page 56 line 22.
[265] See Day 7 page 61 line 23.
[266] See Day 7 page 61 line 15.
[267] See Day 7 page 85 line 10.
[268] See Day 7 page 85 line 24.
[269] See Day 7 page 86 line 7.
[270] See Day 7 page 88 line 21.

remove N. Bassadone from the situation down to the office in respite" (i.e. in Flat 3), contrasting it with Denise Hassan's statement (in her June 2005 statement quoted above) that she witnessed how, after a time, Nigel left flat 2 via the kitchen exit. Denise Hassan explained that Nigel Bassadone did not stay with her in Flat 3, but that she saw him coming down the corridor with Mandy Spencer, and that she overheard what Mandy Spencer said to him[271].

She said that reports were made about incidents occurring in the Home, but that Sharon Berini "used to just leave [them] on a side, because it was all to do with her boyfriend [Nigel Bassadone] working there, or with her friend"[272]. She went on to say that Sharon Berini and Manolita Adamberry used to tell her to keep quiet and not say anything "because if not, you will get into trouble"; that "they had their own little group"; and that she had stopped submitting reports because she had already been "victimised so many times ... and [was] afraid"[273]. She said that she had submitted written reports to Sharon Berini, but not to the Manager (until Joanna Hernandez came)[274].

Denise Hassan went on to assert (somewhat surprisingly) that she did not know about the subsequent disciplinary process which led to Nigel Bassadone receiving a written warning in respect of his conduct on the occasion in question[275].

She was asked by counsel for Manuela Adamberry about the incident relating to Resident N (who, she said, was in his forties at that time[276]) which is described in paragraph 20 of her witness statement, quoted above. She said that she was present when Manuela Adamberry and Yvette Borastero were[277]:

> "... playing around with him, fooling around, touching his bum".

Asked by counsel to expand on that, she said this[278]:

> "She [i.e. Manuela Adamberry] laid on top of him, on his bed ... and just started jumping up and down. .... She laid on top of him and she started moving. .... It was a really bad joke. It's like when you get involved with someone and you are in the bed with someone, that's how she was doing it."

She went on to confirm that Manuela Adamberry was (in the words of counsel) "mimicking a sexual act"[279]. She said that Resident N was "distressed"; that she was referring to a single incident; and that she was in the kitchen of the flat (Flat 2) when she witnessed it[280].
Asked whether she could do anything about it, she replied[281]:

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[271] See Day 7 page 89 line 9ff.
[272] See Day 7 page 63 line 8.
[273] See Day 7 page 70 line 3ff.
[274] See day 7 page 70 line 11ff.
[275] See Day 7 page 92 line 8.
[276] See Day 7 page 76 line 7.
[277] See Day 7 page 75 line 25.
[278] See Day 7 page 76 line 16ff.
[279] See Day 7 page 77 line 10.
[280] See Day 7 page 77 line 14ff.

> "I couldn't do anything ... because they always used to make fun of them, and they were all in a group, they [had] their little groups. .... If you would have reported to the senior [Michelle Garro] they wouldn't have done anything. They didn't want to know."

Asked why she made no mention of this incident in her June 2005 statement, she replied[282]:

> "I didn't think of it at the time. .... I decided not to include it [in the June 2005 statement] because it was too strong. .... It didn't come to my mind that day. .... I didn't remember it at the time."

Asked to clarify whether she had decided not to include it in her June 2005 statement, or whether she had not remembered it, she said that she "didn't remember it at the time"[283]. Pressed by counsel, she continued[284]:

> "At the time it was too much. I had too much on ... and I didn't remember it at the time."

Asked why she had remembered it some eight years later, when she made her witness statement, she said[285]:

> "Because when I went through it again, then it came ... to my mind."

She went on to say that she was suffering from depression at the time she made her June 2005 statement, and could not recall everything[286].

Asked whether it was not the case that Resident N had a tendency to grab the buttocks of female carers, she replied that she had never seen that[287]. However, she admitted that she had heard that Resident N used to touch women's buttocks, although she had never seen him do it[288].
She was then questioned by counsel for Yvette Borastero about the reference in her June 2005 statement (quoted above) to Yvette Borastero having told her that she (Yvette Borastero) and Sharon Berini had had to dispose of cocaine down the toilet that Nigel had left beside the sofa in the sitting room. Counsel pointed out that in none of the reports to the disciplinary hearing was this mentioned. However, Denise Hassan said that she could recall Yvette Borastero's exact words[289]. She later confirmed her account in answer to questions from counsel for Joanna Hernandez[290].

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[281] See Day 7 page 78 line 3ff.
[282] See Day 7 page 80 line 19ff.
[283] See Day 7 page 82 line 9.
[284] See Day 7 page 82 line 15ff.
[285] See Day 7 page 82 line 19.
[286] See Day 7 page 84 line 18.
[287] See Day 7 page 83 line 10
[288] See Day 7 page 84 line 8.
[289] See Day 7 page 94 line 2.
[290] See Day 7 page 107 line 16.

Asked by counsel for the GDS about her assertion (in paragraph 22 of her witness statement [**F/23/4**] that she recalled two carers joking with Resident Z that if he continued misbehaving they would "stick his head in the freezer", she said that she actually saw one of the two carers carrying out that threat[291]. She said that at the time Resident Z would have been aged "three, nearly four"[292]. However, counsel did not pursue the point on the basis that it appeared that this incident, if this occurred at all, must have occurred in the Milbury era: that is to say prior to the starting date for the Inquiry's investigation.

Elizabeth Harrison

Elizabeth Harrison was employed by the SSA in 1978 as an unqualified social worker. She is currently employed in that capacity by the Care Agency. She was involved with the Home from its opening in January 1994 until June 2011[293], save for the period from late 1999 until February 2003 when she was working with children.

Elizabeth Harrison did not make a witness statement in the Industrial Tribunal proceedings. However, she made a witness statement to the Inquiry [**F/6/1**], to which she exhibits an earlier statement which she submitted to the Inquiry team on 27 March 2013 [**F/6/7**]. She also gave oral evidence.

In her March 2013 statement (as amplified by her witness statement) she says that following Duncan Jones' resignation as Team Leader (with effect from 31 January 2004), Marie Gomez (then Acting Team Leader) asked her to organise the paperwork which had been left in his office. She says that in so doing she came across a report by a carer whose name she cannot recall which she found alarming, and which she handed to Marie Gomez. She says that she recalls that the report, which she believes to have been made in or around January 2004, referred to the following [**F/6/8**]:

- an unknown substance being put in the Manager's drinks;
- someone breaking through the false ceiling in the Manager's office and tampering with the petty cash;
- individuals interfering with the Manager's stocktaking by tampering with cleaning materials behind the Manager's back; and
- a carer deliberately damaging a car used by the Home so that a particular resident could be categorised as violent, with the consequence that the carer could claim an increased allowance and/or that the resident could be admitted to the mental hospital.

[291] See Day 7 page 104 line 9.
[292] See Day 7 page 104 line 23.
[293] See Day 6 page 122 line 17.

However, no such report has come to light, despite the extensive documentary searches made by the Inquiry team; nor has any direct or credible evidence of any of the above matters been presented to the Inquiry. In the circumstances, I make no further reference to them.

Elizabeth Harrison goes on (in her March 2013 statement) to describe how she and Marie Gomez went together to Bishop Healy, to inspect it. She continues [**F/6/8**]:

> "There were three residents at Bishop Healy. I went into one bedroom and was appalled at the condition. The bed was broken so they had resorted to placing another broken bed on top to balance it out. There was a duvet cover in the pelmet in place of curtains. The room was bare and [in] a sorry state, as to his bathroom.
>
> When I went into the kitchen I was again appalled, missing cupboard doors, beach tables in place of [a] kitchen table.
>
> I then went to the first floor where one of the managers had their office and saw the staff tea/kitchen area. Wooden kitchen table, fridge all looking very well kept."

Elizabeth Harrison goes on to say that she then inspected Flats 1 and 2. She described them as follows [**F/6/9**]:

> "... [T]hese two flats were well made up, but the senior care worker (now unit manager) [i.e. Gabrielle Llambias] very clearly told me that no one was going to tell her how to run her flat. I recall that at the time she took her dog to work, and there were dog droppings in the corridor[.] I pointed out that she should not bring her dog to work, but to no avail she continued to do so."

She went on:

> "I then met with Mr D Rodriguez and Ms M Gomez they explained the need to find a new manager for the [Home], both adding that the solution should be to close the [Home] dismiss all members of staff and start afresh a thing which could not be done, or the joke was that the new manager would have to go in with a machine gun.
>
> There was a need to find a person who would be strong [enough] to be able to cope with the situation, it was also stated that the new manager should not be working on her own, and it was suggested that I would be working closely with her/he at all times, should not be left on his/her own [sic]."

In the course of her oral evidence, Elizabeth Harrison initially said that she "[hadn't] got a clue what happened there pre-Joanna [Hernandez]: between Milbury and Joanna"[294]. However, she goes on to describe her visit to Bishop Healy. She explained that it was a former children's home which was being used by the residents as a temporary measure following flooding at the Home[295]. She went on to confirm her evidence about the conditions at Bishop Healy[296]. She also named the carer who (she said) brought her dog to work as Gabrielle Llambias[297].

[294] See Day 6 page 40 line 12.
[295] See Day 6 page 42 line 21ff.
[296] See Day 6 page 54 line 3ff.
[297] See Day 6 page 54 line 10ff.

Ave Gonzalez

Ave Gonzalez was a Team Leader at the SSA until March 2005, having been employed by the SSA for almost twenty years, with a sabbatical between April 2003 and December 2004. She made a witness statement in the Industrial Tribunal [**C1/5/1**], but did not respond to an invitation by the Inquiry team to assist the Inquiry. Accordingly she did not make a witness statement to the Inquiry, nor did she give oral evidence.

In paragraph 2 of her witness statement in the Industrial Tribunal, she said this:

> "2. On return from [sabbatical: i.e. in December 2004], I found the agency being run by Ms M. Gomez in an acting capacity. Her initial comment on receiving me into the post was that the Agency was in chaos. ...."

As explained in the Introduction to this Report, the remit of the Inquiry is limited to an investigation of the operation of the Home: it does not extend to a wider investigation of the operation or structure of the entire SSA. However, the above evidence is included in this review on the basis that the alleged reference to the Agency being in "chaos" includes the Home.

The remainder of her witness statement is not relevant to the period currently under review.

Douglas Rodriguez

Douglas Rodriguez retired as CEO of the SSA on 8 October 2004. He made a witness statement in the Industrial Tribunal [**C1/12/1**], but has not presented evidence to the Inquiry. He did not reply to a letter from the Inquiry team inviting him to assist the Inquiry.[298]
His witness statement consisted in the main of an account of the appointment of Joanna Hernandez as Manager, but in paragraph 10 [**C1/12/2**] he says this:

> "10. ... [T]he Agency had for some time had concerns about the way the [Home] had been managed in the past. One of the main concerns was that relating to discipline."

He returned to the subject of discipline in paragraph 14 of his witness statement [**C1/12/2**], saying:

> "14. I had an opportunity to discuss [Joanna Hernandez'] possible appointment as Manager before I retired. In this discussion I explained that whoever took up the post would be expected to deal with the matter of discipline which in any situation would not be easy."

His witness statement does not, however, go into any detail as to the particular issues as to discipline which he had mind when making the above comments.

[298] A letter sent to a Gibraltar address was returned. Despite efforts of the Inquiry team and the Care Agency no alternative address was found for him.

Jordan Davis

Jordan Davis made a witness statement in the Industrial Tribunal proceedings, but did not reply to a letter from the Inquiry team inviting him to assist the Inquiry.

His witness statement in the Industrial Tribunal proceedings [**C1/3/1**] contained a litany of complaints. He began by referring to what he described as "poor management and poor, disgraceful running of the [Home]". He complained:

- that management would promote equal opportunities for residents, but failed to take into account their opinions and worries;
- that Sharon Berini spent most of her time in her office and would not even greet residents or say good-bye to staff when finishing her shift;
- that reports involving members of staff went missing;
- that a pregnant member of staff (not named) was twice abused by other members of staff (not named);
- that there were irregularities with the petty cash and with rotas;
- that wages for certain members of staff were incorrectly calculated;
- that on one occasion Nigel Bassadone had a quarrel with Sharon Berini, and reacted with a "thump against a wall, nearly hitting the Senior, Denielle Gomez";
- that Nigel Bassadone was reported for that incident, but nothing was done about it;
- that he (Jordan Davis) was summoned to a disciplinary hearing in respect of a report he had written "detailing the irregularities and how the staff was being treated", and was told by Douglas Rodriguez that what he had written was unacceptable, "in other words to keep my mouth shut";
- that on occasions medication would go missing;
- that "lack of resources and most important lack of income" was a principal reason "why residents and respite users were not being provided with a 100% service"; and
- that during his time in the Home management was "not organised", had poor understanding of residents' needs, and was on the whole "very unprofessional".

CHAPTER 3: November 2000 to November 2004: Evidence (2)

Contents

CHAPTER 3: *November 2000 to November 2004: evidence (2)*

In this Chapter I review the statements made by the individuals in Group 2[299], each of whom made a statement in June 2005 critical of the running of the Home and/or of the conduct of other members of staff[300]. These statements ("the June 2005 statements") were made in response to requests emanating from Joanna Hernandez, in circumstances described later in this Report[301]. They are exhibited to the witness statement of Isabella Tosso in the Industrial Tribunal proceedings.

GROUP 2 Witnesses

Jonathan Dalrymple

Jonathan Dalrymple was interviewed by Joanna Hernandez and Denise Hassan on 11 June 2005. Minutes of the interview were written up by Denise Hassan [**C2/2/37-38**]. The minutes record that Jonathan Dalrymple stated as follows:

- that he had been asked by Sharon Berini and Sean Matto about a missing Ritalin tablet;
- that he explained that he knew nothing about the missing tablet;
- that he suggested that they should ask Nigel Bassadone, who was on the relevant night shift;
- that he suggested that he and Nigel Bassadone should be subjected to blood tests;
- that Sharon Berini said that that would not be necessary and that no further investigation would take place;
- that he was left with a feeling of despair as he could take no action, and
- that had someone other than Nigel Bassadone been involved, further investigation would have taken place.

Christian Santos

Christian Santos made a written statement which is signed but undated [**C2/2/32-33**]. He recounts occasions in December 2004 when Sharon Berini refused to change his shift. He says that he felt "frustrated, let down, ... vulnerable and shocked" at the way she had spoken to him.

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[299] See the introduction to Chapter 2.
[300] Gayle Everest and Denise Hassan, who are included in Group 1, also made statements in June 2005. Their June 2005 statements are reviewed in Chapter 2.
[301] See Chapter 10.

Rose Seruya

Rose Seruya was interviewed by Joanna Hernandez on 11 June 2005. Joanna Hernandez wrote up the minutes of that interview [**E/47/9**]. The minutes record that Rose Seruya stated that she considered that Sharon Berini showed little sensitivity to the fact that she suffered from hair loss and had to wear a wig; and that Sharon Berini "always seem[ed] to accommodate certain people whilst making it difficult for others." She also considered that Sharon Berini should have been more sensitive when dealing with her application for annual leave for family medical reasons.

Jackie Palma (deceased)

Jackie Palma was interviewed by Joanna Hernandez on 11 June 2005. Joanna Hernandez wrote up the minutes of that interview [**E/47/11**]. In the interview, Jackie Palma expressed disappointment that Sharon Berini had apparently told Nigel Bassadone about an interdiction which she had suffered. She regarded that as a breach of confidentiality on the part of Sharon Berini. She went on to say that there were "loads of things that had gone on" at the Home, but that she did not feel comfortable writing a report about them. The minutes record that she nevertheless agreed to write a report, but no such report has been seen by the Inquiry.

Gabrielle Llambias

Gabrielle Llambias made a signed statement dated 14 June 2005 [**E/47/36-38**].

In her statement, she describes Sharon Berini as having "made it her mission and done her utmost to discredit and humiliate her [**E/47/36**]. She goes on to accuse Sharon Berini of bullying, saying this [**ibid.**]:

> "I am well aware that bullying is a very strong word and you will [realise] that I will be using this word quite frequently in this report. This is because I firmly believe that bullying encompasses every kind of abuse that I have been subjected to by her, like intimidation, harassment, belittling, discrediting etc. ... Bullying can occur in a number of different ways. Some are obvious and easy to identify. Others are subtle and difficult to explain. My situation refers to the latter. I do not however see myself as a victim, but rather as a target. Bullying and harassment are linked to abuse of power. I strongly believe that Miss Berini has made use of her authority or power to undermine me personally in the past and continues to do so in a very subtle way now. She has disempowered me to the extent of making me feel vulnerable and powerless.
>
> Miss Berini has tried her utmost in the past to discredit me and turn managers against me."

She continues at some length in the same vein, giving examples of what she regards as bullying and harassment by Sharon Berini.

Gabrielle Llambias was invited to participate in the Inquiry and initially agreed to do so. However, at the first preliminary hearing she applied by counsel to be released from further participation in the Inquiry on the basis that no allegations had been made against her, and she was so released at the second preliminary hearing. Accordingly she did not provide the Inquiry with a witness statement, nor did she give oral evidence.

Emily Dempsey

Emily Dempsey made a signed statement dated 14 June 2005 [**E/47/10**]. In it, she described herself as a domestic who sometimes worked as a carer. She said that in 2004 she had been given a written warning by Sharon Berini and "all for a silly joke". She said that she regarded that as "a bit silly" as there were other members of staff who shouted and swore and who were never given a verbal warning by Sharon Berini.

Maria Gonzalez

Maria Gonzalez made a signed statement dated 14 June 2005 [**E/47/7-8**]. In it, she stated that she, together with Denise Hassan, had been accused of having slept while on shift (allegations which were later dropped). She stated that she considered that she had been victimised by Sharon Berini and Sean Matto in relation to setting her shifts, and she accused Sharon Berini of favouritism.

Maria Gonzalez made another signed statement, which is undated [**C2/2/28**], regarding an occasion on the night of 14/15 May 2005 when Nigel Bassadone turned up at the Home late at night "smelling of alcohol" and saying that he had lost his keys. I consider the evidence relating to this incident later in this Report[302].

Nicholas Hassan

Nicholas Hassan made a handwritten statement dated 15 June 2005 and headed "Report on Sharon Berini". The photocopy provided to the Inquiry is defective in that the last line of the statement is indecipherable.

In his statement [**E/47/13**], Nicholas Hassan says that over the previous two years it had become increasingly difficult to work with Sharon Berini as deputy manager. He expressed the view that Sharon Berini was "using her power for her own advantage, basically to help those [on] her good list, [whilst being] uncaring and cold [towards those on her] bad list". He went on to accuse Sharon Berini of unprofessional conduct, and of favouritism towards Nigel Bassadone.

[302] See Chapter 8.

Nicola Paine

Nicola Paine made a handwritten statement which is undated [**C2/2/29-31**]. In it, she accused Sharon Berini of fostering an "us and them" culture as between management and carers, saying that she felt that Sharon Berini was "engineering chaos and destroying staff morale to the point where myself and others felt undervalued". She accused Sharon Berini of having given favourable treatment to Richard Muscat in the setting of shifts, and of using her position "for personal gain". She described Sharon Berini as having been "corrupted by the power bestowed upon her", saying that she needed management training to give her the confidence to be a team player, rather than "a bossy boss."

She also referred to "concerns which had previously been raised regarding Richard [Muscat] leaving shift while on duty ... and leaving [Resident AE] alone in his flat", implying that Sharon Berini knew of this.

Stacey McKay

Stacey McKay made a signed statement dated 13 June 2005 [**C2/2/42-48**].

She begins her statement by describing an incident in mid-2003 when she mistakenly gave Resident C a dose of medication which had already been given to him by another carer. She says that she subsequently "heard a bang" and discovered that Resident C had fallen and cut his chin open. She states that Sean Matto told her not to inform Resident C's relative of the mistake with the medication "because they are going to think that he has fallen because of that". She says that this was when she began to feel unsupported by management. As to Sharon Berini, she says that although initially relations with her were good, Sharon Berini later created a bad atmosphere and showed favouritism towards Nigel Bassadone and other members of staff. As a result, she says, she felt unappreciated by Sharon Berini.

She goes on to refer to a later occasion when Residents AE and X were taken on a trip to Morocco. I consider the evidence relating to this incident later in this Report[303].

She concludes her statement by saying the she has heard "a lot of horror stories"; and that "there is obviously favouritism, with different staff members"; and that many staff members felt afraid and intimidated by bullying.

NOTE: Also included among the June 2005 statements exhibited to the witness statement of Isabella Tosso in the Industrial Tribunal is an additional statement, in the form of a typewritten letter addressed to Joanna Hernandez and headed "Complaints and issues" [**C2/2/35-36**].

[303] See Chapter 4.

The letter is unsigned and undated[304], and there is no direct evidence as to who wrote it[305]. It refers in general terms to lack of staff, favouritism, lack of support by management, and deteriorating morale amongst the staff.

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[304] It does, however, refer to a conversation with Joanna Hernandez on 11 June 2005.

[305] In her witness statement [**E/3/8**], Sharon Berini says that she believes the author of the letter to have been Karinda Durante, a former support worker.

CHAPTER 4: November 2000 to November 2004: Evidence (3)

Contents

CHAPTER 4: *November 2000 to November 2004: evidence (3)*

In this Chapter I review the evidence of the witnesses in Group 3, in so far as that evidence is directed to the period currently under review (as explained in the introduction to Chapter 2).

Gina Llanelo

Gina Llanelo made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/7/1**]. I will refer to that witness statement as her "2006 witness statement". She also made a witness statement to the Inquiry [**G/20/1**], and she gave oral evidence. Her son, Resident AC, has been a respite user since the Home opened in 1994. He is now 35 years old and suffers from autism. He attends the Home one night a week and one weekend a month, as well as during periods when his mother is away from Gibraltar.

I have placed Gina Llanelo first in the list of Group 3 witnesses as she described herself (in paragraph 15 of her 2006 witness statement [**C1/7/4-5**]) as the "spokesperson" for relatives of respite users.

In paragraphs 2 and 12 of her 2006 witness statement she refers to a "Punishment Room" at the Home. I consider the evidence as to the existence of such a room in Chapter 9 of this Report. In paragraphs 4 to 6 of her 2006 witness statement she said this [**C1/7/1-2**]:

> "4. Some staff were very amiable and very agreeable, they would tell [us what] was happening, other staff were not.
>
> 5. There was Sharon [Berini] who ... said one thing one minute and then you [?find] that she had said something else to someone else and what I don't realise there is that mothers do have contact with one another and we do find out what each one is being told. And always the stories were all different.
>
> 6. That she didn't have staff for that certain person and then we found out that the staff had actually been working but had been put with someone else. But the parent was given to understand that that person had not come in to work. I am talking about the respite service so we were misinformed of where the actual person was going or not going. Listen[:] Be honest with us and let us know that you have had to use this staff member who works with your son or daughter, we have had to use them in Flat 1 or 2, to cover for them. It would have been much nicer, more responsible than just keep telling us lies that people don't turn up .. Then what happened is you ask that person what happened when you saw them, if they were ill, and they would tell you "No I was working." You feel let down."

Gina Llanelo went on (in paragraph 7 of her 2006 witness statement [**C1/7/2**]) to complain about the fact that respite would often have to be cancelled or altered at the last minute due to lack of staff. In paragraph 8 of her 2006 witness statement she referred to the tendency of her son to "do a runner", and to an occasion when he had escaped from the Home through the fire escape while the carer was mopping the floors.

In paragraph 9 of her 2006 witness statement [**C1/7/3**] she said this:

> "9. .... [T]here is no continuity in care. There are no care plans, well there are when a new manager comes in but by the time another manager comes in those care plans have suddenly disappeared. .... "There is [sic] never any files, from one manager to the next, because the files always seem to do a disappearing act in between."

She went on (in paragraph 10 of her 2006 witness statement [**C1/7/3**]) to complain about having to fill in the same forms over and over again, as files kept getting lost; about lack of quality of care in that her son could be doing things he was not doing; and at the absence of parental assessments.

As to the physical facilities for respite users, Gina Llanelo complained (in paragraphs 11 and 13 of her 2006 witness statement [**C1/7/3-4**]) that there was only one bedroom available for respite users, and only one bathroom (without a shower) and one toilet.

In paragraph 14 of her 2006 witness statement [**C1/7/4**] she said that until Joanna Hernandez became Manager new members of staff were not introduced to relatives of respite users, and that opportunities for communication with them was limited. She continued:

> "With Joanna it was different, we always met, because we had the coffee mornings, she introduced the staff."

In paragraphs 15 and 16 of her 2006 witness statement [**C1/7/4-5**] she expressed a low opinion of Marie Gomez, as follows:

> "15. Marie Gomez, the Team Leader, in my opinion, does not know what she is dealing with; she is a waste of space. She has no idea of what is needed or what isn't needed. When she has [a] meeting with us she is supposed to take down minutes. Then when we have another meeting she says[:] "Well who said that, who told you that[?]" Well she was in the meeting, and she doesn't remember, and she never gets back to you. And if you phone her because you have a query about something, she is always in a meeting. I don't know whether it is because it is me or not, but I never seem to be able to get hold of her. And I have been more or less chosen by the respite mothers as the spokesperson. So that is why I am the one who takes the time to phone and find out what is happening.
>
> 16. While we are in the meeting all very nice and very good but then we leave the meeting she tells us "You have got to fight, you have got to carry on fighting", I mean what kind of impression does that give us. It gives us the impression that she cannot do anything, so what is she there for if she cannot back us up. She has got to help us to get what we need. We cannot keep on going out on demonstrations and that; she is supposed to be there to help us, not hinder us. And our feeling is that she hinders us[;] she is not there to help."

In paragraph 17 of her 2006 witness statement [**C1/7/5**] she was less critical of Isabella Tosso, saying this:

> "17. Isabella Tosso, when she took over [as CEO], was very very cold, very unforthcoming would be the word. She has now changed in the last two months [i.e. February and March 2006]. She has now changed her attitude. .... Isabella is now much more open to us than what she was before. And now she is coming round to our way of thinking, things that we have been asking

> [for] for years, now she is realising that that has to be done. .... You cannot have supply workers with respite. You need people permanent, now she has realised that. .... I don't know why but in the last couple of months she is now looking to the ways that we all have been fighting for. For me, at least ten years."

In paragraphs 18 and 19 of her 2006 witness statement [**C1/7/5-6**] she said that in the days when Milbury was running the Home there were two factions among the staff, whereas when Joanna Hernandez became Manager:

> "... she gave us a sheet of paper with what our ideals for the respite/sitting service would be for the whole year. And that was excellent ...."

In paragraph 20 of her 2006 witness statement [**C1/7/6**], she referred to the difficulty of fitting in her and her husband's other commitments with the availability of respite carers, pointing out that if her son did not get on with a carer he would give both the carer and herself "hell".

In paragraph 21 of her 2006 witness statement [**C1/7/6**], she turned to the question of training of carers, saying this:

> "21. We don't know what training [the] carers have. We are not informed of what training they have. Oh yes, you hear that they have done a first aid course they might just have a first aid course. I can do a first aid course. It doesn't mean I am qualified to go and look after someone who has fits."

In paragraph 24 of her 2006 witness statement [**C1/7/7**], she referred to what she considered to be a lack of forward planning in order to cope with increased numbers of respite users.
I turn next to Gina Llanelo's witness statement to the Inquiry [**F/20/1**].

As to her criticisms of Sharon Berini, as expressed in paragraph 5 of her 2006 witness statement, she says this (in paragraph 9 of her witness statement to the Inquiry [**F/20/2**]):

> "9. ... Sharon Berini told people what they wanted to hear so as to dispense with their queries and issues promptly. As we are such a small community and people talk however she was often caught out."

In paragraph 8 of her witness statement to the Inquiry [**F/20/2**], she says that staffing levels at the Home have always been "very poor".

In paragraph 10 of her witness statement to the Inquiry [**F/20/2**], she says this with reference to the lack of staff available for the provision of respite care:

> "10. .... Sharon would advise us that the respite staff were not available and therefore respite could not be granted. This often turned out to be untrue or a modification of the truth as we would see the respite staff working during the hours we had been refused respite. This obviously caused hostility between family members and respite staff as we would query why they were working when we had been told they weren't available. This, in my opinion, was irresponsible management on Sharon's behalf as instead of diffusing a situation and avoiding problems she was aggravating it."

