THE

DR GIRALDI HOME INQUIRY

REPORT

VOLUME 3

THE DR GIRALDI HOME INQUIRY REPORT

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

RT HON SIR JONATHAN PARKER

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CHAPTER 13:
The allegations of Residents T, J and AA and their aftermath

The allegations made by Residents J and AA stemmed from an investigation into allegations made by Resident T.

As already noted, Resident T is the sister of Moira Elmer. She was born in 1955[959]. She is single. According to SSA records, she left Gibraltar as a baby to live in the UK. When she was about five years old, she was diagnosed with a learning disability and attended a special needs school. Her mother died in 1969, and thereafter she and her sister were cared for by their father. In 1974 her father remarried, acquiring five step-children. The family returned to Gibraltar in 1978, where they remained until 1984. Resident T attended St Bernadette's from 1981 to 1983. In 1984 the family left Gibraltar for the UK. In 1988 Resident T's father was diagnosed with cancer. Thereafter, Resident T resided with various members of her family and step-family. From January 1997 onwards she resided with her step-brother and his wife in Gibraltar. In 2002, when she was aged forty-seven, she became a permanent resident at the Home, attending St Bernadette's on a daily basis.

In 1984 an occupational therapist assessed Resident T as having a moderate degree of handicap, but good concentration. In 1997 an educational psychologist assessed her as suffering from "moderate learning difficulties"[960].

On 9 December 2004 Joanna Hernandez wrote an incident report in the following terms [**E/32/38**]:

> "A meeting was scheduled for today the 9th December 2004 upon the request of [Resident T] between the Manager of St Bernadette's [i.e. Annie Risso], myself the Manager of [the Home] and the Deputy Manager of [the Home] [i.e. Sharon Berini]. [Resident T] wished to express concern relating to St Bernadette's Centre. Our involvement was to mediate for [Resident T].
>
> The previous day at 4.15pm I visited Flat 2 where [Resident T] lives and met the residents with Sharon (Deputy) in the Living Area. [Resident T] expressed her concerns relating to St Bernadette's and commented that on Sunday she had had an experience which [she] had "not liked" she then told me that Richard Muscat had instigated another resident this being [Resident AA] to fondle and kiss her. I asked her whether she felt it was appropriate for her to relate this incident with me in the next day's meeting with Mrs Risso ... and Sharon. She consented to this. At this stage of the allegation evidence was being put together by ... me.
>
> I attempted to call Ms Risso as well as Elizabeth Harrison ... concerning the above allegation for further information but I could not establish contact. .... I was aware that Richard Muscat was not on duty in flat 2 that night and therefore no further risks were posed for [Resident T].

[959] In the course of her interview with the RGP (referred to later in this Chapter) Resident T gave her date of birth as 20 May 1955, but Giselle Carreras, the SSA psychologist, in a psychological report dated 7 March 2005, gives it as 20 June 1955 (see **M4/1/1**).
[960] See **M4/4/1**.

> I informed Sharon the next day of the situation and proceeding. At the meeting I prompted [Resident T] as to the previous days allegation to which she related the following:
>
> On Sunday 5th December (approx 10pm) Manolita Adamberry was on duty in Flat 2 due to unforeseen circumstances she was required to take a member of staff up to Bishop Healy for a wake night duty. At the time we had no staff available to cover and she confirmed with Sharon who was on call whether Richard who was working with [Resident AE] and at the time having a coffee in Flat 2 could cover for her. It was acceded.
>
> [Resident T] then related that Richard instigated [Resident AA] to kiss her on the neck and fondle her genital area. She pushed his arm away. Annie [Risso] prompted her as to whether it was a hug [Resident AA] was giving her, acting out the action since [Resident AA] is prone to this behaviour. She was adamant that 'no' he had fondled her and kissed her on the neck area and that Richard had instigated this saying that this was not the first time. [Resident T] was clearly upset and angry.
>
> She further related that on another occasion whilst in her room changing, [Resident AA] barged in. She ... had only her underwear on. He came out of the room, Richard spoke to him and although she could not listen to the conversation she was very clear as to his demeanour and body language when talking with [Resident AA]. [Resident AA] came back into her room with his trousers down. Angelica Williams (support worker on [duty]) slapped [Resident AA] on the face.
>
> She then related that on another occasion both [Resident AA] instigated by Angelica Williams and Richard Muscat went in to [Resident J's961] bedroom (service-user) got on top of her and fondled her, both Richard and Angelica laughed together at this. [Resident T] expressed aversion at this and that she felt she had no need to see this. [Resident T] felt that [Resident J] enjoyed this.
>
> She also queried us as to why both Richard and Angelica when together on previous night shifts made residents not talk by gesturing with their fingers to their mouths, allowing them with this gesture no body space. They would only do this with the verbal service-users but not to the two other non-verbal service-users. She ... argued that [she was] allowed as an adult to speak and who were they to do this. She was very clearly upset by the above.
>
> Annie [Risso] asked [Resident T] whether [Resident AA] had acted in the above manner with her in St Bernadette's and [Resident T] clearly established that [these] incidents only occurred when prompted by Richard Muscat or Angelica Williams.
>
> [Resident T] spoke to the Senior Support Worker concerning the above, Michelle Garro. Her allegations were dismissed and she was told she was a liar. [Resident T] told her and I quote, "I know what has happened and I am not a liar". Richard Muscat happens to be the father of Michelle Garro['s] grandson and the partner of her daughter."

Following the meeting on 9 December 2004, Marie Gomez wrote in similar terms to each of Richard Muscat, Angelica Williams and Michelle Garro informing them that they were provisionally interdicted with immediate effect.

In those letters, Marie Gomez said this[962]:

> "It has been brought to my notice that an allegation has been made against you. It was alleged that you instigated a service user to touch another service user inappropriately or sexually and to get into bed with a second service user. In view of the serious nature of the allegations made against you ... I have to inform you that you are being provisionally interdicted on full pay as from today 9th December 2004.

[961] Resident J is female and single. She was born on 3 March 1958 [see **M14/48/1**].
[962] See the RGP interview with Angelica Williams on 6 April 2005 [**M27/49/3**].

> We will be arranging an investigation as soon as possible. I expect you to be available to give evidence at the hearing at a date to be fixed.
>
> [During the suspension] you are not allowed to contact any of the service users or staff or go into any Dr Giraldi premises.
>
> The interdiction is under ... disciplinary procedures and disciplinary code C10 section 5. I would like to make clear that the suspension is not a presumption of guilt ..."

Soon afterwards[963], Resident T was moved from Flat 2 to Bishop Healy.

On 13 December 2004 Joanna Hernandez contacted Giselle Carreras MSc, the SSA psychologist, to voice her concerns as to the allegations made by Resident T. She asked Giselle Carreras to provide therapeutic support for Resident T and to assist with the evaluation of her allegations[964].

On 16 December 2004[965] Resident T was interviewed by DC Aldra Cerisola (then Aldra Neale) and DS Adrian Bacarisa of the Royal Gibraltar Police. Also present at the interview were Giselle Carreras and Joanna Hernandez. The interview was taped, and the Inquiry has been provided with a transcript of the tape recording and a translation.

Early in the interview [**M27/4/3**] Resident T alleged that Resident AA (she referred to him as "this boy") came into her room when she was naked; and that on that occasion (or possibly on a subsequent occasion, it is not clear which) Richard Muscat "called him to take off his trousers and underpants, to show me what I did not want to see. He came into my room and showed me everything." She went on to say that when she complained to management she was told she was a liar. She also accused Resident AA of having beaten her. In the course of the interview she said this [**M27/44/4ff**]:

> "This boy [i.e. Resident AA] has done many things to me. .... Once, when I was awake, and the other one [i.e. Richard Muscat] said, come, come and kiss her on ... (inaudible) ... I threw the shoe at the boy and he told me, because you have hit me. So don't tell him to kiss me, I do not like the kisses. .... I know he's not well in the head ... When they tell him [to] do this to [me] he goes and does it. .... He hits me ... at times. Nobody tells him anything. He hits me and nobody tells him anything. He also beats me, because he likes beating me. .... He lives with me [i.e. in Flat 2], but at times he also comes into my room and does not leave me in peace... He has done it many times and I am fed up of him. I say they shouldn't come into my room because I have a room for myself and they have their own room. If they have their room and I have mine, why do they have to come into my room and throw things at me? I have not done anything to him. .... Richard is the one who used to work there and he used to tell [Resident AA] to do many things to me. .... [Resident AA] used to come into my room without ... asking permission. He used to come in without knocking at the door, when he should have knocked at the door. .... He doesn't knock, he comes in and that's it. .... At times I am naked and he comes into the room as if I were not naked. .... He used to give me a kiss and I didn't like that either. .... I used to get angry. .... [Resident AA] is not aware because he is not into it ... he does what the others tell him to do."

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[963] The evidence before the Inquiry does not establish the precise date.

[964] See [**M4/1/2**].

[965] The interview was conducted partly in English and partly in Spanish. The Inquiry has been provided with a transcript of the interview which is wholly in English. It is that version which is quoted in this Report. It gives the date of the interview as 20 December 2004, but I have taken the date 16 December 2004 from the English/Spanish version [see **M27/43/2**].

Asked by Giselle Carreras what Richard Muscat told Resident AA to do, Resident T replied [**M27/44/9**]:

> "To caress me ... and to kiss me on the lips. I did not like it. ... It was disgusting."

She said that Angelica Williams was also giving Resident AA the same instructions [**M27/44/9**].

She went on to allege [**M27/44/10**] that "once" Richard Muscat and Angelica Williams told Resident AA to "get on top of" Resident J, and that he did so. Asked what Resident AA did when he had got on top of Resident J, Resident T said that "he didn't do anything: no movement or anything".

She said that Richard Muscat and Angelica Williams "used to sen[d] [Resident AA] to beat me" [**M27/44/13**].

Later in the interview, Resident T said this about Resident AA [**M27/44/14**]:

> "[He] doesn't do anything, because he does what they tell him to do. But when neither Richard nor Angelica are there he is very good, he is very calm."

Resident T went on to repeat that Richard Muscat told Resident AA to kiss and caress her. She continued [**M27/44/15**]:

> "He used to get hold of me but I didn't feel like it ... him on top of me. .... He used to get like that to kiss me."

Giselle Carreras then asked Resident T to identify where Richard Muscat told Resident AA to touch her, to which she replied:

> "[Resident AA] touch me down there and that is as well, that is what he does. When he goes and tells him to touch me down there he goes and touches me down there and I move his hand out of the way and he still does it when he comes round ... when Richard comes round."

DC Aldra Cerisola then established by gesture that by "down there" Resident T was referring to her vagina.

She went on to say that this had occurred only once on the night she was describing [**M27/44/20-21**].

She said that Richard Muscat had told Resident AA to caress her, kiss her and hit her many times, but that the staff took no notice.

She went on to relate that some two years previously (i.e. in about 2002/3) "they" made a lady with learning difficulties who used to visit Resident T at the Home (I will call her "Visitor X")[966] dance with Resident AA, saying [**M27/44/21ff**]:

> "They made her dance with [Resident AA] and she did not want to dance with [Resident AA], she did not like [Resident AA]. He also started to kiss her on the lips, she did not want to kiss him. And they used to urge him to kiss her and dance with him and she did not want ... She then stopped coming to my house because of that. .... They started getting hold of me, to dance. And I said, I will not dance. This is my house, and I will not dance, it's my house."

Resident T went on to complain of lack of privacy in the Home, saying this [**M27/44/24**]:

> "They ask me why do I go into my room. I say I go into my room because I like it. .... Because I have pictures in my room, I have knitting and I can do things in my room. Knitting or writing or painting because I have painting books as well. But they [say] no, they want me to share my room with them, and I can't ..."

She compared this with the time when she was living with her sister, Moira Elmer, saying that during that time she was "all right", but that her sister had told her that she could not carry on living with her because one day when her sister was asleep or out of the house she could have a fall.

The questioning then returned to her complaints about Resident AA kissing her. DC Aldra Cerisola asked her again where Resident AA had kissed her, and she replied that he had kissed her on the back of her neck [**M27/44/26**].

