THE

DR GIRALDI HOME INQUIRY

REPORT

VOLUME 2

THE DR GIRALDI HOME INQUIRY REPORT

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

RT HON SIR JONATHAN PARKER

VOLUME 2

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CHAPTER 8: *Joanna Hernandez' appointment as Manager – Her first few months in post – Staff shortages – Relations between members of staff – Incidents relating to Resident L*

In this Chapter I consider the evidence relating to the operation of the Home during the period from Joanna Hernandez' appointment as Manager on 22 November 2004 until approximately the end of June 2005. In so doing, I leave out of account for the moment evidence relating to alleged abuse towards Resident T. I consider that evidence later in this Report[496].

Joanna Hernandez made a witness statement in the Industrial Tribunal in 2006 [**C1/1**]. I will refer to this witness statement as her "2006 witness statement". In addition, she made three witness statements in the Inquiry [**E/19/1, E/58/1** and **E/67/1**]. The third of those witness statements subsumes the contents of the earlier two. She also gave oral evidence.

Joanna Hernandez first learned of a vacancy in the post of Manager at the Home in 2003, following the resignation of Morag Jack. At that time, she was working as a classroom aide at St Joseph's School, with particular responsibility for a blind pupil who did not possess the necessary skills to access mainstream education. She had also worked on a part-time basis for Milbury as a supply care worker with responsibility for two teenagers presenting with challenging behaviour. In addition, she had successfully undertaken courses in (among other disciplines) counselling skills, including therapeutic counselling. She had had no previous experience of managing a care home[497].

Joanna Hernandez heard of the vacancy through Elizabeth Harrison (an unqualified social worker with the SSA), who knew her from a counselling course which they had attended together[498]. She encouraged Joanna Hernandez to apply for the post, but at that stage Joanna Hernandez decided not to do so. In the event, no one was selected for the post on that occasion, and the vacancy was left open.

In October 2004 applications for the post were once again sought. This time, Joanna Hernandez decided to apply. She was interviewed by a panel consisting of Douglas Rodriguez (the then CEO of the SSA), Marie Gomez (Adult Team Leader) and one other[499]. Her application was successful, and her employment as Manager formally commenced on 22 November 2004.

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[496] See Chapter 13.

[497] In her oral evidence, Joanna Hernandez agreed that managing a care home was a different venture from what she had been doing before: see Day 1 page 92 line 25.

[498] See Elizabeth Harrison's evidence at Day 6 page 44 line 7.

[499] See Marie Gomez' evidence at Day 13 page 67 line 23. She could not recall who the other member of the panel was. Joanna Hernandez recalled that Douglas Rodriguez was on the panel, but she could not recall who the other members of the panel were: see Day 1 page 96 line 25.

In paragraphs 4 and 5 of her 2006 witness statement [**C1/1/2**], Joanna Hernandez recounted how she came to accept the post of Manager of the Home, saying this:

> "4. .... It was a prospectively rewarding enterprise both financially and professionally. In hindsight, I regret having made this decision for a number of reasons. I was happy in the Education Department [i.e. her previous employment] and supported. .....
>
> 5. My experience within the [SSA] has regrettably turned out to be exactly the opposite to that of the Education Department and, as from June 2005, a thoroughly unpleasant one. It never occurred to me that I would find myself so completely unsupported by the [SSA's] senior management despite having been given many assurances to the contrary when I undertook this job. I was warned about some of the difficulties within the Homes but it was not until I took my new post and started to get first hand appreciation of its daily problems, that I realised it was a chaotic working environment and that it would take a huge effort on my part as manager and on the [SSA] itself to put things right.
>
> 6. ... [B]oth Isabella Tosso and [Marie] Gomez know [full] well how hard I worked, the enthusiasm that I devoted to it and the many good things that were achieved within the Service. [At this point, Joanna Hernandez exhibited a schedule recording her daily routine from January 2005 onwards, together with a handover report and records of a number of meetings which she was required to attend.] They also know [full] well that if it had been humanly possible, I would have given more and without having to be told. I had many duties as manager and discharged them to the best of my ability within the serious problems facing the service at the time. This has not been acknowledged or valued by the [SSA] at all."

I am satisfied that it was not the case that Joanna Hernandez was "completely unsupported by the [SSA's] senior management". The evidence (and particularly that of Marie Gomez and Sean Matto) establishes that support was offered to Joanna Hernandez by both management and staff, to the extent she wished to avail herself of it. Nor was it the case that the Home was a "chaotic working environment". As for the need for a "huge effort on [her] part ... to put things right", I have already acknowledged the challenging nature of the job she was taking on. Nor do I doubt that she worked hard to try to improve conditions in the Home.

In paragraphs 9 and 10 of her 2006 witness statement [**C1/1/3**], Joanna Hernandez described "The Overall Situation" in the following terms:

> "9. The true reality of Dr Giraldi's Home will never be known but everyone within the [SSA] including Ms Tosso and Ms Gomez have a fairly good idea of it and so did I as I personally became increasingly aware of inherited problems: staff shortages and problems; no infrastructure, low and poor standards; insubordination, abuse etc.
>
> 10. It is important because it not only affected my daily work but also because my job was sacrificed as a result of management not facing up to it openly. I say this because the ones that truly matter have not been given priority – the service users who are severely disabled and vulnerable human beings. Those whose quality of life depends very largely on those who are tasked to look after and care for them, not as silly little children or adult imbeciles, but as human beings who are entitled to their respect, dignity, personality and basic professional treatment. That was the standard that was so seriously and so much lacking in the service provided at Dr. Giraldi's Homes which I inherited. [At this point Joanna Hernandez exhibited (among other things) a document entitled "Executive Summary Of Draft Audit Report", to which I return later in this Report.]"

As to paragraph 9 of her 2006 witness statement, I have earlier identified the problems which existed in the Home when Joanna Hernandez took up her appointment as Manager. To that extent only, I accept her catalogue of "inherited problems". Beyond that, I reject it. Her evidence in that paragraph exemplifies a tendency on her part, which runs through the entirety of her evidence (both written and oral), to exaggerate the challenges which she faced as Manager, and to depict the operation of the Home during her period as Manager – and the conduct of some members of staff during that period – in the worst possible light.

I have no doubt that this tendency stems from a deep sense of resentment on her part at the SSA's refusal to renew her contract, and it inevitably reflects on the reliability of her evidence generally. It was particularly evident in her oral evidence to the Inquiry. In the course of that evidence she said this[500]:

> "I have thought[501] very hard for nine years, and I would like to be ... given the opportunity to explain properly."

Given that her third witness statement (made as late as September 2013, after most of the witness statements by other witnesses had already been filed) runs to 176 pages and contains 675 paragraphs, one could be forgiven for thinking that she had little more to "explain". However, this impression was dispelled once she started her oral evidence. It rapidly became apparent that she regarded her presence on the witness stand as an opportunity to embark upon a prolonged process of self-justification extending beyond the issues which the Inquiry is concerned to investigate. In consequence, she had difficulty in focusing on the questions asked of her by counsel relating to those issues, and of confining her evidence to responding to those questions. Furthermore, her desire to make good the many serious allegations and criticisms which she levels against the operation of the Home and the conduct of some of her colleagues led her to resort to emotive, and on occasion lurid, language[502], and to make allegations which had not appeared in her written evidence[503].

Returning, then, to her 2006 witness statement, I find the allegation in paragraph 10 of that witness statement that staff at the Home did not give priority to caring for residents and respite users, and the associated implication that residents and respite users were treated as "silly little children or adult imbeciles", to be a travesty of the truth and an insult to the efforts of dedicated members of staff.

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[500] See Day 1 page 88 lines 2-4.

[501] The word "thought" is on the transcript but the audio is unclear. It is assumed Ms Hernandez meant/said "fought".

[502] See, by way of example, her description of a "time-out" room, as described by other witnesses, as a "torture chamber" (see Day 2 page 92 line 1); her description of Resident Z's flat as "not fit for a dog" (see Day 1 page 124 line 4); her description of the alleged conduct of some of her colleagues as "sabotage, sabotage, sabotage everywhere" (see Day 1 page 147 line 22); and her statement that staff had "drugged" another resident "up to his eyeballs" (see Day 1 page 157 line 15).

[503] For example, on the second day of the main hearing she alleged that staff at the Home had "used ... flashlights in [Resident L's] eyes to torture him" (see Day 2 page 72 line 1). This serious allegation of abuse does not appear anywhere in her extensive written evidence (as already pointed out, her lengthy third witness statement was made only a month or so before the commencement of the main hearing); nor is there a shred of evidence to support it. It appears to have been made on the spur of the moment. I have no hesitation in rejecting it.

In paragraphs 20 to 25 of her 2006 witness statement [**C1/1/4**], Joanna Hernandez turned to the question of petty cash accounting, saying this:

> "20. In May 2005, Marie Gomez instructed Ms Berini to take charge of the petty cash because of the on-going accounting problems.
>
> 21. On 14th June 2005 there was a meeting at Dr. Giraldi's Home over this. The Finance Officer attended together with Marie Gomez and Isabella Tosso because irregularities had been reported since January 2005. Two seniors were not accounting properly for the service users' personal money and their Government subsidies for their flats.
>
> 22. I produced a report for senior managers in April 2005 signed by three Respite & Sitting Service Seniors. The monies unaccounted for were in euros and sterling and pertinent to the users of the Respite/Sitting Service.
>
> 23. There was an unannounced audit inspection after the June meeting but with no feedback.
>
> 24. I introduced a system in April 2005, that every Monday morning all seniors had to produce their imprests backed by receipts and countersigned with staff member name and service user. Except for two seniors, the system worked well for the other three seniors. These two seniors failed to comply despite my repeated requests to them and this situation ultimately called for some disciplinary action against them. ....
>
> 25. Ms Berini and I had recommended from the start that a full-time AO [Administrative Officer] be allocated to the Home to deal specifically with the petty-cash and rotas, which was a full time job in itself. [At this point Joanna Hernandez exhibited (among other things) a copy of an undated message from her addressed to the "Team Leader" in which she stressed the urgent need for administration support staff to be appointed, so that she and Sharon Berini could "successfully carry out the predetermined duties in our job descriptions".]

I have already identified management of petty cash as a continuing problem, but I reject Joanna Hernandez' evidence that she succeeded in resolving that problem. I accept the contrary evidence of Natalie Fortuna. In her 2006 witness statement, Natalie Fortuna said this [**C2/6/**2]):

> "[From] November 2004 to September 2005 the weekly imprests [i.e. weekly petty cash returns] were not completed to accounting instructions standards, deadlines were not met, accounts did not reconcile, receipts were missing and in August monies went missing in various imprests given to [the Home]. I kept asking the Manager [i.e. Joanna Hernandez] to set this straight and when monies went missing I asked for written reports. Ms Hernandez provided the report on three occasions but not done to an acceptable standard and on the fourth occasion Ms S. Berini undertook the task."

In oral evidence, Natalie Fortuna explained that the amount of petty cash "missing" from one flat in August 2005 was £37.50[504]. As I indicated earlier, I have seen no evidence of theft or misappropriation of petty cash by any member of staff[505].

I also accept Natalie Fortuna's oral evidence that both she and Joanna Hernandez were trying to resolve the problems in relation to petty cash, but that, despite their efforts, those problems

[504] See Day 4 page 55 line 21.
[505] In her oral evidence, Joanna Hernandez made clear that she was not making accusations against anyone in this respect: see Day 1 page 154 line 22.

continued to be a matter "of great concern" during the period while Joanna Hernandez was Manager[506].

I now turn to the events following Joanna Hernandez' acceptance of the post of Manager.

Once appointed, but prior to taking up her appointment, she had meetings with, among others, Douglas Rodriguez, Marie Gomez, Sharon Berini (who had been acting as Manager since the resignation of Morag Jack earlier in the year) and Yvette Del Agua in order to familiarise herself with the scope of her duties as Manager.

In addition, on 3 November 2004 she convened[507] and chaired a "multi-disciplinary" meeting (the two disciplines concerned being those of the Home and of St Bernadette's). The meeting was attended by Annie Risso (the then Manager of St Bernadette's), Sharon Berini, Elizabeth Harrison and Giselle Carreras (SSA psychologist).

I return to this meeting later in this Report, in the context of Joanna Hernandez' allegations as to the standard of care provided to residents and respite users in 2005. For present purposes I note that, according to the minutes of the meeting [**E/25/21**], concerns were expressed that members of staff who had been the subject of allegations of serious malpractice were still working in the Home. The relevant part of the minutes reads as follows:

> "Through the cases offered within the meeting there [appear] to be serious issues of malpractice in the past to service users in differing aspects only to have the same member of staff still actively working within our service."

This appears to be a reference to concerns expressed by Giselle Carreras as to the treatment of Resident T by certain members of staff. I consider the evidence in relation to that in Chapter 13 of this Report.

The minutes go on to refer to the existence of what was described during the Inquiry as a "punishment room". I address the issue as to the existence or otherwise of a "punishment room" later in this Report[508].

The minutes conclude as follows:

> "We agreed to meet for fortnightly meetings and felt it [beneficial] to invite Mrs Yvette Del Agua (Minister for Social Services) to attend with the intention of promoting a greater understanding of disability and issues pertaining to it."

In paragraph 119 of her third witness statement to the Inquiry [**E/67/38**], Joanna Hernandez says this:

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[506] See Natalie Fortuna's evidence at Day 4 page 58 line 17ff and page 64 line 23.
[507] See Joanna Hernandez' evidence at Day 2 page 198 line 18.
[508] See Chapter 9.

> "119. As can be seen from the minutes of the meeting of 3.11.04, although I discovered important matters at that meeting, I was not given induction or hand-over brief of any value. I was given no understanding of the magnitude of the problems which DGH was experiencing at the time or previously, although serious problems obviously existed from what I had been told."

In the course of her oral evidence, Joanna Hernandez said this[509]:

> "I didn't get a complete handover, which I thought was strange, but under the circumstances I thought maybe because they are very short-staffed that is why I am not getting the full picture."

Earlier in her oral evidence, she complained that she did not know what she was getting into when she applied for the post[510], and that she "wasn't told anything"[511].

However, I am unable to reconcile that evidence with her own evidence (in paragraph 91 of her third witness statement [**E/67/31**]) that Douglas Rodriguez told her:

> "... in unequivocal terms that there were huge and alarming problems with staff at DGH."

Moreover, as noted earlier, Douglas Rodriguez had expressed concerns about discipline. Joanna Hernandez accepts that she was aware of his concerns in that respect[512].

Also, I note that in the course of her oral evidence Joanna Hernandez said this, with reference to what Douglas Rodriguez had said to her[513]:

> "It made me think I am in for a big challenge, but at the time I thought I had the support of the Agency, because I had no problems with either Marie Gomez or Isabella Tosso. That's the truth: we had a very good relationship..."

In paragraph 91 of her third witness statement [**E/67/31**], Joanna Hernandez says that Douglas Rodriguez also told her that there had been thefts of money by staff at the Home; and that members of staff at the Home had on occasion absconded from their posts. As noted earlier, I have seen no evidence of theft by any member of staff at the Home, or of any member of staff at the Home absconding.

According to Joanna Hernandez (in the same paragraph), Douglas Rodriguez went on to say that the police had provided him with videos which "showed ... children in a terrible state and clearly suffering from negligence", albeit without giving the identities of the children to whom he was referring, nor, just as important from the point of view of the Inquiry, stating whether the care of the children in question was the responsibility of the Home or of some other section of the SSA.

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509 See Day 2 page 24 line 4ff.
510 See Day 1 page 95 line 15.
511 See Day 1 page 95 line 23.
512 See Day 1 page 94 line 3ff.
513 See Day 1 page 104 line 22.

I accept that to the extent that Douglas Rodriguez may have advised Joanna Hernandez of the existence of staff shortages and of the other administrative shortcomings noted in Chapter 7 of this Report, he would have been justified in doing so; but in so far as he painted as bleak a picture of the operation of the Home as Joanna Hernandez maintains that he did, that picture would have been a false one. Apart from the incident described earlier, when Resident Z was made to stand with books on his hands, and leaving aside for the moment the evidence relating to Resident T, I have seen no evidence of children at the Home "in a terrible state" or "clearly suffering from negligence". I consider that the likelihood is that Douglas Rodriguez never painted such a bleak picture of the Home as Joanna Hernandez described, and that her description is yet another example of exaggeration on her part.

In paragraphs 93 and 96 of her third witness statement [**E/67/32 and 33**], Joanna Hernandez said this:

> "93. Mr Rodriguez also told me in that meeting that the first directive from the Minister of the SSA [Yvette Del Agua] to me was to "clean up the [Home] from the inside". He told me that this was foremost on the Minister's agenda. ....
>
> ....
>
> 96. .... Ms Gomez introduced me to the then Minister for Social Affairs, Yvette Del Agua. The Minister was deeply concerned about bad work practices at DGH and she told me that I would need to clean the Dr Giraldi Home from the inside. I did not understand what the Minister and Mr Rodriguez meant by this phrase that they both used."

I accept Yvette Del Agua's evidence that she took her ministerial responsibilities in relation to the Home extremely seriously and did all she could to discharge those responsibilities promptly and effectively. That being so, I have no doubt that she was well aware in the autumn of 2004 that there were staffing problems and other shortcomings in the operation of the Home, and that she would have referred to those problems and shortcomings when speaking to Joanna Hernandez. I cannot be sure on the evidence of the precise words she used when referring to them, but it would not have been in the least surprising had she laid stress on the importance of the role of the Manager in taking steps to resolve them. However, I think it most unlikely that she went so far as to use the expression "clean the Home from the inside". It is in any event an ambivalent expression, and had she used it I feel sure that Joanna Hernandez would have asked her to clarify what precisely she meant by it.

I turn next to Joanna Hernandez' allegation that there was no "hand-over brief of any value"[514]. Given that (on her own evidence) she received ample warning that her job as Manager would be a challenging one, had she wished to know more about any aspect of the running of Home, she had only to ask. In any event, I have no doubt that Elizabeth Harrison put Joanna Hernandez fully in the picture as to the responsibilities which she would have to discharge as Manager and as to the challenges she would face in doing so.

[514] Joanna Hernandez repeated this allegation in her oral evidence: see Day 2 page 24 line 5.

As for Joanna Hernandez' assertion (in paragraph 119 of her third witness statement, quoted above) that it can be seen from the minutes of the meeting on 3 November 2004 that she was not given a hand-over of any value, the minutes do not support that assertion.

Joanna Hernandez complains that initially it was not explained to her what were the relevant policies and procedures to be followed in running of the Home, nor (she asserts) was she able to discover what those policies and procedures were. Thus, she says this in paragraph 120 of her third witness statement [**E/67/38**] (echoing the evidence in her 2006 witness statement):

> "120. The Home was being run on a completely *ad hoc* basis. There being no policies for me to read up on, ... I hoped to adopt or work-around the former [Milbury] Booklet on staff policies, procedures and infrastructures with a view to implementing them upon arrival as Manager. However, these policies could not be found at the Home. So I had nothing to work with."

In paragraphs 125 to 128 of her third witness statement to the Inquiry [**E/67/40-41**], she says this:

> "125. My first official day of work at DGH was on Monday 22.11.[04], Within the first 2 weeks of working there, I quickly found that the workplace was in virtual chaos. There was animosity amongst staff members and it appeared that none ... were [willing] to give me any information about patients, workplace policies, procedures or practices. Over a period I came to feel that I was being kept in the dark. I found the culture and the apparent chaos, very unsettling and worrying, particularly as I was only now starting in the post. It seemed to me, that the entire culture at the DGH was one of institutionalised, historic malpractices. By this I mean that there appeared to be no management structure, policies [or] resident care plans at all.
>
> 126. It is important to be aware that the Dr [Giraldi] Home is not on one site. It also covered the Bishop Healy House and 2 separate flats in different parts of Gibraltar. As such, even in the best of circumstances, it would have been very hard to manage, as one simply could not be in four places at once.
>
> 127. The Home was dominated by reacting to crisis and problems as and when they arose on an ad hoc basis.
>
> 128. As stated above, none of [Milbury's] [p]olicies could be found. Some eventually were found; I made inquiries to try to find [them]. In fact, Sharon Berini, the deputy manager, turned out to have some of the policies in her home. She agreed to bring them in, and this gave me at least something to work from."

In so far as that evidence accords with evidence which I have already accepted[515] (in particular, the evidence of Maurice Valarino and Matthew Turnock), I accept it. In so far as it goes beyond, or conflicts with, that evidence, however, I reject it as yet another example of exaggeration.

I am satisfied that Joanna Hernandez' evidence in paragraphs 125, 127 and 128 of her third witness statement presents a significantly distorted picture. In particular, I am satisfied that the broadside against the Home contained in paragraph 125 of her third witness statement is so grossly exaggerated as to be highly misleading.

[515] See Chapter 7.

Moreover, among the staff at the Home at that time were a number of individuals with considerable experience of working in the Home, including in particular Sharon Berini and Sean Matto – experience which Joanna Hernandez had not as yet had the opportunity to acquire. As I indicated in Chapter 7 of this Report, having seen and heard each of Sharon Berini and Sean Matto giving evidence, I am satisfied that neither of them would have allowed themselves to be associated with "virtual chaos" at the Home, still less with a culture of "institutionalised, historic malpractices" (save only to the extent that in the course of his evidence Sean Matto referred to the problem of staff shortages as "institutional abuse", and to its effect on the standard of care which the staff were able to provide as "abusive" [516]). I am also satisfied that neither he nor Sharon Berini would have allowed any sexual, physical, verbal or emotional abuse of residents or respite users to take place in the Home.

I also reject Joanna Hernandez' suggestion that she was "being kept in the dark". I observe once again that had she really felt that she was being kept in the dark in relation to any aspect of the running of the Home, I have no doubt that she would have said so at the time.

In her March 2013 statement [**F/6/7**], Elizabeth Harrison recalls how Douglas Rodriguez and Marie Gomez told her that they needed to find a new Manager, following the resignation of Morag Jack. Her March 2013 statement continues [**F/6/9**]:

> "There was a need to find a person who would be strong 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/[him] at all times, [and that she/he] should not be left on his/her own.
>
> Ms Gomez then asked me after Joanna Hernandez asked me to contact her re [sic] if she was interested in the post.
>
> I met Ms Hernandez and at first she said she was happy in her present role supporting a child with severe visual impediment.
>
> Ms Gomez insisted that I try in [sic] convincing her. We arranged for Ms Hernandez to meet with [us] in the office. Ms Gomez explained the problems encountered in the running of the [Home] and how difficult it would be as some staff could not be trusted.
>
> After a lot of thought Ms Hernandez [agreed] to apply, I remember Ms Gomez asking me to take the application form to Ms Hernandez[']s home.
>
> ....
>
> Between the time Ms Hernandez was selected for the post and starting in the post a new CEO was in place namely Ms Isabella Tosso. From the start Isabella was not in agreement [with] Ms Hernandez being successful to fill the vacancy, she had seen a young English man waiting to be interviewed and thought he would have been a good choice rather than Ms Hernandez. I can say that at the time Ms Tosso knew none of them.
>
> On the first day [that] Ms Hernandez commenced work as Manager of [the Home], Ms Tosso came into my office and informed Mrs J Poole [Jennifer Poole, another SSA social worker] and myself not to offer support to Ms Hernandez in [any way], adding that if Ms Hernandez sought our support we should immediately bring it to her attention."

[516] See Day 8 page 13 line 10ff.

In the course of her oral evidence, Elizabeth Harrison described how Marie Gomez had asked her to try to persuade Joanna Hernandez to take the post of Manager because the organisation at the Home was "collapsing", and they needed someone like Joanna Hernandez, who was "really good" and "really into it"[517]. She continued[518]:

> "Joanna was then promised – well, I mean, they kept saying the best thing to do would be to close it today, sack everybody and start tomorrow again. But we can't do that, right? So Joanna says: "I can't go in there on my own after all these stories you have been telling me". So they said: "Don't worry, Elizabeth Harrison, who has all the experience, will be there with you 24/7". And with that, Joanna agreed to apply."

I accept Marie Gomez' denials that she asked Elizabeth Harrison to persuade Joanna Hernandez to accept the post of Manager[519], or that she ever suggested sacking all the staff[520]. I reject Elizabeth Harrison's evidence to the contrary. As in the case of Joanna Hernandez, I regard Elizabeth Harrison's evidence as characterised by a tendency on her part to overstate her criticisms of the Home and its staff. In the case of Elizabeth Harrison, I regard that tendency as stemming from an instinctive feeling of loyalty towards Joanna Hernandez which has served significantly to distort her recollection of events and hence to raise doubts as to the reliability of her evidence on contentious issues. I do not, however, suggest that she intended to mislead the Inquiry in any way.

Elizabeth Harrison went on to confirm that Marie Gomez was keen for Joanna Hernandez to be appointed Manager, and that Marie Gomez asked her to support Joanna Hernandez. However, she said that that support lasted "only for a week"[521]: a statement which I reject.

I will return later in this Chapter to Elizabeth Harrison's evidence that on or shortly after Joanna Hernandez' appointment she and Jennifer Poole were instructed by Isabella Tosso and Marie Gomez not to support Joanna Hernandez.

As to Joanna Hernandez' evidence of a lack of policies and procedures, the minutes of a management meeting held on 8 December 2004 [**J1/35/1**] (that is to say, little more than a fortnight after Joanna Hernandez took up her appointment) record that Isabella Tosso said that as from 22 November 2004 the SSA was following "the Milbury policy and procedures", and that each member of staff would be given a copy of that policy.

Moreover, as Joanna Hernandez acknowledges in paragraph 128 of her third witness statement (quoted above), Sharon Berini later provided her with copies of the relevant policies and procedures.

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[517] See Day 6 page 44 line 12.
[518] See Day 6 page 44 line 21.
[519] See Day 14 page 44 line 16.
[520] See Day 14 page 44 line 9.
[521] See Day 6 page 45 line 17 and page 46 lines 6 and 10.

Based on the minutes of the meeting on 8 December 2004, I find that by the end of December 2004 at the latest (if not earlier), Joanna Hernandez was fully informed as to the policies and procedures to be followed at the Home.

I also note that the minutes of that meeting do not contain any record of complaints by Joanna Hernandez (who was present at the meeting) of the kind which she now makes. On the contrary, she is recorded as reporting only that she had contacted the Gibraltar Health Authority with a view to the implementation of "courses based on counselling skills, awareness training etc."; and that she had made inquiries as a result of which health professionals would be available to help with training. In addition, in relation to the appointment of members of staff to "acting" positions, it was, according to the minutes, suggested that she would be looking at the relevant rotas.

Given the wide-ranging nature of the discussion which took place at that meeting, as recorded in the minutes, Joanna Hernandez' presence at the meeting would have afforded her an ideal opportunity to voice any concerns which she might have had. As it is, there is nothing in the minutes of that meeting to suggest that at that date Joanna Hernandez was not sufficiently *au fait* with her duties and responsibilities as Manager, and with the challenges which she would face in discharging them. Had she felt at that time that the Home was "in virtual chaos", that the "entire culture ... was one of institutionalised, historic malpractices", or that there was "no management structure", I have no doubt that she would have said so loudly and clearly, and that the minutes of the meeting would have recorded it.

I turn next to the issue of staff shortages, which I have already identified as a continuing problem in the Home.

In paragraphs 26 and 27 of her 2006 witness statement [**C1/1/4-5**], under the heading "Rota System", Joanna Hernandez said this:

> "26. The Home was clearly operating without the required full staffing [complement]. It depended on a large volume of supply workers that was [continually] changing.
>
> 27. Ms Berini and I devised a new system and the seniors had to report to us before any changes were made and, if made, they had to be immediately recorded in the charts. In addition, the supply workers were given forms to complete and to verify with the seniors to produce a reliable record. This gave a better control but it required, in the circumstances, a full-time AO [administrative officer] to deal with this, the petty cash and sick/annual leave, which the deputy and I had recommended in line with the Children & Families Team. ...."

I accept that the widespread use of supply workers made setting rotas – an already difficult task – even more difficult. I also note that it is apparent from paragraph 27 of Joanna Hernandez' 2006 witness statement (quoted above) that at this early stage in her managership she and Sharon Berini were working well together.

In paragraph 133 of her third witness statement [**E/67/42**], Joanna Hernandez says this:

> "133. From the moment I took up my position as [manager] of DGH it was completely clear that the Home was very understaffed. In fact there simply was not enough available staff to meet the minimum needs of the residents and Home. It was clear also that many staff felt unhappy and under great stress. There was a very high incidence of sickness absences, which further reduced the staff available to care for the residents. A significant number of staff were also suspended from work for disciplinary matters."

In paragraph 139 of that witness statement [**E/67/43-44**], she concludes, with reference to the problem of staff shortages, that:

> "139. .... The residents could not be adequately cared [for], the staff and [Home] properly managed due to this overriding issue."

In paragraph 141 of her third witness statement [**E/67/44**], she says this:

> "141. The consequences of the severe lack of staff, high sickness rates and low morale were very serious and had implications for every aspect of resident care and the running of the homes [sic]. There simply was not the staff to do the basic work required. Also, many of the staff had little training for the difficult job of caring for vulnerable people. There was also a severe lack of administrative support, which I reported to the CEO ...."

As of November 2004 there was, as I have already found, a continuing problem of staff shortages at the Home. There were also a number of other shortcomings in the operation of the Home, as described in Chapter 7 of this Report, but they were of a far less serious and less dramatic nature than Joanna Hernandez now seeks to maintain.

The continuing problem of staff shortages is also a constant theme running through the reports of the Social Workers (Elizabeth Harrison, Jennifer Poole and, in particular, Debbie Guinn) in late 2004 and early 2005, to which I refer later in this Report.

A further meeting was held between staff, management and the Union on 8 February 2005, attended by Isabella Tosso, Marie Gomez, Joanna Hernandez, Nigel Bassadone and Luis Montiel. Under the heading "Policy and Procedures", the minutes of the meeting [**J1/37/1**] record that three-quarters of the copies of the Disciplinary and Grievance Procedures had already been handed out, and that the remainder were to be collected. Under the heading "Annual leave entitlement", the minutes record that the Home was at that point "11 members down"; that feedback was awaited on recent investigation into "complement"; and that an advertisement for supply workers had been placed in the Press on 7 February 2005.

On 22 February 2005 Joanna Hernandez wrote to Isabella Tosso [**J1/38/1**] recommending the recruitment of three additional Senior Support Workers, and that the posts of the two acting support workers be made permanent. She also once again expressed concern that residents were being placed in a vulnerable situation by reason of the shortage of staff. She described in vivid language the consequences of that shortage, as follows:

> "For the past several years the sole responsibility of running flats 1,2 and respite has been that of 1 Senior Support Worker per unit. Consequently when there is no SSW [Senior Support Worker] at weekends or during the nights when standards of practice fall into disarray. There are serious

> cases of medication not being [administered] to residents or residents being overdosed. Medication not being collected... PRN's[522] not administered correctly due to lack of communication between staff. Staff not turning up to work on the weekends and flats working extremely understaffed, staff refusing to work with clients with sick issues, etc... it is practically impossible for the person on call to monitor the above malpractice's [sic] effectively without being on the premises and it is practically impossible for the on-call person to be able to monitor the diversity of areas within [the Home] at large."

An unsigned fax to Marie Gomez dated 21 May 2005 [**J1/39/1**] contains details of the staffing complement for each of the flats, and for the respite and sitting service. The fax includes the following:

> "What we actually need is very difficult for me to say at this stage as I do not know what the future holds for the respite and sitting services. Assessments have not yet been carried out for our current service users and future needs for individuals with a learning disability within Gibraltar who will potentially become service users have not yet been taken into account.
>
> ....
>
> There has been no stability for staff members, service users or service users families. This is due to having to rely on supply support [workers] who soon look for other employment as they need more stability or they cancel shifts at short notice because they can. Using supply [workers] actually works out to be more expensive than employing conditioned staff.
>
> It is in everyone's interest that this service works and runs as smoothly as possible and the only way in which this can be done is to have the majority of the service being covered by conditioned staff with supply support workers being used on an as and when basis.
>
> Based on the service that we are currently providing of 800 care hours I would like to make recommendations that a further 8 – 10 contracts of 20 hours be given out and one of 42 hours to cover some of the wake nights in Respite. This would mean greater stability for the service, more productivity and better reputation for the service being provided. It would also mean that vital documentation, individual personal files and everyday living skills would progress and be up to date with keyworkers being allowed time for this within their conditioned hours.
>
> ....
>
> At the moment in each area we are having a *staffing crisis* due to the fact that we do not have the full staffing [complement] that is desperately needed to sustain the current residential and respite & sitting service that is being provided. We currently have 3 conditioned staff and one supply support worker interdicted. 6 of our new intake of 9 [supply workers] inducted in March have terminated their contracts or will be terminating their contracts for a variety of [reasons].
>
> *We are really struggling to cover the basic needs of the service due to the staffing shortages*. There is also a <u>lot</u> of sick leave and annual leave that needs to be covered which means that the overtime that is being paid out is going to be a large amount of money. In some cases staff are having to cover 7 wake nights in a row. Supply support [workers] are working in all of the different [areas] which is leading to confusion and [errors] with [rotas] occurring.
>
> The situation cannot be allowed to continue for a longer period of time as the service is vulnerable and open to legal implications due to staffing shortages. We require a staffing inspection to be carried out as soon as possible so that we can further progress the service." (Emphasis supplied)

[522] Medication which is administered as required.

The evidence before the Inquiry does not establish whether these particular recommendations for an increase in staff numbers were accepted by the SSA, but it is clear from the further documentation to which I am about to refer that the problem continued for some time thereafter, so that the clear implication is that they were not.

Further issues concerning staff shortages were recorded in the minutes of a management meeting held on 1 July 2005 [**J1/40/1**]. Present at that meeting were Marie Gomez and Sharon Berini (an apology for absence was received from Joanna Hernandez[523]). Under the heading "Staff Matters", the minutes read as follows:

> "Staffing shortage to cover respite and sitter [sic] service staff is being taken out of Flat 1 and Flat 2 which affects residents[']' daily living, and even any activity planned. SB [Sharon Berini] asked for directions on what they should be doing; whether they carried on covering respite which meant stretching staff to the limits and sometimes cancelling residents' activities or just cover the residential unit and cancel more respite. **Action MG** [Marie Gomez] **to let CEO know.**
>
> ....
>
> Staff morale and sick record is at an all [time] high record. People are worried about their jobs and their own security."

The impact of staff shortages on the operation of the respite service is evident from the minutes of a further management meeting between Marie Gomez and Sharon Berini which took place only a week later, on 8 July 2005 [**J1/40/2**]. Under the heading "Staff Matters" the minutes recorded, echoing the complaints of the relatives[524]:

> "Huge problem with respite service having to be cancelled.[525]"

The minutes went on to record that Joanna Hernandez and Sharon Berini had carried out some interviews of potential supply support workers, and that after Joanna Hernandez had left[526], Sharon Berini and Kirushka Compson had carried out the remainder of the interviews.

Then, under the subheading "Staffing shortage", the minutes contain the following:

> "There has been 4 staff leaving which worsen situation together with annual, sick, maternity sick is making it increasingly difficult to provide an adequate service both residential and respite. To avoid putting both service users or staff at risk services will have to be cancelled."

A further meeting was held on 4 August 2005, attended by Joanna Hernandez, Marie Gomez and Denise Hassan. The minutes of that meeting [**J1/40/4**] include the following:

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[523] Joanna Hernandez was absent on special leave from 26 June 2005 to 8 July 2005, caring for her daughter at Great Ormond Street Hospital in London.
[524] See Chapter 7.
[525] It appears from minutes of management meetings held on 28 October 2005 [**J1/44/1**] and 9 November 2005 [**J1/45/1**] that the respite service was still closed at these dates. It also appears that it had to be cancelled once again in early 2006 due to shortages of staff (see **J1/17/1** and **J1/18/1**).
[526] i.e. left on special leave.

> "Huge staff crises consequently there's poor level of care that the service can provide to residents e.g. unable to attend medical appointments, hospitals etc. Also staff safety at risk i.e. [Resident AE]."

At around this time, Sean Matto compiled a report (which is undated) entitled "Report Re: Flat 1" [**M23/1/1** or **J1/41/1**]. In the course of his oral evidence to the Inquiry he said that he was not clear when he wrote the report but thought that it must have been "either when Joanna Hernandez was there or just after"[527].

The first two paragraphs of the report read as follows:

> "The purpose of this report is to formally communicate how the staffing shortfalls/crisis throughout the Dr Giraldi Services ... impinges on Flat 1.
>
> In essence, Flat 1 is understaffed and personnel stressed and overworked. Despite the commendable efforts of staff which often surpasses the expected call of duty, the situation is such in the Flat that the environment does not always safeguard and promote the welfare of vulnerable adults. Residents often do not get the rightful level of support and as such [cannot] always be encouraged/supported to participate as fully as possible towards a lifestyle that is happy, dignified and reflects the concept of normalisation. The overall effect of this has been that these people with learning disabilities have been denied the basic right to carry through the most basic decisions about their lives. This seems at best unfair, at worst abusive."

The report goes on to list the names of the nine contracted support workers allocated to Flat 1, together with their contracted hours of work totalling 276.5 hours per week. It continues:

> "The *minimum staffing complement* of contracted staff to provide a good service at Flat 1 would require 4 persons working during the day, a senior and 2 persons working during the night. This would involve a total of 520 hrs per week, this leaves us 243.5 hrs short. This excludes any consideration for annual, sick or special leave.
>
> At present, the shortfall in contracted hours is covered as far as resources permit by supply support workers, some of which work full time hours. Although it is rarely the case when we have the full staffing complement, due to constant shortfalls throughout the service, a minimum standard of care is always sought. Nevertheless, in recent weeks Flat 1 has found itself too often in a situation where the staffing ratio has been 1 or 2 support workers a shift. This has put the residents, staff and organisation in an extremely vulnerable position. Furthermore, the level of care provided has been minimum, disempowering and lacking social justice and equality. The right to live in the least restrictive environment possible and the right to developmental opportunity has been unsustainable at times."

The report goes on to give a brief description of each of the seven residents currently residing in the flat.

The final section of the Report is headed "Reflections". The first paragraph of that section reads as follows:

> "Our role as support workers carries the responsibility to consider the best interests of our clients. The law, the Social Services Agency, the client's family and the public at large, expect us to protect the clients from harm and are likely to hold us responsible if things go wrong. In the light of the current situation at Flat one, at present I feel that numerous things can go wrong and

[527] See Day 7 page 205 line 3.

> have been going wrong to the point that even a resident had to be sectioned at K.G.V. This was due to lack of monitoring and implementation of appropriate management strategies."

The final two paragraphs of that section of the Report read as follows:

> "There is a need for an active support model through clearly defined structures for planning staff and resident activity and for the delivery of practical help to residents to meet the behavioural demands of common[-]place situations. This is an essential component of high quality provision.
>
> Very importantly, staffing levels should be enough for clients to be able to have one-to-one attention if that is what is necessary for them to have [their] basic needs met. The role, pay and level of qualification of support workers also needs to be reviewed."

In answer to questions from counsel for Joanna Hernandez, Sean Matto agreed (as mentioned above) that the understaffing at the Home could, "in the main", be described as "abusive"[528]. Asked what he meant by "abusive", he said that it meant that the lack of staff had a serious direct effect on the standard of care which it was possible to provide for the residents. He went on[529]:

> "The thing is if you are understaffed, then obviously there is less monitoring ... that takes place from management. .... And ... when I talk about the most basic decisions, if you choose to go out, for instance, and if there is four service users, three of them, for instance, require a one-to-one support and you have two staff and three of them want to go out, either you compromise health and safety both of the service users, the public and the individual, or you have to then convince the individual that they can't go out now. You are creative, and maybe you reduce ... the time of the outing, and then they have an opportunity to go out. .... What I am talking about, really, is institutional abuse. .... Like a medication error, for instance, because it's contingent on the staffing and the support that the individual requires."

As noted earlier, further confirmation of the extent of the problem of staff shortages, and of its consequences in terms of the care which the staff was able to provide to service users (both residents and respite users), is to be found in the reports of SSA social workers, and in particular of Debbie Guinn (a senior SSA social worker), to which I refer later in this Report[530].

In the light of all this evidence, it is clear that from the time when she took up her post as Manager Joanna Hernandez was faced with a situation in which a chronic shortage of staff had resulted in the staff becoming seriously overstretched, with many members of staff suffering from stress – a problem which was compounded by high levels of sick leave. In the circumstances it is not in the least surprising that staff morale was low. This was a delicate situation which cried out for a sensitive and sympathetic approach by management, and by Joanna Hernandez in particular, towards members of staff. Regrettably, as I shall relate[531], this was an approach which Joanna Hernandez signally failed to provide: indeed, the subsequent breakdown of her relationship with Sharon Berini (among others) led her to embark on an "investigation" which served only to exacerbate that situation.

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[528] See Day 8 page 13 line 8.
[529] See Day 8 page 13 line 10ff.
[530] See Chapter 11 of this Report.
[531] See Chapter 10 of this Report.

The problem of staff shortages continued for the entirety of Joanna Hernandez' time as Manager and thereafter – and I accept that this had a direct impact on the standard of care which the staff was able to provide to residents and respite users. At the same time, I am satisfied that it was not the case there were not enough members of staff "to meet the minimum needs of the residents and Home"[532]; that "the residents could not be adequately cared [for]"[533]; or that "[t]here simply was not the staff to do the basic work required"[534]. Through the commitment and hard work of the staff, the minimum needs of the residents and respite users were being met and the "basic work" was being done – albeit it was undoubtedly a "struggle" for the staff to achieve that. However, as I said earlier, there can be no doubt that with greater numbers of staff a higher standard of care could have been provided.

As to interdictions of members of staff, it was indeed the case that three members of staff – Richard Muscat, Angelica Williams and Michelle Garro – were interdicted shortly after Joanna Hernandez took up her post as Manager following allegations of abusive conduct made by Residents T, J and AA. I shall consider the circumstances of those interdictions later in this Report[535]. No doubt these interdictions served to aggravate the continuing problem of staff shortages.

I turn next to the evidence as to relations between members of staff in late 2004 and early 2005.

Joanna Hernandez accepts that, initially, her relations with Isabella Tosso, Marie Gomez and Sharon Berini were good. Indeed, as I indicated earlier, the contemporary documentary evidence bears this out. In her oral evidence, she said this[536]:

> "I had no problems with either Marie Gomez or Isabella Tosso. That's the truth. We had a very good relationship."

Later in her oral evidence she confirmed this, saying[537]:

> "I didn't have a personal problem with any of them, in the beginning."

However, she also asserted that she subsequently had professional problems (albeit not personal problems) with Isabella Tosso, Marie Gomez and Sharon Berini[538], saying that Isabella Tosso and Marie Gomez were "the two people that told me either shut up or I would lose my job".

So far as Marie Gomez is concerned, Joanna Hernandez says (in paragraph 96 of her third witness statement [**E/67/33**]):

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[532] See paragraph 133 of Joanna Hernandez' third witness statement.
[533] See paragraph 139 of Joanna Hernandez' third witness statement.
[534] See paragraph 141 of Joanna Hernandez' third witness statement.
[535] See Chapter 13.
[536] See Day 1 page 104 line 24.
[537] See Day 2 page 20 line 19.
[538] See Day 1 page 120 lines 22 to 42.

> "96. .... I had a very good impression of Ms Gomez initially, and for some time after taking up the post of manager of the [Home]. She made it very clear that she knew that there were serious problems at the [Home]. She assured me ... that she would ... support me. ...."

She goes on to say, however, that this later proved to be an incorrect impression on her part. As to that, it is material to note that in a letter to Isabella Tosso and Marie Gomez dated 12 June 2005 [**C1/1/61**], to which I refer later in this Report, Joanna Hernandez said this about Marie Gomez:

> "... [T]he only person I can trust to temporarily assume my duties as manager would be Marie Gomez and it is my recommendation that she should step in for the two weeks that I am away at Great Ormond Street Hospital[539]."

Asked about the above statement in the course of her oral evidence, she said this[540]:

> "Because I thought highly of her. .... I never thought badly of her. I thought very highly of her. .... We had a good working relationship. We had no problems. It was the minute that I stood my ground, and they said "Keep quiet or you lose your job", that was it, I lost my friendship with them, they became like – I cannot explain, because bullies have [stolen] my life and that behaviour to me was shocking because they were my friends."

So it is clear that at least up to that date Joanna Hernandez enjoyed a good working relationship with Marie Gomez.

In paragraphs 20 and 21 of her witness statement to the Inquiry [**E/17/5**], Marie Gomez described her impressions of Joanna Hernandez during her first few weeks as Manager as follows:

> "20. Joanna may have been enthusiastic however she simply did not understand how to run the home. Once she had grasped the basics, then we would have been able to share ideas and plans for the future, but you cannot (build a house by the roof) change everything in one day. The most basic tasks of updating the rota and the petty cash required to be learned, and she needed to learn how to conduct supervision sessions. There was no way that her ideas could even be looked at until she learned the basics. ....
>
> 21. Joanna did not have supervision sessions every fortnight because she did not always attend despite appointments being made. Joanna was very volatile and when she did attend, she would arrive in an erratic state and we would not achieve anything worthwhile until she had calmed down. Only then would we be able to focus on preparing the Agenda for the session."

In the course of her oral evidence, Marie Gomez elaborated on these paragraphs, saying[541]:

> "Basically Joanna Hernandez had wanted to run before she could walk. She had huge ideas for the service, but we needed to have the basics done in the service ... And the basics were: let's get the rotas right, let's get the petty cash [right], and let's get the supervision in place so that you can be telling people what is happening, what they are doing wrong, and let's sort whatever is happening in the Home. .... Of course I was troubled [by the breakdown in relations between

[539] As noted earlier, Joanna Hernandez was about to depart on two weeks' special leave in order to care for her daughter at Great Ormond Street Hospital in London.
[540] See Day 2 page 151 line 8.
[541] See Day 13 page 59 lines 10-17, and page 74 lines 18/19.

> Joanna Hernandez and Sharon Berini] but I also knew Joanna was very volatile and erratic and I couldn't trust that what she was saying was true."

On the other hand, favourable opinions of Joanna Hernandez' performance as Manager were expressed by three of her colleagues in their witness statements in the Industrial Tribunal proceedings (i.e. in their 2006 witness statements). The three colleagues in question were Dean Lopez, Denielle Gomez and Nicole Viagas.

Dean Lopez qualified as a social worker in July 2004, but did not start practising as such until 2006. He was employed by the SSA in October 2004, initially as a support worker in the Adult Team, based at the SSA's offices. In February 2005 he was transferred to the Home. In his 2006 witness statement[542], he said this [**C1/20/1-2**]:

> "Early into my career at [the Home] it became quite clear that Ms Hernandez was a very competent, transparent individual who truly wanted to make a positive change. This could be observed by the fact that she revised and introduced a new format of assessing the developmental needs of [the Home's] service users. Namely makaton client centred care plans, everyday living skills (ELSI documents) and risk assessments.
>
> Ms Hernandez came across as an approachable manager that had an empathetic understanding of not only learning disabilities but also effective people skills. This could be observed by the fact that she used to take an active interest in your work and offered her support if so required. She also had an open door policy for service users and was never too busy to listen to their concerns.
>
> On the whole I believe Ms Hernandez made a difference during her term in post not only to the staff [complement] but also to the service user group. This could be observed by the revised structure she introduced, staff's renewed enthusiasm for their work and service users['] positive outlook/attitude regarding Ms Hernandez['] managerial skills."

Denielle Gomez was employed as a support worker at the Home from January 2002 to April 2005, so she worked under Joanna Hernandez as Manager for about five months. In paragraph 3 of her 2006 witness statement, she said this [**C1/21/1**]:

> "3. I can therefore say that by working alongside Ms Hernandez, Ms Hernandez demonstrated to be a good manager, listener and worked towards the [Home] residents and all its employees in a professional and exemplary manner."

Nicole Viagas is a qualified social worker. In November 2004 she was managing the Children's Residential Service. She had little contact with Joanna Hernandez during the first few months of Joanna Hernandez' managership. During the latter part of 2005 contact increased between the Home and the Children's Residential Service, but Nicole Viagas never worked at the Home[543]. In her 2006 witness statement [**C1/22/1**], she said this:

> "I first came to know Ms Joanna Hernandez when she was appointed as Manager for [the Home] and I was managing the Residential Service for Looked after Children. During the first few months of her appointment we had very little contact. However, during the months before her dismissal, contact between the two service managers grew as a result of a change in the [SSA's] structure.

[542] The paragraphs in Dean Lopez' 2006 witness statement are not numbered.
[543] See Day 12 page 2 line 14.

> Both services had regular meetings where we would discuss practice, operational and other issues pertinent to either or both services. Ms Joanna Hernandez always came across during those meetings as an enthusiastic and committed worker whose focus was purely on ensuring that the service users were provided with high standards of care. As I understood it Ms Joanna Hernandez was faced with an extremely difficult task, as her working ethos was not widely accepted or understood by some members of the workforce.
>
> Ms Joanna Hernandez did on many occasions seek support from workers from the Children's Services Team, especially when she felt unsupported by her team. I can recall numerous occasions where Ms Joanna Hernandez sought advice and guidance from our team of workers."

I take full note of those complimentary comments. I also take note of the fact that a witness statement was made in the Industrial Tribunal by Stuart Borastero, who had dealings with Joanna Hernandez in her previous employment in connection with negotiations relating to a pay review. In his witness statement [**C1/19/1**] he describes her intentions as honourable and her contribution to the negotiations as exemplary.

Nonetheless, having had the opportunity of seeing and hearing Joanna Hernandez giving oral evidence to the Inquiry, and having heard the evidence in relation to her June 2006 "investigation" (as to which see Chapter 10 of this Report), I cannot agree with Dean Lopez that Joanna Hernandez possessed "effective people skills". On the contrary, whilst I do not doubt that she tried hard to improve conditions in the Home, I find that she was seriously lacking in such skills. In the context of a relatively small staff undertaking a challenging and stressful job, this was undoubtedly a significant factor when it came to introducing new policies and practices in the Home. Moreover, I accept Marie Gomez' evidence that Joanna Hernandez tried to run before she could walk, and that her conduct as Manager tended to be volatile and erratic. This was certainly due, at least in part, to the fact that she had had no previous experience of managing a care home.

Returning to Marie Gomez' oral evidence, when asked by counsel to the Inquiry about the initial relationship between Joanna Hernandez and Sharon Berini, she replied[544]:

> "To begin with she got on very well with Sharon Berini and they were practically joined at the hip. They went everywhere together. Sharon supported Joanna Hernandez from the very beginning, [when] she started working [at the Home]. But then later on, months later, I can't remember exactly, probably June, she turned against Sharon Berini. .... Their relationship broke down. .... She started saying that Sharon wasn't doing what she was supposed to. I can't remember exactly, but it was ... to that effect."

Later in her oral evidence[545], she said this:

> "I think that when [Joanna Hernandez] started as Manager people were willing to give her a chance and people cooperate, because basically that is what has been happening there. .... But then if they find that you are not doing what you are supposed to be doing, eventually people are going to turn against you, because they are fed up [with] not having a proper manager [or] ... having somebody to guide them and [enable them to] do what they are supposed to be doing."

[544] See Day 13 page 62 line 5.
[545] See Day 13 page 78 lines 11-20.

I accept that evidence.

Marie Gomez went on to deny that she ever "warned" Joanna Hernandez about Sharon Berini[546]; or that she had ever told Joanna Hernandez to keep quiet or otherwise lose her job[547]; or that she had ever told Joanna Hernandez to tell an untruth. I accept those denials.

As to Joanna Hernandez' evidence that Douglas Rodriguez and Marie Gomez "warned" her about Sharon Berini, I can certainly accept that it is probable that, when discussing with Joanna Hernandez her forthcoming appointment as Manager, Douglas Rodriguez and Marie Gomez – and possibly also Isabella Tosso – alerted her to the need to treat Sharon Berini (who would be her deputy) with sensitivity and understanding, given that Sharon Berini had considerable experience of working in the Home, that she had been acting as Manager since the resignation of Morag Jack, and (perhaps more significantly) that she had herself applied unsuccessfully for the post of Manager. If Joanna Hernandez interpreted that as a "warning", so be it: at all events, I am satisfied that no greater "warning" about Sharon Berini was given to Joanna Hernandez than that. I am also satisfied that neither Marie Gomez nor Isabella Tosso ever told Joanna Hernandez to "shut up, or [she] would lose [her] job".

In paragraph 345 of her third witness statement to the Inquiry [**E/67/95**], Joanna Hernandez alleges that, before she took up her post, Marie Gomez told her that "some night staff would lock patients in their rooms and go out drinking in Casemates in Gibraltar". In her oral evidence, Marie Gomez denied having told her that[548]. I accept that denial. For completeness, I should also say that no evidence has been presented to the Inquiry to suggest that such behaviour ever occurred.

As to her initial relationship with Sharon Berini, Joanna Hernandez says this in paragraphs 129 to 131 of her third witness statement [**E/67/41**]:

> "129. The Deputy Manager of the Home was Ms Sharon Berini. She had been acting manager for a long time. .... Before I had taken up my post, I had been given a very bad impression of her by Marie Gomez ... and Isabella Tosso... They had told me that I should be very careful with Sharon, as they felt she was responsible for many of the problems at the Home.
>
> 130. However, when I met Ms Berini, she seemed very friendly towards me and appeared to be very helpful. I would say we quickly became working colleagues. ....
>
> 131. .... [I]nitially and for some months after I started work at the DGH, I believed Ms Berini to be a person who wished to help me."

As I indicated earlier, in the course of her oral evidence, Joanna Hernandez confirmed that she had no personal problems with Sharon Berini[549]. She said that until she handed in the June

[546] See Day 13 page 103 line 10.
[547] See Day 13 page 103 line 25.
[548] See Day 13 page 99 line 23ff.
[549] See Day 1 page 120 line 18.

2005 statements (referred to earlier) her professional relations with Isabella Tosso, Marie Gomez and Sharon Berini were good. She went on[550]:

> "I had lunches with them. I had no problems. I get on well with most people, and it was when I handed in the [June 2005 statements] that all the bullying and harassment [began]. They tried to intimidate me."

On the other hand, in paragraph 132 of her third witness statement [**E/67/42**] she gives a different account of the breakdown in relations between herself and Sharon Berini, saying this:

> "132. Later, and over a period of time, I came to understand that Ms Berini was a very difficult person, who had significant responsibility for, and was a significant cause of, problems at the Home with residents and staff. As stated above, this was known to the SSA Team Leader [Marie Gomez] and CEO [Douglas Rodriguez] before I took up the post of manager. It is fair to say that they did warn me about Sharon Berini, but I thought they had got her wrong."

In her oral evidence, Joanna Hernandez described Sharon Berini as having a "double character"[551].

I find that, contrary to Joanna Hernandez' oral evidence, the breakdown in the relationship between Joanna Hernandez and Sharon Berini pre-dated her June 2005 "investigation" (described later in this Report) and the handing in of the June 2005 statements. I find that it can be traced back to at a meeting with Sharon Berini and senior members of staff (including Sean Matto and Nigel Bassadone) which Joanna Hernandez convened in April or May 2005. In paragraphs 316 to 318 of her third witness statement [**E/67/86-87**], Joanna Hernandez describes this meeting as follows:

> "316. I called a meeting of the deputy manager and all seniors to completely revamp the rota system and use of staff. This was in approximately April or May 2005. I put a large sheet of paper on the wall detailing all of the flats for DGH and the other flats and teams. I said that we were going to rearrange all of the teams to make best use of time and in order to best serve the residents[']s needs. The deputy [manager] and Sean Matto (team leader flat one and previously acting deputy manager) became very angry. Some of the seniors were totally resistant to change. Sharon Berini became so angry and upset that she went to the toilet and vomited[552]. She came back into the meeting and said that if I moved Nigel Bassadone (senior of [Resident L's] team), her children would be without a home. She had 2 children with Nigel and she lived with them in Nigel's grandmother's house free of charge.
>
> 317. Sean Matto stormed up to me and shouted that I could not change the teams He said to me, in regard of the seniors, that they were "the untouchables". It must be remembered that he had been the acting deputy manager; as such he had a lot of influence. I naturally wanted to be able to look to and rely upon such senior staff for support in improving the care at the Home. However, they were very resistant to change.
>
> 318. I do wish to be clear that there were many staff and seniors who were supportive of positive change, and who genuinely cared for the residents."

[550] See Day 1 page 121 lines 11 to 14.
[551] See Day 1 page 213 lines 1-5.
[552] In her oral evidence, Joanna Hernandez described Sharon Berini as "vomiting on the table": see Day 1 page 140 line 14.

In her oral evidence, Sharon Berini denied Joanna Hernandez' account of the meeting. After denying that she "went to the toilet and vomited", she went on[553]:

> "What I can say [is that] if I had any strength of feeling in relation to this, this was specifically in relation to Resident L. ... He needs a very dedicated staff team who are well aware of his behaviours, and any changes to Resident L seriously impacts on his behaviour in a very, very negative and aggressive manner. And if I showed any resistance, which I believe I did ... it was simply due to the fact that I wanted to ensure that any transitional period for this child specifically was done in the best way possible, and that was to keep the staff team as tight as possible. .... I certainly don't remember Sean Matto storming up to her and shouting that she could not change the teams."

I accept that evidence.

In his oral evidence, Sean Matto also denied Joanna Hernandez' account of the meeting, saying this[554]:

> "... it is not in my character to talk in this manner, first of all. Secondly, if someone was untouchable it must have been Joanna Hernandez, [who] had the support that no-one had."

I accept that evidence.

Nigel Bassadone, in his oral evidence (to which I refer below), also denied Joanna Hernandez' account of this meeting. I accept his denial.

I accordingly reject Joanna Hernandez' account of this meeting in so far as it conflicts with the evidence of Sharon Berini, Sean Matto, and Nigel Bassadone. The truth, as I find, is that they were understandably concerned to learn of Joanna Hernandez' decision to reorganise the rotas by "rearranging all the teams", and in particular Resident L's team. I have earlier recognised the desirability of maintaining continuity of care for residents and respite users so far as possible, and a decision to make major changes in the personnel of the various teams – in particular, Resident L's team – ought to have been preceded by a process of careful consultation between Joanna Hernandez and the senior members of staff involved. However, no such process took place. Instead, Joanna Hernandez began the meeting by "putting a sheet of paper on the wall" detailing the changes. In the circumstances it is hardly surprising that her decision met with a degree of resistance from those present. That said, I am satisfied that conduct of those present at the meeting in reacting to her decision was entirely professional. The fact that Joanna Hernandez has chosen to interpret their responses to her decision in the way she has is a clear example of her apparent inability to give objective consideration to reasonably expressed views which happen to be contrary to her own. Instead, the reasonable expression of such contrary views prompted an emotional reaction on her part which significantly affected her subsequent conduct towards them, and which inevitably impacts upon the reliability of her evidence to this Inquiry.

[553] See Day 8 page 107 line 4ff.
[554] See Day 8 page 43 line 20ff.

Joanna Hernandez returns to the theme of her relationship with Sharon Berini in paragraphs 382 and 387 [**E/67/103 and 104**] of her third witness statement to the Inquiry, where she says this about Sharon Berini:

> "382. Before taking up my position I had been strongly warned about Sharon Berini ... by Marie Gomez and Isabella Tosso. I had not believed those warning[s] as I found her pleasant and helpful. However over the weeks and months I continued to receive comments and concerns from staff and parents of residents regarding Ms Berini. Both junior and senior staff had regularly raised concerns with me that they felt bullied and victimised by Sharon.
>
> ....
>
> 387. It became clear to me that Sharon was undermining staff morale and effectiveness, [and that she was] unprofessional and untrustworthy."

I reject that evidence. In the first place, it is not the case that Joanna Hernandez was "strongly warned about Sharon Berini ... by Marie Gomez and Isabella Tosso". No concerns or criticisms about Sharon Berini's conduct had previously been expressed to her by either Marie Gomez or Isabella Tosso. Indeed, there was nothing in her conduct as Acting Manager to justify concern or criticism. I also reject the allegations in paragraph 387 (above) as unfair and untrue.

By 14 May 2005 Joanna Hernandez was also suspecting Sharon Berini of having stolen a file containing allegations against Nigel Bassadone. In paragraphs 375 to 381 of her third witness statement [**E/67/101-102**], Joanna Hernandez says this:

> "375. A most serious issue of security arose in regard [to] the theft of a serious incident report I had received from Maria [Gonzalez] regarding an incident on the 14 May 2005 [**C2/2/28**]. The report was taken from the manager's office after I had locked the office at the end of my working day. This was serious for two reasons. First because of the content of that report and secondly because I was certain that the report was taken deliberately by the deputy manager, Sharon Berini, in order to protect the father of her children, Nigel Bassadone, from disciplinary action arising from allegations contained in that report...
>
> 376. Ms [Gonzalez] handed me a report in my office. I read it. It stated that Nigel Bassadone had arrived at Bishop Healy House (where he was the senior in charge of [Resident L's] care) at around 3am – 3.30am. Ms [Gonzalez] who was one of his staff was on night duty. She reported that Nigel smelt of alcohol and wanted to sleep the night at the Home. She found it difficult to challenge him on this, as he was her supervisor, and she suggested he ring me for authorisation. She then encouraged him to leave and return in the morning for his shift at 9am. He left at approximately 3.30am.
>
> 377. Obviously I was very concerned that a senior in charge of a child would arrive at the child's home under the influence of drink in the middle of the night seeking to sleep there. I intended to report this incident to Marie Gomez (the Team Leader). I told Sharon Berini about the report... She made no reply.
>
> 378. I placed the report in a [drawer] in my desk, before locking up the office for the night. The next morning I came into the office and unlocked it. I went to get the report to take it to senior management to report the incident The report was missing.
>
> 379. The only other person who had keys to the manager's office was Sharon Berini. As I have detailed previously, she is the mother of Nigel Bassadone's two children and lives with his grandmother. I believed that Sharon Berini had taken the report... She said no. She also said that Maria Gonzalez was a liar and her report regarding Nigel was untrue. I said to her that I

> believed that she had taken the report, as no one else could have had access to it. Sharon denied this.
>
> 380. I asked Maria [Gonzalez] to re write [sic] her report. She did so. I took the report to Marie Gomez (Team Leader) and reported the incident. I also said that I believed that Sharon had removed the original report. I recorded the theft of this report in a minuted meeting of the 3.06.05 [**M29/26/5**]. [Marie] Gomez read the report and said that she believed we should get rid of Nigel from DGH. She suggested moving Nigel to the children and families team along with [Resident L]. I said that this was not a good idea, given the concerns raised in this report.
>
> 381. This incident made me lose all trust [in] Sharon."