In paragraph 11 of her witness statement to the Inquiry [**F/20/3**], she continues on the theme of staff shortages, saying this:

> "11. .... Staffing levels was a major problem. When you leave your child at the Home you expect to be able to rely on the service and the people employed to take the service forward. On numerous occasions, after dropping [Resident AC] off at the Home for respite, I have been called up half an hour later and been asked to collect [him] immediately due to lack of staff. This is of course unnerving especially when, on occasion, I have actually been in Spain when called. On one occasion, Craig [Farrell], who is a brilliant carer, was left on his own to care for 5 different service users due to the staffing level problem. I was called and asked to collect my son as his safety could not be guaranteed. Whilst it is astonishing that I was given that ultimatum, I believe this occurred as a result of bad management and irresponsible planning on the manager's behalf. The manager at the time was Sharon Berini."

As will be seen in due course, Craig Farrell is much criticised as a carer by Joanna Hernandez, so it is noteworthy to find that Gina Llanelo regards him as a "brilliant carer"[306].

In paragraph 12 of her witness statement to the Inquiry [**F/20/3**] she refers to the incident described in paragraph 8 of her 2006 witness statement where Resident AC ran away from the Home. She says that when he arrived at a neighbour's house the neighbour rang the Home and was told that he was asleep in his room. She refers to other incidents when Resident AC has attempted to escape from the Home and has injured himself in the process. She says that she is usually advised of such incidents, but "never at the time or immediately after the event".

As to Marie Gomez, she says in paragraph 17 of her witness statement to the Inquiry [**F/20/4**] that Marie Gomez "was not helpful at all", and had "no affinity with the service users or staff"; and that concerns raised with her were "brushed under the carpet". She goes on:

> "17. .... Service user files went missing from the Home on a regular basis and despite being advised of this, Marie did nothing to prevent it or to implement an organised system to improve this. Behaviour and attitudes like this contributed to parents[']lack of faith in the system."

In paragraph 20 of her witness statement to the Inquiry [**F/20/4**] she says that "initially" many of the carers at the Home were not sufficiently qualified to care for persons with disabilities. She goes on (in paragraph 21 of that witness statement [**F/20/5**]) to describe an occasion when a resident was having a fit in the back of the van, and the carer (not knowing how to deal with the situation) had thrown cold water over him. This, she says, is the kind of situation which is apt to occur where a carer has not been properly trained.

By contrast, in paragraph 22 of her witness statement to the Inquiry [**F/20/5**] she compliments Morag Jack as having been a good Manager, and as being the only Manager she had met who had personally visited the homes of respite users for the purpose of conducting surveys to ensure that the future needs of each respite user could be met.

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[306] In paragraph 24 of her witness statement to the Inquiry [**F/20/5**], Gina Llanelo commends Craig Farrell for having "contributed to [Resident AC's] advancement and development over the years". In the course of her oral evidence she described Craig Farrell as having a lot of patience. She went on [Day 4 page 12 line 1ff] to say that "...he went out of his way ... to try and get everybody together and have some social life ... [and] do a lot of things out of hours".

In her oral evidence, referring to staff shortages, she said respite was often cancelled at the last minute due to lack of staff due to the need for respite staff to be transferred to care for permanent residents[307].

She described the frequent changes of Manager as "a big problem"[308].

She said that she never got on with Sharon Berini; that there were always two factions among the staff, i.e. old staff and new staff; and that Sharon Berini was in the former category, which had, as she put it, "got into certain habits"[309].

She said that Marie Gomez was also in "the old camp" and that she did not get on with her either[310]. She went on[311]:

> "... I found her unhelpful in any situation, whether it be upstairs [i.e. in the Home] or downstairs [i.e. in St Bernadette's]. .... When we asked her for back-up, she wasn't bothered. .... This lady had no affinity with the disabled at all, as far as I am concerned. She was there doing her job, but [she was] not helpful. She didn't come to the parents and say: "What is it that you need? How can we help?" There was nothing there... She wasn't helpful to try and find a way to get what was needed."

She said that, after Milbury had left, attempts were made from time to time to prepare care plans, but that in recent years care plans had become more formalised and refined[312].

In response to questioning by counsel for Sharon Berini, she described the situation in relation to staff shortages as "desperate"[313].

Elizabeth Featherstone

Elizabeth Featherstone made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/11/1**]. I will refer to that witness statement as her "2006 witness statement". She also made a witness statement to the Inquiry [**G/5/1**], and she gave oral evidence. Her son, Resident C, was born in 1982[314] and has been a respite user since the Milbury era.

In paragraph 2 of her 2006 witness statement [**C1/11/1**]), Elizabeth Featherstone stressed the importance of the respite service to parents in her position. However, she went on to point out that only one bedroom was available for respite users, adding:

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[307] See Day 4 page 7 line 19ff.
[308] See Day 4 page 12 line 18.
[309] See Day 4 page 17 line 20ff.
[310] See Day 4 page 21 line 14ff.
[311] See Day 4 page 23 line 12ff.
[312] See Day 4 page 31 line 14ff.
[313] See Day 4 page 38 line 2.
[314] See Day 3 page 4 line 21.

> "... although I am desperately in need [of] respite, I dread to think of leaving [my son] there."

She went on to describe an occasion some three years previously (that is to say, in or about 2003) when she was telephoned by someone from the Home who told her that her son (who was at that point using Bishop Healy for his respite care) had had an accident and had been taken to hospital but that he was all right, although he had stitches in his chin. The next day she was told that he had been taken to hospital again. She continued (in paragraph 3 of her 2006 witness statement [**C1/11/1-2**]):

> "3. .... I don't have anything written, because nobody wanted to give me anything written in those days, but what happened was that he had had an overdose. Apparently on Saturday lunchtime, the carer who left had given him his medication, but he never said that he had given [him] the medication, and the following carer gave it to him again. So obviously imagine the amount of medication [my son] takes given twice [sic]. He was drugged, completely drugged. He fell. Obviously he was not attended properly and he had to have the stitches and the following day he had another fall. He obviously was too drugged, he fell again and he had another bump on his forehead.

In paragraph 4 of her 2006 witness statement [**C1/11/2**], Elizabeth Featherstone referred to the problem of understaffing, saying, with reference to the incident described in the previous paragraph:

> "4. This, as far as I know, has been the worst that has happened to [Resident C] apart from the times that he has run away from the Home, [the] reason being that they were under[-]staffed as usual. They found him in the ICC or they found him half way up Queensway, then near the sea."

In paragraph 5 of her 2006 witness statement [**C1/11/2**], Elizabeth Featherstone described other "bad experiences", for example when her son's carer rang to say that her son would not take his medication and that he (the carer) was not going to force him to do so. As a consequence, Elizabeth Featherstone had to go to the Home herself in order to administer her son's medication. She says that the carer apparently found this "very funny", although she herself found it annoying, as "those are life saving medications". She added:

> "5. .... [U]nfortunately I cannot afford a baby sitter, or someone to look after him continuously as I need. I am a single parent and [my son] is a strong chap with a will of his own, and I need, I desperately need respite."

She went on to say (in paragraph 6 of her 2006 witness statement [**C1/11/2-3**]) that in or about November 2005 she had a meeting with the then Chief Minister, The Hon Peter Caruana QC MP and the then Minister for Social Services, The Hon Yvette Del Agua MP. Unfortunately, the copy of her witness statement which has been provided to the Inquiry is incomplete in that a passage following her reference to that meeting has been omitted[315]. However, paragraph 6 ends with the following reference to the facilities for respite users:

[315] In the course of her oral evidence, Elizabeth Featherstone said (at Day 3 page 24 line 15) that she recalled having a meeting with Yvette Del Agua; that at that meeting she raised her concerns with her; that they tried to help her by giving her more respite; and that a social worker was appointed so that she could have a contact.

> "They are overcrowded, understaffed and quite frankly, even if they gave it to me I would not take it any more, because I don't think my son is in a safe environment and quite frankly, it is just not on."

Elizabeth Featherstone ended her 2006 witness statement by saying this (in paragraph 7 [**C1/11/3**]):

> "7. To conclude, I would like to say that, the way things are right now, I would not leave my son, or anybody, there for them, because I do not consider the place safe. Not safe in the sense that the building is falling to bits or anything like that, [but] in the sense that he is not properly looked after. The last time I left [Resident C] nobody gave me a report, a written report. Everybody seemed to be in a rush, nobody knows exactly what is happening and quite frankly this has to change because we are talking about human beings and they are not doing us any favours. This is a Social Service's duty to supply us with caring people and trained, obviously trained, people, which is what one wants, because if I want to go for simply shopping, I want to have the peace of mind that my son is well looked after and not worrying all the time, wondering what he is doing, wondering whether he has escaped. ...."

In paragraphs 5 and 6 of her witness statement to the Inquiry [**G/5/1**], Elizabeth Featherstone said this, with reference to the incident described in paragraph 3 of her 2006 witness statement (quoted above):

> "5. No official report was given but I was informed that the reason why he fell was because he had been given a double dose of his medication and was drugged. It seems that the carer gave him [his] medication at lunchtime and when he left the next carer gave him the same medication again. In fact, he had fallen on Saturday and injured his chin and then on Sunday he fell again and bumped his head. I understand that a mattress had been placed by his bed [in case] he fell. [Resident C] had got up and as he was not used to walking on a mattress he had fallen over again.
>
> 6. Obviously there was no communication between the carers and they didn't know whether he had received his medication or not. Also [Resident C] had not been properly supervised as he fell twice."

As to the occasion referred to in paragraph 4 of her 2006 witness statement, when Resident C ran away from the Home, Elizabeth Featherstone says this (in paragraph 7 of her witness statement to the Inquiry [**G/5/2**]):

> "7. .... The reason why they claimed he managed to leave was because they were understaffed and therefore unable to properly supervise him."

Elizabeth Featherstone concludes her witness statement to the Inquiry by saying this (in paragraph 10 of the witness statement [**G/5/2**]):

> "10. At the time I wrote my witness statement [a reference to her 2006 witness statement] I do not believe that the Home was properly run. The staff were not adequately trained and there was no communication between staff and family members. No one knew what was happening, the staff always seemed to be rushing around, without caring for the residents. No one ever produced a report when [Resident C] was there."

In her oral evidence she described Bishop Healy as being "in no condition to look after anybody; because there wasn't a fire escape or anything"[316]; and that "there were very steep steps to go up"[317]. However, she went on to say that they (i.e. the relatives) accepted it because it was only temporary accommodation[318].

As to the incident described in paragraph 3 of her 2006 witness statement and paragraph 5 of her witness statement to the Inquiry, she said this[319]:

> "I received a phone call that my son had been taken to hospital, because there had been an accident. So immediately I asked: "What accident?". I immediately thought: the stairs. They said no, unfortunately there has been an error, they have given his medication twice. .... [They said] that he had been taken to hospital [and] that some stitches were necessary. .... The next day, in the morning, they called me again: he has been taken again to hospital. .... Obviously if ... they thought he was going to be sort of dopey, they put a mattress beside his bed. Well, they should have put chairs or something, ... because there weren't any special beds or anything. .... So up to the hospital because he had an enormous bump. So where were the staff at night? They weren't there, obviously, because if I am looking after you I don't need to put a mattress there. I am going to keep an eye on you."

She described the situation in relation to the administering of medication as "pretty chaotic, to say the least"[320]. As to the incident (described in paragraph 5 of her 2006 witness statement) when the carer had been unable to administer a dose of medication, with the result that she was called on to do it herself, she said that she was "furious", and that the staff had taken the incident too lightly[321].

She said that there were meetings between the staff and relatives of respite users, but that "at the end of the day, things didn't happen"[322].

Violet Sullivan

Violet Sullivan made a witness statement in the Industrial Tribunal in 2006 [**C1/15/1**]. I will refer to that witness statement as her "2006 witness statement". She also made a witness statement to the Inquiry [**F/12/1**], and she gave oral evidence. She is the grandmother of Resident I, whom she has adopted. Resident I is in his twenties, and has been a respite user for most of the last eighteen or so years[323]. He was brain-damaged at birth and has special needs.

In paragraphs 1 and 2 of her 2006 witness statement [**C1/15/1**], she said that there was "a lack of understanding as far as [Resident I's] needs were concerned", and that her grandson became frustrated because his needs were not properly understood. She accepted that the key worker

316 See Day 3 page 6 line 14.
317 See Day 3 page 6 line 18.
318 See Day 3 page 6 line 20.
319 See Day 3 page 10 line 12ff.
320 See Day 3 page 12 line 18.
321 See Day 3 page 14 line 13ff.
322 See Day 3 page 17 line 22.
323 He was a permanent resident for some three months in about 1994.

with responsibility for him was "extremely good", but recalled that due to shortage of staff the key worker was from time to time called away on other duties, and that on those occasions she would take food to Resident I herself, and take away his dirty clothes for washing. She went on to describe the occasion when the Home was flooded (October 2002), with water coming in through the roof. She recorded that Resident I's carer, Kelvin Ball, "didn't want anything to do with it", so she had to call the fire brigade herself (she happened to be visiting Resident I, who was at that time a permanent resident at the Home). Following the flood, Resident I ceased to be resident at the Home and became a respite user.

Violet Sullivan went on to describe an incident which she had observed involving another child. She did not name the child in her 2006 witness statement, but in paragraph 11 of her witness statement to the Inquiry [**F/12/2-3**] she said that the child in question was Resident Z. She said this (in paragraph 5 of her 2006 witness statement [**C1/15/2**]):

> "5. .... There was a five year old who had a lot of problems and the approach was sort of overpowering him. He would actually be frightened of this person because she would scream over him. That is all they did with him. They would literally just scream at him all the time. It was all shouting and shouting at him. This child was behind the armchair, frightened, and she was screaming and screaming at him. And when I reported this to the minister, to Mrs Del Agua, she said she couldn't accept that because I was not the parent, so [the] parent would have to go. And when I said well the parent has not seen what I had seen, she said it didn't matter."

In paragraph 6 of her 2006 witness statement [**C1/15/2-3**], she said this:

> "6. I had to buy [Resident I] a small fridge to put in his bedroom with a key because [he] couldn't take sugar so I would have to buy him sugar free [yoghurts] and things like that and they would disappear. The food would disappear from the fridge."

In paragraphs 7 and 8 of her 2006 witness statement [**C1/15/3**], Violet Sullivan complained of a lack of communication (in paragraph 13 of her witness statement to the Inquiry [**F/12/3**] she described the lack of communication as "horrendous"). As an example of this, she described an occasion when Resident I suffered a stomach upset and was seen by a doctor, but she was only told of this after the event. She also complained that the hygiene at Bishop Healy was "very poor"; that Resident I was not being given a daily shower; and that he "smelled".

In paragraph 9 of her 2006 witness statement [**C1/15/3**] she said this:

> "9. .... I remember a carer taking [Resident I] out, and instead of taking him out, she would take him home to her house, and I know this happened to a few of the children and this person had an accident in her car with [Resident I] inside. She was hit on the back of the car, where [Resident I] was sitting, and he grazed all his back because the car was not adequate for him."

In paragraph 15 of her witness statement to the Inquiry [**F/12/3**], she said that she did not know that Resident I was being taken to a carer's home, and that had she been told about it she would not have consented.

Turning to her relationship with Sharon Berini, Violet Sullivan said this (in paragraph 11 of her 2006 witness statement [**C1/15/4**]):

> "11. Sharon many times did not tell me the truth, and when you don't have that confidence in a person then it becomes .... [sic] for instance the incident I mentioned about him not being washed every day that was a meeting I had with this person, because we used to have meetings when Morag [Jack] was there, we used to have meetings every two weeks where sometimes she didn't even turn up and she left me waiting, but this was when they stopped me reading the communication book. This was when I caught her ... [sic] on the grounds that I knew for a fact that this was happening. And she was not aware, and she was supposedly aware of everything."

In paragraphs 13 and 14 of her 2006 witness statement [**C1/15/4-5**], Violet Sullivan said this:

> "13. When the incident with the bathroom happened, I had warned, I warned these people that somebody was going to have an accident in that bathroom. I have taken him on Saturday morning at one o'clock for instance and they have called me up to tell me that they were sorry but it was at my own risk if you leave him here because there is nobody to take care of him. And I had to take him home, and you cannot work like that. Especially as I look towards the future, because I happen to be a pensioner now, I am sixty five, and he is an eighteen year old, very active and very strong and he needs young people. When I look towards the future I cannot see it. Because there are very few people that are doing their job within Dr. Giraldi Home.
>
> 14. Being a one parent family I have no choice about being able to enjoy my other grand children or anything like that, and I am frightened. I am really frightened of losing [Resident I] now overnight, because I have had so many bad experiences that it frightens me now. Every time they talk about in the future we will have to look into him becoming permanent it really frightens me. Because everything has been so disagreeable that it has not been a smooth road. So if I could see good will [sic] and see that he is happy and that things are running smoothly, then it would give me the courage to say yes, yes I can leave him now. But at the moment I cannot because it frightens me."

In paragraph 15 of her 2006 witness statement [**C1/15/5**], Violet Sullivan said this:

> "15. He has been punished. I was not told, I know he has been punished. .... Recently he was punished and I told them because he was put in his bedroom with no lights and the door was locked shut. He could not open it because the lock was at the top. And it was just a coincidence that I happened to go a half an hour earlier for him and when I saw this I reported it, and I said I am sure it[']s not probably the carer who is at fault but people who are over the carer telling the carer what the punishment should be. .... [A]nyway it was stopped, but the fact that he was alone in his room in the dark and no, I don't like that."

In paragraph 16 of her 2006 witness statement [**C1/15/5**], Violet Sullivan referred to two occasions when Resident I was under- or over-medicated. She described this as negligence on the part of the carers.

Violet Sullivan went on to refer to a carer she had been told about who was said to have behaved improperly in relation to her grandson during the Milbury era.

In paragraph 19 of her 2006 witness statement [**C1/15/6**], Violet Sullivan said this:

> "19. Recently I was offered a weekend and I asked about the bathroom and they said that the shower was not working, there is no hoist for the bath, and I said and how do you expect me to leave [my grandson] for the weekend ... and on top of everything, if I leave him on the weekend I leave him his food, because there is no one to make food for him. The carers, apparently the carers are making lunch and all that. The food is not being prepared by the cook."

In paragraph 23 of her 2006 witness statement [**C1/15/7-8**], Violet Sullivan complained that on one occasion when she left for a visit to her daughter in the USA Resident I was moved to an upstairs room (whereas previously he had been in a ground-floor room at Bishop Healy and had been happy there). She also describes an occasion when Sharon Berini asked her for money for Resident I. She refused, saying (according to her witness statement): "[W]hat am I giving money for when I bring his food, I wash his clothes, what do you want money for[?]". In the end, however, she complied with Sharon Berini's request.

I turn next to Violet Sullivan's witness statement to the Inquiry [**F/12/1**].

As to paragraph 11 of her 2006 witness statement, Violet Sullivan explains (in paragraph 16 of her witness statement to the Inquiry [**F/12/3**]) that when she referred to Sharon Berini as lying she was referring to occasions when she had not been allowed to see the daily log books entries, and Sharon Berini would not disclose all the information contained in those entries and would not tell her about some of the incidents which had occurred. She cites an example the fact that Resident I was not given showers daily.

As to paragraph 13 of her 2006 witness statement (quoted above), Violet Sullivan refers (in paragraph 17 of her witness statement to the Inquiry [**F/12/3-4**]) to an occasion in September 2002 when Resident I slipped and fell in a bathroom at the Home. Since this incident pre-dates November 2002 (and is not the subject of any allegation made by Mandy Spencer), I make no further reference to it.

In paragraph 19 of her witness statement to the Inquiry [**F/12/4**], Violet Sullivan says that although she has heard of the existence of a "punishment room", Resident I has never to her knowledge been placed in such a room. (The issue as to the existence of a "punishment room" is addressed later in this Report.)

As to paragraph 16 of her 2006 witness statement (referred to above), Violet Sullivan recalls an occasion when three anti-convulsion tablets which had been prescribed for Resident I were returned to her without explanation (see paragraph 20 of her witness statement to the Inquiry [**F/12/4**]).

In paragraph 28 of her witness statement to the Inquiry [**F/12/5**], Violet Sullivan exhibits correspondence between her and Sharon Berini relating to Resident I. The exhibit includes a letter from her to Sharon Berini dated 19 May 2004 [**F/12/51**] in which she complains of lack of staff, saying that she had been telephoned on a Sunday morning to be told that there was a problem with staffing and could she pick up Resident I to take him home. She went on to say that she was extremely concerned as to Resident I's future care. Sharon Berini responded by letter dated 24 May 2004 [**F/12/52-53**] apologising for the fact that Violet Sullivan had been put in a situation where she felt stressed and concerned, and explaining that the situation had arisen out of a misunderstanding by the senior carer concerned. The letter went on:

> "The senior wrongly assumed that as you had had [Resident I] for the previous two Sundays, then you would not mind having the option to spend time with [Resident I] again and apparently you said yes. The senior felt that he was doing the right thing for you and [Resident I].
>
> I have since spoken to the senior and informed him that the action that he took was inappropriate and should not have happened and will not happen again. Within residential services we are going to be put in situations where members of [Resident I's] team are off sick on annual leave or unavailable, in this instance the seniors on duty will try to find cover or will support [Resident I] themselves.
>
> ....
>
> I do appreciate that these are very difficult and painful circumstances for you and we are doing our best to make sure that [Resident I] has a steady team of people around him to progress with his needs and skills and to make this transitional period as easy as possible for him."

Given the criticisms made of Sharon Berini's style of management (both in the witness statements in the Industrial Tribunal and in evidence presented to this Inquiry), the above letter serves to place her style of management in a different light. Violet Sullivan could hardly have hoped for a more thorough or sympathetic response to her complaint.

Lastly, for present purposes, in paragraph 34 of her witness statement to the Inquiry [**F/12/7**] Violet Sullivan says this:

> "34. I have even witnessed a carer dressing up a male resident as a woman (including a wig), ridiculing them in front of others. This is not treatment which is moral, constructive or helpful and is a factor which has influenced my lack of faith in the Home."

In her oral evidence Violet Sullivan was very complimentary about Morag Jack (as was Gina Llanelo), saying that she had "a great knowledge and understanding of disability", and that she was very sorry when Morag Jack left[324].

She said that the bathroom in Bishop Healy (Bishop Healy has since closed) was, as she put it, an "issue". She went on[325]:

> "I did say that there was going to be an accident, but nothing was done, until there was."

She was referred by counsel to the Inquiry to a letter which she wrote to Morag Jack on 27 January 2003 [**M12/2/1**] expressing her concerns about the bathroom and suggesting that a professional be consulted about its design. However, nothing appears to have been done about it, because on 5 October 2004 she wrote to Sharon Berini saying that "the bathroom had not changed one iota since last year" [**M12/8/1**], and once again expressing concerns for Resident I's safety in using the bathroom.

She was also referred to a letter which she wrote to the then Chief Minister dated 3 May 2004 [**M12/5/1**] complaining about conditions at Bishop Healy, and about the level of carers' pay. The letter is headed: "Re: Disability and Lack of Funds", and it included the following:

[324] See Day 4 page 87 line 14ff.
[325] See Day 3 page 89 line 3.

> "As a parent of a service user at the Bishop Healy Home, I feel it is now time for the Government to make itself accountable for the needs of the small but growing population of disabled people in Gibraltar.
>
> It is quite apparent that the ABC of caring is being overlooked when employing carers. It is appalling that carers receive only £5.25 an hour, an average wage for a baby sitter. Carers are not baby sitters they are employed as professionals who have to deal with the many complex needs of disabled people. They should be qualified to a minimum standard and their wages should reflect this.
>
> Added to this are the poor facilities and conditions the Home [i.e. Bishop Healy] provides, resulting in the service users being put at risk. For example, there are no suitable fire exits in the Home. Many of the service users have mobility issues and would find it almost impossible to evacuate the building in an emergency. The bathrooms are unsafe as they are not properly equipped to cater for the needs of the users and could therefore result in an accident. The stairs to the first floor has a banister on one side only. There isn't a nurse to oversee the administering of medication and there have been mishaps in the past and to date. If the previous users of the Bishop Healy Home were found suitable accommodation in the community because these living conditions were not acceptable, why should disabled people be valued any less."

In her oral evidence, she said that she regarded carers as "hopelessly underpaid"[326], and that she did not think that they were properly screened or sufficiently trained[327]. As she put it[328]:

> "To deal with that kind of disability was a bit too much to ask from someone who had never been in that situation."

She also referred to staff shortages. She said that she was content with the present staffing arrangements, although she felt that, as she put it, "there is still a lack of carers coming"[329].
As to her dealings with Sharon Berini, she said this[330]:

> "Sharon Berini was a very good carer, but I must say that once she was given authority I found it, communication-wise, very difficult. .... If you spoke to her, she didn't seem to understand the pressure we were under. .... It was difficult communication. .... my son had her at the beginning as a carer, and I know that she had other children in her care, and I must say she did a good job."

Maurice Valarino

Maurice Valarino made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/16/1**]. I will refer to that witness statement as his "2006 witness statement". He also made a witness statement to the Inquiry [**G/6/1**], and he gave oral evidence. He is the father of Resident X. Resident X was born in 1985[331]. He was initially a respite user, but in 2003 he became a permanent resident when his mother became terminally ill.

[326] See Day 4 page 92 line 17
[327] See Day 4 page 94 line 6ff.
[328] See Day 4 page 94 line 12ff.
[329] See Day 4 page 94 line 21.
[330] See Day 4 page 98 line 23ff.
[331] See Day 3 page 85 line 13.

In paragraph 5 of his 2006 witness statement [**C1/16/2**], Maurice Valarino said this:

> "5. Over the years we have had concerns and dissatisfaction [with] the [respite] service. Very often there were concerns, minor concerns, which gave us cause to often be uncertain and unsure of the quality of the service. We have had things like, in isolation each incident or each occurrence may appear insignificant, but overall it builds a picture of certain dissatisfaction with the service. For example we would sometimes go to get [Resident X] on a Sunday evening, or indeed at the end of the day, and we would get an improper handing over of [Resident X]. .... For example we would not be told what he had done, where he had been, what he had eaten or not eaten and so on. Sometimes we were, and sometimes we were not. It seemed to depend basically on who ... the staff was. Also we would be introduced to new staff and told that they were learning to work with [Resident X]. And then perhaps we would never see the member of staff again. And we were given no explanation as to why. Sometimes we might not ask, we might think they were on shift, and then we were told by so and so that they had left the service."

Maurice Valarino went on (in paragraph 6 of his 2006 witness statement [**C1/16/2**]) to refer to the flood at the Home, which had necessitated the transfer of the residents to Bishop Healy. He described the accommodation at Bishop Healy as "unsuitable", pointing out that a facility which was supposed to be temporary had in fact continued to be used for some eighteen months.
In paragraph 7 of his 2006 witness statement [**C1/16/3**], Maurice Valarino recalled that while their son was at Bishop Healy they used to hand over small amounts of pocket money to staff at the Home, so that Resident X could have money for small items such as snacks, saying that on a number of occasions they were surprised to be told that there was no money in the kitty. He continued:

> ".... Perhaps it would suggest bad accounting management, so to speak. After a while this kind of pattern began to emerge which used to cause us concern but quite frankly we were getting the respite that we needed ... and for three or five pounds we were not going to make a fuss."

In paragraph 9 of his 2006 witness statement [**C1/16/3-4**] Maurice Valarino went on to describe how Resident X's increasingly excitable nature had caused them to seek advice from a psychiatrist, who had prescribed promozine (a tranquiliser). They used to supply the Home with this medication, but on several occasions (he recalled) either medication appeared to have gone missing or there was medication remaining which indicated that Resident X had not been given his proper dose.

In paragraph 10 of his 2006 witness statement [**C1/16/4-5**], Maurice Valarino referred to an occasion when Resident X had been taken out by a carer who was later discovered to be an alcoholic. He was told that the carer had been subsequently dismissed, but he expressed surprise that in the meantime the carer had been permitted to have charge of Resident X.