Later in the interview (following a change of tape) Resident T said of Resident AA [**M27/46/1**]:

> "I am fed up of [Resident AA]. I'm fed up. I can't live with him. .... He doesn't let me live my life. I want to live my life, my life is nothing with him."

She went on to object to Richard Muscat and Angelica Williams gesturing with a finger to indicate the need to keep quiet or to stop talking [**M27/46/2**].

Reverting to her account of Visitor X being made to dance, she said this [**M27/46/3**]:

> "She started to dance with [Resident AA] and Resident AA used to tell her: "Come on, 'morena', kiss me on the lips". And she did not want to kiss him on the lips... ... It was Richard's fault that she had to kiss him."

She went on to complain that another member of staff, Rose Seruya, used to laugh at her and make fun of her.

Reverting once again to her account of Resident AA kissing her, she repeated that he kissed her on the neck. She went on:

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[966] See paragraph 26 of Giselle Carreras' witness statement, quoted below [**J1/123/4**].

> "After on the face and he wanted the mouth and I didn't give it on the mouth."

She said that this happened in the kitchen, when she was fully dressed.

As to Resident AA coming into her bathroom when she was having a bath, she said that things were better, now that she was using the shower [**M27/46/7**].

Finally, she complained that Manuela Adamberry used to tell her to put away her clothes and to go to bed too early [**M27/46/10**].

On 7 March 2005 Giselle Carreras duly produced her written Psychological Report on Resident T [**M4/1/1-15**].

Under the heading "Prior Recorded Existing Issues of Concern as Presented within St Bernadette's Council Group", Giselle Carreras set out nine concerns which had been expressed by Resident T and recorded in the minutes of Council Group meetings. Some of these are recorded as having been reported to management.

As appears from Giselle Carreras' Report, the first of Resident T's nine concerns appeared in the minutes of a meeting of the Group held on 28 November 2002. It is set out in the following terms in her Report [**M4/1/4**]:

> "[Resident T] expressed her upset reference [Resident AA] ... further continued to add much uncomfort that [Resident AA] also constantly kisses her up at the flat. She added that she gathered he was being encouraged and teased to do this ..."

The Report continued:

> "Concerns at the time were discussed with management. It was decided that the situation would be monitored."

The second of Resident T's nine concerns appeared in the minutes of a meeting of the Group held on 20 March 2003. As stated in Giselle Carreras' Report [**M4/1/4-5**], it was recorded in those minutes that Resident T had alleged that on two or three occasions carers had made Visitor X dance and clap; and had laughed at her.

Giselle Carreras' Report recorded [**M4/1/5**] that the allegation was reported to management at the time.

The third of Resident T's nine concerns is, in effect, a reiteration of the second. Giselle Carreras said in her Report [**M4/1/5**] that the minutes of a meeting of the Group held on 27 April 2003 record that a discussion took place concerning "how the service users did not appreciate being at what seemed to them to be the receiving end of jokes". She went on to say that this further information was also presented to management at the time, as an adjunct to the report of the alleged incident at the meeting of the Group held on 20 March 2003.

The fourth of Resident T's nine concerns related, once again, to Resident AA. Giselle Carreras referred in her Report [**M4/1/5**] to the minutes of a meeting of the Group held on 15 May 2003, saying that she had to leave the meeting when Resident T had started to describe an incident at the Home, and that she had left it to Marie Gomez (in her role as social worker) to take the minutes. The minutes included the following (as quoted in Giselle Carreras' Report):

> "[Resident T] explained that the week before she had been in her room changing with Gerica[967] (carer) when [Resident AA] barged in 'without knocking' and took down his trousers in front of her. [Resident T] expressed her concern about this incident and when I asked her if Gerica (Carer) had told him off she said yes. Gerica had slapped [Resident AA] on the face. According to [Resident T] when they asked who had told him to do this [Resident AA] had answered 'Richard'."

Giselle Carreras' Report went on to say [**M4/1/5**] that "this information was again at the time forwarded to management".

The fifth of Resident T's nine concerns was (as appears from Giselle Carreras' Report [**M4/1/6**]) recorded in the minutes of a meeting of the Group which was held on 20 May 2003. The minutes of that meeting (prepared by Marie Gomez) included the following:

> "[Resident T] also complained about [Resident AA] shouting at her and that when she had complained to Michelle [Garro] (Senior Carer at Flat 1) about the incident she had talked about the previous week when [Resident AA] took down his trousers, she had been told to talk to Morag [Jack] (Manager for [the Home] at the time).

The sixth of the nine concerns related once again to the alleged incident referred to in the minutes of meetings of the Group held on 15 and 20 May 2003. Giselle Carreras' Report referred [**M4/1/6**] to the minutes of the meeting of the Group held on 12 June 2003 (prepared by her). Those minutes recorded that Resident T complained that when she tried to tell Michelle Garro about that incident, Michelle Garro replied:

> "If you are not happy with us you can go and [Resident AB] will take your place."

As appears from Giselle Carreras' Report [**M4/1/6**], the seventh of the nine concerns appeared in the minutes of a meeting of the Group held on 23 October 2003, where Resident T is recorded as saying that she was afraid of "them", and that she did not like getting involved with them.

As appears from Giselle Carreras' Report [**M4/1/6**], Resident T's eighth and ninth concerns were recorded in the minutes of a meeting of the Group held on 13 November 2003. Her eighth concern was as to lack of privacy, and related primarily to Resident AA. Her ninth concern was a general complaint as to the restrictive nature of life in the Home.

[967] This appears to be a reference to Angelica Williams.

The minutes of the meeting in question (which were prepared by Giselle Carreras) included the following [**M4/1/6-7**]:

> "[Resident T] explains she is unable to have baths since [Resident AA] seems to insist on entering the bathroom when she is there. [Resident T] further explains that there are no locks in the bathroom for privacy. She added that she feels it is worse if she actually bathes since if in the actual bath, she is exposed to anyone and everyone. She continues to say that if she has a shower instead although anxious and unable to relax, the shower at least has the clouded glass door. In her view, even though the outline of her figure can also be seen she feels more protected to exposure. [Resident T comments that she is] quite upset that she has been seen naked several times.
>
> [Resident T] further comments she has no privacy in her bedroom. Apparently her key was lost and although she explains having asked for a replacement, none has been provided. [Resident T] questions why sometimes [Resident AA] and sometimes ... another service user ... do not respect her space by simply knocking versus barging in. She explains having been seen in underwear or changing many times ... [Resident T] explains she has reported this to the staff – Angelica, Yvette and Michelle – and that "sometimes he gets told off. Other times, I get told 'Bueno, he had to go to the bathroom to get something'".
>
> [Resident T] feels as if sometimes what is being projected is that if she is exposed she simply has to put up with it; that her feeling embarrassed, ridiculed or having her privacy violated is not that important to anyone.
>
> [Resident T] relates how she used to live before with her mother and how events after her mother's death led her sister and niece to take over her mother's and her house and she found herself in [the Home]. [Resident T] expresses that ultimately she is unable to do in Flat 2 the stuff she so freely did at home. [Resident T] examples this with her own experiences. [Resident T] comments that she feels that when living in her own home she had choices over how she spent her time and who she spent it with, choices over what time she [chose] to get up or what time she went to bed. [Resident T] related how in her experience the notion of this choice has been replaced by what she seems to internalise as a form of instruction from certain members of staff ...."

Giselle Carreras' Report went on to say that the above information was "again reported at the time".

On 9 March 2005 DC Aldra Cerisola wrote to Johann Fernandez at the Attorney-General's Chambers [**M27/57/2-3**] summarising the allegations which had been made by Resident T and seeking guidance as to what (if any) criminal offence had been disclosed, and, should any potentially criminal conduct be involved, asking that "consideration be given as to the type of witness in this case before the matter is taken criminally or it is recommended to be taken disciplinary [sic]": i.e. that consideration be given to the question whether in the circumstances it might be preferable to leave the matter to be resolved by an internal disciplinary process rather than by recourse to a criminal prosecution.

In April 2005 the three interdicted employees were interviewed under caution by the Royal Gibraltar Police. Angelica Williams and Michelle Garro were interviewed on 6 April 2004; Richard Muscat was interviewed on 15 April 2004. Each of the interviews was conducted principally by DC Aldra Cerisola, although two other detective constables were present. In each case a lawyer was also present. The interviews, which were conducted almost entirely in English, were taped, and typed transcripts have been provided to the Inquiry (for Angelica

Williams' interview [**M27/49/2-23]** and **[M27/48/2-15]**; for Michelle Garro's interview [**M27/47/2-24]**; and for Richard Muscat's interview [**M27/50/2-3**]).

I turn first to Angelica Williams' interview.

At the start of the interview, DC Aldra Cerisola explained to Angelica Williams that the interview was part of an ongoing investigation into allegations made by Resident T. This was the first time Angelica Williams had been made aware of the identity of the complainant or the nature of the complaints. She said that she had been handed Marie Gomez' letter but that she had not been told what the complaint was, or who had made it.

Angelica Williams went on to confirm that since October 2003 [**M27/49/12**] she had been working day shifts in Flat 2 with Richard Muscat, and that the senior care worker in that flat was Michelle Garro. Prior to that, she had been working in Flat 1.

She said this about Resident T [**M27/49/9**]:

> "I've always got on very well with her. She's got on very well with me. The only thing is from what her sister says she was a bit of a problem so we were ... aware that if we have to go out to a Doctor's, an appointment or whatever to be always [with] another person ..., if we had to change clothes ... or go shopping with her always with two people. Because ... basically [Resident T] is a [compulsive[968]] liar."

She went on to say that that was how Moira Elmer had described Resident T to her [**M27/49/10**]. She confirmed that Resident T could talk eloquently, despite her learning difficulties, and that she "would talk with you like any other normal person" [**M27/49/10**]. She described Flat 2, saying that there were separate bedrooms for each of the six residents in the flat [**M27/49/13**]. She said that the doors were not locked, and that although the residents had their own keys they were not allowed to lock anybody in [**M27/49/13**]. She said that Resident T was the only resident in the flat who closed her bedroom door at night [**M27/49/14**]. She said she had never had problems with Resident AA [**M27/49/15**], and that she knew nothing about any misconduct of the kind alleged in relation to Resident J [**M27/49/17**]. She said she would never make fun of a resident, commenting [**M27/49/17**]:

> "I wouldn't be working where I'm working if I would be making fun."

Later in her interview, Angelica Williams denied that she had ever seen Richard Muscat being nasty to, or making fun of, any service user [**M27/49/20**]. She said she had on occasion seen Resident AA hitting Resident T by slapping her on the head, and that on one occasion that had happened when Moira Elmer was present, and that, in accordance with her usual practice, she had reported that incident to Michelle Garro [**M27/49/20**]. She went on to deny all Resident T's allegations [**M27/49/21-23 and M27/48/2-3**]]. She said that Resident T had made no complaints to her at the time. She said that there was always a third carer present when she and Richard Muscat were working in Flat 2 [**M27/48/5**], and that if she had seen him doing any of

[968] The transcript uses the word "compulsory", which is clearly an error.

the things he was alleged to have done, she would have "quickly gone and reported it" [**M27/48/6**]. She said that she had never had any problems with Richard Muscat, and that she considered that he dealt with the residents appropriately and caringly [**M27/48/7**].

She said that she had had a good rapport with Resident T. As an example of this, she described a holiday in September 2004 when she shared a bedroom with Resident T. She recalled that this had been Resident T's choice, saying [**M27/48/8**]:

> "She was asked who she wanted to share the bedroom with. She mentioned me. .... She could have gone with other people on holiday, but she wanted to go on holiday with the group that I was going on holiday with and share the bedroom with me."

She said that for Resident AA women were "taboo"; that the television programme "Thunderbirds" was "his life"; and that he would not be attracted in any way by women [**M27/48/12-13**].

I turn next to Michelle Garro's interview.