In the course of her oral evidence, responding to a question from counsel for Nigel Bassadone, Joanna Hernandez referred to the "theft" described in the above paragraphs of her third witness statement as "theft by Sharon, by Sharon or whoever, because only she had the key ..."[555].

The report by Maria Gonzalez referred to by Joanna Hernandez in the above passage from her third witness statement contained the following [**E/2/29**]:

> "On Saturday 14th May '05 I Maria Gonzalez was working at Bishop Healy with [Resident L] on a wake night shift. At about 03:15 Sunday 15th May '05 morning, Nigel Bassadone turned up at Bishop Healy smelling of alcohol saying that he had lost his keys. I told Nigel that I had not seen his keys around [Resident L's] house. Nigel came in Bishop Healy and started to look for his keys. He then went to [Resident L's] car which was parked inside Bishop Healy's patio, and said that he had found them. (He did not show me the key which he had found.) He then said he would stay the night at Bishop Healy. I did not reply. Then he said maybe he should phone the on call which that night was Joanna Hernandez for permission to stay. I then said that would be a good idea because it would not put me in a compromising situation. He then said it would be better for him to go home and come back at 09:00 to start his working shift. I then said that would be for the best. He then left Bishop Healy at about 03:30."

Among the documentation provided to the Inquiry is a minute [**M25/55/1**] of a management meeting held on 3 June 2005 and, according to the minute, attended by Marie Gomez, Joanna Hernandez, and Sharon Berini. Under the heading "Staff matters", the minute reads:

> "Disciplinary file from office was stolen."

Sharon Berini denies having taken the report[556], and I accept her denial. I can see no rational motive for her having taken the report, and such conduct on her part would have been wholly out of character. Moreover, I accept Nigel Bassadone's evidence (summarised below) as to the incident described in Maria Gonzalez' report.

In her first witness statement to the Inquiry [**E/3/1**], Sharon Berini says this[557]:

> "Although I, together with other staff members, questioned how Ms Hernandez could go from being a classroom aide to managing a large residential and Sitting Service with a staff team of about 50-60 persons, I did not have any issues working with and supporting her. In fact I believed that we had a very good working relationship and even socialised outside of the

[555] See Day 2 page 162 line 23.
[556] See Day 8 page 108 lines 15 and 24.
[557] The paragraphs in this witness statement are not numbered.

> workplace. Managing the Dr Giraldi Home was a huge task for any one person but Ms Hernandez from the very first day was firm in her approach. However over time I found her to be inconsistent in her approach to work. Sometimes Ms Hernandez would come into the office manic and shouting out things that we needed to achieve and other times she would be very low complaining of pain to her ovaries amongst other things, she either had highs or depressive lows. .... I started to feel insecure about the way that certain events were unfolding. Due to the lack of Support and Supervisions, lack of guidance and support from my manager as well as her poor attendance record and Ms Hernandez's sudden close relationships with Ms Hassan and [another carer] our working relationship started to break down and communication between us was strained.
>
> Ms Hernandez started to restrict me from attending certain meetings including one with relatives. I found this very strange at the time as Ms Hernandez always wanted me present during meetings. Sadly she stopped listening to me or supporting me in [any way] and totally ignored my experience knowledge and skill base. It got to the point where I felt that I needed to protect myself by putting certain things in writing with regards to the inadequate [on-call] phone, lack of Senior Support Workers out of office hours and the procedure in relation to being the [on-call] person and the low staff morale and the benefits of team building workshops to boost this."

Sharon Berini's reference (in the above passage) to a meeting with relatives is a reference to a coffee morning for relatives arranged by Joanna Hernandez which took place on 11 April 2005. An "abstract" of what transpired (I will refer to it as a minute), prepared and signed by Joanna Hernandez (and also signed by Elizabeth Harrison), is included in the documentation available to the Inquiry [**C2/2/12**]. As already mentioned, Sharon Berini did not attend that meeting, and in her oral evidence she told the Inquiry that she was specifically told by Joanna Hernandez that her presence at the meeting was not required[558]; and that she did not see a copy of the minute until it came to her notice in the context of the proceedings in the Industrial Tribunal in 2006[559]. I accept that evidence.

According to the minute, the members of staff who attended the coffee morning were Joanna Hernandez, Elizabeth Harrison and a social worker. Violet Sullivan is recorded as saying that she "did not trust Sharon". Susan Ignacio[560], another relative who was present, is recorded as saying that "Sharon was the worst manager the service had ever had". The minute goes on to observe that the facial expressions of Gina Llanelo, another relative who was present, "clearly supported both these allegations".

The fact that Joanna Hernandez chose to exclude Sharon Berini from the coffee morning is testimony to the degree of mistrust which Joanna Hernandez felt towards Sharon Berini by that time: a mistrust for which there was no rational justification. Moreover, I draw the clear inference that by that time Joanna Hernandez was already preparing to mount a campaign against Sharon Berini: a campaign which reached its apogee with the "investigation" which she carried out in June 2005, as described later in this Report[561].

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[558] See Day 8 page 90 line 25ff.
[559] See Day 8 page 91 line 23.
[560] As noted earlier, Susan Ignacio provided a witness statement in the Industrial Tribunal, but has since requested that that statement be treated as withdrawn and its contents given no weight.
[561] See Chapter 10.

In the course of her oral evidence, Sharon Berini was asked by counsel to the Inquiry about her relations with Joanna Hernandez prior to June 2005. She replied[562]:

> "My relations were good until around April time, May time, when I started to see close relationships forming between Ms Hernandez, [another carer], and Denise Hassan. .... So when those close relationships started forming, I did see a change [in] Ms Hernandez's attitude towards me. She stopped me attending meetings, she disregarded my experience, skill and knowledge base in relation to Resident L, specifically."

Asked whether the difficulties in her relationship with Joanna Hernandez impacted on the care of the residents, she replied[563]:

> "I would say that it impacted on the care of the residents, not from myself or Joanna particularly, but due to the fact that it was common knowledge that the deputy manager – myself – had been victimised by the manager and other workers at the time. That's bound to cause unease within the staff team, and that is only going to reflect on the service users. Because if the staff team have issues or, even more, low staff morale, then ... the ones that are going to be mainly affected are the service users within [the Home]. So yes, I would say that that whole time did impact on the care being given. Although staff were still very good, they were still very committed to doing their jobs effectively. And I would say, if I may, throughout this 8-year period in which this has been hanging over the staff team's head and been very public ... I think the staff team have done very well to continue [with] their jobs and dedicate so much time and effort to the service users and residents."

Asked by counsel for Joanna Hernandez to comment on the favourable views about Joanna Hernandez expressed by Gina Llanelo, Sharon Berini said this[564]:

> "What I will say about Ms Hernandez is that she was the first Gibraltarian manager since prior to Milbury's time, and there was a different response to Joanna because she was a Gibraltarian manager. There was a difference in the way in which the English managers maybe approached things with regards to their professionalism, and they [i.e. the staff] did respond in a different way towards Joanna."

Once again, I accept Sharon Berini's evidence. I am satisfied that she was not a "difficult" person; nor was she responsible for problems at the Home. On the contrary, she was a highly competent and experienced care worker with a full appreciation of the needs of residents and a strong motivation to do her best to ensure that those needs were met so far as possible.

I turn next to the evidence of Nigel Bassadone.

Amongst the documentation provided to the Inquiry is a copy of an unsigned letter from Joanna Hernandez to Nigel Bassadone dated 17 May 2005 [**M15/2/1**] containing a "first written warning". The copy letter contains the following:

> "It has been brought to my attention that on 14.05.05 at 3.15am you again turned up at Bishop Healy house smelling of alcohol stating to the night staff on duty that you were going to stay the

[562] See Day 8 page 76 line 16ff.
[563] See Day 8 page 77 line 16.
[564] See Day 8 page 95 line 21ff.

> night as you had misplaced some keys. You were informed that you could not stay and to call the on call at which point you left.
>
> As dictated by the [SSA] Disciplinary procedure and disciplinary code 1.25 this is "Professional conduct which falls short of the normally accepted professional standards but which is less serious than when such conduct arises from gross or wilful negligence".
>
> Consequently I am giving you this first written warning."

It appears that the unsigned letter referred to above may have found its way into Nigel Bassadone's personnel file, but I accept his evidence that he never received a signed version of it, and that the first time he saw the unsigned version – or heard anything about a first written warning in relation to this alleged incident – was when he saw a copy of the unsigned letter among the documents provided to him by the Inquiry team in 2013[565].

A minute of a Management Meeting between Marie Gomez and Joanna Hernandez held on 27 May 2005 includes the following passage under the heading "Staff Matters" [**M23/54/1-2**]:

> "Support worker Nigel B turned up at Bishop [Healy] last Saturday 14/5/05 when he was not working wanting to stay the night. Night staff refused to let him unless he called the out of hours manager as he had already been warned against doing this. He refused [and] left. Manager had already given him a verbal warning and will now proceed to written warning for this incident."

As to the incident itself, Nigel Bassadone says this, in paragraph 18 of his witness statement to the Inquiry [**E/2/12**]:

> "18. I can briefly recall that on one occasion I did attend the Bishop [Healy] Home in the early hours of the morning as I had genuinely misplaced my keys. I remember that Maria Gonzalez was on duty that night but at no point did I request to stay overnight had to leave [sic] as the person on duty requested that I call the off duty manager. Furthermore this only happened once and not on two occasions as stated in the .... Management Meeting. .... I had never wanted to stay, all I did was go to look for my keys I had left in [Resident L's] car. Whenever I used to go out in Gibraltar although I live in Spain if I was on morning shift I would stay at my mother's house in Queensway and that is the reason that I had lost her key as I did not have it on my bunch of keys as it was a loose key that my mother had given me that same day. .... Furthermore the fact that I have been given a verbal warning before is also denied as this never occurred."

In the course of his oral evidence, Nigel Bassadone confirmed the above account of the incident, saying this[566]:

> "So my Mum had given me a key, which was by itself, you know, I didn't have it in my bunch. .... When I had finished my shift, ... I realised when I got to my Mum's house I had misplaced the key. Obviously I knew where the key was, and I had left it in the side pocket of the car we used to have up there."

He went on to say that he had no recollection of Joanna Hernandez having ever mentioned the incident to him[567].

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[565] See Day 7 page 149 line 8.
[566] See Day 7 page 148 line 11ff.

I accept Nigel Bassadone's evidence about this incident.

As to paragraphs 376 and 377 of Joanna Hernandez' third witness statement [**E/67/101**], I note that Maria Gonzalez' report did not say (as Joanna Hernandez alleges in paragraph 376 of her third witness statement) that she "encouraged [Nigel Bassadone] to leave and return in the morning for his shift at 9am": it merely states that when Nigel Bassadone "said he would stay the night at Bishop Healy" (which he denies), Maria Gonzalez "did not reply". Furthermore, consistently with the tenor of much of her evidence to the Inquiry, Joanna Hernandez clearly felt no difficulty in depicting the object of her criticism (in this particular case, Nigel Bassadone) in the worst possible light when she went on to say (in paragraph 377) that she was concerned that "a senior[568] in charge of a child would arrive at the child's home under the influence of drink in the middle of the night seeking to sleep there".

In paragraphs 236 to 239 of her third witness statement [**E/67/66-67**], Joanna Hernandez describes an incident concerning Resident L, in which Nigel Bassadone was involved. Before turning to those paragraphs, and to Nigel Bassadone's evidence in response to them, it is appropriate to set the context by referring to Resident L's history in the Home.

Resident L became a respite user in 1996, when he was aged about three. He subsequently became a permanent resident following what Duncan Jones described in a lengthy memorandum to Douglas Rodriguez dated 11 April 2003 [**M1/2**] as "significant violence within the family home". He has been diagnosed as suffering from hyperkinetic conduct disorder (a type of autism), moderate to severe learning disability and severe social disability. In addition, he suffers from "ADHD" (attention deficit hyperactive disorder) and chromosome X deficiency (for which he takes Ritalin)[569]. Manuela Adamberry says (in paragraph 22 of her witness statement [**E/1/4**]):

> "He also took oral drops and other medicines for his different symptoms. He was sometimes given tranquilizers as and when needed, though I never had the need to request that he be sedated."

In about May 2002 he was transferred to Bishop Healy[570], which was at that time vacant, because (according to Duncan Jones' memorandum [**M1/2/3**]) he had started to behave aggressively and violently, "appearing to be extremely unsettled at being in proximity to other service users whether inside or outside the building". He settled in well at Bishop Healy, but when other service users were transferred to Bishop Healy in early 2003, following a flood at the Home, his behaviour once again deteriorated.

In September 2002 he was admitted to the South London and Maudsley NHS Trust for assessment. The Trust's written assessment (which is signed by Dr Bruce Clark, Specialist

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[567] See Day 7 page 149 line 1.
[568] In fact, the senior at Bishop Healy at that time was Kirushka Compson: see Day 7 page 159 line 3.
[569] See paragraph 22 of Manuela Adamberry's witness statement [**E/1/4**].
[570] As noted earlier, Bishop Healy was formerly a children's home run by the SSA.

Registrar to Dr Jacobs, a Consultant Child & Adolescent Psychiatrist) includes the following description of Resident L's behaviours [**M27/39/5**]:

> "[Resident L] was noted to display repetitive, restricted interests e.g. watching the same video again and again, rearranging and lining up videos and books (after completing the task he would return a few minutes later to repeat it). For instance in mornings it was noted that he seemed to be faecally incontinent, possibly with the means to gaining a bath as a defined end point to these behaviours. He was, however, faecally and urinary incontinent on most nights on the unit. ....
>
> In terms of other behaviours noted, [Resident L] has on several occasions demonstrated faecal smearing, vomiting, stripping of clothes, biting, scratching and various other assaultative behaviours. It was noted that his mood fluctuated very dramatically and markedly. Even when in seclusion it would be noted that he could be fairly cheerful and enjoying himself, however he would then quickly lapse back into violent disturbed behaviours which would made it unsafe to terminate his period of seclusion."

Under the heading "Conclusions", the assessment reads as follows [**M27/39/6**]:

> "[Resident L] is an overweight young boy who, whilst engaging in some activities showed difficulties in transitions with new people and different environments. His functioning is markedly impaired by his motor restlessness, poor attention and distractability. He shows some ritualistic behaviours. Aggressive incidents appeared [to be] related to his wishes not being fulfilled, his preoccupations and difficulties understanding other [people's] social behaviours. There is a history of delayed motor and language milestones, with [Resident L] showing difficulties in expressive and receptive language areas as well as sensory motor functioning. His level of motor functioning is significantly below his chronological age. This aspect is compounded by his weight issue. ...."

The final section of the assessment, headed "Discussion", includes the following paragraph [**M27/39/8**]:

> "Because of [Resident L's] extremely disturbed and aggressive behaviours, we would like to lend our support to the hypothesis that [Resident L] does pose a very high risk of injury to himself and others both adults and children in all aspects of his life and his care package should reflect the level of support that such a risk requires."

In his memorandum referred to above [**M1/2/1**], Duncan Jones attributed Resident L's improved behaviour following his transfer to Bishop Healy to [**M1/2/3**]:

> "... the intensive work carried out with him over a period of time by a consistent staff group working within an environment that is his own and precluded proximity with other service users."

However, as noted above this improvement in Resident L's behaviours was not maintained once other service users joined him at Bishop Healy. As a consequence, he was later transferred to the flat at Flat Bastion Road.

What appears to have prompted Duncan Jones to write his report was his strong opposition to a proposal by Douglas Rodriguez to transfer Resident L and another child resident to Flat 3 at the Home (a proposal which in the event was not implemented). Duncan Jones took the view that it would not be safe to return Resident L to an environment where he was in proximity to other service users. He went on to say this [**M1/2/5**]:

> "[Resident L] should be living in accommodation that affords him separation from other service users together with sufficient space in which to reside with his dedicated staff team. Such an environment will optimise his potential to develop socially and afford him and others (family, staff, other service users and himself) greater physical safety."

In paragraph 2 of his witness statement to the Inquiry [**E/2/1**], Nigel Bassadone describes Resident L as "a very violent and very volatile young man".

Manuela Adamberry cared exclusively for Resident L for some four or five years, both at Bishop Healy and at the flat at Flat Bastion Road[571]. Her evidence about Resident L is to the same effect. In her witness statement [**E/1/2**] she says that she first came to know Resident L when he used to come to the Home for respite care. He was then about three years old, and was still living with his mother. She says that she and Resident L soon grew close, and that Resident L used to call her "Mum" [**E/1/2-3**]. In paragraph 15 of her witness statement she says this [**E/1/3**]:

> "Although [Resident L] was prone to violent outbursts, these rarely happened when he was with me. In fact, he would sometimes ask me to hold both of his hands to help restrain him when he knew he was feeling aggressive, as he used to get very upset with himself if he ever lashed out at me."

Manuela Adamberry goes on to say (in paragraph 20 of her witness statement [**E/1/4**]) that Resident L was always very big and strong for his age, and by the time he was eight or nine years old he was stronger than her.

In her oral evidence, Manuela Adamberry expanded on her references to Resident L's violent conduct, confirming that he was regularly violent to carers[572], including one incident where Resident L hit a carer in the face so hard that she suffered a detached retina[573]. Asked whether there needed to be two carers present when caring for him, she said[574]:

> "It all depended who was working with him. I could work alone with him; I had no problems. I took him with me to the fair, to the beach, to the Med[iterranean Rowing Club]. I didn't need another carer, but towards the end they had to put two people there – not because I had any problems."

I can now return to paragraphs 236 to 239 of Joanna Hernandez' third witness statement [**E/67/66-67**], where she says this:

> "236. On another occasion I was called to St Martin's Special school by the head teacher. She asked me to come urgently as [Resident L] was acting up and his principal carer, Nigel Bassadone, was unable to control the situation.
>
> 237. I went to the school and found [Resident L] naked and sitting on a bench. He was very upset and had wounds to his arms. Nigel Bassadone was nowhere to be seen.

[571] See Day 9 page 154 line 21ff.
[572] See Day 9 page 162 line 5.
[573] See Day 9 page 162 line 8.
[574] See Day 9 page 163 line 14ff.

> 238. It was a very disturbing incident. [Resident L] was a very young boy. He was very distressed and angry with Nigel. I managed to get him dressed and settled down in the end. I had real worries about [Resident L's] care and as to how Nigel Bassadone was caring for him. As such I wrote up a very detailed report of this incident ... [**E/23/1-5**].
>
> 239. [Resident L's] care worried me throughout my time at the [Home]. He was a troubled boy, but he was just a boy. When treated with love and affection, he always responded well. He was being treated with a lot of medication. It troubled me deeply that a child would be so heavily medicated."

The report to which Joanna Hernandez refers in paragraph 238 (above) [**E/23/1**], which is undated, describes the incident in great detail. It describes Resident L as having self-harmed, with his arms showing bite marks and "wounds which were red and swollen". It records that Nigel Bassadone's arms showed evidence of scratching and slight bleeding. It describes how she went to look for Resident L's clothes and saw Nigel Bassadone "climbing down from the top of the garden with a top that [Resident L] had literally torn off and was literally in shreds". The report continues [**E/23/2**]:

> "I was able to establish by means of a perceptibly initial risk assessment that [Resident L] would not injure me at this point. I therefore … bend down put his underwear on [sic]. Helped him with his trousers and socks, and put his rubber shoes on for him. .... [Resident L] in kind responded. He asked me when Nigel was out of ear shot on several occasions ... "Joanna, why, why he hit me, it's not right". I reassured him that I would stay for a while with him and that everything was okay. He responded he wanted a pen and paper to make a report about Nigel.
>
> I then asked him to stand up, hold my hand and walk with me into the school so that Angela Lucas (who was inside the building and is the Headteacher of the school) could put some cream on his wounds. He complied and walked with me to the entrance of the school holding my hand. ....
>
> However, once we got into the carpark, [Resident L] responded by lashing out at Nigel and shouting for [sic] him "you're naughty" indicating with his little finger (Maketon sign language) that Nigel was bad. .... At this point [Resident L] was running round the car ... whilst Nigel run [sic] out in front of him in circles. .... I told [Resident L] in a firm and strong voice showing no [intimidation] or fear that I would not allow him to hurt Nigel, saying that Nigel was good to him and that it was not right to hurt people. I could not get him to [empathise] with Nigel nor to placate the situation which I could determine at this stage was indeed between them.
>
> At this point out of, I suspect frustration at the situation, [Resident L] set out to 'destroy' what he could of the car; he attempted to pull the side mirror off, throw the car documentation out of the car window, pulled the sun screen [off] and threw it into the garage and finally yanked the inner back view mirror off. At this point I felt that I had observed enough and foresaw that the situation was escalating rather than decreasing and intervened."

The report goes on to describe how Joanna Hernandez gave Resident L a lift back to Bishop Healy in her own car, and how he behaved excellently during the journey, whilst repeatedly saying that Nigel Bassadone was "bad". However, when they arrived at Bishop Healy, and Resident L saw Nigel standing at the door, Resident L is described as having gone "ballistic". He is recorded as having attempted to bite and slap Nigel Bassadone, and to hit him with a broomstick.

The report continues [**E/23/4**]:

> "[Resident L] then proceeded to break his living room up. He threw pictures at Nigel, I was standing beside Nigel at this point and it was [obvious] that he was bulls eyeing Nigel. He threw decorations, papers and books, cushions and when I said that I would then go he banged the Fire Alarm. Calling for help??? Nigel attempted fruitlessly to stop [Resident L] but I told him to let [him] break what he wanted after all they were his belongings and they would not be replaced. [Resident L] stopped throwing [things] about.
>
> ....
>
> We went outside but [Resident L] just could just not tolerate Nigel and every time he saw him he again would lash out. I again observed Nigel running around me in circles with [Resident L] in hot pursuit after him after the 6/7 circle I asked Nigel how many more he was going to run around me ....
>
> ....
>
> I then left with [Resident L] looking up the hill at me all the time (I couldn't see Nigel) and got home. ...."

Under the heading "Reflections", the report concludes by saying that "over such a short period of time", Joanna Hernandez was able to reach the following conclusions (among others): that [Resident L] did not want to be with Nigel Bassadone and was incensed by him; that for an unknown reason his challenging behaviour was directed only against Nigel Bassadone; that for an unknown reason Nigel Bassadone was the "trigger" for his challenging behaviour; that Nigel Bassadone used "no foreseeable interventions" with Resident L; and that Nigel Bassadone appeared to feel angry and upset at not being able to enable Resident L to calm down.

Nigel Bassadone's witness statement to the Inquiry was filed before Joanna Hernandez filed her third witness statement, and in consequence his witness statement did not address the concerns expressed by Joanna Hernandez in paragraphs 236 to 239 of her third witness statement (quoted above) with reference to his performance as member of Resident L's team. However, he was asked about these concerns in the course of his oral evidence to the Inquiry.
He began by recalling that Resident L, plus his team, were transferred to the Children & Families section of the SSA "when Joanna Hernandez came to work as Manager ... because we were told that the child was under[-]aged and was better suited to that service"[575] He added that he had previously been working with Resident L for a good part of his working career. Asked whether he was content with the decision to move Resident L to the Children & Families section, he replied[576]:

> "After working with the child for so long and knowing he had his own problems, I ... personally felt that perhaps it wasn't the best of options, considering that ... Children & Families was a completely different sort of [environment] to Dr Giraldi. [But] we had to go along with it. The bosses tell you what to do."

Asked about his relationship with Sharon Berini, he explained that they were not married but had lived together for some seventeen years; that they have two children; and that their

[575] See Day 7 page 12 line 21.
[576] See Day 7 page 113 line 16ff.

relationship ended in the latter part of 2000[577]. Asked by counsel to the Inquiry whether their working relationship was affected by the ending of their personal relationship, he replied[578]:

> "Not at all. Actually, the working relationship was completely separate [from] our relationship outside."

Asked how he would describe his relationship with Joanna Hernandez, he replied[579]:

> "I knew Joanna before she came into the Home. I knew her family quite well... They knew me very well. .... When she came to the Home ... everything seemed fine. The only time that I can recall that she called me over [to her office] was ... [with] reference to a change in the shifts in the rota, which was sort of a last minute [decision]."

Asked whether he was surprised by Joanna Hernandez' statement (in her draft audit report referred to later in this Report[580] [**M23/5/1**]) to the effect that he was not supportive of her, he said that he was, and that he did not know that that was her view at the time[581].

Asked whether he had ever voiced opposition to any decision made by Joanna Hernandez, he replied that the only instance he could recall when he had expressed concern related to the decision to substitute Sean Matto for Kirushka Compson as the senior member of Resident L's team when Resident L was moved to Bishop Healy. He explained his position in relation to that as follows[582]:

> "Obviously Kirushka knew the ropes of how to deal with [Resident L]. Sean [Matto] knew it, but Kirushka, she had been the senior for the team for quite a while. So we felt ... So that was raised with Isabella Tosso in one of the case conferences, and Isabella didn't approve of the change. It was a change ... organised between Mrs Hernandez and Mrs [Nicole] Viagas, who was [a member of] the Children & Families [section]."

He explained that his concern arose from the fact that Resident L required consistency in the composition of his care team[583].

Asked about the "investigation" carried out by Joanna Hernandez in June 2005 (as described later in this Report[584]), he said that he was aware that "something went on after hours"[585]. Later in his evidence, he described it as follows[586]:

> "... [a] meeting or get-together or whatever, on a Saturday after ... office hours, where Mrs Hernandez, together with Mrs Hassan [i.e. Denise Hassan], together with [another member of staff], together with Mrs Stacey McKay got together and started calling people in, and asking for

[577] See Day 7 page 114 line 24ff.
[578] See Day 7 page 116 line 115.
[579] See Day 7 page 119 line 12ff.
[580] See Chapter 9.
[581] See Day 7 page 120 line 18ff.
[582] See Day 7 page 122 line 15ff.
[583] See Day 7 page 122 line 9.
[584] See Chapter 10.
[585] See Day 7 page 119 line 23.
[586] See Day 7 page 123 line 24ff.

> anything, anything you can think of, negative of ... myself, Sean Matto and Sharon Berini [specifically]. .... When you get to know that, you know that something isn't right."

As to the incident which began at St Martin's Special School, as recorded in Joanna Hernandez' report referred to above, Nigel Bassadone said this[587]:

> "As being one of the main carers for Resident L, working with him for quite a number of years, we knew that he was quite conflictive during handover transitions from school to us, mass, parents and vice versa. Even at times with staff. He came out from school. Obviously ... something must have happened in school. But there was a way we did the handovers and it wasn't followed that day. So obviously Resident L, he ... thrived on having an audience. He knew each person's boundaries, and he knew when he could play up... The thing is, there was care plans which clearly instructed that during the week he was to be walked home. .... [He] always had problems with his weight. .... He needed the walk, he needed the exercise to help him. We used to walk through town, up through Alameda Gardens and home. ..... Before that, certain [carers from his team had] started going for him in a car. .... It was easier to deal with him in a car – just take him and let's go for a drive – than actually having to walk. .... Just in case he played up in town.
>
> Obviously when I got there he started demanding the car, and I said: "No, there is no car, you know there is no car." He started playing up, he started biting himself, ripping his clothes, the usual [thing] he that he used to do ... . He used to target me. .... For example, if I used to be the main carer and you were his teacher, he would look at you and go for me, to see what the reaction is. .... That's why we identified the transitions of handover were the most difficult ones. Once he was outside the vicinity of the school and he knew there was no audience – audience as in teachers, sometimes even parents – he was fine. .... There was a [set] procedure on our side. We cannot control what the school does, we cannot control the teachers [who] want to stay there, we can't tell them what to do.
>
> It was quite obvious that they were not doing very well when they all remained there looking, giving him the audience he wanted. Obviously it got worse and worse and worse. Mrs Hernandez came down (I believe the school phoned her). By this time, I was trying to keep away from him, because he was targeting me. Obviously I am not going to work to get bashed [up]. .... I was definitely there ... [but] I was keeping away from him because he was targeting me. .... He is ... very strong[588]... Eventually Mrs Hernandez drove him back to Bishop Healy. .... [What he wanted on that occasion] was the car. Because he was telling me all the time: "You go for the car, you go for the car". There was no car: with me there certainly was no car. .... If he was driven up to Bishop Healy, he did [get what he wanted]. .... There is a massive patio [at Bishop Healy], and it was like, you know, a dog and a cat running after each other. [He] definitely [had it in for me that day]."

Nigel Bassadone went on to accept as correct Joanna Hernandez' statement (in paragraph 237 of her third witness statement) that when she arrived at the school Resident L was sitting naked on a bench[589]. He said that he was present at the scene, but a "safe distance" away[590].

Asked for his assessment of Joanna Hernandez as a manager, he said this[591]:

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[587] See Day 7 page 150 line 14ff.
[588] Nigel Bassadone believed that Resident L would have been in his early 'teens at the time of this incident: see Day 7 page 153 line 4.
[589] See Day 7 page 156 line 8.
[590] See Day 7 page 156 line 19.
[591] See Day 7 page 159 line 24ff.

> "Yes, she was a good manager. .... It also has to be said that we [i.e. the team at Bishop Healy] didn't have that much contact with her, plus very soon after she came we went over to Children & Families. So until that time the relationship was ... professional."

Asked whether his view about Joanna Hernandez changed when he learned of her June 2005 "investigation", he said this[592]:

> "What I couldn't believe was that somebody who had been so, you know, part of ... not your life, but, you know, socially, could turn so badly against you. .... Why wasn't I called in on a Saturday? .... It was very selective who they called in."

When counsel to the Inquiry put to him the allegations in paragraphs 311 and 313 of Joanna Hernandez' third witness statement [**E/67/85**] (viz. that the problems at the Home "lay almost completely with the senior staff" including him, and that he, in company with Sharon Berini, Sean Matto and Craig Farrell, were "undermining the management of the home, bullying their teams and dragging down the standard of care at the home"), he denied them[593]. He went on specifically to deny that there was any bullying of the care teams[594]. Asked whether he was aware of any bullying of residents, Nigel Bassadone replied[595]:

> "No, definitely not... Not to my knowledge. And if I would have known, believe me, I wouldn't have gone to my senior [i.e. Kirushka Compson] or to my manager, I would have taken it further. .... Because we had the instructions to go through our line manager, but obviously if I have a serious concern, and if I am not paid attention, I definitely take it a bit further."

Asked by counsel for Joanna Hernandez about the incident on 15 May 2005 recorded in Maria Gonzalez' report, Nigel Bassadone denied that he "turned up drunk and wanted to stay the night"[596]. He went on to say that he knew nothing about the report having been allegedly stolen[597].

Counsel for Joanna Hernandez later put to him Joanna Hernandez' statement (in paragraph 316 of her third witness statement) that at the meeting which she describes in that paragraph Sharon Berini "became so angry and upset that she went to the toilet and vomited". He responded[598]:

> "Definitely not. Excuse me for laughing, but definitely not. It's not like she's just found out that something really, really serious has happened."

As noted earlier, he also said that he had no recollection of Sean Matto storming up to Joanna Hernandez at the meeting and shouting that she could not change the care teams, as alleged by Joanna Hernandez in paragraph 317 of her third witness statement [**E/67/86-87**]; nor of Sean

[592] See Day 7 page 160 line 8ff.
[593] See Day 7 page 157 lines 12 and 15.
[594] See Day 7 page 157 line 19.
[595] See Day 7 page 158 line 23ff.
[596] See Day 7 page 173 line 15.
[597] See Day 7 page 174 lines 20 and page 175 line 4.
[598] See Day 7 page 181 line 25.

Matto describing the carers (including Nigel Bassadone) as "the untouchables", as also alleged by Joanna Hernandez in that paragraph[599].

I accept Nigel Bassadone's evidence, preferring it to that of Joanna Hernandez wherever there is a conflict between his evidence and hers.

The incident with Resident L outside the school, as described by Nigel Bassadone, does however provide a vivid illustration of the challenges which face those whose job it is to care for individuals with disabilities such as those from which Resident L suffers (as described earlier). It must have been a disturbing, if not positively alarming, incident to witness, but, as I have said, I accept Nigel Bassadone's explanation of his conduct on that occasion. I have no doubt that Joanna Hernandez acted with the best of motives in taking Resident L back to Bishop Healy in her car, but the fact is that that was precisely what Resident L's violent behaviour was directed at achieving: in other words, as Nigel Bassadone explained in his oral evidence, Resident L got exactly what he wanted. Whilst giving Resident L what he wanted whenever he "played up" (to use Nigel Bassadone's expression) might be a short-term method of calming him down, I agree with Nigel Bassadone that to do so on every such occasion would in all likelihood be seen by Resident L as an encouragement for further violent behaviour. I also note that, whatever may have been the extent of Joanna Hernandez' concern about the care provided by Nigel Bassadone to Resident L, it appears to be the case that she allowed him to continue to provide that care.

In his witness statement [**E/59/2**], Sean Matto describes Joanna Hernandez as lacking "the essential managerial and technical skills to succeed in such a challenging job" [**E/59/7**], pointing out that she had no previous experience of managing a learning disability service of such magnitude and complexity. He goes on to say that he felt unfairly treated, and completely unsupported, by Joanna Hernandez [**E/59/10**]; and that instead of focusing on developing viable solutions to perceived problems, she directed her energies to dwelling on the problems and criticising members of staff involved. He continues:

> "Procedures and standards should be used for the purpose of ensuring quality and improvement[,] not to demoralise and punish[,] which is what I felt and sensed from Ms Hernandez. .... In my experience, Ms Hernandez was only concerned with satisfying her own needs and frequently hurting other people in the process. Ms Hernandez appeared to enjoy the feeling of power that she had[,] and the ability to make people rush about carry[ing] out some of her duties[,] particularly those she lacked the competencies in[,] and generally doing her bidding. Ms Hernandez took advantage of others that were weaker than her and those who felt they were unable to do anything for fear of their job and well[-]being."

Later in his witness statement, he says this [**E/59/12**]:

> "I was perceived as an enemy and a threat by Ms Hernandez and those close to her, as I had a mind of my own. 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."

[599] See Day 7 page 182 line 8.

In answer to questions from counsel for Joanna Hernandez he described Sharon Berini as no less hard-working than Joanna Hernandez, and fairer and more organised than her. He continued[600]:

> "[She] had more of the technical skills necessary. She had been a carer herself. She was able to manage the individuals and thus understand much better as well what the requirements were both for service users and for staff themselves. She was less qualified, though, from what I see in the documentation. But then again she had the experience in the field which, for instance, Joanna didn't have, and which was very much evident. Obviously as well it's unfair to compare [an] individual that works for arguably a year, ... even though she was off sick a lot the time or away. ... And the different regimes as well and the very different circumstances with very little similar type of alleged support as well, because as we have heard, Joanna was actually promised the world. She was going to have the type of support which I've never known any other manager to have had prior to her time. ... [S]ocial workers were going to be helping her out. I remember ... the first time I ever saw the psychologist was in Joanna's time as well. ... I remember ... Joanna Hernandez, the Team Leader [Marie Gomez] and Elizabeth Harrison regularly at Dr Giraldi together, and on many events also. I never saw that type of support for any other manager prior to that time."

I accept the evidence of Sean Matto. In particular, I prefer his evidence to that of Joanna Hernandez and Elizabeth Harrison. I have no doubt that in giving his evidence he was doing his best to assist the Inquiry, albeit he made no bones about the fact that he regarded the Inquiry as a waste of time and money and as an unnecessary and unwelcome distraction for both staff and residents at the Home.

In her third witness statement, Joanna Hernandez asserts that, shortly after she took up her post as Manager, Marie Gomez issued an instruction that she should no longer be supported by Elizabeth Harrison. She says this in paragraph 98 of her third witness statement [**E/67/33**]:

> "98. Unfortunately Mrs [Elizabeth] Harrison was not permitted to assist me. I later learnt that she was prevented from assisting me by Marie Gomez."

She repeats this evidence in paragraph 103 of her third witness statement [**E/67/34**], where she says this:

> "103. .... Unfortunately Mrs [Elizabeth] Harrison was not permitted to provide me with the support that had been agreed and that was clearly needed for me to manage the Home and deal with its many problems."

In the course of her oral evidence, Joanna Hernandez said that her instructions were "to keep quiet or you lose your job"[601] (denied by Marie Gomez: see above); that she felt unsupported "throughout" her time as Manager[602]; that what was needed was greater input from social workers[603]; and that the SSA did not provide sufficient support for senior management at the Home[604].

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[600] See Day 8 page 16 line 9ff.
[601] See Day 1 page 146 line 12.
[602] See Day 2 page 22 line 13.
[603] See Day 2 page 24 line 21.
[604] See Day 2 page 27 line 15.

In paragraph 18 of her witness statement to the Inquiry [**F/6/4**], Elizabeth Harrison says this:

> "Isabella Tosso told me not to support Joanna Hernandez when she started as the Home Manager and if Joanna did ask for my support I should report it to her."

As noted earlier, in her March 2013 statement Elizabeth Harrison says this [**F/6/10**]:

> "On the first day [that] Ms Hernandez commenced work as Manager of the [Home], Ms Tosso came into my office and informed both Mrs J Poole and myself not [to] offer support to Ms J Hernandez in [any way], adding that if Ms Hernandez sought our support we should immediately bring it to her attention."

In her oral evidence, Elizabeth Harrison acknowledged that in the beginning, when Joanna Hernandez was appointed Manager, she was asked to support Joanna Hernandez[605], and that, initially, Marie Gomez had been keen on support being provided to her as Manager[606]. She also gave evidence to the effect that some members of staff (she did not know which members of staff) may have been concerned to make things at the Home look worse than they actually were, or, as she put it[607]:

> "... making things worse for us and for the Manager ..."

She referred to this in her oral evidence as "sabotage"; in other words, she explained[608]:

> "... sabotage to make a fail, to make the Manager fail".

She gave as examples of this the fact that items such as curtain poles, curtains and keys frequently went missing. Asked by counsel to the Inquiry who she thought was responsible for this, she replied[609]:

> "I don't know. These things happen, I don't know who shook the tin. I don't know who put to another side the [curtain] poles. Obviously if I had known, it would have been better."

She also referred to a report by a care worker which she had found in Duncan Jones' file after he left (i.e. prior to Joanna Hernandez' appointment as Manager), which described an incident when an "unknown substance" was placed in a Manager's drink. She continued[610]:

> "When the manager is stocktaking cleansing materials, they go behind the back [of the manager] and empty the materials in the toilet. They bang the car. They bash the car to make it [look as if] the resident is more aggressive. Things like they get the keys of a manager and hide [them]."

She went on to say that she had no personal knowledge of the matters described in that report[611].

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[605] See Day 6 page 45 line 21.
[606] See Day 6 page 55 line 14.
[607] See Day 6 page 81 line 24.
[608] See Day 6 page 75 line 17.
[609] See Day 6 page 76 line 21.
[610] See Day 6 page 82 line 10.

Counsel for Joanna Hernandez asked her whether she would categorise the (alleged) fact that Isabella Tosso told her and Jennifer Poole not to support Joanna Hernandez as "sabotage". She replied[612]:

> "I thought it was sad, and that's the thing. .... I felt guilty because I was sent to [support] her and then [instructed to] abandon her."

Jennifer Poole is currently the Senior Social Worker for Adult Services within the Care Agency. In that capacity she is responsible for providing a social work service for all adults in the community, including those with learning difficulties, those with physical disabilities and the elderly. She has held this position since March 2011. Prior to that, she was one of a number of social workers within Adult Services.

In paragraphs 4 to 7 of her witness statement to the Inquiry [**F/2/2**], she says this:

> "4. When Isabella Tosso was acting in February 2005 as Team Leader Adult Team of ... the SSA, she requested that each resident of the Home had a key social worker. My colleague, Elizabeth Harrison, and I divided up the residents between us. Prior to this, we as social workers used to attend the Home on an as necessary basis.
>
> 5. Joanna Hernandez was appointed as Manager of the Home in November 2004, and we had been supporting her as required, as requested by Marie Gomez who was Acting C.E.O of the SSA as it was felt she needed support in her new role. Shortly after being allocated service users, Ms Tosso told Elizabeth Harrison and I not to engage with Ms Hernandez on the day to day needs of residents or on management issues and not to liaise too closely with Ms Hernandez generally on matters, but to refer such issues to her or alternatively to Marie Gomez, C.E.O.
>
> 6. Generally, so far as I was concerned, I believed that when allegations of misconduct, malpractice, abuse, etc, were made at the Home, they were investigated and there were interdictions. I would say that often residents, family members and employees did not always report issues, perhaps because they had previously seen interdicted staff being reinstated to work, so there did not seem any point. Since Carlos Banderas has been running the home, the situation has changed. He is very proactive and acts on complaints immediately. Disciplinaries are held quickly and measures put in place to try to ensure that there is no repetition of any incident.
>
> 7. I also recall at that time that there was a lack of appropriately trained or qualified employees at the Home to care for the residents."

In the course of her oral evidence, Jennifer Poole was asked by counsel to the Inquiry about Isabella Tosso's instruction not to refer matters to Joanna Hernandez but to her or to Marie Gomez. She replied[613]:

> "The reasons were not given. We were just simply instructed not to engage with Ms Hernandez. .... Basically, we were told to go through our line management ... and they in turn would liaise with Ms Hernandez, because senior social workers were the ones that would deal with practice issues. .... At the time, [as] I recall, ... there were a lot of changes in terms of management, within our management and within Dr Giraldi management, I seem to recall that at that point Debbie Guinn hadn't joined our team; it was Isabella Tosso who was senior but was acting team

[611] See Day 6 page 82 line 21.
[612] See Day 6 page 116 line 10.
[613] See Day 5 page 111 line 9ff.

> leader, so she wanted us to engage with her on any issues relating to [the Home]. That was at that point, before Debbie Guinn came down to be our senior. .... I think there was a period of time when we were working with service users and then the instruction was given. I think I had a mix-up in terms of the dates when the service users were allocated and the time we were told not to engage with Ms Hernandez. .... Obviously this happened in 2004 so my recollection of when exactly things happened is a bit vague."

Jennifer Poole went on to confirm that Marie Gomez wanted her to support Joanna Hernandez; that initially she provided that support; but that there came a time when she was told to report directly to Marie Gomez as her line manager[614]. When counsel to the Inquiry suggested to her that the instruction might have been given in the summer of 2005, she replied[615]:

> "I can't recall when it happened. I recall the incident happening quite vividly in my mind in that I was with Elizabeth Harrison in the social work room when Ms Tosso came into the room and said: "I just need to speak with both of you. I need to issue this instruction: I do not want you to liaise directly with Ms Hernandez on any matters pertaining to the Home. Whatever you need to come directly to me [sic]". So it was done in a very abrupt way. It wasn't in a team meeting or anything like that. She just came in and gave me an instruction. But I can't remember the dates. .... It could have been [in the summer of 2005]."

Asked whether there had been any prior indication that such an instruction might be given, she replied[616]:

> "No. We had always been instructed to support Joanna, because we understood that the culture within the Home was difficult and that she was going to need support because she was very much isolated in her post, and we were instructed to support her, so it did come as a surprise. .... [At the time] there were observed difficulties between management and Ms Hernandez in that, I mean, I wasn't party to management meetings but you could see the general atmosphere whenever a management meeting occurred and how people would leave meetings in a distressed way."

Marie Gomez told the Inquiry, in the course of her oral evidence, that she always supported Joanna Hernandez, and that she always instructed the staff to support her[617]. She went on to say that she had no knowledge of the instruction said by Elizabeth Harrison and Jennifer Poole to have been given to them by Isabella Tosso to the effect that Joanna Hernandez should not be supported, but that so far as she (Marie Gomez) was concerned[618]:

> "I know that I supported Joanna Hernandez practically to the end of the time she was working [at the Home]. .... I was always supporting her: she was either on the phone to me or I was having meetings with her."

I accept this evidence of Marie Gomez, which is consistent with Joanna Hernandez' description of her, in Joanna Hernandez' letter to Isabella Tosso dated 12 June 2005 [**C1/1/61**], referred to earlier in this Chapter, as "the only person I can trust to temporarily assume my duties as manager" during Joanna Hernandez' temporary absence while looking after her daughter at Great Ormond Street Hospital.

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[614] See Day 5 page 113 line 15ff.
[615] See Day 5 page 113 line 25ff.
[616] See Day 5 page 114 line 14.
[617] See Day 13 page 71 line 23.
[618] See Day 13 page 72 line 10ff.

I found Jennifer Poole to be a reliable witness, not least because she was prepared to accept that she could not remember at what stage during Joanna Hernandez' managership the instruction in question was given, and that it could have been given in the summer of 2005. By contrast, I found Elizabeth Harrison's recollection of events in 2004 and early 2005 to be unreliable. I have in mind in particular that in her witness statement she said that the instruction was given "[o]n the first day [that] Ms Hernandez commenced work as Manager", and (in her oral evidence) that she had been able to support Joanna Hernandez "only for a week"[619], whereas she later said that the instruction was issued "the minute that Isabella Tosso became the chief executive"[620], which did not happen until 4 April 2005[621]. When this was pointed out to her, she insisted that Isabella Tosso must have issued the instruction "earlier" than that, i.e. before she became CEO, and while Marie Gomez was acting as CEO[622]. However, besides being inherently unlikely, that evidence would be contrary to the evidence of Marie Gomez that she had no knowledge of the instruction: evidence which I accept.

I find that the instruction described by Elizabeth Harrison and Jennifer Poole was issued by Isabella Tosso not in the early days of Joanna Hernandez' time as Manager but following the "investigation" carried out by Joanna Hernandez in June 2005[623]. Whatever the precise terms of that instruction, it would have made no sense at all for Isabella Tosso to issue it at the start of Joanna Hernandez' managership, when all concerned in her appointment were naturally keen that she should have all the support she needed in meeting the challenges which faced her – challenges of a kind which she had not previously experienced. On the other hand, in the aftermath of her June 2005 "investigation", as described later in this Report, it would not have been at all surprising had Isabella Tosso taken the view that it was preferable that any future concerns of the social workers should be routed through their line manager, Marie Gomez.

I also reject Elizabeth Harrison's suggestion that there was some sort of conspiracy among members of staff to "make a fail" so far as Joanna Hernandez was concerned (an echo of the evidence of Joanna Hernandez in paragraph 313 of her third witness statement [**E/67/85**], to which I refer later in this Report, to the effect that certain members of staff were undermining her efforts to improve the service offered by the Home). This can only have been a subjective perception on Elizabeth Harrison's part, and I find it to have been an erroneous perception.

As to the support provided to Joanna Hernandez, I bear in mind that an attendance note of a meeting which took place on 18 December 2006 in the context of the (then) continuing proceedings in the Industrial Tribunal between Mark Isola QC, Isabella Tosso and Yvette Del Agua [**J1/115/24**] refers to a review carried out by the SSA which "justified the allegation that [Joanna Hernandez] lacked the support/assistance that she required in carrying out her duties".

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[619] See Day 6 page 46 line 10.
[620] Day 6 page 46 line 12.
[621] See Isabella Tosso's introduction to her witness statement to the Industrial Tribunal [**C2/1/2**].
[622] See Day 6 page 46 line 15.
[623] See Chapter 10.

I refer to this attendance note later in this Report, when setting out the history of the proceedings in the Industrial Tribunal[624].

The Inquiry has not been provided with a copy of this review, but it is plain from the reference to it in the above attendance note that the SSA had reached the general conclusion that it had not supported Joanna Hernandez sufficiently. I accept that, no doubt with the benefit of hindsight, the SSA did reach that general conclusion. That said, I am satisfied that Marie Gomez, Sharon Berini and Sean Matto – and indeed the rest of the staff at the Home – tried their best to support Joanna Hernandez, at least until relations between members of staff in the Home were poisoned by her June 2005 "investigation", as related later in this Report[625].

Included in the documentation provided to the Inquiry is an undated incident report [**M1/1/1**] concerning an incident which occurred on 28 April 2005. At the foot of the report Kirushka Compson's name appears in manuscript, and wrongly spelt. Kirushka Compson said in oral evidence that she did not recall the incident described in the report, and she confirmed that that she had not signed the report[626]. However, she went on to say that if she became aware of an incident which should be reported there was a book in which she would write a written report, and she impliedly accepted that she might well have written the report in question. In fact, it is clear from its terms that she did so. The report reads as follows:

> "On the evening of the 28th April 2005 I phoned [Resident L's] team in order to see how things were with him as he had been agitated during that day. During my telephone conversation Manolita [Adamberry] told me that [Resident L] had been saying to her that Mandy [Vallender] had slapped him. On Manolita making this statement I told her that this had to be reported as a matter of procedure.
>
> Prior to reporting the allegations against Mandy I went to speak to [Resident L] first thing in [the] morning in order to clarify the allegations.
>
> On the morning of the 29th April I spoke to [Resident L] who then told me that Mandy had slapped him across the right side of his face. He also stated that Mandy was shouting a lot, this described to me as Chula. He then said report it, report it, Kirushka you must come to Bishop Healy tell Sharon tell Sharon.
>
> During the conversation [Resident L] said Mandy tonight no, no Manolita. Prior to me reporting it to management I went to Bishop Healy to read through the report but saw no apparent incidents with Mandy.
>
> After doing this I went to my managers office and reported it. It was said that the manager [Joanna Hernandez] wanted to speak personally to [Resident L]."

Joanna Hernandez did indeed go to see Resident L on 29th April 2005. Her conversation with him was subsequently recorded by Gabrielle Llambias in a manuscript note in the form of a transcript of the conversation [**M1/3/1-3**]. The note records that Resident L told Joanna Hernandez that Mandy Vallender had slapped him on his right cheek, leaving two marks on it. When Joanna Hernandez asked him how he responded, he said that he swore at her and

[624] See Chapter 12.
[625] See Chapter 10.
[626] See Day 9 page 147 line 25ff.

threatened to kill her with a knife. He complained that his clothes were wet, saying that he had defecated. Asked by Joanna Hernandez whether he had dirtied his clothes, he said (according to the note) that Mandy Vallender had done it. At the conclusion of the conversation, Joanna Hernandez reassured Resident L that she would be removing Mandy Vallender from his care team. At that point, according to the note, Resident L took off his jacket and showed Joanna Hernandez and Gabrielle Llambias bruises on both his arms. I have no reason to doubt the accuracy of the note.

On 4 May 2005 a meeting took place between Mandy Vallender and Joanna Hernandez. The meeting was also attended by Sharon Berini, who wrote up the minutes of the meeting[627]. The minutes of that meeting [**M1/4/1-3**] (the accuracy of which I accept) record that Mandy Vallender said that she had never hit Resident L and never would. She said that she had never raised her voice to him, let alone hit him. In the course of the meeting, she became upset, saying: "I don't know what to say, I work nights and there's no one else there so I don't know what you want me to say?". She went on: "well, you don't know me, but Sharon knows me". Joanna Hernandez told her not to get upset, as "these things happen"; to which she responded: "I know but it's not bloody nice when its [sic] not true". Joanna Hernandez then told her that she would have to move her from Resident L's team for her own benefit, given the threats which Resident L had made. She went on to say that she would be reporting the matter to Marie Gomez and that if there was to be a disciplinary hearing she would let Mandy Vallender know, but that in the meantime Mandy Vallender could continue to work nights "as normal". She explained to Mandy Vallender that in moving her from Resident L's team they were safeguarding both Resident L and her.

The next document relating to this incident is a report by Manuela Adamberry also dated 5 May 2005 [**M1/5/1**]. It reads as follows:

> "When I arrived on my shift Jenny [Poole] told me that [Resident L] had been very high, he had been swearing and disruptive. She had tried asking him what was wrong but he would not say.
>
> When Jenny left, [Resident L] began telling me that Mandy [Vallender] had hit him on his face. He was telling me verbally and physically (slapping himself on the face). I asked him why but I could not understand what he was saying. He then said again that Mandy had hit him on the face and had pulled his hair. (pulling his hair and slapping his face so that I could see how she did it). I asked again why and he said because he had soiled himself.
>
> He then went opened bowels [sic] and went to sleep. He woke up in the morning fine.
>
> I tried getting hold of Kirushka to tell her about this but I was unable [to]. When I returned to work the following night I heard [Resident L] had [had] an incident at school, but he was fine when I arrived[.] H/O [handover] went well.
>
> As soon as Jenny left [Resident L] started telling me again what Mandy had done to him. He also told me he had hit out [at] everyone at school that day and that he would say sorry the following day.
>
> He went to bed that night saying that he didn't want Mandy there. He slept fine.

[627] See paragraph 14 of Mandy Vallender's witness statement [**E/65/3**].

> Jenny phoned at approximately 10.00pm to see how [Resident L] was, I said fine and then Kirushka phoned to see how he was due to the incident at school. I said fine and at this point I referred to her what he had said about Mandy.
>
> The following morning Kirushka phoned again at 8.00am, [Resident L] picked up the phone and he started telling her what he had been telling me about Mandy, also saying that he did not want Mandy there. He only wanted Kirushka or myself there."

The final document to which I need to refer in relation to this incident is a photocopy of the minutes of the meeting between Mandy Vallender and Joanna Hernandez on 4 May 2005 which contains manuscript amendments and additions by Mandy Vallender [**E/65/12-13**]. I need mention only one of them. In answer to Mandy Vallender's question: "what [do] you want me to say?", Joanna Hernandez is recorded as having said: "We only want you to tell the truth.", to which Mandy Vallender is recorded as responding: "I am [i.e. I am telling the truth] these things have not happened."

I turn next to the evidence of Manuela Adamberry.

Manuela Adamberry does not refer to this incident in her witness statement. (In paragraphs 26 to 31 of her witness statement [**E/1/4-5**] she describes an occasion in about 2008[628] when she saw a carer strike Resident L., and I shall address that evidence later in this Report.) In the course of her oral evidence, however, when referred to the documentary evidence of the alleged incident described above, she said this[629]:

> "I didn't see anything. I've said what the child said to me. .... If it's true or not, I didn't see it. .... The cheek was red, but I don't know whether it was true or false. .... But the child was also slapping himself."

I turn next to the evidence of Mandy Vallender.

In paragraph 3 of her witness statement [**E/65/1**], she refers to Kirushka Compson's report (quoted above), saying this:

> "3. .... This lady [Kirushka Compson] was my "senior" at the time [Resident L] made a complaint about me. As I recall there would have been a team of six looking after [Resident L]. They would be made up of two teams of three of whom two people would work with him during the day and one at night. Generally speaking I would be on night shift but I have worked with [Resident L] during the day and at night. ...."

In paragraph 4 of her witness statement [**E/65/1-2**] she says that she vehemently denies the allegations against her.

As to [Resident L's] interview with Joanna Hernandez, as recorded in Gabrielle Llambias' note (referred to above), Mandy Vallender says this in paragraphs 11 to 13 of her witness statement [**E/65/3**]:

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[628] See Day 9 page 176 line 9.
[629] See Day 9 page 171 line 10ff.

> "11. .... I can say I have never slapped or hit [Resident L] or thrown water over him. I always had a very good relationship with [Resident L] and he always used to call me his princess[.] [I]ndeed [Resident L] has never displayed any bad words or behaved in a direct manner personally towards me as a result of not actually liking me; he has had outbursts of challenging and aggressive behaviour towards me and other carers when he feels perhaps he is not in control of a situation or lacks understanding of situations that make him insecure. For example he was very scared of dogs and often hit out if he saw one or on the way to the top of the hill to catch the school bus. Sometimes he did not want to go and did not like waiting for the bus so he would hit out or attempt to throw the school bag over the wall.
>
> 12. .... I remember [Resident L] never soiled himself during the night it was usually first thing in the morning as he got up. Generally he had loose stools and when he woke up he would come to the door and say "***caca Mandy caca***". He would be supported to the bathroom for personal care, dressed and given breakfast with his usual morning tea. As carer I would also support [Resident L] in a dignified and appropriate manner.
>
> 13, As a general comment I also find the whole approach to this interview as odd because if [Resident L] was already displaying agitated behaviour and is asked to come to the office to calm down, the carer should have been allowed to go with him. In other words it does not appear that [Resident L] was in a fit state to be interviewed. I worked with [Resident L] for eighteen months prior to the allegations. I know him intimately, I know how he reacts and on reading the questions put to him several of them are leading and suggestive. ...."

As to her subsequent meeting with Joanna Hernandez (referred to above), and what followed from it, Mandy Vallender says this (in paragraphs 14 to 18 of her witness statement [**E/65/3-4**]):

> "14. .... The meeting was held at the Manager's office on the 4th May [2005]. I cannot remember the exact time. I would describe the mannerism [sic] of Joanna as being slightly aggressive and I was made to feel defensive. I had made it quite clear there was no incident involving [Resident L]. At the end of the meeting and in view of various things which had been said and in particular an entirely gratuitous statement which was to the effect "finger marks could disappear by the morning", I informed Ms Hernandez I was going to see a solicitor. I was told by her I was not allowed [to] because the matter would be dealt with internally. Approximately two days [later] I was handed a typed record of my meeting with Joanna Hernandez. ....
>
> 15. Having been handed the notes I told Ms Hernandez I would need time to read and approve them. I took the draft home and amended it in pencil. On or about the following day I went to see Ms Hernandez. Sharon Berini was in the office, I told them both I could not sign because there were omissions and inaccuracies. I believe Sharon took a photocopy of the record as amended by me in pencil. ....
>
> 16. .... I was never called back to sign the original version or any other version.
>
> 17. I can say within 2 days I received a call from Joanna Hernandez. I remember it well because I was shopping in C&A in Spain. She told me all allegations had been dropped and that I would be working, probably in Flat 2.
>
> 18. .... I have said many times and repeat that the allegations made by [Resident L] are untrue and the version he appears to give to Manolita Adamberry is somewhat different to the one he gave to Ms Hernandez and others."

In her oral evidence, Mandy Vallender described Resident L as "very aggressive at times"[630], and unpredictable[631]. She said that she had not seen Gabrielle Llambias' note of Resident L's

[630] See Day 10 page 131 line 11.
[631] See Day 10 page 131 line 20.

interview with Joanna Hernandez until she was preparing for this Inquiry[632]. As to her own interview with Joanna Hernandez, she said this[633]:

> "... [S]he was very intimidating and just not particularly very nice at all, so I was then getting upset because she was saying this to me and so that's [why] I said what I said[634] because I had known Sharon, she knew me. So I was saying to Sharon, you know, "You know me: she doesn't". So I was very ... upset."

As to Joanna Hernandez' decision to move her from Resident L's team to Flat 2, she said this[635]:

> "If you have been accused of something like that, I didn't understand why they were moving me to Flat 2, where there [are] clients that are more vulnerable than [Resident L] is, and they can't speak, and if I've just been accused of that, for me that just didn't seem to make any sense at all."

Having seen and heard Mandy Vallender giving evidence, I am satisfied that for her to have abused Resident L in the way that he described would have been totally out of character. I accordingly accept her evidence that the alleged incident never occurred. It follows that I consider Joanna Hernandez' decision not to pursue the matter further was the right decision in the circumstances, bearing in mind in particular Resident L's proclivity for self-harm, coupled with the fact that there were no independent witnesses to the alleged incident. As to her decision to move Mandy Vallender from Resident L's team to Flat 2, I regard that as an entirely understandable decision in the circumstances.

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[632] See Day 10 page 132 line 21.
[633] See Day 10 page 136 line 21ff.
[634] A reference to her having said to Joanna Hernandez "Well, you don't know me, but Sharon knows me".
[635] See Day 10 page 138 line 2ff.

CHAPTER 9: The "punishment room" – Care provided to Residents Z and AE – Improvements undertaken by Joanna Hernandez

Contents

CHAPTER 9: *The "punishment room" – Care provided to Residents Z and AE – Improvements undertaken by Joanna Hernandez*

In her evidence to the Inquiry, Joanna Hernandez referred to the existence of a "punishment room" at the Home (i.e. at its premises at Smith Dorrien Avenue), and she also made a number of serious allegations as to the care provided to residents, in particular to Residents Z and AE.

In this Chapter I consider both those aspects of her evidence, together with her evidence of improvements which she attempted to make or succeeded in making.

THE "PUNISHMENT ROOM"

The evidence

I start with the evidence of Joanna Hernandez.

In paragraphs 106 to 114 of her third witness statement to the Inquiry [**E/67/35-37**], Joanna Hernandez refers to the multi-disciplinary meeting held on 3 November 2004 mentioned earlier in this Report[636], and in particular to a discussion at that meeting about a "punishment room", saying this:

> "106. During that meeting, which was before I formally took up my post, I was told about and shown a "punishment room".
>
> 107. The room was a small room that looked like a storeroom. The room had no windows. The door of the room had two very large locks on it. There was a kind of peephole in the door, which had Perspex in it. The room had no light.
>
> 108. I was told that this room had been built by a previous manager and had been in use for years. I was utterly shocked.
>
> 109. I was told that the punishment room had been used for [Resident AE] and other residents. [Resident AE] was a young adult He was autistic and also had mental health issues. He had limited communication ability. ....
>
> 110. I was told that he and others were locked in this room as punishment if staff felt that residents were not behaving properly.
>
> 111. [In this paragraph, Joanna Hernandez refers to a witness statement by Susan Ignacio which was filed in the Industrial Tribunal in 2006 in support of Joanna Hernandez' claim of unfair dismissal. However, this witness statement was subsequently withdrawn by Ms Ignacio. An attendance note prepared by the solicitors to the Inquiry reads as follows: "Mrs Ignacio advised

[636] See Chapter 8.

> that she would be happy for the issues raised in her statement not to be given weight and for its content to be withdrawn."[637]]
>
> 112. I was astonished to learn that an autistic resident [i.e. Resident AE] was being held in a punishment room by staff at the [Home], as were the others present at the meeting.
>
> 113. The punishment room was only about 3 metres from the [Manager's] office ... It was not hidden away[638]. I immediately said that I wanted the room closed. One of the first things I did on taking up my position was to have the door of the former punishment room removed. I installed shelves and turned it into a staff working area.
>
> 114. However, even after I had completely [remodelled] the room, [Resident AE] would still not go near where the room had been. If you wanted him to go to that area for some reason, he would resist strongly and become upset. I also discovered in that meeting that [Resident AE] had not had a psychiatric assessment for many years. Nor had any of the other [residents].

In paragraph 279 of her third witness statement [**E/67/77**], Joanna Hernandez says this:

> "279. As set out earlier, just before I had taken up my post I learned in a multi disciplinary meeting that [Resident AE] was regularly held in a locked punishment room close to the manager's office. I had this room pulled down. [Resident AE] was so affected by the punishment room he would go berserk every time he passed by it."

The minutes of the multi-disciplinary meeting contain the following passage [**E/25/21**]:

> "Ms Risso upon coming to the meeting in the respite unit inquired about a door with several locks on it as if in a strong hold [sic]. We informed her that room had been built by a past manager to [restrain[639]] [Resident AE] – the conditions inside provoked abhorrence for all those present."