In paragraph 11 of his 2006 witness statement [**C1/16/4**], Maurice Valarino referred to an occasion in August 2003 when he and his wife were in London (his wife was seriously ill in hospital) and he was telephoned by the Home to ask if they would agree to Resident X being taken on an outing to Tarifa, together with another service user who knew Resident X quite well. He was told who the carers would be. He was also told that they might also go to Tangier for a day. He thought that Resident X would not be able to cope with a visit to Morocco, but when

he rang the Home to say that they would agree to the outing to Tarifa but not to a visit to Tangier he was told that they had already left Gibraltar. Subsequently he understood that the visit to Tangier lasted a number of days. His concern at the time was that no one in Gibraltar knew where in Morocco Resident X was, or whom he was with.

In paragraph 15 of his 2006 witness statement [**C1/16/8**], Maurice Valarino recalled a further incident involving Resident X, as follows:

> "15. There was one incident once, it might have been a Sunday afternoon, my wife and I went to pick [Resident X] up, in what is now Flat 1. It must have been six pm. The residents were sitting, basically in a square, on the sofas and there was a carer there. As we went in, I think [Resident X] saw us and [he] reached over, stood up and reached over, to what looked like a make-up bag, or a purse, something like that. The carer went over, she had not seen us, she had her back to us, and slapped him across the face. What surprised me at the time was that [Resident X] did not flinch, and the other residents did not react. It led me to believe that this was not an isolated [incident]. I think that in case of an incident like that, especially with young people like that, they would have fallen over laughing or shouting or .... [sic] something like that. But that did not happen. There was a duty senior, or a manager who was Miss Gaby Llambias. She had seen us coming in, she was standing to the side, and before we even opened our mouths or we could actually say something, or react, she said: "Don't worry Agnes [a reference to Mrs Valarino], I will put a report in". But I didn't report, we never complained because Gaby Llambias said she would put a report in, and in fact the carer was dismissed from the Service."

In paragraph 16 of his 2006 witness statement [**C1/16/8-9**], Maurice Valarino recalled that from time to time items of Resident X's clothing would go missing, notwithstanding that they were labelled; and that sometimes he would come home with clothes which were not his.

In paragraph 17 of his witness statement [**C1/16/9**], Maurice Valarino described an occasion when Resident X was given an adult strength dose of medication, whereas he should have been given a dose at paediatric strength. He was apparently left to sleep it off next day. Maurice Valarino recalls that he spoke to the Manager about this.

In paragraph 10 of his witness statement to the Inquiry [**G/6/3**], Maurice Valarino expresses the view that "punishment of an adult of any sort is inappropriate". As indicated earlier, I address the issue as to the existence of a "punishment room" at the Home later in this Report[332].

In paragraph 13 of his witness statement to the Inquiry [**G/6/3**], Maurice Valarino says that he has always been concerned as to how employees at the Home are vetted, if at all.

In the course of his oral evidence, Maurice Valarino said that after Milbury left "there were quite a number of staff shortages"; and he also thought that the quality of training might have dipped as well[333]. He said that in the days when Resident X was a respite user, respite used sometimes to be cancelled at short notice, although at "other times it flowed perfectly well"[334].

[332] See Chapter 9.
[333] See Day 3 page 74 line 14.
[334] See Day 3 page 76 line 2.

As to the incident described in paragraph 15 of his 2006 witness statement, he said this[335]:

> "What happened was that there were two sofas positioned facing each other. We went into the flat. [Resident X] was sitting on the sofa facing the door to the flat. [The carer] was sitting on the sofa with her back to the door. Ms Llambias was to the left of those two sofas. As we came in, [Resident X] saw us, he rose to come to us, [the carer] got up and slapped him to sit down. There was no loss of temper at all. .... Before we could react, Ms Llambias said ... don't worry about this, I'll report it. I'll deal with this. And it was dealt with."

Later in his oral evidence, in answer to questioning by counsel for Joanna Hernandez and with reference to files that went missing, Maurice Valarino said that every time a new manager was appointed "we had to start from scratch giving all the personal details ... because there was never any handing over of any documentation from manager to manager"[336].

Frederick Becerra

Frederick Becerra made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/8/1**]. I will refer to that witness statement as his "2006 witness statement". He also made a witness statement to the Inquiry [**G1/1/1**], and he gave oral evidence. His daughter, Resident O, is now in her mid-forties. She has been a respite user since about 2000.

In paragraph 2 of his 2006 witness statement [**C1/8/1**], Frederick Becerra said that during the period before Milbury came on the scene the residents were well cared for, but that when Milbury came in things changed.

In paragraphs 3 and 4 of his 2006 witness statement, he referred to two specific incidents which occurred prior to 2002. In the circumstances, I do not consider them further[337].

Emilia Bruzon and Denise Evaristo

Emilia Bruzon and Denise Evaristo made a joint witness statement in the Industrial Tribunal proceedings in 2006 [**C1/4/1**]. I will refer to that witness statement as their "2006 witness statement". Their 2006 witness statement was in Spanish, but the Inquiry has been provided with an English translation [**C1/4/10**]. They also made separate witness statements to the Inquiry [**G/2/1, G/3/1**] and each of them gave oral evidence. They are respectively the grandmother and mother of Resident Z. Resident Z was born in 1996. He suffers from a severe form of epilepsy, and has a learning disability and behavioural difficulties.

In their 2006 witness statement and in their witness statements to the Inquiry, Emilia Bruzon and Denise Evaristo make a number of serious allegations against members of staff at the Home

[335] See Day 3 page 86 line 18.
[336] See Day 3 page 105 line 14.
[337] See the explanation in the introduction to Chapter 2.

in relation to their treatment of Resident Z. Similar allegations in relation to Resident Z are also made by Joanna Hernandez in her third witness statement to the Inquiry [**E/67/1**] – allegations which I address in detail later in this Report[338]. In the circumstances, it is convenient to postpone consideration of the allegations made by Emilia Bruzon and Denise Evaristo so that they can be addressed in conjunction with the allegations about Resident Z made by Joanna Hernandez.

There is, however, a reference to two incidents which do not feature in the allegations made by Joanna Hernandez. In paragraph 5 of their 2006 witness statement [**C1/4/10**] Denise Evaristo says this (in translation):

> "5. .... They also put his head in the freezer and he shouted like an animal. They put him on a motor ski, something could have happened to him."

Moira Elmer

Moira Elmer made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/18/1**]. I will refer to that witness statement as her "2006 witness statement". She also made a witness statement to the Inquiry [**F/18/1**], and she gave oral evidence. In her witness statement to the Inquiry she merely confirmed the contents of her 2006 witness statement.

Moira Elmer and Resident T are sisters. Resident T was born in 1955, and has been a permanent resident at the Home since 2002. As stated in the introduction to Chapter 2, evidence relating to specific allegations made in respect of the treatment of Resident T during the period presently under review, and to the repercussions of such allegations, is reviewed later in this Report[339]. However, Moira Elmer's 2006 witness statement contained evidence of other matters relating to the period presently under review, and that evidence is reviewed below, together with her oral evidence in so far as it relates to other matters.

In paragraph 5 of her 2006 witness statement [**C1/18/1**], Moira Elmer said this:

> "5. Other evenings they [a reference to Richard Muscat, among others] picked on [Resident J], another resident in the Home. As she got ready for bed, he [i.e. Richard Muscat] would say to [Resident AA] "Oh go into [Resident J's] room and throw yourself on her", which he used to do, in a sexual nature, and obviously [Resident J] would be screaming. I suppose this was done for his entertainment and I find it disgusting, because as a carer he is there to look after these vulnerable people and not abuse them. He is there as an authority to help them in life not use them for his own entertainment, cheap entertainment."

In paragraphs 6 and 7 of her 2006 witness statement [**C1/18/1-2**], Moira Elmer referred to an incident involving Resident AA, as related to her by Resident T, as follows:

[338] See Chapter 9.
[339] See Chapter 13.

> "6. Another time [Resident T] said to me that she was trying on some clothes that she had bought, and Angelica [Williams] was in the room with her and all of a sudden [Resident AA] burst in and [Resident T] was in her underwear. Angelica turned around and said to [Resident AA] "Go away, [Resident T] is changing", and she slapped him across the face, and told him to get out.
>
> 7. I went into this and spoke to Michelle [Garro] about it and she told me she thought it had been dealt with but I told her that slapping somebody across the face is not the way to go about it. I told her I thought more security should be available and more care should be taken."

In the course of her oral evidence Moira Elmer said that, when Milbury left, the Home[340]:

> "... seemed to be running the same. There were changes of staff every now and again, there were new members coming in or they used to swap them round from flat to flat. .... It obviously didn't affect me, but obviously my sister, she gets used to a certain carer and she finds it difficult to adjust and get used to new members of staff."

Asked whether Resident T was affected by the changes of carer, Moira Elmer replied[341]:

> "Yes, because she's a ... creature of habit. She gets used to a person, she feels confidence with that person, and it's difficult for her to adjust."

Asked whether she had herself witnessed any incidents of bullying of Resident T, or any incidents of abuse of any kind of Resident T, she replied that she had not, and that her account of such incidents was based entirely on what Resident T had told her[342].

Carmen Dixon-Pritchet

Carmen Dixon-Pritchet made a witness statement in the Industrial Tribunal proceedings in 2006 [**C1/13/1**]. I will refer to that witness statement as her "2006 witness statement". When contacted by the Inquiry team, she said that while she did wish to assist the Inquiry she could not commit to do so for medical reasons. Accordingly she did not make a witness statement to the Inquiry, nor did she give oral evidence.

Carmen Dixon-Pritchet is the mother of Resident AD (a son), who is a respite user. In her 2006 witness statement, she describes Resident AD's experiences at St Bernadette's Occupational Centre (which occupies the ground floor of the building where the Home is situated). She says (in paragraph 8 of her 2006 witness statement [**C1/13/2**]) that at one point (she does not say when) respite care for Resident AD was cut off altogether, due, it would appear, to lack of staff. Her only reference to conditions in the Home in the period presently under review is to be found in the final paragraph of her 2006 witness statement (paragraph 11 [**C1/13/2**]), where she described the Home as being "under a staffing crisis". She went on to say that "the system" (which in context would appear to include both the Home and St Bernadette's) was "failing its clients and seriously impacting [on] the lives of many families who

[340] See Day 6 page 11 line 18ff.
[341] See Day 6 page 12 line 12.
[342] See Day 6 page 12 line 21ff.

are desperate" (in context, this would appear to refer to families such as hers, who were desperate for respite care).

M. A. Beiso

Mrs Beiso made a short witness statement in the Industrial Tribunal proceedings in 2006 [**C1/14/1**]. I will refer to that witness statement as her "2006 witness statement". She is the mother of Resident AJ, who was a respite user. He has since died. When contacted by the Inquiry team, Mrs Beiso said that she did not wish to assist the Inquiry. Accordingly she did not make a witness statement to the Inquiry, nor did she give oral evidence.

In her 2006 witness statement Mrs Beiso says, with reference to Isabella Tosso and Marie Gomez:

> "Ever since these two took up their present position in Social Services, there has only been heartache not only to the parents and our children but also to some members of Staff who were trying to improve the LIMITED LIVELIHOOD/LIFESPAN of our Sons/Daughters."

She exhibited to her 2006 witness statement a bundle of correspondence which appears to relate principally to St Bernadette's, and most of which appears to have been written in 2006. However, the bundle of correspondence does include an undated copy letter (possibly a draft letter) to the editor of an unnamed newspaper and signed "THE CONCERNED PARENTS OF THE DISABLED" [**C1/14/14**]. The letter includes a complaint that a promised extension to the accommodation available for respite care had not as yet been provided.

The bundle of correspondence also includes a letter to Mrs Beiso from Yvette Del Agua (the then Minister for Social Affairs) dated 3 August 2004 [**C1/14/17**], in which the Minister sends her condolences on the death of Mrs Beiso's husband, and assures her that the SSA would assist her with whatever help she might need in looking after Resident AJ.

CHAPTER 5: November 2000 to November 2004: Evidence (4)

Contents

CHAPTER 5: *November 2000 to November 2004: evidence (4)*

In this Chapter I review the evidence of the witnesses in Group 4[343], and of Yvette Del Agua, to the extent that their evidence is relevant to the period currently under review.

Marie Gomez

Marie Gomez is a qualified social worker. She was employed by the SSA in 1992. In June 2004 she became Team Leader (Adult Services), with responsibility for the Home and for St Bernardette's. In about 2009 she was appointed to the newly created post of Disability Team Leader (also with responsibility for the Home and for St Bernadette's). From October 2004 to April 2005 she was Acting CEO of the SSA (Isabella Tosso being the Acting Team Leader during that period), but in April 2005 she reverted to being Team Leader and Isabella Tosso became CEO of the SSA. She retired in 2011.

Marie Gomez made a witness statement in the Industrial Tribunal [**C2/4/1**], but that witness statement contains nothing of relevance to the period currently under review. She has made two witness statements in this Inquiry [**E/17/1** and **E/70/1]**, and she gave oral evidence.

In paragraph 7 of her first witness statement in this Inquiry [**E/17/2**], she says this with reference to petty cash:

> "7. .... Each flat is allocated a set amount per week for essentials and the procedure is that [when] a purchase is made, a receipt is given and the figures should add up at the end of each week. It is deposited with the Finance Officer [Natalie Fortuna] once a week. It is the Senior Support Workers who use the petty cash box, but ultimately the responsibility for ensuring that the numbers are correct lies with the Manager. It is for the Manager to ensure that the money is used appropriately and that receipts are provided. It cannot simply be put off until the next week, because receipts are lost and forgotten. It is the Manager's responsibility to ensure that the receipts are provided and logged."

Marie Gomez' second witness statement in this Inquiry was filed after Gina Llanelo had given oral evidence. With reference to Gina Llanelo's criticisms of her, she says this (in paragraphs 2 to 5 of that witness statement [**E/70/1-2**]:

> "2. Having read the transcript of [Day 4 of the Inquiry] I note that Ms Gina [Llanelo] alleges that I was unhelpful and "*not bothered*" about complaints or requests made.... I believe that what Ms [Llanelo] failed to understand is that just because I listened to requests and agreed with them the ultimate decision was taken by the Government of the day. We were given a budget and could not go beyond that funding and anything extra had to be approved by the Government.
>
> 3. Ms [Llanelo] does not appreciate that behind the scenes I worked tirelessly to improve the service i.e. requesting more staff, more funding, new services etc., and I would prepare reports making a case for certain services or individuals. I encouraged them to "*fight*"[. A]s a civil servant I cannot divulge confidential information, but I knew that as a pressure group they needed to keep fighting for what they wanted.

[343] See the introduction to Chapter 2.

> 4. Neither Ms [Llanelo] nor many other carers know how hard we worked to change the centre hours [a reference to St Bernadette's]. To begin with workers have acquired rights and having had certain conditions of work for many [years] they cannot be changed from one day to the other, especially as they were classified as classroom aides and were government employees. We had tried to transfer the classroom aides to schools but were refused by Government. It was only when we were allowed to employ people under the agency that we were able to introduce new conditions of work. This still created many problems as we had staff doing the same work but with different hours and pay. All this took many months of requesting different venues to finally achieve our aim.
>
> 5. She also alleged that files were going missing and [that] she had to repeatedly re-fill forms ... I understand why parents such as Ms [Llanelo] feel there was a lot of paperwork they had to fill in. Up to the time when I started working as the Team Leader, in 2004, social workers had not been involved with any of the residents in the Home. At the time Douglas Rodriguez instructed that we fill in new forms for carers [i.e. relatives] requesting respite service. Eventually Isabella Tosso decided that as we were trying to cover a very large area of work with just 3 social workers i.e. as the Adult Team we worked with anyone over 18yrs including the elderly and disabled. A social worker was therefore assigned to each person. Consequently the social workers carried out comprehensive assessments with the families with copies kept in the main office."

In her oral evidence, she described the difficulties with petty cash as follows[344]:

> "They were never ... properly done. I am not saying all of the flats didn't have the petty cash properly done, but the majority of them, and there was always problems, and I was getting told by the Financial Officer [Natalie Fortuna] that the petty cash was not in time or not properly done with receipts and the correct amount of money. .... The flats didn't have large sums, but certainly every week there were problems. .... If the Senior is not providing [sic] the petty cash properly, then it's up to the Manager to take it up with the Senior. .... [There was] a very basic [piece of] A4 paper and all you had to do was fill in ... all the receipts with all the money spent, and deduct it from the original amount that you had been given. .... They went personally to the Finance Officer ... and then they got back ... the money for the petty cash for the next week."

In the course of her oral evidence she denied Elizabeth Harrison's allegation that she and Douglas Rodriguez told Elizabeth Harrison that "the new manager would have to go in with a machine gun"[345].

The remainder of Marie Gomez' evidence (written and oral) relates to matters which fall outside the scope of the period currently under review, and will be reviewed later in this Report.

Sharon Berini

Sharon Berini started working at the Home in 1998. She was employed by Milbury as a supply support worker (i.e. not on a permanent contract), before being appointed Deputy Manager by the SSA in late 2002. She resigned in July 2006 to join the Royal Gibraltar Police. During her seven or so years working in the Home, she worked under no less than five Managers.

[344] See Day 13 page 48 line 9ff.
[345] See Day 14 page 44 line 9.

Sharon Berini made a witness statement in the Industrial Tribunal proceedings in 2006 [**C2/25/1**], but it contains nothing of relevance to the period currently under review. She also made a witness statement to the Inquiry [**E/3/1**], and she gave oral evidence.

On page 1 of her witness statement to the Inquiry [**E/3/1**], she says this:

> "I loved my job and I together with the other dedicated staff members worked tirelessly hard to overcome many challenges within the service. These included staff shortages, a lack of training, inadequate facilities and funding and almost yearly changes in the management structure."

On page 4 of her witness statement to the Inquiry [**E/3/4**], she says this with reference to Mandy Spencer's allegations of bullying and manipulative behaviour by her and others:

> "I remember being asked to read [Mandy Spencer's 2006 witness statement] prior to the commencement of [Joanna] Hernandez's Industrial Tribunal claim and being extremely shocked and upset by the content. I was not aware of [Mandy Spencer] having any issues or concerns with regards to my conduct at work yet 4 years after she was unsuccessful in her re[-]application for the Manager[']s post she was writing such things about me. We would frequently socialise outside of work together with her husband Kelvin Ball and other staff members. I was employed as a Senior Support Worker during the period that [Mandy Spencer] managed [the Home] and cannot understand, that if they had existed which I deny, why as manager at the time, she didn't take any steps to prevent these said regimes to be occurring [sic]. Surely conduct such as she describes should have been addressed by her as the manager even without written proof had such conduct been occurring. At the very least her concerns should have been raised with me in order to give me the opportunity to refute them at the time or if indeed it was true to be given the opportunity to rectify my alleged behaviour. They were never raised with me at the time. I totally refute these allegations ...."

As to Mandy Spencer's evidence (in paragraphs 18 and 19 of her 2006 witness statement) that it was she who decided to take Resident Z off medication, she says this (on page 5 of her witness statement [**E/3/5]**):

> "I categorically deny this allegation.... At no time under any circumstances would I have stopped nor did I stop ever any Service User's [m]edication without his/her Doctor having advised it[;] neither would I have permitted this to happen."

As to Mandy Spencer's allegation (in paragraph 22 of her 2006 witness statement) that she manipulated her "for a long long while", Sharon Berini says this (on page 5 of her witness statement [**E/3/5**]):

> "I feel that this must be elaborated on further and explained so that I can have the opportunity to respond properly to a clear and precise allegation. In order to be able to respond I would need to know in what way she claims that I manipulated her and what did it take for her to see through it. In the two years that [Mandy Spencer] was my manager she never spoke to me in relation to this or make any references or accusations to me about this. As far as I was always aware we had a good working relationship and there were no issues or concerns raised about my performance and certainly never anything mentioned in relation to me being manipulative and a bully. As a manager I would expect that that kind of behaviour would not be tolerated by any staff member especially a Senior Support Worker. I find it difficult to understand why it wasn't addressed at the time yet documented over 4 years later."

On pages 7 to 10 of her witness statement [**E/3/7-10**], Sharon Berini turns to the June 2005 statements. In her oral evidence she said that the first time she saw these statements was when copies were provided to her by the Inquiry team in preparation for the Inquiry[346].

As to the statement made by Jonathan Dalrymple, she says that she has no recollection of the alleged incident [**E/3/9**].

As to the statement made by Christian Santos, she explains [**E/3/8-9**] that it had always been the case that staff were given the choice of working either over Christmas or over New Year, and that it was very difficult to find cover for shifts at short notice at that time of year. She says that she cannot comment further as she does not recall the specific occasion to which he refers.
As to the statement by Rose Seruya, she asks the Inquiry to take account of the fact that Rose Seruya has since told her that she was contacted at home by Joanna Hernandez the previous weekend and called into the office; that she was told to use the rear entrance and not to tell anyone where she was going or what she was doing; and that she was asked to put in writing "anything against [Sharon Berini], anything at all" [**E/3/8**].

As to the statement purportedly made by Jackie Palma, she queries the authenticity of the typed up version and expresses surprise that Jackie Palma should have made a statement critical of her, as "she was extremely supportive towards me and did not agree with the management tactics being used against me" [**E/3/9**]. As noted earlier, I consider the circumstances in which the June 2005 statements were obtained later in this Report[347].

As to the statement made by Gabrielle Llambias, Sharon Berini says that she strongly believes that Gabrielle Llambias harboured "prolonged resentment" against her, arising from (among other things) the fact that she (Sharon Berini) had been promoted over Gabrielle Llambias to become Deputy Manager [**E/3/7**].

As to the statement by Emily Dempsey, Sharon Berini explains [**E/3/9**] that on the occasion to which Emily Dempsey refers she (Emily Dempsey) had told a resident with aggressive behaviour to hit her (Sharon Berini); and that the resident in question did not have the capacity to understand that it was meant as a joke. In the circumstances, Sharon Berini regarded Emily Dempsey's behaviour as inappropriate. She accordingly stands by her decision to give Emily Dempsey a warning.

As to Maria Gonzalez' written statement dated 14 June 2005, Sharon Berini says [**E/3/8]** that she cannot recall the particular incident described in the statement, or the details of the investigation which followed it. However, she does recall that both staff members were removed from the night shift and placed on day shifts while an investigation was carried out. She stresses that it was unacceptable for staff members to sleep on night shift unless they were on a "sleep-in". As to Maria Gonzalez' allegation that she was "victimised" by Sharon Berini

[346] See Day 8 page 60 lines 9-13.
[347] See Chapter 10.

and Sean Matto, Sharon Berini says that she and Sean Matto acted appropriately in order to safeguard service users and to protect the two staff members from further allegations while the investigation was being carried out.

As to Maria Gonzalez' undated statement, she says that she was not present when the incident with Nigel Bassadone took place, and that accordingly she can neither confirm nor deny the truth of the statement.

Sharon Berini's witness statement contains no specific response to Nicholas Hassan's statement, but his accusation of favouritism on her part is covered by her other evidence.

As to the statement by Nicola Paine, Sharon Berini denies all the allegations against her. In particular, she denies any knowledge of Richard Muscat having left his shift, or of his having left Resident AE alone in his flat, commenting that had that occurred he would have been removed from night shift, and there would have been a record of the incident [**E/3/8**].

As to the statement by Stacey McKay, Sharon Berini denies all the allegations against her, which she describes as "petty and childish" [**E/3/10**].

As to Gayle Everest's June 2005 statement, she says [**E/3/9-10**] that she cannot recall the conversation alleged to have taken place on 21 July 2004, and she denies having used the words attributed to her in a conversation alleged to have taken place on 30 March 2004. She also denies having been responsible for the decision to dispense with Gayle Everest's services – a decision which, she says, was taken by Joanna Hernandez when she took up her post as Manager. She says that she cannot recall any report by Kirushka Compson about Nigel Bassadone having used a service user's passport for a different service user.

As to the unsigned statement which she believes was written by Karinda Durante [**C2/2/34-35**], Sharon Berini says [**E/3/8**] that she believes that this statement was only provided after Karinda Durante was approached by Joanna Hernandez. She goes on to say that Karinda Durante has since apologised to her for making it.

In the course of her oral evidence, in answer to a question from counsel for Mandy Spencer about their relationship, she said this[348]:

> "I would say that my working relationship with [Mandy Spencer] throughout was a good one. We went out socially as part of a group. So I was quite surprised by Mandy's report against me, or statement that she gave."

In answer to a question from counsel with regard to Mandy Spencer's allegation that their relationship had "deteriorated", she said this[349]:

[348] See Day 8 page 86 line 5ff.
[349] See Day 8 page 86 line 13.

> "Not in my view or my opinion. I was not aware of any difficulties between myself or [Mandy Spencer]. And again, if there [were] difficulties, they were never brought to my attention, never brought up in a support and supervision, never discussed with me in any format whatsoever."

Asked by counsel for Joanna Hernandez about Mandy Spencer's allegation (in paragraph 9 of her 2006 witness statement) that she was a ringleader of a group of "influential, manipulative and bullying" members of staff, Sharon Berini said this[350]:

> "When Mandy [Spencer] was the manager at the time, I was a senior support worker, and there would have been a deputy manager above me. Where she states that I was influential, manipulative and bullying, and ... [the] ringleaders were myself, Nigel, Richard, Sean, Jenny and Jackie, why as the manager was that not tackled at the time? Why is the first time that all of us are hearing about this now, or at the time that statements have been given for [Joanna] Hernandez's Industrial Tribunal [claim] or for the public inquiry? These matters, as far as I am aware, were never raised with any of the staff members that have been named within them. And it's like I said, as far as I was aware, I had a very good working relationship, and relationship outside of work, with [Mandy Spencer]."

As to Gina Llanelo's allegations (in her 2006 witness statement) that Sharon Berini used to tell lies about the availability of members of staff to provide respite care, and that she would say one thing to one relative and another thing to another, she says this (on page 5 of her witness statement [**E/3/5**]):

> "I cannot comment [on this allegation] as I do not know what this is in reference to. I was not inconsistent in the manner suggested or at all. I was consistent at all times and undertook my duties responsibly and properly. .... The Respite and Sitting Service was run mainly on supply Support Workers ... If a staff member did not turn up for a shift or phoned in sick then changes of course needed to be made as staff were redeployed and often cancellations of [an] individual's service would occur."

As to Violet Sullivan's allegations (in paragraph 11 of her 2006 witness statement) that Sharon Berini prevented her from reading the communication book (the implication being that she did so in order to prevent her from learning of an incident or incidents involving Resident I), and that on many occasions Sharon Berini told untruths, Sharon Berini says this (on page 6 of her witness statement [**E/3/6**]):

> "I do not have any idea what this is with regards to and therefore cannot respond appropriately. I deny that I was untruthful."

As to Violet Sullivan's description of her (in paragraph 23 of her 2006 witness statement [**C1/15/7**]) as "wicked" for having arranged to move Resident I to an upstairs room at Bishop Healy, Sharon Berini says this (on the same page [**E/3/6**]):

> "I have a very vague recollection of this move occurring but do not recall the reasons why this decision was made. However what I do recall is that the room that [Resident I] was residing in while temporarily at Bishop Healy was indeed on the ground floor leading out to the patio offering [Resident I] a certain amount of freedom to go in and out supported by a carer. However, as I recall this room had glass patio doors and windows which presented certain Health and Safety issues to [Resident I] who had the potential to bang on these therefore risking them breaking and causing potential harm to himself or others."

[350] See Day 8 page 88 line 14.

In her oral evidence, Sharon Berini agreed that lack of staff was "an ongoing issue"[351]. As regards the training of staff, she said this[352]:

> "I don't think in the field of learning disabilities you can ever have enough training. We were trying to work on it. In fact, in 2004 we commenced a rolling programme of training with Debbie Guinn (who I believe was a senior social worker at the time), and Morag Jack had been the Manager prior to that. So in January [2004] we [did] various training [programmes] with regards to essential life planning, risk assessment, training around medication administration – all sorts."

Later in her oral evidence, she returned to the matter of staff training, saying this[353]:

> "I don't think you can ever have enough training. .... In 2003/4 we had commenced a rolling programme of training for the staff team. We were trying to improve the service, we were looking at as well our recruitment and selection policies, and that was all going on at the same time. So we did do specific training with staff in January and July and August of 2004."

She said this, with reference to the frequent turnover of Managers[354]:

> "Yes, ... it was a difficulty. I worked with various Managers I believe in the time in which I was there, from when I commenced as a supply worker until termination, we had five or six Managers who were there initially on a one-year contract. I think that the most time that any one Manager stayed was for a two-year period. So, yes, that was very difficult for all of the staff."

She went on to say that the large amount of sick leave was also a problem[355].