In the course of her interview, Michelle Garro said that she had a very good rapport with the residents in Flat 2 [**M27/47/4**]. She said that she had never been informed by Marie Gomez what the allegations were which had caused her interdiction [**M27/47/7**], but that on 19 December 2004 she had had a conversation with Resident T in which Resident T had described an incident when (according to Resident T) Richard Muscat had encouraged Resident AA to make a noise like a monkey (a noise which, apparently, Resident AE frequently made). This had upset Resident T, and Richard Muscat had (according to her) told her that she had to be friends with Resident AA. Michelle Garro went on [**M27/47/8-9**]:

> "She was very upset, she kept on telling me that she had come to the police, she had been forced, she was in [a] party and that Giselle and Joanna had brought her out of that party to bring her up to the Police Station. .... I then repeated ... that I did not know anything about that incident, I hadn't been informed and it was best for her to speak to ... Joanna and Giselle .... And I told her ... not to worry, that soon she would be going back to the Home [she was at that time at Bishop Healy], because all she wanted was to go back... I said: "Look, don't you worry and soon you'll be back". Because she didn't want to be up at Bishop [Healy]."

She went on to say that Moira Elmer had never complained to her about Resident T's care or about any alleged sexual incident; and that she "hadn't seen her" [**M27/47/9 and 14**]. As to complaints by Resident T, she said that Resident T complained all the time about relatively minor things (for example that she did not want to go out, or she wanted to watch a television programme, when she wanted to; or that she did not like the food [**M27/47/17-18**]); but that she had never complained about anything serious [**M27/47/18**].

She said that she had never been informed by management of any of the incidents described in Giselle Carreras' reports. She said that she had "never, never ever, seen [Resident AA] ... [pulling] his pants down" [**M27/47/16**].

As to Resident T's allegation that Resident AA barged into the bathroom while she was in it, Michelle Garro said that although that might have happened initially, Resident AA now used a separate bathroom [**M27/47/19**].

She said that although Angelica Williams was her sister, and although she had a family connection with Richard Muscat, she would have reported them should that have been appropriate [**M27/47/20-21**].

I turn next to Richard Muscat's interview, which was also attended by Maurice Turnock and a lawyer [**M27/50/1-3**].

I can deal with this interview shortly, because to each of DC Cerisola's questions Richard Muscat responded: "No comment". As he explained in evidence to the Inquiry[969], in so doing he was following the advice of his lawyer; something which he now regrets.

On 3 May 2005 Dr Rene Beguelin MB BS, in his capacity at the time of acting locum consultant psychiatrist, wrote to Giselle Carreras giving his assessment of the ability of Resident AA to cope with a police interview [**M10/1/1**]. In the course of his letter, he said this:

> "In my opinion although able to speak quite fluently in English and Spanish, this man has a mental age of 4 or 5 years and is unable to recall events accurately in terms of when they occurred as he is disoriented in time although he was able to tell me the day of the week. He was reluctant to discuss the probability of romance between Parker [the chauffeur], and Lady Penelope, two puppet characters [in the television series "Thunderbirds"]. I was told he ... always avoids discussion of a sexual nature.
>
> He is easily persuaded or confused into incorrect conclusions so that his testimony could be most unreliable unless elicited in a carefully controlled non-threatening way. This could be carried out in private either video recorded or in chambers by experts in special needs and in the company of his carers."

On 16 May 2005 Giselle Carreras provided a Psychological Report on Resident AA [**M10/7.1/1-30**]. In the introduction to that Report she gave Resident AA's date of birth as 16 April 1949 but she also gave his age (as at the date of her Report) as forty-nine. One of those statistics is clearly wrong. For the purposes of this Report, I will assume that in May 2005 Resident AA was between forty-nine and fifty-six years of age: his exact age does not matter for present purposes. In the section of her Report headed "Case Overview", Giselle Carreras said this [**M10/7.1/3**]:

> "Ms Hernandez notified her urgent concern over one of the residents. This concern involved service user [Resident T]. [Resident T] had allegedly disclosed that one of the [SSA] Carers namely Mr Richard Muscat had instigated another service user namely [Resident AA] to kiss her on the neck and fondle her genital area. This said disclosure further entailed other incidents of a similar nature which have according to [Resident T] occurred before. The said incidents further involved [SSA] Carers Ms. Angelica Williams and Ms. Michelle Garro plus Service User [Resident J]. ....
>
> At the said time, [SSA] CEO (Ag), Ms. Marie Gomez had already been notified. Ms. Hernandez had further notified Ms. Isabella Tosso Team Leader (Ag) for Adult Services.

[969] His evidence is reviewed later in this Chapter.

> My immediate instructions were primarily to provide therapeutic support for Service User [Resident T] and assist with the evaluation of such allegations.
>
> A full psychological evaluation has already been provided for [Resident T].
>
> The Senior Management Team has now equally requested an additional psychological evaluation for Service User [Resident AA]."

In a section of her Report headed "Behavioural Description", Giselle Carreras reported that Resident AA could be "physically annoying towards others" [**M10/7.1/7**]. However, she went on to state that there was no recorded evidence of sexual promiscuity or any other "alarming or anti-social behaviour" by Resident AA. Under the heading "General Behavioural Description", she said this:

> "[Resident AA's] behaviour in the workshop is generally quite good. He never has any tantrums or outbursts but will occasionally retaliate if teased by others.
>
> He has a constant desire to please the staff and will be very helpful.
>
> He becomes slightly agitated and fidgety when presented with a new or difficult task.
>
> The family report that he will use verbal threats often to his father but that this is likely to be because his father is very strict with him.
>
> [Resident AA] also likes to get involved in the other trainees [sic] arguments and will verbally tease the other trainees [sic] to see what reactions he will get."

The Report went on to record that Resident AA's general educational attainment performance was categorised as "Level 1" only; that is to say that he was among "the lowest functioning clients with learning disability" [**M10/7.1/9-14**].

The Report went on to say that a "therapeutic session" was carried out on 9 May 2005 [**M10/7.1/15**]. The next two pages of the Report [**M10/7.1/16-17**] contained quotations of a number of oral statements by Resident AA (in Spanish), accompanied by Giselle Carreras' description of his body language when making them. The quotes all relate to Resident AA's carers, and in particular to Richard Muscat. Plainly Giselle Carreras must have directed him towards that topic, as part (no doubt) of her attempt to "evaluate" the allegations made by Resident T, as she had been instructed to do. For example, Resident AA is quoted as saying repeatedly that Richard Muscat told him to do things, including sending him to Resident T's room. He is also quoted as saying that it was wrong what they (i.e. presumably Richard Muscat and Angelica Williams) did to him. However, not surprisingly given his mental age (as assessed by Dr Beguelin), none of the quotes makes reference to conduct towards Resident T or Resident J, or for that matter any other resident, which might possibly be interpreted as being of a sexual nature. One of the quotes refers to Angelica Williams laughing; presumably laughing at Resident AA, although the exact circumstances in which this occurred do not appear. In another of the quotes Resident AA is recorded as saying that he told Michelle Garro that Richard Muscat had sent him into Resident T's room, commenting that if Richard Muscat were not employed in the Home this would not have happened.

In a section headed "Conclusions" the Report included the following [**M10/7.1/28**]:

> "The evaluation establishes that [Resident AA's] educational and intellectual capacity lies within that found for children aged three to five years of age. Furthermore the evaluation presents [Resident AA's] emotional age to lie within that found for a three-year-old child.
>
> ....
>
> In addition results furthermore present that the possibility that [Resident AA] **self** premeditated any sexual advancement or sexual conduct towards [Resident T] is **most minimal (0-5%)**.
>
> The evaluation moreover establishes the possibility that [Resident AA] was proposed, suggested or enticed in the alleged sexual conduct towards [Resident T] as he has alleged occurred via his disclosure during therapy is **extremely high (95-100%)**."

There follows a section headed "Recommendations" [**M10/7.1/29**]. I set it out in full:

> "Based on the above findings it is my recommendation that Senior Management at [the SSA] thus continue with their full investigation.
>
> Moreover it feels imperative to highlight at this stage that clearly there will be codes of professional conduct and specific definitions of abuse attributed to working with clients with learning disability. The Management Report from [the Home] should indicate such conducts and definitions.
>
> It is further important that all relevant Professional Agency Staff and Carers working alongside [Resident AA] and [Resident T] provide fully structured personal profiles in addition to development and record of contact profiles on these clients. It will be important to equally review such professional evaluations, recommendations and conclusions.
>
> Having read Dr Beguelin's ... assessment on [Resident AA] I further concur with his conclusion that any court testimony on the part of [Resident AA] would be most unreliable unless elicited in a most carefully controlled and non-threatening manner.
>
> It would be absolutely essential that should the above mentioned testimony be required this would be conducted in private either video recorded or in chambers strictly by professionals already working within special needs and certainly in the company of his carers. I would suggest that should the need arise, the same provision be established for [Resident T]. The emotional impact, which may evolve if such needs are not taken into account, could be extremely traumatic for the clients in question.
>
> Finally and most importantly I would recommend that such an investigation equally makes provision, supports and safe-guards the emotional needs of the above mentioned clients via continuous social work and therapeutic input."

I note that in her Report Giselle Carreras referred to her interview with Resident AA as a "therapeutic session". However, her instructions required her, in addition to providing therapy for Resident AA, to "assist with the evaluation of [Resident T's] allegations" [**M10/7.1/3**]. That process required her to ascertain Resident AA's reactions to those allegations and to assess his capacity to give oral testimony. The fact that the interview had this additional purpose inevitably placed Giselle Carreras in a position of considerable difficulty and sensitivity, given that the provision of therapy for Resident AA was not necessarily consistent with the process of eliciting his responses to allegations that he had been abused by his carers. In short, the two

purposes were potentially in conflict. The existence of that conflict is most apparent in Giselle Carreras' comment (quoted above) that Resident AA's "disclosure during therapy" [**M10/7.1/28**] gave rise to a strong possibility (which she put as high as 95 to 100%) that Resident T's allegations were true. However, as noted earlier, none of the statements made by Resident AA "during therapy" which are quoted in the Report describe conduct of a sexual nature.

I make no criticism of Giselle Carreras' conduct of her interview with Resident AA. She was carrying out her instructions. Nonetheless, it is right that I should draw attention to the lack of any detail in the Report as to the manner in which, or as to the terms in which, she elicited from Resident AA the statements quoted in the Report. This lacuna in the Report is of some significance given Dr Beguelin's description of Resident AA as "easily persuaded" (see his letter dated 3 May 2005, quoted above [**M10/1/1**]).

On 10 June 2005 Sharon Peralta, Crown Counsel at the Attorney-General's Chambers, wrote to PS Adrian Bacarisa in the following terms [**I2/1/5**]:

> "I write to confirm the advice given to DC Cerisola at the end of April regarding this matter.
>
> After considering the evidence in this case as supplied by [Resident T] in her interview, the inability to interview [Resident AA] and the psychological reports submitted by Giselle Carreras, the Attorney General was of the opinion that were this matter to go to trial, there would be no realistic prospect of a conviction.
>
> As I informed DC Cerisola at the time, this would appear to be a matter best left to any internal disciplinary proceedings."

An internal disciplinary hearing was accordingly arranged for later in the year to investigate the allegations against Richard Muscat, Angelica Williams and Michelle Garro[970]. Johann Fernandez was instructed to represent the SSA in those proceedings. However in the event the hearing never took place. In his second witness statement to the Inquiry [**I5/1/1**], Johann Fernandez explains that the matter was due to be heard by a Disciplinary Panel on 13 December 2005, but that on 7 December 2005 he was informed by Isabella Tosso that disciplinary proceedings were not to proceed. He made a file note to that effect which was produced to the Inquiry in the course of the hearing[971].

It was (as I find) a matter for Isabella Tosso (as CEO of the SSA) – not for the Gibraltar Government – to decide whether disciplinary proceedings should be taken against the three interdicted employees. The fact that disciplinary proceedings were instituted indicates that at least at that stage Isabella Tosso considered that such proceedings would be appropriate. So the question arises: What made her change her mind shortly before the scheduled hearing? In addressing that question, it is necessary to consider the contemporary documentation, together with the oral evidence of Ernest Montado, who kindly agreed to attend the Inquiry at extremely short notice to assist on this aspect.