The minutes do not record any further discussion about this room. Rather, they go on to record that Joanna Hernandez requested greater support and counselling, training of staff in disability awareness, and the provision of an advocacy facility for residents.

In the course of her oral evidence, Joanna Hernandez returned to the issue as to the existence or use of a "punishment room" a number of times; and it was clear from the tone of her evidence, and from the emotive language to which she resorted, that she regards that issue as central to the Inquiry's investigations.

At an early stage in her oral evidence, Joanna Hernandez was asked by counsel to the Inquiry whether what she had been told about a "punishment room" at the multi-disciplinary meeting was of concern to her. She replied[640]:

> "It threw me ... when Annie Risso told me, because one thing is that you don't have policies and procedures, and [another] thing is neglect or abusive practices or allegations about it. So when Annie turned round and said – because the room was right behind us, I will never forget, and she says to me: "You know what that room is?"; and I thought it was a store room because it was a

[637] This attendance note was read out by counsel to the Inquiry in the course of counsel for Joanna Hernandez' closing submissions: see Day 19 page 52 lines 16-18.
[638] Both Gina Llanelo and Matthew Turnock describe the room in question as being in the respite flat (Flat 3).
[639] The minutes read: "... with strain ...".
[640] See Day 1 page 102ff.

> very little room with no light, no ... windows, and it had this big door with a little window and massive locks, so I thought it was a store room .... It was a punishment room."

Later in her oral evidence, she said that the expression "time-out" meant nothing to her[641], and that the room in question was a "punishment room". She went on[642]:

> "I only know because Annie Risso was the one who said: "Joanna look at that room" – with massive locks like that."

Asked by counsel to the Inquiry whether she understood the difference between a "time-out room" and a "punishment room", she replied[643]:

> "Well, if you call a time-out room being in a locked up room without a window, without a light, and leaving you for hours. .... I don't call it a time-out. Time-out I say to a child: sit here and don't move, [stay] with me, and let's see what's wrong. I don't call that locking a person who doesn't understand in a room on their own. I call that torture."

Joanna Hernandez took offence at the tone of counsel to the Inquiry's questions in relation to her allegations about a "punishment room" (albeit without any good reason for doing so), and this prompted the following outburst[644]:

> "He [i.e. counsel to the Inquiry] thought that a punishment room, a cell without a light, where you stick a child in for hours and hours without any food, pissing and shitting on the floor, is time-out. I give it [sic] to your child."

Later in her evidence, as noted earlier, she went so far as to refer to a "time-out" room as described by other witnesses, as "a torture chamber"[645].

Asked by her own counsel about the "punishment room", she returned to her theme, saying this[646]:

> "It was during that meeting ... that I was officially shown the punishment room, because I [had] never heard about it before. I want you to understand that. ... [It has] been played down as a time-out room as if this was nothing, this was where if you behave badly ... [N]o, sir. This was a small room which looked like a storeroom, which is what I originally thought. It had no windows. It had massive locks on it. The door is still there, you can go and have a look. [It had] a kind of peephole, with Perspex, and I was told that it had been used by previous managers. I had been told that this room was being used for [Resident AE], who was a young adult at the time with autism and mental health issues. He had limited communication abilities. .... I was told that him and other people were actually locked in this room, to the point that we couldn't even get him to go from his room ... and he wouldn't even go past it. He was so aggrieved by the way that he was being treated [and] that is why he reacted violently."

I turn next to the evidence of Elizabeth Harrison.

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641 See Day 1 page 202 line 14.
642 See Day 1 page 202 line 23.
643 See Day 1 page 203 lines 13 to 21.
644 See Day 2 page 56 lines 3-6.
645 See Day 2 page 9 line 1.
646 See Day 2 page 198 line 20ff.

In paragraph 16 of her witness statement to the Inquiry [**F/6/3**], Elizabeth Harrison says this:

> "16. I confirm that I did not witness any sexual or physical abuse in the Home. I did however witness bad practice by carers towards the residents and I was aware of the existence of a punishment room. ...."

In the course of her oral evidence, she referred to a "punishment room", as follows[647]:

> "And another thing was like we took the lock [off] ... what they said was a punishment room. It looked horrible, so we said: "Let's get rid of this lock here." And that's it. .... I think it was myself, Joanna; I don't know what other people were there on the first day, but we said: "Let's get a screwdriver and get this lock out of this room". I even think Sharon Berini was there, because she mentioned like she was able to stop the punishment room because she highlighted that there was no ventilation. .... I'm not sure if she called Environmental or she said that the Environmental would not allow anybody into this room."

Later in her oral evidence, in response to questions from counsel for Craig Farrell[648] about her references to a "punishment room", she said this[649]:

> "When we first came in that's what we were told. It was in the respite area. It was this room, right, with this small window. Everybody mentioned it as a punishment room. ... I doubt that ... it was a relaxation room. I would never say that was a relaxation room, honestly. It had no windows, it had just a small sort of glass to look in, no ventilation. I could hardly think somebody could relax in there."

Asked by counsel for Craig Farrell whether she was happy having worked for so many years in an institution which had a punishment room, she replied[650]:

> "Not in my time. That punishment room must have been from 1999 to 2003/4. There was a gap area. That room hasn't been like that from the very beginning in [the Home]."

Asked by counsel to confirm that there had not been a punishment room in operation during the time she had worked at the Home, she replied[651]:

> "No, I saw it. It had been converted because I had never seen that sort of box room with that small window in the door. I mean, there are other rooms adjacent to that one in the following room and has no windows at the door [sic]. That's why I tell you it's really weird if they used it for relaxation."

She went on to confirm that she had no direct knowledge of the existence of a "punishment room", and that she was aware of it only "because they told me"[652]. Asked by me whether she had actually seen the "punishment room" (i.e. seen it in operation), she replied[653]:

> "No, so I went to see it."

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[647] See Day 6 page 47 line 14ff.
[648] Craig Farrell's evidence is reviewed later in this Chapter.
[649] See Day 6 page 83 line 17ff.
[650] See Day 6 page 84 line 11ff.
[651] See Day 6 page 84 line 20ff.
[652] See Day 6 page 85 line 4.
[653] See Day 6 page 85 line 9.

I turn next to the evidence of Gina Llanelo (the mother of Resident AC).

In paragraph 2 of her 2006 witness statement [**C1/7/1**][654], Gina Llanelo said this about a "punishment room":

> "2. .... When [Joanna Hernandez] first came in the first thing that she saw was the P[unishment room], which she took away immediately. The Punishment Room [was a room where] children [were placed] that misbehaved [and] ... [they] were locked in this room which was [a room that] had no windows, until they calmed down supposedly. The problem [was that] some people forgot how long they were in there for. The parents [had never] been in agreement with this punishment room. We made repeated [requests for] it to be taken away and this was ignored until Joanna Hernandez came [and] the first thing she did was remove it."

In her witness statement to the Inquiry [**F/20/1**], Gina Llanelo referred to the above paragraph, saying this [**F/20/2**]:

> "I make reference at paragraph 2 of my 2006 witness statement to a punishment room. As far as I am aware, [Resident AC] was never placed inside this room, but I would not be surprised if this was not the case. I was actually shown the punishment room by Amanda (not Mandy Spencer Ball but the manager of the Home at the time)[655] when I attended the Home during a coffee morning just after the Home had been converted into flats. Parents were being invited to look round the Home as it had been converted into flats. When the Home first opened, the punishment room was not present.
>
> The punishment room was a store room located in the respite flat which was padded out with mats on the ceilings, walls and floor. It contained no windows. The staff at the time referred to it as a "time out" room. I was absolutely horrified by the inclusion of such a room in the Home and expressed my concerns and disagreement with it immediately. I was advised that this room would only be used for 5 minutes at a time and its purpose would be to enable users to calm down and not hurt themselves. I do not agree that this was or is an effective method of behaviour management as the majority of children and adults who use the Home do not understand the concept of right and wrong. I regard the use of such a room as inappropriate and unnecessary.
>
> I understand that the carers often forgot how long they left users in the punishment room. Many complaints about this room from various people were ignored. When Joanna Hernandez came on to the scene she removed it."

In her oral evidence to the Inquiry, she confirmed that Resident AC had never been put in the room which she had described, so far as she was aware[656]. Asked by counsel to the Inquiry whether she knew of anyone actually being put in the room which she had described, she said that she had heard from certain members of staff at the Home that that had happened, but she did not know the identities of those members of staff[657].

I turn next to the evidence of Violet Sullivan.

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[654] The copy of the witness statement provided to the Inquiry is defective, but it has not proved possible to obtain a better one.

[655] This must be a reference to Amanda Kircher, who was the first Manager in the Milbury era: see the evidence of Michelle Garro at Day 8 page 146 line 13.

[656] See Day 4 page 6 line 11.

[657] See Day 4 page 6 lines 14-23.

In paragraph 15 of her 2006 witness statement [**C1/15/5**], she said this, with reference to Resident I:

> "15. He has been punished. I was not told, I know he has been punished. Because if people who are not as challenging as [Resident I] have been punished, well imagine [Resident I]. 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 ... half an hour earlier for him and when I saw this I reported it, and I said I am sure it is probably not the carer who is at fault but people who are over the carer telling the carer what the punishment should be. I don't know, I really don't know, but anyway it was stopped but the fact that he was alone in his room in the dark and no, I don't like that."

In paragraphs 18 and 19 of her witness statement in the Inquiry [**F/12/4**], she refers to paragraph 15 of her 2006 witness statement, saying this:

> "18. .... Morag Jack allocated [Resident I] a room on the ground floor of the Home. [Resident I] loved to be outside and as he could not walk or climb stairs without assistance, the room provided him with a certain level of independence and access.
>
> Before [Resident I] was allocated such a room I recall often finding him in an upstairs bedroom lying in the bed on his own in the dark. I complained every time I encountered this problem as it limited [Resident I] drastically.
>
> In my 2006 statement at paragraph 15 I describe an incident where I found [Resident I] in his bedroom in the dark with his door locked shut. I was angry and shocked when I found him as I could not believe that such measures had been taken to punish [Resident I]. I reported this as soon as I found [Resident I] as it was unacceptable and inhumane.
>
> On one occasion, after [Resident I] had been allocated the downstairs bedroom, I went to visit my daughter in America. When I returned to the Home I found that in my absence [Resident I] had been put in an upstairs bedroom by Sharon Berini.
>
> 19. I have heard that the carers at the Home made use of a "punishment room" but I have never seen it nor have I witnessed anyone being put into it. [Resident I], to my knowledge, has never been placed in a "punishment room"."

I turn next to the witness statement of Matthew Turnock.

In paragraphs 109 to 112 of his witness statement [**K/1/26-27**], under the heading 'The Punishment Room', Matthew Turnock says this:

> "109. I understand that the Inquiry is interested in information regarding what some people call 'the Punishment Room' and when and how it was used.
>
> 110. This was a small room, around the size of an airing cupboard that was built in the respite facilities upstairs in the Home during the time I was still in school [i.e. prior to 2002]. The door of the room had a number of locks on the outside and was intended to be used to help restrain one of the Residents when their behaviour was difficult.
>
> 111. After it was built, however, Mrs Berini informed the Public Health Department of its intended use and had the room checked over for its suitability for such purposes. The room was checked and was deemed unsafe due to the fact that a person could suffocate in it because it had no ventilation. I myself tested it for just half a minute and found it to be very claustrophobic.

> 112. The room was therefore used to store food instead. I never once saw it being used for any other purpose and would doubt that it would have been used during times when I was not there. This is because I was a frequent visitor to the Home. I was there every lunchtime and every day after school, it would not be possible for the carers to empty the room of all the food, place a Resident inside for some time, and then place all the food back inside."

I turn next to the evidence of Maurice Valarino (the father of Resident X).

Maurice Valarino exhibits to his witness statement in the Inquiry [**G/6/1**] the minute of a meeting held on 9 October 2008 at the offices of The Hon. Jaime Netto MP (successor to Yvette Del Agua as Minister for Social Affairs) between himself, the Minister and Iain McNeil (the then Manager of the Home) [**G/6/13**].

Under the heading "Reason for Mr Valarino's attendance", the minute reads as follows [**G/6/13**]:

> "Mr Valarino came to see the Minister so that he could clarify an Answer that was given to a Question at Parliament on the 18 September 2008 and reported in the Gibraltar Chronicle. Mr Valarino believed this question was not accurately answered and wanted to be fully aware that [the] Minister was informed accurately. Mr Valarino made it clear that his intention[s] were not to blow up the Dr Giraldi situation further as his son is a user and this would not benefit him.
>
> Question 455/08 made by Hon N Costa – The existence of a 'punishment room' at Dr Giraldi Home, how long was it used for and when it was closed down.
>
> The answer given to this question and supplementary answer by the Chief Minister was 'No, and there has never been a punishment room'.
>
> [The] Minister was able to ease Mr Valarino's concerns and read out to him the supplementary answer that he was never able to speak out due to interruption. His answer would have been: Government doesn't confirm this. What it can confirm is that in 1997-1998 a behaviour specialist visited the service and recommended the use of "time-out" which was considered an appropriate form of managing specific challenging behaviours. Time out was carried out at the time in service users' bedrooms. Due to refurbishment works in one of the user's rooms, the possibility of using a specific room was explored by the Deputy Manager at the time. An environmental health inspection of the room concluded that the room could not be used because of inadequate ventilation. The Agency is not aware of any punishment room.
>
> Mr Valarino stated that he was the person who had carried out the inspection and pointed out the lack of ventilation in that room, making it non-suitable. Mr Valarino accepted this point as being consistent with his recollection at the time.
>
> ....
>
> Mr Valarino left reassured and commented that he does not find that the problems that existed at Dr Giraldi were now in existence, like in any organisation he is certain that there will be minor problems which can be easily dealt with."

In paragraph 23 of his witness statement to the Inquiry [**G/6/5-6**], he says this with reference to the above minute:

> "23. .... As can be seen, I was not content with the answer provided by the Chief Minister during question time in that there had never been a punishment room at the Home. The Hon Jaime Netto explained that he was unable to continue with his answer due to being interrupted

> and explained [he then repeats the content of the Minister's explanation, as recorded in the above minute] ... I left reassured with the explanation provided by the Hon. Jaime Netto."

In the course of his oral evidence, Maurice Valarino confirmed that, in his capacity as environmental health inspector, he had inspected the room described by Matthew Turnock and found it unsuitable, due to lack of ventilation[658].

Later in his oral evidence, in answer to questioning by counsel to the Inquiry, he said that he knew that the room had existed for a particular purpose[659]; that the room was not suitable for anything more than a cupboard[660]; and that he had recommended that it should not be used, whether for "time-out" or for "punishment"[661]. He went on to confirm that he had no direct knowledge as to whether the room was ever in fact used for that purpose[662].

Counsel for Joanna Hernandez asked him whether, in his professional opinion, the room in question was a punishment room or a time-out room. He responded that he could not know which it was, but it would have been an unusual time-out room[663], given that any occupant of the room would have been "totally excluded from everything, even from normal sensory perceptions like hearing or speaking to people"[664]. He went on to describe the room as "for all intents and purposes ... just like a padded room in a psychiatric hospital but without any padding"[665].

I turn next to the evidence of Jennifer Poole.

Her witness statement in the Inquiry [**F/2/1**] does not specifically address the issue as to existence or otherwise of a "punishment room". However, in commenting generally on issue 15 in the List of Issues[666] she says this [**F/2/8**]:

> "I have not witnessed any instances of abuse or cruelty towards the residents. .... During my time at the Home I never saw a punishment room. I was told by Elizabeth Harrison and Sharon Berini that there was one in the respite flat during the Milbury era, but that it was removed, I think by Sharon Berini. I do not believe that locking someone into a room is ever appropriate, nor is isolating a person for long periods of time. Time out might be appropriate as a behaviour management tool but always with the door of the room open, depending on the individual's risk assessment, care plan, level of understanding etc. These will be constantly changing."

Asked by counsel to the Inquiry whether she had ever seen a "punishment room", she replied[667] that she had not. She went on:

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[658] See the second page of exhibit 2 to his witness statement [**G/6/14**].
[659] See Day 3 page 93 line 1.
[660] See Day 3 page 94 line 23.
[661] See Day 3 page 95 line 1.
[662] See Day 3 page 95 line 6.
[663] See Day 3 page 100 line 18.
[664] See Day 3 page 101 line 14.
[665] See Day 3 page 102 line 19.
[666] Issue 15 (as amended) is in the following terms: Were there any instances of abuse of or cruelty towards residents, including punishment?
[667] See Day 5 page 145 line 23.

> "That was before my time."

In the course of her oral evidence, she also confirmed that during her time at the Home she had never seen any incidents of abuse (including alcohol abuse), cruelty, sexual misbehaviour, drug-taking, or anything of that nature; and that if she had done she would have reported it straightaway[668].

I turn next to the evidence of Jessica Perez.

Jessica Perez was, from September 2004 until March 2007, the SSA social worker with responsibility for Resident Z, a child who was resident at Merlot House. Resident AE was also resident at Merlot House during that period. Jessica Perez says in paragraph 9 of her witness statement to the Inquiry [**F/10/2**] that Resident Z was not, to her knowledge, ever left uncared for. In the course of her oral evidence to the Inquiry, counsel to the Inquiry asked her whether Merlot House had a punishment room or a "time-out" room. She replied[669]:

> "No, nothing at all, no. What used to happen was sometimes, you know, as children do sometimes, they misbehave, [and] he was sent to his bedroom for a time-out, but there was no punishment room, no."

I turn next to the evidence of Javier Millan.

Javier Millan is currently the Manager of a children's home run by the Care Agency. He joined the SSA in 2004 and was placed as a carer in the flat at Flat Bastion Road, with responsibility for Resident L, who was residing there. The flat at Flat Bastion Road is not part of the Home[670].

In paragraphs 12 to 15 of his witness statement to the Inquiry [**F/17/2**], Javier Millan describes a "time out" room in the flat at Flat Bastion Road, as follows:

> "12. This room was the spare room in [Resident L's] flat on Flat Bastion Road. It was designated as a time out room and was used to calm [Resident L] when his behaviour escalated – to protect him and others. I was told by my superiors at the time ... that this was the behaviour management method to be implemented with [Resident L]. These instructions had presumably been given to them by a higher authority and were conveyed down the chain to me.
>
> 13. [Resident L] was normally placed in the time out room for periods of approximately 5 minutes at a time. Whilst [Resident L] was in the room, the door was closed on him but not locked (I do not think there was a lock). We would check on [Resident L] when he was in the time out room.
>
> 14. If we took [Resident L] out of the time out room and he continued to kick off, we would place him back inside the room and repeat this action until he had fully calmed down. I did not particularly agree with this method of behaviour management but followed the instructions given to me by my superiors. ....

[668] See Day 5 page 145 line 11 – page 146 line 14.
[669] See Day 5 page 168 lines 21 to 24.
[670] See the explanation in Chapter 1 of this Report.

> 15. The time out room at Flat Bastion Road was not appropriate for its use. It was a normal room which contained items such as furniture which [Resident L] could have used to harm himself or others."

In his oral evidence he confirmed that the "punishment room" that he was referring to was a room in the flat at Flat Bastion Road.

I turn next to the evidence of Elizabeth Elbrow (Resident L's mother).

Elizabeth Elbrow made a witness statement in the Inquiry [**F/1/1**], and she also gave oral evidence (with the aid of an interpreter). In paragraph 5 of her witness statement [**F/1/1-2**] she says this:

> "5. I was also informed that the carers used to lock my son in a room when he misbehaved. They also used to call a psychiatrist to sedate him when he became violent. When this occurred when I was around, he always used to say 'Mum please no more injections'."

She does not say when these incidents are said to have taken place.

In her oral evidence she confirmed that she was speaking of the flat at Flat Bastion Road[671]. She also contradicted the evidence of Javier Millan, saying that she saw a lock on the door of the room to which he had referred[672].

I turn next to the evidence of Manuela Adamberry.

Manuela Adamberry said in the course of her oral evidence that she had never seen a time-out room in the flat at Flat Bastion Road. She went on[673]:

> "There was a room where we would sit, he [Resident L] would do some yoga, he would sing, he would dance, we sat with him. We played with him. .... It was a room to go and relax."

I turn next to the evidence of Kirushka Compson.

Kirushka Compson was given full responsibility for the care of Resident L in 2003. At that time, Resident L was living at Bishop Healy. Asked by counsel to the Inquiry whether she had ever seen a "punishment room" in the Home itself, she replied[674]:

> "I was told ... there was a room. ... I am not aware of the room. I was told it was supposedly the room. .... There [were] toys in there and all different things, but I never ever was aware of the room. I don't know, it was never in my time, so I can't help you ..."

Later in her oral evidence, she was asked whether there was a "punishment room" in the flat at Bishop Healy[675]. She replied[676]:

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671 See Day 6 page 137 line 25.
672 See Day 6 pages 136 line 21 and 137 line 8.
673 See Day 9 page 164 line 15ff.
674 See Day 9 page 101 lines 3-10.

> "Obviously [Resident L] did have a room in his flat where it was empty. He used to use that as a relaxation room. [Resident L] used to go by himself, actually. .... [H]e would always be in there with obviously a member of staff where he used to relax, sometimes even do yoga and calm himself down in there as a relaxation room."

She was not sure whether there was a lock on the door of the room, but she said that the door was never locked; it was always open "because obviously a member of staff had to be with him"[677].

I turn next to the evidence of Richard Muscat.

Richard Muscat was asked by his counsel about use of a time out room where Resident AE would be taken to calm down. He confirmed that the room in question was Resident AE's bedroom; and that there was never a room without windows which was used for that purpose, or a room which was locked. "Time out space", he said, "was his actual bedroom"[678].

Later in his oral evidence he was asked by counsel for the Gibraltar Disability Society whether he recalled any occasion when he had needed to give Resident AE a time-out or to take him to a place of relaxation. In response to that question, in what I found to be a confused (not to say confusing) passage of evidence, he referred to the existence of a room with bars on the window[679]. Counsel then asked him whether he had ever seen anybody placing a resident in such a room. After some equivocation on his part, counsel repeated the question. This time he answered "No".

I turn next to the evidence of Yvette Del Agua.

Yvette Del Agua says this in paragraphs 9 and 10 of her second witness statement in the Inquiry [**E/8/2**], with reference to the 2006 witness statements filed in support of Joanna Hernandez' claim of unfair dismissal.

> "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 instances alluded to in the statements as I recalled being informed of them and the outcome of the subsequent investigations at the time that they occurred. Nevertheless I recall asking Management ([I] cannot specifically state whether it was Ms Tosso on that occasion) to make the pertinent inquiries as I wanted to be satisfied, beyond any doubt, that the alleged incidents had been investigated and action taken. ....
>
> 10. I recall that something that I had not heard of before and which caused me particular concern, was the mention of a "punishment room". I was subsequently informed that no "punishment room" existed. It was explained to me that before my appointment as Minister for Social Services, a behaviour

[675] Kirushka Compson said (at Day 9 page 117 line 3) that she was speaking of the flat at Bishop Healy.
[676] See Day 9 page 116 line 18.
[677] See Day 9 page 117 line 5ff.
[678] See Day 11 page 110 line 9.
[679] See Day 1 page 104 line 11ff.

> specialist from the UK had visited [the Home] and had recommended a specific method (known as time out) which at the time was considered an appropriate form of managing some challenging behaviours. Time out used to be carried out in the service user's bedroom, but due to ongoing refurbishment, a separate room was looked at for this purpose but was discarded as not being adequate. I can only assume, as I assumed then, that this is the punishment room which is referred to in witness statements."

Given that Yvette Del Agua was appointed Minister for Social Services in 2000[680], she is referring to some time during the Milbury era.

In her oral evidence, she confirmed that the first she had heard of a "punishment room" was when she saw references to it in the 2006 witness statements[681]. Asked by counsel to the Inquiry what was her reaction when she read those passages, she replied[682]:

> "It concerned me. ... I had never heard of this room before, a punishment room in inverted commas. That is not an allegation that had been brought or a complaint that anybody had ever made to me or I had heard of. .... I was a very sort of hands on Minister. I liked, not to get involved, but to be kept informed when there were complaints, serious issues going on, and the staff knew it and they did inform me when these things happened. .... So on reading [the witness statements] the vast majority of the allegations reminded me that I had heard of this before and it also jolted my memory to the fact that they had been investigated. So all these allegations didn't cause me undue concern, because I was confident and satisfied that they had been investigated when they occurred. These were historic, many of them. But when I read about the punishment room, I had never heard of that before, and it did cause me alarm and concern. So I immediately called Ms Tosso. .... I called her in and said: "Look, this concerns me". We actually went over all the allegations. .... I told her: "Look, all of these, I know that they were investigated, but you go back and check". But this one I wanted her to come back to me because I had never heard of this punishment room [and] it did cause me concern. Basically she came back to me explaining that the punishment room was not a punishment room, it was a time out room which was a method of controlling people with challenging behaviour that had been recommended by specialists that had come over before my time [i.e. before February 2000]. I think he was called Luke Perry[683]. It wasn't used very frequently, but it was – I am not talking about the punishment room, what they call the punishment room itself, [but] the method of time out. .... It was used sometimes when things got out of control. So I was completely satisfied that there was nothing there."

Yvette Del Agua went on to say that she had visited the Home on a number of occasions. Asked whether she had been shown a "punishment room", she replied[684]:

> "No, I wasn't looking for anything when I went. I wasn't looking for a punishment room, and nobody ever showed it to me."

I turn next to the evidence of Debbie Guinn.

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[680] See Day 12 page 46 line 2.
[681] i.e. in the 2006 witness statements of Gina Llanelo and Violet Sullivan quoted earlier.
[682] See Day 12 page 58 line 15 – page 60 line 24.
[683] Luke Perry was an employee of Milbury: see the evidence of Michelle Garro at Day 8 page 133 line 6.
[684] See Day 12 page 61 line 4.

In 2004/5 Debbie Guinn was a social worker within the Children & Families Team. In July 2005 she was promoted to Senior Social Worker within Adult Services, but did not take up that post until October 2005. I refer later in this Report to the reports which she prepared relating to the standard of care provided by the Home in late 2005/early 2006. In paragraph 46 of her witness statement in the Inquiry [**E/68/7**], she said this:

> "46. I was not aware of a punishment room being used in the Home and would not support the use of this method of containment. There are strategies and de-escalation techniques used to ensure people do not hurt themselves or others whilst having a challenging episode but this does not involve locking someone in a room or in solitary confinement."

In the course of her oral evidence to the Inquiry she confirmed the contents of that paragraph, saying that she:

> "... was never aware at all, never saw a punishment room"[685].

I turn next to the evidence of Sharon Berini.

In the course of her oral evidence to the Inquiry, Sharon Berini was asked by counsel to the Inquiry whether she was aware of any instances of cruelty or abuse while she was working in the Home (she started working in the Home in 1998)[686]. She recalled an incident where a respite user had scalded his foot when getting into a bath in which the water was too hot, and instead of reporting the incident the carer had put his socks on and sent him home[687]. She went on to say that the incident was investigated at the time, and that the carer in question was interdicted (suspended). Asked by counsel to the Inquiry whether she was aware of any instances of what she would describe as "really serious abuse or cruelty", she replied[688] :

> "No. What I was aware of ... with regards to any abuse was reported effectively and dealt with at the time."

I turn next to the evidence of Mandy Spencer.

In her witness statement in the Inquiry [**E/63/1**], Mandy Spencer refers to a witness statement by Susan Ignacio which was filed in the Industrial Tribunal in 2006 in support of Joanna Hernandez' claim of unfair dismissal. As noted earlier, Susan Ignacio has since advised the Inquiry team that she would be happy for the issues raised in that witness statement not to be given weight and for its contents to be withdrawn. For completeness, however, I note that in her witness statement, Susan Ignacio referred to a "small, dark, locked room". As to that, Mandy Spencer says this in paragraphs 3 to 5 of her witness statement [**E/63/2**]:

> "3. The only 'small, dark, locked' room that there was in the respite unit was the seclusion room. This was already built into the unit when I took up my post, and when it was shown to me, I was appalled.

[685] See Day 15 page 194 line 19.
[686] See Day 8 page 81 line 13.
[687] See Day 8 page 82 line 1.
[688] See Day 8 page 82 line 14.

> 4. It was built for the purposes of a young adult permanent resident of the respite unit, who displayed, on occasions, seriously aggressive behaviour, consisting mainly of furniture destruction and window smashing.
>
> 5. I disagreed that this was an effective method of reducing this resident's behaviour, and after a period of working there of 6-8 months [i.e. in about mid-2003] I turned this room into a store cupboard, so that it couldn't be used without my knowledge."

I turn next to the evidence of Sean Matto.

Sean Matto has worked in the Home since 2000. In the course of his oral evidence to the Inquiry he was asked by counsel for the Gibraltar Disability Society whether he had any knowledge of a "time-out" or "punishment" room. He replied[689]:

> "I presume that a punishment room, which I have never been aware of, is something from institutional days when major hospitals existed, et cetera. That I cannot comment on, other than [to say that] I disagree with it [i.e. with the concept of a punishment room]. With regards to a time-out room ... at Dr Giraldi, as far as I am aware, when I was employed, the term was coined for one particular service user that was very challenging, and when I was employed he was the only service user [who] had a two-to-one ratio carer. He had two carers for himself. He presented very challenging behaviour. .... That is when this time-out room ... was first sort of used. Not the one that I've read in the documentation which is a small room with a small window. In fact, the time-out room this individual used was in effect his bedroom ... and that's why his bedroom was particularly bare.
>
> The purpose of the time-out really I think is pretty much self-explanatory. .... [It is] to give the individual time to actually calm down. He's got minimum stimulation ...; he shouldn't be able to hurt himself. This is why his bedroom was so bare."

Asked by counsel whether there was an element of deterrence in the use of 'time-out', he replied[690]:

> "It is more about a safe environment, safe for the individual and anyone else in the vicinity. .... When I started working [at the Home] the door wasn't locked. .... The thing is, after this service user, ... we had two new service users coming in, which [were] Resident L and Z, which were quite challenging, and I have had all sorts. In all fairness I wasn't involved in the works [i.e. the construction works], because that time-out room which is mentioned within the documentation with the small window, no ventilation et cetera, I don't know who actually requested for that to be built. But on the basis that a lot of things have happened through the years that I have noticed at Dr Giraldi's, the constructor was given some information and the constructor took it upon himself to devise whatever under their own ... observations or what they thought was being requested. Because as far as I am aware that room was never used. In fact, when they were going to move back to respite I remember a gentleman [who] used to work in the Environmental Agency[691] and he came round in his capacity ... as Environmental Officer and he gave his professional opinion on it. ...[The bedroom] was bare for safety reasons. I am not going to go into it, because I don't think it is relevant, but you are talking about a [particular] service user. Just to elaborate slightly, this service user would self-inflict."

[689] See Day 7 page 215 line 22ff.
[690] See Day 7 page 217 line 6ff.
[691] This is a reference to Maurice Valarino (see his evidence, referred to above).

He went on to agree that Resident AE's bedroom was bare "because of the characteristics of the particular service user"[692], and that "there was not a specific time-out room"[693]. He continued:

> "So [a time-out room] was built but it was never used because it was deemed inappropriate."

Asked what provision was made for other service users exhibiting challenging behaviour, Sean Matto replied that a time-out room was not available, and they had to use other strategies. He continued[694]:

> "To elaborate, ... basically sometimes rooms would have to be made secure for these individuals. If someone started displaying certain behaviours and started throwing furniture around, you had to remove the furniture."

I turn next to the evidence of Denise Hassan.

In paragraph 19 of her witness statement, Denise Hassan refers to the existence of a "time out room" in Merlot House, saying this (in relation to Resident AE) [**F/23/3**]:

> "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. [A named carer] would 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."

I do not accept her evidence that Resident AE would be locked in a time-out room at Merlot House. I accept the evidence of Craig Farrell as to the care provided to Resident AE (see below). I also note that Denise Hassan does not profess to have direct knowledge of what she describes, so presumably her knowledge is derived from what others may have told her. In any event, for reasons given earlier[695], I regard the entirety of Denise Hassan's evidence as unreliable.

I turn next to the evidence of Craig Farrell.

Craig Farrell started working with disabled patients in 1994 in Preston, Lancashire. In 2003 he and his family visited Gibraltar for a holiday. While in Gibraltar he met the late Agnes Valarino (the wife of Maurice Valarino). Mrs Valarino was the president of the Gibraltar Disability Society. She was interested to learn of his experience with disabled patients, and as a result he was invited to apply for a job with the SSA. He duly did so, and in June 2003 he was interviewed by Douglas Rodriguez, the CEO of the SSA. His application was successful, and in September 2003 he started work as a supply worker at the Home, which at that time was under the management of Morag Jack. About a month later, he was told that he was being promoted to senior support worker for Resident AE, who was living in a flat at Merlot House. He continued in that post until April 2012 when he was moved to Goole House as unit manager. As already noted, Resident AE exhibited challenging behaviour.

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[692] See Day 7 page 218 line 22.
[693] See *ibid.* line 25.
[694] See *ibid.* 219 line 12ff.
[695] See Chapter 7.

Craig Farrell confirmed in oral evidence that during his time in the Home (he started working there in 2003) there was no punishment room in the Home[696]. He said that he had seen cuddly toys and "bits of things for clients" in the room which he had heard had once been a punishment room[697].

Asked by counsel to the Inquiry what he would do with Resident AE when he was behaving particularly badly, Craig Farrell replied[698]:

> "It's unfortunate for him, but if you visited his bedroom ... there [are] not many things in it, ... because what will happen is with one of his outbursts ... he could throw it at you or he would definitely pick it up and smash it on the floor. So his room is quite sparse. That's why we like to get him out a lot and get him into Spain, because in that different environment it will calm him. .... Definitely, his bedroom would be his time[-out] room. .... But ... on time-out, you would ask him, it would be voluntary by himself. You wouldn't be locking him in time-out. You would ask him and get his support. "Come on, come on." And you would sit with him if you could. If you couldn't, you would stay outside his room. Now sometimes you can't sit with him. You have to sit out [i.e. outside his room] because unfortunately you have your health and safety as well ..."

Asked about "time-out", Craig Farrell described the nature of "time-out" as follows[699]:

> "When you are saying 'time-out', I would say it's a time when he can reflect and focus on being positive and come back out. That's how I would say 'time-out' is. Time-out is not a punishment: "Get in that room". Basically he is supported but you need to put him in a safe environment for yourself and the client. That's what we're looking at. You are looking at the utmost safety for the client and the staff."

Asked by counsel for Joanna Hernandez whether he had ever seen the punishment room described by Joanna Hernandez in paragraph 279 of her third witness statement (quoted earlier), he replied[700]:

> "Yes, but hearsay. I've never seen it. Hearsay. That's gossip, isn't it. .... There is a lot of gossip. No. .... I was told ... there was a room originally. .... I never ever was aware of the room. I don't know. It was never in my time."

I turn next to the evidence of Jonathan Teuma.

Jonathan Teuma was the senior carer with responsibility for Resident Z, who was also resident at Goole House until April 2005. Like Resident AE, Resident Z (although very much younger than Resident AE) also exhibited challenging behaviour. Residents AE and Z occupied different floors at Goole House.

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696 See Day 9 page 65 line 3.
697 See Day 9 page 65 line 5.
698 See Day 9 page 65 line 10.
699 See Day 9 page 66 line 11.
700 See Day 12 page 100 line 21ff.

In the course of his oral evidence to the Inquiry, Jonathan Teuma was asked by counsel to the Inquiry about "time-out" as a method of calming Resident Z down. He replied[701]:

> "... what was said to us was when they are acting out, when they are very stressed, if they become violent, invite them or help them to the room and give them time-out to allow them time to kind of calm down and maybe reflect. ... In [Resident Z's] case it would have been his bedroom. At that time, ... given the lack of training that I had, I basically associated it [with] the way I think many of us are brought up. ... Very often I made up for the lack of training by kind of drawing on my own personal experience. At the end of the day, [Resident Z] is disabled but he is also a child. ... So I would draw on my personal experience, and I didn't think anything of it. ... So OK, send him to his room."

He went on to say that there was no separate room which was used for this purpose, repeating that in Resident Z's case it would be his bedroom. He stressed that there was no lock on the door of Resident Z's bedroom, and that it would have been impossible to have locked Resident Z into that room.

Findings re the "punishment room"

In paragraph 108 of Joanna Hernandez' third witness statement, she describes the room which she was shown as having been "in use for years". She goes on to say that she was astonished to learn that an autistic resident (a reference to Resident AE) "was being held in a punishment room" by members of staff; that she "immediately said that [she] wanted the room closed"; and that she completely remodelled the room by removing the door, installing shelves and turning it into a "staff working area". In paragraph 279 of her witness statement she refers to a locked punishment room close to the Manager's office, which, she says, she arranged to have "pulled down".

The impression created by Joanna Hernandez' evidence is that as at November 2004 a "punishment room" was not only physically in existence but was currently being used as such. I am satisfied that that impression is a false one.

I find, on the basis of the totality of the evidence presented to the Inquiry in relation to the possible existence and use of a "punishment room" in the Home, that at some time in or about 1999 or 2000, during or following the 'unitisation" process carried out by Milbury (i.e. the process of converting the Home into separate flats), a room in Flat 3 was designated as a room to be used for "time-out"; but that it has not been used for that purpose at any time during the period which the Inquiry is concerned to investigate. For what it may be worth, I doubt very much whether it was ever used for that purpose, but I need make no finding about that.

The room in question (i.e. the room referred to by Joanna Hernandez in her evidence quoted above) has, throughout the period which the Inquiry is concerned to investigate, been used as a store-room.

[701] See Day 10 page 44 line 9ff.

Nor, as I find, was there a "punishment room" (in the sense in which Joanna Hernandez has used that expression) in any of the other premises in which the Home operated.

Gina Llanelo's reference in her witness statement[702] to having been told about the room in question by the then Manager, Amanda Kircher, demonstrates that she is referring to some time at the start of the Milbury era (Amanda Kircher was the first of the Managers appointed by Milbury[703]). The same applied to Yvette Del Agua's evidence of what she was told about a "punishment room" by Isabella Tosso (see her reference to Luke Perry, a Milbury employee, in the passage from her oral evidence quoted earlier).

Moreover, Gina Llanelo's references to Joanna Hernandez having taken away, or removed, the room are inconsistent with the evidence of other witnesses. I can only conclude that this is something which Joanna Hernandez herself told her, or that she had heard this from some other source. As for Joanna Hernandez' evidence that she remodelled the room and/or that she had it removed or "pulled down", save to the extent that that evidence is intended to refer to works carried out to the store-room, it is not true. I also reject her evidence that Resident AE went "berserk" every time he passed the store-room, at least in so far as that evidence raises the implication that as at November 2004 he was being regularly locked in that room.

I have referred earlier to a tendency on the part of Joanna Hernandez to frame her evidence (both oral and written) in emotive, and on occasion, lurid, language. Her evidence about a so-called "punishment room" is a prime example of that.

As to Violet Sullivan's evidence that she saw Resident I on one occasion locked in his bedroom in the dark, I accept that evidence. That was an inexcusable lapse by the carer responsible, but I note that Violet Sullivan says that this was "stopped".

THE CARE PROVIDED TO RESIDENTS Z AND AE

The evidence

In a section of her third witness statement headed "My initial observations of residents and practices at Dr Giraldi Home", Joanna Hernandez says this (in paragraphs 186 and 187 [**E/67/54**]):

> "186. When I took up my post at the Home I immediately set about the task of getting to know the residents, staff who cared for them and the accommodation in which the residents lived in different parts of Gibraltar. For obvious reasons it took a considerable period of time to gain a clear understanding of the Homes, its residents, their complex needs and the staff; as this was a 24-hour service, spread over multiple sites.
>
> 187. I do want to state clearly that I came to understand that the majority of carers were good, hardworking committed people."

[702] See paragraph 2 of her 2006 witness statement, quoted earlier.
[703] See the evidence of Michelle Garro at Day 8 page 146 line 13.

She goes on to make serious allegations as to the care provided to Residents Z and AE in particular.

The evidence in relation to Resident Z

In paragraphs 244 to 256 of her witness statement [**E/67/68-71**], she says this:

> "244. There was also a flat in Merlot House, which came under the [Home]. I went to assess it. [Resident Z] lived there. He was about 7 years old. He had epilepsy (petit [mal]) but could have more than 60 seizures a day. In fact I ensured that his seizures were monitored and counted. He was a very small boy. He was very nice to me. He liked to have the back of his head scratched, which I did for him when he was agitated. He did not speak much; although he did use swear words. He had been in care from a very young age. I do not know where he learned these swear words.
>
> 245. Shortly after taking up my post as manager, in December 2004, the acting CEO (Marie Gomez] informed me that [Resident Z's] diet consisted of an excessive amount of "takeaways", which she rightly deemed inappropriate for a small child.
>
> 246. I had also been told by the head teacher (Angela Lucas) of St Martin's Special School, where [Resident Z and another child who was also a resident] were pupils, that she had serious concerns about the children. She said that she thought that he had been coming to school without medication. He came dirty to school without underpants. She said that he had been taken into care as it had been alleged that his mother was hitting him, as he had bruising to his body. She told me that now the bruising was worse than before. She also told me that he had lost a lot of weight. She was also concerned that [he] was not doing any child orientated activities. She also told me that after school his carers took him to the flat, put him in his room, and then the carers watched videos. She also told me that the police had been called by neighbours of the flat in the past as they alleged that staff members had been seen smoking cannabis on the balcony. I do not know how she knew these things, other than the things she could see with her own eyes. However, [Resident Z's] mother/grandmother worked at St Martin's as a caretaker.
>
> 247. When I went to the flat, I went with his social worker, Jessica Perez[,] I found it in a very poor decorative state. There was very little furniture, a very dirty sofa and an old TV. There were a lot of adult [v]ideos [in] the sitting room (not sex videos but 15 plus and 18 plus video films). It was filthy; the dirt seemed ingrained as if it had not been cleaned for months. In his room there was only a bed and nothing else. There was no sheet on his bed, he would sleep on a bare mattress and he had one sheet to cover him. He had very few clothes indeed.
>
> 248. I checked his medications, which were kept in the kitchen. Most of them were out of date.
>
> 249. I looked for what food was in the flat. There were only tinned spaghetti and tins of beans. Some of the food was expired.
>
> 250. I opened the fridge and it was almost black with dirt and mould.
>
> 251. I asked Jessica Perez, who was his responsible Social Worker and was supposed to be visiting the child 2 – 3 times a week, how the child was allowed to live in these conditions. She said that she did not think it was that bad. I did.
>
> 252. I arranged for a team of people to come to the flat to clean it. I was told that they had to [use] knives to [scrape] the dirt off the fridge.
>
> 253. I also got bedding for his bed. I got curtains for his windows. I got him furniture for his flat. I got him new clothes.

> 254. Jonathan Teuma was the senior of the flat. I removed him immediately as I was deeply unhappy with the care that was being provided for this young child. I replaced him with Ms [Denielle] Gomez. I got her to begin counting the bruises on his body.
>
> 255. I believe that [Denielle] gave him good care. In fact shortly after taking over his care she called me to say that she wanted to take him to hospital, as she was worried about his health. I said to do so immediately. She took him to the hospital. He was admitted. I believe, but do not know for certain, that he was found to be anorexic. He also had chicken pox.
>
> 256. His parents later complained to me that, prior to my taking up post and replacing Jonathan Teuma as his carer, that they believed that their child had been maltreated. They said he had been given cold showers as a punishment. They said that he had been taken to Spain without their knowledge or permission."

It appears that in January or early February 2005 Joanna Hernandez proposed changes in Resident Z's team, for on 16 February 2005 Jonathan Teuma (whose evidence I consider below) wrote a lengthy letter to Joanna Hernandez setting out his concerns about the proposed changes [**M7/8/1-2**]. He copied the letter to (among others) Marie Gomez, Sharon Berini, Kirushka Compson and Jessica Perez. The letter merits being quoted in full in so far as it refers to Resident Z. It is headed "Re: Changes in [Resident Z's] Team", and it reads as follows so far as Resident Z is concerned:

> "I am writing to comment on the up and coming changes, which will affect [Resident Z's] team in the next week or two. As commented to you verbally last week I am happy to assist in any restructuring process that may be implemented in the service. However any such change should have the interests of the Service Users as its primary concern and I am afraid that in this case those interests have been overlooked.
>
> It saddens me that in the face of such overwhelming changes there was absolutely no consultation with any team member. The team does not expect to be consulted on every decision taken by management (that would be ludicrous). However, the complete replacement of the team (including Senior) can have monumental consequences in terms of [Resident Z's] development and it seems only logical that his team should be consulted in this case. It should also be noted that while being extremely competent, the team's Senior (now to be replaced again) had only been with us for approximately two months thus making team consultation all the more important.
>
> [Resident Z's] progress over the last year has been phenomenal (and that is no exaggeration). He has gone from smearing and eating his own faeces; wetting himself at the slightest sign of losing attention; almost continually swearing and having frequent violent outbursts to being a very well mannered boy, who has now almost entirely left behind all of the above anti social habits. Not only that but he is now making good progress at school, starting to interact with his peers in parks and will soon start extra-curricular activities such as music lessons. This progress has been the result of a lot of hard work by [Resident Z's] team as well as school staff and Doctor's influence. Changing the team in such a haphazard manner will undoubtedly disrupt his progress and could even lead to regression in his behaviour.
>
> Such a move would completely undermine the stability that [Resident Z] now has in his life. [Resident Z] is extremely wary of new people and this shows in his behaviour. I am not suggesting that there should be no change in [Resident Z's] team, however it should be a lot more gradual. The 2 or 3 shadowing sessions that have been arranged for new staff are simply not enough. In fact my departure (and replacement) from the team was discussed in meetings last year and it was agreed that this should be done over a period of at least 1 month (preferably more) and now we are trying to replace the whole team within less than 2 weeks. It makes no sense.

> The timing of the move is also not very appropriate as we are in the middle of a school term and this will undoubtedly affect his scholastic performance. Doing this move during the holiday period would prove less intrusive to [Resident Z's] progress. It would also prove less disruptive for him as the stress of getting used to new people could be offset by the more fun activities that can be undertaken in the holiday season.
>
> [Resident Z] suffers from many insecurities that manifest themselves through the anti-social behaviours described above. These have largely disappeared as a result of the encouragement and reassurances given by staff who have, over a period of time bonded with the child. Taking all these staff members away in one go will create an atmosphere of abandonment, which will no doubt give rise to these insecurities (and consequent behaviours) once again.
>
> The move also proves to be a violation of [the SSA's] policy to give Service Users choice in their lives (one of O'Brian's points of achievement). Obviously [Resident Z] is not going to dictate management decisions but some consideration to his wishes should be given. He is very young and therefore should have an advocate to voice his views and feelings. Having worked with him for a year I can affirm that he would prefer the familiar (support worker) to the unfamiliar. Again this is not to say that there should be no change in the team, only that it should be better managed.
>
> ....
>
> I would like to restate my eagerness to aid any restructuring management want to undertake and suggest that a meeting be held between management, [Resident Z's] team and his Social Worker in order to find an appropriate balance between practicalities and the interests of the Service User."

I regard the above letter as an extremely impressive contribution from a carer who manifestly had Resident Z's best interests at heart, and who was genuinely concerned that the wholesale changes to his team as proposed by Joanna Hernandez would put at risk the considerable progress which Resident Z had made. At the very least, it called for an understanding response from Joanna Hernandez. However, there is no evidence that Joanna Hernandez responded to the letter. Indeed, in his oral evidence Jonathan Teuma said that the first he heard of the reasons for the changes to his team was when he was given a verbal warning by Joanna Hernandez in relation to a later incident (as to which, see below)[704].

Joanna Hernandez did, however, write to Isabella Tosso on 21 February 2005 in the following terms [**M7/9/1**]:

> "At present changes to [Resident Z's] team are currently underway. The reason[s] for these changes [are] simply due to issues of gross misconduct by staff members. There has been a transitional period of two weeks for these changes to take place which has been further extended to another two weeks. After this, the full changes will take place."

Jonathan Teuma told the Inquiry that he was not aware of any gross misconduct by staff members at that or any other time, and that he regarded his colleagues as "very professional"[705].

In the course of her oral evidence, Joanna Hernandez was asked about this letter by counsel to the Inquiry. She gave a very different account from that given by Jonathan Teuma in his letter quoted above. She said this[706]:

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[704] See Day 10 page 70 line
[705] See Day 10 page 70 line 15.
[706] See Day 1 page 123 line 4ff.

> "When I walked into this resident's flat, he was seven [or] eight years old, he had petit mal, which means that he continuously fitted 70 to 80 times a day... He had one fit after the other. .... This little boy had no language, very, very poor language. So when I went to his flat, what I saw was the living room, ... they had some sofas, they had a TV, they had all their computer games, all the stuff, videos, all of the DVDs, him in his bedroom, the house was stark, there was absolutely nothing, it was not child oriented. He had never been to a park; they didn't take him anywhere. .... The two weeks I am talking about here [a reference to her letter to Isabella Tosso, quoted above] was two weeks to clean it up and to bring furniture to make it into a flat that is fit for a human being. Because that place was not fit for a dog. ... We didn't change the entirety of the team. .... We put in a new team because of the grave concerns that both St Martin's and myself were having about the child. What happened next, remember that this is a service that's supposed to [provide] for adults, not for children. So when this child – when we put in a care plan for him, we did a risk assessment, he started going to parks and he started having a life, he started seeing his parents ... The child, I had to actually rush him to hospital, he had been fed on baked beans and tinned food. .... The child was half anorexic..."

When counsel to the Inquiry referred Joanna Hernandez to Jonathan Teuma's letter dated 16 February 2005, she replied[707]:

> "I can see it's written to me, but I have never read this before, and I've got a very good memory."

Even if that statement is true (and I have the gravest doubts whether it is), the fact remains that Joanna Hernandez was prepared to introduce wholesale changes to the personnel of Resident Z's team without discussing those changes with any of the existing members of the team, and in particular with Jonathan Teuma. Furthermore, she felt able to inform Isabella Tosso that members of the team were guilty of (unspecified) "gross misconduct" without telling them what the alleged misconduct was and without giving them the opportunity to respond to the allegations against them. In that respect, Joanna Hernandez' conduct bears all the hallmarks of her June 2005 "investigation"[708].

As to Joanna Hernandez' evidence about Resident Z, the contrast between her evidence and the contents of Jonathan Teuma's letter is nothing less than dramatic. I have no hesitation in accepting Jonathan Teuma's version as a true one. I conclude that in giving her evidence about Resident Z Joanna Hernandez has once again resorted to unacceptable hyperbole, and that she has presented to the Inquiry a view of Resident Z which is grossly distorted.

In paragraphs 361 to 368 of her third witness statement, Joanna Hernandez describes a later incident relating to Jonathan Teuma, saying this:

> "361. Jonathan Teuma was [by this time] the senior of [the flat at Goole House occupied by another resident who was referred to during the Inquiry as Resident X]. He said that he was going to do charity work in Morocco (Cheshire Homes) and wished to take [Resident X] with him. He sought the permission of [Resident X's] father who was enthusiastic about it. They went to Morocco for a few days.

[707] See Day 1 page 126 line 11.
[708] As to which, see Chapter 10.

> 362. Upon Jonathan and [Resident X's] return to Gibraltar, Jonathan Teuma was arrested by Gibraltar Customs.
>
> 363. I was sitting in a meeting with Marie Gomez when she received a call from the Royal Gibraltar Police. They told her that Jonathan Teuma had been arrested on drugs [charges]. Apparently a RGP trained sniffer dog had detected it. Marie told me that he was arrested with drugs up his rectum.
>
> 364. I was shocked to hear what Marie Gomez was telling me, as Jonathan had a resident with him. I asked if [Resident X] had been arrested also, Marie said no. I said this was very serious and if true would warrant dismissal.
>
> 365. Marie Gomez directed me to dismiss Jonathan Teuma. I did so on her direction. I thought her decision was right, as the exposure of the resident to such risk was intolerable.
>
> 366. I called Jonathan Teuma and explained the decision to dismiss him. He accepted the decision and told me that he was awaiting a court hearing.
>
> 367. I later received a call from Marie Gomez (who is also sister-in-law to Minister Mr James Netto). She told me that I didn't know what I had done because Mr Teuma was the nephew of Minister James Netto and Michael Netto (a trade union leader). I was astonished, as she had directed me to dismiss Jonathan. I was also very upset and concerned by what she said.
>
> 368. I remained very concerned about the safety and security of patent drugs throughout my time at Dr Giraldi Homes."

Joanna Hernandez' evidence about the state of the flat at Merlot House is corroborated by Denise Hassan. In paragraph 18 of her witness statement in the Inquiry [**F/23/3**], Denise Hassan says this:

> "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."

Denise Hassan was not asked by any counsel to elaborate on that evidence, but I note that it is directly contradicted by the evidence of Jessica Perez, to which I refer below.

I turn next to the evidence of Emilia Bruzon.

In her witness statement in the Inquiry [**G/2**], she makes a number of serious allegations about the care (or lack of it) provided to Resident Z. Some of the evidence in her witness statement is hearsay, and she was understandably vague about dates. In paragraph 3 of her witness statement, she recalls being told by Denise Evaristo that a carer called Jonathan had made Resident Z balance books on his hands, with his arms extended to the side, as a punishment. I have considered this incident earlier in this Report[709]. In paragraph 4 of her witness statement [**G/2/1**], she says this:

> "4. I was also told by my grandson that he was given cold showers as punishment during the time that Mandy [a reference to Mandy Spencer] [worked] there and that carers had threatened to stick his head in the freezer. On one occasion I was with [Resident Z] in the Home and he showed me a photo of one of the carers and said[:] "Mama that's the one that pours cold water on my head so that [I don't] shout [any more]"."

[709] See Chapter 7.

In paragraph 5 of her witness statement [**G/2/1-2**], she refers to bruising on Resident Z's body and an injury to his eye, saying this:

> "5. On one occasion he was examined by Dr [Benady] who saw bruises and bite marks on his arm. At the time [Resident Z] was at the Home and [had] been looked after by carers. Further he fractured his leg on one occasion and then his arm. At no point did anyone explain how it happened and we were not informed about it until he was already out of the A&E department, already with a plaster on. He also had a very bruised and swollen eye on another occasion, and yet again we were unaware how he had [sustained] the injury."

In paragraph 6 of her witness statement [**G/2/2**], Emilia Bruzon refers to a trip to Jarandilla (wrongly translated as Gandillo), which in the event did not take place. She says that the trip was cancelled because there was no carer available to accompany Resident Z.

In paragraph 7 of her witness statement [**G/2/2**], Emilia Bruzon says this:

> "Whilst in the care of the Home, [Resident Z] was always unkempt; he was dirty and even developed scabies. Also at one stage he had chickenpox, and the carers refused to go into the room for fear of contracting the disease."

In paragraphs 8 to 13 of her witness statement [**G/2/2**], Emilia Bruzon says this:

> "8. I recall visiting [Resident Z] at the Home and seeing him sitting in front of the television with carers, viewing inappropriate violent movies. I would want to take him out of doors but the carers would say that it was too hot and that he should stay [indoors]. I couldn't take him to parties because they claimed [Resident Z] could not be around other children. [Resident Z] was practically locked up in the Home.
>
> 9. However when the [c]arers wanted to, they would take him out. In fact one night they took him to the summer nights events in Casemates and kept him out until midnight. However I was not allowed to take him the week after.
>
> 10. I also recall that on one occasion the carers took [Resident Z] and other residents to the beach. [Resident Z] was given a ride in a jet ski which I feel is completely irresponsible as he could have fallen. He had gone on the [j]et [s]ki with carers Hamish and Jonathan. [Resident Z] was only 7 years old at the time.
>
> 11. [Resident Z] was also taught English [swearwords] by the carers like "Bloody Hell", "Fuck" and "Shit". I do not speak English so I could not have taught him these words.
>
> 12. I wanted to speak to Marie Gomez who was the team leader at the time and Isabella Tosso, but they refused to meet with me. Jessica [Perez] was the only one who would meet with me and she claimed she would then inform the others of my complaints/concerns.
>
> 13. I believe that [Resident Z] during that time was ill[-]treated, insulted and [they] even told him they would kill him."

In the course of her oral evidence (which she gave through an interpreter), Emilia Bruzon was asked by counsel to the Inquiry why she, rather than her daughter, was looking after Resident Z. She explained that Resident Z was placed in the Home because it was thought that her daughter was ill-treating him. She agreed that there was a history of a disturbed family background, with

"lots of problems"[710]. She said that Resident Z had since left the Home, and was currently being cared for "at home"[711]. As to paragraph 3 of her witness statement, she was unable to say when this alleged incident occurred. As to the incident described in paragraph 4 of her witness statement, Emilia Bruzon thought that it must have occurred in about 2001[712]. Later in her oral evidence[713] Emilia Bruzon described an occasion when Resident Z spoke to her about cold showers. She said this:

> "The child was playing with me at the home one day, and he was getting toys from a box, and he got a photograph. [He said] "These two sort of shower me with cold water". I called the person who is there, and said: "Look what the child is saying". [The carer said:] "No, that's not possible, that's not possible". [Resident Z then said:] "Yes, Mum, cold water, cold water".

As to paragraph 5 of her witness statement, she was referred by counsel to the Inquiry to a number of entries made in a daily record kept by Jessica Perez [**D9/59/43**]. Jessica Perez is currently a probation officer, but in 2004/5 she was employed by the SSA as a qualified social worker in children's services[714]. The entries in question refer to an occasion in October 2004 when Resident Z had injured his wrist as a result of a fall at school. According to the first entry, on 26 October 2004 Angela Lukas (the head teacher at St Martin's School) telephoned Jessica Perez to say that Resident Z had fallen in the park, whilst on an outing from the school; that he had apparently broken his wrist; and that he was being taken to hospital. The entry records that Mrs Lukas had already been in touch with Emilia Bruzon and had asked her to visit Resident Z in hospital. The entries go on to record that on the following day Jessica Perez visited Resident Z in hospital, and found him "looking well". He had only dislocated his wrist, and had had a minor operation to put the bone back in place. The entries further record that on 28 October 2004 Jessica Perez telephoned the hospital to inquire about Resident Z and was told that Resident Z would be kept in hospital as the swelling had not gone down and he was not doing his exercises, and that the situation would be reviewed next day. In the event, Resident Z remained in hospital for two days.

Emilia Bruzon confirmed that she remembered that incident[715].

She was also referred by counsel to the Inquiry to another entry made by Jessica Perez [**D9/59/60**] of an incident which occurred on 11 July 2005, when Resident Z twisted his ankle while in the garden at the Home in the company of a carer. Later that day his ankle swelled up, and the carer took him to A & E. Following an X-ray, it was ascertained that Resident Z had a minimal fracture to his ankle and a temporary plaster was applied. According to the entry, Resident Z's father, Paul Evaristo, was present while this was done[716]. At the time of this incident, discussions were ongoing concerning the supervised access to Resident Z of his mother

[710] See Day 3 page 28 line 9ff.
[711] See Day 3. page 29 line 3.
[712] See Day 3. page 41 line 5.
[713] See Day 3 page 40 line 20ff.
[714] See para 4 of her witness statement.
[715] See Day 3 page 39 line 8.
[716] This was confirmed by Emilia Bruzon: see Day 3 page 37 line 12.

and father. Subsequent entries by Jessica Perez record various meetings with Resident Z's parents, and with Emilia Bruzon, at which this was discussed.

Another document to which Emilia Bruzon was referred by counsel to the Inquiry was an "Annual Medical Report" on Resident Z by Dr Ismail, a consultant paediatrician at the Gibraltar Health Authority, dated 16 May 2005 [**M7/20/1**]. In his report Dr Ismail expressed concern at Resident Z's recent weight loss, although on examination that day Resident Z "looked well in himself". He also expressed concern about a report by Resident Z's schoolteacher that he "had recently presented with multiple bruises over his body which was not explained by his carer", and for which there appeared to be no medical cause. In the final paragraph of his report, Dr Ismail said this:

> "I have some concern about these bruises and advised that in the future if he arrives to school with the bruises he should be referred to the A & E for documentation and assessment and if the bruises are still unexplained should involve the social worker."

Counsel to the Inquiry also referred her to a report by Dr Higgs (a consultant paediatrician at St Bernard's Hospital) dated 25 May 2005 of an examination of Resident Z which he carried out on 10 May 2005 [**M7/21/1**]. Dr Higgs begins his report by saying:

> "Concerns were his bruising, frequency of [epileptic] attacks, appetite and academic progress."

In the final paragraph of his report, Dr Higgs says this:

> "On examination: He was very amenable and co-operative. His bruising appeared less but was more noticeable around the knees and lower limbs. His activity level was normal. Central nervous system appeared intact. His muscular tone appeared normal. He had recently had his full blood count and protein profile checked and this was also normal. He seems to be making good progress. *I think that the bruising is probably related to trauma and I do not think there is non-accidental* [i.e. deliberate] *injury here.* His Lamotrigine level is rather high (16) and I am not sure whether this is related to easy bruising. He will be reviewed by Dr Jardim on his next visit at the end of May. In the meantime I have asked for protective tags to be put to his knees." (Emphasis supplied)

Counsel to the Inquiry drew Emilia Bruzon's attention in particular to Dr Higgs opinion that the bruising was not "non-accidental" (i.e. – not deliberate – see above), and put it to Emilia Bruzon that there was no question of anyone ill-treating Resident Z. She replied[717]:

> "Not as far as I know."

As to the cancelled trip to Jarandilla to which Emilia Bruzon refers in paragraph 6 of her witness statement, counsel to the Inquiry referred her to a further entry by Jessica Perez in her daily record [**D9/59/56]** which records that on 7 June 2005 she telephoned Emilia Bruzon to explain why the trip had been cancelled. According to the note, the reason was indeed the fact that there was no carer available to accompany Resident Z. The material part of the note reads as follows:

[717] See Day 3 page 35 line 7.

> "Telephone call to Mrs Bruzon to explain why the Jarandilla trip was not taking place. That the carer we had available had only been working with [Resident Z] for 2 weeks and we had tried other carers from [Resident Z's] team but nobody was available. I also informed [her] that [Resident Z's] current health situation was also an issue given that he was constantly having drops and absences.[718] Mrs Bruzon stated that last weekend [Resident Z] was much better. ...."

When the above passage was put to her by counsel to the Inquiry, Emilia Bruzon responded that she felt that the carers did not want to take him on the trip[719], although she admitted that she could not remember the incident[720].

I turn next to the evidence of Denise Evaristo.