As to the June 2005 statements, she said that she was not aware of their contents at the time, and that she first saw copies of the statements when she was asked to assist the Inquiry (i.e. in 2013)[356]. Later in her oral evidence, she said this about the June 2005 statements in answer to counsel for Joanna Hernandez[357]:

> "It would be fair to say that those statements are based on a lot of hearsay. People [assume] that things [which they] have not seen or heard for themselves to be true. Staff members that gave those reports against me had themselves been interdicted for one reason or another, and the way in which those reports were obtained, I think it would be fair to say, was completely unreasonable and unprofessional."

Sharon Berini returned to this theme towards the conclusion of her oral evidence, saying this[358]:

> "It would be fair to say that had all of the staff team at [the Home] been asked to produce a report – the whole staff team, which was the staff team of 60 – previous Managers that I had worked with, who I am still in contact with, and I know hold me in high professional regard, had that been the case then I would have said the outcome would have been very different. What

[351] See Day 8 page 57 line 2.
[352] See Day 8 page 57 line 5ff.
[353] See Day 8 page 78 line 14ff.
[354] See Day 8 page 57 line 20ff.
[355] See Day 8 page 59 line 23..
[356] See Day 8 page 60 lines 9-13.
[357] See Day 8 page 97 line 2ff.
[358] See Day 8 page 111 line 1ff.

> you have at the moment is a very biased small collection of people and reports against me, whereas the bigger picture I am very sure would have been different."

As to the administering of medication, she said this[359]:

> "The medication was pre-packed within the pharmacies, so all the medication was pre-packed in small sections, and there was a Medication Administration Record, an MAR sheet, where the staff had to, when they administered medication, check the times in which they were giving it and sign accordingly with that. So there was a medication procedure in place. .... There were issues with regards to the pre-packed system. Initially we were using Morrisons' pharmacy and then we did have to change to another one. .... Obviously throughout my time there certainly there was resistance from staff that they should be administering medicine. We did in January 2004 some training with regards to the administration of medication. But ideally we would have had nurses to have administered the medication for the residents. There was medication that went missing ... . I am [not[360]] saying that the system was perfect. There [were] probably still errors in administering medication. There was human error at the end of the day and we are all humans and we do make mistakes..."

As to care plans, Sharon Berini said this[361]:

> "My recollection of the care plans is very much merged. I know all along through the way we were trying to introduce care plans and ... improve the care planning system. So I wouldn't say that we ever really got there with regards to the care plans, but it was work in progress, definitely."

Asked by counsel for Mandy Spencer to describe the working environment and conditions at the Home, she said this[362]:

> "I think it was probably the same throughout my experience there, that everything could have been improved [on], we were still probably short-staffed, the environment was never really adequate for the purpose in which residents or service users were there."

Asked by counsel for Joanna Hernandez whether she thought she had a good relationship with relatives of residents and respite users in 2004 and 2005, she said this[363]:

> "2004, 2005. I thought I had a good relationship with some parents, relatives, family members. What needs to be understood is that these relatives, first of all, when their relative is a service user or a resident or becomes a new resident, they have to deal with the guilt issues of that, and not being able to deal with their own relative effectively at home, so for whatever reason they come into a residential service. So they are dealing with a lot of guilt, a lot of anxiety, a lot of stresses and a lot of worries. And that's very difficult to deal with, and when they don't feel that their service user is being looked after in the correct manner, because nobody else can do the best job as well as the parent or the relative could, those are big issues for the relatives. But I believe I had a good working relationship with them. Obviously they were never always happy with the responses that I gave as the Manager, but I had to work within the resources, the staffing levels and everything that was available to me. So I can understand if there was some anxiety from them."

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[359] See Day 8 page 79 line 7ff.
[360] The word "not" is missing from the transcript, but in context this is clearly a transcription error.
[361] See Day 8 page 80 line 18.
[362] See Day 8 page 84 line 20.
[363] See Day 8 page 89 line 16ff.

As to Gina Llanelo's criticisms of her operation of the respite service, she said this[364]:

> "This is in relation to staffing. .... Because the respite and sitting service was mainly run on supply staff, which was an 'as and when' basis, staff would cancel at short notice or there would be sick leave, and obviously the residential services took priority with regards to our staffing levels. And also, if a staff member for a specific client didn't turn up, we would look to see whose service had previously been cancelled and we would try to balance it out. So although the staff member was working who was allocated for [Resident AC], they were then moved to somebody else who needed that support."

As to Violet Sullivan's allegations that she lied to relatives of service users, Sharon Berini said that she could not defend herself against those allegations as she did not know "what the actual incidents were in which I wasn't telling the truth"[365]. As to Violet Sullivan's complaint that Sharon Berini had not allowed her to see the communication book, Sharon Berini said this[366]:

> "The communication book was there for staff to read. That was information solely for staff members between shifts. [It] was not for any relative to read information contained within communication books."

The documentation provided to the Inquiry supports Sharon Berini's concerns as to staff shortages. As Albert Bruzon (the current CEO of the Care Agency) explains in his witness statement to the Inquiry [**J1/1/1**], during the period 2003 to 2006 there were frequent complaints by members of staff that staffing numbers were too low for the services being provided[367]. An example of this is an undated document created in 2003 [**J1/29/1**] stating that the respite service was working at maximum capacity and advocating the recruitment of additional permanent staff. On 27 October 2004 a letter was sent by staff at the Home to the Minister highlighting staffing issues at the Home. Further, on 29 October 2004 Sharon Berini (in her capacity as Acting Manager of the Home) sent an internal memorandum [**J1/30/1**] to Isabella Tosso, copying in Marie Gomez and Sean Matto, expressing concern for the safety of residents as a result of low staffing levels during nights, and asking for funding for the employment of an additional member of staff to man each flat at night time. On 3 November 2004 Yvette Del Agua acknowledged receipt of the letter from staff [**J1/31/1**] and stated that she had asked Isabella Tosso and Marie Gomez to look into the issues raised and to initiate a consultation process with representatives of the staff. This was followed by a letter from Marie Gomez to the staff [**J1/31/2**] acknowledging the existence of the problem, stating that a new Manager was being appointed (i.e. Joanna Hernandez), and pointing out that a meeting with staff representatives would be held before the end of the year.

On 12 November 2004, Sharon Berini wrote a memorandum [**J1/31/4**] to Isabella Tosso providing details of staffing levels and numbers of residents in each flat at the Home, and setting out the issues to be faced as a result of there being only one "wake night worker" per flat.

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[364] See Day 8 page 93 line 24ff.
[365] See Day 8 page 93 line 7.
[366] See Day 8 page 93 line 3ff.
[367] See Chapter 1.

The minutes of a management meeting held at the Home on 19 November 2004 [**J1/32/1**] record that Yvette Del Agua had referred the matter to the Chief Minister, and that a staff and financial inspection was being undertaken on the instructions of the Chief Minister.

On 23 November 2004 Sharon Berini sent a further memorandum to Isabella Tosso [**J1/33/1**] setting out the full complement of staff at the Home as at 15 October 2002, 18 December 2003 and 22 November 2004 (the day when Joanna Hernandez became Manager). Further discussion of the impact of staff shortages took place at a supervision meeting at the Home, as recorded in a Supervision Record dated 26 November 2004 [**J1/34/1**].

There followed the management meeting held on 8 December 2004, attended by Joanna Hernandez, Sharon Berini, Marie Gomez, Luis Montiel (representing the staff members' Union), and three other members of staff (Nigel Bassadone, Sean Matto and Craig Farrell). The minutes of the meeting [**J1/35/1**] record that Luis Montiel opened the meeting by saying that there were "many problems" affecting the Home and that an "agreement of understanding" had to be concluded between staff and management. In referring to "many problems" he was undoubtedly referring, among other things, to the problem of understaffing. He added that in previous meetings many things had been discussed and agreed, but no action had as yet been taken in relation to them: again, a reference to, among other things, the problem of understaffing.

Sean Matto

Sean Matto has worked at the Home since 2000. For his first two years he was a support worker. Since then, he has managed various aspects of the services provided by the Home, and he has been Acting Manager of the Home since October 2012. In his witness statement in the Inquiry [**E/59/2**] he points out that during his time at the Home there have been at least eleven different managers, seven different Team Leaders, and ten different Chief Executives. Added to that, there have been no less than three organisations responsible at different times for the Home: Milbury Care Services, the SSA, and now the Care Agency. He describes himself as having an appetite for responsibility and as being highly motivated to succeed. Those qualities certainly came across strongly when he gave oral evidence.

As to Mandy Spencer's references (in paragraph 9 of her 2006 witness statement) to members of staff being "split into two distinct groupings", to "bullying", and to "weak-minded people who thought they would get far by following them like Carol, Sean, Jenny and Jackie and people like that". Sean Matto had this to say (on page 7 of his witness statement to the Inquiry [**E/59/8**]):

> "What did [Mandy Spencer] do in her two years [as Manager] to deal with the situation she describes (which I deny ever existed)...[?] .... As a manager, why didn't she use her conflict management competencies? I can categorically state that Mandy Spencer did not raise any of her concerns to me about my practice or conduct, she did not work through the alleged interpersonal conflicts I presented and did not ensure any alleged problems were addressed in order that

> relationships were strengthened. As a manager, if this was happening, this was her responsibility. Bullying is a very serious matter."

As to Mandy Spencer's assertion (in paragraph 17 of her 2006 witness statement) that "[i]t was just a regime, and ... your bullies ... would manipulate people how they wanted to get what they wanted, and power, basically, was what they wanted", Sean Matto denies that this was the case[368]. He goes on to say that he finds it "impossible to reply [i.e. reply in detail] to such a generalised assertion".

As to the alleged incidents involving Resident C described in paragraphs 12 and 13 of Mandy Spencer's 2006 witness statement, Sean Matto says this (on pages 7 and 8 of his witness statement [**E/59/8-9**]):

> "[Resident C's] mother [Elizabeth Featherstone], as you would expect[,] is a very protective mother who has never hesitated to raise her concerns and make a complaint about her son's care. I would like to know where the complaints are relating to [Resident C] where I was allegedly involved... Mandy [Spencer] as an ex-Manager was well aware of Complaints, Adult protection and whistle blowing policies and procedures. .... Why did [Mandy Spencer] not raise her concerns at the time?"

As to Mandy Spencer's assertion (in paragraph 23 of her 2006 witness statement) that "Sean is very manipulative ...", he describes that assertion as "inaccurate, unsubstantiated and untrue"[369]. As to Stacey McKay's June 2005 statement, he describes her [**E/59/12**] as "an ambitious carer who from early on wanted a senior[']s post". He describes her June 2005 statement as dishonest and untruthful. He goes on:

> "It is no secret that individuals were approached and coerced by Ms Hernandez and her gang and promised positions and all sorts in exchange for these types of reports and they were not interested in whether they were truthful or factual as ... is evident."

In the course of his oral evidence, he had this to say about the alleged lack of policies and procedures after Milbury left[370]:

> "I have read ... that during Ms Hernandez' time there were no policies and procedures and that she had to implement them, when in effect the same procedures ... were [there] when this team of social workers were sent in[371] ... All that Isabella Tosso did was to get the Milbury policy and change the letterhead and continue to use what we still use today as well as a complementary policy to our current one, which is the 2002 Directives .... This is why in effect the Milbury policy was brought back into the picture by Isabella Tosso. .... Because the problem we have always had at [the Home] is in my time I think we have [had something] like ten Managers. Every time a new Manager comes in ... someone wants to re-invent the wheel again."

As to Jonathan Dalrymple's complaints, he recalled that they were looked into, but he could not recall the outcome[372].

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[368] See page 7 of his witness statement [**E/59/8**].
[369] See page 8 of his witness statement [**E/59/9**].
[370] See Day 7 page 195 line 10ff.
[371] See Chapter 11.
[372] See Day 7 page 200 line 6.

In relation to petty cash, he said this[373]:

> "Probably it's important to raise and highlight for everyone to be aware of that there have been numerous problems, throughout my time anyway, and ... probably ... before, with regards [to] moneys because basically the system that's always been in place has been full of flaws. .... This is a 24-hour service, ... so basically you are talking about two-thirds of the time that the service is running ... there is no management [i.e. no Manager is present in the Home]. So when service users go out with staff, staff are always allocated money, then they don't have anyone to hand it over [to], so they will leave it for whenever the Manager comes back to actually process it. The system has now changed and that's why we don't have the same problem."

Asked about references in Mandy Spencer's evidence to petty cash going missing, he said this[374]:

> "I have always been honest and I have actually raised that it's missing. I write the necessary reports because at the end of the day there is a system in place whereby if things go wrong you just report them. Errors are made, staff make errors, same as I made errors, and I am sure ... everyone makes errors."

As to the various allegations of unfairness by him and Sharon Berini, and of favouritism on the part of Sharon Berini, he said this[375]:

> "Fairness for me is a very relative concept. At the end of the day, you will only see what it is in your interests to see. There are very few people that will actually try particularly in those circumstances to see the more holistic picture. So it may have appeared that she [i.e. Sharon Berini] was favouring Angela [Berini] … – I don't remember this, in all fairness, but I am sure that when Mrs Berini was taking this decision it was not based on her sister, it was purely based on the client."

Asked by counsel for Kirushka Compson why the previous practice of taking residents to carers' homes had since been banned, Sean Matto said this[376]:

> "The reasons are obviously very much to do with health and safety. .... If you take a service user home ... and it happens to be a challenging service user and they do something, they present some behaviour which puts them into a very difficult position, and imagine your son is there, and he as well is in a difficult position, you are going to have to choose between the two. So you shouldn't be put in a position where you actually have to choose between your son and a service user. .... You will be put in a position where you have a conflict of interest. .... Whereas in the past, ... if you had a young person with a learning disability, you need[ed] to understand that maybe if you took them to the park, parents would actually fear for their children and you would actually isolate the person with disabilities because sometimes it took individuals that worked within the Home to actually integrate the service user with their own family members. Now that people with disabilities are very much more integrated into society, that is definitely not an issue, and I'm sure that that's why it hasn't actually influenced whether people or relatives feel that their children are isolated."

[373] See Day 7 page 200 line 25.
[374] See Day 7 page 202 line 11.
[375] See Day 7 page 211 lines 12-20.
[376] See Day 7 page 213 line 4 to page 214 line 18.

Asked by counsel for Joanna Hernandez for his assessment of Sharon Berini as Deputy Manager, he said that she was no less hard-working than Joanna Hernandez, and fairer than Joanna Hernandez. He went on[377]:

> "[She was] more organised [and] had more of the technical skills necessary. She had been a carer herself. She was able to manage the individuals and thus understood much better as well what the requirements were both for service users and staff themselves. She was less qualified [than Joanna], though, from what I see in the documentation, but then again she had the experience in the field which Joanna didn't have, and which was very much evident."

Asked by counsel about Denise Hassan's allegations of misconduct by carers in relation to Resident N, Sean Matto said that he was not aware that any such incident had occurred. He continued[378]:

> "I am aware that Resident N does have some inappropriate behaviour ...with regard [to] inappropriate touching. .... That ... was addressed at the time. Until a few years ago it was a particular problem. .... He used to actually have inappropriate behaviour towards staff. .... I'm not saying it was acceptable, but it's common with people with learning disabilities because the fact they have got a learning disability doesn't help in individuals responding adequately..."

Asked by counsel about Mandy Spencer's allegations of bullying and manipulative behaviour by him and others, he said this[379]:

> "Firstly, I disagree. ... Secondly, I would not have actually participated in any bullying .., or manipulative behaviour. Thirdly, I would actually have brought it up to management's attention. So I can't say anything more."

Asked by counsel for Joanna Hernandez about the incident relating to Resident C described in paragraph 12 of Mandy Spencer's 2006 witness statement, Sean Matto said this[380]:

> "If there was a mattress it's because a manager must have actually – or even the mother must have actually requested that it be put there. With regard to the other parts [of paragraph 12], it's ridiculous. .... It's untrue; didn't happen. It's very much in line with a lot of other allegations that are made in order to discredit me, really."

He went on to say that he could remember Resident C having a head injury but he could not remember the specific occasion described by Mandy Spencer. He went on to say that there was a procedure for calling an ambulance or taking the resident to hospital[381].

Asked by counsel for Joanna Hernandez about Mandy Spencer's reference (in paragraph 17 of her 2006 witness statement) to a "group of bullies", he replied[382]:

> "No, there wasn't a group of bullies, and I can elaborate really, individuals who probably felt threatened by the fact that Mandy [Spencer] worked there, her husband worked there, her

[377] See Day 8 page 16 line 7ff.
[378] See Day 8 page 20 line 13ff.
[379] See Day 8 page 22 line 12ff.
[380] See Day 8 page 24 line 11ff.
[381] See Day 8 page 24 line 24.
[382] See Day 8 page 25 line 15ff.

> husband's daughter worked there, and ultimately that's not very conducive to the right type of environment where people are going to feel comfortable coming forward with things. The thing is, sometimes a common trend I have found with managers is that when staff disagree with managers with regards [to] care and with regards [to] strategies, it all quickly turns round. It's turned round and they actually state that bullying took place; that individuals were being manipulative, et cetera."

He went on to describe the allegation as false, saying[383]:

> "Firstly, if it was taking place, why didn't the manager come forward and actually investigate and do the necessary work that was required, requesting – the thing is, if people don't come forward, usually (or in my experience anyway) sometimes people will say: "I am telling you this, but I don't want you to write it down". That to me suffices, as a manager. I don't require it to be written. And yes, obviously the outcome might be slightly different, but you can still deal with things. ... It has happened in the past. Not with bullying, it's happened with things. And things which individuals are – sometimes they come with that because individuals are unsure, unfortunately due to lack of knowledge and training they are unsure about whether a practice is good or not or there's something they feel uncomfortable about, usually there's a lot of directives that come down from management which they don't seem to understand, maybe they were not explained appropriately, and that in itself does raise concerns and at times people come and say: "Well, this has been implemented. It's not working, but I don't want you to say it's actually me that's complaining."

Nigel Bassadone

Nigel Bassadone was employed as a support worker at the Home from 1997 to 2008. During this time his main duties consisted of the general care of adult residents, their medical care and development of their everyday living skills. For his first year he was part of the team caring for Resident AE, who had previously been in a care home in Malaga. Resident AE required a 2:1 care ratio as he was (in Nigel Bassadone's words: see paragraph 2 of his witness statement [**E/2/1**]) "a volatile and quite violent young person who was diagnosed as having bi polar, manic depressive".

He was then moved to another team which cared for a respite user, Resident L, who arrived at the Home aged 3 years. Nigel Bassadone describes him as "also a very violent and very volatile young man" [***ibid.***]. Resident L was subsequently relocated to Bishop Healy. Later, during Joanna Hernandez' time as Manager, Resident L was relocated to a flat at Flat Bastion Road, where he was cared for by the Children's Service section of the SSA[384].

As to Mandy Spencer's suspicion that he may have been involved in taking and/or disposing of her passport (see paragraph 2 of her 2006 witness statement), he says this in paragraph 6 of his witness statement [**E/2/4**]:

> "These allegations are totally denied. I have never been involved in the taking of a passport from [Mandy Spencer's] bag or disposing of the same in the loft or the claim that I burnt the passport in question. This is the first time that I have heard that the passport had been taken

[383] See Day 8 page 26 line 17.
[384] At no stage was the flat at Flat Bastion Road part of the Home. See Chapter 14.

> from her handbag, or the fact that it had been disposed of by throwing it in the loft or that I had burnt the said document. I am startled at this given that I have always had such a good relationship with [Mandy Spencer] and her husband Kelvin ... who we used to on a very frequent basis go out and socialise together in La Linea Spain and these allegations have never come to my knowledge."

In paragraph 5 of his witness statement [**E/2/4**], he says that he has no recollection of the incident described by Jordan Davis in his 2006 witness statement.

In paragraph 7 of his witness statement [**E/2/5**] he addresses Mandy Spencer's allegation of sexual activity on the trip to Lourdes in April 2001 (see paragraph 3 of her 2006 witness statement) as follows:

> "This allegation is denied. .... The train trip was from Malaga to Barcelona and thereafter we took a coach to Lourdes. I was the support worker for [Resident A: a male resident], whose disability is [Downs syndrome]. .... The train journey was overnight. In the train the cabins were assigned to the service users in accordance with their disability and the more disabled service users had the bigger cabins so to cater for their disability. .... [Resident A] and I had to share a cabin with [Resident V: a female resident] who was supported by care worker Jennifer Garrett. There were two sets of bunk beds and we decided that we would each sleep above the service user that we were not supporting so that we could have full view from the top bunk bed. So I slept above [Resident V] and Jennifer Garrett slept above [Resident A]. ....
>
> The very first time that I have heard of these allegations was when I was handed the documents for the Inquiry and although it is not true it is having an adverse effect on me and my family life.
>
> Again I do not understand this as it has never been mentioned to me by [Mandy Spencer] who I have always had a good working relationship with and would also socialise with her and other members of staff in La Linea Spain. I am sure that if what she claims is true that they did inform her of that incident that I totally deny she would have mentioned it before. Furthermore why I was never approached by her and I was informed of this gross misconduct and indecency and why she allowed me to continue working with the service users and seemed happy with my performance at work and there was never a mention of being supervised is also a surprise to me after seeing the contents of this allegation. ...."

As to the incident on 27 January 2002 (described by Mandy Spencer in paragraph 5 of her 2006 witness statement), he says this in paragraph 8 of his witness statement [**E/2/7**]:

> "Notwithstanding the fact that the substantive claim is accepted in so far as ... there was an incident and I was suspended and subsequently disciplined, the facts as [Mandy Spencer] claims them in her [2006 witness statement], four years after the incident are untrue and don't reflect the facts as they occurred on the date in question.
>
> [Mandy Spencer] and the other witnesses to the incident provided contemporaneous statements and the same formed part of the disciplinary. The facts contained within [those] statements are totally different to the facts that [Mandy Spencer] included in her [2006 witness statement].
>
> I never assaulted Jennifer Garrett by pinning her against the kitchen door [sic], there has never been a mention that Angelica Williams was in tears, there is no mention that I flew over to [Mandy Spencer] and she had to cling to out of [sic] the balcony as she thought that she was going to fall backwards out of the balcony. Furthermore she now claims that in her own opinion ... I was either drunk or stoned and that from the look in my eyes I was stoned and that she could smell alcohol.
>
> At the disciplinary I gave a full version of what had happened.... I had gone out the night before and I had been on medication and had not read the small print that I could not drink alcohol with the said tablets and I had a very bad reaction. It is true that I had consumed 4 or 5 beers that night and I apologised profusely as my behaviour was unacceptable."

He goes on (in paragraph 10 of his witness statement [**E/2/8]**) to deny the allegations made by Mandy Spencer in paragraphs 6 and 7 of her 2006 witness statement to the effect that he, together with others, formed a group that were manipulative, influential and bullies.

As to the allegation (in paragraph 19 of Mandy Spencer's 2006 witness statement) that he told Resident Z's carer to make Resident Z stand facing the wall with heavy books on his hands, he says this (in paragraph 11 of his witness statement [**E/2/8**]):

> "This is totally denied and all I can say is that if this would have occurred, ... a full investigation would have taken place and I would have at least had the chance to have been made aware of such an accusation and the right to reply to the same. I have never been the senior in [Resident Z's] team or whilst at the Home and again this is the first time that I have been made aware of such an accusation."

As to the allegation (in paragraph 21 of Mandy Spencer's 2006 witness statement) that he bullied and manipulated Sharon Berini, he says this (in paragraph 12 of his witness statement [**E/2/9**]):

> "Sharon and I were a couple and we have two children out of our union. Although we may have had our differences and as a result we ended our relationship we have always maintained a very cordial relationship and when we were at work we maintained a very professional relationship.
>
> I would like to add that if I were grossly manipulative or a bully it would be Sharon Berini that would have to say this."

As to the reference in paragraph 22 of Mandy Spencer's 2006 witness statement to "Nigel taking tablets", he says this (in paragraph 13 of his witness statement [**E/2/9**]):

> "I have never taken tablets as claimed by [Mandy Spencer], I am unsure what she is referring to but if they are the tablets referred to in paragraph 11 of her [2006] witness statement this is totally denied, when in fact I was questioned over this incident by the CID and nothing untoward was noted and I was the person who raised the issue with her and requested that the CID were to get involved."

As to the allegations (in paragraph 23 of Mandy Spencer's 2006 witness statement) that he is "very manipulative and hostile" and "a dangerous human being", and that he "went through drug rehabilitation in the UK for four weeks" while she was working in the Home, he says this (in paragraph 14 of his witness statement [**E/2/9-12**]):

> "I would like to start by saying that these allegations are denied[.] I am not a manipulative person and I have never threatened any member of staff and I put [Mandy Spencer] on strict proof of the same and request that she provides evidence to corroborate her malicious statement. ....
>
> In relation to the assertions that she makes about me having attended rehab in the UK, and I was given four weeks unpaid leave; that is denied. I have never been in rehab in the UK or anywhere else and I have never been given 4 weeks unpaid leave and this can be checked in my personal file and rotas and records of leave which have always been kept by the [SSA]."

As to Jonathan Dalrymple's allegation (in his June 2005 statement) that Nigel Bassadone was in some way responsible for the missing Ritalin tablet, Nigel Bassadone says (in paragraph 16 of his witness statement [**E/2/10-11**]) that he cannot recall the alleged incident.

In paragraph 17 of his witness statement [**E/2/11**], he denies Gayle Everest's allegation (in her June 2005 statement) that he used a resident's passport for another resident, saying that the incident never occurred. In paragraph 22 of his witness statement [**E/2/15**], he refers to the previous practice of taking service users to carers' homes. With reference to Resident L, he says this:

> "I have never ever been made aware that I could not take [Resident L] home.... [Resident L] has always been taken home by the carers as he has always had very little contact with other children of his age. This was a way of [Resident L] interacting with young boys of his age being my children and children of other carers and at the same time he would be monitored by us reducing the possibility of him harming any of our children, something that he never did and he always enjoyed being around them..."

In the course of his oral evidence, he said that his relationship with Sharon Berini came to an end in late 2000, at which point they (as he put it) "called it a day"[385].

As to the trip to Lourdes, he explained[386] that although he was the assigned carer of Resident A on the journey to Lourdes, once they reached Lourdes he was assigned to Matthew Turnock (at that time, a resident at the Home[387]) and thereafter shared a room with him. He was not sure whether he travelled back from Lourdes with him. He confirmed that Mandy Spencer never mentioned the alleged incident to him, neither did anyone question him about it at the time[388].

As to the incident on 27 January 2002, he said this[389]:

> "I have never denied ... the incident actually happened. I took full responsibility [for] what I did. I know I did wrong; perhaps I should have gone home and phoned in sick. That's probably a mistake that I made. But ... obviously I was there and ... I felt that I was capable of working. Obviously I wasn't, but I've never hidden the fact. And I went to the disciplinary knowing I could be dismissed or fired. .... At the time I was under treatment for depression, and I had just started the treatment, I believe, just started, or the medication wasn't compatible with alcohol, so I had met a few friends, gone out for a few drinks, and obviously ... it didn't work out. So I went, actually I did go in, took my clothes off, I don't know, taking a jacket [off] and lying on a sofa. .... And it was all because I insisted I wanted to stay and work, and the other persons there were advising me to just go home."

He went on to admit that he raised his voice, but denied that he was violent[390].

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[385] See Day 7 page 115 lines 15 and 17.
[386] See Day 7 page 134 line 1ff.
[387] Matthew Turnock is a witness in Group 4. He subsequently ceased to be a resident at the Home and was employed at St Bernadette's Occupational Centre, which was – and is – situated in the same building as the Home. The Home is on the first floor: St Bernadette's is on the ground floor. Matthew Turnock provided a witness statement to the Inquiry [**K/1/1**], but did not give oral evidence. In his witness statement, Matthew Turnock says that Nigel Bassadone "slept in the carriage with me at all times".
[388] See Day 7 page 136 line 13ff.
[389] See Day 7 page 139 line 21ff.
[390] See Day 7 page 140 lines 22-25.