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[970] See the oral evidence of Ernest Montado at Day 17 page 90 line 5ff.
[971] See Day 17 page 94 line 18ff.

Ernest Montado was the Chief Secretary to the Gibraltar Government from 1986 to 2007. He told the Inquiry[972] that in late 2005 a complaint had been made to the Chief Minister by the Transport and General Workers' Union, on behalf of the three interdicted employees, to the effect that they had been effectively placed "in limbo" for nearly a year, and that no disciplinary decision had as yet been taken. He said that, following that complaint, the Chief Minister had asked him to look into the matter, and he had done so[973]. Asked whether the Chief Minister had told him what to do, he replied[974]:

> "No, no. .... I asked for the papers, or whatever papers [were] available, ... obviously I am very detached from the actual Home, I have no knowledge [of] how it works... But I examined all the papers, the Attorney-General had advised that there was no case for a prosecution, or rather the evidence wasn't strong enough. And therefore the only question pending was: Should there be a disciplinary? .... My inclination, and that of the Attorney-General himself, with whom I did discuss the matter, initially was that given the sensitivities attached to this particular case, that the disciplinary should proceed. But in looking through ... all the material we were given, ... I basically had handwritten reports ... from a number of care workers and so on, managers... Given also that the workers had been suspended for a very long time and management had failed to take proper action at the right time, I came to the view, and I stand by that view actually, that a disciplinary which would take a month or whatever was unlikely to come up with any result in the sense that the workers themselves would be disciplined. I think the evidence was too unreliable. That meant that if they were cleared they would go back to their jobs and so on. Because I had this residual concern, given ... the position of the service users, I felt – and it was trying to be a bit like Solomon – that we had a duty to look after the users and a duty to protect the employees as well, because it's not only a question of a year's suspension, it's also the questions that arise in public, people asking why have they been suspended for so long. What have they done? All of this in a small community is a factor that you have to take into account. So ... I drafted a letter, I met with Mrs Tosso a number of times, she was very clear that she did not want to reinstate the employees. .... My advice was: look, I don't think we are going to have an outcome on this, but I think you need to protect your position, and therefore I will draft a letter which will reserve management's right to take a disciplinary on this, because other evidence might emerge later, and you make that point clear, and then you recognise, acknowledge, that ... it's taken nearly a year to come to a decision, and therefore in consideration of that you are willing to reinstate, but – and this I think was the key matter – this will be subject to conditions. So in other words, you [i.e. the interdicted employees] will not be allowed to work with, or be responsible for, the service users that ... were making the allegations."

Ernest Montado accordingly drafted a letter in those terms. In his oral evidence, he went on to make clear that he did not regard himself as giving instructions to Isabella Tosso to send such a letter[975]; rather, he described himself as "advising her very strongly" to that effect[976]. He went on[977] :

> "What I said to her was, given the issues which arise here, given the delay which management ... is responsible for, although ... it took a few months for the police to report back (that explains part of the delay), I think this is the best way forward."

[972] See Day 17 page 76 line 1ff.
[973] See Day 17 page 78 line 1ff.
[974] See Day 17 page 78 line 8ff.
[975] See Day 17 page 82 lines 13-15.
[976] See Day 17 page 83 line 17.
[977] See Day 17 page 83 line 23ff.

Isabella Tosso duly took Ernest Montado's advice, and on 3 January 2006 she wrote a letter to each of the three interdicted employees[978] in the terms of Ernest Montado's draft. In her letter [**M28/1/55**], she said this:

> "As you know, I assumed my position as [CEO] in April this year[979], four months after the allegations against you were made and the decision to interdict taken. I have had to take some time to become acquainted with the details of the case following completion of an investigation by the Royal Gibraltar Police. The [SSA] subsequently undertook its own internal investigation and has sought legal advice.
>
> Having reviewed all the relevant papers and consulted with colleagues, I am satisfied that the original decision to interdict was correct. I have considered the evidence in the case and in particular the assessment of the clinical psychologist [Giselle Carreras] who was asked to advise on the credibility of the service users and their ability to distinguish between fantasy and reality. My primary duty and concern must obviously lie with the service users whose welfare and environment has to be protected and I take the view that formal disciplinary action would not be appropriate.
>
> That said, I also have a duty of care, which duty requires me to take proper account of the welfare and interests of staff including yourself and your two work colleagues. I am able to take into account the fact that the allegations, whilst serious, are of incitement of improper behaviour by the service users rather than allegations of improper acts having been committed by members of staff upon service users. I am also mindful of the length of time during which you have been interdicted pending a final decision as to the resolution of the matter.
>
> In all the circumstances I take the view that it is possible to protect the welfare of the service users, without necessarily having recourse to formal disciplinary proceedings provided that the following conditions are strictly complied with:
>
> 1. That [Resident T] and [Resident AA] are not placed directly under your care, as far as is practicable.
>
> 2. That for the foreseeable future your performance at work is closely monitored.
>
> If you agree to these conditions I would be prepared to reinstate you from the date of the letter. In the absence of any such agreement I am of the view that the interests and welfare of service users could only be protected by commencing formal disciplinary procedures.
>
> I await your response."

However, having sent those letters Isabella Tosso took no further steps to reinstate the three interdicted employees. The fact that she was concerned as to the effect which their reinstatement might have on the Residents who had made the allegations against them is evidenced by the fact that at a Management Meeting held at the Home on 20 February 2006 Isabella Tosso instructed Giselle Carreras to provide a further report on how best to deliver the news of their reinstatement to Residents T, J and AA.

Giselle Carreras' further report, which is dated 22 February 2006, is headed "Psychological Evaluation" [**M14/48/1-20**]. I will refer to it as her "Evaluation", in order to distinguish it from her earlier reports.

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[978] The Inquiry has been provided only with the letter addressed to Richard Muscat, but in oral evidence Ernest Montado confirmed that three letters were sent [see Day 17 page 89 line 17].
[979] i.e. 2005.

In section 4 of her Evaluation, Giselle Carreras set out her instructions in the following terms [**M14/48/2**]:

> "My immediate instructions were primarily to provide therapeutic facilitation in informing the Service Users [i.e. Residents T, J and AA] of such employees return to work and moreover where applicable evaluate the objectives as highlighted in section two of this report".

Those objectives were:

> "1. Assess and evaluate client perceptions on previously Interdicted Employees returning to work at [the Home].
> 2. Where applicable assess and evaluate impact of above-mentioned situation including [prognosis] of such for Service Users."

The Evaluation goes on to record (in section 5 [**M14/48/3**]) that Giselle Carreras held separate interviews with each of the three residents.

The Evaluation records that Jennifer Poole (Resident J's Social Worker) and Iain McNeil were present at her interview with Resident J.

Under the heading "Clinical Observations and verbatim of the client [Resident J]", the Evaluation records that Resident J's facial expressions were mainly indicative of "elation and happiness through grinning and smiling"; that her posture and movement was generally relaxed save where "reference is made to alleged incidences [sic]". As to her speech, the Evaluation records:

> "Pitch and tone was generally constant indicating comfort being experienced aside from session point where specific reference is made to alleged incidences [sic]."

Under the heading "Verbatim (translated where applicable into English)", Resident J is recorded as saying that she was very happy that the three employees were coming back; that Michelle Garro was her friend; and that she liked Richard Muscat and Angelica Williams. She is then quoted as having said this:

> "Yes I remember ... [Resident AA] would lie on top of me ... Richard would tell him, Richard ... with Angelica ...
> "I felt it disgusting ... disgusting, did not like it, did not like it."
> "Happy, very happy they are coming back ... my friends."

The contrast between on the one hand Resident J's happiness at the return of the three employees and her description of them as her friends, and on the other hand her expression of disgust when, apparently at Richard Muscat's bidding, Resident AA would lie on top of her, is striking. It demonstrates once again the importance of knowing precisely how, and in what terms, Giselle Carreras directed Resident J's mind to the relevant incidents alleged by Resident T.

I turn next to Giselle Carreras' interview with Resident T, as recorded in the Evaluation [**M14/48/5**]. It appears that the interview may have taken place over three separate sessions. The Evaluation records that Elizabeth Harrison (Resident T's Social Worker) and Iain McNeil were present during the first session, and that Elizabeth Harrison was present during the third session.

Resident T's facial expression during the interview is described[980] as being one of anguish and anxiety. As to her speech, the Evaluation states that "pitch and tempo was generally slow and carried pauses indicative of a depressive state", but that "tempo and pitch also increased in volume and amount as the session progressed indicating anxiety".

The next section of the Evaluation contains her "verbatim" statements, translated into English where applicable. I set this section out in full, omitting the Spanish phrases save in one case where the Spanish phrase is quoted by another witness[981]. The note of the first session reads as follows [**M14/48/5-7**]:

> "No ... No ... No."
> "Don't want to see any of them again."
> "Why? How have they won? How? Want to talk to who decided that."
> "I am scared. Very scared."
> "Don't want them near me ... not in the building ... I will shout ... I will and will. No No No."
> "They will get to [Resident AA]. They will."
> "I did not do anything wrong. I said the truth. Now who can I talk [to]."
> "I know the staff treats me differently ... differently ... because of me saying the truth ... the truth ... the sister Yvette looks at me and the eyes are not nice ... (con la vista sucia) comes to my house sometimes to get things ..."
> "I am very scared ... scared ... scared ..."
> "Just like Barcelona ... things happened there ... I said it ... said it did did ... and nothing ... nothing."
> "I told Sharon ... Sharon ... two times ... I did I told her."
> "Had to sleep in room ... with Rose and her husband... They on big bed ... me on little bed on floor ..."
> "Michelle also with husband and [Resident E] ... not right, no? Us on little beds and husbands there no?"
> "Barcelona ... horrible ... hated it ... no trips on boats ... no ... hate it ... will not go [any more] on boats ... hate it."
> "Why ... because in Barcelona I wanted to pee. I could not wait ... the truth ... it hurt ... hurt ... wanted to go back to the boat ... my legs hurt ... pee hurt ... was told to pee on my knickers ... but it was coming out ... it hurt ..."
> "Could not walk ... the pee hurt ... wanted to go back to the boat ... but them no because shopping ... no, for me no ... I was not shopping ... was sat in church on bench ... yes sat by Rose ... and Michelle ... husbands came looking for me later ... Think I was there for long time ... yes sitting on bench ... yes ... alone ... they were shopping and I did not want to shop ..."
> "Was then told I had been very bad and was punished ... yes bad ... because of pee ... but it hurt ... what do I do ... was told I could not go to restaurant ... eat in room ... they told me ... Michelle and Rose ... but I did not eat ... was sad ... only had my drink ...only my drink ... told them you are against me ... they said I had been bad ... told Sharon ... but what ... nothing and now the same."
> "Feel very sad, hurt, hurt, hurt."
> "When I went to the police ... said the truth ... no-one can lie to the police ... was scared but I told them ... told them because it had to stop „„ Take no more ... then I felt guilty ... guilty ... because

[980] It is not clear from the Evaluation whether this and other descriptions of Resident T were intended to apply to each of the three sessions. For present purposes, I assume that it was.
[981] The witness in question is Yvette Borastero (her evidence is reviewed later in this Chapter).

I was told I was bad ... was told that because of me they got in trouble ... because I did not want to get them into trouble but they did bad ... not me ... they did bad, no, ...they did and it had to stop ..."
"And [Resident J] ... worse for [Resident J] ... worse because she does not understand like me, ... I know that what they did was like a rape ... yes like a rape ... because if you do not want to it is like a rape."
"Because I would shout, yes, I shout ... with me only touching ... my cunt ... my cunt ... Arghhh... but with [Resident J] they ... they ... got [Resident AA] to lie on top of her ... they thought it was funny ... and no ... no it was not funny.
I am scared of Richard and Angelica the same and then Michelle."
"Who will help me now? I am scared and hurt, hurt, hurt."
"Used to get angry with [Resident AA] ... hit [Resident AA] all the time ... but really angry at them ... but hit [Resident AA] instead."