In her oral evidence to the Inquiry, Denise Evaristo confirmed that Resident Z was born on 17 July 1996[721], and that he lived in the flat at Merlot House until 2005[722] (she was not specific as to the date in 2005 when he ceased to reside in the Home). She said that the incident involving the placing of books on Resident Z's hands took place in 2001[723]. She went on to say[724]:

> "They used to shower him with cold water, they used to tell him they were going to put his head in the freezer like an animal. .... I was in front when they used to do those things to my son."

When asked by counsel to the Inquiry why they were doing that, she replied[725]:

> "Because he was shouting and that."

She went on to say that this also occurred in 2001[726], and that since then things were "much better". She described Joanna Hernandez as "a good person", and said she was satisfied with the way Joanna Hernandez had dealt with her[727]. In response to questions from counsel for Joanna Hernandez and from myself she said that she did not find it difficult to complain, but that when she did complain nothing was done about it[728].

I turn next to the evidence of Jessica Perez.

Jessica Perez gave both written [**F/10/1**] and oral evidence to the Inquiry[729]. Her connection with the Home was as the social worker for Resident Z[730]. In paragraph 6 of her witness

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[718] Evidence was given to the Inquiry by a particular carer that this Resident suffered from a condition by which he would "absent" himself for a few seconds from whatever he was doing and then "come to" suddenly. This was described by carers as his absences or drops. See the evidence of Jonathan Teuma later in this Chapter.
[719] See Day 3 page 40 line 7.
[720] See Day 3 page 40 line 17.
[721] See Day 3 page 50 line 20.
[722] See Day 3 page 51 line 15.
[723] See Day 3 page 52 line 22.
[724] See Day 3 page 52 line 24.
[725] See Day 3 page 53 line 9.
[726] See Day 3 page 52. line 21
[727] See Day 3 page 54 line 16ff.
[728] See Day 3 page 55 line 13ff.
[729] See Day 5 page 163 line 12ff.
[730] See Day 5 page 163. para 7.

statement [**F/10/2**] she describes Resident Z as suffering from Lennox-Gastaut Syndrome which is a severe form of epilepsy, a learning disability and behavioural difficulties. She goes on to say, in paragraph 9 of her witness statement, that there were sometimes problems in arranging cover at the Merlot House flat when care workers were ill or on leave, but that Resident Z was never to her knowledge left uncared for. She describes staff in the flat as having good working relationships[731].

As to the flat itself, and the issues as to hygiene raised by Joanna Hernandez, Jessica Perez says this (in paragraphs 13, 15 and 19 of her witness statement [**F/10/3-4**]):

> "13. .... The Flat was not particularly child focused or friendly and I remember thinking that I would have liked to have seen more soft furnishings, although I did not have severe concerns. I recall that there was an issue with the safety of one of the windows and I suggested that a railing should be put up, which seemed to take a very long time.
>
> 15. .... The physical facilities at the Flat were of a satisfactory standard. I would have liked it to be more child focused. However, the physical facilities in place were meeting Resident Z'[s] needs, such as the bathroom.
>
> 19. .... The level of hygiene at the Flat was of a satisfactory standard. The Flat was cleaned on a regular basis and there were no hygiene issues in respect of Resident Z of which I was aware."

As to communications with Resident Z's family, Jessica Perez says this (in paragraph 14 of her witness statement [**F/10/3**]):

> "14. .... I think there was good communication with Resident Z'[s] family. I used to talk to his mother, father or grandmother, often on a daily basis. At this time, I was also trying to pave the way for Resident Z to move into the family home, if possible, with support from carers so I also worked with the family in the Flat on occasion. If there was an incident, the carers would report this to the family and also to me and I would then report it again to the family."

As to the standard of care provided to Resident Z, Jessica Perez says this (in paragraphs 16, 17 and 23 of her witness statement **F/10/3-4**]):

> "16. .... The care provided to Resident Z was of a satisfactory standard with regard to his mental and physical health and social development. He attended St Martin's School, apart from when he was unwell. The care workers used to encourage and organise some after-school activities for Resident Z. Resident Z was able to walk but he used to get tired very quickly. At the time, he was not using a wheelchair and it was necessary for the carers to encourage him to exercise. In addition, Resident Z was under the care of the Hospital paediatrician and a UK specialist, who would come twice a year to Gibraltar. He would adjust Resident Z'[s] medication as necessary from time to time.
>
> 17. .... I think that appropriate provision was made for the safety of Resident Z.
>
> 23. .... When carers began working at the Flat, they were trained and informed of their roles. I used to meet up with the carers regularly to discuss Resident Z'[s] care and his needs as well as any issues or concerns. I think that the care provided by the care workers to Resident Z was of a satisfactory standard."

[731] See Day 5 page 163 para 12.

In paragraphs 20, 21 and 22 of her witness statement [**F/10/4**], Jessica Perez says this:

> "20. .... During my visits [to] Merlot Flat, I did not observe any instances of abuse of or cruelty towards Resident Z. I was aware that when he was acting up, he would be given "time out". This meant that he was sent to his bedroom with the door open for very short periods of time to help him calm down and understand that what he had done was unacceptable. To my knowledge, he was never locked in his bedroom or left for long periods of time.
>
> 21. There was no punishment room in the Flat. However, I had been told that Resident Z had been mistreated whilst a small boy living at [the Home] by being made to stand motionless with two books in his hands, as a punishment. However, I never saw this personally and of course would have reported such an incident of cruelty had I seen it.
>
> 22. .... I have not seen any instances of misconduct by members of staff ... If I had witnessed any such incidents, I would have reported it immediately to management."

In her oral evidence to the Inquiry, Jessica Perez described her criticisms, such as they were, of the care provided to Resident Z as[732]:

> "... not big issues, they were more minor issues in relation to the actual home where the child was being cared for [i.e. the flat in Merlot House]. As I have said in my witness statement, ... it could have been a bit more child focused. By that I am not suggesting that his basic needs were not being met, but I think part of the problem there was initially because the carers that were caring for him were not really used to dealing with children, they were more dealing with adults, perhaps that was the issue. But you know, he did have toys, and he did have a play room, so I didn't see any or observe anything which really concerned me."

Asked by counsel for the Inquiry whether she was aware of any incidence of abuse, she replied[733]:

> "No, not at all."

Asked about any incidence of unpleasant behaviour of that sort, she replied[734]:

> "Not directly, not during that time, no. And remember as well that for quite a big chunk of that period I think initially this service user [i.e. Resident Z] was being cared for by the Dr Giraldi carers but then he was moved to Children's Service, so I believe that for most of my involvement he was more to do with the Children's Services rather than with Dr Giraldi."

Asked by counsel for Joanna Hernandez whether her recollection of the conditions in which Resident Z was living at Merlot House accorded with Joanna Hernandez' description, as quoted above, Jessica Perez replied[735]:

> "I can't remember it being to that degree. I remember, as I've said, that it could have been more child focused and I think I mentioned that in my statement. But to that degree, no, I can't say I do."

[732] See Day 5, page 167 line 19.
[733] See Day 5 page 168 line 7.
[734] See Day 5 page 168 line 9.
[735] See Day 5 page 176 line 4ff.

I then asked her whether, if she had found conditions in the flat at Merlot House to be as Joanna Hernandez described them in her witness statement, she would have done something about it, to which she replied[736]:

> "Absolutely, I would have gone and reported it back to my manager, and it would have been dealt with there and then. Certainly, I would not have allowed a child to have lived under those conditions. But, as I say, I can't remember seeing it. And that he didn't have any bedding? No, I can't remember that either."

Counsel for Joanna Hernandez put it to Jessica Perez that the state of the flat at Merlot House was "appalling", to which Jessica Perez replied[737]:

> "No, I can't recall that, no."

Jessica Perez was referred by counsel to the Inquiry and by counsel for Joanna Hernandez to a detailed report about Resident Z prepared by Jessica Perez, in advance of a meeting to be held on 14 April 2005 to discuss various matters concerning him [**M7/3/1**]. The report is signed by Jessica Perez and dated that day. It does not record who was to be present at the meeting in addition to Jessica Perez herself. It begins with a section dealing with Resident Z's health. I set that section out in full, as follows:

> "[Resident Z] suffers from Lennox-Gastaut Syndrome, which is a severe form of epilepsy. For more details on this condition look at the information enclosed.
>
> Dr. Higgs sees [Resident Z] every fortnight at St Martin's School and he monitors his medication. Currently [Resident Z] takes Lamotrigine 62.5mg two times a day, in total 125mg which is the maximum dose for his weight. However, he does continue to have drops and absences and this is being recorded by carers to see if there is a pattern. This information is then being passed on to Dr. Higgs.
>
> [Resident Z] is due to see the Neurologist in May. Although he sees [Resident Z] twice a year, once a year he does an in-depth assessment. This will take place sometime next month.
>
> Concerns were raised by the senior care worker about [Resident Z's] weight. This was brought to the attention of Dr. Higgs and although there appears to be a behavioural component to his refusal of food, Dr. Higgs has prescribed Minnedex vitamin, plus a milk drink, which has all the vitamins. Justin Gafan, [Resident Z's] class teacher is carrying out some work with [Resident Z] at lunch-time around his refusal to eat.
>
> Concerns were also raised that [Resident Z] had not been seen by a Physiotherapist since 2002. After speaking to Angela Lukas, Head Teacher, St Martin's school she confirmed this was not the case as there are physiotherapists within St. Martin's school and [Resident Z] is monitored throughout the week. In fact in January Carole Williams saw [Resident Z] after he complained of pain in his feet and suggested he wear firm supportive shoes. The senior care worker has already informed carers that [Resident Z] is to wear these shoes at all times and not trainers.
>
> Concerns have also been raised in respect of [Resident Z's] level of bruising. Some of the bruising is around the inside of his thighs. This is being monitored and recorded by carers and [Resident Z] is checked out in the morning and evening. As [Resident Z] has drops he wears a bicycle helmet and sport pad around his elbows and knees when he walks as a safety precaution. When [Resident Z] spent some time in hospital towards the end of last year when he fractured his

[736] See Day 5 page 176 line 11ff.
[737] See Day 5 page 177 line 17.

> wrist, blood tests were carried out to find out if there was a blood deficiency which caused [Resident Z] to bruise easily. The results came back negative.
>
> A core group meeting will shortly be arranged with Dr. Higgs to find out if there are any reasons why he bruises so easily or whether this is as a consequence of his condition and the fact he has drops.
>
> Angela Lukas ... reported that [Resident Z's] attention and socialisation have improved. The senior care worker has also noticed an improvement in this area."

Under the heading "Care situation", the report went on to say this:

> "[Resident Z] is a child with disabilities and is placed in an adult's services, this isolates him from other children and does nothing to help his social development."

The next section of the report dealt with Resident Z's accommodation at Merlot House, saying this:

> "[Resident Z] was initially placed at Merlot House but this was only a temporary accommodation. [Resident Z] had been residing at Merlot for over 2 years. Discussion took place with Marie Gomez about [Resident Z] being re-housed into a smaller flat and this was being looked into in consultation with the Minister.
>
> In the meantime [while] this is being considered a few basic essentials in his present flat could make a big difference. New bedding, curtains, a rug and some painting would be sufficient to make the required changes. The estimated cost for this would, I anticipate be no more than £150.00. These basic things are the sort of things that any child could and should have and what any reasonable parent would provide. As and when [Resident Z] moves flat most of these things he will be able to take with him. [Resident Z] has a right to live in basic and comfortable surroundings, which is child[-]focused.
>
> Currently £65.00 is provided every week for the care of [Resident Z]. However between food, cleaning materials and bus fares to take [Resident Z] to school there is no money left to pay for his activities. For e. g. arts and crafts, and music classes. Can these monies be increased to £100.00 per week including petty cash?"

The next section of the report is headed: "Concerns raised by Mr. & Mrs. Evaristo and Mrs. Bruzon". It reads as follows:

> "During a meeting between Mr. & Mrs. Evaristo, Mrs Bruzon, Joanna Hernandez, Manager, Dr. Giraldi Home and myself they reported that 3 years ago whilst [Resident Z] resided at Dr. Giraldi Home, he was given cold showers and made to stand with books on his hands for an hour. They also reported that a carer who was working until recently in [Resident Z's] team used to shout at them and [Resident Z].
>
> Mr. & Mrs. Evaristo and Mrs. Bruzon were advised that in the future if they have any concerns they are to report this directly to either Joanna Hernandez or myself."

In the next section of the report, Jessica Perez referred to a proposal by [Resident Z's] carers to take him on a trip to Spain. In the event, the trip never took place, due (among other things) to the fact that not enough time had been allowed to consider the risks to [Resident Z] of going on the trip.

The report went on to refer to a proposal by [Resident Z's] parents to take him for a fortnight's holiday in Portugal. However Jessica Perez considered that, given that the holiday would involve [Resident Z] travelling by bus, train and taxi, it would not be in his best interests to go. As a possible alternative, she suggested that [Resident Z] should go with his parents for one week only, with two carers in support, and stay in a hotel.

The report turned next to a proposed three-day trip for Resident Z to Jarandilla, staying in a location specifically designed for those with disabilities. Jessica Perez considered that this would be a better option for [Resident Z] than a trip to Portugal.

I need not refer to the final section of the report, which concerned the supervised access to Resident Z currently enjoyed by his parents.

Counsel for Joanna Hernandez reminded Jessica Perez of the evidence of other witnesses that the condition of the flat at Merlot House was "disgusting", and suggested that the references in the above report to the need for new bedding and curtains appeared to corroborate that evidence. Jessica Perez responded[738]:

> "No. All I can think of maybe is that the bedding and the curtains he did have were a bit tatty, but not that he didn't have any bedding, no."

I turn next to the evidence of Jonathan Teuma.

As noted earlier, Jonathan Teuma was the senior carer looking after Resident Z in the flat at Merlot House until about April 2005. He gave written and oral evidence to the Inquiry.

In the first of his two witness statements [**E/64/2**], Jonathan Teuma says that he worked full-time at the Home from the summer of 2003 until the summer of 2005. During the early part of that period he was assigned to care for Resident AE, but thereafter he became the senior carer with responsibility for Resident Z. In paragraphs 14 to 16 of his witness statement he describes Resident Z as follows:

> "14. [Resident Z] suffers from a form of epilepsy. The epilepsy manifests itself in what we called 'absences' of 3-4 seconds in which [Resident Z] would forget what he was doing. This often resulted in him wetting himself or spitting food out while he was eating because he would 'come to' with food in his mouth and not understand why it was there. There was also a period of several months during which he had to wear a bicycle helmet at all times to protect his head from falls caused by more prolonged 'absences'.
>
> 15. Aspects of his challenging behaviour consisted of frequent swearing, scratching and violent outbursts which would develop very suddenly and unpredictably. It was generally understood that [Resident Z] often used these outbursts in order to gain attention and particularly so when he was around other people or did not have his carer's full attention.
>
> 16. It was usual to use a 'time-out' method in order to calm him down. This would involve leaving him to himself in his room or, if out in public in a safe environment, walking away as if ignoring him in order to encourage him to moderate his behaviour. This last method of

[738] See Day 5 page 177 line 9ff.

> disciplining [Resident Z] was often used by the carers and is recorded in the Communications Book entry dated 14 April 2004 by Gayle Everest [a copy of which he then exhibits] who explains how she walked away from [Resident Z] when he was sat on the ground in the street in order to get him to behave and follow her. These were the only two methods that the Home instructed us to use when dealing with [Resident Z's] challenging behaviour."

In paragraphs 17 to 23 of his first witness statement [**E/64/3-4**], Jonathan Teuma describes the difficulties he faced in caring for Resident Z. He says that he worked with Resident Z for several months without having received any formal training and with very little guidance or supervision, but that he was nevertheless able to form a good relationship with Resident Z. He says that he took great interest in Resident Z's care, and encouraged his participation in activities including playing the guitar, which Resident Z particularly enjoyed. He says that Resident Z's behaviour improved during this time. He gives as one of the main reasons for that improvement the fact that for some time Resident Z had had the same four carers looking after him, thereby providing the stability which he needed.

In paragraph 24 onwards of his first witness statement [**E/64/4**], Jonathan Teuma refers to an incident which occurred on 13 December 2003, shortly after he began working with Resident Z. He recorded this incident in manuscript in the Communications Book [**E/64/25**], a copy of which he exhibits to his witness statement. His description of the incident includes the following:

> "Shortly after [breakfast] he [began] shouting and being obnoxious so I put him in his room. When he calmed down I brought him out but he started misbehaving again. This process was repeated several times over 1 hour. He urinated and [defecated] in the room. At this point I cleaned his hands (which were covered in shit) and gave him a cold shower to finish cleaning him. He did not like this and the threat of sticking him in a cold shower since then has helped me control his behaviour. After the shower I kept him in his room to [calm down] and at 10.45/11.00am allowed him to watch TV. He was now much calmer and well[-]behaved."

After referring to the above entry in the Communications Book, Jonathan Teuma says this (in paragraphs 25 to 36 of his first witness statement):

> "25. On 13 December 2003 I was having a very difficult morning with [Resident Z] who was playing up and I was attempting control his behaviour with the usual 'time-out' as explained above. I put him in his bedroom to calm down several times during the course of an hour but his behaviour was failing to improve.
>
> 26. On one occasion when I went into his room he had urinated and defecated in the bedroom. He was covered in his faeces and it was getting everywhere. I found the situation distressing to say the least because it was the first time I had encountered such a situation.
>
> 27. My main concern was to stop [Resident Z] making a bigger mess and to get him cleaned up straight away. I first cleaned his hands so that he would not keep smearing his faeces everywhere. I then removed his clothes and put him in the shower.
>
> 28. At the time he was quite agitated and uncooperative and I believed this to be the most practical way to clean him up quickly.
>
> 29. In my attempt to do this as quickly as possible I did not take the trouble of adjusting the water temperature as I usually would when bathing or showering [Resident Z]. I just used the cold water setting to eliminate the possibility of scalding him with hot water.

> 30. He complained about the cold water but I continued cleaning him quickly until he was fully clean.
>
> 31. The fact that I chose to use cold water was certainly not as a form of punishment. In the stressful circumstances it was simply the most practical and safe way of dealing with the situation that occurred to me at the time.
>
> 32. I documented the incident in the Communications Book and also recorded that he did not like the use of cold water as he had said so to me. The only reason I mentioned it was because he complained about it and I thought it right to record his complaint.
>
> 33. The Communications Book also mentions that later that day I threatened to stick him in a cold shower which helped me to control his behaviour. In retrospect, my use of the word "threat" was unfortunate because it does not reflect the nature of my conversations with him. The use of the word 'warning' would have been more accurate. I naturally had no intention whatsoever of actually doing so, but I used it as a way of preventing him acting up in such a way again that day.
>
> 34. Later that day he behaved much better and I also recorded this in the Communications Book. I noted that he was "much calmer and well[-]behaved" and that during the Christmas party in Casemates his behaviour was excellent.
>
> 35. I therefore recorded all events and [Resident Z's] behaviour whether good or bad.
>
> 36. The reports in the Communications Book were always written after the end of the shift. Even though I aimed for the best possible language, at the end of a long, tiring and difficult shift it would inevitably result in less than perfect language/terminology."

In paragraph 46 of his first witness statement [**E/64/6**], Jonathan Teuma refers to another of his entries in the Communications Book relating to Resident Z. This entry is dated 10 January 2004 [**E/64/36**]. It refers to an incident on the afternoon of that day when, according to the entry, Jonathan Teuma was driving Resident Z back to the Home and Resident Z started swearing and shouting and began "grabbing the steering wheel and gears", to the extent that Jonathan Teuma had to pull over. The entry continues:

> "We came home and I locked him in his room for ½ an hour. When he came out his bad mood seemed slightly better (though still edgy)."

In paragraph 46 of his first witness statement he says this, with reference to the above entry:

> "46. In the Communications Book I have used the words "locked him in his room". This choice of wording is not accurate because I did not on that occasion, or ever, actually lock the door. I merely meant that I sent him to his room for a 'time-out' in the same way that I had done on other occasions. As far as I can recall [Resident Z's] door did not have a lock on the outside."

Jonathan Teuma goes on to say that on occasion he would take Resident Z to his house, which was only a short walk away from the Home; that he was not aware of any rule forbidding carers from taking service users to their own homes; and that it was common practice for them to do so. In paragraph 50 of his first witness statement he says this:

> "50. Given Gibraltar's small size, the lack of infrastructure and facilities for the disabled, the lack of training and guidance offered to carers and the general ignorance which abounded as to how

> to interact with disabled people at that time in our community, the only available means of integration left to carers was to make use of their own personal resources. This sometimes included making use of their homes, personal belongings and families."

In paragraphs 55 to 69 of his first witness statement [**E/64/6-7**], Jonathan Teuma describes how he put forward a detailed written proposal to take Resident Z and another resident (a child) on a 3-day country holiday at the end of March 2005 to Atajate, near Ronda, accompanied by himself and two other carers [**E/64/40**]. Activities were to include country walks, fruit picking, cooking, flower arranging, and a visit to a goat farm. Medication would be kept under lock and key, and a first-aid kit would also be available. The proposal went on to state that the parents of both children had been consulted and had agreed to the holiday going ahead, and that Resident Z's parents had offered to make a contribution towards the cost of the holiday. The final section of the proposal included the following:

> "We are aware that there are concerns regarding putting two children who have in the past displayed very difficult and anti-social behaviour together. However, there is documentary evidence to suggest that their behaviour has vastly improved over the last year ... Furthermore both children have undertaken many activities together over the last year and have, as a result[,] developed a good friendship."

The proposal is an impressive document, and was plainly the result of thoughtful and detailed planning on the part of Jonathan Teuma for which he deserves considerable credit.

In paragraph 61 of his first witness statement [**E/64/7**] he says that he made it "absolutely clear" to Resident Z's parents that the holiday would need to be approved by management and by Jessica Perez. In paragraphs 62 to 69 he says this [**E/64/7-8**]:

> "62. Having drafted the Proposal in my own time I expected to be able to present it in a meeting with the management of the Home and [Resident Z's] social worker [Jessica Perez] in the hope and expectation that it would be approved. This meeting was scheduled for around 2 months prior to the date of the trip [i.e. around the end of January 2005]. Neither of them turned up for the meeting and so I gave the Proposal to them to look at as I was still eager for the holiday to go ahead for [the two children]. [NOTE: The reference to "two months" was corrected in Jonathan Teuma's second witness statement [**E/69/1**].]
>
> 63. Two months passed and neither I, nor any other team member had been contacted with regard to the Proposal. As the proposed date for the holiday approached, I contacted [Jennifer Perez] on the telephone to ask if it would go ahead. She said that it would not be possible and highlighted some concerns. When I commented that these had been dealt with in our Proposal, she admitted not having read it and said that she had only looked at the photographs. [NOTE: In his second witness statement, Jonathan Teuma accepts that he contacted Jessica Perez the day after he had submitted the proposal.]
>
> 64. Some weeks after the proposed date of the holiday, Joanna Hernandez, manager at the Home, called me to arrange a meeting which was attended by Joanna, Sharon Berini and Stacey McKay. The purpose of the meeting was to give me a verbal warning for having informed [Resident Z's] parents of the trip prior to getting their [i.e. management's] approval.
>
> 65. I was very upset as my intention had only been to do something nice for [Resident Z] and [the other child]. I also believed that it was very unprofessional of Joanna Hernandez to hold this meeting over two months after the date of the Proposal and particularly as it was she who had not turned up to the initial meeting to discuss the Proposal...

> 66. This delay also suggested that the Proposal had not been considered earlier which I found disappointing considering the effort I had put in. I therefore challenged this and Joanna flared up, which led to a heated debate about other issues to do with [Resident Z's] care.
>
> 67. I was particularly concerned by the fact that ... Joanna had changed three of [Resident Z's] carers almost overnight. This brought about a regression in [Resident Z's] behaviour as he had become used to having the same carers and this consistency had [begun] to help him settle down in a more lasting way. It must be understood that three new people had just been thrown into [Resident Z's] life and would now be feeding, washing, putting him to bed and aiding him in the most personal aspects of his life. The fact that no reasonable transition period had been given to phase new carers in and old carers out led directly to a marked regression in his behaviour and quality of life.
>
> 68. After the meeting I was very upset and left in tears as I felt that my efforts in trying to do a good thing for [Resident Z] had been completely and unfairly reversed to look bad on me.
>
> 69. I felt that the real issue here was that management had failed to properly consider the Proposal in good time. The verbal warning therefore came across as [a] way of removing attention from that fact."

Included in the documentation provided to the Inquiry is a copy of a letter dated 4 May 2005 from Jonathan Teuma to Joanna Hernandez, copied to Jessica Perez, Sharon Berini and Kirushka Compson [**D9/142/26**]. The letter is headed in the matter of the proposed holiday. It reads as follows:

> "I am writing to request a written response to the Holiday Proposal I submitted prior to this year's Easter break. It has now been almost 2 months and I have yet to receive any official notice regarding my plans. The dates for the actual holiday are now long gone however I am still interested in Management's feedback and ideas on a possible future holiday.
>
> I contacted J. Perez ([Resident Z's] social worker), the day after submitting the proposal. She informed me that she had not been able to read the proposal but that nevertheless the holiday would not take place due to the proposal coming at too short notice. Here I would like to point out that the proposal is extremely thorough and that had Management and J. Perez read it promptly it would only have taken a short meeting between yourselves, staff and family to iron out any details or incongruities. J. Perez did also say that it was a good idea and that there should be further discussion in the future. When will this take place?
>
> I would like to inform Management that all the planning for the holiday and the composing of the proposal was carried out in my spare time, (approximately 10 to 12hrs of unpaid work) in conjunction with other staff members (including the consultation of seniors) who contributed valuable information and advice. I do not mind doing this in the least, if my efforts are reciprocated. Having my (and other staff's) efforts ignored is very disheartening and can only be to the detriment of the quality of care given at the [Home].
>
> Finally I would like to reiterate my request for written feedback on my proposal as well as an explanation and apology for this exaggerated delay."

There is no evidence that Joanna Hernandez replied to that letter, or that Jonathan Teuma ever received the written feedback he was asking for. As in the case of his previous letter dated 16 February 2005 (quoted earlier) [**M7/8/1**], this letter once again illustrates an intelligent and caring approach by Jonathan Teuma.

In his second witness statement to the Inquiry [**E/69/1**], Jonathan Teuma refers to the occasion described by Joanna Hernandez in paragraphs 361 to 368 of her third witness statement (quoted

above) – an occasion which is also mentioned in the witness statement of Resident X's father, to which I refer elsewhere in this Report. Jonathan Teuma says (in paragraph 6 of his second witness statement) that he apologised to Resident X's father unreservedly for his actions and for any distress which they may have caused him. In paragraphs 7 to 11 of his witness statement he says this:

> "7. This event has been the lowest point in my professional, social and private life. I am deeply ashamed of my conduct on that occasion and I have worked very hard since that time to show my family, friends and peers that it was a one off incident which was wholly out of character and by which I certainly do not wish to be judged in the future.
>
> 8. I never belonged to any team dedicated to [Resident X's] care before or after that incident. My contact with him was through odd shifts via the Respite Service.
>
> 9. I never worked in Goole House and I was never a Senior at any of my places of work. This is borne out by my letter dated 4 May 2005 [referred to below], towards the end of my employment with the Home, where I refer to myself as a Key Worker.
>
> 10. I resigned from my job after the incident by way of a letter although Ms Joanna Hernandez ... claims that she terminated by contract.
>
> 11. She never called me to discuss the issue as she states in paragraph 366 in her statement dated September 2013 or at all. I could never have mentioned that I was awaiting a Court hearing because I accepted a police caution which was voluntarily offered to me by HM Customs on the very morning following my arrest ...."

Findings in relation to Resident Z

Having carefully considered all the relevant evidence on these issues, I accept without qualification the evidence of Jessica Perez and Jonathan Teuma – both as to the condition of Resident Z's flat at Merlot House and as to the standard of care provided for him. I find the evidence of Joanna Hernandez on these issues to be exaggerated to the point of being seriously misleading.

I accept Jonathan Teuma's evidence quoted above, and in particular I find that (contrary to Joanna Hernandez' evidence[739]) she did not dismiss him: he resigned[740]. His evidence that he accepted a police caution is corroborated by documentary evidence provided by the Royal Gibraltar Police [**H/16/25**], which in turn throws doubt on Joanna Hernandez' assertion (in paragraph 366 of her third witness statement (denied by Jonathan Teuma) that he told her that he was "awaiting a court hearing". In the circumstances I accept Jonathan Teuma's denial that he said that.

Jonathan Teuma is, of course, right to acknowledge that the incident in question represents a serious lapse on his part from the standard of conduct expected of any member of the public, let alone of a carer acting in the course of his employment. That said, as I have already indicated I found Jonathan Teuma to be an intelligent and frank witness, with a full appreciation of the needs of residents and of the best way to meet those needs consistently with the level of resources available at the time.

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[739] See para 365 of Joanna Hernandez' third witness statement and her oral evidence at Day 1 page 128 line 10.
[740] This was also confirmed by Marie Gomez: see Day 13 page 100 line 13.

As for the evidence of Emilia Bruzon and her daughter Denise Evaristo, whilst I entirely absolve them of any attempt to mislead the Inquiry, I find that their respective recollections of issues which have arisen from time to time between them and the staff at the Home regarding the care provided to Resident Z have been significantly affected by the tensions which are bound to exist between members of staff and relatives, to the point where I am unable to rely on their evidence save where it is corroborated by other witnesses whose evidence I accept.

Resident AE

The evidence

In paragraphs 259 to 280 of her third witness statement to the Inquiry [**E/67/71**], Joanna Hernandez says this:

> "259. [Resident AE] was 19 or 20 years old. He lived in a self-contained flat at DGH. I had worked with [Resident AE] about 6 years before and when he had first arrived in Gibraltar from a special disability home in Spain. I had been told when I first worked with him that it had been alleged that he had been sexually molested in care in Spain. I was told this by Mrs Annie Risso. She told me this so that I would be aware of it when working with him. [Resident AE] displayed sexualised behaviours. He was autistic and had complex needs. When I had worked with him previously he had been fit and healthy.
>
> 260. Before taking up my post I had read in the Gibraltar newspapers that [Resident AE's] parents had been complaining publicly that they were not allowed to see their son. At the time I found this a bit hard to believe.
>
> 261. I went to see [Resident AE] with the deputy manager, Sharon Berini. When I went to see him in DGH at his flat I was absolutely horrified at his condition. He was wearing nappies. He was unable to eat, walk or talk. His flat was in an appalling state. The doors were broken and had holes [in] them. The light switches were smashed.
>
> 262. On entering the flat I found him sitting at a table with food in front of him. As I watched him, his head fell forward into his plate of food. He had passed out in front of me. I picked up his head out of his food and got the carers to take him to his room. When I went into his room I saw a mattress on the floor with a plastic cover on it, which was badly cracked. There were no bed sheets. The carers laid him on the mattress. I was hit with a very strong smell of urine. There was no other furniture in the room, except for a rack for clothes. There were very few clothes. There was no decoration. There was no window in his bedroom.
>
> 263. The senior of the flat was Craig Farrell. I questioned him about [Resident AE]. I asked why he was wearing nappies, as he had not needed them previously. Craig told me that [Resident AE] was [medically] restrained. This means that he was being given powerful drugs to sedate him, including lithium.
>
> 264. I continued checking the flat. The living area had two [laptop] computers, TV, videos, DVDs and computer games. It became clear that the living area was being used exclusively by the staff. I checked the [k]itchen cupboards. There were no plates, cups or knives and forks. There was no food in the cupboards. In fact the cupboards were full of staff papers. There was no food in the fridge.
>
> 265. I asked Mr Farrell what was [Resident AE] being fed. Mr Farrell told me that they gave him hamburgers from McDonalds and Burger King, because that is what he enjoyed.
>
> 266. I told Mr Farrell that this was completely unacceptable. I told him that this was [Resident AE's] flat and that I required him to immediately remove all of his and his staff's [personal]

belongings from the flat. I told them to begin cleaning the flat. I told him that the kitchen was for [Resident AE]... I told him to call a meeting immediately with the CPN and the psychiatrist. I told him that I wanted to see the drugs that [Resident AE] was being given. I demanded an explanation for the mattress that [Resident AE] was lying on. Mr Farrell told me that Social Services did not want to buy him a bed. I found this hard to believe.

267. I asked Mr Farrell if [Resident AE's] parents visited him. He said no. He said that they were not allowed into the building. He said that they did not help [Resident AE's] behaviour and that his behaviour was difficult after his parents visited.

268. I turned to the deputy manager, Ms Berini, and asked her if this was true. Sharon Berini told me that there had been several incidents with [Resident AE] and his parents and she had stopped the parents coming to the Home.

269. I went to see Marie Gomez (Team Leader) about this and [Resident AE's] flat's condition. Apparently he had not seen his parents for a year. Ms Gomez supported Ms Berini's decision fully, and said that the parents had caused a lot of problems. I asked Ms Gomez if she had ever met [Resident AE]. She said no. I asked her if she had seen the state of his flat and how he was living. She said no. I explained the conditions and asked if the Service would give me the money to bring the flat up to a [liveable] condition. She said no. She said that the Service would provide half the money required to buy a new bed for him and his parents would have to provide the rest of the money. They did allow me to fix the electricity and the doors, as these were so obviously dangerous.

270. I called his parents to ask if they could provide the extra money needed to buy a new bed. They were initially very hostile towards me. I asked them if they could meet with me. They said yes, but they said they would not meet with Ms Berini. I told Sharon what they had said. She said that the parents blamed her for everything. She seemed quite sad. I felt quite sorry for her; due to the way she spoke and described his parents.

271. I called Mrs Annie Risso. I explained the situation. I asked her if she could help by providing furniture, mats and kitchen utensils she could give me from a flat in St Bernadette's. She very kindly gave me a whole lot of furniture and decorations for [Resident AE], including picture frames.

272. Within the first month I fixed up the whole of the flat, put in a proper bed, removed office furniture and the like, put in curtains, installed picture frames of him with his family and friends and essentially converted it into a little home for him. I used some of my own money to get things for him and I also asked people for contributions, which they kindly gave.

273. I met with [Resident AE's] family. They were very angry and very mistrustful. They were very critical of Ms Berini, they said Ms Berini had caused their family a lot of pain. At the time I believed that the parents were exaggerating about Sharon, but I did not say this, as they were so angry. I later came to believe their criticisms of Ms Berini.... [Note: there follows a reference to the evidence of Susan Ignacio, which, as mentioned earlier, she has since withdrawn.]

274. I told [Resident AE's] parents about the actions I was taking for [Resident AE]. I told them that I would ensure that they would see [Resident AE]. They were grateful and were able to provide a little money to help me with the cost of [Resident AE's] new bed (Euro 60).

275. I met with a psychiatrist from KG5 and with a senior mental health officer. I talked about [Resident AE's] care and talked about behaviour management strategies for [Resident AE]. I told them that I was opposed to him being medically restrained all the time. I said that I would be developing a behaviour strategy plan. I said that I wanted him weaned off the drugs.

276. The psychiatrist blamed the mental health officer and said he based his prescriptions upon what he was told by the senior mental health officer. The mental health officer said that he was following the information and advice of Craig Farrell and his team. I asked how often they had seen [Resident AE]. The psychiatrist said he had seen him about twice in the years that [Resident

> AE] was in care. The [m]ental health officer had never seen him in the [H]ome. I asked him to come weekly for observations of patients under mental health care. He did not.
>
> 277. I was not happy with Mr Farrell's care of [Resident AE]. I took this up with Ms Berini. She was adamant that Mr Farrell was the only one who could work with challenging behaviour of [Resident AE's] type. I later learned that Mr Farrell was a very close friend of Sharon Berini. I spoke to Mr Farrell and he assured me that he had been working within the restrictions that were imposed upon him. He said he agreed with my strategies and would work with [Resident AE] in the way I wanted. I took some reassurance from this. Also, we simply did not have the staff to replace him.
>
> 278. I also looked into his care rota. I discovered that Ms Stacey McKay and other women carers were working night shifts with [Resident AE] on their own. I and the Mental Health Officer were very concerned about this. It simply was not safe for a lone female member of staff to be caring for [Resident AE] at night. He was large and strong and displayed sexualised behaviours, it was not safe for a lone female to be with him all night. I changed the rota and I ensured that no women worked with [Resident AE] alone.
>
> 279. [Note: I have already quoted and considered this paragraph in connection with the so-called "punishment room"[741].]
>
> 280. Over time I managed to get him off the drugs. I went to all of his doctor's appointments. I arranged for his parents and sister to be able to visit him. I arranged for carers to take him to his mother's house and outings. His behaviour [improved] dramatically. He no longer needed nappies; he was able to talk a bit. I arranged for him to use a communication tool called "Maketon" language. He could feed himself. I also got him to socialise and eat with other residents."

In her oral evidence[742], in response to questioning by counsel to the Inquiry, Joanna Hernandez referred to Resident AE as having been:

> "... locked up in his bedroom without a window – shit everywhere."

I also have in mind Mandy Spencer's description of Resident AE's weight problem, quoted in Chapter 2 of this Report.

I turn next to the evidence of Craig Farrell.

In paragraphs 10 to 12 of his witness statement in the Inquiry, he says this [**E/14/3**]:

> "10. When I first began working with [Resident AE] he had very severe aggressive outbursts and daily challenging behaviour. Due to this he was assigned two carers to look after him at all times. This was not however implemented as they did not have the available staff and so I worked with [him] often on a one to one basis. I am pleased to say that during my care of [Resident AE], I built up a relationship of trust and his behaviour greatly improved.
>
> 11. In about December 2003, 3–4 months into my position as senior support worker, I was asked if I would assist in the care of a client, [Resident Z,] in addition to working with [Resident AE]. This role included supporting staff that were looking after the client by covering shifts and managing rotas.

[741] See Chapter 9..
[742] See Day 2 page 109 line 24.

> 12. In 2006/7 I was delighted to be given a permanent contract with the Agency as a Unit Manager. I continued to work on [Resident Z's] team as a Senior Support Worker until April 2002 when I was moved to Goole House as Unit Manager."

In paragraphs 31 to 34 of his witness statement [**E/14/6-7**], Craig Farrell addresses Joanna Hernandez' allegations concerning the standard of care provided to Resident AE, saying this:

> "31. Ms Hernandez states on page 5 of Schedule IV exhibited to her [witness statement in the Industrial Tribunal] that Resident AE is "*unable to eat without [his] head touching the table and bumping into walls*".
>
> 32. There was an occasion in about March 2005 when Ms Hernandez contacted [Resident AE's] family and psychiatrist and called a meeting because she felt that [Resident AE] needed more medication. Further to this meeting it was agreed that [Resident AE] would be prescribed more medication. When he was prescribed more medication he began acting very drowsy and lacked coordination and awareness. I raised my concern [with] Sean Matto who was a senior at the time. Mr Matto called a meeting with [Resident AE's] mental health team and asked them to review his medication. Upon review it was determine[d] that [Resident AE] had been over-prescribed and this was immediately rectified. It was concerning at the time to Mr Matto and myself that Ms Hernandez had not requested opinions of [Resident AE's] team and myself.
>
> 33. In relation to [Resident AE] and food the only other episode was at the beginning of my employment with the Agency when I began shadowing his previous carer. [Resident AE] was eating far too quickly and I warned the carer that he had to slow him down. Shortly thereafter [Resident AE] began choking on his food and as the carer panicked, I had to assist him.
>
> 34. Ms Hernandez also outlines on page 6 of Schedule IV that [Resident AE] was sleeping on a urine[-]soaked mattress. This has never been brought to my attention and I am unaware of when this took place."

In his oral evidence, Craig Farrell described Resident AE as being 33 years old, very obsessive and very unpredictable[743], with a voracious appetite ("If you didn't support him with a healthy diet, his weight would just balloon."[744]) and "very complex individual needs"[745]. He described how Resident AE could be violent with members of staff; biting them, spitting at them, and on occasion smearing them with faeces[746]. The important thing, he explained, was to handle Resident AE properly, so as to gain his respect[747].

Asked by counsel to the Inquiry about Joanna Hernandez' allegation in the executive summary of her draft audit report (quoted earlier) [**C1/1/39**] that Resident AE was left "unable to eat without his head touching the table and bumping into walls", Craig Farrell said this[748]:

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[743] See Day 9 page 27 line 22.
[744] See Day 9 page 27 line 8.
[745] See Day 9 page 27 line 25.
[746] See Day 9 line 30 line 10ff
[747] See Day 9 page 31 line 23ff.
[748] See Day 9 page 60 line 25.

> "Not at all, that never happened. .... [I am] very clear [about that], very clear. Not when I have been, not at all when I have worked with [Resident AE], not at all. .... When I first came [i.e. in about 2003] ... he was very heavily medically restrained. .... He used to sleep a lot because he was always wanting to go to sleep ... because that much medication he had, he was ... always dropping off. .... We managed to reduce his medication which then helped me to put behaviour strategies in ... There was one time I can remember where he bumped his head. .... One of the things that our gentleman friend does, AE, and he is a little tinker, what he does, if you give him his food, ... [he was eating too fast]. The gentleman who I worked with at the time was a care worker and I said to him: "Watch him, keep an eye on him", and he ended up choking on a bit of food, and his head fell forward and of course nothing happened but it was just a split second, but that's the only time I have ever seen him fall forward. But I have never seen him bumping into walls, [apart from one occasion when] he was over-medicated[749].

As to the allegation on the following page of Joanna Hernandez' draft audit report that Resident AE was "sleeping on a urine-soaked mattress", Craig Farrell said this[750]:

> "You need to see the larger picture here. When I first arrived at Dr Giraldi's [Resident AE] ... was living in the community at Merlot House, [and] the neighbours couldn't wait for [him] to go because he constantly screamed, upsetting all the neighbours. So the Government ... needed to get him back to Dr Giraldi's. But I believe at the time there was a lot of water damage, so round about I think July, September, August, we moved him back to Dr Giraldi's. I was part of that move ... because it was quite difficult for him. .... [Social Services had purchased for him] a single bed which was covered in ... PVC. It was made for him purposely, so he couldn't rip it and damage it. ... So that was one of the first things that had gone and changed when we could, and we bought him now a double bed. .... But the mattress, I've never ... urine-soaked? Never, never. Because one of the things with people with difficult behaviours in the community – ... one of the most important things – is they have to be looking like clean-shaven, smelling ... [So] that [is] something never, never – that's never, not that I've seen, never. Soaked mattress[?] No."

Asked by counsel to the Inquiry what he would do with Resident AE when he was behaving particularly badly, Craig Farrell replied[751]:

> "It's unfortunate for him, but if you visited his bedroom ... there [are] not many things in it, ... because what will happen is with one of his outbursts ... he could throw it at you or he would definitely pick it up and smash it on the floor. So his room is quite sparse. That's why we like to get him out a lot and get him into Spain, because in that different environment it will calm him. .... Definitely, his bedroom would be his time[-out] room. .... But ... on time-out, you would ask him, it would be voluntary by himself. You wouldn't be locking him in time-out. You would ask him and get his support. "Come on, come on." And you would sit with him if you could. If you couldn't, you would stay outside his room. Now sometimes you can't sit with him. You have to sit out [i.e. outside his room] because unfortunately you have your health and safety as well ..."

Asked by counsel for the Inquiry whether he recalled Joanna Hernandez asking him about Resident AE, and whether Resident AE was wearing nappies, Craig Farrell replied[752]:

> "I've known [Resident] AE for ... ten years ... and he has never worn a nappy. That's news to me ... since I got the [witness] statement. He has never worn a nappy. In fact, I think if you put something like that on him he would rip it off."

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[749] Asked by counsel to the Inquiry whether that was corrected, he confirmed that it was: Day 9 page 62 line 19.
[750] See Day 9 page 63 line 1.
[751] See Day 9 page 65 line 10.
[752] See Day 9 page 68 line 22ff.

As to the allegations in paragraphs 264 and 265 of Joanna Hernandez' witness statement, Craig Farrell had this to say[753]:

> "Again, I'm going to explain ... myself. TV, videos and computer games, those could be weapons and they could be thrown or smashed on the floor, so they would not be in his living area. [As to the suggestion that there were no plates or cutlery] ... they are certainly going to be there. There is no way I am going to sit down with the gentleman for dinner and not have any [cutlery ... that's not true at all, sir, no. And I would never feed him McDonalds, [or] Burger Kings because at one stage, and you can ask the parents, he went right up to 135 kilos, because that is the only way they could control him, sir...."

He denied that Resident AE was being fed on takeaways, saying[754]:

> "Not at all, not at all. Now and again you might take him out as a special treat, and if he was walking at night, if his behaviour was a bit difficult for night staff, they might walk him and take him out for a drive and then on the way back purchase a takeaway and have it with him, but that might be once a fortnight or once a week if you are lucky, due to his weight, because it [i.e. his weight] is something we have got to support him with and help him with."

Asked whether he recalled Joanna Hernandez inspecting the flat and finding the mattress soaked with urine, Craig Farrell replied[755]:

> "No I don't, and I am a little bit surprised as well. .... Because the thing that I can recall with Mrs Hernandez was on several occasions when AE would come out of his house along the balcony, which you have to walk right along to go out to the main car park, and he bangs on the windows, and I have always got to place my hand on the window .... He used to see Mrs Hernandez and she immediately went for the office and locked the door, and he used to go past and hold the door because he knew that Mrs Hernandez wasn't too keen on him, and he used to play [those] kind[s] of games. So I am very surprised that he was there when this conversation was going on because she didn't really ... get involved with him that much."

When reminded that Joanna Hernandez' evidence in her witness statement was that she came to inspect the flat in the company of Sharon Berini, Craig Farrell replied[756]:

> "If that's what she said, I am definitely not aware of that. I wasn't there. If she said I was there, I wasn't there."

As to paragraph 277 of Joanna Hernandez' witness statement, Craig Farrell said he had no recollection of the conversation in question[757].

As to Joanna Hernandez' allegation (in paragraph 310 onwards of her third witness statement [**E/67/85**]) that he was a member of a clique which was undermining her authority, Craig Farrell denied this. He went on[758]:

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[753] See Day 9 page 69 line 12ff.
[754] See Day 9 page 70 line 11ff.
[755] See Day 9 page 73 line 4ff.
[756] See Day 9 74 line 2.
[757] See Day 9 page 75 line 1.
[758] See Day 9 page 76 line 22.

> "I can assure you I ... definitely would not do that. I'm not a type of person who would [act] like that, and the type of gentleman, AE, that I work with is so demanding that I wouldn't have time. .... That's not true at all: no, no."

Findings in relation to Resident AE

I accept Craig Farrell's evidence without qualification, and I reject as untrue the evidence of Joanna Hernandez wherever it conflicts with his evidence. I find that the staff (and in particular Craig Farrell) were doing their very best to cope with Resident AE's challenging behaviour, and to provide him with as full and independent a life as possible, consistently with his disability (including his weight problem) and given the resources available.

CARE PROVIDED TO RESIDENTS GENERALLY AND IMPROVEMENTS UNDERTAKEN BY JOANNA HERNANDEZ

I turn now to the other criticisms, complaints and allegations made by Joanna Hernandez in her third witness statement to the Inquiry about the standard of care provided to residents (including respite users) in 2005, and to her evidence of improvements which she attempted to make or succeeded in making.

In paragraph 104 of her third witness statement [**E/67/35**], Joanna Hernandez says that she was astonished to discover that "medication for residents was being dispensed out of pill boxes by untrained carers". There were undoubtedly continuing problems to be addressed in relation to the control and dispensing of medication (as evidenced by the reports of the social workers in late 2005 and early 2006 to which I refer later in this Report). I return to the issues relating to medication in Chapter 11 of this Report.

In paragraphs 189 to 192 of her third witness statement [**E/67/54-55**], Joanna Hernandez says that she arranged for Resident A to be placed in a flat at Goole House, and that he benefited greatly from that arrangement. In paragraphs 190 to 199 of that witness statement she describes how she succeeded in obtaining a 9-seater van for the use of the Home. I have no reason to doubt that evidence. That said, these were just the sort of constructive improvements which any Manager would have been expected to strive for. The fact that she achieved such improvements does not reflect in any way on the rest of the staff at the Home.

In paragraphs 200 to 203 of her third witness statement [**E/67/57-58**], Joanna Hernandez accuses Sean Matto of having acted contrary to her "explicit" instructions in arranging for Resident T to be admitted to King George V Hospital at a time when she (Joanna Hernandez) was absent on special leave. Having seen and heard Sean Matto give evidence, I am satisfied that he would not have acted contrary to explicit instructions given to him by Joanna Hernandez. I find that no explicit instruction to that effect was given to him: had it been, he would have complied with it.

In paragraphs 206 and 207 of her third witness statement [**E/67/59**], Joanna Hernandez refers to a lack of security at the premises. This was a concern which was also addressed in the reports of the social workers, to which I refer later in this Report[759]. I accept that it was a legitimate concern when Joanna Hernandez took up her post as Manager, but I note that, according to the social workers, it remained a concern in early 2006, after Joanna Hernandez had left.

In paragraphs 208 and 209 of her third witness statement [**E/67/59-60**], Joanna Hernandez raises concerns as to the diet offered to residents. She also describes an occasion when she discovered members of staff eating food which was intended for residents. As to the diet offered to residents, I am satisfied that it was unobjectionable, given the level of resources available. As to the allegation that members of staff ate food intended for residents, whilst it is possible that this may have occurred occasionally, I am satisfied that there was no general practice or culture to that effect. In any event, whenever a Manager became aware of such an incident, it would be within the day-to-day remit of that Manager to take the necessary steps to ensure that such an incident did not re-occur. There is no evidence of any Manager having failed to do so.

In paragraph 212 of her third witness statement [**E/67/60**], Joanna Hernandez says that she discovered that residents were not registered with a GP, and that some residents had dental problems. As to that, I am satisfied that the health needs of residents were adequately met, including arranging for medical treatment (or dental treatment) whenever such treatment was reasonably required.

In paragraph 217 of her third witness statement **E/67/72**], Joanna Hernandez says that she set up a procedure for the monitoring of the use of residents' clothing allowances, and that she arranged for more suitable clothing to be provided to Resident J. In paragraph 219 she describes how she arranged for improved care for Resident E. Again, these were matters which would have fallen within her day-to-day remit as Manager.

In paragraph 224 of her third witness statement [**E/67/64**], Joanna Hernandez says that Resident AB (who is physically disabled) needed help to move around her flat. She goes further, saying: "None of the flats were [sic] adapted for disabled people." As to that, I am satisfied that as a matter of policy succeeding managements attempted to achieve improvements of the physical facilities at the Home, consistently with the level of resources available.

In paragraphs 234 and 235 of her third witness statement [**E/67/66**], Joanna Hernandez points out that the fire alarm system at the Home was faulty, and in paragraph 304 of that witness statement she says that she managed to get a new fire alarm system installed in the Home. I have no difficulty in accepting that evidence, but I reject her evidence (in paragraph 235) that Yvette Del Agua refused to take account of safety considerations. I have no doubt that safety considerations would be uppermost in Yvette Del Agua's mind in any discussion about upgrading the fire alarm system at the Home.

[759] See Chapter 11.

In paragraph 257 of her third witness statement [**E/67/71**], Joanna Hernandez says that she discovered that "staff had been taking different residents to Spain without permission", and that she "took all residents' passports and kept them in the safe in the Manager's office". If the procedures for taking residents to Spain needed tightening up (and it appears that they did), that was a matter for the Manager to deal with. However, it does not follow that any resident suffered from any laxity in the existing procedures.

In paragraph 287 of her third witness statement [**E/67/79**], Joanna Hernandez says this:

> "287. It is hard to describe properly how poor the level of care was and the complete lack of management, planning or organisation was. There did not appear to be any plan at all regarding the running of the Homes, the care of the residents. It was overwhelming."

This is yet another attempt by Joanna Hernandez to depict the Home in its worst possible light. The true position appears, in particular, from the reports and evidence of Debbie Guinn, to which I refer in detail later in this Report. As for the alleged lack of plans and policies, the booklet of Milbury policies was provided to her at an early stage in her managership.

I can well believe, however, that Joanna Hernandez was "overwhelmed" by the demands of her job, but I regard that as a reflection on her own ability and attitude rather than on the challenges which she faced as Manager.

In paragraphs 294 to 307 of her third witness statement [**E/67/81-84**], Joanna Hernandez lists a number of improvements which she made or attempted to make. In so far as these paragraphs contain criticisms of the care provided to Residents Z and AE, I reject that evidence. I also reject the implication in paragraph 302 [**E/67/83**] that there was some general culture among staff members of excluding relatives of residents from visiting the Home. That said, I accept her evidence:

- that she attempted to improve the physical facilities at the Home (including its associated premises);
- that she took steps to ensure that the diet provided to Residents and respite users was satisfactory;
- that she introduced a system of visitors' books designed to keep track of who was visiting the Home;
- that she introduced restrictions on the extent to which members of staff could invite guests into the Home;
- that she instituted regular group meetings with relatives of Residents and respite users;
- that she arranged for the installation of a fire alarm system at the Home's premises at Smith Dorrien Avenue;
- that she ensured that Residents' passports were kept secure in a safe in the Manager's office; and

- that she lobbied for the installation of air conditioning units and for the replacement of Perspex windows with glass panes (improvements which were made after she had ceased to be Manager).

As to Joanna Hernandez' evidence that she "developed care programmes for all of the residents" (see paragraph 295 of her third witness statement [**E/67/81**]), I accept that she attempted to collate material relating to the care of Residents and respite users, but I reject that evidence in so far as it is intended to refer to formal "care plans" properly so called (as described by Debbie Guinn in her evidence). Such care plans only came into existence after Joanna Hernandez had ceased to be Manager.

I do not accept Joanna Hernandez' uncorroborated evidence (see paragraph 296 of her third witness statement [**E/67/81**] that she arranged for carers to help with the homework of Residents L and Z. There was no reference to this in the evidence of other witnesses, and there would have been potential difficulties in such an arrangement given that a number of the carers spoke little English.

In paragraph 297 of her third witness statement [**E/67/82**], Joanna Hernandez makes certain criticisms of Nigel Bassadone's care of Resident L. I reject those criticisms. I also reject her associated assertion (in paragraph 300 of her third witness statement [**E/67/82**] that she "ensured that all residents were taken on age appropriate outings" in so far as it suggests that residents had previously been taken on outings which were "age inappropriate". There was no reliable evidence that that had ever occurred.

In paragraphs 310 to 315 of her third witness statement [**E/67/85-86**], Joanna Hernandez says this:

> "310. I later learned, over a period of time, that there were a number of very poor staff who were undermining the management of the homes and care of the residents.
>
> 311. It became clear to me that the problems lay almost completely with the senior staff, including the deputy manager (Ms Berini) and the seniors of the flats, Nigel Bassadone, Sean Matto and Mr Craig Farrell. A number of them were also union representatives.
>
> 312. The deputy manager and the seniors of the flats were the people that I had to rely upon for the on the ground day to day (and nightly) management of the carers and residents.
>
> 313. It became clear to me over the months that the deputy manager and seniors were undermining the management of the home, bullying their teams and dragging down the standard of care of the home.
>
> 314. Over time I came to the realisation that they were working together to undermine the working of the Home and to suppress any criticism of themselves and each other.
>
> 315. A very good example of how this finally manifested itself clearly [was] in April or [M]ay 2005. I felt that the staff were not being effectively used for the care of residents. For example, Nigel Bassadone was the senior and his carer for [Resident L] and was responsible for him from 8am – 8pm. However, [Resident L] was at school from 9am till 3.30pm. Thus Nigel only had to work for 4 hours out of a twelve-hour shift. There were many such examples of poor use of

> staff. I made many attempts to improve the rota system, however, I discovered over time that Sharon Berini (deputy manager) was constantly undermining the rotas I established."

I reject the allegation that Sharon Berini and other members of staff were "undermining the management of the home, bullying their teams and dragging down the standard of care in the Home". The evidence is to the contrary. I find that Sharon Berini and the senior members of staff at the Home were doing their best to maintain standards of care at the Home. Nor is it right to say that the problems at the Home "lay almost completely with the senior staff"; and the fact that some of them may have been Union members is of no relevance. As to the conspiracy theory advanced in paragraph 314 above, I reject that too. To say that members of staff were "undermining the working of the Home and to suppress criticism of themselves and each other" is to distort the truth. Moreover, the fact that Joanna Hernandez clearly considered that staff could be "more effectively used" (see paragraph 315 above) provides no support for that allegation. As for the example which she gives in that paragraph, in his oral evidence Nigel Bassadone denied that he only worked four hours out of his shift. In answer to questions from counsel for Joanna Hernandez he said this[760]:

> "I can guarantee you that those hours from 9 o'clock to 3.30 were always used effectively, either cleaning up the house or his house, you know, putting all the washing, medications, whatever."

I accept that evidence.

In paragraph 319 of her third witness statement, Joanna Hernandez says this:

> "319. The key point is that, at the time I took up post the Homes[761] had been allowed to fall into an appalling physical state. There were no management practices or policies in place at all. The culture of care of the residents had gone through the floor. The Homes had become the offices and personal areas of the staff, particularly the [senior] staff; rather than the homes of the residents. The Homes were heavily understaffed. The junior staff, who did most of the work, but had least power were completely disempowered and frightened to complain or speak up, as they had no one to speak up to. They believed that if they did speak up about practices at the Homes they would be punished."

Much of the evidence in that paragraph is repetitious, but I should comment on the reference to junior members of staff being afraid to complain to management. In the first place, it would be only natural for any member of staff considering making a complaint against another member of staff to feel a degree of reluctance before doing so. However, if and to the extent that junior members of staff may have felt apprehensive about doing so, it was for the Manager to rectify that situation by promoting harmonious relationships amongst the staff. As explained later in this Report[762], by her June 2005 "investigation" Joanna Hernandez did precisely the opposite.

It is also to be noted that the contemporary documentation does not record Joanna Hernandez as having expressed her views as to the situation in the Home in early 2005 in anything like such extreme terms as those which she uses in paragraph 319 of her third witness statement (quoted

[760] See Day 7 page 181 line 1.
[761] A reference to all the premises which together comprised the Home.
[762] See Chapter 10.

above). On the contrary, on 2 March 2005 Joanna Hernandez was sufficiently sanguine about the situation in the Home to ask Marie Gomez if she could be allowed a period of study leave [**E/21/17**].

In paragraphs 338 to 344 of her third witness statement, Joanna Hernandez refers to what she describes as "a culture of highly unprofessional conduct" among members of staff, naming in particular Sharon Berini. This is echoed in paragraph 351 of the witness statement, where Joanna Hernandez says that there was "a very unhealthy and unprofessional atmosphere within the Home which derived in part from the significant family and close friendships and relationships within the Homes". However, it was only to be expected that relationships (whether family relationships or other relationships) should exist between some members of staff, and I am satisfied that there was nothing untoward, still less "unprofessional" in the existence of such relationships.

In paragraph 349 of her third witness statement, Joanna Hernandez refers to the practice of carers sometimes taking residents to visit their own homes (a practice which has since been terminated). There is evidence that that did indeed happen in 2005, but, as I said earlier[763], I am satisfied that the carers in question were acting in good faith in what they believed were the best interests of the residents concerned. Thus, in her oral evidence Jennifer Garrett described how she would take Resident L to her own home, saying this[764]:

> "We were very, very close with him. We worked with him for a long time. He liked being involved with you. So it was just me and him. I am a single mum, so when I am working my daughter is not there, he would come. He would make his food in my house. He would borrow some of the DVDs that I've got there. I lived in Spain at the time so we would go over to Spain to do shopping, or we would go over and I would take him to the horse stables and things and then we would come back to mine and we would have dinner there and I would take him home ready for ... the changeover to the night- time carer."

Joanna Hernandez goes on to suggest that carers took residents to their own homes so that the carers could do housework during their working day. I regard that allegation as a slur on the good intentions of the carers concerned, and I reject it.

To the extent that I have not specifically referred to any allegation by Joanna Hernandez in her third witness statement relating to the standard of care provided to residents at the Home in 2005, I make it clear that I regard such allegations as established only to the extent that it is directly and clearly corroborated by other witnesses whose evidence I accept, including in particular by the evidence and reports of Debbie Guinn. The reason for this is that, as appears from the preceding pages, I regard the entirety of Joanna Hernandez' evidence, both written and oral, as inherently unreliable.

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[763] See Chapter 7.
[764] See Day 8 page 122 line 12.

CHAPTER 10: Joanna Hernandez' 'investigation' – Its aftermath – The decision not to renew Joanna Hernandez' contract

Contents

CHAPTER 10: *Joanna Hernandez' 'investigation' – Its aftermath – The decision not to renew Joanna Hernandez' contract*

As noted earlier, in her oral evidence to the Inquiry Joanna Hernandez accepted that initially she got on well with Sharon Berini[765]. However, as I have already found[766], their relationship began to break down following the staff meeting held in April or May 2005 (when Joanna Hernandez made changes to the personnel on the various teams). That breakdown culminated with the "investigation" which Joanna Hernandez carried out in June 2005, and which resulted in the 2005 statements referred to earlier in this Report[767]. The circumstances in which this occurred were as follows.

On 4 June 2005 Sharon Berini wrote two letters to Joanna Hernandez [**C1/1/54** and **55**]. On 6 June 2005 she wrote a further letter to Joanna Hernandez [**C1/1/56**]. She left the letters on Joanna Hernandez' desk, but Joanna Hernandez apparently did not discover them until some days later.

Each of the letters indicates, on its face, that it was copied to Isabella Tosso and Marie Gomez. However, as Sharon Berini explained in evidence to the Inquiry[768], she did not in fact send copies to them as she was waiting to hear from Marie Gomez whether that would be the appropriate procedure for her to adopt.

In her oral evidence to the Inquiry, Joanna Hernandez accused Sharon Berini of having deliberately hidden the letters under some other papers, rather than handing them to her[769]: an insinuation which she had earlier made in paragraph 37 of her 2006 witness statement [**C1/1/6**]. I find that accusation to be unfounded. There would have been no sensible purpose in Sharon Berini writing letters to Joanna Hernandez and then attempting to prevent those letters from reaching her. The fact that Joanna Hernandez saw fit to make such an accusation does, however, demonstrate the depth of her mistrust of Sharon Berini. I find that by June 2005 Joanna Hernandez perceived Sharon Berini as a threat to her authority and to her position as Manager, and that this perception not only shaped and coloured her attitude towards Sharon Berini but also distorted her judgment in her dealings with her – the June 2005 "investigation" being a prime example of that.