Counsel to the Inquiry then referred him to the submissions made by Duncan Jones at the disciplinary hearing, as recorded in the minutes of that hearing [**M15/4/6**]. The relevant passage in the minutes reads as follows:

> "There is support for everything said by [Nigel Bassadone's counsel] on behalf of NB.
>
> Mr Jones explained that for him it was not that NB was drunk or not but there had been an interaction of alcohol and medication.
>
> Mr Jones said he is aware of NB's work and they met around 3 years ago. He is a person who is committed to his work, highly thought of both by colleagues, service users and family. He is also aware that part of the reason NB went to work was not to let a colleague down and the team. He is a person that works and undertakes any task, is good with people and reliable. Mr Jones added he doesn't want to lose NB and this was an unfortunate event. Mr Jones is aware NB has done something about it by going to the doctor and the facts are that he was intoxicated with alcohol and medication.
>
> Some action must be taken, but the service does not want to lose NB."

He confirmed that following the disciplinary hearing he was given a written warning[391].

As to Mandy Spencer's allegations that he was involved in petty cash and drugs going missing, he described them as untrue[392]. As to her reference to "Nigel taking tablets", he said this[393]:

> "At the very beginning when Milbury came, there were certain tablets, ... and tablets did go missing. I was the one that raised the alarm. I was the one that went over to St Martin's School and spoke to the nurse there, if there was a procedure or anything to store medication because obviously the cabinet was on the floor, it wasn't on the wall, there was no key to it, there [were] no records, there was nothing. And she produced what I think she [called] a DDA book. CID were called in, I was [one] of the people being questioned. But that's the only recollection I've got of tablets going missing."

He went on to say that that incident occurred in 1997 or 1998[394].

In answer to counsel for Joanna Hernandez, he denied Maria Gonzalez' allegation (in her undated June 2005 statement) that on an occasion in May 2005 he turned up at the Home smelling of alcohol[395].

As to the suggestion that he used the hours when Resident L was at St Martin's School to do the housework at his home, he said this[396]:

> "I don't think you know me, but people who know me [know that] I'm very passionate about my work, and I can tell you and I can guarantee you that those hours from 9 o'clock to 3.30 were always used effectively, either cleaning the house or doing up his house, ... putting [away] all the washing, medications, whatever. .... I am not workshy."

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391 See Day 7 page 143 line 19.
392 See Day 7 page 144 line 23.
393 See Day 7 page 144 line 25.
394 See Day 7 page 145 line 14.
395 See Day 7 page 173 line 15.
396 See Day 7 page 180 line 23ff.

Richard Muscat

Richard Muscat worked in the Home for some thirteen years until 2004, when he was interdicted pursuant to the 2002 Directions. I will consider the circumstances of his interdiction, and the subsequent history relating to it, later in this Report[397]. He now works in the shipping industry.

On page 3 of his witness statement to the Inquiry [**E/60/3]** he says this about Mandy Spencer's allegation that he was complicit in the matter of her missing passport (see paragraph 2 of her 2006 witness statement, referred to above):

> "I totally deny that I ever did this and do not understand why I would not want her to come to the Christmas staff dinner which is why she claims I did this. I was never confronted for having allegedly done this at the time, either by her or by the witness. I cannot understand why Mandy would make this accusation against me at all but especially in the absence of any evidence."

As to Mandy Spencer's allegation (in paragraph 17 of her 2006 witness statement, quoted above) that he was a bully who manipulated people to get what he wanted, he says this on page 3 of his witness statement [**E/60/3**]:

> "I deny adamantly that I have ever bullied or manipulated anyone, let alone the staff at the Home. Given the nature of the work it is very important that staff work together and I would have never done anything to undermine this. This would in fact make it very difficult to carry out our duties appropriately."

He goes on (on page 4 of his witness statement [**E/60/4**]):

> "When I disagreed with decisions made by the management which I believed were wrong I would however raise these with Mandy. I felt my 7 year working experience at the home allowed me to do this. When doing so I always used to question her in a civil and correct manner. I think Mandy lacked leadership skills and had little self[-]confidence. It may be for this reason that she may have interpreted my questioning of her decisions as overpowering and as bullying. If this was the case it was certainly not intended in that manner. My questions were raised in an adequate and appropriate manner and in a manner in which I felt entitled to raise them as a long[-]term employee."

On the same page of his witness statement he has this to say about Moira Elmer's allegation (in paragraph 5 of her witness statement) as to his conduct towards Residents AA and J [**E/60/4**]:

> "Moira does not mention me directly, but it can be implied that I am included in the word "they". She claims that [Resident AA] was told by these persons to lie on top of [Resident J] whilst she was getting ready to go to bed and claims that this was done in a sexual manner and [Resident J] would be screaming. I totally deny being part of this if this in fact occurred. Furthermore, from my recollection shifts were changed at 21.00. I never worked night shifts in Flat 2 and could not have therefore been present."

[397] See Chapter 13.

As to the allegations made by Nicola Paine and Stacey McKay in their June 2005 statements, Richard Muscat says this (on page 6 of his witness statement [**E/60/6**]):

> "[Nicola Paine's statement] mentions that Sharon displayed favouritism towards me, to move me into [Resident AE's] team on night duty. Nicola also writes down that I left [Resident AE] unattended in his flat. This is totally untrue as [Resident AE's] challenging behaviour has to be monitored 24 hours a day. This is why he had two carers during the day and one during the night. I deny leaving [Resident AE] alone at any time when I was supposed to be minding him. I had worked with [Resident AE] ever since he came from the UK and had a really good relationship with him. I think Sharon's decision to put me back into his team was purely because of my experience, as I had been the person who had worked longest with him.
>
> [In Stacey McKay's statement] she claims that she saw me out whilst working. She is correct in that I was out, but she did not unfortunately see [Resident AE] who at the time was a few metres in front of me. At the time I worked with [Resident AE] at [Merlot] House in Vineyards estate. On that day we both went to my mother's house which is five minutes walking distance away from Vineyard House to collect my bike which needed fixing which is something I did during my night shift. At the time when I was allegedly seen alone Stacey was indoors and sitting around a table with other individuals and was not therefore able to see [Resident AE] walking in front of me. When she saw me passing by I gestured bye to her. To my surprise when this was brought to management's attention by Stacey, I explained what had really happened and clearly stated that I had not left [Resident AE] alone. She also accuses me of flirting with Sharon and comes to a conclusion that Sharon did not do anything about the incident because of this. Sharon and I had a good but purely working relationship. In any event at the time I was in a long term relationship with Michelle's daughter ... , the mother of my two youngest children. Not only would it have been wholly inappropriate to be flirting with Sharon, but it would have been noticed by Michelle, ... who would have inevitably confronted either of us. This simply did not happen."

In his oral evidence, Richard Muscat confirmed that Mandy Spencer's allegation against him relating to her missing passport was not true[398].

As to Mandy Spencer's description of him as a bully and a manipulator, he denied it, but he said that he "could see maybe where she is coming from"[399]. He went on:

> "I got on well with Mandy ... but obviously Mandy for me lacked a bit of leadership. .... I used to question things that she maybe – change of care plans and obviously that is why maybe she is calling me a bully. Obviously every time I approached her it was professionally and for the better of the service, not actually bullying. .... I think she lacked management skills and leadership, and that's my personal opinion. .... We used to not agree with certain things, but seldom were the times that I think we came to disagreement about something."

Counsel for the GDS asked him about the existence of a timeout room at Merlot House, and in particular whether he could recall giving Resident AE a "time-out" or taking him to a place of relaxation. He replied[400]:

> "Resident AE was challenging ... to his own health, and maybe he used to smash glass, ... I remember ... at the time there was a room which ... had metal bars on the outside, which didn't really look ... very nice, but obviously at times we felt that maybe he needed time out .... But the room was an empty room. .... But my relationship with Resident AE was really, really good. I was adding the times that I had to ... and I think never [had to resort to] time-out or something

[398] See Day 11 page 96 line 13.
[399] See Day 11 page 97 line 1.
[400] See Day 11 page 104 line 11ff.

> like that with him. .... It was a place ... to protect ... Resident AE and ... vulnerable people around him. Because remember Resident AE didn't live in his home alone at that time. Other residents were around, so there had to be a place where – and that was the whole idea behind it. .... I suppose that if residents around him would have been in danger, then that would have been an appropriate time to move him to the time-out room. .... I didn't experience any aggressiveness towards staff or individuals, which was the main concern. .... He had an obsession with fire alarms, and ... he could break glass, [so] he could attract attention that way; but I don't think he was aggressive to any individuals as such. .... I never had [to] put him into the room."

He went on to say that he did not know of any other carer putting Resident AE in that room, but that the room was there in case something "escalated and happened"; it was, he said, "part of the care plan"[401].

Jennifer Garrett

Jennifer Garrett worked in the Home as a care worker/support worker from 1999 to 2005, with a two-year break from 2002 to 2004. Following Milbury's process of 'unitisation', she worked mainly in Flat 3 (respite). She later worked for a time in Flat 2. When she returned to the Home in 2004 she worked as a supply worker until she left the service in October 2005, to join the ambulance service. She gave written and oral evidence to the Inquiry.

In paragraph 4 of her witness statement to the Inquiry [**E/15/2**] she addresses Mandy Spencer's allegation of sexual behaviour by staff members on the trip to Lourdes. She says that she recalls the trip; that it involved an overnight train journey; that she was accompanying Resident V; that Nigel Bassadone was accompanying Resident A; and that the four of them shared a cabin. She corroborates Nigel Bassadone's evidence that she slept in the bunk above Resident A and Nigel Bassadone slept in the bunk above Resident V "so that we could have full view from the top bunk bed". She goes on (in subparagraph j. of paragraph 4):

> "The allegation[s] contained within Mandy [Spencer's] statement are untrue and I would like to get to the bottom of this allegation as I cannot understand why this has been claimed and would like the person who has started this malicious rumour to be put on strict proof. The very first time I have heard of these allegations was when I was handed the documents for the Inquiry and although it is not true it is having an adverse effect on my life and family as everyone in Gibraltar is now talking about this and I have had people even come up to me and ask me directly whether this is true or not. Unfortunately I have an 11 year old daughter who has also been approached by friends in school and who I have had to give explanations to and this again is a big concern and is causing me an added stress that is very unfair as I have never done anything of that nature and least of all in front of service users."

In her oral evidence she confirmed the truth of her witness statement, saying, with reference to Mandy Spencer's allegation[402]:

> "It's not true. It didn't happen."

[401] See Day 11 page 107 line 11ff.
[402] See Day 8 page 121 line 4.

When counsel to the Inquiry referred her to Matthew Turnock's evidence that Nigel Bassadone accompanied him throughout the trip, she confirmed that on the train journey Nigel Bassadone was accompanying Resident A[403].

In answer to counsel for Nigel Bassadone, she gave the year of the Lourdes trip as 2001[404].

Michelle Garro

Michelle Garro worked at the Home from 1994 to 2006. For the first eight of those years she was a care worker; she then became a senior care worker for the rest of her time at the Home[405].

On 23 September 2004 Jonathan Dalrymple, a recently-arrived care worker, wrote a memorandum of complaint to Sharon Berini and Sean Matto [**M23/22/1-2**][406]. His memorandum reads as follows:

> "In the two and a half weeks I have been working at Flat 2 I have witnessed unprofessional conduct and unpleasant treatment/behaviour towards the residents and staff.
>
> I am writing a formal complaint because what I have witnessed is not nice and [I] would not like for others what I do not like for myself. The following are brief descriptions:
>
> [Resident AA: a male resident] has been taught how to provoke and wind up [Resident J: a female resident] by saying to her "mimosin dice que no". [Resident J] will get worryingly tense and distressed and answer back shouting "mimosin dice que si". This sometimes goes on like a tug of war. [Resident J] will start to cry and complain that her forearms hurt (from getting so tense) still nothing would be done mainly by Angelica [Williams] and Yvette [Borastero] who are too busy laughing.
>
> Then on Monday (after the last wknd of the fair in La Linea) when I got to work I read the reports and it [sic] said they had been resting all weekend. This I know was due to members of staff sleeping in during the day time as they were tired from the night before as they had been to the fair in their own time. This while residents wandered around during two very hot summer days and the flat was left in a mess and dirty. On Monday morning [Resident Z's] bedroom stunk to an extent that I had to leave. To get in again I had to hold my nose with my fingers.
>
> Michelle G [Garro] [is] always telling management she has time owing from the day before so she could go early but never actually did extra hours.
>
> Every single thing Michelle G does not like about new members of staff at flat 2 she would share with [the] rest of the family. On one occasion I was preparing [Resident Z's] room in the morning and [overheard] Michelle repeating a conversation she had had with me earlier over the phone, so I walked back to her office and asked her if she was speaking to management. She replied no, and that is when I told her that I did not think that was professional enough. I then asked ... two residents if they wanted to go out which they did and went. Whilst out we popped over to see Sharon but [she] was not there. Spoke to Kirushka C [Compson] and Craig [Farrell] about this but although they felt it was not right they referred me to Management.

[403] See Day 8 page 119 line 19.
[404] See Day 8 page 123 line 10.
[405] See Day 8 page 125 line 18.
[406] Sharon Berini did not refer to this memorandum in her witness statement. In her oral evidence, she said that she could not remember it (see Day 8 page 83 line 1).

> Then another morning I [overheard] two staff members commenting that Michelle had been trying to contact [Resident Z's] family to get them to complain that they did not want me to work with [Resident Z] but for [their] bad luck they were on holiday."

Jonathan Dalrymple did not give evidence to the Inquiry.

In paragraphs 6 to 10 of her witness statement [**E/16/1**], Michelle Garro said this about Jonathan Dalrymple's memorandum, addressing it paragraph by paragraph:

> "Paragraph 3:
> 6. [Resident J] has been using the phrase "mimosin dice que si" well before she began to stay at the Home. It is true that [Resident J] used to have arguments with [Resident AA] but this was because [Resident AA] used to like hugging everyone, including [Resident J], and [Resident J] did not particularly enjoy being hugged. [Resident AA] is a calm individual who would never participate in "mimosin" conversations as alleged in the [memorandum].
>
> Paragraph 4:
> 7. The Service Users were always taken out on weekends, even during winter. There would only be the occasional weekend during the year when the Service Users would stay indoors to watch television.
>
> Paragraph 5:
> 8. I would never get paid for staying at work beyond my normal working hours. I fail to understand how after having only been working for 2 weeks in Flat 2, Jonathan [Dalrymple] had gained such an understanding of private matters in relation to my employment at the Home.
>
> Paragraph 6:
> 9. I am at a loss to understand how Jonathan could be certain about who I was speaking to on the phone. In any event this could not have been true as I always spoke in person, i.e. face to face, to those family members (including my sisters) who worked in the Home.
>
> Paragraph 7:
> 10. I do not know where Jonathan has heard this allegation, but I would not have called [Resident Z's] family personally. Instead I would have reported the matter to my deputy or my manager. I believe that Jonathan has fabricated these allegations."

In her oral evidence, Michelle Garro described Resident AA as "a very loveable person" who "likes hugging people all the time, but never in a nature of hitting anybody"[407]. She put his current age at about 60[408]. As to his mental capacity, she described him as "like a 10-year old boy"[409]. She went on to say that she had known him all her life because "he used to come to the beach, his parents and my mother"[410]. Later in her evidence she described Resident AA as "very repetitive all the time and sort of constantly speaking"[411].

She described the atmosphere in the Home for the first few years after it opened in 1994 as "just like a big family"[412]. Asked for her general impression of the Home during the Milbury era, she said[413]:

[407] See Day 8 page 141 line 20.
[408] See Day 8 page 141 line 24.
[409] See Day 8 page 142 line 7.
[410] See Day 8 page 142 line 15.
[411] See Day 8 page 147 line 15.
[412] See Day 8 page 126 line 13.
[413] See Day 8 page 127 line 3.

> "It was OK because they divided [it into] three flats, separate flats, so that they became smaller and we had more residents; the Home started increasing."

She went on to say that in her view there was no noticeable difference in the Home when Milbury left in 2002[414]. It was the same, she said[415]. She explained that during the four years she worked at the Home after Milbury left there were three senior care workers, one in each flat[416]; and that some of the care workers had been working in the Home since it opened in 1994[417]. She said that she did not recall any kind of induction training when the SSA took over from Milbury[418]. As to the training of personnel, she said that she recalled trainers being sent over by Milbury (including one called Luke Perry). She went on[419]:

> "We did have some sort of training, maybe not all the training we should have had, but there was some training."

She went on to say that while she worked at the Home there were always "issues" in terms of shortage of staff[420]. Asked about the quality of care delivered by the Home when she worked there, she said this[421]:

> "In the period that I was working there, even if we were understaffed, we all gave good and great care to the residents, even if that meant sort of leaving [the Home] an hour later."

She went on to confirm that normal shifts lasted a full 12 hours. "That's the way it was", she said[422].

Asked to describe a normal day of a carer in the Home, she said this[423]:

> "They would start their shift at 8 o'clock because there was one night staff and they would support in getting people up and getting them ready because they used to go down to [St Bernadette's Occupational Centre] from 9 to 4. .... They would come up at 4. Obviously in my flat people couldn't cook, so we had to cook for them, and then support them at 4 o'clock, attend to any appointments, any doctor's appointments or chiropodists or whatever there was to do, so not always were the appointments at 4 o'clock in the afternoon. Some of them would have to stay and we would have to take them to the doctor's or wherever needed."

Asked whether it was right to say that the carers were "almost fulfilling the function of a member of the family", she replied[424]:

> "Yes, that's correct."

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[414] See Day 8 page 127 line 5.
[415] See Day 8 page 128 line 6.
[416] See Day 8 page 129 line 11.
[417] See Day 8 page 129 line 19.
[418] See Day 8 page 130 line 18.
[419] See Day 8 page 130 line 25ff.
[420] See Day 8 page 131 line 25.
[421] See Day 8 page 132 line 6ff (note the correction at line 23).
[422] See Day 8 page 132 line 18.
[423] See Day 8 page 133 line 8ff.
[424] See Day 8 page 133 line 24.

She confirmed that that extended to doing the cooking, as no cooks came in to do that[425]. As to cleaning the Home, she said this[426]:

> "There was a cleaner: she used to come in from 9 to 1. .... That cleaner would cover sort of like washing the floors, doing the toilets, the rest would have to be done by us. .... We would be changing the curtains, like you do in your house. .... The washing of residents' clothes we would do."

She went on to say that they would also bathe the residents[427]. "There was always something to do", she said[428].

Asked to describe a night shift, she said this[429]:

> "Even if we had a cleaner from 9 to 1, [that] didn't meant to say that [the Home] was going to stay clean all day. So the night shift would wash floors again, toilets, they would do the ironing, that was the job description of the night [staff], they would clean the cupboards inside [and the] kitchen area."

Asked to explain the concept of a "sleep-in", she said this[430]:

> "There was one sleep-in to cover the three flats, because obviously there was only one carer on each flat at night. So they would need an assistant. That sleep-in would attend the three flats. .... She had a bed. .... If you didn't need assistance, that person would just sleep through, basically, and then start a shift in the morning .... or maybe could go home."

She went on to say that she could not recall any occasion when a carer had been required to start a shift immediately following a "sleep-in" (thus being at the Home for a continuous period of 24 hours), but she acknowledged that it could have happened[431].

She told the Inquiry[432] that in Flat 2 (of which she was the senior care worker from 2002 onwards) there were initially six residents, five of whom were female and one of whom – Resident AA – was male. Among the female residents was Resident T.

Asked whether there was any policy or practice in terms of housing residents of differing genders in the same flat, she said that there was no policy against that, and that in the other flats the residents were also mixed. She went on to point out that in the Milbury era it was Milbury who allocated residents to particular flats, and that so far as she was aware the same practice continued after the SSA took over; she was not aware whether the Manager of the Home was involved in those decisions[433].

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[425] See Day 8 page 134 line 1.
[426] See Day 8 page 134 line 6ff.
[427] See Day 8 page 134 line 16.
[428] See Day 8 page 134 line 19.
[429] See Day 8 page 134 line 23ff.
[430] See Day 8 page 135 line 11ff..
[431] See Day 8 page 136 line 8.
[432] See Day 8 page 137 line 1ff.
[433] See Day 8 page 137 line 16ff.

She went on to agree that she got to know the six residents in her flat (Flat 2) "pretty intimately". She repeated her earlier evidence that it was[434]:

> "... like a big family."

As to the members of staff assigned to Flat 2, she said that apart from herself there were ten to twelve support workers assigned to that flat, including her sisters Yvette Gonzalez and Angelica Williams. Her sisters were assigned to Flat 2 during the Milbury era. Subsequently, Richard Muscat was also assigned to the flat. Michelle Garro confirmed that she was not involved in the decisions to assign her sisters and Richard Muscat to the flat[435].

Yvette Borastero

Yvette Borastero (formerly Gonzalez) has worked at the Home since 1996. She has provided a witness statement to the Inquiry [**E/4/1**], and she also gave oral evidence.

In her witness statement she refers to a lengthy report by Jonathan Dalrymple dated 23 September 2004, as dictated to Sean Matto and signed by Jonathan Dalrymple [**M23/51/1**]. In that report, Jonathan Dalrymple describes in great detail a day (7 August 2004) when he, together with his partner and daughter, took Resident AA on an outing to the beach. In the course of that account, he makes a number of criticisms of members of staff including Yvette Borastero. He accuses her, among other things, of sitting in the kitchen of Resident AA's flat, "looking out of the back door" and "having teas and cigarettes", while he did the chores in the morning. He also accuses her of lying to management, and of having shouted at him when he returned from the outing.

In paragraph 5 of her witness statement [**E/4/1**], Yvette Borastero says that she had never worked with Jonathan Dalrymple prior to 7 August 2004. She goes on (in paragraph 6 of her witness statement [**E/4/1**]):

> "Since working with him, I have come to realise that Jonathan has a very aggressive, argumentative and headstrong character and I am led to understand from my colleagues that he has not seen eye to eye with many other employees within the Home. I also understand that he is no longer employed in the Home, and as I do not have access to his employment records I am unable to comment on the circumstances of his departure. ...."

She goes on to deny each of the accusations made against her by Jonathan Dalrymple in that report.

In paragraph 8 of her witness statement [**E/4/2**], she says this:

[434] See Day 8 page 139 line 18.
[435] See Day 8 page 145 line 9.

> "Jonathan's recollection of events on the morning of 7 August 2004 is wrong. Never, during the entire time in which I have been employed by the Home, have I simply been sat in the kitchen looking out the backdoor, particularly whilst there was still work that had to be carried out. I truly believe in the duty of care that I have with respect to the Service Users who use the Home, and that I am there to work, not to sit down and chat to other Support Workers. Despite what Jonathan says, at the material time I would have been helping out with the same chores that he says he was undertaking."

After denying a number of further statements in Jonathan Dalrymple's report, she says this (in paragraphs 22 and 23 of her witness statement [**E/4/4**]):

> "22. Jonathan has omitted what happened after [the discussion referred to in his report]. Kirsten [the other carer mentioned in the report] came upstairs after informing Jonathan that she was going to report him, and he followed her upstairs shouting at her in a threatening manner. He became extremely aggressive in his demeanour and actually lunged towards Kirsten in the kitchen at one point. In fact, I had to physically intervene to prevent Jonathan from potentially hurting Kirsten. I am unsure what happened immediately after that as it all happened so quickly but Jonathan then left the scene. I do recall however that [Residents AA and J] witnessed Jonathan's aggressive behaviour and were very upset to see him behave in this way.
>
> 23. Kirsten and I both filed a report with the Home after this incident. Unfortunately I do not have a copy of this report in my possession."

She then turns to the report by Jonathan Dalrymple referred to above in relation to the evidence of Michelle Garro, which is also dated 23 September 2004 [**M23/22/1-2**], in which Jonathan Dalrymple describes the alleged incidents where Michelle Garro, Yvette Borastero and Angelica Williams abused Resident J.

In paragraphs 27 to 30 of her witness statement [**E/4/4**] she says this:

> "27. I deny having ever laughed at [Resident J]. If I have ever laughed in her presence, I have laughed with her and never laughed at her.
>
> 28. I am there to take care of Service Users in accordance with my duty of care to them, and if possible, to have a good time with them and have fun with them as well, but never at the expense of their dignity as that would be bullying which I do not condone.
>
> 29. I have seen [Resident J] demonstrate similar behaviour to that which Jonathan alleges in his letter, specifically the use of different voices. Whilst using one of these voices she often quotes "mimosin dice que si" and sometimes an argument does ensue with [Resident AA], but again, I have never laughed at her behaviour. I disagree with the suggestion that [Resident AA] has been taught by anyone to say those words to provoke [Resident J], who had long used that voice and those words before joining the Home in 2004. I have never heard [Resident AA] trying to provoke [Resident J] in this manner in any event.
>
> 30. I have never seen support workers resting during the day during the shift whilst there was work to do."

In the course of her oral evidence, Yvette Borastero was asked whether she could recall any incident of abuse of a resident, whether Resident Z or anyone else. She replied[436]:

[436] See Day 11 page 44 line 12ff.

> "Certainly not. Certainly not. I mean, as ... a carer I would have been an abuser as well if I had seen anything and just kept quiet, and I've never seen or reported anything like that, because I haven't come across it. .... The people I've worked with, they have done their job. I have never seen any abuse or anything like that."

Asked about Jonathan Dalrymple's allegation (in the first of the two reports dated 23 September 2004 mentioned above) that she was sitting in the kitchen looking out of the backdoor, she said[437]:

> "That is not true. That is not true. I go to work and I do whatever is needed to do ... I don't go there to sit down. Come on, I wouldn't be there after 17 years if I was sitting down all the time."

She went on to say that she had never seen Jonathan Dalrymple's report until July 2013, when preparing for the Inquiry, and that he had denied that he had submitted any such report[438].
As to the incident involving abuse of Resident J described in the second of the two reports by Jonathan Dalrymple mentioned above, she said this[439]:

> "That's not true. .... I would never laugh at them, I would laugh with them. I would never entice [sic] this distress to a service user. That is not true. .... To this day she [i.e. Resident J] still continues to say "mimosin", and puts [on] different voices, and that's her. It was an advert of I think a fabric conditioner, and it came on television years and years and years ago, and to this day she still continues with that phrase. ... [Laughing at her] would be bullying, and I don't condone that."

She was then asked about an occasion when she was interdicted for sleeping while on duty. The minutes of the subsequent disciplinary hearing [**M23/53/1**], which was held on 29 October 2004, record that she pleaded guilty and was reinstated on terms that she worked two shifts without pay. She explained that she was off sick at the time and taking medication when she was called in at short notice to cover for another carer; and that it had been agreed that someone would come in to relieve her at 8am (the night shift normally ended at 9am), but that did not happen[440]. She continued[441]:

> "I can't really say how long I was asleep, but I know it was only a short period of time because I had already given personal care to the client that was awake. I had given her her tablets, her medication, her breakfast, and I just sat down beside her and I fell asleep. It was only a space of 15 or 20 minutes [before I was relieved], not more than that."

Kirushka Compson

Kirushka Compson began working for the SSA in 2000 as a supply care worker looking after children in care. In 2001 she was assigned to the Home to look after children with severe physical or mental disabilities so as to provide respite for their families. In 2003 she became a

[437] See Day 11 page 48 line 2ff.
[438] See Day 11 page 50 line 2ff.
[439] See Day 11 page 53 line 16ff.
[440] See Day 11 page 56 line 12ff.
[441] See Day 11 page 57 line 5ff.

full-time employee, as Acting Senior of Resident L at Bishop Healy. She also assisted from time to time with other children on an *ad hoc* basis. As noted earlier, in about 2005 Resident L was relocated to the flat in Flat Bastion Road, where he was under the care of the Children's Services & Families Team[442].

In about 2008 Kirushka Compson ceased working with Resident L and resumed working as a senior care worker. She continued in that position until 2010, when, for health reasons, she ceased working as a carer and became a receptionist for the SSA in the social workers' department (a post which she still holds).

Kirushka Compson made a witness statement in the Inquiry [**E/5/2**], and she also gave oral evidence.

In paragraph 10 of her witness statement she says this [**E/5/3**]:

> "10. My role as Acting Senior included managing the staff rotas, petty cash, medication, covering shifts, attending training conferences and medical reviews. I was not offered specific training on accepting this position and I do not recall being provided with any procedures or policies in relation to the same. I received a basic handover one day and the next day I was on my own. The Manager at the time was Morag [Jack] and the deputy was Sharon Berini. ...."

In paragraphs 16 and 17 of her witness statement, she says this [**E/5/4**]:

> "16. During my time at the Home I was managed by Morag, Mandy [Spencer], Ms Tosso, Ms Gomez and Ms Hernandez. I always felt as though I could always raise any issue that I had with any member of the management team.
>
> 17. In addition, I do not recall one instance when a member of management came to me with any grievances."