The note of the second session reads as follows [**M14/48/8**]:

"Been thinking if they come back ... and start again ... is like saying that they did nothing that nothing happened ... but it did ... it happened ... and now I am back ... back at the beginning ... back where I started ...[all] for nothing ... scared...
Been thinking I would like meeting with who decided they can come back ... I want to know who it was ... want to know ... want to know so I can tell them ... what really happened and what they did to us.
I want to know and find out who it is so I can talk to them.
I have done nothing wrong. I suffered. I suffered...
I have to find the people who have made the decision ... yes the decision ... I want to know who it is ... I don't want to leave it like this ... I can't ... I can't.
I am taking this out of my heart now ... but before it was all inside me.
I have even suffered when Eric Pozo told me in my appointment for the feet that because of me Michelle had been thrown out of the home...
I have suffered a lot ... a lot ... could not take things any more.
Richard would tell [Resident AA] to touch... and no ... no ... yes, to touch ... my cunt ... my cunt ... and no. No. No..."

The note of the third session reads as follows [**M14/48/9-10**]:

"I am very scared ... very scared ... can't sleep well ...
I cried yesterday ... could not stop crying ... told Liz [Gallagher] ... and Sharon ... told them how scared I was ... I am very scared ... scared they will get me ... scared they will get [Resident AA] ... I am scared ... they said to me ... not to worry ... because I have not done anything wrong ...I am not bad.
If they do come back ... I want to leave ...leave ... but where ... but I cannot stay there ... maybe they don't come to flat two ... but if I see them or have to go to see my friends in flat one and they are there ... what ... I stay in my room all the time? ... I will stay in my room ... because no-one can come in my room if I don't want ... and I don't want to see them ... can't ... can't. No. No. No...
Have also left something out ... from them ... want to tell you ... about beach in Spain. ... did not want to walk on wood ... scared of falling ...can't walk on the sand ... wanted my walker for the wood ... but no, told no to walk on wood ... scared ... could not have walker ... Rose ... not as bad as the other ones ... Angelica, Michelle and Yvette ... the sisters all the same ... walked on my knees ... all the way down the wood ... and on my knees ...to have a shower ... knees hurt and white ..."
"Was ... then told off for asking a man for help to walk on wood to shower ... they said man complained to them ... that I was bothering him ... I asked them first but since no ... I asked man ... Angelica shouted at me because man had complained ... she got my arm ... yes got like this ... and pushed me on the wood."
"Did not like the beach ... anyway ... would try to stop going ... then stopped going ... stopped because also I did not like it when Yvette would tell me to go in the water ... the water was cold ... and I had to go in ... and she would get my head and put it under the water and under the water

> and under the water ... three times ... and I would swallow water and I was cold ... did not like it ..."
> "And what ... No ... don't want to see them ... I don't want to hear more things ... don't want them to say things to me ... things like when in the restaurant Richard said to me ... when he said to me that [Resident AA] had a good dick ... and that [Resident AA's] dick was a good dick ... that for someone like me ... yes like me ... that dick would be ok ... No. No. No. ... I said that he spoke very dirty things from his mouth ... and they laughed ... always laughing ... No. No. ..."
> "I could not stop crying yesterday ... was crying and crying ... cannot let it not make me cry ... cannot stop crying ..."
> "Sometimes I sit down in the kitchen ... and my head goes round and round and round ... thinking about them ... thinking of the [scary] things ... [Resident AA] kept asking me yesterday if I had seen them ..."
> "I cannot rest ... my head does not stop ... cannot rest ... I can't. No. I can't ..."

I repeat the comment I made earlier as to the lack of any detail as to the manner in which, and the terms in which, Giselle Carreras elicited the quoted responses from Resident T.

By way of preface to the interview with Resident AA, the Evaluation states [**M14/48/11**]:

> **"**Imperative to note is that due to the nature of [Resident AA's] medical condition and moreover due to the reactions, which [Resident AA] was exhibiting as the interview progressed with reference to the previously interdicted employees it was deemed in the client's best interest **not to inform** over their return."

Giselle Carreras proceeded with the interview nonetheless (this being Resident AA's second interview).

The Evaluation describes Resident AA's facial expression during the interview as indicative of elation and happiness through grinning and smiling. However, it continues [**M14/48/11**]:

> "When the session however progresses to looking at the potential scenario of seeing the aforementioned interdicted employees again anguish was mainly indicated through swallowing and quiver of jaw, raised eyebrows and dilated pupils."

Given that Resident AA was not to be informed of the reinstatement of the three employees, it appears that Giselle Carreras must have sought his reaction to the possibility that they might be reinstated. This, indeed, is confirmed by the descriptions of his posture and movement and of his speech (quoted below).

The Evaluation describes his posture and movement as generally relaxed. However, it continues [**M14/48/11**]:

> "When the session however progresses to looking at the potential scenario as mentioned above high indications of anxiety were exhibited through shaking of head, restlessness and clasping of chest with strong rocking movements upon every specific mention of each previously interdicted employees' names."

As to his speech, the same contrast appears. The Evaluation states [**M14/48/11**]:

> "Pitch and tone was generally constant indicating comfort being experienced aside from when the session progressed to the potential scenario as explored above. At this stage pitch dropped and

> speech and tempo became more forceful in tone indicating level of discomfort and anxiety being experienced."

A number of quotations follow. Resident AA is quoted as saying words to the effect that he did not want to be hit on the face, or to have his trousers pulled down. He is quoted as saying [**M14/48/12**]:

> "My trousers would be pulled down by Richard, and Angelica hit me and hit me and hit me ...."

Later, he is quoted as saying [**M14/48/12**]:

> "No in my house they cannot come and if I see them go near flat one then I run and tell flat one so they close the door and they can't come in ... How frightening. .... If I see them I will call the police or the thunderbird captain. .... For me the three are the same ... how frightening."

The final section of the Evaluation contains Giselle Carreras' conclusions and recommendations. Under the heading "Conclusions" the following appears [**M14/48/19-20**]:

> "This Report as instructed by Senior Management sought to evaluate the impact (where applicable) upon the service user of the previously interdicted employees returning to post ...
>
> Findings as specifically clarified and presented in each pertinent section of this report establish that all three service users indicate significant levels of anxiety and tension ranging from negative experience of discomfort to traumatised stress and fear.
>
> Verbatim [i.e. the quotations] as presented within clinical interview for all three service users was consistent with disclosures as stated in previous evaluations for the year 2005. Such consistency and similarities in statements indicate that [Resident T's] original testimony is highly credible.
>
> Verbatim as presented within clinical interviews for two of the service users introduced further information, which although not available at the time, has been disclosed and offers cause for concern and investigation."

Under the heading "Recommendations", Giselle Carreras said this [**M14/48/20**]:

> "Based on new findings which have arisen at the time of this evaluation as instructed by Senior Management it is my recommendation that a full review be conducted on the initial investigation as undertaken in 2005.
>
> ....
>
> This evaluation indicates severely significant concerns for the service users in the instance that the previously interdicted employees return to post.
>
> Concerns as pertinent to this report highlight the potential risk increase for the service users in trauma, anxiety, stress and depression.
>
> In the instance of [Resident AA] and specifically [Resident T] such risk in trauma and stress is already at a disturbingly high level.
>
> In the instance of [Resident J], her ability to recall the alleged incident but yet lack of projected understanding over the implications of such, indicate highly significant levels of vulnerability.
>
> This evaluation thus concurs that in the specific instance where [Resident T] and [Resident AA] find themselves in a position of either coming face to face with the previously interdicted

> employees within their flats or even the parameters of [the Home], such could be potentially impacting in a significantly negative capacity.
>
> Moreover such impact may develop deterioration for these two service users. Such deterioration is not only deemed pertinent to levels of anxiety, stress and trauma but furthermore in social isolation leading to depressive disorders requiring medical attention.
>
> The emotional impact, which may evolve if such needs are not taken into consideration, could be extremely traumatic and consequential for the service users in question and poses risks of a serious nature."

The contents of Giselle Carreras' Evaluation did not serve to allay Isabella Tosso's concern as to the effect of reinstating the three interdicted employees on the Residents, and she continued to procrastinate on the question of their reinstatement.

This prompted the Union, in May 2006, to make a further complaint to the Chief Minister about the delay. The Chief Minister duly referred the matter once again to Ernest Montado[982]. This in turn led Ernest Montado to write to Isabella Tosso on 19 May 2006 (with a copy to Yvette Del Agua) criticising her for the delay which had occurred in effecting the reinstatement of the three interdicted employees following her letters dated 3 January 2006. Ernest Montado's letter was in the following terms [**M28/1/72**]:

> "I understand that Messrs Muscat, Williams and Garro have yet to be reinstated in their employment with the [SSA] notwithstanding the fact that you wrote to them early in January this year and that they accepted the terms of your letter of reinstatement.
>
> This contradictory position ultimately exposes Government to the risk of legal action and costs. Moreover, it is unacceptable for three employees to continue to receive their full pay from public funds for such a prolonged period and not be at work, with the added cost of employing replacement staff.
>
> In the light of this, I have been asked to instruct you to reinstate the employees concerned with immediate effect."

In his oral evidence, Ernest Montado said that this was the only instruction which he was asked to give: up to that point, his function had merely been to give advice, albeit strong advice[983].

Isabella Tosso replied to Ernest Montado's letter on 22 May 2006 [**M28/1/70-71**]. In that letter she said this:

> "I am writing to explain why Messrs Muscat, Williams and Garro have not been reinstated after I wrote to them in January 2006.
>
> In the first instance I met with the Manager of [the Home], the Adult Team Leader and the Senior Social Worker with practice responsibility for the service, to consider the practical arrangements that needed to be made to reinstate the workers while protecting the welfare of the service users. Once the practical arrangements were determined I instructed the Counselling Psychologist [Giselle Carreras] to prepare an Assessment report [i.e. the Evaluation] on the potential impact of the re-instatement on the service users who had made the allegations.

[982] See Day 17 page 86 line 2ff.
[983] See Day 17 page 92 line 15ff.

> [She then referred to the Evaluation, and to the concerns there expressed by Giselle Carreras.]
>
> On 3rd March 2006 I met with the Minister of Social Affairs [i.e. Yvette Del Agua] and presented her with the [Evaluation] and explained that as a result of these findings I was unable to re-instate the workers and at the same time safeguard the welfare of the service users.
>
> Your letter, which I received today, is the first official communication I have had since that meeting. I note that notwithstanding the contents of the [Evaluation] and my recommendation you are still instructing me to reinstate the interdicted workers. I will therefore commence the process of carrying out your instructions."

On 2 June 2006 Isabella Tosso wrote to Yvette Del Agua [**M28/1/75**] saying that following receipt of Ernest Montado's letter she had met Iain McNeil and Marie Gomez "to plan for the reinstatement of the three workers"; and that they had agreed to attend for "induction training" at the Home on 12 June 2006. The letter concluded:

> "Our undertaking is that the workers are not directly responsible for the care of the service users who made the allegations and that their work is closely monitored. We are taking all possible measures to meet these two criteria but as I explained to Mr Montado in my letter, regardless of any measures that we put in place, I have to inform you that by reinstating them I am unable to safeguard the welfare of the service users."

In the meantime Moira Elmer[984], Resident T's sister, had consulted lawyers, Charles Gomez & Co, with a view to Resident T bringing legal proceedings in her own name against the SSA, and an application for legal assistance had been duly made by Charles Gomez & Co on Resident T's behalf.

On 6 June 2006 Charles Gomez & Co wrote to Isabella Tosso [**M28/1/83**] saying that they had been instructed by Resident T, "who is assisted by her sister Moira [Elmer]". In their letter, they noted that there were "indications that the Carers were being reinstated", and complained that "the outcome of the investigation or any disciplinary procedures have not been divulged to the victim or her family". They asked that that information be provided as a matter of urgency. They also asked that they be informed of the conclusions of the police and internal investigations; and that they be provided with a copy of Giselle Carreras' "report" on Resident T.

On 9 June 2006 Charles Sisarello, the Branch Officer of the Union, wrote to Isabella Tosso [**M28/1/78-80**] saying that the three employees would make themselves available for induction training on 12 June 2006, but that none of the three interdicted employees should be required to attend for such training. The letter went on:

> "This Union does not accept that staff with the necessary training and experience should be required to "induct" again when the reason for their being absent from work has been an illegal and improperly imposed "suspension"."