In the longer of Sharon Berini's two letters dated 4 June 2005 [**C1/1/54**], she expressed a concern at the lack of availability of senior staff at weekends to supervise the activities of junior

[765] See Day 1 page 119 line 24.
[766] See Chapter 8.
[767] See in particular Chapters 2 and 3.
[768] See Day 8 page 65 line 15, Day 8 page 66 line 22 and Day 8 page 67 line 6.
[769] See Day 1 page 135 line 20 and Day 2 page 125 line 11.

members of staff, expressing the view that this placed the service "at risk". She also asked Joanna Hernandez for guidance as to the obligations of members of staff who were on call.

In her other letter to Joanna Hernandez dated 4 June 2005 [**C1/1/55**], Sharon Berini asked that the on-call telephone phone be replaced as soon as possible, as it had not been working properly. She considered this to be important, especially as:

> "... we now do not have senior members of staff to take control of any [incidents] that may occur over the weekends."

In her letter to Joanna Hernandez dated 6 June 2005 [**C1/1/56**], Sharon Berini expressed her concerns about what she saw as a serious deterioration in staff morale. In the course of that letter, she said this:

> "... I feel that staff morale is at an all time low and the recent levels of sickness will reinforce this. This is worrying me as staff will not be giving their all to the residents and services [sic] users.
>
> Many changes have occurred over the last 6 months or so, as well as 5 interdictions, and numerous resignations and terminations of contracts. This has obviously contributed to staff being [de-motivated] and [demoralised].
>
> Consequently my recommendations are that we try to resolve this as soon as possible by having various team building sessions or [workshops]. The benefits of this will be that staff can get together with management have fun and learn all about what makes a team a failure and what makes a team a good one. This will of course benefit us as managers as well as the service users and the [SSA].
>
> The successful organization is one in which individuals work harmoniously in groups to achieve set objectives.
>
> I sincerely hope that you take note of this and that we can discuss it further. ...."

On 8 June 2005 an informal supervision meeting took place between Marie Gomez and Joanna Hernandez, at which Joanna Hernandez expressed her concerns about Sharon Berini's attitude and conduct. I have earlier noted that in her oral evidence to the Inquiry Joanna Hernandez went so far as to describe Sharon Berini's conduct (without any rational basis for doing so) as "sabotage, sabotage, sabotage everywhere"[770].

The minutes of the meeting on 8 June 2005 [**E/25/42**], which were prepared by Marie Gomez and signed by Joanna Hernandez[771], recorded that Joanna Hernandez was:

> "... very distressed because of staff's attitude."

The minutes went on to record that a meeting was subsequently held with Isabella Tosso, who:

> "... directed both TL [i.e. Team Leader] and Manager on how to resolve problems."

[770] See Day 1 page 147 line 22.
[771] See the evidence of Marie Gomez at Day 13 page 63 line 9ff.

The minutes continued as follows:

> "Manager to instruct staff to do whatever work she feels is necessary if they fail to do so bring up matter in supervision. If not resolve[d] then [take] to 3rd person nominated.
>
> If manager finds out that deputy is intentionally demoralising staff with her criticisms then she should proceed to disciplinary procedures."

Sharon Berini's non-contentious, indeed constructive, letters to Joanna Hernandez provoked an uncompromising and combative response from Joanna Hernandez. In a letter to Sharon Berini dated 10 June 2005 [**C1/1/58**], Joanna Hernandez said this:

> "I am taken somewhat aback by your decision to write to me directly within the space of two days, with copies to Marie Gomez and Isabella Tosso, when two days before we had our regular management meetings in which you could have raised issues of genuine concern for team discussion and resolution as opposed to this individualised approach on your part.
>
> I am therefore obliged to reply to the points you raise in the sequence you have adopted."

As to the on-call telephone, Joanna Hernandez pointed out that a request had already been made for mobile phones, and suggested that in the meantime Sharon Berini should make regular checks of the existing telephone to ensure that she had coverage and was contactable.

As to the lack of availability of seniors at weekends, Joanna Hernandez' response was in much stronger terms. I set it out in full:

> "This was a management decision that was taken, and in which you were present, because of the poor service and problems that have become evidently clear to me and others and the impact upon the service and its resources. I am not sure, because you do not expressly say so, whether you are advocating a return to the system under which you formerly managed the service.
>
> If you are, I believe that you have made a serious error of judgment at this stage that would only serve as a retrograde step to all the good work and effort that has been devoted to improving the service and one that only compounds the mistakes of the past. This I am not prepared to do and my concern is to ensure risk avoidance and management within the current system.
>
> If your dilemma relates to your own personal circumstances and whether you can manage the responsibilities of the on call supervision service that has replaced former practices with seniors, I am glad you have raised the issue early on for discussion and only point out at this stage that the service has very limited options to accommodate you in this respect without undermining its operational policy and efficiency.
>
> I can only refer you to the written "On Call Responsibilities" guidelines with which you are familiar and refer you to the second paragraph which states, inter alia, that "*The On-Call person will ... also be available for duty if they deem it necessary*". It may well be that you are unable to discharge these responsibilities without compromising them in view of your own access arrangements over your children.
>
> I note your expression of unease, as deputy manager, but I am unable fully to assess for myself the basis upon which you say so. You fail to identify those members of staff you may have spoken to and the feedback you may have received, if any. It would have made more sense, in accordance with established CEO procedures, that staff grievances should be accurately recorded, brought to the immediate attention of myself and raised within management meetings for a full

> objective evaluation by senior management as opposed to subjective assumptions that may or may not be justified.
>
> I see no merit in your suggestion, unless this is what staff members you may have spoken to have specifically told you, that there is a justifiable link between low staff morale and 3 interdictions and two suspensions which the Agency, at the highest levels, has deemed necessary and justified in the interest of the service. Resignations are a personal matter for those that wish to exercise their right to do so and terminations of employment are considered on their own facts and circumstances.
>
> I am very concerned that you seem to associate yourself with "negative feedback" from your contact with staff members, when you have been fully acquainted with all the facts and issues that have forced changes to a service that otherwise threatened to perpetuate itself risking vulnerable adults, the actual service provided, the reputation of the service, poor administration with no proper checks and accountability of staff members and practices, and risking the resources available for the welfare of service users.
>
> Unfortunately, I detect an unexplained sense of resistance on your part to the service's renewed objectives, the establishment of a proper standard system, and directives from the CEO and Team Leader. It is my responsibility to manage the service under the direction and guidance of senior management within the Agency, who are ultimately responsible to the Minister for Social Services in turn responsible to the public. Whilst I am open to constructive suggestions and criticisms, in relation to all matters affecting the service, I am not prepared to feel undermined by you in this fashion.
>
> In particular I now feel, having seen and heard from first hand from service users, staff members, parents and liaising professionals, that your former management of the service left a lot to be desired and I am not prepared to be burdened by it directly or indirectly or unresolved personal issues that you may harbour over them.
>
> Staff appraisal procedures had already been forwarded to the Team Leader for consideration within the Staff Training & Strategy Group and expect implementation shortly."

The next day (11 June 2005) Joanna Hernandez wrote a further letter to Sharon Berini [**C2/5/35**] referring to a report which Sharon Berini had written concerning a visit by a resident to a heart specialist in Cadiz in April 2005. It appears that there had been a degree of confusion as to which member of staff was to accompany the resident on that visit, for which Sharon Berini, as the member of staff on call at the time, had taken full responsibility. In her report of that incident, however, Sharon Berini had also expressed concern at the fact that Joanna Hernandez had telephoned her at home on a number of occasions when she was not on call. Sharon Berini had gone on to say that she did not consider that she should be held "accountable" for telephone conversation which had taken place in her spare time.

In her letter to Sharon Berini dated 11 June 2005 [**C2/5/35**], Joanna Hernandez accused her of having (among other things) "failed to report the truth" of the incident in question. She went on:

> "I strongly felt at the time that you had deliberately placed me as the Manager, Dr Giraldi's reputation and service in a precarious situation at a political and professional level whatever your motivation and you wish to be adeptly unaccountable for. On the basis that you did not even mention any of the above. (sic)"

Joanna Hernandez handed her two letters to Sharon Berini on 17 June 2005.

In the meantime, over the weekend of 11/12 June 2005 Joanna Hernandez, Denise Hassan, Gabrielle Llambias and Stacey McKay contacted a number of members of staff (including supply workers) and invited them to attend at the Home to make statements expressing their concerns about the operation of the Home, and, in particular, any complaints they might have in relation to Sharon Berini and/or Nigel Bassadone.

Gayle Everest said, in the course of her oral evidence[772], that she was asked to provide information relating to Sharon Berini[773]; that she did not have very much information to give; and that she had provided what information she had. As noted earlier, she acknowledged that her June 2005 statement did not disclose "anything terribly serious"[774].

Some of the members of staff who were contacted, including Manuela Adamberry, Kirushka Compson, Craig Farrell and Matthew Turnock, declined to provide statements.

Manuela Adamberry said, in the course of her oral evidence[775]:

> "They called me to make a report against Sharon Berini and Nigel Bassadone, and I refused to do that because I hadn't seen anything and I didn't know anything. [That was] the first time. .... [T]he second time, Gabrielle Llambias rang me, sort of like bullying me, intimidating me, [saying] I had to do this report against Nigel Bassadone. I said to her that I [had] already said it once before, that I hadn't seen anything and I didn't know anything, and I couldn't do what they asked me to. And [on] the third occasion, Mrs Joanna Hernandez sent me a letter asking me to say something against Nigel and Sharon, and I again said "No, and don't bother me any more".

Counsel for Joanna Hernandez then put it to her, on instructions, that Joanna Hernandez denied ever having written such a letter. Manuela Adamberry replied[776]:

> "She sent me a letter. I opened the letter. I saw who it was from, so I tore it up and threw it away."

I accept Manuela Adamberry's evidence.

In the course of her oral evidence, Kirushka Compson was asked whether she was aware of any friction between Joanna Hernandez and any other members of staff. She replied that she was aware that there was (as she put it) "a bit of confliction". She went on[777]:

> "I was called in as well to do a statement ... by Denise Hassan."

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[772] See Day 11 page 22 line 10ff.
[773] Gayle Everest's June 2005 statement, which is addressed to Joanna Hernandez, begins: "As per your instructions on Saturday 11th June 2005, please see below a list of complaints from myself regarding Miss Sharon Berini" [**C2/2/40**].
[774] See Day 11 page 22 line 24.
[775] See Day 10 page 35 line 3ff.
[776] See Day 10 page 36 line 13.
[777] See Day 9 page 134 line 16ff.

She confirmed that Denise Hassan had asked for a statement relating to Sharon Berini and Nigel Bassadone, but she said that she had never seen anything untoward, so she was unable to write such a statement[778]. She went on[779]:

> "She actually phoned me at home and they were saying they were actually collecting information about incidents [involving] Nigel and Sharon, but as I had never seen anything [I said that] I won't be able to help her with that."

I accept Kirushka Compson's evidence.

Craig Farrell said, in the course of his evidence, that he had been approached by Stacey McKay to make a statement in relation to Sharon Berini. He went on[780]:

> "I was asked, I was approached by a young lady, Mrs McKay, to write a report on Mrs Berini, and when I asked why, but I think she saw the reaction of me, and ... just left me alone, so I never heard anything of it. But I knew there was people trying to get everybody to write reports against Mrs Berini. I was aware of it, but ... I don't get involved in politics ..."

Asked to explain what the requested statement was to relate to, he replied[781]:

> "Any bad practice I had seen Sharon Berini do, and I hadn't. I hadn't seen anything ... with Nigel, I had never seen that ... I didn't particularly get into conversation with it because Stacey, Mrs McKay, realised that with my reaction, because I was quite surprised, because the year before we had been on a clients' holiday together, and I was a bit surprised ... I didn't expect that of Mrs McKay... I was a bit taken aback."

He went on to confirm that what Stacey McKay asked him for was a statement about any bad practice on the part of Sharon Berini, as opposed to a statement as to Sharon Berini's conduct generally[782]. He continued[783]:

> "She was quite insistent [as to what] she wanted, but she realised then, ... when she had seen me, ... that I wouldn't do that."

Asked to explain what Stacey McKay was insistent about, he said this[784]:

> "That she was – that Nigel and Sharon Berini ... were together, they was like seen together and he had done this and he has been – and I just didn't really listen. .... I'm a bit shocked with it all, really. That's the only thing I can tell you ..."

I accept that evidence of Craig Farrell.

Matthew Turnock says this, in paragraph 144 of his witness statement [**K/1/34**]:

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778 See Day 9 page 135 line 3.
779 See Day 9 page 135 lines 7-10.
780 See Day 9 page 43 line 17ff.
781 See Day 9 page 45 line 5ff.
782 See Day 9 page 45 line 14ff.
783 See Day 9 page 45 line 22ff.
784 See Day 9 page 46 line 2ff.

> "144. .... Mrs Hernandez at this time [June 2005] approached me twice and asked if I would make a statement against Ms Berini. She wanted me to say that I felt bullied by Ms Berini and that I did not receive the care I needed from her. I point blank refused as this was not the case. In fact I felt bullied by Mrs Hernandez in her approach."

In paragraph 145 of his witness statement [**K/1/34**] he says that two further members of staff had told him that they had been approached to provide statements "against Ms Berini" but had refused to do so.

I accept that evidence of Matthew Turnock.

However, a number of members of staff did attend at the Home over that weekend. This led to the making of the June 2005 statements reviewed earlier in this Report[785].

In a letter to Joanna Hernandez written on 29 July 2005 [**E/26/10, C2/5/38**] (but wrongly dated 29 August 2005) which she exhibited to her witness statement in the Industrial Tribunal, and which she invited the Industrial Tribunal to treat as part of her evidence, Sharon Berini described the process which Joanna Hernandez had undertaken over that weekend in the following terms:

> "From Saturday the 11th June and out of working hours [Joanna Hernandez and Denise Hassan, among others] were all involved in calling staff members into the office either using the office phone ... or their personal mobiles. All of these staff members were told that the meeting was highly confidential and they could not discuss with their family members. Some staff were even told to use the back entrance into the building so that they would not be seen and that they were holding an investigation against me as directed by the CEO of the [SSA]. Staff were then asked if they had seen me doing anything that they did not like and if they had ever felt bullied, abused or intimidated by me in anyway [sic], staff were asked to go as far back as they could remember in my 8 year working history within Dr Giraldi's of anything that they had seen that I had done wrong also involving Nigel Bassadone."

Sharon Berini confirmed this account in her evidence to the Inquiry[786]. Notwithstanding that this is hearsay evidence, it was not challenged and I accept it as true.

All this was done, and deliberately done, behind the backs of Sharon Berini and Nigel Bassadone. It was a covert exercise, orchestrated by Joanna Hernandez and designed to elicit enough material critical of Sharon Berini – and her former partner Nigel Bassadone – to support a campaign by Joanna Hernandez to have them both sacked. As such, it was nothing short of a disgrace. In her oral evidence, Sharon Berini referred to it as a "witch-hunt"[787]. I agree.

In the circumstances it is hardly surprising that the June 2005 statements reviewed earlier in this Report focused largely on Sharon Berini's style of management and her behaviour towards other members of staff. As noted earlier, she was variously described as (among other things): "engineering chaos", "destroying staff morale", favouritism, encouraging an "us and them"

[785] See Chapter 3.
[786] Day 8 page 60 line 18.
[787] See Day 8 page 113 line 14.

culture, failing to support other staff members, lack of professionalism, "bullying" members of staff, and "a bossy boss".

On 12 June 2005 Joanna Hernandez, in furtherance of her campaign, wrote to Isabella Tosso and Marie Gomez [**C1/1/61**] referring to the statements which she had obtained (but not at this stage enclosing them), and inviting them to interdict Sharon Berini and Nigel Bassadone immediately for "gross misconduct". In her oral evidence to the Inquiry, Joanna Hernandez stated that she was helped in writing this response by her then lawyer, Mr (now The Hon.) Daniel Feetham[788]. The fact that at this point Joanna Hernandez felt that she needed the assistance of a lawyer is, in itself, a further indication of the extent to which relations between Joanna Hernandez and Sharon Berini had deteriorated, and of the depth of Joanna Hernandez' irrational mistrust of Sharon Berini.

As one would expect, the terms of Joanna Hernandez' letter of 12 June 2005 to Isabella Tosso and Marie Gomez [**C1/1/61**] reflect the input of a lawyer. The letter reads as follows:

> "Dear Isabella and Marie,
>
> Six months into my appointment as Manager of Dr Giraldi's, it is with regret that I have to advise you that events over the last couple of months, and certainly over this long weekend involving my deputy Manager Sharon Berini, have [led] me strongly to believe that the relationship of trust and confidence that should exist between a Manager and Deputy has been totally destroyed by her actions and I feel that I can no longer be expected to continue working with her because of her continuing undermining of my position and the positive changes which have been introduced with your sanction.
>
> However, of even greater concern, is the loss of trust and confidence that had been brewing for some time now but which has surfaced as evidenced in the reports that approximately twenty members of staff have made against her because of the intolerable way that staff members have been treated, exposing the Agency [to] potential constructive dismissal cases had these support workers decided to take the issue forward. The overwhelming fact that came through was that no one had spoken out before through fear and the risk of losing their livelihood.
>
> They are not prepared to work with her any longer.
>
> But the most fundamental issue that this raises, is the effect that her conduct and others still working within the service has had on the service-users (who have been put at risk and their dignity not respected) and their welfare totally mismanaged – financially and otherwise – putting the whole service at risk of closure and a public scandal to the detriment of service users, their families and public resources.
>
> I therefore feel, in the genuine interest of the service, that you seriously consider immediately interdicting Ms Berini and charges of gross misconduct brought against her should you agree with my analysis of the situation. I also recommend that her former partner Nigel Bassadone should likewise be interdicted and charges of gross misconduct be brought against him.
>
> It is imperative that these two individuals, who appear to have been at the heart of all the major troubles formerly encountered within the service, along with Richard Muscat and Sean Matto (I reserve my recommendation on him pending the outcome of his application for another job), being banned from all the services premises and contact with those who have given reports for possible risk of intimidation and threats. Only recently, a bottle of water with squash appeared

[788] See Day 2 page 150 line 5.

> to be laced with ... some form of petrol [sic] chemical and which the police are investigating and it is ignored why this was done, who did it and for what reason would Liz Gallagher ... be targeted.
>
> I am also very concerned that my file on ongoing investigations disappeared from my office the same week that a complaint was filed by a support worker against Nigel Bassadone and the only two persons within the building to my knowledge, who had keys to access my office were myself and the Deputy Manager and therefore my reasonable suspicion is that she took the file.
>
> I also strongly recommend that you should seek legal advice if there are any doubts from the material presented that this should be the way to proceed.
>
> It is also my suggestion that the only person I trust to temporarily assume my duties as manager would be Marie Gomez and it is my recommendation that she should step in for the two weeks that I am away at Great Ormond Street Hospital. This will show to staff members, service-users, families and those interdicted that the Agency, and unlike it was unable to do in the past with Milbury Services, is seriously committed to overhauling the service and making individuals accountable if they fail in their basic duties and expected performance."

It appears that attempts by Joanna Hernandez to deliver the above letter to Isabella Tosso had been unsuccessful, since on 17 June 2005 Joanna Hernandez wrote again to Isabella Tosso [**C2/2/10**] enclosing her earlier letter together with the June 2005 statements. In this second letter she said this:

> "Following your instructions on 9th June 2005 to investigate issues of malpractice at Dr Giraldi reference Sharon Berini. On Tuesday 14th I informed you that all the reports were nearly ready. As from Wednesday 16th I have tried to no avail to contact you in order to submit relevant paperwork.
>
> Please find enclosed the reports and my letter of recommendations.
>
> Since I feel extremely vulnerable under these circumstances I am submitting all my evidence to Marisa Salazar for safe keeping for your perusal on Monday."

On the same day (17 June 2005) Joanna Hernandez handed Sharon Berini her letters dated 10 and 11 June 2005. She did not tell Sharon Berini about the June 2005 statements, but later that day another member of staff telephoned Sharon Berini and told her that statements had been taken. In the event, Sharon Berini did not see the June 2005 statements until some time after July 2006, when she left the SSA and joined the Royal Gibraltar Police.

Sharon Berini told the Inquiry that her reaction on reading the letters was one of "complete shock"[789]. She returned to this later in her oral evidence, saying this[790]:

> "I was handed those letters on a Friday, and because there had been no prior warning that these letters were coming my way, there [were] no prior meetings with regards to myself and Ms Hernandez where she put any concerns or issues to me, giving me the opportunity to respond to them, or to work on those errors, or to develop myself in any way. .... I was obviously shocked, upset and mortified. I just was not expecting it. I had worked with various managers before who had always been very complimentary about my work ethics and my professionalism. So to be given this information in such a way in these [letters] – I wasn't prepared for it."

[789] See Day 8 page 61 line 16.
[790] See Day 8 page 68 line 7.

On or around that date (17 June 2005), the June 2005 statements reached Yvette Del Agua. In paragraphs 3 and 4 of her second witness statement in this Inquiry, Yvette Del Agua said this about them (referring to them as "the dossier") [**E/8/1**]:

> "3. I recall that the dossier contained no allegations of abuse towards service users. The reports from staff members (some anonymous, unsigned or undated) centred primarily on individual complaints against the then Dr Giraldi Home Deputy Manager, Ms Sharon Berini, for allegedly favouring some members of staff over others in terms of rosters, substitution, etc. and for having disciplined some of the report-writers in the past (allegedly undeservedly)."

On Monday 20 June 2005 a meeting took place between Isabella Tosso and Joanna Hernandez at which Joanna Hernandez handed Isabella Tosso her letters dated 12 and 17 June 2005, together with copies of the June 2005 statements. In her witness statement in the Industrial Tribunal [**C2/1/1**], Isabella Tosso described her reaction on considering these documents as follows[791]:

> "12. .... [I]n June 2005 Ms Hernandez handed me a number of reports that she had obtained from staff at [Dr] Giraldi Homes where she had invited individuals to comment on any retrospective grievances they had against the Deputy Manager, Ms Berini, and her practice. Contrary to the statement in her letter to me of 21st June 2005 [as to which, see below] this was not done on my instruction. .... The collation of these reports was not undertaken on the instruction of line management and disciplinary procedures as set out by Employment Directives 2002 were not followed. Ms Hernandez at no point informed Ms Berini of what she was doing and why, the first required step of an investigation. The content of the reports was subjective, not evidence based and anecdotal. They catalogued impressions and opinions of those making the allegations, often based on hearsay of dated and third party information and did not contain contemporaneous, evidence based facts. As a result of these findings Ms Hernandez requested that I dismiss Ms Berini immediately.
>
> 13. I explained to Ms Hernandez that the process of the exercise she had undertaken seriously concerned me as procedurally non-compliant. It was inappropriate, could be construed as covert and victimising Ms Berini and the information [was] open to challenge and potentially libellous. In fact, the disregard of the process as outlined in the disciplinary proceedings of Employment [Directives] 2002 or General [O]rders raised serious doubts over Ms Hernandez[']s competence to investigate concerns in practice in a fair, transparently and procedurally correct manner. I therefore did not feel I could comment on the content of the allegations."

Marie Gomez also denied that in carrying out her investigation Joanna Hernandez was acting on instructions[792].

In her letter to Isabella Tosso of 29 July 2005 [**C2/5/38**], Sharon Berini relates that she also met Isabella Tosso on 20 June 2005, and that at that meeting Isabella Tosso assured her that she had not instructed Joanna Hernandez to carry out the investigation. Sharon Berini suggested to Isabella Tosso that she should speak to the members of staff who had made statements, but Isabella Tosso declined to do so, saying that two wrongs do not make a right. However, Sharon Berini was hopeful that the matter would be resolved at the next meeting with Isabella Tosso, which was scheduled for 13 July 2005, and that she would be provided with an explanation as to why she had been victimised and why SSA policy and procedures had not been followed.

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[791] See paras 12 and 13 of Isabella Tosso's witness statement in the Industrial Tribunal [**C2/1/4-5**].
[792] See para 8 of Marie Gomez' witness statement in the Industrial Tribunal [**C2/4/3**].

In her letter to Isabella Tosso dated 21 June 2005 [**C2/2/11**] (referred to in paragraph 12 of Isabella Tosso's witness statement quoted above) Joanna Hernandez said this:

> "I refer to our meeting yesterday at 2.00pm [and] the documentation I left you regarding Sharon Berini and other staff members at Dr Giraldi's.
>
> As you saw for yourself I was quite stunned when you categorised the extensive statements of members of staff as a 'witch hunt', '[hearsay]' and 'emotional'.
>
> Unfortunately you have not had the opportunity to assess for yourself firsthand the strength of feelings testified to by a very large number of our members of staff based on firsthand experience, and in common with others, of former management practices and some of recent origin.
>
> These members of staff did not speak out due to cohesive fear, quite illegitimately, at the hands of Sharon Berini and her foot soldiers – Nigel Bassadone and Sean Matto.
>
> The above staff's behaviour though may be considered historical by some requires action to be taken in view of the undeniable repercussions this had on the service-users. Now that I am aware of the above and without the appropriate investigation, I cannot guarantee that I am running a safe service; which leaves me as the Manager in an extremely vulnerable situation.
>
> My recommendation, with respect, is that you reconsider your initial reaction and possibly share this information with the Team Leader and Minister and together put a plan of action to regress [sic] the situation in order to safeguard both service-users and determined staff in order to run a safe and uncorrupted service.
>
> I trust that as professional colleagues, you will not take what I say badly and that you will not leave any stone unturned to ensure that the Agency meets its legal obligation towards its employees and the service-users."

It is obvious that the makers of the June 2005 statements felt (to put it no higher) a strong personal antipathy towards Sharon Berini, and that they found it difficult, if not impossible, to accept her style of management. Equally, however, it is clear that other members of staff took a contrary view: hence the complaints of favouritism on the part of Sharon Berini.

It is also clear, in my judgment, that to the extent that an "us and them" culture existed amongst members of staff, this was largely attributable to Joanna Hernandez' inability to deal objectively with the expression by members of staff of views which happened to be contrary to, or at variance with, her own. The introduction of new policies and procedures in the Home by a newly appointed and inexperienced Manager – in this case Joanna Hernandez – required a sensitive and conciliatory approach on her part. Instead, her decision to embark on her June 2005 "investigation", far from being sensitive or conciliatory, was calculated to aggravate the situation by promoting just the kind of "us and them" culture of which the makers of the June 2005 statements complained. It can only have caused further damage to relations between members of staff (see, in particular, the suggestion that Sharon Berini, Nigel Bassadone, Richard Muscat and (possibly) Sean Matto should be banned from contact with those members of staff who had made statements).

I find myself in complete agreement with the observations of Isabella Tosso in paragraphs 12 and 13 of her witness statement in the Industrial Tribunal (quoted above), and in complete

sympathy with the concerns expressed by Sharon Berini in relation to this process. In particular, I reject Joanna Hernandez' contention that the process which she had undertaken was authorised by Isabella Tosso at the meeting which took place between them on 8 June 2005 (as to which, see above). The minutes of the meeting refer to recourse to "disciplinary procedures", yet the process which Joanna Hernandez undertook over the weekend of 11/12 June cannot be so described, for the reasons which Isabella Tosso gave in her witness statement. Moreover, I am satisfied that someone of Joanna Hernandez' intelligence must have fully appreciated that. I conclude, therefore, that Joanna Hernandez' attempt to rely on what Isabella Tosso said to her at their meeting on 8 June 2005 as authorising what she did over that weekend is no more than a spurious attempt on her part to justify, ex post facto, a process which she well knew at the time was both unjustifiable and unfair, and which would inevitably exacerbate an already delicate situation in the Home.

On 1 July 2005 a Management Meeting took place at the Home, attended by Marie Gomez and Sharon Berini. Joanna Hernandez did not attend, as she was at that time on special leave, attending her daughter who was in Great Ormond Street Hospital. The minutes of the meeting [**C2/1/41**] refer to the perennial problem of staff shortages in the following terms:

> "Staffing shortage to cover respite and sitter service staff is being taken out of Flat 1 and Flat 2 which affects the residents[']daily living and even any activity planned. SB [Sharon Berini] asked for directions on what they should be doing, whether they carried on covering respite which meant stretching staff to the limits and sometimes cancelling residents' activities or just cover the residential unit and cancel more respite. .... Discussion on the memo send (sic) round by M. Santos on the use of supply workers it was quite obvious that DR. G cannot follow these instructions as respite is run by supply workers and the residential unit still need more staff. ....
>
> Staff morale and sick record is at an all[-time] high record. People are worried about their job and their own security."

On 13 July 2005 the scheduled meeting took place between Isabella Tosso, Joanna Hernandez and Sharon Berini. At this meeting, Isabella Tosso stressed once again that she had not requested Joanna Hernandez to carry out an investigation into "malpractice" by Sharon Berini. It would appear from Isabella Tosso's subsequent letter to Joanna Hernandez that at that meeting (or, possibly, following the meeting) Joanna Hernandez may have expressed some degree of regret at the actions which she had taken, and that she may have offered Isabella Tosso a degree of reassurance that she would not embark on such a course of action again. That, at least, is how Isabella Tosso interpreted what Joanna Hernandez said at the meeting. For her part, however, Sharon Berini remained, understandably, thoroughly aggrieved at the way in which the meeting had proceeded.

Sharon Berini referred to this meeting in the course of her oral evidence to the Inquiry, saying this[793]:

> "Ms Hernandez did not speak at all throughout the meeting. She did not say anything to me, so she did not admit to her error of judgment in my presence at all."

[793] See Day 8 page 71 line 4.

In her letter to Isabella Tosso of 29 July 2005 (mis-dated 29 August 2005) referred to above [**C2/5/41**], Sharon Berini said this:

> "After this meeting I felt that although you had acknowledged that I had been victimised and [that] the way these reports were obtained was wrong it was made very clear to me that the individuals involved in this were not going to be made accountable for what they had done. Therefore [the members of staff involved] had all got away with clearly victimising me as the deputy manager. What kind of message is this sending out to all of the staff at Dr Giraldi's? When I asked you how I was supposed to continue working with a manager who had so openly victimised me I was informed that it was a personal thing for me to decide what action I wanted to take."

Joanna Hernandez, on the other hand, considered that it was she who had been victimised by Isabella Tosso and Marie Gomez. In paragraphs 9.6.1 to 9.6.5 of her first witness statement in the Inquiry [**E/19/30-31**], in a section of the witness statement headed "My dismissal as Manager of [the Home]", Joanna Hernandez says this:

> "9.6.1. As from June 2005 my experience [as] Manager of [the Home] became very unpleasant. Certain persons started bullying, harassing, intimidating and cohering [sic] me.
>
> 9.6.2. MG [Marie Gomez] and IT [Isabella Tosso] went personal on me and would say ... poor Sharon ... without looking into the allegations and wrongly stating that all was fine, requesting that I withdraw the letter requesting an independent investigation and the 12 allegations [a reference to the June 2005 statements]. ....
>
> 9.6.3. MG and IT told me that (on the advice of the former MSA [Minister for Social Affairs: i.e. Yvette Del Agua] I was to retract the letter of recommendations and the statements of the witnesses or I would lose my job as Manager of [the Home].
>
> 9.6.4. I felt bullied, cohered [sic] and intimidated by SB [Sharon Berini], MG and IT. I was continuously spoken down to in front of everybody at work, undermining my managerial position. IT and MG would shout at me and disempowered me completely as Manager of [the Home]. .... SB worked in the same office as I did and she was terrible with me. They would ignore me in the passages of the residence. I was given no support whatsoever.
>
> 9.6.5. Under pressure from the former MSA they continuously threatened me verbally that I would lose my job and career."

I accept that, as a result of Joanna Hernandez' June 2005 "investigation", the atmosphere amongst the staff in the Home was fraught, to say the least. One could hardly expect it to be otherwise. I also accept that she felt that her authority as Manager had suffered as a result of that "investigation". No doubt it had. Subject to that, I reject her evidence quoted above. In particular, I reject her evidence that she was bullied, "cohered", intimidated or disempowered by any member of staff or management. I also reject her evidence that she was given "no support whatever".

I accept the evidence of Matthew Turnock in paragraphs 142 and 146 of his witness statement [**K/1/1**].

In paragraph 142 of his witness statement he says this [**K/1/33**]:

> "142. .... Mrs Hernandez, was in fact, the only Manager, in my experience, who was over supported by senior management. Mrs Gomez would come into the Home every day in order to oversee Mrs Hernandez and, in essence, carry out her job for her. ...."

In paragraph 146 of his witness statement he says this [**K/1/34**]:

> "146. Mrs Berini did not bully the staff at the Home. In fact, if there was an issue of bullying it would have been from Mrs Hernandez. Her bullying manner often resulted in staff not showing up to work or taking time off sick due to the stress. Staff morale was very low during the time that she was there."

As to Joanna Hernandez' allegation (in paragraph 9.6.5 of her first witness statement, quoted above) that Yvette Del Agua pressured Isabella Tosso and/or Marie Gomez into threatening her with losing her job and career, in oral evidence Yvette Del Agua described that allegation as "an outright lie"[794]. I accept Yvette Del Agua's evidence, and find the allegation to be wholly without foundation.

On 3 August 2005 another supervision meeting took place between Marie Gomez and Joanna Hernandez [**E/32/1**]. In the course of that meeting, Joanna Hernandez reported that she had sorted out the petty cash as far as possible, but was unable to balance the books; and that she had accordingly submitted a report to the Finance Officer (Natalie Fortuna) explaining the situation. The minutes of the meeting include the following:

> "Huge staff shortage has deteriorated even further with the residential service being seriously at risk even though Respite is closed.
>
> ....
>
> Re professional development JH had failed her latest exams because of all the pressure but felt confident she would pass the overall exam as her marks were quite high.
>
> Personal Agenda
> JH on medication due to her stress levels. Is very worried because residents are at severe risks. ... [S]everely challenging behaviour with minimum cover.
>
> Action Points
> MG to inform CEO of the services severe shortage and consequences."

Isabella Tosso's next letter to Joanna Hernandez was dated 11 August 2005 [**C1/1/65**] and was in the following terms:

> "Further to our meeting on 13.07.05 I am writing to reiterate that I did not ask you to carry out an 'investigation into malpractice' in respect of Ms Sharon Berini, Deputy Manager, and I am deeply concerned about the manner in which you decided to undertake this task. You did not follow procedures and your behaviour would easily have been construed as blatant victimisation and unfair treatment of a member of staff in direct contravention with [sic] the Agency's Policies and Procedures.

[794] See Day 12 page 47 line 6.

> I am also very concerned that since you took up appointment, on numerous occasions, I asked you to implement Supervision on a fortnightly basis with your Deputy Manager. You did not follow my instruction or give me an explanation as to why you had not. It is my opinion that this has been a fundamental factor in the absence of meaningful communication and the ultimate breakdown in your working relationship with Ms Berini.
>
> However, as you have admitted to your error of judgment, expressed remorse and reassured me that this will not happen again I am prepared to forego instigating disciplinary proceedings.
>
> I am instructing you not to write to Ms Berini. You will raise any issues in the mediation sessions that will be set up to facilitate the re-establishment of a working relationship between you and her. I have issued her with a similar instruction."

Isabella Tosso's observations in relation to Joanna Hernandez' "investigation" are entirely justified. Moreover, if in fact Joanna Hernandez had admitted to an error of judgment, expressed remorse and reassured Isabella Tosso that such an error of judgment would not occur again (and I have no reason to doubt that she did so), that is directly contrary to the position she has taken in this Inquiry, as is apparent from her evidence.

The letter went on to describe a number of changes in management practice, which would be monitored by Debbie Guinn (Senior Social Worker). It continued as follows:

> "All practice will ensure that staff is treated fairly and equitably. Any further failure to follow instruction or policies and procedures will result in the instigation of disciplinary proceedings."

On the same day (11 August 2005) Isabella Tosso wrote a letter to Sharon Berini [**C1/1/63**] describing in similar terms the changes in management practice which would be put in place.

On 1 September 2005 Isabella Tosso addressed a Memorandum to Joanna Hernandez [**C1/1/69, also C2/1/57**], copied to Marie Gomez, in the following terms:

> "Re: Probation and Confirmation of Appointment
>
> Following consultation with the Labour Inspectorate of the Employment Service I am writing to inform you that you may not be recommended for confirmation of appointment on 22nd November 2005.
>
> The reason for this is that presently I am unable to confirm that you have performed the duties of manager to a standard that I consider satisfactory.
>
> You have failed to provide regular supervision to designated members of staff when instructed to without advising your line manager, you failed to ensure that all expenditure and budgets operated within the home were properly kept and used, you have failed to ensure that rotas are correctly drawn up as required by the Personnel Officer, you have failed to follow policies and procedures [e.g.] investigations of incidents, and you have failed to follow reasonable instructions from your line manager without explanation [e.g.] the equitable distribution of senior substitution.
>
> You will have the opportunity to discuss with your Supervisor/Line manager in supervision how best to address these shortfalls in order that we offer you every opportunity and support to acquire the necessary skills to achieve the required standard."

On 6 September 2005 (by which time she had not as yet seen Isabella Tosso's Memorandum dated 1 September 2005) Joanna Hernandez wrote to Isabella Tosso [**C1/1/67**], adopting a more conciliatory tone. The letter began as follows:

> "Dear Isabella,
>
> I thought long and hard about your letter of 11 August.
>
> Going forward I am quite prepared to be guided by you and work within the parameters you set in the penultimate paragraph of your letter. Since I have been involved in the home I have worked very hard and I am committed to the highest standards of care. Some of the points you suggest are ones which I have felt were needed and I welcome them. That applies to anything that improves the standard of care at the home."

The letter went on to ask Isabella Tosso to clarify the respects in which the investigation which she had undertaken did not comply with the prescribed disciplinary procedures. This was a disingenuous request, for reasons already given. The letter continued:

> "I also do not understand how even if there had been a technical breach of procedure, which I dispute, you could then jump to the conclusion that this was "blatant victimisation" on my part. I had sufficient evidence, backed up by written statements from people of very serious allegations, to act the way I did. Allegations, which I would add, any organisation [which] cares about its service users and their families would take seriously.
>
> My concern is that in your letter you appear to promote procedure over substance and the care of people in the home. I find it hard to understand how the Agency can ignore very serious allegations that are contained in writing even if my investigation was procedurally flawed. Some of the allegations are of a criminal nature (e.g. one person consuming drugs in one of the flats). I believe that if these issues are not dealt with, then support workers and staff will not come forward when these incidents reoccur because they will have no faith in the Agency having the courage to tackle these issues.
>
> Finally you say that you are prepared to forgo disciplinary proceedings. I am very grateful that you should consider that you should not open formal disciplinary proceedings against me for not following correct procedure. I have to say, however, that to the extent that you believe that you might have instituted proceedings for what you describe as "blatant victimisation" or because there is any suggestion that I carried out my investigation in bad faith or without the necessary evidence, I would ask you to go ahead with those proceedings. I prefer to clear my name and explain by reference to written evidence not speculation exactly why I did what I did."

In the event, no disciplinary proceedings were taken against Joanna Hernandez in respect of her "investigation".

In her handling of the matter of Joanna Hernandez' 'investigation' Isabella Tosso could – and in my judgment should – have given much greater support to Sharon Berini, who had indeed been "victimised" in a completely unacceptable manner, and who was understandably nursing a strong sense of grievance at the manner in which she had been treated. It is not in the least surprising that this whole episode led to Sharon Berini resigning from the SSA in August 2006 and joining the Royal Gibraltar Police.

I find it hard to envisage any process more calculated to damage staff relations and staff morale, and hence (inevitably) the efficient and harmonious operation of the Home in the best interests

of both residents and respite users, than the vindictive and clandestine process which Joanna Hernandez saw fit to conduct against Sharon Berini.

In the event, the "mediation sessions" proposed by Isabella Tosso did not take place. No doubt this was due, at least in part, to the fact that Joanna Hernandez was absent on sick leave or special leave for a total of no less than 62 days during the period from 27 June 2005 until her employment was terminated on 22 November 2005 (including 38 days from 5 September 2005 onwards) [**C2/8/2**].

On 16 September 2005 a supervision meeting took place between Marie Gomez and Joanna Hernandez [**C2/1/59**]. In the course of that meeting, Marie Gomez handed Joanna Hernandez Isabella Tosso's Memorandum dated 1 September 2005 [**C1/1/69**].

The minutes of the supervision meeting on 16 September 2005 [**C2/1/59**] record that, when handing Isabella Tosso's memorandum to Joanna Hernandez, Marie Gomez advised Joanna Hernandez that "the probationary period would be extended". In evidence to the Inquiry, Marie Gomez explained[795] that her understanding at that time was that Isabella Tosso was considering the possibility of extending Joanna Hernandez' probationary period, but that in the event Isabella Tosso had concluded that to do so would make it difficult for the SSA thereafter to terminate Joanna Hernandez' contract at the end of the extended period, should it wish to do so.

The minutes continued:

> "JH felt that if she had failed [it] had been because she had not been given the staff to be able to do the work e.g. admin staff/secretary for all the minutes, notes, phone calls etc. She had been unable to give supervision to staff because of the tremendous workload. Imprests [for petty cash] had not been correctly [completed] because seniors had failed to do so correctly even though she had sent memos round requesting this. Rotas were changed against her instructions [while] she was off. JH felt that I as Team Leader should have given her all these resources. I explained that it was her responsibility as Manager to see that all the above was done but JH strongly disagreed because she could not do so [without] the proper support.
>
> **JH very upset unable to set time and date for next meeting.**"

On 23 September 2005 Joanna Hernandez wrote to Isabella Tosso as follows [**E/25/23**]:

> "Dear Isabella,
>
> Thank you for your unsigned letter of 1 September which was handed to me on the 15 September [the correct date was 16 September]. Given the seriousness of its contents, I would not have expected an unsigned letter hand delivered to me two weeks after it was purportedly written. You talk about fairness in procedure – where is the fairness and the dignity in that?
>
> I also feel that I have not been given any opportunity to even answer the very serious, but very general and unparticularised, issues you raise in the letter.

[795] See Day 13 page 87 line 2.

> I am also very concerned that the contents of your letter are out in the open. Yesterday I received a call from someone from the disability society who had heard that my contract was not going to be renewed, This is embarrassing for me and again is very unfair on me.
>
> Be that as it may my first concern is the care of service users and the improvement of the service. Everything I have done has been to that end. With that end in mind of course I am prepared to discuss your views with my Supervisor in order to help improve my skills either by continuous education or otherwise."

At some date in October 2005 (but, I infer, prior to the meeting on 24 October 2005 referred to below) Joanna Hernandez produced a lengthy written report entitled "Service Audit for Children/Young People & Adults with Learning Disabilities" [**E/23/6**]. The report related to the period from the date of her appointment as Manager (22 November 2004) until 30 September 2005.

In her report, Joanna Hernandez painted a bleak picture of the service provided by the Home during that period. As to her own position, Joanna Hernandez complained yet again of lack of support by senior management, saying [**E/23/23**] that she felt "undermined and disempowered as a Manager" by the reactions of senior management to her investigation into the conduct of Sharon Berini. She continued [**E/23/25**]:

> "At a personal level I strongly feel that I have been bullied, cohered [sic] and intimidated by Sharon Berini, Marie Gomez and Isabella Tosso. My expertise and professionalism [have] not been listened to, respected or acknowledged. They have demonstrated on many occasions with many witnesses how they have directed themselves to me, their tone of voice, harshness and total lack of support after the reports (staff allegations) were handed [in] on that fateful day. At different points they have [subjected] me to 'humiliating spectacles' in senior staff meetings where voices have been raised and you are constantly [talked down to] by other professionals who do not have to their credit a certificate in disability, inclusion, special needs or therapeutic work. Power imbalances within the agency have affected and are affecting the lives, rights and livelihood of many."

In relation to care plans, she reported as follows [**E/23/11**]:

> "To date we have achieved an excellent format for the Care Plans which complies with Milbury's Policies and Procedures and have been edited and produced in a design accessible to ALL. It is estimated that 18/24 months will be required to formalise the Care Plans/Elsi's[796] and Risk Assessment[s] for all residential clients.
>
> An updated risk assessment specific to user is yet to be approved by the CEO."

She reported that the fire alarm system was substandard when she was appointed, and that the staff had had no proper training in fire alarm practices. She described the efforts she had made to rectify these deficiencies, noting that a budget had been allowed for the updating of the system, and that works were under way [**E/23/11-12**].

In a section of the report headed "Staff Training & Strategy Development Group (STSDG)" she said this:

[796] The acronym ELSI stands for Everyday Living Skills Inventory.

> "On appointment one of my first responsibilities was to present a Staff Training Needs Proposal, after evidencing that only 3.3% of the workforce was qualified. The staffing [complement] for the service is that of 55 of which only 6 are being paid the enhanced rate for qualified staff. No feedback was given by senior management of the proposal[. I]n its place the STSDG was sited collectively by the then acting team leader Ms. Tosso.
>
> The staffing [complement] fails to meet the service needs and a staffing inspection has been persistently requested.
>
> A Staff Training & Strategy Development Group has been put together, comprising the Team Leader, Manager, counselling psychologist, and of a representative for each of the distinct working areas of the home. The ethos underpinning the STSD group is the collation of a strategy document to determine the training needs of the support workers in the home. Residential care is still dominated by historical attitudes towards looking after children and/or disabled adults, seeing residential care as a 'women's work', in which the skills are inherent or intuitive and the commitment of the workforce is 'exploitable'. The pay scales do not encourage many 'male' supply workers to apply leaving a shortfall within the service as it continuously fails to meet the individual needs of its residents and clients.
>
> It is crucial for residential care workers to understand the philosophy upon which care work stems. It is this knowledge and training that allows understanding of why what appear to be natural qualities (embodying good-heartedness and a love of others) to be so highly valued and count for so much...."

After referring to the interdictions in relation to Resident T, she said this [**E/23/18**]:

> "Several other allegations have been made by other members of staff ranging from minor to gross misconduct and for which the Disciplinary procedure was followed. However, when an allegation was handed to the Manager concerning the Deputy Manager[']s partner [Nigel Bassadone] the 'Staff Disciplinary Folder' disappeared from the Manager/[Deputy's] offices, who are the only two who had keys to such. The Team Leader was informed and the CEO requested that the police were informed. This never occurred.
>
> Additionally, no activity plans were available and it was found that there was falsification of daily reports on activities which the CEO is aware of.
>
> Family members and staff who were not on duty entered the premises as and when they wished and openly transferred onto [on-duty] staff and residents their own value systems, judgements and concepts, in the whole influencing and manipulating the judgments and choices of the residents which residents voiced in advocacy meetings. Certain staff members would take clients to their own homes with their family which was detrimental to the clients and placing at risk their homes and families. Management had been aware of this in the past."

Under the heading "Reflections", the report continued [**E/23/19**]:

> "There had been a complete disregard towards procedures and no infrastructure was present or being adhered to; staff [were] left [on] their own. ....
>
> Families disclosed that they had felt manipulated by certain staff members for staff personal issues and gains and expressed feelings of inadequacy and helplessness[.] Residents did not have the privilege of living inclusive lives in our community, social inclusion and participation was hardly existent, in fact they expressed feeling [helpless], oppressed and resigned to their fate coping as best as they possibly could."
>
> ....
>
> Even prior to being appointed as Manager, the serious crisis that the service was under was made extremely clear to me[.] I was also informed that all past records from Milbury Services['] time to

present date were unaccounted for in the Agency and Dr Giraldi's – this in itself was extremely alarming and required me to basically 'start from scratch'. Once appointed it became disconcerting as a professional to observe staff's rapport with the deputy and myself, in their majority staff were demoralised, appeared intimidated, began raising serious concerns highlighting [bullying] and abusive practices which allegedly were twofold. They impacted on staff, families and clients. Staff would break down crying how [such allegations] had affected their health, emotional and [psychological] well being. The Team Leader and CEO were made aware of this ... The Team Leader on repeated occasions instructed me to be very careful of Sharon Berini and not to fall into her trap... further relating that both Elizabeth Harrison – Social Worker [–] and herself had serious concerns about her and expressed professional misconduct. I explained to the Team Leader that I was attempting to do the best that I possibly could with what I had inherited and that without offering Sharon an opportunity to change her practices, the service would have difficulties in overcoming [its] shortfalls. The Team Leader again warned me against her.

At a management level, Management was overburdened and overworked by the fact that I had to cover the extreme staffing shortfalls. The CEO and Team Leader were continuously being informed of this. ....

Other areas of concern were the petty cash and rotas. .... It was practically impossible to improve standards without a secretary and AO [Administrative Officer], leaving rotas and petty cash in disarray for which the Manager sought [sic] the Deputy. However, she failed to do so after repeated instructions.

In the time that Sharon had been instructed to work solely on rotas, petty cash, sick leave and annual leave, no complaint was made by either the Team Leader or Marie Carmen Santos of her performance, in fact the Team Leader commented that the above had improved.

The CEO then gave Sharon a directive to do so; Sharon felt that she had been brushed aside from her managerial post. Therefore I was left to cover the duties of the Deputy as well as those of my own, and additionally of a secretary. Senior staff was well aware of how overrun the service was, but failed to offer any type of support. The CEO and Team Leader at this point failed to even meet staff or residents. I then invited the Team Leader and CEO to the Senior Meetings to experience first hand the alarming situation. The Team Leader and CEO showed no interest."

In relation to Joanna Hernandez' own supervision of Sharon Berini, the report said this [**E/23/21**]:

"Sharon had repeatedly been "cancelling" her supervision sessions with me. I [had been] instructed to supervise the Seniors and deputy. The seniors were in turn to supervise their respective teams. Sharon was asked by the CEO not to supervise anyone. Sharon's refusal to be supervised by me was taken up in supervision with the Team Leader, who decided to start supervision with Sharon [for] the time being herself – it is to be noted that the Team Leader offered me no feedback. As a consequence and at a managerial level I had been effectively cut out of the loop with my Deputy, her performance or issues of practice. At the above meeting and others I also informed the Team Leader I was having major difficulties with the supervision of staff, due to the tremendous workload that I was under and which the seniors in a meeting with the Team Leader called for myself actively voiced the above and their own serious concerns, The service was seriously undermanned. The seniors also informed the Team Leader that it was practically impossible for them to offer their teams supervision [in] the present situation."

The report went on to refer to matters affecting individual residents.

I make the following observations on the above report.

In the first place, it is to be noted that nowhere in the report does Joanna Hernandez acknowledge any shortcomings in her performance as Manager of the Home throughout the relevant period, still less any responsibility for the bleakness of the picture which she paints.

Secondly, Joanna Hernandez' criticisms of Sharon Berini are, as I indicated earlier, clearly coloured by an irrational distrust of Sharon Berini's motives coupled with a desire to see the back of her.

Thirdly, I reject Joanna Hernandez' assertion that Sharon Berini repeatedly cancelled supervisions.

Fourthly, I accept Joanna Hernandez' criticisms of current systems and practices in the Home (as expressed in the above report) only to the extent that they reflect a continuation of the shortcomings which I earlier identified as existing when she took up her appointment as Manager[797], or to the extent that they are corroborated by the evidence of Debbie Guinn (to which I refer later in this Report[798]). To the extent that Joanna Hernandez' criticisms go further than that, I regard them as yet another example of exaggeration on her part, driven by a desire to depict the operation of the Home in the worst possible light in order to justify her own position.

On 24 October 2005 a further meeting took place between Isabella Tosso and Joanna Hernandez. According to the minutes of that meeting [**C2/2/6**], Isabella Tosso opened the meeting by referring to her memorandum dated 1 September 2005 (quoted above), saying that Joanna Hernandez' performance had since been reviewed and that it was felt by the SSA that she had failed to meet the required standard and that her contract would not be renewed.

The minutes continued:

> "Although Employment Directives of the Agency 2002 do not require that either party give each other reasons for ending the term of employment or to give notice it was only professional and courteous to do both, hence the meeting today.
>
> Ms Hernandez was passed the letter by the CEO for her to read. Ms Hernandez asked for clarification about notice and the CEO once more explained that none was needed. The CEO wished Ms Hernandez well for the future and the meeting ended."

The letter referred to in the above minutes [**C2/2/4**] was dated the same day (24 October 2005) and read as follows:

> "RE: Probation and Confirmation of Appointment
>
> Further to my memorandum dated 1st September 2005 I am writing to inform you that your performance in your position as Manager of Dr Giraldi has been reviewed and it is the conclusion of the [SSA] that you have failed to meet the required standard.

[797] See Chapter 7.
[798] See Chapter 11.

> I therefore regret to inform you that your contract will not be renewed at the end of the probationary year."

Joanna Hernandez' employment by the SSA accordingly terminated on 22 November 2005, and she ceased to be the Manager of the Home on that date. In due course, she was replaced as Manager by Iain McNeil.

On receipt of Isabella Tosso's letter dated 24 October 2005, Joanna Hernandez approached a number of relatives of respite users, and a meeting took place between them at which notes were taken and the contents of which were taped by Joanna Hernandez[799]. Following that meeting, Gina Llanelo (one of the relatives) drafted a letter to be released to the Press on behalf of all the parents of respite users expressing regret at the decision not to renew Joanna Hernandez' contract, praising her performance as Manager, and calling for an independent inspection of local residential services.

Before releasing the letter to the Press, Gina Llanelo sent an advance copy of it to Yvette Del Agua, [**F/20/7**] informing her that the letter would shortly be released to the Press and giving her the opportunity to comment on it. There is nothing in the documentation provided to the Inquiry to indicate that the Minister availed herself of this opportunity, and the letter [**F/20/8**] was duly released to the Press a day or so later. It is dated 25 October 2005 and is addressed "To whom it may concern". It is signed simply "Parents of respite users". The body of the letter reads as follows:

> "It is with much regret that we have learned [that] the Social Services Agency will not be renewing the contract of Ms Joanna Hernandez, current Manager of the Dr. Giraldi Home. The families of the service users at the Dr. Giraldi Home have therefore decided to publicly show their support for Ms Hernandez and condemn the decision not to renew her contract. We find Ms Hernandez to be a very dedicated, professional and qualified person and are very concerned that this is the fourth manager of the Dr. Giraldi Home to be replaced in as many years. We believe that there are inherent problems within the service and these problems have caused the [loss] of several professional and dedicated members of staff over the last few years. With this in mind we also wish to publicly voice our backing for the Disability Society's call for an independent inspection into the local residential services by the Care Standards Commission from the UK. We call upon all members of our community to support us in this call for an independent inspection."

Thereafter, correspondence ensued between Isabella Tosso and Hassans (acting for Joanna Hernandez, under the reference of Daniel Feetham). In their letter dated 14 November 2005 [**C1/1/73**] Hassans asserted that Joanna Hernandez had been treated unfairly in the procedure followed for her dismissal, given the timing of Isabella Tosso's letters and the lack of reasons supplied. Hassans also complained that Isabella Tosso's letter dated 1 September 2005 was not handed to Joanna Hernandez until 16 September 2005 (the letter wrongly gives the date as 15 September), thereby reducing the time available for Joanna Hernandez to consider Isabella Tosso's comments.

The letter continued:

[799] See the evidence of Gina Llanelo: Day 4 page 35 line 20.

> "Given the circumstances as we know them, we have come to form the view that this unfair treatment towards Ms Hernandez has come about because of the investigation Ms Hernandez has carried out into aspects of the running of Dr Giraldi and the complaints made against senior members of staff. It appears that the Agency has chosen, instead of dealing with the problems voiced by Ms Hernandez, to avoid matters and turn them against Ms Hernandez. This victimisation is clearly unwarranted given that Ms Hernandez was merely dealing with numerous complaints raised by staff under her management."

The letter went on to invite Isabella Tosso to reconsider the decision to dismiss Joanna Hernandez and in any event to provide reasons for that decision. The letter ended by threatening court proceedings.

Isabella Tosso responded by letter dated 5 December 2005 [**C1/1/75**]. She began by explaining that the reason why her letter of 1 September 2005 had not reached Joanna Hernandez until it was handed to her at the meeting on 16 September was that she considered that that was the appropriate way to deliver such a communication, in order to give Joanna Hernandez "the opportunity to address the identified shortfalls". She pointed out that Joanna Hernandez was away until 12 September 2005, and that the meeting on 16 September 2005 was the first occasion when it had been possible to deliver the letter. Her letter continued:

> "On 23rd October 2005 a full review of Ms Hernandez's performance as Manager of Dr Giraldi was undertaken examining the preceding 11 months in their entirety, with specific attention to the shortcomings described in my letter of 1st September 2005 and her response to my request to discuss and address them in supervision with her line manager.
>
> On the date of the review it was decided that her overall performance throughout the probationary period and her failure to meet with her supervisor to address the identified shortcomings in the five weeks following the receipt of the letter was unsatisfactory and a decision was taken not to renew her contract."

Thus the scene was set for Joanna Hernandez' claim of unfair dismissal in the Industrial Tribunal. I address this in Chapter 12 of the Report.

CHAPTER 11: Staffing problems – The 'Four Month Plan' – Social Workers' Reports – Rod Campbell's Report – The Business Plan – Issues regarding medication

Contents

CHAPTER 11: *Staffing problems – The 'Four Month Plan' – Social Workers' Reports – Rod Campbell's Report – The Business Plan – Issues regarding medication*

In or about September 2005, Isabella Tosso decided that in order to address the various shortcomings in the operation of the Home, greater input from social workers was required. To that end, she commissioned a review of working practices in the Home, to be conducted by two of the social workers with responsibility for social work at the Home, namely Elizabeth Harrison and Jennifer Poole, under the supervision of their line manager Debbie Guinn (a Senior Social Worker). She asked each of three social workers to report in due course on what they found. She described this as the "Four Month Plan".

As Isabella Tosso put it in paragraph 14 of her 2006 witness statement [**C2/1/5**]:

> "... I considered it appropriate to undertake an assessment of standards of practice and the absence of competent Management oversight at Doctor Giraldi Homes. I instructed the Social Work Team to undertake a thorough assessment of practice in all flats and identify the need for training and new practices; the Senior Social Worker, Ms Debbie Guinn, supervised this. I was also aware that staff were aware of the investigation carried out by the Manager and needed reassurance that Senior Management was going to closely monitor practice and standards of care."

The plan was that Elizabeth Harrison and Jennifer Poole would spend time in each flat in the Home; and that they and Debbie Guinn would report to Isabella Tosso on what they found and make suggestions for improvement.

Debbie Guinn had been employed by the SSA since 2002, initially as a social worker within the Children and Families Team. In July 2005 she was promoted to the post of Senior Social Worker within the Adult Services Team; a post which included responsibility for social work at the Home. She did not formally take up that post until October 2005, but during the period from August to October 2005 she undertook various tasks relating to the Home and in so doing became familiar with its working practices. Among other things, she was asked by Isabella Tosso to provide support for Joanna Hernandez on her return from sick leave[800]. Debbie Guinn already knew Joanna Hernandez from supervision sessions in connection with a counselling course which Joanna Hernandez had attended as a student before she became Manager of the Home, but had had little professional contact with her when she was Manager of the Home. One reason for this was that Joanna Hernandez was away sick for most of October 2005[801] and from 9 to 17 November 2005 (her employment terminated on 22 November 2005).

[800] Joanna Hernandez was away on sick leave from 15 to 26 August 2005.
[801] Joanna Hernandez was away on sick leave from 26 September to 7 October, from 10 to 14 October, and from 25 to 28 October 2005.

Debbie Guinn did not at any stage have managerial responsibility for the Home, although on occasion she stood in as acting Team Leader for Adult Services during periods of sickness or annual leave.

As Debbie Guinn put it in paragraph 18 of her witness statement in the Inquiry [**E/68/3**], her understanding of the Four Month Plan was:

> "... for the social workers to review the systems that were in place, and through discussion with both the workers and service users identify any changes that might need to be made in order to improve the environment for both the service users and workers. Any concerns were to be noted and recommendations made by the different parties in a general report to be shared with the different flats. This plan was fully supported and welcomed by Marie Gomez, Team Leader, Isabella Tosso, CEO, and Minister Netto[802]."

On 11 October 2005 Debbie Guinn sent a long email to Marie Gomez **[J1/42/1]** setting out a number of "factors and issues that need to be considered as they could account for some of the ongoing difficulties". Among those factors and issues, the email cited:

- staff shortages (leading to workers becoming disillusioned with the care they are able to provide);
- high levels of sickness and annual leave;
- absence of "care plans";
- little ongoing training, resulting in workers feeling "vulnerable, undervalued and isolated";
- lack of supervision (with a similar result);
- the fact that a number of workers who had worked at the Home for many years felt threatened by the proposed introduction of new systems and consequent changes in working practices and found it difficult working in a different way, giving rise to a need for "more input and training in order to change basic values and beliefs in respect of changing service provision";
- "veiled concerns from different workers around the management of [the Home] and an inconsistent approach to individual workers", coupled with awareness of "the incident that took place between the managers" – a clear reference to Joanna Hernandez' "investigation" – and a feeling that "the staff team could be easily split";
- lack of documentary records containing basic information concerning residents;
- "difficulties and discrepancies around the completion of some of the medication records, the administration of medication and recording of medical appointments and changes to medication programmes", which "obviously leaves service users at risk";
- the fact that the Manager (Joanna Hernandez) and the Deputy Manager (Sharon Berini) "appear unclear of their job descriptions and the different roles that [they] should be carrying out", coupled with the fact that they both considered the role of the Manager to be too large for one person, due to pressure of work on the Manager; and

[802] The Minister at the time was Yvette Del Agua. Jaime Netto did not take over from her until 2007.

- the fact that the Manager and the Deputy Manager were rarely able to leave their offices, resulting in a lack of monitoring of practice and procedures within the different flats and an inconsistency of care, and giving rise to a perception that the Manager and Deputy Manager were only to be seen in the flats when something had gone wrong.

I have no doubt that these shortcomings did exist in October 2005, and that Debbie Guinn was justified in identifying them.

However, the email went on to summarise what is described as "The Good News". Among the items of good news were:

- the existence of structures which enabled the social work team to have direct contact with workers and residents via both formal and informal channels;
- good feedback in respect of the social work input, with workers feeling supported and no longer working in isolation;
- excellent work by workers at the Home in respect of setting down guidelines and behavioural programmes, "even though formal care plans and risk assessments are not in place";
- improvements in communication; and
- reports from the Managers that they had received feedback from the workers that they felt more part of a team and valued.

I accept that list of improvements as correct.

The email concluded with a list of suggestions. These included:

- the need to ensure that new workers were retained;
- the need for care plans, supervisions and policies to be put in place;
- the need to resolve "the known conflict between the Managers", so that "the workers no longer feel they are operating in a climate of blame" – a further reference to the events of June 2005;
- the need for administrative support for the Managers, enabling them to spend more time around the Home;
- the need for more in-service training of workers;
- an enhanced rate of pay for workers dealing with residents presenting challenging behaviour;
- the need for established staff teams in each of the flats, with workers being moved to other flats only when absolutely necessary, thereby providing residents with a consistency of care and enabling better relationships to develop between residents and their carers; and

- the need for more permanent posts to be provided, so as to lessen the proportion of supply workers and the consequent difficulty of organising rotas so as to maintain consistency of care where possible.