The minutes of a supervision meeting between Marie Gomez and Joanna Hernandez held on 14 July 2005 [**C2/1/27**] include the following passage relating to petty cash:

> "Concerns about [Residents'] money in Respite from December, 2003 to March, 2005 seniors were Sean M and Karisuhka C [sic]. .... This problem with the petty cash has been ongoing so much so that the auditors came round and could not audit his [i.e. Resident L's] account. .... Petty cash money missing in [Resident L's Team."

The minutes conclude by recording [**C1/2/28**], under the heading "Action Points":

> "JH to check Resident L's team about money."

In paragraphs 23 to 33 of her witness statement [**E/5/5-6**], under the heading "Petty cash procedures", Kirushka Compson says this:

> "23. During my time as a carer at the Agency I had to purchase various items on behalf of different clients.

[442] Resident L was then aged about 12: see Kirushka Compson at Day 8 page 123 line 15.

24. Clients such as [Resident L] who lived in their own property would have their own petty cash box. Respite on the other hand would accommodate various different clients as and when they needed to use the facilities. For that reason the box would contain petty cash for several different clients.

25. On average [Resident L's] petty cash box would have a weekly sum of £55 and Respite about £155 per week.

26. It was standard practice that [Resident L's] box would stay in [Resident L's] room and Respite's in the seniors' office.

27. Although I was based for the majority of my time with [Resident L] I would also have to use petty cash money for respite. Although each box was always locked, the key would remain in the lock. For [Resident L's] petty cash it was decided that staff needed to be able to access his funds at any time of the day in case he required something. Given the numbers of rotating staff covering shifts, anyone would in fact be able to access [Resident L's] petty cash box.

28. When an item was purchased the buyer would return with a receipt and change and place it back in the client's box. There were occasions when the accounting of a petty cash box would not automatically balance with the receipts available. This might be if a carer was required to purchase an item towards the end of their shift and were not able to return the receipt and change before the beginning of their next shift. Or if a carer was not able to purchase an item as they were busy working with a client then they would have to ask another to purchase the item for them. Depending on when the request was made and when staff shifts ended, the carer might have a delay in tracking its receipt and change back to the petty cash box. This was accepted and understood at the time by management.

29. From 2003 I joined as Acting Senior of [Resident L] and together with 6 other full time staff and several supply workers (attending as and when needed) we had access to [Resident L's] petty cash. Each senior on duty would have responsibility for [Resident L's] petty cash on their shift. Every week I would have to take all of the records for the petty cash on behalf of [Resident L] to the Finance Officer, Natalie Fortuna. Natalie would often praise me for my correct records and comment that I always brought ... them back on time.

30. I now understand from Ms Hernandez's statement that she believed there were issues in relation to the management of petty cash. At no time during my employment did I realise that there were any concerns by management about the clients' petty cash. Ms Hernandez did not ever inform me during our supervisions that she had any concerns about petty cash and the procedures in place. However, in 2005 the petty cash procedures were changed.

31. It was decided that carers requiring petty cash would need to request the funds from a senior and sign confirmation in a book that they had taken possession of the money. At the end of a shift the carer would have to sign the petty cash back into the office. I would always try to ensure that there were always two signatures authorising this process. At the end of every week it was my responsibility to collate all the paperwork for either Respite or [Resident L's] petty cash depending on where I had been working. I would then hand it over to the Finance Officer who would check and provide the next week's petty cash. If there was inaccuracy with the accounting the new funds would not be released until any queries had been resolved.

32. I am aware that despite these efforts and new procedures a senior might not always be available due to staff shortages and so a carer could still have access to the petty cash when necessary.

33. During my employment I was never informed of any money that was missing from either Respite or [Resident L's] petty cash by the Finance Officer or by management. In addition I was not informed of any issues relating to other staff members and petty cash."

In paragraph 39 of her witness statement, Kirushka Compson says this [**E/5/7**]:

> "39. .... I have never been aware of any complaint of my handling of petty cash during my time in the agency. I was never informed of any issue and would have thought this imperative, had management had any concerns at all."

In the course of her oral evidence, she was asked whether during her time at the Home she had witnessed any instances of bullying between members of staff. She replied[443]:

> "No, I haven't."

Asked about funding for the provision of food, she said[444] that the weekly allowance of £55 was meant to cover food not merely for Resident L but for his permanent carers as well. She explained that that was why carers spent their own money to buy food for Resident L and to help pay for his outings. She said[445]:

> "All his provisions, all his food, his cleaning things, everything that was needed for the flat would be the £55 [per week] .... People used to bring sandwiches ... or lunch in for themselves".

Asked about funding for clothes, she explained that that was nothing to do with petty cash, and that a different form had to be filled in for that[446].
She went on to say this[447]:

> "You are trying to create a sort of homely atmosphere, if I can put it that way, for L in the community in a flat, and there is a two-to-one ratio, so that means that there are always, or at least the intention is that there should always be two carers there, nights and during the day. It is part of the sort of homely recreation of the atmosphere for the carers to have dinner with him. The carers that used to work with him on the night shift obviously would sit down with him and have the meal. If you worked [the] night shift ... most of the people used to bring ... things from [their home] that they could have during the night."

Manuela Adamberry

Manuela Adamberry has three grown-up daughters, eight grandchildren and two great-grandchildren. In or about 1995, she volunteered to work at the Home as a supply care worker. She found the work so satisfying that she gave up her hairdressing business and was employed by the SSA as a full-time care worker at the Home. She continued to be employed by the SSA (and by its successor, the Care Agency) until 2010. During her employment, she has worked mainly with children with disabilities, in particular with Resident L. There were periods during her employment when she worked exclusively with Resident L.

[443] See Day 9 page 132 line 15.
[444] See Day 9 page 137 line 10ff.
[445] See Day 9 page 139 line 6ff.
[446] See Day 9 page 132 line 22ff.
[447] See Day 9 page 140 line 18ff.

Manuela Adamberry made a witness statement in the Inquiry, and she gave oral evidence.
In paragraphs 9 to 25 of her witness statement [**E/1/2-4**], she describes the close relationship which she formed with Resident L. She says that Resident L first became a respite user when he was only two or three years old (i.e. in about 1995/6), but that he became a permanent resident when he was about nine years old (i.e. in about 2002/3). Initially, he lived at Bishop Healy, prior to his being relocated to the flat at Flat Bastion Road.

In paragraph 23 of her witness statement [**E/1/4**], she describes Resident L as follows:

> "23. Resident L was a bright boy who was fluent in both English and Spanish. However, he had communication difficulties and tended to become agitated and confused, particularly when recalling [a] past event. On these occasions, he would speak very erratically, gesticulating and only using key words. He was often inconsistent in his accounts, combining a number of separate incidents in one story, and he would often invent memories or exaggerate events. Having known him from such a young age I had no real problem understanding him and communicating with him, although I found other people had great difficulty with this. I used to attempt to encourage him to slow down and think before he spoke so that he could make himself better understood."

She goes on to describe how, following his transfer to the flat in Flat Bastion Road, the introduction of a new team to care for him, and a change in his medication, his condition deteriorated and his aggressive outbursts became much more frequent. She says that he did not get on with most of the members of his new team, in particular Sharron Openshaw.

Her witness statement goes on to refer to later events, to which I shall return in due course[448].
In the course of her oral evidence (which she gave in Spanish, with the assistance of an interpreter), Manuela Adamberry was asked by counsel to the Inquiry about the allegation made by Denise Hassan in paragraph 20 of her witness statement, as amplified in the course of her oral evidence[449], that she witnessed Manuela Adamberry mimicking a sexual act with Resident N (a male resident, then in his forties). When the question was put to her, Manuela Adamberry became visibly upset. She responded[450]:

> "No. I've never done this. I haven't even thought about that. It wouldn't even cross my mind. This is all lies. He [i.e. Resident N] sometimes used to touch our bottoms, and we used to say to him, you know: "You don't do that". But I've never done this, never."

She was reminded by her own counsel of Denise Hassan's evidence that the alleged incident with Resident N took place in his bedroom in Flat 2 at the Home; and that she (Denise Hassan) had witnessed it from the kitchen of that flat. Counsel placed before her a plan of the Home at the relevant time, on which she identified Resident N's bedroom (and the position of his bed within that room) and the kitchen. Counsel then asked her[451] whether, in her opinion, someone who

[448] See Chapter 14.
[449] See Day 7 page 75 line 21ff.
[450] See Day 10 page 18 line 18ff.
[451] See Day 10 page 34 line 3.

was in the kitchen could have had a view of Resident N's bed from that position. She replied[452]:

> "Neither in the kitchen nor outside the kitchen. Because you can't see the bedroom. You [can] see the door, but can't see the inside of the room."

Asked by counsel for Mandy Spencer about the trip to Lourdes, she said that she had not informed Mandy Spencer of any incident of the nature described by Mandy Spencer because she had not witnessed such an incident. As she put it[453]:

> "I did not report this because I never saw it."

Angelica Williams

Angelica Williams began working at the Home as a supply care worker in 2001. Subsequently she became a full-time carer. She worked mainly in Flat 2 at the Home. She was interdicted in December 2004 as a consequence of allegations made against her in relation to Resident T (as explained in the introduction to Chapter 2, these allegations, and their repercussions, are considered later in this Report[454]). In July 2006 she declined an offer of reinstatement and resigned.

Angelica Williams made a witness statement to the Inquiry [**E/66/1**], and she gave oral evidence. Her witness statement is directed almost exclusively at issues involving Resident T, and I will return to it in due course in that context[455].

In the course of her oral evidence, she was asked by counsel to the Inquiry about the atmosphere in the Home while she was working there (i.e. prior to her interdiction). She replied[456]:

> "Throughout my four years that I was there the atmosphere, say, in Flat 1 or in respite [i.e. flat 3] ... or in Flat 2 was a good atmosphere. .... The three flats were a good atmosphere; it didn't matter where you worked."

Asked about support from management, she said that she did not have much contact with the successive Managers, and that, as she saw it, "the support was given by the seniors, carers and ourselves as well"[457].

[452] See Day 10 page 34 line 6.
[453] See Day 10 page 31 line 3.
[454] See Chapter 13.
[455] See the Introduction to Chapter 2.
[456] See Day 8 page 178 line 20ff.
[457] See Day 10 page 182 line 18.

Yvette Del Agua

Yvette Del Agua was the Minister for Social Affairs under the GSD Government from February 2000 until October 2007, when she became Minister for Health. She made three witness statements in the Inquiry [**E/6/1, E/8/1,** and **E/12.1/1**]. She also gave oral evidence.

In paragraph 11 of her first witness statement [**E/6/3**], she says this:

> "11. I have no recollection of meeting Mrs Violet Sullivan, officially or unofficially, over the incident which she describes in her witness statement. If I met her officially in my offices, there should be minutes of that meeting on file[458]. I can therefore not comment on Mrs Sullivan's version of what I said to her, other than to say that hypothetically, in a situation such as the one she describes in her witness statement, I would have asked Management to look into her allegation, irrespective of whether she was the parent or not. I do not however discard the possibility that I might have suggested to her that it would be more appropriate and useful if the parent or guardian would also report the incident that she had alluded to."

In her second witness statement [**E/8/1**], she recalls that on or about 17 June 2005 Joanna Hernandez handed her a dossier containing the various June 2005 statements referred to earlier in this Report. In paragraph 4 of that witness statement she says this [**E/8/1**]:

> "4. One of the reports (written by Stacey McKay) did contain an allegation of malpractice involving a service user [Resident C]; an incident which had been investigated when it occurred and which I remembered immediately upon reading it because it had actually been brought to my attention by [Resident C's] mother at the time that it occurred."

She exhibits a photocopy of a letter to Resident C's mother dated 11 September 2003 [**E/9/3**] in which she reported that she had asked Douglas Rodriguez (the then CEO of the SSA) to look into the matter as quickly as possible.

As to the various 2006 witness statements filed in support of Joanna Hernandez' claim of unfair dismissal, she says this (in paragraph 9 of her second witness statement [**E/8/2**]):

> "9. I do recall ... reading the witness statements and taking notes of those that contained allegations of malpractice and potential abuse. I was familiar with some of the incidents alluded to in the statements as I recalled being informed of them and of the outcome of the subsequent investigations at the time that they occurred. Nevertheless I recall asking Management (I cannot specifically state if it was Ms Tosso on that occasion) to make the pertinent inquiries as I wanted to be satisfied, beyond any doubt, that all the alleged incidents had been investigated and action taken. ...."

In paragraph 10 of her second witness statement [**E/8/4**], she refers to reports of the existence of a punishment room. I will address this issue later in this Report[459].
In paragraph 20 of her second witness statement [**E/8/3**] (the concluding paragraph), she says this:

[458] No such minute is to be found in the documentary material provided to the Inquiry Team.
[459] See Chapter 9.

> " ... I can honestly say that I am satisfied that every complaint or allegation that was brought to my attention, or to the best my knowledge to the attention of either Milbury or the Agency, was duly investigated and acted upon, including the allegations contained in witness statements filed in the Industrial Tribunal case of Ms Joanna Hernandez."

In the course of her oral evidence, she said this about the June 2005 statements[460]:

> "I do remember that they were mainly sort of anecdotal hearsay allegations mainly about carers. They were things to do with the Deputy Manager favouring some workers over others, giving her rosters, because there were family members, that sort of thing. There were no serious allegations, so to speak, about abuse against service users except one which could have been construed as malpractice by a carer, which I immediately recalled when I was reading this dossier, because the mother of this service user had already come in to see me to complain, and the issue had been dealt with."

Asked whether she heard any more about the matter, after she had referred it to Douglas Rodriguez, she replied[461]:

> "I'm sure I did. I can't recall, but I always made sure that every issue that I brought to the attention of management, because it had initially been brought to mine, I made sure that I had feedback, always."

She went on to say that she had discussed the dossier of June 2005 statements with Isabella Tosso[462].

Asked by counsel for Joanna Hernandez about staff shortages, she said this[463]:

> "We did conduct a review. In fact I remember bringing in Rod Campbell, who was the operations manager of Milbury at the time, and in whom I had a lot of confidence, and he came over, he spent about three months here, he conducted the review, made recommendations and as far as I remember those recommendations were implemented. Staffing reviews. .... I must say that all Government departments and agencies (I mean, I have run the health service for four years) they are always asking for more resources. That's a fact of life, and ... the Government cake is divided into sections and there is so much you can give. But, as I say, there were two reviews .... In fact we began with social services ... with a handful – or [the Home] rather specifically – with a handful of staff and volunteers ... and we ended up with I think it was 170 members of staff when I left in 2007. So that in itself indicates the enormous funding in both human resources and other areas that the Government did."

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[460] See Day 12 page 55 line 22ff.
[461] See Day 12 page 56 line 19ff.
[462] See Day 12 page 57 line 9.
[463] See Day 12 page 90 line 24ff.

CHAPTER 6: November 2000 to November 2004: Evidence (5)

Contents

CHAPTER 6: *November 2000 to November 2004: evidence (5)*

In this Chapter I review the evidence of the witnesses in Group 5[464], to the extent that their evidence is relevant to the period currently under review.

Matthew Turnock

Matthew Turnock suffers from mild to moderate cerebral palsy. He also has a problem with his eyesight. He was a respite user from 1994 (that is to say from the date when the Home was established) until about 2000 or 2001, when he was 17 years old. Thereafter, he began working as a receptionist/telephonist at St Bernadette's. Initially, this was under a work experience scheme, but after a short time he was given the job on a permanent basis. He continued in that job until July 2006.

Matthew Turnock made a witness statement in the Inquiry [**K1/1/1**]. It had been his intention to give oral evidence, but in the event he was, for good health reasons, unable to do so.

In paragraph 13 of his witness statement [**K/1/4**] he says this:

> "13. In my case most of the effects [of his disability] are physical and, although this stems from damage to my brain, my cognitive functions, i.e. my ability to understand and communicate my thoughts are fortunately not affected by the condition."

He goes on to say (in paragraph 16 of his witness statement [**K/1/4**]) that because his mobility and eyesight are poor, his hearing is very sharp and his memory is very accurate.
In paragraphs 22 to 25 of his witness statement [**K/1/5-6**], he says this:

> "22. Although there is a distinction between the Centre [i.e. St Bernadette's] and the Home, both sections were run by the [SSA] through the same Team Leader. Therefore the two sections were linked and were run alongside each other.
>
> 23. My job description was 'Receptionist/telephonist' for the Centre however my actual role extended to far more than this as I knew the system well and had a good relationship with the carers in the Home/Centre. Having been a service user of the Home's respite facilities for many years, the carers were generally friendly to me and very comfortable around me. I was viewed as 'one of them' and many of the carers confided their day to day concerns in me. I therefore had a real understanding of the pressure they had to face in their jobs.
>
> 24. The Residents of the Home/Centre also felt more comfortable talking to me and I became the unofficial link between the management and the Residents as I would communicate complaints or concerns from one to the other.
>
> 25. However, some members of staff, in particular Marie Gomez ... and Mrs Annie Risso ... (Manager of the Centre) were not comfortable with the role that I had fallen into and were of the view that I should stick to my job as Receptionist. They felt that I should not 'stir up trouble'

[464] See the introduction to Chapter 2.

> when, in reality, I just wanted the Home/Centre to run as smoothly as possible and provide the best possible service to the Residents. At all times their well-being was my main concern."

In paragraph 28 of his witness statement [**K/1/7**], he says this:

> "28. Despite these problems with the management, this 'role' of mine continued over the years and I was therefore very in touch with what was happening at the Home and was in very frequent contact with the Residents, carers and all members of the management."

As to whether the SSA provided sufficient support for senior management at the Home, he says this (in paragraphs 32 to 34 of his witness statement [**K/1/7-8**]):

> "32. From my experience, it did not appear that the Agency gave much support to senior management. One of the reasons I say this is that during my time at the Home, one of the former Team Leaders Mr Duncan Jones ... was pressured into leaving his position because he had flagged up certain incidents that concerned him which were occurring at the time.
>
> 33. One particular incident that caused this reaction from the [SSA] involved a senior carer**....** Mr Jones reported that [the carer] had used foul language and generally been very disrespectful towards one of the Residents. The [SSA], particularly Mr Douglas Rodriguez, CEO at the time, did not offer his support in investigating this or any other incidents and did not take any action to discipline [the carer]. Instead, he deliberately ignored the issue asking Mr Jones to drop it or leave his job. This put Mr Jones in an impossible position which obliged him to resign.
>
> 34. The lack of support and negative response from the [SSA] made it very difficult for any Team Leader to carry out their job effectively."

As to whether carers working at the Home were sufficiently supported by the SSA and senior management, he says this (in paragraph 35 of his witness statement [**K/1/8**]):

> "35. Senior management were well known for not giving carers the necessary support or encouragement that is so needed in this profession. Very little opportunity was given to the carers to obtain the necessary training; instead they were criticised for mistakes often made as a result of inadequate training and were given no guidance as to how they could improve their working practices so as not to repeat such mistakes in the future."

As to whether there was an adequate recruitment process for workers at the Home, he says this (in paragraphs 38 to 40 of his witness statement [**K/1/9-10**]):

> "38. I recall that there was a general perception amongst the public that anyone could get a job at the Home. This is because the disabled are unfortunately often regarded as second class citizens. It is therefore seen as easier to get a job working with them in the caring profession because the required standard of care is lower than with, for example, the elderly who are not regarded with the same prejudices and can speak up for themselves, resulting in the requirement of higher standards of care.
>
> 39. In the Home the recruitment process was not taken at all seriously and, as far as I can recall, there were no formal requirements or procedures in place for the recruitment of carers. It seemed that very little consideration was given to a potential carer's qualifications or experience and therefore some of the carers were dropped straight into very difficult situations which they were wholly unprepared for.
>
> 40. Despite this, most of the carers did an amazing job caring for the Residents as they were generally compassionate and went the extra mile to provide the highest possible standard of care that their training and experience allowed them to. I often wonder whether if they had received

> the necessary support and training from the [SSA] and the senior management the level of care that they offered would have improved even further."

Matthew Turnock goes on (in paragraph 41 of his witness statement [**K/1/10**]) to describe an occasion when an individual with a criminal record (a conviction for armed robbery in the US) was engaged as a carer. He says that, following the discovery that amounts of petty cash had gone missing, Mandy Spencer (the Manager at the time) and Sharon Berini had become suspicious and the carer duly "vanished". He says (in paragraph 42 of his witness statement [**K/1/10**]) that following that incident screening was introduced, and that things further improved in 2007 following a review of the recruitment process.

As to the training of staff (or lack of it), he says this (in paragraphs 46 to 48 of his witness statement [**K/1/11-12**]):

> "46. .... Initially the only training given to the carers was a one week course about once a year. During this time Ms Berini while Deputy Manager of the Home and [Mandy] Spencer while Manager, did push for further training but those above them in particular Mrs Gomez, Team Leader, were unable to approve this due to a lack of funding within the department.
>
> 47. Later Mrs Gomez realised that more training was needed because many of the carers had sustained bruising and scratches while working with some of the Residents and she pressed harder for the funding which was eventually provided. This was the typical approach of the [SSA] and senior management in that they were reactive rather than proactive; they only introduced the extra training after an unacceptable number of such incidents had occurred and it was unsustainable to require carers to continue to work without training.
>
> 48. Eventually some training in certain areas became commonplace. .... These training courses were initially provided by a certified trainer from the UK who was brought over by [Milbury] but was later provided by certified local trainers. These training courses started after 2002 but I am unsure of the exact date."

As to the setting of rotas for staff, he says this (in paragraphs 49 and 50 of his witness statement [**K/1/12-13**]):

> "49. .... It was well known that many of the Residents suffered from attachment issues and their behaviour would only improve when their care was consistently provided by the same carers each day. On paper it seemed that the Home took this into consideration when drawing up the carer rotas by ensuring that the Residents received their care from specific carers where possible. In reality however, these rotas were not kept to as the Home was chronically short staffed. The staff shortage problem was compounded by the fact that it was addressed through the use of supply workers who were free to accept or reject requests to cover shifts.
>
> 50. While Ms Berini was Deputy Manager she was able to keep her team well organised despite the chronic problems with staff shortages. Contrary to previous deputy managers, she was always on the scene and had a different perspective because of the route she had taken to get to her position. Ms Berini had started her career as a carer and had worked her way up which gave her a better understanding of the fundamentals of the work carried out by the carers and she was therefore able to organise her team more practically and effectively."

As to supervision of carers by management, he says this (in paragraph 51 of his witness statement [**K/1/13**]):

> "51. .... The main form of supervision was the use of the Communications Book. Following every shift the carers were required to record the day's events in the Communications Book. This would include details of medication administered, food eaten by the Residents and their general behaviour. This was checked daily by the senior carers and if there were any concerns it would be shown to the managers. The management was therefore able to oversee the care that was provided to the Residents and assess how the carers and the Residents were getting on with each other. From my time as a respite user I often saw the Communication Book being checked daily. In my opinion, the carers were therefore adequately supervised through this process."

As to whether the performance of staff at the Home was properly appraised, he says this (in paragraph 52 of his witness statement [**K/1/13**]):

> "52. .... From both my time as a service user and an employee it did not appear that there were any regular, formal appraisals. This was very evident from the fact that the carers were often very stressed out by chronic issues which remained unaddressed for months on end leaving them completely unsupported."

As to whether there were sufficient procedures in place in respect of internal reporting and record-keeping at the Home, he says this (in paragraphs 53 and 54 of his witness statement [**K/1/14**]):

> "53. The main source of record-keeping was the Communications Book ... Generally carers would report any incidents in the Communications Book as this was the best and quickest way to notify the managers. However, there were also 'incident slips' that could be given to senior management if the carers felt it was necessary to report an incident more formally.
>
> 54. In addition, files were kept in relation to each section of the Home i.e. each individual flat and the respite section. Each of these sections had a small office where the file for that section would be kept so that it could easily be found and referred to."

As to care plans, in paragraphs 55 and 56 of his witness statement [**K/1/14**] he says that he never had a formal care plan prepared for him; and that he has no knowledge whether care plans were prepared for other residents.

As to working relationships between members of staff, he says this (in paragraphs 57 to 64 of his witness statement [**K/1/14-16**]):

> "57. Within the Home there were 'cliques' which some people belonged to. Some of those cliques were favoured by some of the managers most particularly [Mandy] Spencer. This meant that these carers were treated better than others in that they got more support and understanding when, for example, caring for the more challenging Residents. They could also do as they pleased and even when they made mistakes, there were very few repercussions.
>
> 58. For example, I once witnessed a carer Mr Christian Santos act improperly with one of the Residents by unnecessarily restraining him without trying any other means of calming the Resident down. Mr Santos had a quick temper and would regularly cause or allow incidents to escalate, but because he was one of [Mandy] Spencer's 'favourites' he was never criticised for his conduct and no disciplinary action was ever taken against him. He was viewed by other members of staff as 'untouchable'.
>
> 59. In addition Mrs Spencer extended this favouritism to her [then] husband Mr Kelvin Ball. .... From day one of his employment Mr Ball was treated as one of the favourites, he was initially assigned to me because I was considered one of the 'easier' service users. Also when shifts were available for substitute carers he would be offered the most hours over other substitute carers.

> 60. Later he was moved to work with more challenging Residents and I became concerned about the care he was providing for them. Some of the Residents he worked with became very reserved and timid around people and there was an incident where a Resident flinched and cowered away from me when I raised my hand slightly in front of him.
>
> 61. ....
>
> 62. ....
>
> 63. Those carers that were not one of [Mandy] Spencer's 'favourites' were generally unsupported and treated more harshly. This caused some of the carers therefore to become very stressed and unhappy which would at times reflect in the standard of care they provided because they felt demoralised and under-valued.
>
> 64. While Ms Berini was Deputy Manager she tried to stop these cliques and discouraged favouritism to promote a fairer work place but she quickly clashed with Mrs Spencer who then retaliated by making complaints about her."

As to whether appropriate arrangements were made for the care of younger residents and residents of differing genders, he says this (in paragraphs 65 and 66 of his witness statement [**K/1/16-17**]):

> "65. Generally, young service users did not reside at the Home but would use the respite service. As explained previously, the Residents and most particularly children, needed consistency in their care. The respite users however generally did not have assigned carers. There would be around 4 or 5 carers on each shift and they would alternate frequently helping here and there with different respite users and so the arrangements were far from ideal for these children.
>
> 66. As to Residents of differing genders there were certain rules about their care. For example male carers could not bathe female Residents, but female carers could bathe male Residents. ...."

As to communication between members of staff and relatives of residents, he says this (in paragraphs 71 to 73 of his witness statement [**K/1/18**]):

> "71. Generally communication with the parents was important for the care of Residents, children particularly, and the carers would try to consult with them as often as possible. However with some parents, particularly of children, this was difficult to do. A few of the parents clearly and understandably felt guilty that they could not look after their children themselves and this often resulted in them over-compensating by getting too involved with the child's care arrangements at the Home, often in an aggressive manner. This would cause the carers to only report to the parents when absolutely necessary and not to engage with them fully on a regular basis, as this was not always ... helpful to the carer and could therefore impact upon the care given to the child.
>
> 72. Although I understand that this was very difficult to deal with on a daily basis, I believe that some of the parents may have been easier to liaise with if they had been encouraged to be more involved in the care of their child. The Team Leader, Mrs Gomez, could have provided for training programmes (as she had some say in funding) to assist carers in their relationship with parents or developed a better system for communication with parents rather than rely on ad hoc conversations with carers.
>
> 73. While Deputy Manager at the Home, Ms Berini was very good at empathising with the parents and was therefore able to manage situations when parents would flare up and become argumentative, which unfortunately happened frequently."

As to the physical facilities at the Home, he says this (in paragraphs 74 to 77 of his witness statement [**K/1/19**]):

> "74. The actual building was not purpose built to house the Home. It had been converted for these purposes and so the layout was certainly not ideal. The rooms were scattered around with little apparent logic or rationale.
>
> 75. I was able to access all parts of the Home and importantly there was a lift up to Flat 5 and the respite section upstairs.
>
> 76. Access to the toilets in general was adequate but this could have been much improved with the provision of more support bars. Also, in the bathing facilities some of the hoists were often broken which made it difficult to bathe some of the Residents. It was the senior management's responsibility to provide funding for these improvements and remedial works.
>
> 77. There were also cooking facilities which could be used for the carers to cook for the Residents and themselves while working a shift. The actual facilities were adequate but often the carers were unable to take a break to eat their own food on busy shifts."