In response to that letter, Marisa Salazar (in her capacity as Acting CEO) emailed Charles Sisarello the same day (9 June 2006), saying this [**M/28/1/81**]:

[984] Her evidence is reviewed below.

> "I am happy to go along with the term "refresher" on the understanding that there ought to be a procedure for re-introduction to the service. The reason for this is that the service has evolved in the last 18 months with a new manager being appointed at [the Home] [i.e. Iain McNeil]. Therefore the service is not as your members left it and they need to be briefed and updated on current service provision and standards expected from all staff."

On 26 June 2006 Charles Gomez & Co wrote to Moira Elmer [**F/18/13**] saying that the SSA had informed them that "a protection plan had been put in place" in relation to Resident T, and that they were attempting to find out the details of that plan. The letter went on to refer to the application for legal assistance which had been submitted in Resident T's name, saying that if Resident T's doctor felt that she was not competent to bring proceedings, the application would have to be made in Moira Elmer's name.

Before turning to the evidence of the witnesses, I refer to a Psychosocial Report relating to Resident T provided by Olga Sanchez as recently as 26 September 2013 [**M4/15/1**]. In her report (which has been translated from Spanish), Olga Sanchez describes herself as a speech therapist with "academic training relating above all to the care of people with special social educational needs: mainly people with intellectual disabilities". Under the heading "Emotional area" the report says this [**M4/15/2**]:

> "[Resident T] has no difficulty expressing her feelings and demands perceiving affections from others. She has no problems communicating her situations and emotions ..., but within her own reality."

Later in the report, under the heading "Emotionally", the report says this [**M4/15/3**]:

> "[Resident T] has difficulty expressing herself adequately, but not to perceive emotions. These emotional limitations apparently include isolation and denial, demanding the attention of those around her, especially professionals, being very selective in the attention of those that care for her. She struggles to socially integrate and participate in the activities if they are not to her liking. Her emotional psychological characteristics are as follows: she does not control her emotional impulses, flashes and emotional outbursts, but she does not present uncharacteristic behaviour, but rather tantrums."

Under the heading "Assessment", the report says this [**M4/15/6**]:

> "... it has been observed that [Resident T] has a moderate intellectual disability .... I believe that [Resident T] is able to tell the reality of what happened to her and there seems to be actual events related to her reality (which cannot be accurately verified), it is seen both in conversation, and in her actual behaviour and body language which affected her negatively, creating stressful situations, when they occurred and when currently remembered. ...."

I can now turn to the evidence of the various witnesses who gave evidence to the Inquiry concerning the allegations made by Resident T, J and AA.

I turn first to the evidence of Joanna Hernandez. In paragraphs 147 to 184 of her third witness statement [**E/67/46-53**], she said this:

"147. Approximately three weeks into my engagement, on (08.12.04), one of the patient residents [sic], [Resident T], raised a very serious complaint to me directly. I was going from flat to flat, as I did [every day], checking on residents and staff. [Resident T] grabbed me by my hand that day and told me, *'Joanna , menos mal que has venido, mira lo que me estan haciendo, help me'. "Joanna, thank god you have come, look what they are doing to me, help me".*

148. [Resident T] was Gibraltarian, but had lived in the UK for some years. She came to Gibraltar with her sister [Moira Elmer] after her parents died. [Resident T] had a fairly low mental age, but was well able to communicate if allowed to do so very well. She was a very lovely woman. She had been a resident at the Home for a long time, and she continues to live at the [Home].

149. She alleged that another staff member, Richard Muscat (DGH care worker), had forced another resident, [Resident AA], to kiss her on the neck and fondle her genital area. [Resident T] was very clear that staff member Richard Muscat had instigated this. [Resident T] said that this had happened before and that Richard [Muscat] encouraged [Resident AA] to do this for his (Richard's) entertainment.

150. [Resident AA] was also a long term resident. He also had a low mental age. In fact he had a lower mental age than [Resident T]. He was a big man, who was in his 40s or 50s. He also still lives at the [Home].

151. Richard Muscat was not on duty in the flat that night, so I thought it was safe to allow [Resident T] to remain in the flat that night.

152. The next day I took [Resident T] downstairs to see Ms Annie Risso (who was the Manager of St Bernadette's ... which is situated underneath the [Home]). [Resident T] repeated these allegations to Annie Risso and me. Ms Risso was a very experienced woman, and I thought it important to have a witness to [Resident T's] disclosures. Annie carefully checked with [Resident T] to see if she thought that [Resident AA's] actions were just a friendly hug or something else. [Resident T] was adamant that he had fondled her genital area and kissed her on the neck, and that Richard Muscat had instigated this. [Resident T] told us that this was not the first time. [Resident T] was clearly upset and angry.

153. [Resident T] also told us that on another occasion [Resident AA] had stormed into her bedroom when she had only her underwear on, he had left her bedroom; [Resident AA] had spoken to Richard Muscat and returned into her room with his trousers down. [Resident T] said that Angelica Williams [and] (a support worker) saw this and slapped [Resident AA] on the face.

154. [Resident T] also told us that on another occasion [Resident AA] was encouraged by Richard Muscat and Angelica Williams went into [Resident J's**]** bedroom and got on top of her and fondled her. She said that Richard Muscat and Angelica laughed at this.

155. [Resident T] was obviously upset by what she had seen. She said that she felt that she did not need to see this.

156. [Resident J] was a resident. She was an older woman in her late fifties. She had mental health problems; she also had a glass eye. She was very pleasant but very vulnerable.

157. [Resident T] said that these incidents only occurred when prompted by Richard Muscat and Angelica Williams.

158. Ms Risso and I reported this allegation to the CEO Marie Gomez ... Ms Gomez asked us to fax her incident reports, which we did.

159. Ms Gomez telephoned us back to say that she had called in the CID of the Royal Gibraltar Police to raise the complaint. She also said that she would suspend the staff members.

160. Two police officers arrived; they were an Officer Barton and Officer Aldra Cerisola. They wished to arrest [Resident AA]. I had to explain that [Resident AA] had a very low mental age

and that I understood that he had been encouraged or forced to sexually assault [Resident T] by Richard Muscat [and] Angelica Williams.

161. The Officers took [Resident T] and [Resident AA] for questioning at the police station along with a social worker. When they were released I placed them in another flat away[985] from [the Home] because [Resident T] was very frightened of repercussions that might come from the staff she had named and others.

162. It is relevant to point out the family relationship of those working in [Resident T's] flat. The senior of the flat was Michelle Garro, she was the sister of Angelica Williams and Richard Muscat had a daughter with Michelle Garro's daughter.

163. Michelle Garro was also suspended by Marie Gomez, as Marie Gomez suspected that she knew of the alleged abuse of [Resident T] and [Resident J] by her relatives/staff and had not reported it.

164. I also informed the acting Adult Team Leader, Isabella Tosso, of the allegation by telephone (see my record of that telephone report of 13.12.04).

165. The three staff members, Richard Muscat, Angelica Williams and Michelle Garro were suspended.

166. A few weeks after the incident Officer[s] Barton and Cerisola came to see me at [the Home]. They told me that they would be taking action against the three staff members, i.e. charges were to be preferred against them.

167. The police also gave me a copy of a letter from Dr Galloway. Dr Galloway had assessed [Resident T] and had written a letter confirming that [Resident T] was fit to give evidence in court.

168. In a report of 07.03.2005 requested by the Police of the [SSA], SSA psychologist, Giselle Carreras, conducted an assessment culminating in a psychological report of [Resident T] on the incident. ....

169. The psychologist[']s report made for very difficult reading. It appeared to confirm [Resident T's] allegations of abuse. The report also stated that [Resident T] had raised allegations of physical and sexual abuse as long ago as 28 November 2002. Her allegations had been recorded at St Bernadette's Council Group on that date. The psychologist[']s report confirms that these allegations were discussed with management and it was decided that the situation would be monitored.

170. The allegations were recorded again in a meeting of 28 March 2003, and were recorded by the SSA psychologist.

171. The [p]sychologist also recorded that allegations of abuse were noted in regard of [Visitor X]. Reportedly this resident[986] had been forced to dance and sing for the entertainment of staff and guests of staff members.

172. The report also indicated that [Resident AA] was also forced to dance in a sexualized manner with [Visitor X], which he did not want to do.

173. Even more worryingly the report indicates that Richard (Muscat) and Angelica (Williams) forced [Resident AA] [to kiss Visitor X] on the lips and that the staff members told [Visitor X] that [Resident AA] was her boy friend.

174. The report confirmed that these serious matters were recorded again on 27 April 2003 and 15 May 2003, and again that these reports were forwarded to management.

[985] A reference to Bishop Healy.
[986] As noted earlier, Visitor X was not a resident: see paragraph 26 of Giselle Carreras' witness statement [**J1/123/4**].

175. The report confirmed that these allegations were also recorded by Ms Marie Gomez, in her role as social worker. Ms Gomez went on to become acting CEO of the SSA and thereafter Team Leader Adult Services.

176. The report records a series of further occasions upon which this serious abuse of three vulnerable residents had been effectively sexually abused by staff of [the Home] (although a fourth staff member, Michelle Garro ... was ... aware and threatened [Resident T] when she sought help regarding the sexual abuse).

177. Obviously these reports of sexual abuse were prior to my becoming [manager] of the Home. I had never been told that there was such a well-documented history of reported abuse by named staff members over such a long period of time.

178. I am deeply concerned that this abuse was known by very senior staff of the SSA for a very long time, and the residents were not protected. I was and am very concerned that I was not informed of this long history of abuse when I took up post as manager of [the Home].

179. This is a stark example of where senior managers of the SSA had been aware of long term and repeated abuse of vulnerable residents, but had done nothing to protect those residents and had not advised me of this prior to my appointment.

180. A few months later, CID Police Officer Aldra Cerisola ... came to see me. She told me that the case against the staff members for the abuse of [Resident T] had been dropped by the Attorney General. My memory is that the police officer said, "*it had been binned*". I asked her to explain, as I was shocked. She said to me words to the effect "in Gibraltar the police had been instructed not to investigate any cases of abuses [sic]". She said it was up to the SSA to carry out its own internal investigation.

181. I reported this to Marie Gomez and told her that the SSA would have to undertake an internal investigation, as the police would not proceed with the prosecution. Ms Gomez told me that the SSA would arrange for a board to investigate the allegations.

182. There was a long delay in the SSA taking action. This investigation board was never established. As a result, the 3 members of staff were reinstated. They had been suspended for a year. As no action had been taken within a year, which I understand to be the longest period in which they could be suspended, they were entitled to reinstatement.

183. Finally on this point, I later asked the Officer Aldra Cerisola (who had investigated the abuse of [Resident T]) if she was prepared to give evidence in court in my Industrial Tribunal case for unfair dismissal, regarding the investigation, the dropping of charges and the attitude of the Attorney General's officer. She agreed. However, I had to seek the permission of Police Commissioner Wink to call her to give evidence in the Industrial Tribunal. Commissioner Wink wrote to me and agreed that Officer Cerisola could give evidence if subpoenaed.

184. The incident with [Resident T] really shook me up. I became very conscious of the need to record incidents that I found that concerned me and to report these as and when they happened. ...."

In the course of her oral evidence, Joanna Hernandez described Resident T as capable of giving evidence[987]. She went on to say that one of the police officers involved in investigating Resident T's allegations (plainly a reference to DC Aldra Cerisola) told her "that the police had been instructed not to investigate allegations of abuse in Gibraltar"[988]; and that she had been told that "Mr Caruana" had given instructions to that effect[989].

[987] See Day 2 page 97 line 19.
[988] See Day 2 page 97 line 24.
[989] See Day 2 page 98 line 12.