In the course of her oral evidence to the Inquiry, Debbie Guinn was asked to explain her reference to workers' "veiled concerns" about the management of the Home. She responded[803]:

> "People were very cagey about saying anything, but there were these veiled indications that they felt they were like two almost like separate groups of people aligning themselves with different managers. .... People knew what had taken place between the two managers; [that] there had been conflict between the two managers."

In a Report dated 26 October 2005 and entitled "Report of findings of operational problems within Dr Giraldi Home", Jennifer Poole described in detail the current situation in the Home as she found it. In her oral evidence to the Inquiry she confirmed the terms of this Report, and elaborated on aspects of it.

The Report is divided into ten sections: "Meetings", "Visitor's book", "Medication", "Acting", "Reporting of incidents", "Health and Safety", "Procedure for allegations", Communication problems", "Senior's role" and "Transport".

Under the heading "Meetings", Jennifer Poole reported that during the previous two months or so a number of staff meetings had had to be cancelled because of lack of staff in attendance. She noted that there were a number of different reasons for their non-attendance, including the fact that night staff were not staying on for meetings, the fact that in some cases staff were not made aware of the meeting, the lack of suitable space in the Home to hold meetings, and the fact that staff were performing other duties within the Home. She suggested that a formal procedure should be introduced under which staff would be given appropriate advance notice of meetings.

Under the heading "Visitor's book", Jennifer Poole reported that although there was a policy under which a visitors' book was to be maintained in each flat, to be signed by every visitor on entry, that policy did not appear to have been properly observed. She suggested that a visitors' book be placed in plain view at the entrance to the Home.

Under the heading "Medication", Jennifer Poole identified a number of instances where medication had not been properly administered. She reported that in one instance a carer had decided, of his or her own accord, to give a resident what was in effect a placebo. Fortunately, however, a senior member of staff was present at the time and was able to rectify the situation.

Jennifer Poole also reported that in two instances medication was not given at the right times, with the consequence that staff had to be reminded to do so; and that in some instances medication had not been given at all or had not been signed for. She suggested that two full-

[803] See Day 15 page 184 line 2.

time nurses should be employed on alternating shifts to administer medication. She concluded this section of her report by saying:

> "I feel we are putting residents and staff at risk from medication being administered wrongly and causing damaging effects and are leaving the service wide open to possible legal action if this were to occur."

In the course of her oral evidence to the Inquiry, Jennifer Poole reiterated her criticisms of the ways in which medication was administered in the Home[804]. She considered that the mistakes which were made were caused by carelessness on the part of the staff, coupled with the lack of a proper system. She considered that medication should be administered by qualified nurses, saying[805]:

> "People weren't comfortable in administering medication when they didn't know what they were giving, and people were put in that position."

She regarded the administration of medication as "a serious continuing problem"[806].

Under the heading "Acting", Jennifer Poole identified a number of problems in relation to staff acting as seniors on a rotation basis. She noted that new supply workers had acted as seniors after having worked for only two weeks, and that as a result permanent staff had felt unsupported and had had to instruct the acting seniors in their tasks as the acting seniors were unsure of their role. She also noted that problems of communication had arisen in relation to Spanish-speaking supply workers with little command of English. She continued:

> "Although everyone should be given a fair opportunity to be able to act we also have to look into the [person's] skills and capacity to act up in the post and also the experience they have had within the service. Having someone acting who has only been there a couple of weeks places residents at risk because two weeks is not sufficient to get to know the residents and instruct other workers in the best ways of dealing with that client. I also feel it is unfair for supply workers to be given the opportunity to act in several different flat[s] due to their supply status and permanent staff only being able to act up in their own flat."

She accordingly suggested that "criteria should be implemented when deciding who may be eligible to act"; and that staff should have worked in the service a minimum of one year before they should be considered for an acting role.

Under the heading "Reporting of incidents", Jennifer Poole reported that:

> "... [t]he standard of recordings in terms of incident reports is extremely bad. Reports are either not being made of incidents or if they are most of the information is being omitted."

She went on to list four incidents which she had observed. The first related to a resident with bipolar disorder. She recorded that on almost every occasion when she had visited that resident

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[804] See Day 5 page 122 line 24 and following.
[805] See Day 5 page 126 line 11.
[806] See Day 5 page 127 line 25. The fact that the administering of medication was a continuing problem is confirmed by the evidence of Simy Herbert (considered later in this Report).

"there has been an incident [whereby] she [i.e. the resident] has accused people of stealing or has been verbally abusive to staff", yet no record of such an incident had been entered in the incident book. The second incident related to an occasion when she had asked members of staff where the incident book was, but no one could tell her. Thirdly, she noted that incidents which were recorded in the incident book tended to be played down in that staff did not follow the guidelines by explaining the situation in which the incident had occurred. Lastly, she noted that incidents were being reported verbally days after the actual event. She gave as an example an occasion when a supply worker had insinuated that one of her colleagues may have been asleep on duty, but had not recorded that in the incident book. When asked to write a report, the supply worker said that "she did not feel safe to do this as she did not want to be labelled".

Jennifer Poole accordingly suggested that staff should be better trained on how to write an incident report; that seniors should "do a handover to find out what has been happening the previous night" and check what has been written in the incident book; that members of staff should write up incident reports before leaving shift; and that the Deputy Manager should monitor the situation to ensure that incident reports are up to date.

Under the heading "Health and Safety", Jennifer Poole listed a number of concerns which had been raised. These included: doors to flats being left open; staff not asking visitors to identify themselves; staff not answering the door; not knowing where staff members are; the kitchen door being closed at night; keys being left unattended; ceiling tiles which have been moved to enable alarm systems to be installed being liable to fall down.

I accept Jennifer Poole's report as containing a fair and accurate account of the shortcomings then existing in the operation of the Home. As to her reference to a supply worker not feeling "safe" in reporting a member of staff for sleeping while on duty, as I indicated earlier one can well understand why a supply worker would feel reluctant to rock the boat by initiating a process which would almost certainly result in disciplinary proceedings against a member of staff, at which the supply worker would be required to give evidence. At all events, I am satisfied that there was no greater risk to the "safety" of members of staff or supply workers than that.

On 11 November 2005 Isabella Tosso attended at the Home and gave a talk to the staff and service users[807]. She exhibited the notes of her talk to her 2006 witness statement [**C2/3/17**].

According to those notes, she entitled her talk "The Launch". She began by saying that there were two main reasons for her presence at the Home on that day. The first was to meet the staff and service users; the second was to share with them what had happened since she took up the post of CEO and to explain the direction she was hoping the Home would take in the next six months. In effect, she said (according to her notes), it was "the launch of a new vision" for the Home.

[807] See para 14 of her witness statement in the Industrial Tribunal.

She went on to refer to the numerous managerial changes which had taken place since the SSA took over responsibility for the Home from Milbury. This, she said, had given rise to a number of problems for the staff. She listed these as:

- poor direction;
- lack of clarity;
- a sense of being overlooked by management and being left to "flounder alone";
- despondency;
- overworked;
- lack of clarity as to whether staffing levels are adequate;
- no supervision;
- slipping of care standards;
- absence of training; and
- "failure [of] managers to grasp the reality of the day to day work and to provide solutions".

Isabella Tosso went on to say that one of her first concerns was the lack of social work support in the Home and the need to listen to staff who were "at the front line of the concerns". She described their common aim as being "to deliver the best possible standard of care to our service users". Her notes continue as follows [**C2/3/18**]:

> "**Operational matters**
> 1. **Meetings.** These are not discretionary they are where decisions about practice are made and without one person attending everybody else may be wasting their time. [It's] an essential duty. Expectation that you attend. This will be obligatory from now on.
> 2. **Visitors books** These will be kept without fail, and a procedure followed.
> 3. **Medication.** Training and procedures will be provided and consistency followed in all flats.
> 4. **Substitution.** Although I want this to be equitable. I hear that in practice at the moment consistency needs to be more important. For a finite period we will have consistent substitution and this will be reviewed after 4 months.
> 5. **Reporting of incidents.** Training on Procedures and standards of report writing will be given and standards monitored.
> 6. **Accountability.** No visits by family of workers, by prior arrangements. A system for whereabouts of workers/managers/service users to be set up. Staff not on duty should not be on the premises unless on official business and not with their families.
> 7. **Health and safety** [Intercom] system to close doors and not allow access to all and sundry.
> 8. **Seniors.** Recently working weekdays Mon/Fri 9-5 has not worked. They will return to shifts to maximise availability of a manager to staff at all times.
> 9. **Supervision.** For all staff.
>
> **How?**
> **Four month blitzes, Social workers supporting Care workers, delivering training, setting up systems and when things up and running 4 weeks we will move onto the next. Make sure the nuts and bolts are working.**"

In relation to staff shortages, Isabella Tosso said that she felt that the reasons for this were the fact that sufficient account had not been taken of the diverse needs of service users, the changing composition of the staff, new resident admissions and no new permanent staff.

Her notes of her talk conclude with the following:

> "**Conclusion**
> I hope that this shows you that what you have been saying has been heard and has reached me and I am prepared to act on it. I am not ignoring anything that is happening in [the Home] on the contrary [it's] right at the top of my list of priorities. And the task is now to address the areas that have concerned you.
> 1. I see this as a new beginning.
> 2. You are not alone. We are doing this together."

This was in every respect a thoroughly laudable attempt by Isabella Tosso to lift staff morale in the aftermath of Joanna Hernandez' "investigation", and to set a positive course for the future.

Elizabeth Harrison was due to spend a fortnight monitoring the operation of Flat 1 in the Home starting on 14 November 2005, but due to other commitments she could not start that process until 17 November 2005. She set out her findings in a Report dated 12 December 2005 [**E/68/12, M23/10/1**]. She reported that the main problem which she found was the daily shortage of staff, and that on occasions the flat had been short-staffed, with no senior member of staff available. She continued:

> "The support workers take it upon themselves to sort out the day. The danger in this being that some workers [take] more than their fair share of responsibility and end up in burnout, and doing things their way as they are not aware of procedures. This is done in goodwill, and is not recognised by management."

She went on to refer to the high level of sick leave, coupled with the high turnover of staff, saying that many of the members of staff felt that this was due to the high levels of stress to which they were subjected. The Report continued:

> "What was interesting was that their individual work with the residents was not a cause of stress for them, this they thoroughly enjoyed and was what kept them going. They expressed [the view] that the main source of stress from the job was the way things were being run, not feeling supported, feeling vulnerable, and demotivated. I advised that such issues they should take to supervision. Supervision is not happening.
>
> Spanish speaking staff members are demoralised, even though they give of their best to the job. They have no prospect for the future. Those on twenty-hour contract[s] are on permanent [37½] hr shift[s] unable to get permanent contract for shift[s] they are working for a number of years. They feel that they will be done away with and so no job security.
>
> In order to address some of the issues stated above, I feel that formal support and supervision should be at the top of the list as a must that should be given to the entire staff group on a regular basis preferably once a fortnight. This should be given away from the workplace. I also feel it should be explained thoroughly to the staff members what supervision is and what they can take to supervision.
>
> Persons giving supervision should undergo training on how to give supervision, with observed role-plays.
>
> Activity sheet[s] should be set up within the flat by the senior support worker, in this way staff will know how to contact him/her at all times. Management should provide the senior with their activity sheet, in this way they will know when management is available. I have seen vast amounts of time lost by staff members in seeking out the whereabouts of other staff members.

> The times when there has been no senior in the flat, the residents have not been able to access their money, staff members have not been able to access the petty cash.
>
> I feel that the above-mentioned problems could be overcome, by having the deputy manager or manager going into the flat first thing in the morning 8.45am for the handover. If the senior is not in, they should do the handover and make the arrangements for the day. I also feel that if no one is going to act as senior the deputy should then carry out his/her work from the flat."

Elizabeth Harrison went on to recommend that the Visitors' Book should be kept in a designated place and should be used properly and regularly checked. She also noted a number of occasions when workmen had had unrestricted access to the Home, with the main door being unlocked. She recommended that management should decide how the flats should be accessed. She also noted that on occasion conversations about confidential matters would take place in front of workmen.

Under the heading "Medication", Elizabeth Harrison reported that medication was sometimes given late, and that medication sheets were not being signed. She recommended that medication sheets and packs should be regularly checked throughout the day. On other occasions medication could not be administered as supplies of it had run out. Elizabeth Harrison recommended that staff should be told that they should not wait until supplies had run out before requesting further supplies. She also described an occasion when a member of staff had been upset at what she regarded as lack of support from management, saying this:

> "Staff felt that it was not fair on them who try their best to work towards the best interest of the resident, even to the point of having to put up with verbal abuse, and then having no support from management."

The Report went on to recommend improvements to the maintenance of the Communications Book, including training for the staff in how to use it properly, rather than using it to "pass the buck".

Under the heading "Daily/Night Reports", the Report said this:

> "These reports are done for each resident. The format is a form with different headings one for the day staff and another for the night staff, the columns are personalised to meet the resident['s] needs.
>
> These I found were chaotic and at times sad. One of the headings is daytime indoor activity for some residents it mainly said watching TV. Another column is to record if the resident has helped in any household chore this column more often than not empty, this being the flat where the most ... able residents reside shows that we are not preparing them towards being more independent.
>
> ....
>
> I feel that these forms too should be checked frequently by [social service workers] and monthly by management."

Under the heading "Incident Report Book", the Report said this:

> "There is an incident report book for each resident. This book too had its flaws in the way recording was made for some incidents, and the lack of recordings. There has been incidents during my time in the flat, and these were not recorded.
>
> I also feel that [if] there is a major incident with any resident, management should be informed on the on call [sic] or first thing in the morning.
>
> Management should also be reading these books on a regular basis, checking how recordings are down, especially with such a turnover of staff and lack of ongoing training.
>
> ...."

The Report went on to refer to the low attendance of staff at staff meetings, saying this:

> "I have realised the poor attendance of staff meeting and the last minute cancelling of such meetings. The short notice given to staff and the way of giving out this information I feel is to do with the poor attendance.
>
> Date and time of meeting is written in the communication book, if a staff member has been away either on annual or sick leave how far back do they read the communication book, this being one of the reasons why staff members are not aware of staff meetings.
>
> To overcome this I feel that at least two weeks in advance the date and time of the staff meeting should be put up [on] the notice board and staff to initial it on reading it. Minutes of previous meetings[s] should be made available to staff to read before the meeting and also initial it."

Finally, under the heading "Communication with Residents", Elizabeth Harrison's Report said this:

> "It was very evident to me that because of lack of staff, large turnover of staff, and so [sic] flat continuously having new staff members or staff members from other flats covering staff are overstretched. They seem very concerned with doing all their chores but these were mainly household chores, accompanying residents to appointments, and crisis intervention.
>
> Very little normalised interaction between staff and residents. That is why I feel the residents are also de motivated, and each day that goes by want to do less. I feel they look upon the staff members as their maids, this is because they are used to seeing them mostly doing the household chores.
>
> Residents are not informed of changes happening within their flat as regards implementation of rules, changes of staff members, why staff members leave employment. So it is hard for them to feel at home in their own home."

I accept Elizabeth Harrison's Report as identifying current shortcomings in the operation of the Home. As to her comment about staff feeling unsupported by management, I accept that this was a matter to which management ought to have given greater attention. This was a problem which had existed while Joanna Hernandez was Manager, and which she had clearly failed to recognise. As Matthew Turnock says, in paragraph 120 of his witness statement [**K/1/29**] (evidence which I accept):

> "120. .... [Joanna Hernandez] would often unfairly put carers down and tell them they were bad at their jobs and this often resulted in carers taking time off sick as they could not work around her."

Jennifer Poole also spent a number of days observing what went on in Flat 1 in the Home. In the first section of her Report dated 12 December 2005 [**E/68/34**], under the heading "Time Management", she noted that much time was wasted by staff having to go to the office to ring for cover, and in looking for members of staff to implement rotas, and that there was no proper system for recording where members of staff were. She also found that tasks were not being prioritised effectively, and that staff spent more time carrying out menial chores than in spending quality time with residents. Much time was also wasted by staff being unable to locate information or keys. Staff were also arriving late for their designated shifts, with the result that handovers had to take place later in the day and that further time was wasted in handing over and reading documents "which should have been done in the first half hour on shift".

Under the heading "Communication", Jennifer Poole stressed the importance of handovers, recommending that tasks should be rotated so that everyone could have an opportunity to carry out each task. She noted that staff had been arriving late; that managers had not carried out handovers until well after 9am; and that staff had for the most part had to choose what tasks they would undertake. She recommended that proper notice be given of staff meetings; that such meetings should not be held in the presence of residents; and that minutes of such meetings should be circulated promptly. As to the daily reports which staff were required to complete, Jennifer Poole found that the information currently being recorded was of little use and frequently did not reflect accurately what had happened during the day. She noticed, however, that the communication book was now being used appropriately. The only problem with the communication book was that it tended to be left around for anyone to read.

Under the heading "Health and Safety", Jennifer Poole noted that main doors continued to be left unlocked, despite instructions to the contrary, reporting that she had seen delivery men and relatives of residents in other flats entering by the main door without knocking. She also noted a number of problems in relation to the administering of medication. Sometimes medication was not given at the right time; at other times it was not given at all, or a dose was forgotten; medication was not always signed for; new workers had been giving medication without supervision; relevant records sometimes went missing; staff on occasion had to collect medication direct from the chemist, without prescription, due to shortage of available staff; and it was not always possible to check whether the pharmacist had supplied the correct medication (on occasion the pharmacist was found not to have done so). She also noted that the Visitors' Book was frequently missing, and that workmen were frequently signing themselves in for the whole day rather than signing in and out. As to confidentiality of information, she noted that confidential documents were frequently left out for anyone to read, and that confidential information was frequently discussed in front of residents. She considered that this was due in large part to the office being locked when the senior was not on shift and to the fact that "people are in and out of the medication room making it very easy to [eavesdrop] on the conversation".

Under the heading "Working Practices", Jennifer Poole noted that incident reports were now being written more regularly, although not always immediately after the event; and that members of staff tended to record incidents which affected them directly and not incidents affecting residents on their own. As to smoking, she noted the SSA policy of not allowing residents to

smoke within the Home: a policy which was causing distress to a particular resident who had a compulsion to smoke. She noted, however, that there was no way of physically removing cigarettes from that resident, or of ensuring that she only smoked outside. As to access to the flats, she noted that people (including workmen) were broadly able to come and go freely without being challenged; and that people ringing the door bell were being invited to walk in without first being required to explain who they were. She noted that it was common practice for members of staff to bring presents for residents from their own home to cheer residents up. As to this, she commented that such a practice could create favouritism between staff and that it was not conducive to good practice to do so. She noted that for the most part there were three male residents in Flat 1, whereas most of the available carers (particularly new support workers) were female. She concluded that this presented a problem since two of the male residents needed support with personal care and were not comfortable with female carers. As to the induction of new workers, and the process of "shadowing" existing members of staff, she considered that this process was not working properly, adding:

> "Flats are quite short staffed as they are, and the last thing staff need is to show how they do the job."

Jennifer Poole went on to say that supply staff had often been "thrown in the deep end without much chance to shadow as they have been put directly on shift as there has been no staff to cover". She also considered that workers needed clarification as to the nature of their roles and as to what was expected of them, in order to prevent anxiety levels from building up. She noted that keys were often left lying around, notwithstanding that members of staff were responsible for keys in their possession. She reported that vehicles available to Flat 1 were inadequate, causing frustration amongst the staff and demoralisation among the residents. She noted that new vehicles were being purchased, but was concerned that if the new vehicles were looked after in the same way as the existing ones the same problems would be likely to recur.

As to relations between members of staff and relatives of residents, Jennifer Poole reported that the staff had encountered problem in that relatives would come into the flats unannounced, would refuse to sign the Visitors' Book, and would be rude to staff. The Report continued:

> "On occasions they have shouted to staff about the levels of personal care which they do not feel are up to an acceptable standard. With other residents they [i.e. the staff] feel that their work is being [undermined] by relatives who tell staff to go against guidelines under their authority or give relatives inappropriate gifts which trigger some of their behaviours. They also have problems in relatives saying they will visit and then not turning up leaving residents vulnerable and in a bad mood for the rest of the day."

Jennifer Poole went on to say that there was a problem with relatives retaining residents' money and administering it themselves. She regarded this as very demeaning for the residents, who had to ask permission to spend their money, as well as being very awkward for members of staff who had to act as go-betweens. She went on to say that some relatives viewed the flat as their resident's home and accordingly did not feel that they needed permission "to go in and look around the room and criticise the level of care given"; and that, rather than reporting any perceived lack of care to senior management, relatives tended to take it out on the staff. She

considered that this placed the staff in a very vulnerable position, leading to the staff taking steps to avoid a confrontation with the relative, a course of action which could in turn be detrimental to the resident.

Jennifer Poole also reported that staff were having problems with the behaviour of residents, saying this:

> "For quite a while now residents have been told that the flat is their home and they have a right to choose what they do in their home. The problem is that there are 7 very different people living together wanting to do their own thing and not wanting to be told by staff that their behaviour is unacceptable.
>
> .... [Residents] have learnt that if they threaten staff with reporting them they can sometimes get what they want. Staff in the past have felt very vulnerable when accusations against them have been made and sometimes feel it is best not to challenge them when they are in that mood.
>
> There are some behaviours that are exhibited by some residents that are extremely out of order. They will be verbally abusive towards other residents and staff. Some have been physically aggressive. They refuse to follow guidelines and know that ultimately staff is powerless to do anything about it. .... This is the legacy that has been left in [the Home] through not having contracts drawn up with the service users when they first came in. Ultimately we are powerless to do anything. If they comply with the care plans it is because they want to but for those who don't conform we are powerless to do anything about it.
>
> This makes the staff feel extremely vulnerable. It also places those residents who do comply at risk from those who feel they can do as they please."

As to supervision, Jennifer Poole reported that a number of appointments for supervision had been cancelled or postponed due to lack of staff. She continued:

> "All staff need supervision in order to be able to [debrief] and be able to go over their practice issues to ensure that everyone is working towards the same standard. It is also a safe forum where staff can ... work through problems they may be having with particular residents or staff members. This is not taking place regularly so therefore a lot of bad practice is not being picked up and challenged and staff are not being able to feel supported."

Under the heading "Staffing", Jennifer Poole reported that staffing levels were a major problem affecting the running of the Home. She concluded that although there might be a full staffing complement, in practice there were not enough members of staff to go round; and that staff were being continually moved from one flat to another in order to provide cover. This in turn made residents feel vulnerable as they continually had to build up relationships of trust with new members of staff and no sooner was such a relationship established than the member of staff was moved. Jennifer Poole commented that she could not think what it would be like to be washed by at least ten different people in the space of one week. She also noted that members of staff were being moved on short notice, adding that this lowered the morale of residents in that they could not plan for anything and continually felt let down.

Jennifer Poole found the morale of both staff and residents in Flat 1 to be extremely low, and that members of staff felt overworked and under-appreciated.

So far as staff were concerned, she listed the causes of their low morale as follows:

> "Underpay
> Long hours
> Spanish workers unable to apply for [permanent] posts
> Lack of supervision
> Lack of guidance/support
> Lack of acknowledgment
> Lack of resources for service users
> Fear of repercussions
> Lack of communication."

So far as residents were concerned, she listed the causes of their low morale as follows:

> "Changes in staff
> Lack of communication
> Lack of resources
> Not being involved in decision making."

The Report continued:

> "There has been a high turnover of staff in the last year and the pattern that is emerging for me is that people are leaving because they are unhappy with their work conditions. Most of the service is being run on the [goodwill] of people who don't want to let the service users down. However, staff are getting increasingly de-motivated and it is only a matter of time when the service is going to lose all the good supply workers that are covering most of the shifts. People need job permanence and security which they are not getting. Good workers are feeling de-motivated because even though they know they are doing a good job and are covering most of the shifts they are not entitled to apply for permanent posts because they don't speak English. It is understandable that from an equal opportunities perspective ... the post has to be given to the best candidate on the day, however, I feel that although the system may be good in recruiting new staff for supply workers it is not a good system for permanent posts as people may not necessarily be good interviewees but may have terrific skills in being a carer."

In the final paragraph of her Report, under the heading "Conclusion", Jennifer Poole said this:

> "This report has looked at several issues that impact on current working practices within Flat 1 in [the Home]. Several suggestions have been given which may help alleviate some of the shortfalls in the service. Ultimately what the 2 week period within [Flat] 1 has demonstrated is the lack of direction and poor morale of the staff. It is felt that unless these vital things are changed it will be very difficult to achieve best practice."

Jennifer Poole also spent a fortnight monitoring Flat 2. Her Report on Flat 2, which was also dated 12 December 2005 [**F/2/70**], followed broadly the same format as her Report on Flat 1, and identified a number of similar shortcomings. She found that there were only limited activities available for the resident of Flat 2, saying this:

> "I have found that in flat 2 that activities are very limited. For the most part service users don't have anything to focus their attentions on. Activities available mostly revolve around getting service users to accompany staff when purchasing items, going for a walk, going for a drive, arts and crafts or watching tv. For the most part they just hang around the kitchen not doing much. Staff have at least demonstrated some initiative by taking service users to 'Fired for you' a shop that specialises in firing clay ornaments which can be painted using hired paints. However this has turned into the highlight and is usually the only activity carried out."

Under the heading "Morale", Jennifer Poole found that there were difficulties of communication between English- and Spanish-speaking care workers, and problems with English-speaking care workers communicating with Spanish-speaking service users. She recommended that a qualified language teacher be employed by the SSA in order to resolve this problem.

Jennifer Poole's Reports on Flat 1 and Flat 2 represented an accurate, thoughtful and constructive response to Isabella Tosso's "four month plan".

Elizabeth Harrison spent 12 to 23 December 2005 monitoring Flat 2. In her Report on Flat 2 [**E/68/20**], which is undated, she noted that, as in the case of Flat 1, workmen walked in and out of the flat "as if in their own home". She found that residents had more opportunities to do things for themselves, but that little guidance was given to them on how to prepare meals. She noted "[c]ontinuous picking of snacks i.e. making sandwiches, biscuits, throughout morning and afternoon". After making a number of recommendations for improvement in relation to various relatively minor administrative matters, she ended her Report by saying:

> "ON A POSITIVE NOTE I LOVED THE TEAM MEETING WE HAD ON THE FRIDAY IT'S THE FIRST TIME I HAVE SEEN SUCH INTERACTION AND NOT JUST LISTENING."

In a written Report dated 12 January 2006 [**M29/18/1**], which had been commissioned by Yvette Del Agua, Rod Campbell (Head of Operations for Milbury) addressed a number of issues, some of which concerned the Home.

Rod Campbell began his Report by considering the ratio of staff to residents at the Home. He found that staffing resources were stretched in meeting the current level of need at the Home. He recommended the creation of a part-time administrative post, to take some of the burden of administration off the shoulders of the managers. He also recommended increasing the numbers of staff so as to provide an additional support worker in each of Flats 1 and 2 for at least half of each day.

Rod Campbell went on to consider the problem of absenteeism. He found the levels of absenteeism at the Home to be higher than at comparable establishments in the UK, saying:

> "There may or may not be legitimate reasons for this difference but effective management of sickness absence is showing that there is room for improvement at [the Home]."

As I have already indicated, I accept that staff shortages and absence of staff through sickness were continuing problems.

Elizabeth Harrison spent from 16 to 27 January 2006 observing what went on in Flat 3 in the Home. Flat 3 was the Flat designated for respite use, but one bedroom in that flat was occupied by Resident AE. As noted earlier, the senior care worker assigned to care for Resident AE was Craig Farrell.

In her oral evidence to the Inquiry, Elizabeth Harrison was critical of the standard of care provided to Resident AE by Craig Farrell, saying that on one occasion he had raised his voice to Resident AE[808]. She also said that she had gained the impression that the carers in Flat 3 wanted an increase in salary to reflect the difficulties in caring for Resident AE, and that they were attempting to demonstrate those difficulties to her[809]. I reject those criticisms of Craig Farrell. As I indicated earlier, I am satisfied that he was an excellent carer, who had built up a very good relationship with Resident AE[810].

In her Report on Flat 3 dated 7 February 2006 [**E/68/9**], Elizabeth Harrison noted that the Communication Book was not being kept up to date. She was also "alarmed to see the amount of times that messages are left by management stating that either respite or [F]lat 1 are [short staffed]". She went on to make a number of suggestions for improvement in the care of Resident AE, stressing the desirability of continuity of his care and suggesting that a team of carers should be identified for that purpose. She noted that on one occasion Resident AE had been made to walk to a shop in pouring rain without water-proof shoes and clothing. She regarded it as "abusive" for him to have to walk "in appalling weather conditions without providing the adequate kit".

Elizabeth Harrison repeats this criticism of Craig Farrell's care of Resident AE in her witness statement in the Inquiry, where she says (in paragraph 16 [**F/6/3**]):

> "16. I confirm that I did not witness any sexual or physical abuse in the Home. I did however witness bad practice by carers towards the residents ....
>
> By way of example of bad practice, I recall one resident [a reference to Resident AE] being deliberately provoked by Craig Farrell which led him to behave badly. I also witnessed the same resident eating on his own whilst the carers were not supervising him and were altogether [sic] in another room. This resident was also forced to walk long distances from the incinerator to the light house in the south district despite there being torrential rain and not wearing the appropriate clothing. The carers did not change his clothes on return."

In the course of his oral evidence, Craig Farrell was referred to the above passage in Elizabeth Harrison's witness statement. Asked whether he recalled deliberately provoking Resident AE, he replied[811]:

> "Absolutely not, sir. No. .... I wouldn't send the gentleman out in the rain. All of a sudden the weather might have changed."

I have no hesitation in accepting Craig Farrell's evidence, in preference to the evidence of Elizabeth Harrison.

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[808] See Day 6 page 50 line 2.
[809] See Day 6 page 51 line 18.
[810] See Chapter 9.
[811] See Day 9 page 100 line 4ff.

In accordance with the original plan agreed with Isabella Tosso, Debbie Guinn then wrote Reports on each of the flats, in the nature of an overview of the Reports prepared by Elizabeth Harrison and Jennifer Poole. As she explained in evidence to the Inquiry[812], she did so because she was concerned that some of the conclusions reached by them were subjective and involved individual residents. She continued:

> "... [w]hich I did not want to then share at a team meeting in the different flats with everybody. I did not think it was relevant. So what I did was I took all the information out of the different reports, collated it into a small report for each of the flats and then I made sure that all the reports, including the ones from Jennifer and Elizabeth were all sent to the managers of [the Home] and also to my senior managers and to the Minister. So everybody was aware of all the information of all the reports, but the people in the flats had the information regarding the systems and I took out the subjective information."

Debbie Guinn's Reports are undated, but the likelihood must be that they were written in February or March 2006.

In her Report on Flat 1 [**E/68/64**], under the heading "Time management", Debbie Guinn said this:

> "There [appear] to be great difficulties around the management and use of time. The senior support worker has to spend large amounts of time away from the flat working on the rotas. The rotas for flat 1 [are] made up using a significant number of supply workers covering permanent shifts and this added to sick leave and annual leave results in large amounts of time being spent ringing around trying to obtain cover for the different shifts.
>
> Workers going off sick have been contacting the flat and their messages have been recorded in the communication book. These messages are not being picked up or dealt with quickly resulting in there being a shortfall of staff until another worker can be identified and put on shift.
>
> Effective handovers have not been taking place resulting in workers on shift in not having the necessary information or direction in order to be able to carry out the various tasks efficiently. Workers are often unclear as to how tasks are to be allocated or what appointments are planned for the day.
>
> There is no clear place to record where different managers or the senior support worker are when they are absent from their workplace and need to be contacted."

Debbie Guinn suggested (among other things):

- that handovers be viewed as a critical part of the daily routine;
- that in the event of the senior support worker not being on shift, the acting manager should lead the handover and allocate tasks first thing in the morning;
- that workers needed to be made aware of the importance of arriving for work at the agreed starting time;
- that an extra quarter of an hour should be built into the rotas to allow for handovers;
- that a request should be made for administrative staff, so that managers could play a more active role in the flats, supervising and leading the workers;

[812] See Day 15 page 128 lines 8 – 24.

- that arrangements should be made to enable the manager to be contacted more easily to report absence through sickness early in the morning to enable cover to be secured quickly; and
- that the SSA's sickness policy should be implemented.

Under the heading "Communication", Debbie Guinn reported (among other things) that managers, service users and support workers had all expressed concern about the need for effective communication; that information recorded in the various records failed to ensure that information was passed on effectively; that the communication book was not being used properly; that workers starting their shifts did not have time to read the relevant records, which resulted in their failing to know the tasks of the day or the specific needs of the various service users; that attendance at team meetings was not regarded as essential and that attendance at such meetings was poor; that workers were not always aware that such meetings were taking place; that the manager and deputy manager were unable to monitor what was happening in relation to record keeping and recording due to pressure of office work; and that service users had complained that they were unaware of what was happening in their flat in relation to staffing. She suggested (among other things):

- that administrative support should be available, to enable the deputy manager to carry out her responsibilities in respect of monitoring practice and procedures and supporting workers in the day-to-day running of the different flats;
- that procedures in relation to record keeping should be tightened up;
- that recording procedures should be unified throughout the different flats; and
- that regular meetings of service users should take place, so that they could be informed of proposed changes.

Under the heading "Workers", Debbie Guinn reported that the morale of workers was low, and that they felt unsupported by management; that service users often threatened to report them if they did not comply with the service user's wishes, e.g. making them tea and cutting their toast; that service users constantly stated that their flat was their home, and that the workers were there to carry out their instructions; that workers complained that they had too little contact with their managers or senior support workers, as a result of pressure of work; that Spanish workers regarded themselves as undervalued and felt insecure; that having mixed teams of Spanish and English speakers was causing communication difficulties; that high levels of annual leave (particularly at the end of the year) and absences through sickness, together with the high level of supply support workers was causing difficulties in providing consistency of care for service users; that support workers appeared generally to be unsure of their role; and that workers had reported that they were not receiving sufficient training to enable them to carry out their roles effectively.

Debbie Guinn suggested (among other things):

- that care plans should be put in place for all service users;

- that effective handovers take place on a daily basis;
- that team meetings take place regularly, with a clear agenda;
- that a rolling programme of training be introduced;
- that supervision be carried out on a regular basis, and regarded as a fundamental part of the support process; and
- that a review of staffing be carried out, in order to ascertain the levels of staffing required in relation to the specific needs of the service users.

Under the heading "Health and Safety", Debbie Guinn reported (among other things): that a number of issues had arisen, which needed to be urgently addressed, in relation to the incorrect administering of medication and to medication having been incorrectly packaged by the pharmacist; that an additional supply of thermometers and rubber gloves was needed; that no fire training had taken place and that a recent inspection had found that various works needed to be carried out urgently to prevent the spread of fire; that the front and kitchen doors to the flat continued to be left open; that verbal handovers were conducted in earshot of service users; that there had been a number of thefts in the flat, in respect of which the police had been called; that on many occasions keys were not available to enable service users to have access to their petty cash; and that the condition of the available vehicles was on occasion unsafe.

Debbie Guinn suggested (among other things):

- that in-house training and an on-going assessment of competence in relation to the administering of medication be undertaken as a matter of urgency;
- that a system be set up to ensure that keys to the petty cash are available when required;
- that the Fire Department be contacted with a view to their providing training within the Home, relevant to the needs of each of the flats;
- that a system be put in place to ensure a prompt response in relation to the urgent repairs which need to be undertaken; and
- that a system be put in place to ensure that those using the vehicles were responsible for returning them in an acceptable and safe condition and that any faults were reported promptly.

Under the heading "Working Practices", Debbie Guinn reported (among other things): that that there were no care plans in place for the different service users or guidelines clearly setting down the best way of supporting each resident, making it difficult for established workers, and impossible for supply workers, to work in a consistent way with service users and causing low morale among the workers; that workers were often abused by both service users and their family members, and that they (the workers) appeared to view this as part and parcel of their working environment; that service users often demanded that support workers undertake menial chores, resulting in the service users failing to develop their own daily living skills; that the combination of workers being unclear about their role, the pressure put on support workers by service users and lack of staff available due to annual leave or sickness had resulted in only the physical needs of the service users being met; that service users who did not demand attention

were often overlooked and left to stay in their bedrooms with little or no stimulation or social contact taking place; and that there appeared to be a culture of workers bringing in gifts and second-hand clothing for service users and at times treating them like children, "e.g. hugging or kissing indiscriminately without establishing the service user's wishes and allowing a male service user to pinch women's bottoms".

Debbie Guinn suggested (among other things):

- that care plans and formal review systems be set up;
- that meetings be set up on a fortnightly basis to identify difficulties being experienced in putting care plans and review systems in place;
- that house meetings take place to defuse difficulties between different service users;
- that meetings take place with service users to ensure that they understood the role of the support workers and the purpose of the service in the development of daily living skills;
- that families should play a part in the process of setting up care plans and formal reviews; and
- that training should be provided in relation to "care-planning, supporting people through independence training and the philosophy of care incorporating the underpinning values and attitudes towards people with disabilities".

Finally, under the heading "Conclusion", Debbie Guinn said this:

> "All the above difficulties and suggestions have been raised through briefing meetings that take place on a weekly basis with the Acting Manager at Dr Giraldi and a number of the suggestions have already been implemented.
>
> It has been a very difficult time for Dr Giraldi and the staff group. The general consensus is that urgent changes to support systems and staffing levels need to take place in order to allow consistency of care and to ensure that more than the basic physical needs of the service users are met.
>
> The workers at Flat 1 are very committed and keen to see improvements that will facilitate a safer working environment in which they can meet the sometimes complex and specific needs of the individual service users."

Debbie Guinn's Report in relation to Flat 2 [**E/68/55**] was in very similar terms to her Report in relation to Flat 1, save that she found the atmosphere within Flat 2 to be "calm and relaxed, with workers talking in a manner that would establish good working relationships with service users". Under the heading "Conclusion" in her Report in relation to Flat 2 she said this:

> "A number of suggestions made after the review of Flat One have already been implemented in Flat Two and these have not been included in this report.
>
> The review of [F]lat Two took place whilst the senior support worker was acting as firstly the deputy manager and then for significant periods of time as the manager.

> The two shifts in Flat Two worked in different ways and were perceived as experiencing a number of difficulties as a result of inconsistencies in approach to both the service users and the tasks to be completed.
>
> All the workers in Flat Two are very committed and keen to ensure that the service users receive the level of support they require. This is made difficult at times given the diversity of needs and levels of support and monitoring required by the different service users.
>
> As the medical needs of the service users are likely to increase further given their ages and various medical conditions already being experienced, future planning needs to identify the best way of meeting the complex and diverse needs of the different service users within the flat setting.
>
> It would be important that the different systems in place within Flat Two were monitored on a regular and frequent basis [in] order to ensure that they were working effectively and were consistent with the systems in the other flats.
>
> It is imperative that the deputy manager is freed up in order to be able to monitor the day to day running of the different flats and ensure that the new systems in place continued to be used effectively.
>
> Without adequate administrative support being available it would be very difficult for the deputy manager to carry out the tasks required to ensure that the new procedures were implemented fully and effectively."

Debbie Guinn's Report in relation to Flat 3 (the respite flat) [**E/68/50**] followed the same format as her other two Reports, and identified broadly similar shortcomings. However, much of this Report was taken up with considerations relating to the care of Resident AE, who was (as noted earlier) resident in Flat 3. Thus, she began her Report in relation to Flat 3 by referring to the individual needs of Resident AE, as follows:

> "It was agreed in respect of Flat 3 [that] a unit [would be] created to meet the individual needs of a young man with behaviour that was seen to challenge, that only one of the social workers would work within this flat. This was to ensure as little disruption to the service and routines of the service user and prevent an escalation of inappropriate behaviour. As the service user knew one of the social workers [a reference to Elizabeth Harrison] and the unit was markedly smaller than the other units, the decision was made that she would spend a period of three weeks in the flat."

In paragraphs 38 to 40 of her witness statement in the Inquiry [**E/68/6**], Debbie Guinn said this about recruitment of staff at the Home:

> "38. In terms of recruitment, I do recall there being an effective process of recruitment in place where potential employees were made to undertake group exercises where we could assess their attitudes and interaction skills, as well as interviews. Marie Gomez and someone from Human Resources also played an active role in these interviews.
>
> 39. Within my role as senior social worker I was involved in the interview process. At this time the candidate has an individual interview, participated in a group interview and then completed a test in respect of the petty cash imprest as this was an aspect of the work and had caused some workers in post difficulties. We used a scoring matrix system to ensure the strongest candidates were selected for the post under Equal Opportunities procedures.
>
> 40. At this time, short listing was also implemented and candidates were also given a pack to include information advising them of the need to write their application to the job description and person specification. This was to ensure people being interviewed had the experience, knowledge and skills relevant to the different posts. ...."

In her oral evidence to the Inquiry, Debbie Guinn confirmed the contents of her three reports and elaborated upon various passages in them. She recalled the occasion when Isabella Tosso had asked her to undertake a review of the flats in the Home, saying[813]:

> "She [i.e. Isabella Tosso] said that Joanna Hernandez had brought a number of concerns to her attention which had raised a number of deep concerns, and that she ... had also got conflicting information from different areas, and she was very keen for me to go down to talk to all the different parties and to look at, try and establish what the situation actually was down in [the Home] regarding the systems, care practice, and any concerns that the actual workers actually had around issues to do with the management at that particular time. .... It was [to be] just a general overhaul."

As mentioned earlier, Debbie Guinn had little contact with Joanna Hernandez. She said that she enjoyed good relations with all the managers at the Home, and with her colleagues at the SSA[814]. Asked about her impressions of Marie Gomez, Debbie Guinn said[815]:

> "[S]he was obviously responsible for the social workers as well as I was, so ... when we made suggestions she always took them on board and was quite keen to try and move things forward."

Asked about her impressions of Sharon Berini, Debbie Guinn said[816]:

> "She was very reliable. .... She ... carried out the tasks which were set for her. ... [She] effectively ... worked well with me."

Asked about her impressions of Sean Matto, Debbie Guinn said[817]:

> "All I can say is the tasks I have asked Sean to carry out, he has always carried out."

As to the process of carrying out the review, Debbie Guinn said[818]:

> "I spoke to the different seniors and also spent some time with the care workers to try and find out what systems in place they felt were working well and what was making their job more difficult, with a view to being able to look at the systems and support which we might be able to put in to make everybody's job better and easier, and also to make sure the service users were fully supported."

Commenting on her Report on Flat 1, Debbie Guinn said[819] that one of the problems in relation to time management was that:

> "... every time somebody went off sick, they had a rota system, so the senior support worker was continually pulled off. If somebody was sick, they had to find cover. So a lot of their work and the sickness levels were very high and annual leave would be asked for, a lot of the time was taken away from the flat in order to be able to fulfil the rota."

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[813] See Day 15 page 125 line 4.
[814] See Day 15 page 126 line 11.
[815] See Day 15 page 126 line 5.
[816] See Day 15 page 121 line 17.
[817] See Day 15 page 198 line 8.
[818] See Day 15 page 122 line 19.
[819] See Day 15 page 168 line 19.

In relation to staff morale in Flat 1, Debbie Guinn said[820] that that was a particular problem because one of the female residents in that flat had mental health issues which resulted in conflicts between her and other service users, thereby causing additional pressure on, and additional stress to, the staff. Furthermore, some of the other service users would threaten the staff, saying that they would report them if they did not do what they wanted and treating them "like maids"[821]. She continued[822]:

> "[T]here was a problem with the service users treating it like a hotel, really, ... [and] these people were more able than the people in Flat 2, so they should really have been able to develop their daily living skills to a greater extent than the people in [Flat] 2, but with their attitude they saw the carers' role as doing everything for them. ... [S]o they weren't happy to participate in preparing meals, to learn ... how to cook, or making their beds, or helping [by] doing the washing. They saw that as the carers' role, and they ... didn't wish to participate."

As to visits to the Flat by family members, Debbie Guinn said[823]:

> "... there were certain family members of service users who would feel it was their right just to access the flat whenever they wanted to, and make demands, and when those demands weren't met were quite abusive to the workers. So I suggested that if they did come to the flat and they did want certain information then they needed to talk to the Deputy Manager ... or the senior support worker, as opposed to the care workers."

However, Debbie Guinn acknowledged that it was definitely not all "doom and gloom"[824]. She continued:

> "You had lots of dedicated workers who were keen to move the service forward. I think a lot of the difficulties have been around systems and lack of systems which were actually in place at that time. ... [T]here were lots of dedicated people who were very keen to do their job well and to improve the service they could provide for people."

Commenting on her Report on Flat 2, Debbie Guinn stressed[825] that use of language was important when working with people with disabilities, because:

> "... at the end of the day language is power in a way, and you can either disempower people or empower people. So that's why I think work was done around the use of language generally, and around how people liked to be addressed ..."

As to the residents in Flat 2, Debbie Guinn said this[826]:

> "They ... were physically less able than a lot of the other service users within the flats, but within this flat they actually actively encouraged people so if somebody might ... only be able to like chop up something, but the workers would encourage them to do whatever task they could with them. And that's why they sometimes became frustrated because they didn't always have the amount of time they would like to encourage the service user to be able to reach their full potential, really."

[820] See Day 15 page 173 line 15.
[821] See Day 15 page 175 line 1.
[822] See Day 15 page 178 line 2.
[823] See Day 15 page 177 line 15.
[824] See Day 15 page 179 line 25.
[825] See Day 15 page 161 line 15.
[826] See Day 15 page 161 line 25.

She also said that the Manager and the Deputy Manager had so much office work to do that "there wasn't enough monitoring around the different flats and making sure there is consistency of approach throughout the [Home]"[827].

As to staff shortages, she agreed that staff were "spread pretty thinly", and that the problem was aggravated by high levels of sick leave[828].

Asked about staff morale and motivation, Debbie Guinn said this[829]:

> "There are lots of people there who are really, really committed to their job, but I think because they feel they ... were only able to do ... the daily tasks as opposed to doing any meaningful activities with them [i.e. the residents] sometimes. .... You had lots of dedicated workers who were very keen to move the service forward. I think a lot of the difficulties have been around systems and lack of systems which were actually in place at that time ... As I said, there were lots of dedicated people who were very keen to do their job well and to improve the service they could provide for people."

Commenting on her Report on Flat 3 (the respite flat), Debbie Guinn stressed the need for a consistent staff team to care for Resident AE, given his autistic tendencies and challenging behaviour[830]. Hence her suggestion that the membership of that team should be changed as little as possible. She explained that there would always be two carers caring for Resident AE: either a senior support worker plus support worker, or two support workers[831].

In relation to handovers in Flat 3 and generally, Debbie Guinn had this to say[832]:

> "The difficulty with handovers was that they weren't taking place very effectively inasmuch as the people leaving the night shift might ... write a few lines in a book to state what had happened to the person overnight, but it wasn't always picked up by the day staff. So what we were suggesting, which was actually implemented in the end, was that they had a quarter of an hour handover period during which the night staff used to give a verbal handover as well as a written handover to the next people coming in so that everybody was quite clear about what had happened, and there was a consistency of information."

Debbie Guinn explained[833] that by the expression "care plan" when used in her Reports she meant:

> "[A] comprehensive document which looks at all the different areas of [a resident's] life and looks at things which actually could cause levels of risk to that person or to other people."

She went on to say that she found such documents were lacking in 2005[834].

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827 See Day 15 page 164 line 19.
828 See Day 15 page 166 line 22.
829 See Day 15 page 159 line 12 and *ibid.* page 179 line 25.
830 See Day 15 page 132 line 11.
831 See Day 15 page 136 line 20.
832 See Day 15 page 133 line 13.
833 See Day 15 page 141 line 25.
834 See Day 15 page 142 line 13 and *ibid.* page 156 line 22.

I accept the findings and conclusions of Debbie Guinn in her Reports, based (as they were) on her own experience and on the Reports provided by Elizabeth Harrison and Jennifer Poole. I also accept her evidence to the Inquiry (both written and oral) without qualification. I regard her evidence, coupled with her Reports, as providing a comprehensive and accurate picture of the operation of the Home in late 2005 and early 2006. The general picture which she paints is of an operation still bedevilled by a shortage of staff (aggravated by high levels of sick leave), with committed care workers struggling to deliver the best possible care to service users, some of whom presented with challenging (and in at least one case violent and/or abusive) behaviour and others of whom tended to treat the Home like a hotel. Added to that, the Manager and Deputy Manager had only limited time available to oversee the day to day operation of the Home, due to the amount of paperwork which they were required to undertake.

It is also clear from Isabella Tosso's initiation of the Four Month Plan, and from her talk on 11 November 2005, that she was aware of problems in the Home and that she was concerned to try to resolve them so far as possible.

In April 2006 Isabella Tosso instructed Iain McNeil (who had by then replaced Joanna Hernandez as Manager of the Home) to draw up a Business Plan in relation to standards of care in the Home [**see C2/2/50**]. On 8 May 2006 a meeting took place between Isabella Tosso, Marie Gomez, Iain McNeil and Debbie Guinn, at which the proposed Business Plan was further discussed. It was agreed that Iain McNeil should produce a first draft of the Business Plan at their next meeting, which was scheduled for 26 May 2006 [**see C2/2/50**].

In the event, the final version of the Business Plan ("the Plan"), which was dated July 2006 [**D44/57/1**], was the joint work of Iain McNeil and Sharon Berini. It is clear from its terms that it is based on a precedent from the UK. It is an impressive document covering in exhaustive detail all aspects of the services provided by the Home, setting standards and identifying points for action. I find it difficult to envisage a more constructive and comprehensive blueprint for the future running of the Home.

The introductory paragraph to the Plan reads as follows:

> "The long-term goal of Dr Giraldi Residential Services is to develop quality service provision for Adults with a Learning Disability in Gibraltar. Services that are accountable and which can demonstrate good practice in all aspects of service provision and can demonstrate that what is provided is value for money. By developing standards we will be able to provide a service which not only meets the needs of current service users more effectively but one that is open to change and which will meet the needs of future users and in which quality provision is a major foundation of service provision and development."

The purpose of the Plan is expressed to be:

> "... to look at how the services provided can develop and how standards of service provision can be improved upon so that we can mirror and exceed those standards set down throughout the rest of Europe."

The substantive part of the Plan sets out no less than 43 "standards" (in effect, aims), each of which is considered in detail, and to each of which is appended a list of action points.

Many of the standards and action points overlap. I paraphrase the standards as follows:

- to ensure that prospective service users have the information they need in order to make an informed choice about where to live by providing them with a guide to the Home, setting out the aims, objectives and philosophy of the Home, its services and facilities and its terms and conditions in a clear and accessible form (standard 1);
- to carry out assessments of prospective service users' individual aspirations and needs, in the presence of an independent advocate where appropriate (standard 2);
- to demonstrate to prospective service users that the Home can meet their needs by (among other things) developing care plans, coupled with effective staff training (standard 3);
- to invite prospective service users to visit the Home on an introductory basis before any decision is taken to move into the Home, and to do so in consultation with existing service users (standard 4);
- to draw up effective, legal and above all comprehensible terms and conditions for each new service user (standard 5);
- to draw up plans for each service user (based on his or her care plan) covering all aspects of the service user's personal and social support and healthcare (standard 6);
- to respect the rights of service users to take decisions about their personal circumstances, subject only to such limitations as may be required in the best interests of other service users and consistently with the Home's legal duties and responsibilities (standard 7);
- to ensure that service users are consulted on, and given opportunities to participate in, all aspects of life in the Home (standard 8);
- to support service users, so far as appropriate, in taking responsible risks as part of an independent lifestyle (standard 9);
- to handle information about service users appropriately, whilst ensuring that the records of each service user are accurate and secure, and that confidentiality is maintained as required (standard 10);
- to give service users opportunities to develop socially and emotionally, and to acquire and improve communication and independent living skills (standard 11);
- to help service users to find and keep appropriate jobs, to continue their education and training, and/or to take part in valued and fulfilling activities (standard 12);
- to support service users in integrating into the local community (standard 13);
- to ensure that service users have access to appropriate leisure activities (standard 14);
- to maintain family links and friendships within and outside the Home, welcoming family members and friends into the Home and encouraging their involvement in daily routines and activities (with the agreement of service users) (standard 15);

- to ensure that so far as appropriate daily routines and house rules promote independence, individual choice and freedom of movement for service users (rules on alcohol, smoking and drugs being clearly stated in the contract with each service user) (standard 16);
- to offer service users a healthy diet, and to encourage them to enjoy their meals and mealtimes (standard 17);
- to provide sensitive and flexible personal support and nursing care so as to maximise the privacy, dignity and independence of service users, and their control over their lives (standard 18);
- to ensure that the healthcare needs of service users are assessed and recognised and that procedures are in place to address them (standard 19);
- to ensure that, where appropriate, service users retain, administer and control their own medication, and that they are suitably protected by the Homes' policies and procedures for dealing with medicines (training for staff to include a basic knowledge of how medicines are used and how to recognise and deal with problems in their use) (standard 20);
- to handle ageing, illness and death of service users with respect and as the individual service user would wish (standard 21);
- to ensure that service users feel that their complaints are listened to and acted on (standard 22);
- to protect service users from abuse, neglect and self-harm (standard 23);
- to ensure that so far as possible service users live in a homely, comfortable and safe environment (standard 24);
- to ensure that so far as possible the bedrooms of service users suit their individual needs and lifestyles (whilst accepting that no practical alterations or changes could currently be made) (standard 25);
- to ensure that each service user is provided with a bedroom with furniture and fittings sufficient and suitable to meet his or her individual needs and lifestyle and to promote his or her independence (standard 26);
- to ensure that toilets and bathrooms provide sufficient privacy for service users and meet their individual needs (standard 27);
- to provide a range of comfortable, safe and accessible shared spaces within the Home (standard 28);
- to provide service users with such specialist equipment as they may require (standard 29);
- to ensure that the premises are kept clean, hygienic and free from offensive odours, and that systems are in place to control the spread of infection (standard 30);
- to ensure that members of staff have clearly defined job descriptions, and that they understand their own and others' roles and responsibilities (standard 31);
- to ensure that service users are supported by competent and qualified staff (standard 32);

- to ensure that the Home has an effective staff team, with sufficient numbers and complementary skills to support the assessed needs of service users (standard 33);
- to put in place a thorough recruitment procedure based on equal opportunities and ensuring the protection of service users (standard 34);
- to ensure that so far as possible the needs of individual service users are met by appropriately trained staff (standard 35);
- to ensure that staff obtain the support and supervision they need in order to carry out their jobs (standard 36);
- to ensure that service users benefit from a well-run Home (standard 37);
- to ensure that service users benefit from the ethos, leadership and management approach of the Home (standard 38);
- to ensure that effective quality assurance and quality management systems, based on seeking the views of service users, are in place with a view to achieving the aims and objectives of the Home (standard 39);
- to ensure that the rights and best interests of service users are safeguarded by the policies and procedures of the Home (standard 40) and by its record-keeping (standard 41);
- to ensure so far as is reasonably practicable the health, safety and welfare of service users and members of staff (standard 42); and
- to ensure that service users benefit from competent and accountable management of the Home (standard 43).

In the light of the various criticisms of the running of the Home which have come to light in the course of this Inquiry, it is relevant to return briefly to some of the above standards.

I turn first to standard 20, which is headed "Medication". In this context, the Plan recommends:

- that a service-user who has been assessed as able to self-administer medication should have a lockable space in which to store medication, to which suitably trained and designated members of staff may have access with the permission of the service user;
- that a record is kept of current medication for each service user;
- that medicines in the custody of the Home are handled according to legal requirements and in conformity with the guidelines promulgated by the Royal Pharmaceutical Society of Great Britain;
- that nursing staff should abide by the UKCC Standards for the administration of medicines;
- that controlled drugs administered by staff are stored in a metal cupboard, which complies with current regulations and guidance promulgated by the Royal Pharmaceutical Society of Great Britain;
- that medicines should be administered by a medical practitioner or a registered nurse;
- that a policy on medication be developed and adopted; and

- that staff be trained in the administration of medication.

In relation to standard 22 (headed "Concerns and Complaints"), the Plan recommends that a complaints procedure be developed and adopted, so as to ensure that the Manager and staff listen and act on the views and concerns of service users and others, and that the Manager should monitor complaints on a monthly basis. It also stresses the need for service users and their families to be assured that they will not be victimised for making a complaint.

In relation to standard 23 (headed "Protection": i.e. protection from abuse, neglect, and self-harm) the Plan provides as follows (so far as material):

> "23.1 The service manager ensures that service users are safeguarded from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm or inhuman or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policy.
>
> 23.2 Robust procedures for responding to suspicion of abuse or neglect (including [whistleblowing]) ensure the safety and protection of service users .... *No secrets*.
>
> 23.3 All allegations and incidents of abuse, and action taken, are recorded.
>
> 23.4 ....
>
> 23.5 Physical and verbal aggression by a service user is understood and dealt with appropriately, and physical intervention is used only as a last resort by trained staff ....
>
> 23.6 ....
>
> ACTION
> 1. Training for staff concerning values and attitudes.
> 2. Training for staff concerning abuse.
> 3. Development of policy and procedure regarding concerning abuse.
> 4. Development of policy and procedure concerning working with vulnerable adults.
> 5. Development of policy and procedure concerning [whistleblowing].
> 6. Introduction of [effective] recording systems.
> 7. Staff training concerning dealing with physical and verbal aggression.
> 8. Policy and procedure concerning managing service users[']' finances.
> 9. Introduction of appointees for those individuals considered not yet able to manage their own finances."

In relation to standard 24 (headed "Premises"), the Plan recommends (among other things) health and safety training for staff; and in relation to standard 27 (headed "Toilets and Bathrooms") it recommends that a review be undertaken of existing facilities.

In relation to standard 30 (headed "Hygiene and Control of Infection"), the Plan recommends (among other things) that staff receive training concerning basic hygiene and infection control.

In relation to standard 34 (headed "Recruitment"), the Plan recommends that service users be involved so far as possible in the selection process for new staff and in the review of those employed for a probationary period.

In relation to standard 35 (headed "Training and Development") the Plan recommends the introduction of a rolling training and development programme for each individual member of staff, for the operation of which the Manager should be responsible.

In relation to standard 41 (headed "Record Keeping"), the Plan recommended that all record keeping systems be overhauled and standardised.

The Plan concludes by listing no less than 201 "Action Points". These action points includes those which are appended to the various standards as set out earlier in the Plan, but they also include a number of action points which are expressed to apply specifically to the Home. These include:

- each of the flats is to produce a brochure for each service offered, involving both staff and service users (point 3);
- in the event that it is felt that the Home is unable to meet a particular need of a service user, a clear report demonstrating evidence of this is to be prepared and passed to the appropriate persons (point 16);
- emergency admissions are to be assessed and a report prepared as to the suitability of the service provided by the Home (point 20);
- a care planning system within the Home is to be introduced and developed (point 24); and
- a guide is to be produced of what is available in Gibraltar and the surrounding area (point 46).

Appended to the Report (among other things) is a paper issued by the Department of Health in England entitled "Health Action Plans".

It would be all too easy to dismiss the Plan as no more than an extensive wishlist, but, as I indicated earlier, it was in my judgment a significant and constructive attempt by Iain McNeil and Sharon Berini to chart the course of the Home for the future.

I turn next to particular issues regarding medication.

On 13 September 2006 Simy Herbert made a witness statement in the Industrial Tribunal proceedings [**C1/10/1**] covering the period from August 2005 until February 2006. I will refer to it as Simy Herbert's "2006 witness statement". In addition to her 2006 witness statement, she also made a witness statement in the Inquiry [**G/4/1**] and she gave oral evidence.

Simy Herbert has worked as a nurse all her professional life. She was employed for some 27 years as a senior enrolled nurse at St Bernard's Hospital. She retired from the Hospital to care for her mother, who was terminally ill. In August 2005, after her mother died, she started

working at the Home as a supply worker. She only worked under Joanna Hernandez for a short time[835]. She has also worked under Sharon Berini and Iain McNeil[836].

In paragraph 1 of her 2006 witness statement she said this:

> "1. .... I started whilst Joanna Hernandez was there as Manager, and work was all right and there was a happy atmosphere, but then things started to go wrong. I had to call Joanna a couple of times during the night and she was very attentive, she answered the phone very quickly and then she gave us solutions to the problems and I was quite happy with that."

She elaborates on this paragraph in paragraph 6 of her witness statement in the Inquiry, saying this [**G/4/2**]:

> "6. .... Joanna Hernandez was the Manager of the Home when I started working there. I always used to inform her of any management issues at the Home which used to concern me and she always used to try to resolve them quickly. After Mrs Hernandez left the Home, I continued to stay in contact with her."

In her oral evidence, she said that she had worked with Joanna Hernandez for "a couple of weeks" before Joanna Hernandez left on special leave, and that she had not worked with her again[837].

In paragraph 3 of her 2006 witness statement she said this [**C1/10/1-2**]:

> "3. After Joanna Hernandez left and Sharon took over things were very very tight in the Home and you could see that people were very very stressed up because there were a lot of problems and they didn't know who to turn to. They didn't know if they spoke up if they had their backs covered. They didn't even want to speak up because they thought that if they said something they would be dismissed [and] some of the people that were there you could not confide in them and it was a very stressful atmosphere. I have worked as a nurse for a very long time, I am an enrolled nurse, and as such the giving out of the medicines was, for me, very very important, and medicines were being given out and they were not signed for, sometimes they were in the wrong boxes and they were given to the wrong people and I pointed this out. I approached the Manager there, Sharon, and she said she would look into the matter. But whether she did or not I don't know. All I know is that the problem was there day in and day out."

She elaborates on the above paragraph in paragraph 9 of her witness statement in the Inquiry, saying this [**G/4/2**]:

> "9. .... The main issue I felt very strongly about whilst working at the Home was how medication was distributed. When we received the residents' medication from the chemist, it did not come individually organised and the staff was therefore required to attribute the correct medication to each resident. It was then placed in a locked medical cabinet in the flat to be distributed by the carers on duty at the required times. However, there were many Spanish workers who did not understand English properly, which concerned me as this impacted on the medication. In addition, medication used to disappear. I informed Mrs Hernandez of this on numerous occasions, but I am not aware that management tried to rectify the problem.