As to the standard of care provided to residents, he says this (in paragraphs 78 to 85 of his witness statement [**K/1/19-21**]):

> "78. The carers were generally aware of the physical health of the Residents and did their best to keep those within their care in good physical health. For example, at one time one of the Residents was becoming overweight and Ms Berini, senior carer at the time, suggested that his diet be adapted which resulted in him losing weight and becoming healthier.
>
> 79. As to the Residents' mental health however, the care was not always adequate/appropriate to their individual needs. This was mainly due to a lack of understanding about the Residents' different conditions. Often the carers did not know how best to handle their behaviour because they had not been provided with the necessary training.
>
> 80. For example, there was once an incident where one of the Residents was scratching the carers. I also suffered from some scratches to the face from this Resident. This situation was generally very distressing and the carers were overwhelmed and at a complete loss as to how to manage the behaviour.
>
> 81. On another occasion one of the Residents was acting up and the carers called the Mental Health team as they were unable to cope with the situation themselves and need outside expertise and support. However the Mental Health team provided very little guidance and as usual ... [the] head of the team ... just advised the carers to medicate the Resident. Following this incident some Residents would sometimes be medicated to the point where they would lose all lucidity and would sit down all day dribbling. Whilst I consider this to have been wholly inappropriate treatment, as it was the only formal instruction given to carers, this was all they could be expected to do in such situations.
>
> 82. The Home generally had a 'quick-fix' culture. The use of strong medication would solve the problem temporarily and no further action would be taken to improve the Resident's behaviour long term e.g. with regular carers and regular mental health checkups.
>
> 83. The Centre [i.e. St Bernadette's] and the charity Faith and Light (which is a relief charity for family members) tried very hard to organise trips and events for the Residents. They would organise frequent day trips to Spain and to the beaches in Gibraltar. This also included events in the evening such as going to the fair and Summer Nights in Casemates. Sometimes the respite users would be invited and so I would join them. These types of activities would allow the Residents to get out of the Home and socialise.

84. In addition, carers would sometimes put forward proposals to the managers for holidays for the Residents. These would have to be approved by the managers and the Team Leader but would often consist of a cruise or a few nights stay in a villa in Spain. Generally the carers believed that keeping the Residents active in this way and treating them to small holidays greatly improved their way of life and was important for their social development.

85. The carers would also frequently talk and communicate with the Residents and try to get them involved in different activities at the Home."

As to arrangements for the safety of residents, he says this (in paragraphs 86 to 89 of his witness statement [**K/1/21-22**]):

"86. Generally, safety in the Home was good particularly in light of the difficult circumstances that the Home had to deal with i.e. chronic shortness of staff and the very stressful environment.

87. Also, on outings with the Home or with Faith and Light a nurse was often taken along, or if not possible, one particular individual would be given detailed instructions and would be responsible for administering medication to the Residents.

88. Occasionally there would be problems in the Home between the Residents themselves such as shouting at each other and even lashing out and hitting each other. These incidents usually occurred because a Resident was not happy to share their flat with another Resident who they did not get on with.

89. Supposedly, each Resident's wishes had to be considered, but in reality the living arrangements were organised for ease of the carers. For example, those Residents who needed more physical assistance would be placed together etc. The safety of the Residents in terms of possible friction/fights that could occur was not really considered."

As to medication, he says this (in paragraphs 90 to 93 of his witness statement [**K/1/22-23**]):

"90. Initially, the control of medication was not satisfactory. All medication was stored in a cupboard within the Home.... However, the key to the cupboard was kept right next to it and everyone, including the Residents, could gain access to the medication. On one occasion medication went missing and there was a police investigation into the matter but seeing as so many people had access to the cupboard the culprit was never apprehended.

91. Following this incident, a more rigorous system for storing and controlling medication was implemented. In order to access medication the carers had to sign a medical sheet and also have a senior carer or manager/deputy manager counter-sign. This recorded what medication carers were accessing and providing to the Residents but as the key was still stored near the cupboard it did not completely prevent others from accessing it.

92. As to the administration of medication, each of the Residents had a set time at which medication would be administered; the carers would keep a record of when medication was given in the Medical Sheet. This would be checked by the senior carers so that if it was not administered within the correct time frame or not at all, the carers would be disciplined by the managers.

93. At one stage I suggested to Ms Berini, who was either a senior carer or deputy manager at the time, that there should be a single person assigned to administer medication on each shift in order to make the process easier and more efficient. Ms Berini was the best person to approach about these things as she would try to make changes where she felt it was needed. I believe that others may have suggested this to her or other managers as well and this change was eventually implemented."

As to the standard of hygiene in the Home, he says this (in paragraphs 94 to 97 of his witness statement [**K/1/23-24**]):

> "94. The Residents that needed assistance to bathe were always attended to on a regular basis.
>
> 95. Some of the Residents however were considered more independent as they were physically able and could carry out such tasks without assistance. The carers therefore respected the right of these individuals to choose whether or not to bathe. The hygiene of such Residents was therefore not properly monitored and some would not bathe at all. The lack of hygiene resulted on one occasion in an infestation of scabies in one of the Residents' rooms which nearly spread to other rooms.
>
> 96. This particular Resident was considered independent. The carers and managers failed to understand that just because some of the Residents were physically able, [it] did not necessarily mean that they could be responsible for their personal hygiene management. Some of these Residents may have been adults but had the mental age of young children and should therefore have been monitored more closely in relation to their personal hygiene.
>
> 97. What management also failed to recognise was that other Residents within the Home who also had rights should not have been exposed to this risk."

As to whether there were any incidents of abuse or cruelty towards Residents, he says this (in paragraphs 98 and 99 of his witness statement [**K/1/24**]):

> "98. Most of the staff within the Home would never intentionally harm or injure any of the Residents. The carers were generally very compassionate and if any of their actions did result in harm, this would have been accidental or from a lack of understanding or training and would not have been intentional.
>
> 99. However, over the years there were a small number [of] exceptions to this and I did witness a couple of incidents during my time at the Home in which some carers did not treat Residents with the respect that they deserved."

He goes on to describe two such incidents. The first (described in paragraphs 100 to 104 of his witness statement [**K/1/24-25**]) took place in 1997/8, and thus falls outside the scope of the Inquiry's investigation. The second (described in paragraphs 105 to 108 of his witness statement [**K/1/25-26**]) relates to a later incident which occurred at St Bernadette's, and which also falls outside the scope of the Inquiry's investigation.

In paragraphs 109 to 112 of his witness statement, he turns to the issue as to the existence of a "punishment room" at the Home. I consider this issue later in this Report[465].

In paragraph 113 of his witness statement [**K/1/27**], he says this:

> "113. I never saw or heard of any instances of staff encouraging inappropriate behaviour between Residents."

As to whether there were any instances of sexual misbehaviour by members of staff while on duty, he says this (in paragraphs 114 to 116 of his witness statement [**K/1/27-28**]):

[465] See Chapter 9.

> "114. .... There were incidents where carers made inappropriate comments about the Residents. One carer, once made comments about one of the Resident's genitalia after bathing him. I stepped into the conversation and told him not to speak about the Residents like that. I understand that the incident was reported by somebody else within the Home as he was later pulled up on it, though I do not know who this was.
>
> 115. I would also like to comment on the allegations that I understand have been made against a carer Mr Nigel Bassadone ... in respect of inappropriate behaviour with another carer. The incident supposedly took place on a pilgrimage by train to Lourdes which was organised by Faith and Light.
>
> 116. On this trip Mr Bassadone slept in the carriage with me at all times in order to assist with anything I might need. I therefore find it hard to believe that he could have been absent from the carriage or involved with any other carer during this time without my knowledge."

In paragraphs 117 and 118 of his witness statement [**K/1/28**], he says that he never witnessed anything that would suggest that any of the carers were using drugs or drinking alcohol while at work.

As to staff sleeping while on duty, he says (in paragraph 123 of his witness statement [**K/1/29**]) that had heard rumours that this had occurred, but he did not witness any such incidents himself.

As to the reporting of incidents of misconduct at the Home to the SSA and other agencies, he says this (in paragraphs 132 and 133 of his witness statement [**K/1/31**]):

> "132. Very few people had confidence in the staff working at the [SSA] and it was generally believed that most of the people there were not fit for the posts that they held. This, combined with the fact that the [SSA] had a reactive rather than proactive attitude to problems, meant that most members of staff at the Home did not bother making complaints.
>
> 133. Reports of certain incidents such as the theft of medication were made to the Royal Gibraltar Police and they investigated thoroughly. It is likely that these incidents would have been reported to the Minister who would have referred them to the Police."

As to the existence of a code of conduct for staff working in the Home, he says (in paragraph 135 of his witness statement [**K/1/32**]) that when he started working at St Bernadette's he was told of the existence of a code of conduct, but he never actually saw one.

As to the implementation of disciplinary procedures, he says this (in paragraph 136 of his witness statement [**K/1/32**]):

> "136. As I explained above, senior management had their 'favourites'. These people seemed to be able to get away with anything with very little or no disciplinary action being taken against them. However those that were not the 'favourites' would be disciplined for very minor incidents."

He concludes his witness statement by making the following final comments (in paragraphs 147 to 150 of his witness statement [**K/1/34-35**]):

> "147. I am providing this statement in order to assist the Inquiry as best I can and in the hope that the Inquiry will interfere with the Residents' lives as little as possible.

148. I wish to repeat that I have the utmost respect and admiration for most of the carers that have worked for the Home under difficult circumstances and with low remuneration.

149. I have in the past tried to flag up some of the problems at the Home and have made my views about Mrs Hernandez' Industrial Tribunal claim and some of the allegations made against the carers abundantly clear by sending letters to the Editor of the Chronicle ... [exhibited].

150. My opinions have not changed over the years and although I do not agree with the Inquiry because the money invested in it could be better employed in the provision of direct care and training, I believe it to be a good opportunity to address some of these issues."

Mandy Vallender

Mandy Vallender started working at the Home as a supply care worker in 2003, but after a few months she was offered a permanent contract. She has continued to work as a full-time carer at the Home to date. She was assigned to the team caring for Resident L, and was the subject of an allegation of misconduct towards him in April 2005 (an allegation which I shall address later in this Report[466]).

She made a witness statement in the Inquiry [**E/65/1**], and she gave oral evidence.

Her witness statement consists largely of her response to the allegation of misconduct to which I have just referred. However, she also makes some general comments with regard to the operation of the Home which are relevant for present

In paragraph 19 of her witness statement [**E/65/4-6**] she makes the following comments:

- that she kept daily diaries of residents who reported any incidents and that she was not aware of any shortcomings in the reporting process;
- that so far as she was aware there were care plans in place for each resident so that "anyone who came along" could see the position with respect to each person using the service;
- that the "vast majority of staff" got along very well;
- that there were issues at Bishop Healy in that teenagers would mix with younger children at recreational times;
- that there were sufficient facilities for communication between staff and relatives, and that there was sufficient communication between them;
- that Bishop Healy was an old building and had limited facilities (e.g. lack of handrails and a bath hoist);
- that the standard of hygiene at Bishop Healy was not satisfactory, and that she had even seen rats in the kitchen;
- that the standard of care provided to residents was generally of a satisfactory standard;
- that appropriate provision was made for the safety of residents;

[466] See Chapter 9.

- that all carers had medication training and used to administer medication to residents and record what they had given (while noting that nowadays medication is administered by nurses);
- that she had never witnessed any incidents of abuse of residents, or of members of staff encouraging or instigating inappropriate behaviour between residents; and
- that she had never seen a code of conduct.

In the course of her oral evidence, she confirmed that she had not witnessed any incident of physical abuse of residents[467].

Asked by counsel to the Inquiry whether there were care plans in place, she said this[468]:

> "They [were] not how they are now. It's done in a different format now, but I know when we started with [Resident L] he had a file, but it would be kind of like what you have there: it's just paperwork, it's lined pieces of paper where people have put in ... how to handle him. .... But it's not how it is now, as in it's a proper care plan on a proper form."

She went on to say that the frequent changes of Manager did not create a problem so far as she was concerned, that she got on well with other members of staff, and that she was not aware of there being two factions amongst the staff[469].

As to mixing teenagers and younger children at recreational times at Bishop Healy, she recalled an incident when Resident AE had thrown a concrete flower pot across the patio, but she agreed that that was a dangerous incident regardless of the ages of those within range[470].

As to medication, she said that she could not recall there being difficulties with regard to the administering of medication[471].

As to the hygiene at Bishop Healy, she said that she personally saw a rat in the kitchen on one occasion, and that she had heard of other such instances[472]. As to the bathrooms, she said that it was a question of "[doing] what you ... can [with] what you have got ... when you look back, it was terrible, really"[473].

Natalie Fortuna

Natalie Fortuna was appointed Finance Officer of the SSA on 12 December 2002. In 2009 she became the executive officer responsible for accounts at Mount Alvernia. During the period

[467] See Day 10 page 144 line 1.
[468] See Day 10 page 144 line 5.
[469] See Day 10 page 145 line 11ff.
[470] See Day 10 page 146 line 17ff.
[471] See Day 10 page 148 line 17.
[472] See Day 10 page 149 line 24ff.
[473] See Day 10 page 150 line 8.

currently under review, and subsequently, she was responsible for checking and reconciling the weekly petty cash returns ("imprests") required to be submitted by the Home, and for distributing the Home's petty cash float for the ensuing week. She never worked at the Home. She made a witness statement in the Industrial Tribunal proceedings in 2006 [**C2/6/2**] which related exclusively to the period November 2004 to September 2005. I will consider the contents of that witness statement later in this Report[474]. She made a witness statement in the Inquiry [**F/21/1**] which merely confirms the contents of her 2006 witness statement, and she also gave oral evidence.

In the course of her oral evidence to the Inquiry, she explained the system for the distribution of petty cash to the Home[475]. She said that on a weekly basis she would hand out a cash float to the senior care workers in charge of flats at the Home (including Flat 3, the respite flat). She gave the example of £200 for Flat 1. A receipt had to be supplied for every penny spent, so on a weekly basis the senior would write up a record of petty cash expenditure during the week, which was submitted to the Manager to check. The written records provided by the seniors would then be submitted to the Finance Officer (i.e. Natalie Fortuna), together with any remaining balance of the cash float. The cash float was distinct from the residents' own money; it was intended to cover the cost of items such as outings for the residents. As she put it[476]:

> "I needed those sheets [i.e. the written records] to be able to hand in another £200. Maybe they were not ready [or] they would not reconcile. The receipts were missing; moneys were missing; everything was wrong."

She returned to this theme later in her evidence, saying this[477]:

> "... when the moneys were handed back over to me, what was remaining, or the receipts were handed back over to me, ... I would do the checking, which was what I had to do, like a minor audit ... entries were missing, receipts were missing, and the money just wouldn't tally, wouldn't reconcile. So that was worrying."

She went on to say that over the years she had a number of meetings with the seniors to explain to them how to fill in the sheets, but it appeared to have little effect[478].
In answer to counsel for Joanna Hernandez, she said this[479]:

> "... [T]here [have] always been problems, because it's always been something I have always been adamant that has to be 100 per cent correct. You know what accountants are like: you want everything to reconcile because I have the auditors who are the ones who question me, so I have to have everything here like black upon white and every penny has to reconcile so there [have] always been problems ..."

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[474] See Chapter 8.
[475] See Day 4 page 47 line 2ff.
[476] See Day 4 page 49 line 1.
[477] See Day 4 page 52 line 23ff.
[478] See Day 4 page 58 line 20ff.
[479] See Day 4 page 64 line 12.

CHAPTER 7: November 2000 to November 2004: Findings

Contents

CHAPTER 7: *November 2000 to November 2004: findings*

Having carefully considered the evidence reviewed in Chapters 2 to 6 – and having seen and heard those witnesses who gave oral evidence – I now set out my findings based on the totality of that evidence.

Mandy Spencer

I start by considering the evidence of Mandy Spencer.

Mandy Spencer had experience of working with adults with learning difficulties in the UK, but she found it difficult to adjust to the different culture which she found when she arrived in Gibraltar. This, coupled with what I find to be her lack of leadership skills, was the main reason why, throughout her time as Manager, she found it difficult to exert her authority as Manager effectively when members of staff queried, or expressed disagreement with, her decisions or her judgment. That in turn led her to perceive such members of staff as bullies and manipulators, and as undermining her efforts to improve the services offered by the Home.

I am satisfied that her allegations that she was bullied or manipulated by certain members of staff are no more than a subjective perception on her part, born out of her own inability to deal effectively with them and to exert her authority over them. I accept that her subjective perception was a genuine one, but the hard fact is that it does not accord with objective reality. She was not bullied or manipulated by any member of staff: rather, she was a relatively weak and ineffective Manager who became increasingly frustrated and exasperated when she found herself unable to exert her authority effectively. I have no doubt that she tried her best to improve standards of care in the Home, but equally I am in no doubt that her deep mistrust of certain of her senior colleagues has unwittingly tainted and distorted the evidence which she has given to this Inquiry about them. This has led to her describing them, and their alleged behaviour, in such extreme and (as I find) unjustified terms.

The same applies to her complaint that members of staff were concerned to obstruct her initiatives, and that it was an "uphill struggle" to implement improvements and "to get past people". To persuade carers more experienced than her, who had been working in the Home for some time, to adopt different practices or to implement new policies required not merely tact and sensitivity on her part, but also a strength of character and purpose which she unfortunately did not possess.

I have seen and heard Sharon Berini, Sean Matto, Nigel Bassadone and Richard Muscat give their evidence, and I have no hesitation in acquitting each of them of the charges laid against them by Mandy Spencer. Sharon Berini, Sean Matto and Nigel Bassadone are strong-minded

and dedicated individuals who were not afraid to express their views whenever they felt that some proposed innovation would not work in practice, or would not be of benefit to the residents; but I am satisfied that their conduct towards Mandy Spencer was never anything other than professional. I also reject Mandy Spencer's allegation that Sharon Berini used to threaten her. As for Nigel Bassadone, he was passionate about his job (as Mandy Spencer herself recognised), but he also has a volatile temperament which on occasion made him difficult to deal with. Nonetheless, in her capacity as Manager Mandy Spencer should have been able to cope with that. Her description of him as "a dangerous human being" says more about her than it does about him. Nor, having seen and heard Richard Muscat give oral evidence, can I see any basis for his inclusion in the alleged group of so-called bullies and manipulators. I also discount completely Mandy Spencer's general reference to members of staff being unwilling to report incidents for fear of repercussions. I have seen no credible evidence to support that suggestion.

I turn next to the various specific incidents described by Mandy Spencer in her evidence.

Firstly, the alleged incident on the trip to Lourdes. There was a degree of confusion in the evidence as to who was travelling in the same compartment as Nigel Bassadone on the train journey to Lourdes. Matthew Turnock's recollection is that Nigel Bassadone slept in the same compartment as he did; whereas Jennifer Garrett's evidence is that she was in the same compartment as Nigel Bassadone, together with Residents A and V. It may be that one is referring to the outgoing journey while the other is referring to the return journey; but whether that be the case or not, I am more than satisfied that no such incident as was allegedly described to Mandy Spencer by an unnamed informant (for Mandy Spencer's evidence about this incident is no more than hearsay) in fact took place. I accept the evidence of Manuela Adamberry (who appears to have been Mandy Spencer's alleged informant) that she never informed Mandy Spencer of any such incident as she never witnessed such an incident. At a later stage in the Inquiry a photograph was produced which was said to have a bearing on this issue, but I found it to be of no assistance. I reject Mandy Spencer's evidence in relation to this alleged incident.

Next, the alleged incident relating to Mandy Spencer's passport.

As Mandy Spencer recognises, her suggestion that Nigel Bassadone and/or Richard Muscat may have had something to do with her passport going missing is based purely on suspicion, as she has no proof. Assuming (without making any finding) that Mandy Spencer's passport was in fact misappropriated by another member, or other members, of staff, I accept the evidence of Nigel Bassadone and Richard Muscat that they had nothing whatever to do with it. Mandy Spencer's unfounded suspicion that they were in some way involved illustrates the need to treat her evidence in relation to her colleagues with particular caution.

As to the incident on 27 January 2002 involving Nigel Bassadone, the general nature of this incident is admitted by Nigel Bassadone, who frankly accepted in evidence that his behaviour on that occasion did him no credit. Indeed, he could hardly do otherwise, since it was wholly inexcusable. He was rightly given a formal warning in respect of it. However, I find Mandy

Spencer's evidence about this incident to be significantly exaggerated: in particular, I reject her suggestion that at the time Nigel Bassadone was high on drugs – a suggestion which she did not see fit to make at the subsequent disciplinary hearing. I accept Nigel Bassadone's evidence in relation to this incident. I also accept his evidence that (contrary to Mandy Spencer's evidence) he has never undergone drug rehabilitation; and that he never took four weeks unpaid leave to enable him to do so.

As to Denise Hassan's description of this incident in her report to Joanna Hernandez dated 13 May 2005, for reasons which I set out below I regard Denise Hassan's evidence, both in her June 2005 statement and in her witness statement and oral evidence to the Inquiry, to be fundamentally unreliable. The same applies to this report (including the reference to Sharon Berini and Yvette Borastero having had to dispose of cocaine left in the flat by Nigel Bassadone).

As to the missing Ritalin tablet, the incident was duly investigated by the police, but it proved impossible to identify the culprit (if, indeed, any criminal conduct was involved, as to which I make no finding).

As to Mandy Spencer's criticism of Sean Matto in relation to an occasion when Resident C had fallen out of bed and bumped his head, I am satisfied that Sean Matto's conclusion that the injury to Resident C was not sufficiently serious to require a medical examination at the hospital was not prompted by, nor did it demonstrate, any lack of concern for Resident C's welfare. That was the implication in Mandy Spencer's evidence, and I reject it. Sean Matto was an experienced and dedicated carer, and I accept his evidence in relation to his care of Resident C.

I reject Mandy Spencer's allegation that Sharon Berini was responsible for an alleged decision that Resident Z should be taken off his medication. I have no hesitation in accepting Sharon Berini's evidence that she was not responsible for any such decision. It is inconceivable that she would have taken such a decision on her own account, without medical advice.

As to the incident when Resident Z was made to stand with books on his hands, this was an act of abuse by an inexperienced carer, for which the carer in question was rightly reprimanded and for which he duly apologised. At the same time, I accept Nigel Bassadone's denial that he had previously told the carer that such treatment of a resident was acceptable. I am satisfied that he would never have authorised or allowed such treatment of a resident, and that if he had witnessed such treatment he would have reported it.

As to Kelvin Ball's report to Mandy Spencer that a senior care worker (unnamed) had been undermining Resident AE's behaviour plans by telling the other carers on his team to allow him to have a burger whenever he wanted one, I am satisfied that the carers on Resident AE's team were at all times well aware of Resident AE's weight problem and that they addressed that problem sympathetically but professionally. As to the allegation made by Emilia Bruzon and Denise Evaristo that Mandy Spencer and another carer "put [Resident Z's] head in the freezer and he shouted like an animal", I accept Mandy Spencer's evidence that she was not aware of any such incident. I also share her doubt that such a horrendous incident was physically possible. I

bear in mind that Denise Hassan said in her oral evidence (albeit not in her witness statement to the Inquiry) that she actually witnessed such an incident, but, as noted earlier, I have (for reasons which appear below) found that evidence to be untrue, and the entirety of her evidence to be fundamentally unreliable. It may well be that this alleged incident pre-dates November 2000 (see footnote 125 in Chapter 2), but for completeness I address the allegation nevertheless. I find that no such incident occurred. The evidence of Emilia Bruzon and Denise Evaristo in this respect can only have been based on a rumour which had no foundation in fact.

As to their evidence that Resident Z was given cold showers, it may well have been the case that from time to time he was given a cold shower, but I reject the implication that this constituted abusive conduct – or, indeed, misconduct of any kind – on the part of the carers concerned. I note (and accept) Mandy Spencer's evidence that from time to time Resident Z would be given a tepid bath during the summer. It may well be that (as with the alleged "head in the freezer" incident) the evidence of Emilia Bruzon and Denise Evaristo in relation to Resident Z being given "cold showers", in so far as it suggests that this was a form of punishment meted out to Resident Z, is also based on unfounded rumour. That said, a particular incident when Resident Z was given a cold shower occurred on 13 December 2003. On that occasion Resident Z's carer, Jonathan Teuma, was faced with an extremely difficult situation, as he explained in his evidence. I consider that incident, and Jonathan Teuma's evidence in relation to it, later in this Report in conjunction with other allegations made by Joanna Hernandez in respect of his conduct and his care of Resident Z[480]. As to the reference made by Emilia Bruzon and Denise Evaristo to Resident Z being "put ... on a motor ski", I accept Mandy Spencer's evidence that she made clear to the carers involved that before allowing Resident Z to sit on a jet ski they should first have made a risk assessment and obtained consent from his relatives; and that to her knowledge there had been no recurrence of such an incident.

In addition to her evidence about the specific alleged incidents referred to above, Mandy Spencer makes a number of general points about the operation of the Home. She refers in the course of her evidence to files and other paperwork (including time sheets, policies and procedures) being misplaced or otherwise going missing. This was a problem identified by many witnesses, and I have no difficulty in accepting that it was indeed a real problem. I can well understand that in the challenging context of a care home for individuals with disabilities, control of record-keeping and paperwork may be accorded a lower priority than in some other contexts, but the fact remains that it was a matter of importance and that procedures should have been put in place – and implemented – which ensured that so far as possible valuable time was not wasted in replicating earlier paperwork which could not be found. Missing paperwork was a problem which an effective Manager should have been able to remedy; it is, however, apparent that it remained a continuing problem after Mandy Spencer left the Home.

Mandy Spencer also refers to problems in accounting for expenditure of petty cash. Her evidence in this respect was corroborated by a number of witnesses, including Natalie Fortuna, Kirushka Compson, Maurice Valarino and Sean Matto, whose evidence on this issue I accept.

[480] See Chapter 9.

As Marie Gomez said, it was ultimately the responsibility of the Manager to ensure that the system in relation to the recording of petty cash expenditure worked properly, and it is clear that that responsibility was not fully discharged by successive Managers. That said, there were obvious difficulties in obtaining a receipt for every item of expenditure of petty cash incurred on behalf of residents: difficulties which the introduction of an element of greater flexibility in the system might have helped to resolve. Moreover, as Sean Matto explained in oral evidence, practical difficulties were likely to occur when a carer had to hand a receipt to another carer on changing shift.

As to references in the evidence (e.g. the evidence of Denise Hassan) to petty cash "going missing" and to "major money discrepancies", I make it clear that I have seen no credible evidence that any carer used residents' petty cash for his or her own benefit or otherwise misappropriated it.

Gayle Everest

I turn next to the evidence of Gayle Everest.

Gayle Everest was not a team player. She was, by her own admission, constantly criticised by her colleagues for her abrupt manner. Those particular characteristics came through strongly when she gave her oral evidence. She also exhibited a degree of abrasiveness which explains why she found it difficult to build up harmonious relationships with her colleagues: a problem which was no doubt exacerbated by the fact that she does not speak Spanish. I find that she was a generally disaffected member of the community within the Home. Moreover, I take the view that her evidence (including her June 2005 statement) has been coloured by a significant degree of resentment at the fact that she had previously been interdicted (she was subsequently reinstated).

As to her June 2005 statement, leaving aside for the moment the circumstances in which the various June 2005 statements were provided (a matter which I consider later in this Report[481]), the complaints which she makes in that statement are of a relatively inconsequential nature. Indeed, she agreed in evidence that they do not reveal anything "terribly serious". They do, however, indicate the unsatisfactory nature of the relationship which must have existed between her and many of her colleagues.

It is not clear what she means when she refers, in her witness statement to the Inquiry, to "a segregation of staff and Service Users". To the extent that she intends that as a criticism of the care regime in the Home, I reject it. The general picture which emerges from the evidence as a whole is of a dedicated staff doing their best in difficult circumstances to provide as high a standard of care as possible for residents and respite users.

[481] See Chapter 10.