As to her reference (in paragraphs 166 and 167 of her witness statement [**E/67/50**]) to the police having given her a copy of a letter from a Dr Adam Galloway "a few weeks after the incident", counsel to the Inquiry put it to her that the only letter from Dr Galloway which had been provided to the Inquiry was a letter dated 30 June 2006 [**E/32/41**] (i.e. after the Attorney-General had decided not to prosecute and after the police had closed their inquiries). However, Joanna Hernandez insisted that the police gave her the letter a year earlier, when they told her that there would be no prosecution[990]. I find the Joanna Hernandez' recollection is at fault in that respect. The overwhelming probability is (as I find) that Dr Galloway's letter was provided by him in the context of the application for legal assistance made in 2006 by Charles Gomez & Co on behalf of Resident T referred to earlier.

In his letter dated 30 June 2006 Dr Galloway said this:

> "To Whom It May Concern:
>
> **Re: [Resident T]**
> **DOB 20/05/55**
>
> The above lady has been my patient for many years. She has mild learning difficulties but is fully able in my experience to express herself clearly and accurately. She has always been clear and concise in her descriptions of events and problems that have occurred in relation to her medical condition and in her life generally."

Returning to Joanna Hernandez' oral evidence, counsel for Richard Muscat put it to her that Richard Muscat mainly worked in Flat 3; that he was hardly ever in Flat 2 (the flat where Resident T and Resident AA lived); and that when he worked in Flat 2 it was during the day. She replied[991]:

> "I don't know. .... I don't even know whether what happened in that flat was accurate or not accurate. What I did was, if an allegation is made to me ... my obligation and my duty of care tells me that I have to report to Senior Management, and that is what I did, full stop."

I turn next to the evidence of Giselle Carreras.

Giselle Carreras has been employed full-time since November 2002 by the SSA, and subsequently by the Care Agency, as the Agency Psychologist. She is currently the Agency Psychologist and Team Manager for the Therapeutic Service. She made a witness statement in the Inquiry [**J1/123/1**] and she also gave oral evidence.

In paragraphs 8 to 49 of her witness statement, she says this [**J1/123/2-7**]:

> "8. It was part of my initial job description to act as a visiting psychologist for the residents of the [Home]. I arranged to attend St Bernadette's ..., which is underneath the residential part of the Home itself. I attended for each week on Thursday afternoons. These were originally called

[990] See Day 2 page 104 line 8.
[991] See Day 2 page 141 line 11ff.

Council Group Meetings and, subsequently Advocacy Council Group Meetings. In general, this did not involve me in going into the Home at all.

9. Occasionally as part of developing particular life skills for the residents who were my clients, I would (for example) take the group upstairs where I would serve tea as part of the therapeutic exercise.

10. On such occasions, whilst I would have seen various care workers in the Home, I would not have any professional or managerial dealings with them. I might recognise people whom I knew anyway, and very occasionally I might be asked to give small piece of advice to a care worker if, for example, a particular resident was demonstrating behavioural difficulties.

11. My remit was to work with the residents. Beyond that, I would provide a consultancy service to the Home's management when required.

12. In the course of my work, I had to consider what some residents had to say about individual named Care Workers. I note the following names from my reports: Richard Muscat, Angelica Williams, Rose Seruya and Michelle Garro. I have never knowingly met any of these people; I do not know what they look like.

13. My weekly sessions were with a stable group of about eight vulnerable adult residents. These people varied greatly in their intellectual and emotional development. I got to know them all very well as individuals. I established a very sound rapport with all of them. I believe that they all enjoyed and looked forward to our Meetings.

14. On 13 December 2004, I was asked ... to undertake an assessment of Resident T, and produced a report shortly thereafter, probably early January 2005 at the latest[992]. ....

15. As the report sets out, I was called in to do an assessment as a result of matters that formed the subject of reports by Joanna Hernandez and Annie Risso on 9 December [2004]. The matter that I was required to report was on Resident T's allegation that Resident AA had been incited by named Care Workers to indecently assault Resident T. I was also required to accompany Resident T to the Police Station where she was interviewed for the purposes of a criminal investigation into the same allegations.

16. My report refers to specific dates and times. That is because at the time I had access to my files and was able to retrieve the information from notes and documents that were on them at that time.

17. By that time I knew Resident T well. In summary, she is a lady of low-average intelligence, who all things being equal could have lived in the community and obtained employment. Her fundamental problems arose from a severely emotionally deprived upbringing [during] her childhood in England.

18. As my report states, Resident T had told me on 28 November 2002 that Resident AA was kissing her up at the flat. Resident T made it clear to me that she felt he was being encouraged to do this. The meeting at which Resident T expressed that concern was one of my weekly therapeutic meetings described above.

19. I go on to record that I reported my concerns to my senior management. As far as I recall, I would probably have mentioned to the [Home] management that I had concerns, but not been specific, because the protocol was for my senior management to raise it with them.

20. I should explain that I wrote a report of every Council Group Meeting. I would always include at the end a section headed 'Action Points'. I always gave the Minutes to my senior management and they were well aware that they were required to read them and, in particular, the Action Points.

[992] As noted earlier, the copy of the Report which has been supplied to the Inquiry is dated 7 March 2005 [**M4/1/1**].

21. Further, whenever there were matters of important concerns I would always personally meet with at least one of my management. This would be Debbie Guinn ..., Marie Gomez ..., Douglas Rodriguez ... and Isabella Tosso ....

22. I am absolutely certain that the 2002 concerns were reported by me to management both in writing and in person, albeit I cannot now remember the particular individual to whom I spoke on specific occasions. Certainly it would have been one of the afore-mentioned persons above.

23. My management were supposed to give me written feedback but normally it was verbal (I can concur that operational requirements made this difficult since they were very busy). It would be management's duty to decide what steps were necessary to ensure that the care workers did not pose a risk to Resident T and other residents. It would have been helpful if I had been kept more informed in process terms what action management was taking so that I could take this into account when dealing with a resident's particular concerns.

24. My role was to support Resident T. .... In particular I would work with her, encouraging her to understand such matters as the fact that she should not blame herself, or internalise any misplaced feelings of guilt or shame. I also would endeavour to work on self-concept, esteem and keep-safe work for the future.

25. ....

26. In summary, Resident T and Visitor X, a lady who has learning difficulties who would visit Resident T at the Home both reported Visitor X being told by named Care Workers to dance and sing for them. They were also clear that 'poor' Resident AA was being made to kiss Visitor X. It was absolutely clear that none of them liked this and all found it upsetting. The overall message was that they were being made to perform for the named Care Workers.

27. ....

28. The general feedback that I was receiving from my management was that this behaviour by the Care Workers was a 'cultural thing' and although inappropriate did not appear to be maliciously intended. I was told that the behaviour was being and would be dealt with via continuous in-house training, monitoring and supervision of staff.

29. The first time that I became aware that the [Home] management was taking matters to a more serious level was when Joanna Hernandez (JH) became the manager of the [Home] in 2004. JH had a background of working with people with learning difficulties and expressed a keen interest and concern that their dignity be respected [at] all times. I felt that she was determined that the inappropriate abusive practice that I have described above would be brought to an end.

30. ....

31. JH would share her concerns with me in a way that the [Home] management had never done before repeatedly requesting advice and support from me in the form of consultation. She valued my professional opinion.

32. It will be noted that at the end of my 2004 evaluation of Resident T's allegations I listed my conclusions and recommendations. I was professionally as well as personally convinced that Resident T was reporting her concerns truthfully and consistently and furthermore that she was being damaged as a result of her experiences.

33. I specifically recommended in terms that my management conduct a full investigation. In my concluding paragraph I made it clear that my concerns were not limited to Resident T and what she said had happened to her but also the other residents, particularly Resident AA and Visitor X who I have mentioned was a regular visitor.

34. I made specific recommendations for safeguarding Resident T.

35. I continued to meet my group of residents each week at our Council Meetings.

36. My next evaluation was of Resident AA. He is a gentleman now in his 6os who as I explain has a mental age of less than 7 but an emotional age of only 3. I interviewed him in the presence of the other professionals mentioned in my report.

37. Resident AA was not able to participate in the Council Meetings because his learning difficulties were too severe. I had, however got to know him on visits to the Home. I would see him every week at St Bernadette's. He was always demonstrably affectionate towards me, but never in a way that could be described as sexual.

38. The best way of describing Resident AA was that his main interest was in the Thunderbirds television show. He called me his Lady Penelope.

39. I was of the clear opinion that he had no concept of sexuality and expressed in my report that he could not have initiated sexual behaviour towards service users. Annie Risso told me specifically that if he woke up in the morning with an erection he would be distressed and crying and disturbed by the experience. That was entirely consistent with my own evaluation.

40. Again I concluded my report with recommendations to my management. It might be considered that I was trespassing on management territory, but the fact is that my professional concerns that nothing seemed to be changing were now acute and I felt it part of my professional code of practice. I had no choice but to spell out their responsibilities to them.

41. Throughout this period I was convinced that JH saw the need for radical change. She consulted me regularly about her concerns. ....

42. Some time after I had written my report on Resident AA, a number of Care Workers were suspended (interdicted) pending what I understand were both internal and police investigations.

43. I understand that it was decided that the interdicted care workers should return to the [Home] and it was for that reason that in February 2006 I was asked to evaluate Resident T, Resident J and Resident AA, with specific reference to establish their concerns (if any) about the fact that the people who [they] said had abused them were coming back to work.

44. My evaluations in my report dated 22 February 2006 show that they were all very distressed at the prospect and further that they expressed fresh concerns about the lack of dignity afforded to them by some of their carers.

45. I made a list of recommendations at the end of my report. These residents were in my opinion at great risk of harm.

46. To the best of my recollection very shortly after writing [my] February 2006 report ... I was informed by my management that as part of a new monitoring system, instead of the weekly Council Meetings there would be weekly flat meetings at [the Home] conducted by relevant social workers and senior care workers.

47. From that point on my involvement with the residents was limited to when I was brought in on an 'as need' basis. I do not recall that I was ever again asked to come and to meet any of the residents to whom I have referred.

48. My role within Social Services thereafter was to prioritise Child Protection and the 'Looked After' Service for children.

49. Whilst I accept that there was an operational need for me to specialise in what I do now, I was and remain very concerned at the decision to dispense altogether with the role of psychologist at the Council Meetings. I was not replaced by a similarly qualified person and in my professional opinion that would almost certainly have been detrimental to the residents."

In the course of her oral evidence, Giselle Carreras described her role at the Council Group Meetings in the following terms[993]:

> "My role was mainly to facilitate. It was more of an advocate in terms of self-empowering, in terms of dealing with any particular issues. .... There was a particular programme that I aimed to implement initially, which was about education and about self-concept and about assertiveness. In trying to introduce the service user more into the community, for them to be more independent about themselves. I would go every Thursday initially, and part of the Thursday was ... a Council Group Meeting, and my role in a nutshell was to act as an advocate where they could express their concerns, their worries, and I would try to empower and work with them as best I could."

She went on to explain that the residents who attended Council Group Meetings were a "higher capacity group", and that her focus was on representing them[994].

She said that Resident T regularly attended those meetings[995]. She did not include Resident AA or Resident J in the list of attendees.

Later in her evidence, she explained that her role vis-a-vis management was "more of a consultancy role"; and that her concerns would be passed to management, and "then they would make their decisions"[996].

She described Resident T in the following terms[997]:

> "Resident T I would classify as a woman with mild learning disabilities. Part and parcel I feel of her processing has been in that she, in my opinion, didn't possibly have the support network that she should have had ... as a child, so emotionally I would say that Resident T sort of ... operates within the mind of a 12- to 13-year old young woman. But Resident T equally, you know, was a very, very verbal and very, very aware sort of ... woman."

Later in her oral evidence she returned to this topic, describing Resident T as follows[998]:

> "Resident T has a fairly adult understanding, but emotionally she is still a very, very young person."

Asked to whom she was referring when she used the expression "my management", she replied[999]:

> "My management would have been people who were senior to me at the [SSA] at the time. That would have been Debbie Guinn, that would have been Marie Gomez and that would have been Isabella Tosso, and that would have been Douglas Rodriguez."

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993 See Day 5 page 8 line 2ff.
994 See Day 5 page 12 line 12ff.
995 See Day 5 page 8 line 23.
996 See Day 5 page 25 line 12.
997 See Day 5 page 15 line 5ff.
998 See Day 5 page 58 line 20.
999 See Day 5 page 18 line 12ff.