[835] See paragraph 12 of her 2006 witness statement [**C1/10/8**].
[836] See paragraph 2 of her 2006 witness statement [**C1/10/1**].
[837] See Day 4 page 106 line 2ff.

> I was also concerned that the Spanish workers used to take residents to the doctors and on many occasions they did not understand what was being said. Then arrangements had to be made for me or another care worker to later go to the doctors to have everything explained again. Another occasion was that Spanish workers used to write in the daily diaries and care plans of the residents and then English speaking care workers could not understand what was written and vice versa."

In paragraph 4 of her 2006 witness statement [**C1/10/2-4**], she described at considerable length an occasion when she and two other carers had been searching unsuccessfully for a bottle of Diazepam tablets for a resident who was becoming agitated, and another carer produced the bottle "as if by magic".

In her oral evidence, she said this[838]:

> "I can't say she [i.e. the other carer] took them, ... because I didn't see her actually taking them. But I can tell you that I looked for the tablets myself and two other carers everywhere because I had to give this tablet to this lady that really needed it [and] I couldn't find it anywhere... .... And I looked everywhere. .... I cannot say she took them, but she did produce them, so you can make your own conclusions [as] to that. .... As we were coming out, I was in the front with the other two carers, and she says: "Oh, is this the tablets?". I said: "Where did you find them?". She says: "In the cupboard". I said: "In the cupboard? How can you have got them from the cupboard when I've got the keys here and it's locked?". Well, I reported that and I made a statement about that and nothing was done about it, nothing at all, no investigation, nothing."

In paragraph 13 of her 2006 witness statement she described how her contract as a supply worker was suspended as a consequence of her having asked a female resident why she was not wearing a brassiere. She was extremely upset by the decision to suspend her contract; a decision which she regarded (and still regards) as grossly unfair. Some two or three months later, following a meeting with Debbie Guinn, the suspension was lifted and she was told that everything had been "sorted out". She thereupon resumed working as a supply worker.

In the course of her oral evidence, she said that working at the Home had "left [her] scarred for life"[839]. This was plainly a reference to the suspension of her contract, which (as I could see for myself from her demeanour on the witness stand when speaking about it) had left her feeling deeply upset, bitter and resentful. She was nevertheless keen to unburden herself by speaking about it in the course of her evidence. She said this[840]:

> "I have worked as a nurse all my life. I've never got into trouble, been very responsible, been working with consultants, with paediatricians, and with everybody, and I have never ever had a report. On the contrary, I have had appraisals and "Simy, carry on working, you are doing fine", and I have been recommended and everything. For this to happen to me in [the Home], and the way I was treated by Sharon Berini and Liz Gallagher, that is inhumane, what they did to me. That was very inhumane what they did to me. .... I got back reinstated because I actually threatened them that because they didn't give me a motive, they didn't know ... Debbie Guinn didn't even know why I had been suspended ... and I told her "Look, why have you done this to me? This will mark me for the rest of my life. If you don't do something about it I will go public and I will tell the whole of Gibraltar what is really, really happening in [the Home] because of malmanagement". That was 100 per cent malmanagement, the way I was dealt with there. I

[838] See Day 4 page 114 line 16ff.
[839] See Day 4 page 108 line 5.
[840] See Day 4 page 118 line 8ff.

> went back home and two hours later Debbie Guinn phones me and she says "Simy, you can go back to work". .... I have been a nurse and a very caring person, and for this to happen to me for a statement which I did for somebody who had ... so that she wouldn't have a backache, because she was a big woman, and for this other carer to intervene and then she was the one who stirred shit ... and she wasn't suspended and I was. .... For me it's very, very stressful because I've never been so humiliated in my life."

In giving her oral evidence, Simy Herbert showed herself to be a proud and emotional person who was not afraid of expressing her opinions in a forthright manner. In assessing her evidence, however, I have to take due account of her feelings of bitterness and resentment, as exemplified in the passage from her oral evidence quoted above. I have no doubt that those feelings unwittingly coloured her evidence, distorting her recollection and prompting her to resort to exaggeration and the use of unjustifiably emotive language.

In paragraph 6 of her 2006 witness statement, she said this [**C1/10/5**]:

> "6. I carried on working but I carried on thinking that at work I was not very happy and things were going on in the Flat [Flat 1] that should not have been going on. Some of the residents were not treated as they should be treated, like human beings. Some times they were talked to wrongly, without any manners. Some of the residents needed help, and one of the carers ... wouldn't help because if they were in a wheelchair she said she was not happy because she had to use the hoist, if it was men she said she wouldn't deal with men ... if it was to give out drugs she wouldn't give them because she said she was not responsible for that, and yet she was there and doing whatever she wanted and she was being called on a daily basis. I told management about this and they did nothing about it. She carried on working there, avoiding most of the things. Most of the carers knew and talked about it, they told Sharon who was acting Manager then but nothing was done about it either."

She elaborates on this paragraph in paragraph 14 of her witness statement in the Inquiry [**G/4/4**], saying this:

> "14. I informed Liz Gallagher (Deputy Manager) about my concerns that some residents were not being treated well and they were being talked to without any respect. Liz responded, telling me that it wasn't important and that I should forget it. I was also concerned that many people in flat 1 were obese or were suffering from gout or high cholesterol and no dietician ever came to the Home to help improve this. I felt that this was wrong."

It is clear from the above evidence that Simy Herbert genuinely felt that on occasion members of staff spoke to residents in terms which were not sufficiently respectful. I do not doubt that this may have happened on occasion, and clearly it should not have happened. That said, it is necessary to bear in mind the challenging nature of the work which the staff had to undertake, and the very considerable pressure under which they were working. I note that Simy Herbert does not suggest that any resident was verbally abused by a member of staff. Had that happened I have no doubt that the carer responsible would have been reported (just as Simy Herbert was herself reported for allegedly abusing a resident).

Simy Herbert asserts that some residents were not treated like human beings. I have no hesitation in rejecting that assertion. The fact that she has felt able to make such an extreme assertion is a demonstration of the depth of her feelings of bitterness and resentment to which I referred earlier.

In paragraph 7 of her 2006 witness statement [**C1/10/5**] Simy Herbert said this:

> "7. In my opinion the management after Joanna Hernandez left had no experience, they didn't know what they were doing and they did not know how to organise control or manage the [Home] at all. That was like I told Yvette [Del] Agua, in a meeting I had with her later. Isabella Tosso was also there, and I told Mrs. Del Agua that that was a time bomb meaning the [Home] was a volcano waiting to erupt and that if it erupted most people would be in the deep end."

In paragraph 11 of her 2006 witness statement [**C1/10/8**] she said this:

> "11. When I spoke to Yvette Del Agua she told me, that when we have the meeting, do you mind if Isabella Tosso is present so she can hear what you have to say, and also Marie Gomez. I told her I didn't mind them being there, but that they should be there to listen...."

Commenting on the above two paragraphs in paragraphs 15 and 16 of her witness statement in the Inquiry [**G/4/4**], she says this:

> "15. .... I informed Minister Yvette Del Agua outside Safeways of my concern that there was not going to be proper management at the Home once Mrs Hernandez left. A meeting was suggested by Mrs. Del Agua and arranged by Mrs. Del Agua's secretary and Isabella Tosso and Marie Gomez were also present. I told them that I wanted to be heard now that finally someone wanted to listen. I again informed them of my concerns regarding the handling of drug distribution at the Home, the way workers spoke to residents inappropriately and the lack of management at the Home. Mrs Del Agua admitted that the Home was a time-bomb during the meeting.
>
> 16. I taped the meeting and gave the tape to Joanna Hernandez at the time of her Industrial Tribunal proceedings."

(I should say that no tape of a meeting between Simy Herbert and Yvette Del Agua, or transcript of such a tape, has been produced in the course of the Inquiry; but that is not to say that no such tape existed.)

In paragraph 8 of her 2006 witness statement [**C1/10/5-7**], Simy Herbert gave various relatively minor examples of what she considered to be unprofessional conduct by carers. In particular, she described at some length an occasion when she found some carers gossiping together. She commented:

> "... [T]hey were all English girls. There was not one Gibraltarian or Spanish carer there."

She went on to complain that when she criticised the carers concerned, Liz Gallagher (who succeeded Sharon Berini as Deputy Manager in 2006) took sides against her, saying that she was "paranoid", and that she "had something against the English". I draw attention to this piece of evidence because it accords with the evidence of Yvette Del Agua, to which I refer below.

Paragraph 8 of her 2006 witness statement continued:

> "... I told her [Liz Gallagher] that she was not there to insult me either, because she should not be telling me in front of the other lady what she thinks. She should be unbiased and listen to both

> of us and then decide, but this way she had acted very unprofessionally. This is the way the [Home] is being run. By unprofessional people who don't [know] whether they are coming or going. They have no courses in management, and they don't understand the problems, and they don't know how to tackle the problems which is the worst thing and it is going from bad to worse."

She elaborates on the above paragraph in paragraph 18 of her witness statement in the Inquiry [**G/4/4**], saying this:

> "18. .... I was of the view that the Home was not being run by professional people. I give various examples in this paragraph. By way of additional example, I did not like the way the carers used to go to other flats and start talking badly about other carers. Also, I do not think that many of the people in management roles had received any management training so they did not know how to tackle the problems which would arise."

Simy Herbert's evidence in paragraph 8 of her 2006 witness statement and paragraph 18 of her witness statement in the Inquiry provides the clearest illustration of a tendency on her part to over-react to relatively minor incidents and to elevate them into examples of misconduct on the part of the other members of staff involved, leading her to make exaggerated accusations against the Home and to refer to it as (for example) a time bomb waiting to explode and a volcano about to erupt. I have no doubt that in so doing Simy Herbert was expressing her genuine feelings. However, the existence of this tendency is an additional reason why I conclude that I must treat her evidence with caution, save where it is corroborated by other witnesses whose evidence I accept.

It is also clear from the above evidence that Simy Herbert was not the easiest person for management to deal with. As she herself said in paragraph 10 of her 2006 witness statement [**C1/10/8**]:

> "10. .... [W]hen there were meetings I used to speak out because I have a very strong character and when there is anything wrong I will tell the person, even if it is [the] Pope or the Bishop, whoever it is. If I have to say things I will say it and that is why I made a lot of enemies of the managerial type in [the Home] because I used to speak my mind and people did not like that."

In paragraph 9 of her 2006 witness statement [**C1/10/7-8**], Simy Herbert said this:

> "9. After that I was alienated, so I went to England and when I came back they didn't give me any more hours. I eventually spoke to Yvette Del Agua outside British Home Stores. When I came back and I didn't get any hours I rang Social Services many many times. .... There was a lack of communication, nobody told me anything at all. .... I was so desperate that I caught Yvette Del Agua outside British Home Stores, and I told her that I was very unhappy with the situation in [the Home]. Something really big is going to happen if it isn't happening already. I told her that most of the things are being swept under the carpet. I told her drugs are being given to the wrong people, they are being signed for and they are not given or given and not signed because the changeover of the night to the day shift, because things are really bad and there is lack of communication everywhere and nobody listens to anybody. I feel very strongly that 'wrong medication' is being given to most of the residents. They are called into the office and they are told to sign and they sign and God knows what they are signing. They could be signing off money to somebody else or maybe they are signing to keep money aside, I don't know that. I feel that it is very unfair because those residents are not in their right mind and they do not know what they are doing. I feel that [it] is wrong to make somebody sign something they

> don't know. Even if they sign something it is not even explained what they are signing for or what it is for. I think that is very wrong."

The Inquiry has heard no evidence that any resident was made to sign any document relating to their financial affairs. I accordingly reject Simy Herbert's assertion to that effect, which I attribute to faulty recollection on her part. As to the administering of medication, I accept Simy Herbert's evidence only to the extent that it is corroborated by the evidence of Jennifer Poole and Debbie Guinn, to which I referred earlier in this Chapter.

In paragraph 12 of her 2006 witness statement [**C1/10/8**], Simy Herbert said that after Joanna Hernandez left, the Home was:

> ".... chaotic because everybody was doing their own thing and people didn't know whether they were coming or going, the system collapsed."

I reject that description of the Home in November 2005. As I indicated earlier, the true position is to be found in the evidence of Jennifer Poole and Debbie Guinn, referred to earlier in this Chapter, and in the evidence of Elizabeth Harrison to the extent that I have accepted her evidence.

In paragraphs 13 and 14 of her 2006 witness statement [**C1/10/9**], Simy Herbert refers to difficulties in obtaining follow-up medical treatment for residents; lack of dental care for residents; the need for greater input from a dietician; and missing petty cash. As to the missing petty cash, she said that it was reported but that she was not aware of any action having been taken in relation to it.

I can only accept that evidence to the extent that it is corroborated by other witnesses whose evidence I accept. It may well be that on occasion there were practical difficulties in arranging follow-up treatment for residents, but there is no evidence that residents were not given proper access to medical advice and treatment. Nor have I seen any evidence from other witnesses that residents' dental care was neglected. As to their diet, I am satisfied that it was more than adequate. I have seen no evidence that any resident was under-nourished.

In the course of her oral evidence, Simy Herbert was asked by counsel for Joanna Hernandez about a female resident who was a heavy smoker. She said that Sharon Berini and (later) Liz Gallagher had implemented a system to control that resident's smoking. She went on[841]:

> "She [i.e. the resident] had to go outside but she got a bit aggressive because she had been all her life a very heavy smoker, and then all of a sudden she was only allowed to have one cigarette an hour, and we had to sign for that cigarette that we were giving to this lady, and I felt very strongly about that. How can you control a 70-year old who had been a very heavy smoker and [who] had a mental [condition]. How can you control that?"

[841] See Day 4 page 125 line 7ff.

I regard this as yet another example of an over-reaction by Simy Herbert to what appears to have been a perfectly reasonable attempt by management to keep this resident's smoking habit under a degree of control. One cigarette per hour can hardly amount to privation.

I turn next to the evidence of Yvette Del Agua.

In the first of her three witness statements in the Inquiry [**E/6/1**], Yvette Del Agua sets out her recollection of her exchanges with Simy Herbert. She says this (in paragraphs 4 to 7 of that witness statement [**E/6/1-2**]):

> "4. .... I was initially approached by Mrs Herbert outside British Home Stores. She asked for a meeting with me as she alleged that her supply contract had been terminated by the [SSA] and she was aggrieved at the fact that she had been accused of inappropriate behaviour. She added that the Home was "a time bomb waiting to explode" or words to that effect, and she also mentioned that "medication was not being properly administered". On the strength of these two worrying allegations (and not because her supply contract had been terminated as that is a managerial issue) I told her to call my P.A. to ask for a meeting and I assured her that I would personally arrange for the CEO of the [SSA] to be present. At that point she did not go into any further detail as we both felt it was not the appropriate place to discuss the matter.
>
> 5. On returning to my office, I called the CEO of the [SSA], Ms Isabella Tosso, and related to her my encounter with Mrs Herbert. I expressed my concern regarding Mrs Herbert's allegations that [the Home] was "a time bomb waiting to explode" and that "medication was not being properly administered". I informed her that I would shortly be meeting Mrs Herbert and that I wanted her (Ms Tosso) to be present. I asked her to look into the allegation about the medication in the meantime and to report back to me. We agreed that we would wait for the upcoming meeting with Mrs Herbert to give her the opportunity to explain and substantiate her more general comment about [the Home].
>
> 6. Prior to our meeting with Mrs Herbert, Ms Tosso reported back to me regarding Mrs Herbert's allegation that "medication was not being properly administered". She explained to me that there had been some issues with the labelling of the medication boxes, and that this had already been dealt with and resolved by [the Home] Manager. I believe that Ms Sharon Berini was acting Manager at the time. Ms Tosso also briefed me regarding the reason why Mrs Herbert was no longer being used as a supply worker. My recollection of this is rather vague but it had something to do with an investigation relating to an incident between Mrs Herbert and a service user. Ms Tosso then asked if Mari [sic] Gomez (Team Leader Adult Services) could also be present at the meeting with Mrs Herbert, to which I agreed.
>
> 7. I subsequently met Mrs Herbert, together with Isabella Tosso and Mari Gomez at my offices in Governor's Parade. I recall that it was very soon after talking to her outside British Home Stores. I made it very clear to Mrs Herbert from the outset, that I would listen very carefully to everything she said, but that I would not get involved or undermine any decision that had been legitimately taken by Management in their professional judgement regarding the termination of her supply contract. I also informed her that I had received feedback about the labelling of medication issue and that this had already been resolved by Management. Mrs Herbert went to great lengths to explain the incident over which she had been investigated and as a result of which she was no longer being called to cover as a supply worker. She spent a considerable amount of time relating her version of events and was at pains to refute anything that Ms Tosso or Ms Gomez said to the contrary in this regard. She repeatedly said that the English and Spanish carers were no good and that more Gibraltarians needed to be employed. This appeared to be her only concern. I recall that I had to remind her about the disturbing allegation she had made outside British Home Stores about [the Home] being "a time bomb waiting to explode", and I had to prompt her to give examples to substantiate this claim. She failed to do so and continued to assert that English and Spanish carers did not understand Gibraltarian culture, that they were cold and unloving towards service users, and that in any case, Gibraltarians should have priority over jobs. Mrs Herbert was not happy with the outcome of the meeting. She expressed

> disappointment at the fact that I had not sided with her against "the English carer who had made the allegations against her". With that, the meeting concluded and Mrs Herbert stormed off."

In paragraph 9 of her first witness statement in the Inquiry [**E/6/2**], Yvette De Agua says this:

> "9. I reiterate and maintain, and am willing to swear under oath, that everything I have set out in the above paragraphs is a true account of what transpired between Mrs Herbert and myself, both when we met outside British Home Stores and then later in my offices at Governor's Parade ... I categorically refute the implicit aspersion contained in Mrs Herbert's witness statement, that I somehow ignored allegations of wrongdoing in [the Home] which she claims she brought to my attention. Nothing could be further from the truth. Mrs Herbert did not provide me with a single shred of evidence, example or illustration to substantiate her allegation that [the Home] was "a time bomb waiting to explode", even after I repeatedly prompted her to do so."

In the course of her oral evidence, Yvette Del Agua confirmed the above account of her dealings with Simy Herbert[842]. She said that she asked Simy Herbert several times during their meeting at her offices what she meant by her reference to "a time bomb waiting to explode". Asked whether Simy Herbert ever gave her an answer, she said this[843]:

> "No. Apart from the fact that she spent most of the time relating what had happened to her when she was being investigated. .... She spent the most part of that meeting relating what had happened, she was very upset about it. .... She focused mainly on her investigation. She also said to me that a lot of Spanish and English carers were being employed as opposed to Gibraltarians and that she felt very strongly about that. I said there was nothing I could do about that. .... She didn't seem to understand that, so she actually left in an angry state. .... Nothing about a time bomb, I can assure you."

Yvette Del Agua went on to say that she did not know that Simy Herbert had taped the meeting which took place in her offices until she read Simy Herbert's witness statement in the Inquiry[844].

I accept the entirety of Yvette Del Agua's evidence as to her dealings with Simy Herbert. In particular, I find that there was only one chance meeting between her and Simy Herbert, not two (as described by Simy Herbert). I find Simy Herbert's recollection to be significantly at fault in that respect. On the other hand, I have no doubt that Simy Herbert was justified in drawing the Inquiry's attention to issues regarding medication at the Home.

In paragraph 25 of her witness statement [**F/2/7**], Jennifer Poole says this:

> "25. .... [I]n 2005, there was not at all a satisfactory regime in place at the Home with regard to the administration of medication. Only one individual was required to sign the medication record sheets ... so sometimes someone would sign and then forget to give the medication. The medication cupboard was locked but the keys would go from person to person. Sometimes the keys would go missing and on occasion the cupboard was left open. ...."

I accept Jennifer Poole's evidence, and I accept Simy Herbert's evidence to the extent that it is corroborated by Jennifer Poole's evidence.

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[842] See Day 12 page 48 line 22ff.
[843] See Day 12 page 49 line 18ff.
[844] See Day 12 page 53 line 2.

I consider the up-to-date position in relation to medication in Chapter 15 of this Report.

CHAPTER 12: The proceedings in the Industrial Tribunal

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CHAPTER 12: *The proceedings in the Industrial Tribunal*

On 26 January 2006 Joanna Hernandez commenced proceedings in the Industrial Tribunal, claiming unfair dismissal by the SSA.

The SSA responded to her claim by taking a preliminary point that the Industrial Tribunal had no jurisdiction to hear her claim as she had not been "continuously employed [by the SSA] for a period of not less than 52 weeks ending with the effective date of termination", as required by section 60 of the Employment Ordinance[845]. At a directions hearing on 26 April 2006 the Industrial Tribunal set the preliminary point down for hearing, and it directed (among other things) exchange of witness statements should the SSA's argument on the preliminary point fail. On 9 June 2006 the SSA filed witness statements in opposition to the claim (including a witness statement by Isabella Tosso). On 27 September 2006 Joanna Hernandez filed her first tranche of witness statements in support of her claim (i.e. the 2006 witness statements referred to earlier in this Report). On 12 December 2006 the Industrial Tribunal ruled against the SSA on the preliminary point[846].

On 28 December 2006 the SSA filed Notice of Appeal to the Supreme Court against the Industrial Tribunal's ruling on the preliminary point. On 13 April 2007 the then Chief Justice dismissed the SSA's appeal. On 22 May 2007 the SSA filed Notice of Appeal to the Court of Appeal for Gibraltar ("the Court of Appeal") against the decision of the Chief Justice. On 10 October 2007 the Court of Appeal dismissed the SSA's appeal.

The substantive hearing of Joanna Hernandez' claim before the Industrial Tribunal took place on 7 April 2008. At that hearing, The Hon. Joe Bossano MP ("Joe Bossano") appeared for Joanna Hernandez and Mark Isola QC appeared for the SSA. Joe Bossano was Chief Minister during the period 1988-1996 and was at the time of the Inquiry Hearings the Minister for Enterprise, Training and Employment. He is currently the Minister for Economic Development, Telecommunications and the Gibraltar Savings Bank.

At the hearing of 7 April 2008 Mark Isola QC informed the Tribunal that the SSA would not be leading evidence in opposition to Joanna Hernandez' claim. This was due to, among other things, the fact that the SSA had been unable to contact Isabella Tosso, and that she was consequently unavailable to give evidence as to the reasons why the SSA had decided to dismiss Joanna Hernandez as Manager of the Home and as to the reasonableness of that decision. The Industrial Tribunal duly found that Joanna Hernandez had been unfairly dismissed. It went on to make a non-binding recommendation of re-engagement, and awarded her compensation.

[845] Now the Employment Act.
[846] It did, however, give the SSA leave to appeal to the Supreme Court on a point of law.

On the first day of the main hearing of this Inquiry (30 September 2013), Joe Bossano provided the Inquiry with a witness statement [**K/2/**1]. He was accordingly invited to attend to give oral evidence relating to the contents of his witness statement, and he kindly agreed to do so. He duly attended the hearing on 9 October 2013 (Day 7 of the hearing) and gave oral evidence.

Mr Bossano has very considerable experience of proceedings in the Industrial Tribunal. In paragraph 6 of his witness statement [**K/2/1**] he says that he believes that he has participated in more unfair dismissal cases in the Industrial Tribunal in Gibraltar, representing claimants (i.e. employees), than anyone else locally. He recalls that when addressing the Supreme Court in a recent case the Attorney-General described him as probably the most knowledgeable person in Gibraltar on unfair dismissal issues, given his long track record. His knowledge and experience of unfair dismissal claims is indeed well-known in Gibraltar and beyond.

In paragraphs 7 to 12 of his witness statement [**K/2/1-2**], he says this:

> "7. In my experience no employer has ever argued before a Tribunal that the Tribunal lacked jurisdiction because of the construction of the terms of continuous employment in that 52 continuous calendar weeks did not necessarily equate to a continuous calendar year. The one single instance was the case of Ms Joanna Hernandez where the legal representative of the [SSA], Mr Mark Isola QC argued that an alternative interpretation required that the first week of employment should be ignored unless the first day of commencement was a Sunday847 which is almost unknown to be the case in any employment relationship that I have ever experienced. Employment generally starts on a Monday.
>
> 8. In the initial stage of the unfair dismissal complaint TGWU acted for Ms Hernandez and referred the case to Hassans for an assessment of the strength of her complaint which was a procedure followed by the Union prior to granting legal support to a dismissed member.
>
> 9. The analysis of the evidence and assessment of the case by the aforementioned legal firm, as I understood at the time, gave a very high probability that the case would be won and charged £10,000 for the research, assessment and preparatory work to proceed with the complaint.
>
> 10. This advice was obtained to determine the entitlement to legal support. The TGWU rule, at the time, was that in order to obtain Union support on the legal fees, the claim in question had to have a greater than 50% probability of succeeding. Notwithstanding the legal advice received, the Union nevertheless decided that the entitlement to legal support would not be given because the cost of the advice obtained had been too high.
>
> 11. To my knowledge, no such decision has ever been taken in respect of any other unfair dismissal of a union member. Indeed, it would seem evidently devoid of logic to engage legal counsel to advise on the probability of winning a case only to abandon the case because of the cost of that advice when such advice is favourable to the case's continuance, and was a pre-requisite in the first place.
>
> 12. I bring this fact to the notice of the Inquiry because I truly believe that from the very outset attempts [have] been made to influence people to prevent the substance of the circumstances and reasons that led to the dismissal being put in the public domain. There has been considerable pressure exerted on individuals. Whilst this is not necessarily evidence that the allegations that have been made are true, it raises the question as to who were the interested parties that did not want the case in the Industrial Tribunal to proceed, and thus avoid the reasons for the dismissal

[847] This summary of the SSA's argument on the preliminary point is not strictly accurate. The SSA's argument was that "week" in the Employment Ordinance meant a continuous period of 7 days starting on a Sunday.

> to be aired [publicly]. Clearly the complainant was not the party who was trying to stop the case."

In paragraph 14 of his witness statement [**K/2/3**], Joe Bossano says that when Joanna Hernandez filed her claim for unfair dismissal[848], he advised her that she should cite whistle-blowing as the reason for her dismissal.

In paragraph 17 of his witness statement [**K/2/3**], Joe Bossano says this:

> "17. The introduction of [Mark Isola QC as the SSA's counsel] was accompanied by a shift in the reason for contesting the Tribunal's jurisdiction. The argument was then made that the first week of employment had to start on a Sunday for the week to count towards the 52 weeks. Since in my experience it is almost unknown for the first week of employment to commence on a Sunday in effect the [SSA] was saying that employees had to be employed for 52 weeks after completing [a] working week from Monday to Friday. This would mean that an employee would have to, in fact, work an initial 53 weeks instead of 52 weeks[849]."

In paragraphs 20 and 21 of his witness statement [**K/2/3-4**], he says this:

> "20. The long list of witness statements prepared for submission [on behalf of Ms Hernandez, i.e. the 2006 witness statements] were basically either (i) in support of the role and good performance of Ms Hernandez in order to demonstrate to the Tribunal that the evidence was overwhelmingly against the contention that it was a dismissal on grounds of incompetence or (ii) they were witness statements given by persons who claimed to have had first-hand knowledge of the instances of abuse or other form of unacceptable treatment of persons in the care of the [SSA] which had been reported, but not investigated or addressed. The [SSA] objected to many of the proposed witnesses and the potential list was greatly reduced. The main argument used by the [SSA] was that the large number of witnesses had to be kept down in order to expedite the time it would take to deal with the substantive hearing. The Inquiry will note the inconsistency of the [SSA's] concern to expedite hearings and the reality of the steps they took to prevent the hearings actually taking place.
>
> 21. The witness statements were provided to the [SSA] and only after they were in the possession of the [SSA] and the contents of these known to it, did the Tribunal receive notice of the decision to appeal to the Supreme Court to reverse the ruling that we should proceed with the substantive hearing[850]. In my opinion this decision was taken either by the [SSA] or the Chief Minister to ensure that the delay would serve to prevent the witness statements being placed or otherwise released into the public domain. The Tribunal adjourned the [substantive] hearing and stated that it could not proceed to hear the case until the Supreme Court made a ruling on the jurisdiction point."

As to the SSA's decision to appeal to the Court of Appeal against the decision of the Supreme Court, Joe Bossano says this (in paragraph 24 of his witness statement [**K/2/4**]):

> "24. The Agency or the then Chief Minister instructed Mr Isola QC to appeal against this Ruling [i. e. the ruling of the then Chief Justice] thus ensuring a further delay in the hearing of the substantive case by the Tribunal. I consulted a wide spectrum of lawyers in the profession (both

[848] At that time, Joanna Hernandez was represented by Fabian Picardo (then of Hassans, now The Hon. Fabian Picardo QC MP and Chief Minister).
[849] This is a correct statement of the effect of the SSA's argument, in so far as it would apply to an employee working a 5-day week whose employment began on a Monday.
[850] As already noted, the witness statements supporting Joanna Hernandez' claim (i.e. the 2006 witness statements) were filed after the SSA had given notice to the Industrial Tribunal of its intention to argue the preliminary point, and before the Industrial Tribunal's ruling on the preliminary point.

> in Gibraltar and in the United Kingdom) and was unable to find one single professional who considered that there was any possibility that the case would be successful on the appeal by the [SSA] on the grounds of lack of continuity of employment."

In paragraphs 25 to 29 of his witness statement [**K/2/4-5**], he says this:

> "25. In my years of dealing with employers, I have never known of any other case of an employer going to such lengths, and incurring such a level of expenditure, to prevent the hearing of a case. This is more so in a case where the employer was defending the claim on the grounds of inability by the employee to perform the work and claiming to have the evidence to prove this inability.
>
> 26. In my opinion, and based on my experience, an employer that does everything possible to prevent a hearing in such circumstances does so because he does not want the evidence in support of the claimant to be in the public domain.
>
> 27. Whilst I appreciate that this Inquiry is not about the conduct of the [SSA] in the unfair dismissal case, I respectfully submit that there is no apparent logical explanation for the desire by the [SSA] to stop the hearing of the substantive case. Therefore if the reason was not as I have suggested, namely to suppress the information in the [witness] statements and prevent them being made public, then those taking the policy decisions on behalf of the [SSA] should be invited to appear in this Inquiry and explain why they took these actions.
>
> 28. The [SSA] appealed from the Supreme Court to the Court of Appeal and then the Court of Appeal dismissed the appeal. However, the substantive hearing was delayed further because by then Ms Isabella Tosso had resigned from her post as CEO of the [Home] and left the jurisdiction. Initially the [SSA] said time was needed to contact her in order to arrange for her to attend as their principal witness. At a later stage she was supposed to be on a cruise in New Zealand and then they allegedly lost track of her. The excuses were to my knowledge not true since during the period when they could not find her, Ms Tosso was in London and in contact with a colleague in the [SSA], Ms Marie Gomez, with whom she discussed the fact that the Tribunal case of Mrs Hernandez, had not been settled.
>
> 29. The [SSA], however, said she was not contactable and produced … substitute witnesses. As the Inquiry is aware on the very day that the substantive hearing was due to start, the [SSA] informed the Tribunal that they could not meet the burden of proof in respect of the defence alleging the employee's inability to deliver her function, and the Tribunal ruled in favour of the claimant."

In the course of his oral evidence, Joe Bossano described the TGWU's decision not to fund Joanna Hernandez' case as "peculiar"[851], for the reasons given in his witness statement. He said that it did not seem to him to be "a very logical way to proceed"[852].

Later in his oral evidence, I asked him what was the basis for the serious allegations made in paragraph 12 of his witness statement (quoted above). He replied[853]:

> "... [W]hat I am saying to you is: on the balance of probability when I see things that are abnormal, I ask myself: Why should somebody want to do this? .... [A]nd therefore I say to myself: Well, if that's what's happened here, could it be that there was somebody discouraging the Union from funding on the premise that if there was no funding there would be no case to answer? .... The reality of it is that, like any small village ... you have a situation where everybody is either closely connected or related to ... somebody else. .... So then you see that

[851] See Day 7 page 8 line 23
[852] See Day 7 page 9 line 6.
[853] See Day 7 page 14 line 14ff.

> the pressure that is put is not the kind of pressure you can get people to come out and say: Well, yes, I was influenced."

Asked by me whether he had any actual, tangible, facts to support his allegations, he said this[854]:

> "You see, if people are being pressured, it's very difficult to produce tangible facts, because if they were willing or able to come out and say so publicly, and in a witness box like this one, the pressure wouldn't work. The people who are pressured are the people who are scared of being intimidated, and there are many, many people who will say "I am intimidated, I will tell you, please do something about it but don't mention my name", and I can tell you that if I could mention their names it would fill up half a telephone directory."

Joe Bossano went on to explain that the basis of his allegation (in the second sentence of paragraph 12 of his witness statement, quoted above) that "there has been considerable pressure exerted on individuals" was no more than belief on his part, based on his "knowledge and experience of dealing with people in unfair dismissal cases and dealing as [a] politician of 41 years' [experience] with my electorate"[855].

He went on to describe the preliminary point taken by the SSA as "a thoroughly spurious point"[856].

When counsel to the Inquiry suggested to him that the SSA's argument was a "respectable" one[857], he replied[858]:

> "Well, it depends frankly if you are doing that with your own money or with taxpayers' money, because I think that if the respectable argument is that you are going to fight it all the way to the Supreme Court at vast expense and at the same time maintain that you are confident that you can win the unfair dismissal case, then why do you want to go to such lengths to stop the case being heard? .... I think it cannot be ignored that these things were happening in situations where, if the Tribunal had proceeded, there was already in the hands of the [SSA] and the Government copies of all the witness statements of what they could expect to come out into the open, which conceivably they might have considered to be politically unwelcome to them."

He went on to say this[859]:

> "I believe the Government's intention in proceeding with all these appeals was ... not that they would win but that the stretching out of the case meant that the witness statements would never see the light of day. Look, if Ms Hernandez had had to fight all those cases in court herself and pay for it, the answer is she wouldn't have got there. .... I think they were not doing it because they thought they could win and they didn't want the case heard."

Later in his oral evidence, in answer to further questions from me, he accepted that the Government's decision to argue the preliminary point before the Industrial Tribunal could possibly be seen as a legitimate decision on its part. However, he continued[860]:

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[854] See Day 7 page 16 line 7.
[855] See Day 7 page 18 line 11ff.
[856] See Day 7 page 24 line 4.
[857] This was a reference to a written Advice of UK counsel obtained by the SSA in December 2006, that is to say shortly after the ruling of the Industrial Tribunal but before the filing of Notice of Appeal to the Supreme Court.
[858] See Day 7 page 25 line 18ff.
[859] See Day 7 page 27 line 19ff.

> "But I think having lost the case at that point, the decision to then appeal against the decision of the Tribunal in the Supreme Court would not make sense in terms of value for money."

He went on to confirm the clear implication in his witness statement that his suspicion was that in deciding to go to appeal – first to the Supreme Court and then to the Court of Appeal – the Government's purpose was to delay matters, with the possibility that Joanna Hernandez would "give up"[861].

Counsel to the Inquiry then took Joe Bossano through the terms of the written Advice of UK counsel referred to earlier[862], to the effect that the SSA's argument on the preliminary point, although on balance likely to fail, was nevertheless a "respectable" argument. Joe Bossano considered that UK counsel's conclusions in fact reinforced his views[863].

He went on to describe the Government's decision to proceed with an appeal to the Supreme Court in the face of that Advice as "not a logical one"[864]

Later in his oral evidence, he made it clear that he was not accusing Mark Isola QC of having done anything improper[865]. Asked whether he was suggesting that Mark Isola QC might have been asked to do something improper, he readily acknowledged that Mark Isola QC was merely acting on instructions, but he reiterated his suspicions as to the Government's motives in giving him those instructions[866].

Asked about his knowledge as to the availability of Isabella Tosso to give evidence at the substantive hearing, he said that to his knowledge she was contactable "all the time"[867]

Notwithstanding that, as he explained in both his written and his oral evidence, Joe Bossano was merely voicing beliefs for which he had no direct evidence, the nature of those beliefs is such that it is necessary for the Inquiry to investigate whether, on the evidence presented to it, they are justified on the facts[868].

The fundamental issue raised by Joe Bossano's evidence is whether or not there was an overarching conspiracy by the then Chief Minister[869], The Hon. Yvette Del Agua MP and The Hon. Jaime Netto MP (the Minister later responsible for the Home) – and possibly others – to prevent the contents of the witness statements filed by Joanna Hernandez on 27 September 2006

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860 See Day 7 page 32 line 3.
861 See Day 7 page 32 line 2ff.
862 This Opinion is reviewed later in this Chapter.
863 See Day 7 page 36 line 7ff.
864 See Day 7 page 39 line 23.
865 See Day 7 page 46 line 14.
866 See Day 7 page 49 line 3ff.
867 See Day 7 page 52 line 4.
868 The issues raised by Joe Bossano's evidence fall fairly and squarely within paragraph 1(b) of the Inquiry's Terms of Reference (see Annex 1 to this Report).
869 The Chief Minister at that time was The Hon. Peter Caruana QC MP, now The Hon. Sir Peter Caruana KCMG QC MP.

(i.e. the 2006 witness statements) "being put in the public domain" (see paragraph 12 of his witness statement and his oral evidence quoted earlier). Although he did not go so far as to say this explicitly in his evidence, I assume that by the expression "put in the public domain" Joe Bossano meant not only that the allegations in the witness statements should become public knowledge, but also that the public should have the benefit of an investigation into those allegations by the Industrial Tribunal: in other words that the suggested conspiracy extended to stifling any investigation of those allegations.

Secondly, there are issues as to what (if anything) was done in pursuance of the suggested conspiracy.

The first such issue, chronologically, is whether improper pressure was placed on the TGWU to refuse funding for Joanna Hernandez' claim (see paragraphs 10, 11 and 12 of his witness statement and his oral evidence quoted earlier).

There are two further issues:

- whether, in its conduct of the Industrial Tribunal proceedings, the Government/SSA adopted a strategy of taking every available procedural step to prolong the proceedings – in particular by appealing the Industrial Tribunal's ruling on the preliminary point first to the Supreme Court and then to the Court of Appeal – in order to delay the substantive hearing of the claim for as long as possible, in the hope (it is alleged) that Joanna Hernandez would "give up"; and

- whether the SSA's stated reason for not leading evidence in opposition to the claim (i.e. that Isabella Tosso could not be located) was no more than false pretext, in that Isabella Tosso was in fact readily contactable (see the paragraphs of Joe Bossano's witness statement quoted earlier, and his oral evidence that she was contactable "all the time").

I turn first to the issue as to whether improper pressure was applied to the TGWU in reaching its decision not to fund Joanna Hernandez' claim. I can deal with that issue briefly. No evidence has been presented to the Inquiry to support Joe Bossano's suspicion. Nor is Joe Bossano in a position to provide details of the precise nature of the pressure which he suspects was exerted, by whom it was exerted, or on whom it was exerted. Mere suspicion will not suffice to establish make good what is in substance a serious allegation. I accordingly reject the suggestion that improper pressure was exerted on the TGWU in connection with its decision not to fund Joanna Hernandez' claim in the Industrial Tribunal.

As to Joe Bossano's reference to people in Gibraltar being reluctant to come forward to provide evidence supporting his beliefs, that may be true as a generalisation – I pass no comment on it. Nonetheless the fact remains that I have to make my findings on the evidence presented to the Inquiry; and in relation to this particular belief of Joe Bossano, the cupboard is completely bare in that respect.

The remaining two issues raised by Joe Bossano's evidence stand on a different footing, in that their resolution requires a detailed consideration of the history of the Industrial Tribunal proceedings, and of the evidence presented to the Inquiry relating to the conduct of those proceedings by the SSA and the availability or otherwise of Isabella Tosso to attend the substantive hearing.

As a preface to embarking on that task, I make clear once again that it is no part of the Inquiry's remit to conduct, in effect, a re-run of the Industrial Tribunal proceedings. The merits or otherwise of the SSA's decision not to renew Joanna Hernandez' contract is not an issue which falls within the Inquiry's Terms of Reference. The investigation which follows is directed exclusively at the resolution of the two remaining issues raised by Joe Bossano's evidence, as summarised above.

I turn, then, to the procedural history of Joanna Hernandez' claim.

In her originating application dated 26 January 2006 [**J1/115/9**] she gave as the principal reason for her dismissal:

> "Raised serious allegations and concerns with Senior Management and they wanted me out of the way."

As described above, the SSA responded to Joanna Hernandez' claim of unfair dismissal by taking a preliminary point that the Industrial Tribunal had no jurisdiction to hear Joanna Hernandez' claim of unfair dismissal since she had not been "continuously employed [by the SSA] for a period of not less than 52 weeks ending with the effective date of termination", as required by section 60 of the Employment Ordinance. The SSA's argument, at that stage, was that the notice of termination of Joanna Hernandez' employment took effect when it was served rather than on the date of termination specified in the notice itself, and that in consequence Joanna Hernandez had not been employed by the SSA for the requisite period. The factual basis for this argument, it appears, was that following receipt of the notice of termination Joanna Hernandez ceased to work in the Home, and was paid one month's salary in lieu of notice.

At this first directions hearing, on 26 April 2006, Joanna Hernandez was represented by Fabian Picardo (then of Hassans, now The Hon. Fabian Picardo QC MP and Chief Minister) and the SSA was represented by Johann Fernandez (Crown Counsel)[870].

At the conclusion of the hearing the Industrial Tribunal directed disclosure of documents by 2 June 2006; exchange of witness statements by 16 June 2006; and exchange of written legal arguments on the SSA's preliminary point by 19 September 2006. It further directed that the hearing of the preliminary point should take place on 26 September 2006; and that in the event that the SSA failed on the preliminary point, the substantive hearing on the merits of Joanna Hernandez' claim would begin on 6 November 2006 (two weeks being set aside for that hearing) [**J1/115/14-15**].

[870] See generally paras 8 and 9 of the witness statement of Mark Isola QC [**J1/126**].

The SSA complied with its disclosure obligations and filed its evidence within the time stipulated by the Industrial Tribunal. Its evidence consisted of witness statements by Isabella Tosso [**C2/1/1**], Marie Gomez [**C2/4/1**], Sharon Berini [**C2/5/1**], Natalie Fortuna [**C2/6/1**] and Marie Carmen Santos (a Gibraltar Government Executive Officer seconded to the SSA) [**C2/7/1**]. No evidence was filed on behalf of Joanna Hernandez by the Industrial Tribunal's deadline of 16 June 2006.

On 6 July 2006 Joe Bossano replaced Fabian Picardo as Joanna Hernandez' legal representative before the Industrial Tribunal.

On 24 July 2006 Johann Fernandez wrote to John Reyes [**J1/115/14**], the Private Secretary (Legal) to the then Chief Minister, reporting on the current state of the proceedings, and in particular on the fact that Joe Bossano was now representing Joanna Hernandez in place of Fabian Picardo. In the light of that fact, Johann Fernandez suggested that the Chief Minister be asked whether he wished him to continue to represent the SSA or whether outside counsel should be instructed in his place. In the course of his letter, Johann Fernandez described the SSA's position in the proceedings as "strong and defendable" [**J1/115/15**].

The Chief Minister took the view that outside counsel should be instructed, and on 31 August 2006 Mark Isola QC of Triay & Triay was instructed to act for the SSA in the proceedings in place of Johann Fernandez.

On 12 September 2006 Mark Isola QC wrote to John Reyes [**J1/115/16**] saying that he would very shortly advise further on the SSA's preliminary point. He concluded his letter by saying this: [**J1/117/17**]:

> "These are the essential facts on the preliminary point and on which I shall be advising very shortly. Could you please confirm to whom I should refer my legal advice to concerning this claim and the merits of the defence or otherwise."

On the same day, Joanna Hernandez having still filed no evidence, Triay & Triay wrote to the Industrial Tribunal seeking a direction that she serve her evidence within the next 14 days, failing which her claim should be struck out.

The Industrial Tribunal held a second directions hearing on 26 September 2006, at which Joe Bossano appeared for Joanna Hernandez and Mark Isola QC appeared for the SSA. The Industrial Tribunal adjourned Joanna Hernandez' claim as she had not as yet filed any evidence, and directed that the hearing of the argument on the preliminary point should take place on 7 November 2006. The substantive hearing, should the SSA's argument on the preliminary point fail, was rescheduled for hearing on 16 January 2007[871].

[871] See para 10 of Mark Isola QC's witness statement in this Inquiry.

On the following day, 27 September 2006, Joanna Hernandez filed her evidence. Her evidence consisted of witness statements by herself and eighteen other individuals[872]. I have earlier reviewed the witness statements of fifteen of those individuals (i.e. their 2006 witness statements), and have made my findings and comments in relation to their contents[873]. As noted earlier, the remaining three individuals have asked the Inquiry that their 2006 witness statements be treated as withdrawn[874].

The hearing of the SSA's preliminary point had to be rescheduled to 5 December 2006 due to the indisposition of the Chairman of the Industrial Tribunal. In the meantime, Mark Isola QC had concluded that the argument which, up to that point, the SSA had intended to put forward in support of the preliminary point had no reasonable prospect of success, on the basis that, in his opinion, the notice of termination took effect not on the date when it was served, but on the date of termination specified in it, regardless of the fact that Joanna Hernandez had accepted a month's salary in lieu of notice. However, he also concluded that an alternative argument was available, viz. that in computing a continuous period of 52 weeks for the purposes of the Employment Ordinance a week was to be taken to begin on a Sunday. Applying that method of computing the relevant period, Joanna Hernandez had not been employed for the requisite continuous period of 52 weeks, as her employment had started on a Monday; consequently she could not bring a claim for unfair dismissal.

On 6 November 2006 Mark Isola QC wrote to Isabella Tosso [**M26/1/2**] enclosing his written Opinion [**M26/1/4**] dated that day. In his Opinion he set out the rival arguments on the preliminary point and concluded that the correct construction of the word "week" in the Employment Ordinance was "any consecutive period of seven days": i.e. that the SSA's contrary argument would fail. However, he went on to say (in paragraph 2.10 of his Opinion [**M26/1/6**]) that the point was not beyond dispute.

In his covering email, he asked Isabella Tosso for instructions as to how he should proceed.

In due course he was instructed to present the SSA's (revised) argument before the Industrial Tribunal at the hearing of the preliminary point on 5 December 2006, and he duly did so. He argued that a "week" for the purposes of the Employment Ordinance meant a continuous period of seven days starting on a Sunday. By its written ruling dated 12 December 2006 (delivered on 21 December 2006) [**E/20/2**] the Industrial Tribunal rejected that argument. It concluded that such an interpretation of the Employment Ordinance was "inequitable", since if that interpretation were right:

> "... a canny employer could effectively enter into one year contracts and ensure that all his employees fell outside the protection of the Ordinance as they would not, on the legal

[872] Four further witness statements were filed by Joanna Hernandez in early 2008: viz. witness statements by Stuart Borastero, Dean Lopez, Denielle Gomez and Nicole Viagas.
[873] Those fifteen individuals were: Mandy Spencer, Jordan Davis, Emilia Bruzon, Denise Evaristo, Ave Gonzalez, Gina Llanelo, Frederick Becerra, Simy Herbert, Elizabeth Featherstone, Douglas Rodriguez, Carmen Dixon-Pritchet, M.A. Beiso, Violet Sullivan, Maurice Valarino, and Moira Elmer.
[874] Those three individuals were: Robert Tavares, Susan Ignacio and John Harris.

> interpretation submitted by Mr Isola, actually have worked "52 weeks" even though they had worked for "one calendar year"".

The Industrial Tribunal accordingly held that a week, for the purposes of the Employment Ordinance, meant a consecutive period of seven days commencing on the first day of employment.

On the same day (12 December 2006), following the Industrial Tribunal's ruling, Mark Isola QC emailed Isabella Tosso [**J1/115/22**] reporting on the ruling. In the course of his email, he said this:

> "I have never felt that our construction was the stronger of the two constructions. If you want to consider pursuing an appeal on this point, I would suggest I get Counsel's Opinion on the matter before we proceed with lodging an appeal with the Supreme Court."

Isabella Tosso replied the same day [**J1/115/22**] saying that she had discussed the matter with Yvette Del Agua, who had asked her whether in the opinion of Mark Isola QC the SSA had grounds for an appeal against the ruling. The email continued:

> "... and if you consider that we do not, then she [i.e. Yvette Del Agua] advises that we do not seek counsel's opinion and prepare for trial."

However, it was Mark Isola QC's view that it would be appropriate to obtain an opinion from UK counsel as to the merits of an appeal, and on 14 December 2006 he emailed Isabella Tosso to that effect [**M/26/1/16**]. He attached to his email a draft letter which he proposed to send to the Industrial Tribunal concerning dates for the substantive hearing. In the course of his email he said this:

> "If the letter meets with your approval, could you please confirm on what dates you are likely to be able to give evidence in 2007 so that we can request that the matter be adjourned to those dates."

On 15 December 2006 Isabella Tosso emailed Mark Isola QC, saying that Yvette Del Agua had not yet decided whether to proceed to an appeal [**J1/115/20**]. She also left a telephone message for Mark Isola QC. The nature of the message appears from Mark Isola's reference to it in his email to Isabella Tosso later that day (15 December 2006) [**J1/115/21**], where he says this:

> "If I have understood the message left with me correctly, you will not be available to give evidence in January as you will be away on leave during that month even though your contract does not officially terminate until the 31st January 2007. If that is the case, could you please confirm whether I should be giving advance notice to the Industrial Tribunal that we will be seeking an adjournment of the hearing which has been set down for 10 a.m. on the 16th January 2007 to the 26th January 2007 ...."

In the event, in circumstances which I shall describe later in this Chapter, Isabella Tosso did not give oral evidence in the Industrial Tribunal; nor does the documentary evidence available to the Inquiry reveal whether or not she gave the confirmation which Mark Isola QC was seeking.

On the same day (15 December 2006), Yvette Del Agua wrote to the Chief Minister [**M26/1/19**]. In the course of her letter she said this:

> "During a preliminary hearing of the case on the 12 December (to which Mr Bossano and [Joanna Hernandez] summoned all the press) the Chairman ruled that the Tribunal has jurisdiction to entertain the claim for unfair dismissal. Mark Isola is asking for instructions on whether he should appeal this decision. He would want to seek Counsel's opinion on whether we would have any reasonable prospect of success. I forwarded Mark's correspondence to John Reyes and asked him to seek your views, but he hasn't come back to me.
>
> The Appeal needs to be lodged by the 22 December."

Also on 15 December 2006 Hassans (on behalf of Joanna Hernandez) wrote to the Industrial Tribunal applying for 31 witnesses to be subpoenaed (i.e. compelled to attend the substantive hearing in order to give oral evidence) on the ground that by the nature of their employment or other circumstances they were not in a position to attend voluntarily to give evidence[875]. Included in the list were Yvette Del Agua and a number of civil servants.

On 18 December 2006 a meeting took place between Yvette Del Agua, Isabella Tosso and Mark Isola QC, at which the prospects of an appeal were discussed. Mark Isola QC made a detailed attendance note of the meeting [**J1/115/24**]. Paragraphs 4 and 5 of that attendance note were in the following terms:

> "4. With respect to the whistle-blowing allegations, the Complainant [Joanna Hernandez] had gone to staff over a weekend to say if they have any complaints about the deputy manager [Sharon Berini] they should make them now and evidence going back as far as four years before was presented. The CEO [Isabella Tosso] felt it was unsubstantiated comments and it was shown to the AG [Attorney-General] as she thought it was highly irregular. No investigation was conducted and the DM [Deputy Manager: Sharon Berini] was not informed. She [i.e. the Deputy Manager] left amicably in August 2006 having resigned and gone to work for the RGP [Royal Gibraltar Police].
>
> 5. A review carried out by the client justified the allegation that the Complainant lacked the support/assistance that she required in carrying out her duties."

The final paragraph of the attendance note (paragraph 14) was in the following terms:

> "14. I would receive instructions on the question of the appeal but could I have Counsel on standby. I explained that I needed to lodge the appeal by no later than the 22nd December 2006 but that if we were only doing it to safeguard the position, they must be aware that legal costs would be incurred by the other side if we subsequently decided to withdraw the matter and it would be preferable to obtain instructions early on and decide how we wished to proceed. I also explained that Government had to be conscious that the point I had raised was politically unpopular, even if correct in law, and one that if we succeeded in for the purposes of defending this claim, one could expect the Government to legislate to change the definition."

In the event it was agreed that the advice of UK counsel should be sought as to the prospects of a successful appeal by the SSA against the Industrial Tribunal's ruling. David Barr, from Chambers at 1 Temple Gardens, London, was instructed to advise.

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[875] See paragraph 14 of Mark Isola QC's witness statement in this Inquiry [**J1/126/3**].

David Barr's written Advice is dated 23 December 2006 [**M26/1/8**]. In his Advice, he concluded that there was "a respectable argument" that for the purposes of the relevant legislation a week meant a consecutive period of seven days reckoned from midnight on a Saturday and expiring at midnight on the following Saturday (that is to say, that the argument which Mark Isola QC had presented to the Industrial Tribunal was correct in law). However, in paragraph 14 of his Advice David Barr sounded a note of caution, saying this:

> "I conclude that the [SSA] has a respectable argument on a significant and undecided point. It is not hopeless in my view. However, I do not feel able to say that I think it more likely than not to prevail. In these circumstances it is for the [SSA] to consider the importance of the case, whether others might follow on the same point, its attitude to the costs that would be involved in pursuing an appeal that might well be unsuccessful, and the desirability of clarifying the law on this point. If this is an important case, or if there is felt to be a need for clarification of the law, the [SSA] may well feel justified in contesting the point at appellate level, even against the odds."

On 28 December 2006 the SSA filed Notice of Appeal to the Supreme Court against the Industrial Tribunal's ruling on the preliminary point.

On 15 January 2007 Triay & Triay wrote to the Industrial Tribunal opposing Joanna Hernandez' application to subpoena witnesses.

At a hearing on 15 January 2007 the Industrial Tribunal stayed the proceedings for one month to allow the SSA to obtain a hearing date for the appeal, with the proviso that the stay should continue so long as the appeal was set down for hearing within that month. The parties were given liberty to seek further directions, should the appeal be unsuccessful.

On 17 January 2007 Yvette Del Agua wrote again to the Chief Minister [**M26/1/34**]. In the course of her letter, she said this:

> "If we lose the Appeal, Mr Bossano has 18 friendly witnesses and intends to subpoena 31 more, including myself and many civil servants. To compound matters even further, our main witness, Isabella Tosso, the only one who could sway things in our favour, is leaving Gibraltar at the end of the month. Mark [Isola QC] envisages that the case will go on for weeks ...
>
> Mr Bossano has already stated to the Press that he will prove that Ms Hernandez was dismissed for whistle-blowing and not because she lacked managerial skills. Mark is not sure that he will be able to limit proceedings to issues of relevance, and feels that Mr Bossano will use the Tribunal as a political platform to air all his alleged misgivings about Social Services.
>
> I therefore seek an urgent meeting to discuss possible options before further legal costs are incurred."

With effect from 5 February 2007 Chris Wilson became interim CEO of the SSA in succession to Isabella Tosso, who by this time was no longer living in Gibraltar.

On 27 February 2007 Mark Isola QC wrote a twenty-one page letter to Yvette Del Agua [**M26/1/35**] setting out in detail the legal requirements of a claim of unfair dismissal, and the difficulties which, in his view, the SSA would face in defending the claim if its appeal failed. He

also discussed the possibilities of reaching a compromise with Joanna Hernandez. In paragraph 6.7 of his letter [**M6/1/55**] he said this:

> "My general overview of the case is that once Ms Tosso was satisfied on the basis of advice from the AG's Chambers that [Joanna Hernandez] could not claim for unfair dismissal if the contract was terminated on or prior to the 22nd November 2005, she decided that there was little purpose in giving Joanna Hernandez further time to improve when it was obvious to her that she would not improve, which problems were aggravated by the considerable amount of sick leave she was taking and which were depriving [the Home] of its General Manager. It would have made little sense to her in such circumstances to have allowed such time for improvement if she would still need to consider dismissal in the short term, except by then in relation to an employee who was protected from unfair dismissal. The legal niceties to which I have referred above were irrelevant if [she] could not pursue a claim for unfair dismissal."

The SSA's appeal to the Supreme Court was heard by the then Chief Justice, Schofield CJ, on 13 April 2007. At the conclusion of the hearing the Chief Justice indicated that he would be dismissing the appeal, and that he would give his reasons later. Later that day the Secretary to the Industrial Tribunal asked Mark Isola QC to confirm his availability for a directions hearing on 10 or 11 May 2007.

Following the hearing before the Chief Justice, Mark Isola QC emailed Yvette Del Agua referring to an earlier meeting between them and reporting that the Chief Justice had indicated that the appeal would be dismissed [**D42/211/1**]. He went on:

> "I appreciate that my instructions at the meeting were to appeal against this decision if it went against us, and would be grateful for confirmation of your instructions to this effect. You know the serious reservations I have had in pursuing this point, even though it was open to interpretation and construction. We will now have a Supreme Court ruling which will state that in the employment context, the interpretation must mean seven successive days from the first day the employee commences employment. I cannot see that interpretation being upset by the Court of Appeal and I would advise that no such appeal be pursued. If the [SSA] is adamant about pursuing an appeal, I would advise that we engage Senior Employment Counsel to advise and deal with the appeal to the Court of Appeal."

On 20 April 2007 Yvette Del Agua wrote to Mark Isola QC [**J1/115/27**] instructing him to do whatever work was necessary in anticipation of the substantive hearing of Joanna Hernandez' claim. The letter continued:

> "Isabella Tosso can be contacted at the following email address: [address given]. If you require instructions you should contact me. However, any further information such as witness statements etc can be obtained from the current Chief Executive of Social Services Agency, Chris Wilson. He is already aware of the case and had read the files."

On 9 May 2007 the Chief Justice delivered his written judgment dismissing the SSA's appeal [**E/20/5**]. In the course of his judgment he said this:

> "In my judgment the following interpretation of section 60(1)(a) of the [Ordinance] is consistent with the straightforward wording of the [Ordinance]. First the effective date of termination of the employee's employment should be determined. The period of 52 weeks should then be reckoned backwards from that date, a week being calculated as a period of seven successive days. In my view this provides a result which is both satisfactory and fair to employer and employee alike."

Later that day or early the following day (10 May 2007), Mark Isola QC emailed Isabella Tosso in the following terms [**M21/5/1**]:

> "I have just received the decision of the Supreme Court dismissing the appeal on the preliminary issue. Unless I am instructed to appeal, and I am awaiting instructions on this, it is likely that the Complainant [Joanna Hernandez] will press for an early hearing. Could you indicate when you would be available to attend a hearing. I appreciate from what you have previously told me, that you would be unlikely to be free in the period prior to August. The Tribunal does not sit in August. Accordingly, when would you be free from September 15th onwards? I estimate that you would need to put aside at least three days and I would present you as the first witness for the [SSA]."

Isabella Tosso replied on 10 May 2007 as follows [**M21/5/1**]:

> "Although keen to be of assistance it is impossible for me to predict with any accuracy where I am likely to be after the 15th September 2007. At this point I am unable to even say whether I will be in Europe. There is a strong possibility that I may be in New Zealand or the States, and wherever I am I would have to negotiate an absence from work with my employer at the time.
>
> I am also aware that we identified the need for thorough preparation prior to the actual hearing do the 3 days include this?
>
> This year is quite fluid and not tied to any deadlines or destinations for me, I apologise if this is going to be problematic in respect of my appearance at the hearing."

On 18 May 2007 Yvette Del Agua emailed Mark Isola QC saying this [**D42/211/3**]:

> "I have now had word from the CM and can confirm that you should proceed with the appeal ..."

On 22 May 2007 the SSA filed a Notice of Appeal to the Court of Appeal against the Chief Justice's decision.

On the following day (23 May 2007), Mark Isola QC had a one-hour meeting with Chris Wilson [**J1/115/29**]. He made a detailed attendance note of that meeting, and I set it out in full, as follows:

> "1. We discussed that the procedural failures were sufficiently serious to render the decision [to dismiss Joanna Hernandez] unfair and that there were noticeable failures in supervision/procedure.
>
> 2. The most meaningful activity concerning warnings/supervision was towards the end of the probationary period as the employer was becoming aware that the probationary period was coming to an end and that if it was ended then there would be no come-back.
>
> 3. The advice received by his predecessor [Isabella Tosso] would explain why there was no due process.
>
> 4. There was a mountain of evidence about her incompetence, but also whether an employer has a duty to develop/train an employee if they lack sufficient standards. When she was left to her own devices, it was clear she lacked competence and did not have sufficient competence to be a superior and did not supervise others.

> 5. He [Chris Wilson] felt that she did not genuinely know what was expected of her and she too needed supervision. She knew she needed to do supervision, but did not do it. She knew she had problems, but did not know how to resolve them.
>
> 6. The inquiries she conducted into Berini [were] off her own [bat], on rules that she made up as she went along, did not know what was a fair procedure and was tantamount to a witch-hunt in that it asked anyone and everyone who had something bad to say about Ms. Berini to say it which would not be hard to find such evidence going back any number of years in relation to a manager. There are many example[s] of her lack of competence.
>
> 7. There was a strong need to monitor her.
>
> 8. She would have [to] know what standards she needed to meet, and just like there would be the obligation to provide her with support, she ought to seek support when she [was] out of her depth/needed support. It was a mutual obligation. She did not ask for support until it was [too] late.
>
> 9. I stated that if my instructions continued to be to defend the claim, and he found the original letter of advice extremely helpful and pertinent to the issues in the case, it would greatly assist me if he could:-
> (a) Review Ms Tosso's evidence and let me have his views on it.
> (b) Identify the most salient points which would show the incompetence of Ms Hernandez to do the job she was engaged to do.
> (c) Let me know how quickly Ms Hernandez's successor [Iain McNeil] dealt with those problems she was unable to deal with.
>
> He said he would revert after a meeting on the 24th May 2007."

On 21 June 2007 Mark Isola QC emailed Yvette Del Agua [**D42/211/5**] saying that he saw no reasonable prospect of success before the Court of Appeal, given that the SSA's argument would (as he put it) "go against the intention of the legislation which governs employees' rights". He asked for an opportunity to discuss the matter further with her. He sent her a further email reiterating his advice on 25 July 2007.

On 6 August 2007 Yvette Del Agua telephoned Mark Isola QC instructing him to proceed with the appeal to the Court of Appeal in accordance with his earlier instructions.