It is also a significant exaggeration for Gayle Everest to say, as she does in her witness statement, that there was "a complete lack of care plans and strategies for assisting and progressing Service Users to allow them to progress". It is the case that only later were formal and comprehensive care plans drawn up for each resident and respite user, and it is also the case that, as noted earlier, record-keeping and control of paperwork were not as efficiently carried out as they should have been; but, that said, policies were in place during the Milbury era, and, as Sean Matto explained in the course of his oral evidence, those policies continued in place when the SSA took over. It is also to be borne in mind when considering Gayle Everest's criticisms of the Home that during the period currently under review she was no more than a supply care worker, working in the Home on an 'as and when' basis.

The same applies to her evidence that she considered many of the ways in which staff treated residents and respite users to be "institutional, draconian, degrading" and a denial of their right to dignity. If that was indeed the view that she took at the time, it was a travesty of the truth. Moreover, it demonstrates a complete disregard for the efforts of her dedicated colleagues. I can only think that in forming that opinion of the standard of care provided to residents and respite users (if indeed she genuinely held that opinion) Gayle Everest allowed the difficulties which she undoubtedly felt in forming harmonious relationships with her colleagues to cloud her judgment.

By the same token, her implied criticism of management for encouraging or condoning friendship amongst members of staff betrays a failure on her part to understand the importance of a friendly atmosphere in the Home, not merely amongst residents and respite users but also amongst members of staff.

She says that her outspokenness, coupled with the fact that she is not a team player, damaged her career with the SSA. I can accept this statement only to the extent that it reflects on her own temperament.

As to the incident when Resident AB needed help to get up from the floor, I accept as true Michelle Garro's report of that incident. The fact that Michelle Garro saw fit to tell Gayle Everest that "she seemed to be detaching from teamwork and looked angry most of the time" only confirms that impression which I have formed of Gayle Everest, having seen and heard her giving evidence.

I also accept as true Sharon Berini's account of her dealings with Gayle Everest as set out in Sharon Berini's letter to Isabella Tosso dated 22 November 2004. It is apparent from that account that, for whatever reason, Gayle Everest acted in a wholly unreasonable manner towards Sharon Berini, who was (as she says in her letter, and as I find) acting in a professional and courteous manner.

As to Gayle Everest's complaint that there were often times when residents or respite users would "bicker amongst each other", it would be surprising if, in such a challenging environment, some degree of "bickering" did not occur from time to time. I regard this complaint as

inconsequential: in lawyers' terms, *de minimis*. I am satisfied that members of staff did their best to keep the minds of residents and respite users usefully occupied so far as possible given the numbers of staff available at any one time and the various duties (including household chores) which members of staff had, in practice, to perform.

As to Gayle Everest's evidence as to consumption of alcohol by residents and respite users, I reject her assertion that there was no policy in place in relation to that[482]. I am satisfied that consumption of alcohol by residents and respite users was properly monitored by the staff, having regard to the health and welfare of those wishing to consume alcohol, and respecting their rights so far as possible and so far as consistent with the health, welfare and rights of other residents and respite users. If in truth Gayle Everest allowed any resident or respite user to consume as much alcohol as they wanted (I have in mind in particular her evidence that she would "quite happily open it" for them) without regard to these considerations, then she should have known better. As it is, I have little doubt that she did know better, and that she never in fact did that.

Gayle Everest's oral evidence to the effect that the care system in the Home did not allow residents to lead a "normal kind of existence", coupled with her inability to accept the proposition that some degree of restriction or restraint in relation to the conduct of residents was inevitable, demonstrates an unrealistically cavalier approach to the role of a carer of individuals with learning difficulties. I am satisfied on the totality of the evidence (in this context I have in mind, amongst other things, Michelle Garro's references to "a big family") that the staff did their best to create as normal a family atmosphere as was possible in the circumstances.

Finally, so far as Gayle Everest is concerned, I refer to her use of the expression "structural institutionalisation", which she used in response to a question by counsel for the Gibraltar Disability Society in which counsel posited an occasion when a resident wanted to go on an outing and there were difficulties in providing staff for that. Gayle Everest explained that in using the expression "structural institutionalisation" she had in mind, for example, a situation in which staff was not able to accompany a service user on an outing, "so the service user suffers". In so far as she is referring to lack of available staff, I fully accept that that was a serious and chronic problem in the Home. Beyond that, however, I can see nothing in the evidence presented to the Inquiry to suggest that there was anything in the structure of the Home which prevented staff from taking residents on outings. Indeed, the evidence shows that outings for residents were arranged whenever possible.

Denise Hassan

I turn next to the evidence of Denise Hassan.

[482] I return to the issue of alcohol consumption by residents in Chapter 15.

As I indicated earlier, I found the evidence of Denise Hassan to be fundamentally unreliable. There are two reasons for this. In the first place, I have no doubt that her (oral) evidence that she witnessed Resident Z's head being placed in a freezer is a deliberate untruth on her part. She repeated this evidence twice, in response to questions from counsel, so it was no accident that she gave it. Had she in truth witnessed such a horrendous incident, it would have appeared in her witness statement in headline terms – and rightly so. Instead, in her witness statement she merely says that she heard two carers "joking" with Resident Z, saying that "if he continued misbehaving they would stick his head in the freezer". Moreover, had she in truth witnessed such an incident, she would undoubtedly have reported it, and a disciplinary hearing would in all probability have followed. As it is, no such report has been produced and there is no record of any such disciplinary hearing.

The second reason is that her evidence that she witnessed an alleged incident where Manuela Adamberry mimicked a sexual act with Resident N is (as I find) also untrue. Not only do I have no hesitation in accepting the denials of Manuela Adamberry and Yvette Borastero that this incident ever occurred, I also take into account the fact that in the course of Manuela Adamberry's oral evidence it was also established (and I find) that it was not possible for Denise Hassan, standing in the kitchen of Flat 2 (as she says she was), to see what was going on in the bedroom of that flat. It is also the case that there is no mention of this alleged incident in Denise Hassan's June 2005 statement.

The fact that Denise Hassan was prepared to give false evidence to the Inquiry in these two important respects is more than enough to lead me to the conclusion that I should treat the entirety of her evidence (including the contents of her June 2005 statement) as fundamentally unreliable, save to the extent that it is corroborated by other evidence the truth of which I accept.

For completeness, I make clear that I also do not believe her assertions (in her June 2005 statement) that Yvette Borastero told her that she and Sharon Berini had had to "dispose of some cocaine down the toilet that which Nigel [Bassadone] had left [in] the sitting room beside the sofa where he had been sleeping", and that Resident E had been "dragged out of bed" so that Nigel Bassadone could sleep there.

Elizabeth Harrison

I turn next to the evidence of Elizabeth Harrison.

I accept her evidence to the effect that the physical facilities for residents and respite users at Bishop Healy were inadequate. There was a consensus to that effect among those witnesses who had seen or experienced them (see in particular, in addition to Elizabeth Harrison's evidence, the evidence of Violet Sullivan, Maurice Valarino and Mandy Vallender). Particular examples of poor facilities were lack of handrails on the stairs, lack of a bathroom hoist,

inadequate fire safety arrangements, and the occasional presence of rats in the kitchen. I bear in mind that Bishop Healy was always intended as temporary accommodation, but even temporary accommodation needs adequate and hygienic facilities.

As to her assertion that Douglas Rodriguez and Marie Gomez told her that "the new manager would have to go in with a machine gun", I accept Marie Gomez' denial that that was ever said. I cannot think of any good reason why Marie Gomez should have expressed herself in those terms. Elizabeth Harrison's recollection is faulty in this respect.

Ave Gonzalez

I turn next to the evidence of Ave Gonzalez.

As to her reference to the SSA being "in chaos", in so far as that description is intended to include the management and/or the operation of the Home, I reject it. There were at all material times experienced carers working in the Home, and I have already said that I am satisfied that the staff did the best they could, in difficult circumstances, to provide the best possible care for residents and respite users. In so far as her reference to "chaos" relates to the wider responsibilities and structure of the SSA, those are not matters which fall within the remit of this Inquiry.

Douglas Rodriguez

I turn next to the evidence of Douglas Rodriguez.

Douglas Rodriguez refers in his witness statement in the Industrial Tribunal proceedings to concerns about discipline, without going into any detail as to the nature of those concerns. He did not give written or oral evidence to the Inquiry[483], and I have seen no evidence to suggest that lack of discipline by staff members was a significant issue during the period currently under review. So far as the available evidence goes, matters which called for disciplinary action were duly dealt with.

Jordan Davis

I turn next to the evidence of Jordan Davis[484].

Some of the criticisms in his witness statement in the Industrial Tribunal proceedings are inconsequential. However, his references to missing paperwork, difficulties in managing petty

[483] The Inquiry team was unable to contact him.
[484] Jordan Davis did not respond to an invitation to assist the Inquiry by giving evidence.

cash, and lack of control of medication were justified in that those were indeed continuing problems affecting the running of the Home. Moreover, in so far as his reference to "lack of resources" includes lack of available staff, that too was a serious continuing problem, as I have already found. Subject to that, his description of the running of the Home as "disgraceful", and to management being "unprofessional", is not borne out by the evidence and I reject it.

Group 2 Witnesses

I turn next to the individuals in Group 2, and to their June 2005 statements. As noted earlier, I consider the evidence as to the circumstances in which the June 2005 statements came to be made later in this Report[485]. For present purposes, I leave that evidence out of account.

As to Jonathan Dalrymple's June 2005 statement, the only relevance of its contents to the issues to be investigated by this Inquiry lies in his suspicion that Nigel Bassadone had something to do with a missing Ritalin tablet. I find that that suspicion was unfounded.

As to the June 2005 statement of Christian Santos, his assertion that he felt frustrated, let down, vulnerable and shocked at the way Sharon Berini spoke to him when changing his shift (if true) does not indicate that she behaved in anything other than a professional manner in exercising her authority as Manager.

The same applies to the June 2005 statement of Rose Seruya.

The criticism of Sharon Berini in the June 2005 statement of Jackie Palma (deceased) is inconsequential for present purposes.

As to Gabrielle Llambias' allegations of bullying by Sharon Berini, I reject them (in the same way that I have rejected similar allegations by Mandy Spencer). I am satisfied that in discharging her duties as Deputy Manager, Sharon Berini acted professionally throughout. If and to the extent that members of staff may have taken umbrage in the face of the exercise of her authority as Deputy Manager, that is a reflection on them, not on her. I would only add, in relation to Gabrielle Llambias, that had she wished to assist the Inquiry by elaborating on her allegations – or indeed making any additional allegations – she had the opportunity to do so but chose (through her counsel) not to take that opportunity.

As to the June 2005 statements of Emily Dempsey, Maria Gonzalez, Nicholas Hassan and Stacey McKay, in so far as they allege favouritism by Sharon Berini in her dealings with members of staff I reject those allegations. I am satisfied that Sharon Berini dealt with all members of staff fairly, including those members of staff with whom her relations were less friendly than her relations with others. In so far as these statements allege bullying by Sharon Berini, I reject them.

[485] See Chapter 10.

Stacey McKay also refers to an incident involving Sean Matto and Resident C. As I said earlier, Sean Matto was an experienced and dedicated carer, and I accept his evidence in relation to his care of Resident C.

As to the unsigned June 2005 statement, without knowing who wrote it I can attach no credence to its contents. In so far as it contains allegations which appear in other June 2005 statements and which I have already rejected, I similarly reject those allegations.

Group 3 Witnesses

I now turn to the evidence of the relatives (i.e. the witnesses in Group 3).

In considering this evidence, I bear very much in mind the evidence of Sharon Berini and Sean Matto as to the inevitably sensitive nature of the relationship between relative and carer. I have not the slightest doubt as to the honesty and integrity of those relatives who gave evidence to the Inquiry, and I am grateful to them for their assistance. Nor do I doubt for a moment their desire to assist the Inquiry to the best of their ability and their recollection. That said, in considering their evidence I must also take account of the tensions which are liable to exist in any relative/carer relationship, and of the extent to which the natural desire of any relative that the best possible care be provided to their family member may lead them unwittingly to overstate what they see as shortcomings in the care in fact provided.

Gina Llanelo

With that in mind, I turn first to the evidence of Gina Llanelo.

In giving her evidence, Gina Llanelo presented as (if I may say so) a woman of strong character, well-suited to be the unofficial spokesperson for relatives of respite users. In the circumstances, I find it hardly surprising that she did not see eye-to-eye with Sharon Berini in a number of respects, and that she came to mistrust her. As Deputy Manager, Sharon Berini was faced with the highly demanding task of organising rotas for staff which preserved continuity of care wherever possible, but which also had to allow for staff shortages and absences of members of staff who were either sick or on annual leave. This task was even more difficult to carry out in the context of the provision of care for respite users – indeed, the evidence is that on some occasions the respite service had to be cancelled altogether for lack of staff available to operate it. In these circumstances it is entirely understandable that Sharon Berini's efforts to organise the staff rotas for the respite service as appropriately and effectively as possible should have led Gina Llanelo to mistrust her and even to accuse her of lying about who was available to man the service and telling relatives "what they wanted to hear so as to dispense with their queries and issues promptly". However, I acquit Sharon Berini of those charges. Sharon Berini was doing

her best to ensure the provision of the best possible care for respite users. If in her dealings with relatives she occasionally gilded the lily in relation to the availability of a particular staff member, that would have been understandable given the pressures she was under in relation to the availability of staff generally.

Gina Llanelo's description of the incident where her son was able to "do a runner" while his carer was mopping the floors is a vivid illustration not only of the many menial chores which carers were expected to carry out in the course of their daily duties, but also of the practical consequences of a shortage of staff in the Home.

Gina Llanelo also complains of missing paperwork, resulting in the same forms having to be filled in once again. Here, she is on firm ground. As I have already said, missing paperwork was a real and continuing problem. No doubt the frequent changes in management personnel were a contributory factor.

As to Gina Llanelo's evidence about the physical facilities available for respite users, I am satisfied that, while no doubt premises of a higher standard could have been provided had funds been available, the facilities in Flat 3 were adequate. Bishop Healy, however, was a different matter, as I have already found.

I find Gina Llanelo's description of Marie Gomez as "a waste of space" to be unjustified. However, I can readily understand that on occasion Marie Gomez and relatives did not see eye to eye, and that this may have left the relatives feeling angry and frustrated. I can also accept Gina Llanelo's criticism that Marie Gomez was not as efficient as she should have been in dealing with missing paperwork and in taking minutes of meetings with relatives; and that in consequence the relatives felt let down. On the other hand, I consider that Gina Llanelo's suggestion that Marie Gomez was "not there to help" the relatives is also unjustified. I find that Marie Gomez did her best to accommodate the wishes of relatives where possible.

As to the existence of "factions" among the staff during the period currently under review, I have already acquitted Sharon Berini of the charge of favouritism. Moreover, there is no evidence that cliques or "factions" amongst the staff (to the extent that they may have existed) impacted on the care provided to residents and respite users.

I accept Gina Llanelo's view that, ideally, carers needed to be more highly trained. This was a view shared by a number of other witnesses, including Elizabeth Featherstone, Violet Sullivan, Maurice Valarino, Matthew Turnock, Sharon Berini ("[Y]ou can never have enough training") and Michelle Garro.

In referring to staff shortages and to training of staff I bear well in mind that employing more staff (particularly more highly-trained staff), and/or providing additional training for existing staff, would have involved greater expenditure of public funds; and that budgetary priorities may have militated against doing so. However, as explained in the Introduction to this Report, that is a matter for Government, not for this Inquiry. What can be said is that it is clear on the

evidence that the presence of a larger and better trained staff in the Home would have benefited residents, respite users and staff alike.

Gina Llanelo's evidence that "staffing levels [were] a major problem" was echoed by a number of other witnesses, including Sharon Berini, Gayle Everest, Elizabeth Featherstone, Violet Sullivan, Moira Elmer, Carmen Dixon-Pritchet and Matthew Turnock (who refers to "chronic problems with staff shortages"). As I have already indicated, I endorse that view. Her description of the situation in relation to staff shortages as "desperate" (the epithet she used in her oral evidence) may be an over-statement, but it is undoubtedly justified to the extent that it describes the pressure which staff shortages placed on both managers and support workers.

As to Gina Llanelo's reference to the lack of forward planning to cope with increased numbers of respite users, it must be questionable what degree of forward planning was feasible, absent the availability of additional premises in which to accommodate the respite service.

I agree with Gina Llanelo that the frequent changes of Manager were "a big problem", not only because they inevitably involved a degree of disruption to the smooth running of the Home but also because, on the evidence, prior to the arrival of Joanna Hernandez in November 2004, handovers between one Manager and the next had been carried out in a relatively perfunctory manner, to the extent that they had been carried out at all.

Elizabeth Featherstone

I turn next to the evidence of Elizabeth Featherstone.

Elizabeth Featherstone was described by Sean Matto as "a very protective mother", and that quality was apparent when she gave her evidence.

I accept her evidence that a mistake occurred in relation to Resident C's medication in that he was given a repeat dose by a carer coming on shift who did not know (and had not checked) whether the dose had already been given. This incident demonstrates that procedures in relation to the administering of medication needed to be tightened up: a view also expressed by (among others) Mandy Spencer, Violet Sullivan, Maurice Valarino and Matthew Turnock. Of course "we are all humans" (as Sharon Berini said), and mistakes will be made whatever system is put in place. However, I am satisfied that the procedures for storing and administering medication during the period currently under review could and should have been improved. For example, keeping the key to the box in which medication was stored next to the box itself was hardly a practice to be recommended. Matthew Turnock draws attention to the fact that improvements were made in relation to medication, but it is apparent from other evidence (which I will consider later in this Report[486]) that problems continued into 2005.

[486] See Chapter 11.

As to Elizabeth Harrison's criticisms of Sean Matto in relation to his care of Resident C, I have, as I said earlier, accepted his evidence in relation to that.

As to her evidence about the physical facilities at Bishop Healy, I have already accepted that those facilities were far from satisfactory, but it is an exaggeration to say that the premises "were in no condition to look after anybody".

Violet Sullivan

I turn next to the evidence of Violet Sullivan.

As to Violet Sullivan's description of an incident where a carer was (according to her evidence) abusing a five-year-old child (this must have been a reference to Resident Z), I consider the standard of care provided to Resident Z later in this Report[487].

As to her evidence that food would "disappear from the fridge", if the implication is that carers were stealing food provided for residents or respite users, I reject it. Far from consuming food intended for residents or respite users, members of staff would (as I find) bring their own food into the Home for consumption not only by them but also by residents and/or respite users.

As to a "horrendous" lack of communication between relatives and staff (including management), I can accept that communication between them was sometimes difficult, and that relatives felt frustrated as a result; but there was communication nonetheless. In this context I bear in mind in particular Sharon Berini's letter to Violet Sullivan dated 24 May 2004. As I said earlier in relation to that letter, Violet Sullivan could hardly have hoped for a more thorough and sympathetic response to her complaint.

As to the practice of taking residents or respite users to carers' homes, I am satisfied this was done in what was considered at the time to be their best interests (as already been mentioned, the practice has since been discontinued). The idea behind that practice was fully explained by Sean Matto in evidence. I do not question the decision to discontinue the practice, but at the same time I note that there is no evidence that any harm came to any resident or respite user as a result of that practice.

As to her evidence (echoing that of Gina Llanelo) that on many occasions Sharon Berini did not tell the truth to relatives, I repeat the observations which I made earlier in relation to Gina Llanelo's evidence.

As to Violet Sullivan's evidence to the effect that Resident I was punished, as I said earlier I consider the whole issue of punishment and the existence of a "punishment room" later in this Report[488].

[487] See Chapter 9.

As to her reference to two occasions when Resident I was either under- or over-medicated, I accept her evidence that those incidents occurred. I also accept her evidence that on one occasion medication which had been prescribed for Resident I was returned to her without explanation. These incidents ought not to have occurred, and they illustrate all too clearly the need which existed at that time – a need to which I have already referred – for procedures in relation to the storage and administering of medication to be tightened up.

Violet Sullivan's reference to there being no cook to prepare lunch for Resident I, and to the carers having to prepare it themselves, illustrates once again the practical consequences of staff shortages.

Violet Sullivan's complaint that Sharon Berini refused to allow her to look at the communications book is misconceived. As Sharon Berini explained in evidence, the communications books contained "information solely for staff members between shifts".

As to her evidence that she witnessed an occasion when "a carer [dressed] a male resident up as a woman (including a wig)", I can only think that she is referring to an occasion when members of staff were engaging with residents in some sort of light-hearted entertainment. Had anything in the nature of abusive conduct taken place on that occasion, I am confident that it would have been reported, not least by Violet Sullivan herself. As it is, there is nothing to that effect in the documentary evidence, and no other witness has made reference to such an incident.

Lastly, so far as Violet Sullivan is concerned, I note the terms of her letter dated 3 May 2004 to Mr Peter Caruana, Chief Minister (as he then was). I agree with her that conditions at Bishop Healy were "poor", for the reasons she gave; that the bathrooms at Bishop Healy were not properly equipped for the needs of users; and that there needed to be a qualified nurse to oversee the administering of medication (an improvement which has since been made[489]).

Maurice Valarino

I turn next to the evidence of Maurice Valarino.

I accept the entirety of Maurice Valarino's evidence without qualification. The incident where a carer slapped Resident X across the face was an act of abuse for which the carer was subsequently dismissed. As to Maurice Valarino's belief that that was not an isolated incident, I cannot say that similar incidents never happened, simply because it would be impossible for the Inquiry to investigate the behaviour of every carer on every shift throughout the entire period of the Inquiry's investigation. What I can say, however, is that there is no evidence of the existence of a culture among the staff whereby incidents of that nature would have been tolerated, and that

[488] See Chapter 9.
[489] See Chapter 15.

every instance of abuse of which the Inquiry has heard evidence (e.g. the incident where Resident Z was made to stand with books on his hands) has, on the evidence, been duly dealt with.

As to Maurice Valarino's evidence about Resident X's trip to Morocco, I consider the evidence about that later in this Report[490].

It is apparent from Maurice Valarino's evidence that handovers of Resident X by carers could have been more sympathetically carried out, but at the same time I have little doubt that the ability of carers to spend time in handing over respite users to their relatives was limited, given the pressures under which they were working. The same applies to his evidence that he would be introduced to a new carer for Resident X but would never see the member of staff again. I have already referred to the difficulties faced by management (and in particular by Sharon Berini) in attempting to ensure continuity of care so far as possible, given staff shortages.

His evidence concerning medication confirms the conclusions expressed earlier in relation to that. The same applies to his evidence about missing paperwork.

I consider his evidence, and that of other witnesses, in relation to the existence of a "punishment room" later in this Report[491].

Frederick Becerra

The evidence of Frederick Becerra raises no issues for the Inquiry to consider, and accordingly I need make no findings in relation to it. His welcome observation that respite care is improving and that Carlos Banderas is an excellent manager are relevant to the current state of affairs in the Home, which I shall consider later in this Report[492].

Emilia Bruzon and Denise Evaristo

I turn next to the evidence of Emilia Bruzon and her daughter Denise Evaristo, in relation to Resident Z.

I have earlier rejected their evidence that carers put Resident Z's head in a freezer as being based on unfounded rumour. In the circumstances, I have to approach the remainder of their evidence with a significant degree of caution. At the same time, I must make it clear that I am not suggesting that in giving their evidence they had any intention to mislead the Inquiry. On the contrary, I am satisfied that they were concerned to assist the Inquiry to the best of their

[490] See Chapter 9.
[491] See Chapter 9.
[492] See Chapter 15.

ability and their recollection. Nevertheless, recollections can become faulty, and that has led to rumour being presented as fact.

I return later in this Report to other issues raised by them and by Joanna Hernandez in relation to the care of Resident Z[493].

Moira Elmer

I turn next to the evidence of Moira Elmer.

As noted earlier, in her oral evidence Moira Elmer explained that her account of the conduct of Richard Muscat and others towards Residents AA and J which she describes in her witness statement is based entirely on what her sister, Resident T, told her. She accepted that she did not witness any such conduct herself. I consider the reliability of Resident T's own account of what happened in the Home later in this Report[494]. For present purposes, suffice to say that I accept Richard Muscat's denial that he was involved in any incident of the kind described by Moira Elmer concerning Residents AA and J. I also accept his evidence that residents in Flat 2 usually went to bed well after 9pm (i.e. after the night shift started), and that he never worked night shifts in that flat.

I accept Moira Elmer's evidence that Resident T finds it difficult to adjust to new carers. I have already noted the importance of maintaining continuity of care, wherever that is feasible.

Carmen Dixon-Pritchett

I turn next to the 2006 witness statement of Carmen Dixon-Pritchet.

Her reference to a "staffing crisis" is a somewhat over-dramatic way of describing the staff shortage which continued throughout the period currently under review (and thereafter). On the other hand, it was (as I have already found) a serious problem.

Her statement that the respite service was "failing its clients" is, however, an unfair exaggeration which fails to reflect the efforts of the staff to operate the respite service as effectively and efficiently as possible in difficult circumstances. As indicated earlier, I accept the more balanced views of Maurice Valarino in this respect.

[493] See Chapter 9.
[494] See Chapter 13.

Witnesses in Groups 4 & 5

I turn next to the evidence of the witnesses in Groups 4 and 5, in so far as it relates to the period currently under review. Given the many references I have already made to that evidence in making my earlier findings, I can deal with this aspect relatively briefly.

I accept the evidence of Marie Gomez that the responsibility for ensuring that the petty cash returns were correct, and that receipts were duly provided, lay with the Manager; and that there were continuing problems in relation to this.

As to Gina Llanelo's criticisms of Marie Gomez, as I said earlier I can readily understand that on occasion Marie Gomez and relatives did not see eye to eye. However, I accept that Marie Gomez worked hard to improve the service in the face of the difficulties described in paragraphs 3 and 4 of her second witness statement.

As to missing paperwork, the considerations which Marie Gomez sets out in paragraph 5 of her second witness statement do not excuse the deficiencies in the system. It is one thing for relatives to have to complete a newly-introduced form, but quite another for them to have to complete a form which had been completed at least once previously, the earlier versions of it having been lost or misplaced.

As to the evidence of Sharon Berini, I have earlier referred to (and accepted) specific parts of her evidence, and I now make clear that I accept the entirety of it, in so far as it relates to the period currently under review. In particular, I accept her evidence that she loved her job (initially as a carer and subsequently as Deputy Manager); and that she, together with other dedicated members of staff, worked hard to overcome the many challenges presented by the service, including staff shortages, lack of training of staff, inadequate facilities at Bishop Healy, and frequent changes of Manager. In this context, I bear in mind the evidence of Matthew Turnock in paragraphs 50, 64, 73 and 93 of his witness statement.

Generally, I found Sharon Berini to be an impressive witness, and I accept as accurate Matthew Turnock's assessment of her.

I also accept the entirety of the evidence of the remaining witnesses in Group 4 and of the witnesses in Group 5, in so far as that evidence relates to the period currently under review. That acceptance is not limited to the extracts from their evidence to which I have referred earlier in this Report. In particular, I accept the evidence of Michelle Garro in relation to the allegations made by Jonathan Dalrymple. The impression I gain from the available evidence is that Jonathan Dalrymple was a dissatisfied member of staff who felt a strong sense of grievance towards his colleagues and especially those in authority over him. The fact that he did not give oral evidence[495] meant that I had no opportunity to assess whether or not that impression is correct.

[495] The Inquiry team was unable to contact him.

I also found the evidence of Michelle Garro to be of particular assistance in relation to the general operation of the Home, and the daily routine of carers, during the period currently under review. As I indicated earlier, I was impressed by her evidence that the atmosphere which the staff was trying to create in Flat 2 (where she worked) was that of a "big family". It goes without saying that relations in big families are by no means always harmonious, but I find, on the totality of the evidence, that members of staff were doing their best to foster a family atmosphere throughout the Home. They deserve considerable credit for that, rather than the unfounded and in many cases offensive criticisms to which they have, regrettably, been subjected.

Last but by no means least, I accept Matthew Turnock's detailed and balanced account of the operation of the Home during the period currently under review. In so doing, I take full account of the fact that he felt (for good health reasons, as I said earlier) unable to attend the Inquiry to be questioned about it.

The scene is now set for the arrival of Joanna Hernandez as the new Manager. For reasons which I have given, the task facing her was undoubtedly a difficult and challenging one, and there were (as I have indicated) a number of aspects of the operation of the Home which needed to be improved. I consider how she met those challenges, and the extent to which she succeeded in implementing such improvements, in the next chapter of this Report.

VOLUME 1 - INDEX

A

B

C

W

Y