On 3 September 2007 Mark Isola QC emailed Yvette Del Agua [**D42/211/8**] noting her instructions that he should proceed with the appeal to the Court of Appeal but reiterating his advice that there was no reasonable prospect of the appeal succeeding. He continued:

> "Whilst I note that there might be sensitivity to withdrawing the appeal, a definitive ruling was obtained from the Supreme Court of Gibraltar and parties do often withdraw proceedings/appeals. In my view it would be preferable to do this than to have a full hearing with the Court of Appeal assailing the arguments put forward by the [SSA] in [what] will be a courtroom packed with representatives from the press. The contention being advanced is not popular with the majority of the public, who are in the main employees, and one would only wish to advance this argument further if there was a reasonable likelihood of success. In my considered view, there is not and the Supreme Court's ruling in this respect will be upheld.
>
> ....
>
> If the appeal is to be withdrawn, we should do so now before further legal costs are incurred."

Yvette Del Agua replied next day (4 September 2007) saying that she would revert "as soon as I receive instructions".

On 14 September 2007 John Reyes emailed Mark Isola QC [**D42/211/9**] saying this:

> "I refer to your various emails to Minister Del Agua advising that the appeal should be withdrawn.
>
> I have discussed the matter with the Chief Minister and he has instructed that you are to proceed with the appeal."

On 18 September 2007 the Court of Appeal heard the SSA's appeal on the preliminary point and dismissed it. (The formal Order dismissing the appeal was issued on 31 October 2007 [**J1/115/32**].)

Sir Paul Kennedy JA gave the leading judgment in the Court of Appeal. In his judgment [**M26/3/1-5**], he gave the SSA's argument short shrift. He noted that the Employment Ordinance did not define the word "week", and concluded that in the absence of a statutory definition "week" could mean either a period of seven consecutive days beginning on a Sunday or simply any period of seven consecutive days, depending on the context in which the word "week" was used. He held that in the context of the Employment Ordinance "week" meant any period of seven consecutive days. He went on (in paragraph 13 of his judgment [**M26/3/4**]):

> "13. Any other approach would lead to the surprising conclusion that for 6 days after the respondent took up her employment and for 2 days before it came to an end, she was not, for the purposes of [the Employment Ordinance], continuously employed. Now that seems very difficult to accept."

Later that day (18 September 2007) Mark Isola QC emailed Yvette Del Agua [**D42/211/10**] reporting on the decision of the Court of Appeal and asking her to confirm that he was not instructed to appeal further and that he should prepare for the defence of the claim. Yvette Del Agua forwarded his email to John Reyes and asked him to show it to the Chief Minister. She added [**D42/211/10**]:

> "I assume that we will not be appealing any further [i.e. to the Privy Council]. Please confirm."

In the event, no steps were taken by the SSA to appeal to the Privy Council.

In the light of the Court of Appeal's dismissal of the SSA's appeal, the Industrial Tribunal directed that a preliminary hearing be set down for 27 November 2007 to hear applications for witness orders (subpoenas) and to identify suitable dates for the substantive hearing, for which two weeks was allowed. The Industrial Tribunal initially offered the two weeks commencing on 28 January 2008 for the substantive hearing, but subsequently it took the view that it would be inappropriate to fix a hearing date for the substantive hearing until all necessary further directions had been given.

The hearing of Joanna Hernandez' application for subpoenas took place on 30 November 2007. In the event, the Industrial Tribunal issued subpoenas in respect of 8 witnesses, out of 29 subpoenas requested. The Industrial Tribunal also provisionally set aside the period 7 to 25 April 2008 for the substantive hearing.

Notwithstanding the Industrial Tribunal's refusal to subpoena the remaining 21 witnesses, Joe Bossano (for Joanna Hernandez) indicated at the hearing that she would be calling several of those witnesses to give evidence, despite the SSA's contention that the subpoenas had been refused because the evidence of those witnesses was not relevant to the issue of unfair dismissal and would, if given, lead to the filing of further witness statements by the SSA.

On 18 January 2008 Mark Isola QC emailed Chris Wilson [**J1/115/38**] attaching a list of witnesses to be called at the forthcoming substantive hearing. In the course of his email he said this:

> "I have e-mailed Isabella Tosso asking her to confirm her availability to give evidence on the provisional trial dates and am awaiting a reply."

On 22 January 2008 Mark Isola QC emailed Chris Wilson saying this [**J1/115/41**]:

> "I have been unable to elicit a response from Ms Isabella Tosso via e-mail as to whether she [will be] available to attend and to give evidence on the provisional trial dates.
>
> I asked for her telephone contact details yesterday but no one appears to have them. Could you assist and provide me with those contact details.
>
> I am expected to confirm to the Tribunal this morning at 10a.m. whether Ms Tosso will be available to give evidence on those dates or at all."

Later that day, following his appearance at the Industrial Tribunal, Mark Isola QC emailed Chris Wilson again **[J1/115/40**]. In paragraph 4 of that email he said this:

> "4. In the absence of any response from Ms Tosso, I have not asked for a postponement of the provisional trial dates. However, I cannot over emphasise the [i]mportance to the Respondent's case of contacting her and having her available to give evidence."

On 21 February 2008 Mark Isola QC wrote to Chris Wilson [**J1/115/34**] dealing with a number of procedural matters, and repeating the substance of the advice he had already given as to the prospects of successfully defending Joanna Hernandez' claim. As to the merits of the SSA's defence to the claim, he said this:

> "Even if Ms. Tosso is available, the Complainant [i.e. Joanna Hernandez] should have been made aware of her shortcomings, and given a reasonable opportunity to improve her performance. The dismissal was procedurally flawed and unfair."

On 29 February 2008 Mark Isola QC emailed Chris Wilson, saying this (in paragraph 3 of the email) [**J1/115/42**]:

> "3. In the absence of any response from Isabella Tosso, I will apply for a postponement of the hearing on the grounds that we have been unable to contact her and she is the principal witness of the Respondent and is required. Please ensure that if Ms Tosso does make contact with the [SSA], and notifies it of her intentions as to whether or not she is prepared to attend the hearing, that I am immediately informed as I must not mislead the Tribunal concerning her availability or otherwise."

Chris Wilson responded by email on 4 March 2008 [**J1/115/43**], saying this:

> "I confirm that to date I have not received a reply from [sic] my email to Isabella Tosso."

A further preliminary hearing took place on 13 March 2008 at which Mark Isola QC applied to the Industrial Tribunal to adjourn the substantive hearing on the ground that the SSA had been unable to contact Isabella Tosso: an application which the Industrial Tribunal rejected.

On 8 April 2008 Mark Isola QC spoke to Chris Wilson on the telephone concerning the availability of Isabella Tosso to give evidence. Mark Isola QC's attendance note of that conversation reads as follows [**J1/115/55**]:

> "Telephone conversation with Chris Wilson on the 8th April 2008 in which he asked me to proceed on the basis instructed. I queried whether the statement by his predecessor [Isabella Tosso] would be viewed as a [mea] culpa on the part of the Agency and whether he would want to amend it with that in mind. He said no and did not expect any reaction, given that the Agency had done everything in its power to contact her, and in view of the fact that it could not establish contact, it had to be assumed she was unwilling to attend and he could not blame her. He said he would confirm in writing his instructions to proceed on the part of the Agency."

Later that day, Chris Wilson emailed Mark Isola QC [**J1/115/62**] confirming the instructions not to call evidence as to the reasons for not renewing Joanna Hernandez' contract: in effect, to capitulate in the face of her claim.

So far as the availability or otherwise of Isabella Tosso to attend the substantive hearing is concerned, at this stage I merely make it clear that so far as Mark Isola QC was concerned, he was, as one would expect, simply acting throughout on the basis of the instructions and information given to him by the SSA. He had no personal knowledge of the availability or whereabouts of Isabella Tosso, or whether she could be contacted. All he knew was that since January 2008 he had received no communication from her in response to his emails.

The substantive hearing of Joanna Hernandez' claim of unfair dismissal took place on 9 April 2008. At that hearing Mark Isola QC duly followed his instructions by making a statement to the effect that, despite its best efforts, the SSA had been unable to contact Isabella Tosso. The statement acknowledged that without the evidence of Isabella Tosso the SSA would be unable to satisfy the Tribunal that Joanna Hernandez' dismissal was not unfair, and went on to inform the Industrial Tribunal that the SSA would not be leading evidence in defence of her claim.

Faced with that situation, the Industrial Tribunal made a finding that Joanna Hernandez had been unfairly dismissed. It went on to award her compensation. It also made a non-binding recommendation that she be re-engaged by an associated employer, namely the Gibraltar

Government (a recommendation which, in the event, was not accepted by the Gibraltar Government).

In paragraph 29 of his witness statement in this Inquiry [**J1/126/6**], Mark Isola QC set out at length the reasons why he had advised the SSA not to dispute Joanna Hernandez' claim, "regardless of whether Ms Hernandez was competent to satisfactorily carry out the role of manager of [the Home]". He expressed his reasons as follows:

> "a. The Agency needed to, firstly, establish that the ground for dismissal was incompetence, and secondly, to have acted reasonably in so concluding. The Agency's principal witness, Ms Isabella Tosso, the decision-maker for the dismissal, was not available to give evidence by the time of the substantive hearing;
>
> b. Even if Ms Tosso had been available, and the Agency discharged the burden of proof that this was a dismissal on grounds of performance and not for whistle-blowing, there were a number of other issues which needed to be addressed by the Agency to show that it had acted fairly and reasonably in dismissing her for that reason, and which essentially revolved around the procedural fairness of the dismissal and not its substance: -
>
> i. Ms Hernandez should have been made regularly aware of her shortcomings from early on in her employment, and given a reasonable opportunity to improve her performance. There was no effective appraisal system in place and any warnings to improve came very late in the day when she had no reasonable time to improve as she was on sick leave for a large part of the time between the warning and the dismissal;
>
> ii. By the time a form of warning had been given, on 16th September 2005, the warning in itself was not explicit, indicated that the Agency still believed there was room for improvement, and Ms Hernandez was then absent on sick leave for a large period of the interval between the dismissal and the notice of termination of her employment. Given that the reasons for sickness were not disputed by the Agency at the time, one could not reasonably expect improvements in carrying out her duties, and in particular supervision, if Ms Hernandez was unable to attend at work because of illness for a significant period of time following the warning. By 24th October 2005 Ms Hernandez had been given notice of dismissal;
>
> iii. There was reference in a supervision minute from Ms Marie Gomez, Ms Hernandez' Team Leader, on 16th September 2005, that the probationary period would be extended, which Ms Tosso was of the view should not have been said, but which was nevertheless on record;
>
> iv. Ultimately, it was Ms Tosso who took the decision that no amount of warnings/reasonable period for improvement would actually result in Ms Hernandez meeting the standards required to manage the [Home], and she was not available to give evidence. Ms Tosso took the decision not to renew the contract in the belief that Ms Hernandez would not be entitled to pursue any claims as she would not have had sufficient continuity of employment to present a claim for unfair dismissal, and therefore issues of procedural fairness did not in her mind at the time of the dismissal need to be addressed;
>
> v. No consideration was given to looking for suitable alternative employment for Ms Hernandez;
>
> vi. Nor had management necessarily provided her with the necessary supervision as she struggled to cope with her duties at the [Home];
>
> vii. Following the reports of the Social Workers of 11th October 2005, and as I later ascertained from her successor as a consequence of his specific proposal and request, administrative support was provided in the form of an Administrative Officer to assist the Manager of the [Home].

> c. Ms Hernandez's representative had indicated that he would be asking those persons not the subject of subpoena to attend voluntarily despite objections by the Agency on the grounds of relevance, and which the Tribunal did not agree with the Agency on. Tribunals have a wider discretion than ordinary Courts of Law in determining what evidence to allow. As Ms Hernandez was arguing that she inherited the Home with a history of problems, was not given the assistance/resources to resolve these problems, and had been dismissed because of the whistle-blowing allegations, the Tribunal could take, and appeared to be taking, a very broad view of what was relevant in the exercise of its discretion, and this would inevitably prolong the substantive hearing and the number of witnesses;
>
> d. The costs of preparing for, and attending a 3 week hearing, would be substantial despite the number of witnesses having been reduced. It would be very difficult to restrict the evidence to whether Ms Hernandez was competent to carry out her duties, which was the Agency's position;
>
> e. There were still issues of disclosure of documents which needed to be addressed and which the [SSA] was to ask the Chairman to only order disclosure of if they were relevant to issues and in a redacted form so that any confidential aspects in the documentation such as client names were removed unless necessary to retain."

He went on to acknowledge that his advice had run contrary to the SSA's view that it could establish on the totality of the evidence that the dismissal of Joanna Hernandez was not unfair.

In the course of his oral evidence, Mark Isola QC was asked by counsel to the Inquiry whether he had ever met the Chief Minister in relation to Joanna Hernandez' claim. He replied[876]:

> "To the best of my recollection, no. But I did meet him on several occasions on other matters I was dealing with over a very long period of time. ... [B]ut I don't believe I met with him specifically on this claim. But I wouldn't exclude either that he might have commented about this claim because ... it was very heavily publicised."

As to the availability of Isabella Tosso, he said he had hoped that she would be available, and that he had believed that "certain persons were trying to make contact with her"[877].

In response to a question from me as to the importance of having Isabella Tosso present at the substantive hearing, he said this[878]:

> "It was going to be more difficult. We had Ms Gomez, but she wasn't quite the decision-maker, and we of course had the manager who took over [Iain McNeil] ... but there were going to be a lot of very wide allegations or suggestions about the real reason for the dismissal in this case, so you really need the decision-maker to say "That was not my reason for dismissing the complainant", and she wasn't present, and that of course in itself was going to lend itself to further possible arguments at the hearing."

In response to questions from counsel for Joanna Hernandez, Mark Isola QC pointed out that the Industrial Tribunal proceedings were "publicised in a lot of the Press at the time"[879].

He went on to point out that the Industrial Tribunal had set a tight timetable, so that it was necessary for him to start preparing for the substantive hearing at an early stage[880].

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[876] See Day 11 page 134 line 25ff.
[877] See Day 11 page 135 line 21ff.
[878] See Day 11 page 144 line 18ff.
[879] See Day 11 page 148 line 3.

Asked by counsel for Joanna Hernandez whether he had ever had experience of the Government "fighting and defending a claim to quite this extent", he replied that he had, and he went on to give an example[881].

Mark Isola QC's evidence was not challenged and I have no hesitation in accepting it without qualification. I note in particular his advice to the effect that, regardless of the non-availability of Isabella Tosso, the dismissal of Joanna Hernandez was "procedurally flawed and unfair" (see his email to Chris Wilson dated 21 February 2008 [**J1/115/35**], quoted earlier). I have no doubt that the procedural defects to which he referred resulted from a belief on the part of Isabella Tosso that the non-renewal of Joanna Hernandez' probationary contract would not give her a right to claim unfair dismissal. It appears that that belief may have derived from legal advice which she had received from another quarter, but it is not necessary for me to make any finding as to that.

I turn next to the evidence as to the availability or otherwise of Isabella Tosso to attend the substantive hearing of Joanna Hernandez' claim.

I start with the evidence of Chris Wilson. As noted earlier, on 5 February 2007 Chris Wilson became interim CEO of the SSA in succession to Isabella Tosso. He left the SSA in March 2009. In paragraph 11 of his witness statement in the Inquiry [**J1/115/3**], he says this:

> "11. .... During this period [i.e. the period leading up to the Industrial Tribunal hearing] it became clear that it was impossible to get hold of Ms Tosso, who was no longer in Gibraltar and not answering emails, despite attempts by both Mr Isola ... and myself to contact her. This proved to be problematic because, although the advice received was that Ms Tosso's evidence would probably not have been sufficient to mount a complete defence for the SSA, her evidence would have assisted the SSA's defence to an extent, as well as setting out Ms Tosso's arguments that Ms Hernandez was inadequate in her position. ...."

That is the only reference which Chris Wilson makes in the body of his witness statement to the non-availability of Isabella Tosso. Moreover, his reference to attempts by Mark Isola QC to contact Isabella Tosso is misleading in so far as it suggests that both he and Mark Isola QC were attempting to locate her. As appears from the email exchanges between them referred to above, Mark Isola QC had merely reported in January 2008 that he had emailed Isabella Tosso but had received no reply. He naturally left it to Chris Wilson to attempt to make contact with her, whilst continually stressing the importance of having her available to give evidence.

In the course of his oral evidence, Chris Wilson said his instructions in relation to the Industrial Tribunal proceedings came from Yvette Del Agua. As he put it[882]:

> "My bit of the chain was to the Minister."

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[880] See Day 11 page 151 line 11ff.
[881] See Day 11 page 153 line 23ff.
[882] See Day 11 page 160 line 23.

Asked whether Yvette Del Agua ever told him that she was getting instructions from elsewhere, he replied[883]:

> "Certainly. I think further down the line, when we were getting into the nitty gritty of the substantive case, there was certainly reference to the Chief Minister and in fact at one stage I drafted a letter [to the Chief Minister] for her."

He went on to confirm that he had no personal knowledge of the issues raised in the Industrial Tribunal proceedings[884].

Asked whether he knew where to find Isabella Tosso after she left the SSA in early 2007, he replied[885]:

> "No. I knew she had gone back to the UK. I had an email address and, I think, I believe, a Gibraltarian mobile telephone number."

He went on to say that he had sent "emails" to that email address, but that he had received no response.

In answer to questions from me, Chris Wilson said that he did not have any address for Isabella Tosso in the UK, but that "it was possible" that some people in the SSA did know where she was[886]. He said he had tried to find out where she was by asking them[887]. He said that he personally did not take any further step to try to obtain her contact details[888].

Asked by counsel to the Inquiry whether he had asked Marie Gomez, he replied[889]:

> "Yes, I think I did ask Marie Gomez, but Marie Gomez I think said that she didn't know where she was. .... She couldn't contact [her]."

Counsel went on to refer him to the letter which he had drafted for the Minister to send to the Chief Minister [**J1/115/48-49**]. The draft letter is undated, but in paragraph 12 of his witness statement [**J1/115/3**] Chris Wilson said that it was drafted in March 2008 (by which time Yvette Del Agua had been succeeded as Minister for Social Services by Jaime Netto). In oral evidence, he said that he believed that a letter in the form of the draft was in fact sent, although he did not recall receiving a copy[890].

The first two paragraphs of the draft letter are in the following terms:

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883 See Day 11 page 161 line 5ff.
884 See Day 11 page 165 line 2.
885 See Day 11 page 168 line 23ff.
886 See Day 11 page 169 line 22ff.
887 See Day 11 page 170 line 9.
888 See Day 11 page 170 line 14ff.
889 See Day 11 page 170 line 25 to page 171 line 5.
890 See Day 11 page 174 line 19.

> "I am writing to you further to consultations between officers of the [SSA] and Mark Isola (Triay & Triay) regarding the progression of the above case.
>
> As I believe you are aware, the original situation regarding the termination of Joanna Hernandez's employment from her position as the Manager of [at this point Chris Wilson – the draftsman of the letter – wrongly refers to St Bernadette's] at the end of her probationary period was not particularly well handled by the [SSA]. It now seems clear that Ms Isabella Tosso (ex Chief Executive – Social Services Agency and decision maker for the dismissal of the Employee) does not intend to return to Gibraltar as the principle [sic] witness for the [SSA]. It is now my view that these two factors threaten to undermine the "winnability" of the case and I have therefore taken this step of writing to you to outline the reasons why I believe it may be sensible to consider alternative approaches."

The draft letter goes on to review the strengths and weaknesses of the SSA's case. It continues [**J1/115/49**]:

> "The [SSA's] case will not be helped by the non-appearance of Isabella Tosso. Ms Tosso was the officer who took the decision to dismiss the Complainant and her evidence would have been relied on to refute, or provide an alternative perspective to, most of the points listed above. Without her physically giving evidence and being cross examined we will only be able to submit her witness statement."

Chris Wilson was then asked whether the fact that he had drafted a letter for Jaime Netto to send to the Chief Minister indicated that he knew that Jaime Netto wished to communicate with the Chief Minister. Chris Wilson appeared to find difficulty in answering such an apparently straightforward question. His immediate answer was: "Yes"[891]. However, he quickly went on to qualify that answer, saying this[892]:

> "I'm not saying that – I've never said that – I'm not saying that there wasn't a line of communication between Ministers and the Chief Minister. I'm just saying that I wasn't particularly aware of it."

I am at a loss to understand what Chris Wilson meant by that answer. As acting CEO of a Government agency he must have known that lines of communication existed between Ministers and the Chief Minister: after all, absent such lines of communication, no Government could function effectively. In any event, as counsel was correctly suggesting, the very fact that he had drafted a letter for the Minister to send to the Chief Minister shows that he was aware that the Minister wished to communicate with the Chief Minister about the Industrial Tribunal proceedings. Nor, I should add for the sake of clarity, was there anything remotely sinister or unusual in his wishing to do so.

In response to questions from counsel to the Inquiry, Chris Wilson went on to confirm (and I accept) that he never gave instructions to delay the substantive hearing of Joanna Hernandez' claim and that it was not his objective to prevent investigation of the allegations contained in the 2006 witness statements[893].

[891] See Day 11 page 173 line 6.
[892] See Day 11 page 173 lines 8-11.
[893] See Day 11 page 180 line 14ff.

Counsel for Joanna Hernandez asked Chris Wilson why, if he knew that Isabella Tosso was leaving Gibraltar permanently in early 2007, Joanna Hernandez' claim was not conceded at that point. He responded[894]:

> "There were other factors to take into account. I had only just arrived in the [SSA], for example. I was working for three or four months part-time in both jobs[895], and so probably in fairness I didn't have the chance to focus all my attentions on it."

Pressing the point, counsel for Joanna Hernandez put it to Chris Wilson that it seemed odd that the case was not dropped when Isabella Tosso left Gibraltar in January 2007. He replied[896]:

> "Well, she had gone. There wasn't an indication at that point in time that she wasn't prepared to come back as a witness. .... It only later became apparent that there may be an issue about whether she would want to come back."

Counsel for Joanna Hernandez then referred Chris Wilson to a series of emails passing between Marie Gomez and Isabella Tosso which (counsel suggested) showed clearly that, throughout the period leading up to the Industrial Tribunal hearing and thereafter, Marie Gomez knew where Isabella Tosso was and how to contact her[897]. I will review these emails when I consider the evidence of Marie Gomez as to her knowledge of the whereabouts of Isabella Tosso (see below). In answer to questions from me, Chris Wilson confirmed that he had not seen these emails before, but he said that he was aware that Isabella Tosso and Marie Gomez were on very friendly terms (as is, indeed, apparent from the emails)[898]. He went on:

> "That's why I would have asked Marie Gomez. .... If I'm honest, I can't remember saying it, but I think it was the sort of thing I would have done, because I was aware of their friendship."

I then asked him a series of further questions. The relevant passage from the transcript reads as follows[899]:

> "THE CHAIRMAN: Are you satisfied that you did everything possible to locate her?
> A. (Pause) We emailed, "we" meaning both myself and Mark Isola, I had a Gibraltarian telephone number which was clearly – I probably tried ringing once or twice, and that obviously because she was in the UK –
> THE CHAIRMAN: I don't know, does she have family in Gibraltar?
> A. I presume so.
> THE CHAIRMAN: Did you try and find out?
> A. No.
> THE CHAIRMAN: Did you make enquiries of any neighbours of hers in Gibraltar?
> A. No.
> THE CHAIRMAN: Did anybody make any inquiries like that?
> A. I don't think so, no."

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[894] See Day 11 page 182 line 4ff.
[895] A reference to his previous job at the Gibraltar Health Authority.
[896] See Day 11 page 182 line 14ff.
[897] Copies of these emails are exhibited to the witness statement of Elizabeth Harrison [**F/6/13 – 20**]. They cover the period from 20 August 2007 to 10 December 2007, and there is a further email from Isabella Tosso dated 12 August 2008.
[898] See Day 11 page 186 line 3ff.
[899] See Day 11 page 187 line 2ff.

In the circumstances, I found Chris Wilson's evidence in relation to the availability of Isabella Tosso to be singularly unhelpful, to put it no higher.

I find that he wholly failed to give this matter the importance it deserved (an importance which he had himself recognised in his email correspondence with Mark Isola QC), or to treat it with an appropriate degree of urgency. Moreover, the fact that he made no effort himself to discover how to contact Isabella Tosso beyond making inquiries of some of his colleagues demonstrated a quite remarkable degree of passivity on his part. That said, I accept his evidence that he asked Marie Gomez whether she knew how to contact Isabella Tosso – that, after all, was the very least he could have done, as he effectively admitted in evidence. I also accept his evidence that Marie Gomez' response was in the negative.

For completeness, although it was not put to him directly in the course of his oral evidence, I should say that there is no evidence whatever that his passive attitude towards Isabella Tosso's availability represented a deliberate attempt on his part to prevent or delay discovery of her whereabouts. On the contrary, I am satisfied that it was simply a case of slackness and inefficiency on his part.

I turn next to the evidence of Marie Gomez in relation to the availability of Isabella Tosso to give evidence at the substantive hearing in the Industrial Tribunal. This was not a matter which was covered in her written evidence, but she was asked about it in the course of her oral evidence.

In answer to questions from counsel to the Inquiry, she said that she was "never close friends" with Isabella Tosso[900]. She went on[901]:

> "No. I was friends with her, and, you know, people you make friends [with] at work, but I haven't seen her since [i.e. since she left Gibraltar] ...."

Counsel to the Inquiry then referred her to the series of emails between her and Isabella Tosso which had been put to Chris Wilson in the course of his oral evidence (see above). In response to counsel's questions, she confirmed that she was on good professional terms with Isabella Tosso, but that they were not particularly friendly[902]. However, the emails sent during the period from August to December 2007 show that answer to be untrue. They also show that Marie Gomez and Isabella Tosso were in regular email contact during that period.

The first email of the series [**F/6/13-20**] is an email from Isabella Tosso to Marie Gomez dated 20 August 2007. In it, Isabella Tosso says this:

> "I don't seem to be able to [get] myself sorted to come in September so it looks like I'll be coming for October. .... So trying to work out how I come for the wedding ... My landline isn't working at the moment and hasn't been for a couple of weeks but my mobile is fine."

[900] See Day 13 page 43 line 23ff.
[901] See Day 13 page 44 line 20ff.
[902] See Day 13 page 106 line 5.

Referring to that email, Marie Gomez accepted in the course of her oral evidence that at that time she had Isabella Tosso's email address. She went on[903]:

> "That's all I had. I never had a phone number or a home address."

In her reply to that email [**F/6/13**], which is undated, Marie Gomez said that she would not be around on that weekend as she had booked a weekend in Madrid.

Isabella Tosso emailed Marie Gomez again on 5 September 2007 [**F/6/13**], saying that she would be coming to Gibraltar on Friday 5 October 2007 to attend the wedding to which she had referred earlier. She went on:

> "I would have wanted to ask you but that would have been complicated! Anyway I will be busy packing and stuff but I would like to see you on the Saturday in the day if you are free."

Isabella Tosso ended that email:

> "Un beso amiga, think of you often xxxx".

In her response, which must have been sent either that day or early the following day (6 September 2007), Marie Gomez said this [**F/6/14**]:

> "... will hopefully see you in October if you can fit it in what with the wedding and everything else!! Need to sort out your money. Love Marie"

Isabella Tosso emailed Marie Gomez again on 6 September 2007 [**F/6/14**]. The terms of this email indicate that there has been further communication between them: communication which must have taken place over the telephone. The email reads as follows:

> "Ohhhhhhh noooooo!!!!!!!! Really I can't believe it, how unfortunate! I'm gutted. Even more reason why you have to plan a weekend here as soon as I'm back in my place. Esp because I've been worried about you, you don't sound your usual self recently and I wanted to sit down with you and have a good natter, the phone or email is not really a substitute.
>
> The fault at home on the phone means we can only have one or the other (phone or internet) on at a time which is a nightmare but [if] you wanted to call and the landline doesn't work its probably not connected so you can text me and I'll plug it in. Also my direct line number at work is [number given].
>
> I'm not as busy as you are.
>
> I miss you my friend and I'm worried about you
>
> Big hug
>
> Isabella xxx"

[903] See Day 13 page 107 line 4

Isabella Tosso's reference in the above email to the phone being no substitute for a meeting, coupled with her suggestion that Marie Gomez should text her if she (Marie Gomez) wanted to call her on her landline at a time when it was connected to the internet, establish – contrary to her evidence – that at that time Marie Gomez had Isabella Tosso's landline number and her mobile telephone number, and that she had been making use of them. The email also gave her Isabella Tosso's work number. So on receipt of the email, Marie Gomez had Isabella Tosso's email address, home landline number, her mobile telephone number and her work telephone number. The overwhelming inference, which I have no hesitation in drawing, is that Marie Gomez also knew the postal address of Isabella Tosso's "place".

On 10 September 2007 Isabella Tosso emailed Marie Gomez again [**F/6/14**], saying that she had not been at home over the weekend and so had been "unable to call". Marie Gomez responded [**F/6/15**]:

> "Isabella, I am now at work but lets talk after my return from my hols when I will be feeling better!!"

Isabella Tosso sent Marie Gomez a further email on the following day (11 September 2007) [**F/6/15**], in the course of which she said this:

> ".... I hope you know that whatever has happened you mean the world to me and so does our friendship. Anyway I won't put upon you, I'm sure you are under enough pressure at work without me adding to it. As upset as I am to be left worrying about 'us' I will wait until you come back. ...."

On or about 30 September 2007 Marie Gomez emailed Isabella Tosso [**F/6/16**] saying that she had just returned from her holiday. She went on to say that she would, after all, be staying in Gibraltar for the weekend of the wedding which they had discussed in their earlier emails (6/7 October 2007), and she suggested that they should meet some time on the Saturday for a chat.

In her response [**F/6/16**], which was sent the same day, Isabella Tosso said this:

> "How wonderful to hear from you. .... A mi no me a llegado la camisa al cuerpo desde ke [sic] te fuiste, I haven't stopped thinking about you. Ive missed you, I've been sick with worry that I've upset or hurt you, please believe, if I have, I didn't mean to."

She went on say that she had a doctor's appointment in Cadiz on the Saturday morning, and suggested that Marie Gomez should go with her so that they could have lunch on the way back. She ended her email:

> "Bueno, happier now I've heard from you."

On 6 November 2007 Marie Gomez sent Isabella Tosso an email wishing her a belated happy birthday [**F/6/17**].

On 7 December 2007 Marie Gomez sent Isabella Tosso a long email in the course of which she said this [**F/6/19**]:

> "As you will be coming in January for the Tribunal I hope we can meet but [another named individual] wants to do so as well s[o] put us both down even if its just for a drink in your diary!!"

In the course of her response, which was sent on 10 December 2007 [**F/6/19-20**], Isabella Tosso said this:

> ".... Marie I was surprised to hear about the tribunal. Last communication I've had was in May when I told them I was not going to be able to commit to dates after that because I didn't know what plans I had or where I would be living and also that I needed closure with Gib for both personal and professional reasons and I couldn't have something hanging over my head indefinitely. This email I sent to Mark Isola, I think I even suggested that he press the minister to settle. And I honestly thought that this is what had happened. But you are right it's about the Chief Minister's [agenda] now, not the [SSA's].
>
> Since then I haven't heard. And I'm not really expecting to as they would have consulted me for dates before setting them down.
>
> .... So please look at weekends for the New Year to come and visit, although I wouldn't mind meeting up with you somewhere else [i.e. somewhere other than Gibraltar]."

Asked by counsel to the Inquiry whether she was asked by Chris Wilson how to contact Isabella Tosso, she said that she could not recall his asking her that[904]. (I have already found that Chris Wilson did in fact ask her that.) She went on to say that she could not remember exactly but she did not think so[905].

I then suggested to her that she must have known very soon after the substantive hearing in the Industrial Tribunal, if not before, that the non-availability of Isabella Tosso to give evidence at the substantive hearing in the Industrial Tribunal meant that the SSA was not in a position to defend Joanna Hernandez' claim; and I asked her whether that had come as a surprise to her, and whether she was aware of the difficulties which had been encountered in locating Isabella Tosso. She replied[906]:

> "To tell you the truth, I was very busy. I didn't have time for the Tribunal, I had to get on with my work, and you know, if this happened I would have to go to give evidence or whatever, but I was very busy, I didn't have time to look at anything else but work."

I do not believe that answer.

Asked by counsel to the Inquiry whether she knew anything about Isabella Tosso's reaction towards co-operating with the Inquiry, she replied[907]:

> "I told you I haven't seen or heard of Ms Tosso since 2007."

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[904] See Day 13 page 110 line 19.
[905] See Day 13 page 110 line 24.
[906] See Day 13 page 112 line 5ff.
[907] See Day 13 page 112 line 13.

That answer is inconsistent with the fact that the latest in the series of emails to which Marie Gomez was at that stage being referred was an email from Isabella Tosso to her dated 12 August 2008 in which Isabella Tosso described her as "my friend" and signed off with kisses [**F/6/20**].

Counsel to the Inquiry concluded his questioning of Marie Gomez at close of business on Friday 18 October 2013 (Day 13 of the Hearing), and the Inquiry adjourned until Monday 21 October 2013 (Day 14 of the hearing) on the basis that other counsel would then be given an opportunity to question Marie Gomez. However, over the weekend the Care Agency produced a number of additional emails passing between Marie Gomez and Isabella Tosso which (as counsel to the Inquiry explained at the outset of the hearing on Monday 21 October 2013) appeared to have been in the possession of Chris Wilson since 2008 but which had not previously been disclosed. In the circumstances, I allowed counsel to the Inquiry to question Marie Gomez about these additional emails.

Counsel to the Inquiry began by reminding Marie Gomez of her earlier evidence[908], referred to above, that although she had an email address for Isabella Tosso she did not have a phone number or home address for her. Marie Gomez confirmed that that was the case, and that her only method of communication with Isabella Tosso was via email[909].

Counsel then referred her to an email from Isabella Tosso to her dated 20 August 2007 [**J1/115B/7**], in the course of which Isabella Tosso said this:

> "I [don't] seem to be able to get myself sorted to come in September so it looks like I'll be coming for October. .... So trying to work out how I come for the Wedding. .... My landline [isn't] working at the moment and [hasn't] been for a couple of weeks but my mobile is fine."

Marie Gomez responded[910] that she "might" have had Isabella Tosso's landline number, but she could not remember Isabella Tosso giving it to her, and that in any event she never called her on it. As to whether she had Isabella Tosso's mobile phone number, she said that she could not remember. I do not believe that evidence.

In the course of her oral evidence, in answer to a question from me, she confirmed that she was aware in the run-up to the substantive hearing that the whereabouts of Isabella Tosso were not known by the SSA[911]. I then put it to her that all she needed to do was to contact Isabella Tosso's office number (which Isabella Tosso had given her in one of the emails referred to above) and ask her to come to Gibraltar to give evidence. She replied[912]:

> "To tell you the truth I didn't even realise I had the office number. I probably just scanned through the email and just, you know, went on working. I was too busy."

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[908] See Day 13 page 107 line 4.
[909] See Day 14 page 2 line 3ff.
[910] See Day 14 page 5 line 4ff.
[911] See Day 14 page 15 line 7.
[912] See Day 14 page 15 line 16.

I do not believe that answer.

Marie Gomez proceeded to give a number of equally evasive answers to questions by counsel to the Inquiry and by other counsel about these additional emails. I see no purpose in setting out their content in any further detail. They demonstrate beyond any doubt that prior to the substantive hearing on 9 April 2008 Marie Gomez not only knew how to contact Isabella Tosso but was in regular contact with her – and, for that matter, that they remained in contact thereafter. Her repeated attempts to disguise this obvious fact in her oral evidence cannot be attributed to a faulty recollection. I find that her evidence on this discrete aspect represented, for whatever reason, a deliberate attempt to mislead the Inquiry.

In the light of those findings, I have had to consider whether Marie Gomez' false evidence on this one aspect (i.e. the non-availability of Isabella Tosso) taints the entirety of her evidence to the Inquiry, with the consequence that I should treat the entirety of her evidence as inherently unreliable; or whether I can safely treat her evidence as reliable in so far as it relates to other issues which the Inquiry is concerned to investigate. In so doing, I have naturally borne in mind my earlier conclusion that Denise Hassan's false evidence of two serious acts of abuse of residents has rendered the entirety of her evidence unreliable. Having done so, however, I have concluded that there is a significant distinction to be drawn between the false evidence given by Denise Hassan and that given by Marie Gomez. In the case of Denise Hassan, her false evidence of abusive conduct by carers goes to the very heart of the Inquiry's investigation, and had that evidence been believed the consequences for the carers concerned would have been potentially extremely serious. On the other hand, Marie Gomez' false evidence relates to a discrete aspect of one of the matters which the Inquiry is concerned to investigate, namely the SSA's conduct of – and eventual withdrawal of – its defence to Joanna Hernandez' claim.

For all I know, Marie Gomez' motive for her not revealing to Chris Wilson that she knew how to contact Isabella Tosso may have been a misguided sense of loyalty to a friend, or it may have been a personal antipathy towards Chris Wilson, or it may have been both or neither of those things. At all events, there is no evidence that Marie Gomez was party to any conspiracy to put forward Isabella Tosso's non-availability to give evidence as a false pretext for the withdrawal of the SSA's defence; nor was this suggested to her. Indeed, counsel for Joanna Hernandez questioned her on a different basis. He put it to her that her failure to disclose that she knew how to contact Isabella Tosso "potentially and probably did really undermine the [SSA's] ability to defend the Industrial Tribunal [proceedings]"[913].

I have therefore concluded, in all the circumstances, that the false evidence given by Marie Gomez in relation to the supposed non-availability of Isabella Tosso does not lead to the conclusion that I should treat her evidence on other aspects of the Inquiry as inherently unreliable.

[913] See Day 14 page 73 lines 6-8.

I turn next to the evidence of Yvette Del Agua, in so far as it relates to the issues raised by Joe Bossano's evidence.

In paragraph 13 of her second witness statement in the Inquiry [**E/8/3**], Yvette Del Agua says this:

> "13. The [SSA] abandoned its defence of the Joanna Hernandez Unfair Dismissal claim due to the fact that Ms Tosso had left Gibraltar and was untraceable. The [SSA] was unable to secure the attendance of Ms Tosso (who took the decision not to confirm Ms Hernandez in her post at the end of her probationary year) to give evidence at the hearing of Ms Hernandez's claim for unfair dismissal. The [SSA] was thus unable to discharge the burden of proof in defence of the claim without having the person who took that decision available to give evidence as to the reasons for it and the manner in which she arrived at that decision. Accordingly, the [SSA] did not call evidence as to the reason for the dismissal of Ms Hernandez."

In her oral evidence, Yvette Del Agua said that Isabella Tosso had sought her advice on some issues relating to Joanna Hernandez' claim, and that she in turn had from time to time consulted the then Chief Minister[914]. She said that she recalled suggesting that Mark Isola QC be asked to advise on the prospect of a successful appeal to the Supreme Court against the Industrial Tribunal's ruling on the SSA's preliminary point[915]. She went on to say that she considered it appropriate to involve the Chief Minister at that point not only because he was a lawyer, but also because any appeal would raise questions of funding[916].

She went on to describe the suggestion that she wanted to suppress or "bury" the allegations of misconduct in the witness statements filed by Joanna Hernandez in the Industrial Tribunal as "outrageous"[917]. She denied that there was any strategy to delay or obstruct the Industrial Tribunal proceedings[918], describing Joe Bossano's "conspiracy theory" as "unfounded"[919].

I turn next to the evidence of Jaime Netto (who succeeded Yvette Del Agua as the Minister responsible for the Home).

Jaime Netto made a witness statement in the Inquiry (in the form of a letter dated 5 August 2013 and addressed to Keith Azopardi QC [**J1/114/1**]) and he also gave oral evidence.

In paragraph 4 of his witness statement, Jaime Netto says this:

> "4. The collapse of the Joanna Hernandez Industrial Tribunal case was as a direct consequence of the [SSA's] inability to locate Ms I Tosso who was at the time the CEO of the former SSA. As a result of this the SSA lost its star witness and the person in the centre of decision making throughout that time. This meant that Ms. J Hernandez won her case in the Industrial Tribunal by default. ...."

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[914] See Day 12 page 73 line 1.
[915] See Day 12 page 73 line 25.
[916] See Day 12 page 74 line 18ff.
[917] See Day 12 page 77 line 11 and page 82 line 8.
[918] See Day 12 page 82 line 18.
[919] See Day 12 page 83 line 3.

In the course of his oral evidence, Jaime Netto said that Joanna Hernandez' claim was something that he inherited when he succeeded Yvette Del Agua as Minister for Social Affairs, and that he recalled having some discussions about it with Mark Isola QC and Chris Wilson[920].

Asked by counsel for Joanna Hernandez whether he felt that he had used his best endeavours to contact Isabella Tosso, he replied[921]:

> "No, because I wouldn't have been involved in the actual nitty gritty of the preparation or putting forward the case [before] the Industrial Tribunal. I mean, I wouldn't have been. That would have been a matter for our lawyer, it would have been a matter for senior management, but certainly not for me."

However, he went on to accept that the case was "a very high profile case"[922].

Asked whether he was aware that Marie Gomez and Isabella Tosso were "very close friends", he replied[923]:

> "No, I wouldn't, because I never had the opportunity of meeting Mrs Tosso, bearing in mind that by the time I got into the scene Mrs Tosso wasn't in Gibraltar ... I can't even put a face to the name of Mrs Tosso."

I turn finally to Sir Peter's evidence. He did not provide the Inquiry with a written witness statement, but he kindly agreed to attend the hearing to give oral evidence in relation to the issues raised by Joe Bossano's evidence. He gave his oral evidence on Thursday 17 October 2013 (Day 12 of the hearing).

In the course of his oral evidence, Sir Peter was asked by counsel to the Inquiry, by reference to the concluding paragraph of Mark Isola QC's letter to John Reyes dated 12 September 2006 (quoted earlier) [**J1/115/17**], whether Mark Isola QC's advice was referred to him directly. He replied[924]:

> "I don't think so. I don't recall having very much involvement or exposure to the nitty gritty of the conduct of the unfair dismissal proceedings. I was consulted in the beginning about the matter we have just covered [a reference to Mark Isola QC's letter dated 12 September 2006], in the middle I remember I was consulted about whether there should be an appeal on the preliminary point and at the end on another matter ... which you will no doubt come to [a reference to the decision not to call evidence at the substantive hearing]. .... It may be that John Reyes was kept informed and it may even be that from time to time he may have made remarks to me, but we were in no sense involved. Indeed I was quite unfamiliar with the facts of the whole matter."

Asked whether he had seen Mark Isola QC's Opinion dated 6 November 2006 on the preliminary point of law [**M26/1/4**], Sir Peter replied[925]:

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920 See Day 12 page 110 line 3ff.
921 See Day 12 page 112 line 13ff.
922 See Day 12 page 112 line 24.
923 See Day 12 page 113 line 5ff.
924 See Day 12 page 5 line 16ff.
925 See Day 12 page 7 line 14ff.

> "I can't remember whether I saw the Opinion. Certainly I don't think I would have read it in detail, but I was certainly aware of this "week" issue [i.e. the preliminary point], because that is the one I was consulted upon about the appeal later. .... I would not normally have read in detail documents of this sort, unless somebody particularly wanted me or recommended that I should, and I don't recall that being the case here. .... I was generally aware that Mark Isola, whilst not claiming that there was no point at all, ... would much have preferred not to take the point than to take it. He was not confident in its merit. .... Certainly I remember being intimately involved in the decision of whether to appeal or not."

Asked whether he recalled seeing David Barr's Advice, Sir Peter said this[926]:

> "I don't, but again that should not be interpreted as an assertion that I didn't. I could easily have seen it, and certainly it would have been brought to my attention, its content, during the discussion about whether we should appeal. I can't imagine that anybody would have allowed me to express a view on that question without having acquainted me with the content of this. But I don't have any immediate recollection of having read it myself."

Asked about his discussions with Yvette Del Agua concerning a possible appeal, Sir Peter said this[927]:

> "I remember having a discussion about it internally in the office. I think I discussed it with John Reyes. I certainly remember ... having a conversation about it with Mrs Del Agua. She had clearly sought my guidance on it, which I gave."

As to whether he had had any direct contact with Mark Isola QC at that stage, he said this[928]:

> "I don't think we had any direct contact specifically about this case, but I would have bumped into Mr Isola socially on many occasions."

As to Yvette Del Agua's letter to him dated 17 January 2007 [**M26/1/34**], referred to earlier, he said this[929]:

> "I don't remember the letter, but clearly a letter from a Minister I would have seen, so I must have seen it. If there wasn't a meeting immediately upon receipt of this letter, certainly there were lots of discussions between me and Mrs Del Agua at which this matter would have arisen in one form or another. I might have asked her for a briefing of what was going on, she may have volunteered, so certainly there were conversations between me and Mrs Del Agua, but I don't recall whether this particular one led to an immediate meeting."

Asked what his concern was at that time, in relation to the Industrial Tribunal proceedings, Sir Peter said this[930]:

> "To the extent that I was being asked to express a view on whether we should continue to take [the preliminary point], I think my views were clear, and there were two. First of all, this was an Industrial Tribunal case, the Government was being sued as employer – or the [SSA] was being sued as an employer – and like any employer what you want is the quickest and easiest win. ....

[926] See Day 12 page 9 line 22ff.
[927] See Day 12 page 10 line 8ff.
[928] See Day 12 page 10 line 18ff.
[929] See Day 12 page 12 line 20**ff.**
[930] See Day 12 page 13 line 8ff.

> If you could win quickly, easily and more cheaply by establishing that your opponent does not have the right to have you in the Tribunal, I don't see why the Crown should forego that opportunity any more than any other litigant.
>
> There was also lurking at the back of my mind, although – I don't say that it was any stronger than that ground – the fact that I had seen that there were differences of opinion between lawyers about this point. It seems to be clear that there was no definition of "week", that the Attorney-General's Chambers had originally obviously thought that it was a good point, because they took it of their own volition[931]. Mark Isola said: "You know, the two things are arguable. I prefer the argument that was against us". The English barrister [David Barr] said more or less the same thing, in slightly different terms. I think he used some expression that suggested that we wouldn't be making complete fools of ourselves by going to court. And it seemed to me also that there was some virtue in having this matter established for the benefit of the public service as an employer generally and others.
>
> So ... those were the two issues, I think. But I think the most important one was that we should not forego an opportunity for a quick win, if [that opportunity] existed. And it turned out not to be so."

Asked about Mark Isola QC's lengthy letter to Yvette Del Agua dated 27 February 2007 [**M26/1/35-55**], referred to earlier, Sir Peter said this[932]:

> "I can't place things in terms of date, because I am not familiar with the date chronology, but I do recall that Mark Isola wrote a very long [letter]. I don't think I read it in full, but I remember being impressed by the thoroughness of the advice that he had given the [SSA] on all the issues as he saw them when he took [over] the matter. .... I was aware that he was not enamoured of this point [i.e. the "week" argument] and he became less enamoured after the Supreme Court ruled. .... And therefore he was even less enamoured of the subsequent appeal [to the Court of Appeal]."

Asked whether he gave instructions to appeal to the Court of Appeal against the decision of the Chief Justice upholding the ruling of the Industrial Tribunal, Sir Peter said this[933]:

> "Certainly I was consulted and ... I expressed a view that we should give it one more run. .... Of course "instructed" is a debatable word, but certainly recommendations, advice and suggestions from the Chief Minister have that effect, whatever might be the technicality. So if I expressed a view to the Minister that the matter should go to appeal, I think everybody's expectation, including mine, would be that that would be the case."

As to the apparent unavailability of Isabella Tosso, Sir Peter said this[934]:

> "I became aware ... that the [SSA] was having trouble getting Ms Tosso to return, and it was clear to me, without the benefit of legal advice, that ... if she was not available it was not clear to me how the Government could possibly succeed, given that she was key."

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[931] In fact, the Attorney-General's Chambers had advanced the argument that the notice of termination took effect on the date it was served, given that on that date Joanna Hernandez ceased working and accepted a month's salary in lieu of notice: an argument which was subsequently abandoned by Mark Isola QC in favour of the "week" argument.
[932] See Day 12 page 15 line 8ff.
[933] See Day 12 page 18 line 18ff.
[934] See Day 12 page 20 line 9ff.

He went on to say that although he could not recall receiving a letter from Jaime Netto in the form of the draft provided by Mark Isola QC to Chris Wilson [**J1/115/50-53**], referred to earlier, the Inquiry should proceed on the basis that he did[935]. He went on[936]:

> "Look, if this letter did not reach my desk, which, if I were a betting man, I would bet that it did, and also that I saw it, certainly its content would have been explained to me orally by somebody, and I was well aware that this situation had arisen and that this advice was being given. .... My own personal view [was] that it was inevitable: I mean, either settle or submit to the ruling of the Chairman [of the Industrial Tribunal]. If the Government was not going to be able to defend itself, it seemed to me that ... the matter was going to end without success for the employer. How the [SSA] and the Government between them chose to bring that about might have been for discussion, but the outcome was inevitable the moment the Government or the [SSA] was unable to produce Ms Tosso for the hearing."

Asked what his views were as to an appeal to the Court of Appeal on the preliminary point, Sir Peter said this[937]:

> "I took the view that the point was worth one more outing in a court, if only to (a) maximise our opportunity of a quick and easy win and (b) to establish the point about the "week" authoritatively."

Asked about the possibility, raised by Mark Isola QC shortly before the hearing of the appeal to the Court of Appeal, that the appeal should be withdrawn, Sir Peter said this[938]:

> "Well, certainly at that late stage the idea would not have appealed to me, but in the event it didn't appeal to me earlier. I mean, I had plenty of opportunity to decide not to appeal to the Court of Appeal, and didn't take them, and I chose to proceed. .... [I did so] in the knowledge that we had received advice from Mark Isola that he thought that we would fail. ... It's a fact that you take into account, but it doesn't determine ... Presumably every case that goes to the Court of Appeal is the subject of one lawyer's advice that his client ... – they can't both be right in thinking that their client would win or lose."

He went on to say that an appeal from the Court of Appeal to the Privy Council was "never even contemplated", so far as he could recall[939].

As to whether he knew of the SSA's eventual decision not to call evidence in opposition to the substantive claim, Sir Peter said this[940]:

> "I think it was within my knowledge, not necessarily the nitty gritty. In other words, I'm not particularly aware of how much of its case the [SSA] could have established without the help of Mrs Tosso, but certainly I proceeded on the assumption whenever I was consulted on this that she was absolutely key. And from my own limited knowledge of the facts of what had gone on and what the allegations were against the [SSA], it seemed to me that the case would be lost for certain, and there was really no point in ... So I think I was asked whether it was OK, in other words, my agreement was sought to not offering evidence. And although I have no clear recollection of the conversation in which it happened, my present recollection of what my

[935] See Day 12 page 20 line 22.
[936] See Day 12 page 21 line 1ff.
[937] See Day 12 page 22 line 15ff.
[938] See Day 12 page 24 line 21ff.
[939] See Day 12 page 26 line 9.
[940] See Day 12 page 26 line 17ff.

> position was at the time leads me to assert that I gave it. I agreed that the Government should not – that the [SSA] should not – present evidence, if that is what the [SSA] felt was the best thing for it to do."

Asked whether he was aware at the time of the suggestion that Joanna Hernandez had been dismissed for whistle-blowing, Sir Peter said this[941]:

> "I think as far as the Government was concerned, not only did I not know about it, but I don't think it was true. I have no sense that, now, whether others may have had that thought lurking in their mind, of course I cannot say, but it was not an issue of which I ever became aware, still less participated in making a decision in consequence of. It's simply not the case. .... I think the [Inquiry] ... can safely proceed on the basis that I was aware that there were some allegations of a management type, you know, sort of management issues with each other, and staff unhappinesses, and then there was another category of allegation, and I don't recall whether they arose at the same time, about allegations of actually quite serious wrongdoing ... involving ... service users[942]."

Asked whether he was consulted about the "nitty gritty" of the allegations, or whether he was merely aware of them in general terms, Sir Peter replied[943]:

> "I certainly would have asked the Minister for an explanation or for information about what was going on, and I seem to recall I received assurances that to the extent that they were issues for management, management was looking into them and had looked into them, and to the extent that the allegations raised matters which could constitute criminal offences, management had properly referred them to the Royal Gibraltar Police. It seemed to me that that was in both cases that was the appropriate course. So I saw no need for me to intervene further."

Asked whether he had given instructions that the investigation of the allegations should be obstructed, he replied[944]:

> "Certainly not. .... I never did. I find the ... suggestion ... quite extraordinary. .... [It] would have required the police and the Attorney-General to do my bidding, which evidently they didn't, because the matters were thoroughly investigated in any event. But to the extent that the [Inquiry] is interested whether I unsuccessfully attempted to prevent investigations, the answer is no."

Sir Peter went on to deny that he had masterminded a strategy aimed at delaying or blocking the Industrial Tribunal proceedings[945] . He added this[946]:

> "I'm aware of the suggestion that the issue of the appeal was somehow to prevent the matters from coming to light. If the Government had been in anything it did motivated by a desire to prevent matters that were not immediately relevant, or perhaps damaging matters to the [SSA], from coming to light, [there] had always from the very beginning [been] an easy device with which to bring it about, namely not to contest and to concede the unfair dismissal claim. And we never did that. We could at any time have prevented the alleged feared publicity by simply not contesting the Industrial Tribunal and writing a cheque with taxpayers' money for £30,000

[941] See Day 12 page 27 line 25ff.
[942] A reference to allegations concerning incidents involving Resident T, which are considered in Chapter 13 of this Report.
[943] See Day 12 page 29 line 1ff.
[944] See Day 12 page 29 line 15ff.
[945] See Day 12 page 30 line 10.
[946] See Day 12 page 30 line 12ff.

> odd, or whatever the maximum then was at that time, which the Government didn't do. It was never the Government's strategy to prevent this matter from getting ... Just as it would not be the Government's strategy to prevent serious allegations affecting the well-being of service users from being looked into and investigated. Why would the Government, at a political level, have an interest in doing that?"

When I put to him Joe Bossano's suspicion that the SSA had taken and pursued the preliminary point in order to create delay in the hope that Joanna Hernandez would give up, with the result that the claim would never be heard, Sir Peter replied[947]:

> "I think Ms Hernandez enjoyed the Union's support. Mr Bossano was helping her. I don't know what arrangements she had for the hearing in the Supreme Court and the Court of Appeal. I can see that that might be a burden to an employee litigant. But ... there was never any linkage in terms of motivation. .... One thing is to go for a quick win, and [another] thing is just to out-financial-power your opponent. I don't think that was the Government's intention. .... But we would certainly have liked to win the preliminary point and avoid having to go to a full trial. That is undoubtedly true."

Counsel for Joanna Hernandez put it to Sir Peter that in early 2007 both Yvette Del Agua and Mark Isola QC were begging him to settle the claim. He replied[948]:

> "To the extent that my views on settlement were sought, no one would have had any joy from me until I was told that Ms Tosso was not going to be available. .... If the [SSA] ... has made a decision, and has chosen to defend it, then technical arguments about whether jurisdiction exists or not my view was that they should defend it. It was only when successful defence was impossible, I recall that it was the first time I contemplated settlement. Well, settlement? Capitulation. I won't call it settlement."

When counsel put to him that he knew that Ms Tosso was leaving Gibraltar in January 2007, he said this[949]:

> "My understanding at the time was that she had committed to return; that that was the expectation of the [SSA]. .... I don't think the position was – I may be mistaken, because, as I say, I dipped in and out of this very irregularly and infrequently – my understanding was that she was going, but that she had agreed to return to make herself available to give evidence. And so at some point, I don't know when, by reference to dates, at some point there is some issue about whether she could be contacted and whether she hadn't said that she wasn't coming. Anyway, she wasn't available on the date. .... And that was the time at which the capitulation occurred; for that reason."

Asked by me whether he had himself made any attempts to contact Isabella Tosso, he replied[950]:

> "No, nothing whatsoever. Nothing whatsoever. The notion that she would not be available was not known to me until around the time of that draft letter that has been put to me [**J1/115/48-53**], and I have already said that it may be possible that I might have had some forewarning, a day or two ... I would not discount that possibility, although I am not saying that it was the case, I am just not willing to discount the [possibility] ... but fixed around at that stage."

[947] See Day 12 page 32 line 18.
[948] See Day 12 page 34 line 19ff.
[949] See Day 12 page 35 line 7ff.
[950] See Day 12 page 36 line 8ff.

Counsel for Joanna Hernandez then put it to him that he had made no enquiry at all over a period of the fourteen months between January 2007 and April 2008 as to whether his "key witness" was to return. He responded[951]:

> "Not my key witness. No, not my key witness... I did not have the conduct of the case. My involvement in it and in making decisions in relation to it are the ones that I have expressed. The Chief Minister is not an unbusy chap ... and the idea that I was somehow involved on a day-to-day basis in guiding the strategy of this case ... could not be further from the truth. Unless somebody brought the case to me in the context of this specific issue or unless I asked the Minister for an answer because I had read something in the Chronicle or heard it on local media – this matter did have quite a lot of notoriety – I would not have been involved or aware of what was going on. .... This was not a matter I would call in. It was a matter into which I was called from time to time."

I then asked him whether I was correct in forming the impression from his evidence that when he was apprised of the fact that Isabella Tosso was not going to be available to give evidence, he had concluded that that was effectively fatal to the defence of the claim. He replied[952]:

> "Yes. Initially to myself I thought that, and then that was converted following discussions, I don't remember exactly with who or whether it was on the phone or at a meeting, [into] a decision to capitulate for that reason."

Counsel for Joanna Hernandez then put it to him that notwithstanding his evidence that he was not involved in the "nitty gritty" of the case, his instructions to Yvette Del Agua that the appeal to the Court of Appeal should not be withdrawn were an example of his having had his "hand on the tiller, directing that people should proceed despite counsel's strongest possible advice not to". He replied[953]:

> "Yes, this was one of the three matters in which I did dip in; and when I do dip in, I do dip in."

Counsel for Joanna Hernandez then asked him to explain once again why he had decided that the appeal to the Court of Appeal should proceed, notwithstanding that it was funded by taxpayers' money and notwithstanding that Mark Isola QC could not have been clearer in saying: "Don't appeal". He responded[954]:

> "[The reason] is the one I have given: that I didn't think that the matter should be dropped without it having one more airing in [a court]... Despite Mr Isola's view to the contrary. The Attorney-General had had a different view on Day 1, Mr Barr thought that the point was not a completely foolish one, or words to that effect. Mr Isola had initially thought that it was arguable. He had a preference for one, and his preference firmed up when a High Court judge agreed with him, which is not unnatural. I wouldn't say that that is definitive ... The Court of Appeal exists for a reason."

Counsel for Joanna Hernandez then asked him whether he was "taking it [i.e. the claim] personally". He replied[955]:

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[951] See Day 12 page 36 line 20ff.
[952] See Day 12 page 37 line 21ff.
[953] See Day 12 page 38 line 6ff.
[954] See Day 12 page 38 line 24ff.
[955] See Day 12 page 39 line 17ff.

> "No. No. We certainly believed that the opposition was milking it mercilessly and unfairly for political reasons; that is true. But I don't think I have ever met – I'm not certain I have ever met Ms Hernandez. There is no possibility of [anything] personal as between the Government and her."

Asked by counsel for Joanna Hernandez whether he had considered contacting the SSA psychologist to inquire about the allegations of abuse, he replied[956]:

> "The onus is not on the Chief Minister to make phone calls about things that may or may not be happening. Sufficient to say that I was aware of the allegations ... and that I was satisfied that the matter was being dealt with ... in the proper way, which is that they should have been immediately which they were, I understand, by management, reported to the police, whom I was aware conducted an investigation. I can't think that any other institution in Gibraltar is more appropriate or better resourced and equipped and qualified to consider such allegations than the police."

Counsel for Joanna Hernandez then suggested to him that he might have telephoned the Care Quality Commission in the UK and asked them to send a team to Gibraltar to investigate the allegations. He replied[957]:

> "Why would I? .... We have our own police, we have our own management, we have our own administrative legal capability. Why should I? .... People were suggesting a local Inquiry. I don't think anybody suggested what you are now suggesting, and we resisted even the local Inquiry because we didn't think that, absent some finding by the police of systematic abuse, that an allegation that had been investigated was the right material for a public Inquiry. So certainly ... I accept political responsibility for the view that no information was brought to my attention that would have justified a public Inquiry. But beyond that, I would not have contemplated going outside Gibraltar."

Finally, counsel for Joanna Hernandez asked him whether he would agree that he and his Government had "handled this very badly". He replied[958]:

> "No, I would not. .... My personal view is that it was handled impeccably. It is true that the decisions that were made were not the ones that your client wanted the Government to make, but that is not the definition of "bad governance"."

I can now state my findings.

I accept, without qualification, the evidence of Yvette Del Agua, Jaime Netto and Sir Peter. I find that there was no conspiracy by anyone in Government, or indeed anyone else, to prevent the allegations in the witness statements filed on behalf of Joanna Hernandez from being put into the public domain and/or becoming the subject of judicial investigation, whether by delaying or obstructing the hearing of the claim, or by stifling the claim by prolonging the proceedings unnecessarily, or by any other means.

[956] See Day 12 page 40 line 8ff.
[957] See Day 12 page 41 line 6ff.
[958] See Day 12 page 41 line 25ff.

As to the preliminary point, the initial decision to take it before the Industrial Tribunal, and the subsequent decisions to pursue it to appeal (first to the Supreme Court and then to the Court of Appeal), were entirely legitimate decisions in the context of hostile litigation. They were made in good faith, in the hope (as Sir Peter put it) of a quick and easy win. The fact that in the event that hope was disappointed does not taint those decisions. Little is certain in litigation, as every lawyer knows; and both Mark Isola QC and David Barr had advised that the point was arguable.

I accordingly find that there is no factual basis for Joe Bossano's suspicion that the Government's motive in taking and pursuing the preliminary point was to prevent the allegations contained in the witness statements filed by Joanna Hernandez coming into the public domain. Had that been the Government's motive, it could (as Sir Peter said) have easily been achieved at any stage in the proceedings by capitulating and paying compensation to Joanna Hernandez.

As to the non-availability of Isabella Tosso, I repeat the findings made earlier in this Chapter. When Sir Peter was told that Isabella Tosso would not be available to give evidence at the substantive hearing, he was presented with a *fait accompli*. As he said, it was not for him, as Chief Minister, to take active steps to try to locate her. That was the responsibility of Chris Wilson: a responsibility which, as I have already found, he signally failed to discharge. The eventual decision not to offer evidence in opposition to Joanna Hernandez' claim was made in good faith, on the basis that Isabella Tosso was not available to give evidence. That was the information which had been presented to Government: those were the instructions which Mark Isola QC had been given.

Accordingly, I find Joe Bossano's suspicions in relation to the conduct of the Industrial Tribunal proceedings by the Government/SSA to be unfounded in every respect.

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