She went on to say that she did not recall reporting her concerns to the senior care worker in charge of Flat 2[1000]. She explained that at that time she had no direct contact with care workers, although she may have come across them when visiting the Home[1001]. She said that she felt very concerned at the response of management to her recommendations, in that (as she put it[1002]):

> "... full investigations needed to start to happen and that full ... education needed to happen for the staff."

Later in her evidence, she said this[1003]:

> "Personally I ... would have wanted to speak directly to the staff involved. But my management at the time felt that they could be ... dealt with by monitoring and training of the staff, creating more of a cultural awareness."

She elaborated on this by saying[1004]:

> "I felt that other things needed to be done in terms of our agency. .... Like a tighter ... regime in terms of monitoring, a tighter regime in terms of education, a tighter regime in terms of even supporting the staff to understand what would be appropriate and inappropriate behaviours."

As to her evaluation of Resident T, she said that she felt that Resident T was credible and consistent. She confirmed that she had made that assessment based solely on her conversations with Resident T: she had not conducted any wider investigation[1005].

As to Resident AA, she said that his mental capacity was equivalent to a six-year-old child and that in consequence she considered it highly improbable that he had initiated behaviour of the kind described by Resident T. As she put it[1006]:

> "It had to be encouraged by someone."

Later in her oral evidence she said this in relation to her assessment of the credibility of Resident T[1007]:

> "Unless something has been relived, it's very, very hard for a person to actually verbalise it, and in this particular case what happened with Resident T was that she remained credible throughout. The story remained the same. The story remained consistent. And that is why I derived that the probability of her saying the truth and her being credible was high."

Asked whether in her experience Resident T was prone to exaggeration, she replied[1008]:

[1000] See Day 5 page 20 line 7.
[1001] See Day 5 page 30 line 51ff.
[1002] See Day 5 page 32 line 7ff.
[1003] See Day 5 page 33 line 10ff.
[1004] See Day 5 page 48 line 5ff.
[1005] See Day 5 page 34 line 24ff.
[1006] See Day 5 page 36 line 16.
[1007] See Day 5 page 39 line 1ff.
[1008] See Day 5 page 39 line 11.

> "Not in my experience of her, no. And certainly not in my experience of this particular incident."

She went on to confirm that she was reasonably confident that Resident T was telling the truth[1009]. She went on[1010]:

> "I felt that in Resident T's case she just remained consistent all along, and maybe ... that is what impacted [on] me the most, that the consistency was kept, and for someone with a learning disability, that consistency would be difficult to keep."

Later in her evidence, she confirmed that in her opinion Resident AA would not have the capacity to give evidence at a court hearing, whereas Resident T would be capable of doing so if she were treated as a vulnerable witness would be treated in a child protection case[1011].

As to the quoted statements which appear in her reports, she said that the interviews were not recorded, but that she took notes[1012].

She said that Resident J's capacity was significantly lower than that of Resident T, and that her credibility "can get confused", with "a mix and match of innocence and confusion going on"[1013].

As to the reinstatement of the three employees, she said that Iain McNeil had consulted her as to the steps which should be taken to minimise the impact of their reinstatement on residents[1014]. She recalled Iain McNeil telling her that steps would be taken to ensure that there was no interaction between them and Residents T, AA and J[1015]. She went on to say that she was satisfied with what he had said[1016]. Asked whether the steps which he had described were in fact taken, she confirmed that (so far as she was aware) they were[1017].

Counsel then referred Giselle Carreras to Olga Sanchez' report. She agreed with Olga Sanchez' comment about Resident T communicating problems "within her own reality" (see above)[1018].

Giselle Carreras explained that the expression "within her own reality" referred to Resident T's perceptions of events, but that in her view Resident T's perception of events would not alter the basic facts that she was describing[1019].

She said that in February 2006 she handed over her file to Maria Elena Macias, who then took over the Council Group Meetings[1020]; and (as she put it) "that was it"[1021].

[1009] See Day 5 page 40 line 10.
[1010] See Day 5 page 43 line 15ff.
[1011] See Day 5 page 53 line 4.
[1012] See Day 5 page 56 line 23.
[1013] See Day 5 page 8 line 1ff.
[1014] See Day 5 page 63 line 4.
[1015] See Day 5 page 62 line 7.
[1016] See Day 5 page 62 line 22.
[1017] See Day 5 page 63 line 23.
[1018] See Day 5 page 67 line 23.
[1019] See Day 5 page 70 line 8ff.

In response to questioning by counsel for Michelle Garro and Angelica Williams, Giselle Carreras reiterated that her role as advocate[1022]:

> "... was simply to pass on what was ... alleged to me. That was my role and that was what I had to do within my role as advocate."

She went on to say that her role at the police interview with Resident T was to enable Resident T to understand the questions being put to her[1023].

Asked by counsel for Joanna Hernandez for her view as to Joanna Hernandez' determination to stop abuse, Giselle Carreras replied[1024]:

> "I think she was determined to educate ... and determined ... to change. .... The whole culture base needed to change around disabilities."

I turn next to the evidence of Resident T herself.

Resident T made a witness statement in the Inquiry, although she did not wish to attend the hearing to give oral evidence (a decision which I fully respect). In the circumstances, I took the view that it would be out of the question to require her to do so[1025].

In her signed witness statement [**F/19/1-3**], which (as appears from the witness statement itself) was prepared with the assistance of the solicitors to the Inquiry, Resident T says this:

> "1. I am 58 years old and suffer from muscular dystrophy (as well as other less serious ailments). The only drugs I am currently taking are anti-depressants and a bone strengthener. I spent my earlier years in London and then we moved as a family to Gibraltar.
>
> 2. On Thursday 29th August 2013, a meeting was arranged with my sister Moira Elmer, Carlos Banderas, together with lawyers Gabrielle O'Hagan and Cristina Linares (Triay Stagnetto Neish) at [the Home] in order to discuss my concerns and past happenings at the Home. I understand that what follows is an account of what I told Gabrielle and Cristina.
>
> 3. One of the memories I find most upsetting is a cruise holiday I went on with other residents at the Home – [Resident AA], [Resident S: since deceased] and [Resident J], together with carers, Richard Muscat, Yvette Gonzalez, Rose Seruya and Rose Seruya's husband. I had to share my room with Mr and Mrs Seruya, which I did not like as I had no privacy. There were also some occurrences which took place during this holiday which were very upsetting to me.
>
> 4. Firstly, I cannot control my pee very well and when I need to go, I find it very hard to control it. When we were out one day and I told the carers that I needed to go, they did not want to take

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[1020] See Day 5 page 73 line 3.
[1021] See Day 5 page 74 line 11.
[1022] See Day 5 page 92 line 21ff.
[1023] See Day 5 page 97 line 3.
[1024] Day 5 page 103 line 20ff.
[1025] In the course of her oral evidence Giselle Carreras said (Day 5 page 52 lines 23-25): "Resident T wouldn't be able to sit here like I am sitting now, she would be terrified. She wouldn't understand the concept of what we are doing."

me to the toilet. I was taken back to the cruise in a taxi and I was pushed out of the taxi. I was then left in the room by myself.

5. I also recall that during the holiday, Richard used to shout at me for no reason when nobody was around.

6. In the period before Joanna Hernandez started working at the Home, I was very unhappy there. This was mainly because of the way I was being treated by the carers Richard Muscat and Angelica Williams. Richard used to tell [Resident AA] to make bad gestures, touch me in inappropriate places and say bad things to me. Richard and Angelica used to watch this happening. It was like they did not care and found it funny. This I found extremely upsetting and I cried a lot. I went through a very bad time due to this.

7. Another time, when I was changing my bra in my room, [Resident AA] walked in. This happened as a result of Richard telling [Resident AA] to do it. Angelica Williams was in the room with me and hit [Resident AA] across his face. This upset me a lot.

8. Richard and Angelica used to encourage [Resident AA] to touch [Resident J] inappropriately, but [Resident J] cannot really complain or say what has happened to her.

9. I used to inform Yvette Gonzalez and also Michelle Garro, who was in charge of the flat, about this. However, they used to ignore me. At times, Michelle was also present when these things happened and although she did not encourage it, she did not stop it from happening.

10. I think that [Resident AA] did not understand exactly what he was doing to me when he used to touch me but he loved Richard very much and always did what he said. Richard also used to make [Resident AA] do gestures at me. This made me get angry with [Resident AA].

11. It seemed like everyone wanted to please Richard and I did not like this.

12. By the end of this period, I used to spend most of my time in my room. I tried to tell my sister, Moira, what was happening, but when she asked the carers about it they did not listen. I began not wanting to talk to anyone and I was very depressed and frightened. When Joanna came, she understood what had happened and helped me to tell what had happened to the police.

13. I was upset and frightened when they told me that Richard, Angelica and Michelle were coming back to work at the Home after the investigations did not go ahead.

14. I certify that Cristina Linares of Triay Stagnetto Neish has read the contents of this statement to me."

I turn next to the evidence of Resident T's sister, Moira Elmer.

In her witness statement in the Inquiry [**F/18/1**], Moira Elmer merely confirmed the contents of her 2006 witness statement.

In paragraphs 2 to 20 of her 2006 witness statement [**C1/18/1-5]**, which was dated 17 September 2006, she said this:

"2. ... [Resident T] has been depressed for quite a while. It was unbeknown to me what is going on in the home, because she didn't really mention anything until months later. It has taken me a while to realise that she is being bullied and mentally abused. I thought at first that it was the fact that she lived there and she wanted to live with me. Because of her disability it is not feasible for her to live with me.

3. It was problems created there and at the time, and I thought it was [Resident T's] fault, because whenever I went to approach Michelle [Garro] who is the senior at the flat, and tell her

that [Resident T] has been telling me that she is being bullied/abused and all this, it was all reversed and she told me that [Resident T] was coming up with stories, because of the fact that she wants to leave the Home. When I questioned [Resident T] in front of Michelle – [Resident T] said maybe. She never really came clean.

4. It wasn't until later on that it came to light that Richard Muscat was actually mentally abusing her and others. On the occasions that he was on night duty he would get [Resident AA] to pick on [Resident T] and tease her and give her cuddle and give her a kiss and [Resident T] obviously was feeling uncomfortable as she didn't want him to do this. He used to tease [Resident AA] and as [Resident AA] already knew Richard's manners all Richard had to do was look at [Resident AA] and use his eyes for him to go to kiss [Resident T], hug [Resident T] and touch her leg, walk in her bedroom without knocking and [on] a couple of occasions caught her still in her underwear as she was changing.

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

6. Another time [Resident T] said to me that she was trying on some clothes that she had bought, and Angelica was in the room with her and all of a sudden [Resident AA] burst in and [Resident T] was in her underwear. Angelica turned around and said to [Resident AA] "Go away, [Resident T] is changing," and she slapped him across the face, and told him to get out.

7. I went into this and I spoke to Michelle about it and she told me she thought it has been dealt with but I told her that slapping somebody across the face is not the way to go about it. I told her I thought more security should be available and more care should be taken.

8. Another time [Resident T] complained to me that [Resident AA] had been bullying her and she had been complaining to the seniors and that nobody was doing anything about it. I went to tell them that I understood that [Resident AA's] disability is worse than [Resident T's] and mentally he is like a child. Instead of telling him off they laughed and they said that he was only joking, but it came to the stage where [Resident AA] was touching [Resident T] on the arm, the back and sometimes he would hit her, and instead of saying that [Resident AA] shouldn't be doing this, all they said was that he didn't mean it and just left it like that. What they did not tell me [was] that they were putting him up to it, and obviously [Resident AA] couldn't explain this to me because he doesn't use language either.

9. When I approached Michelle, on numerous occasions, and Angelica on this matter, they said that [Resident T] is taking everything out of proportion and that it didn't happen like that. Whenever I questioned or I went to see Michelle, [Resident T] was always present. I never spoke to them behind her back because I wanted [Resident T] to be there. And then [Resident T] went back on what she had said and obviously I thought at the time that [Resident T] was making it up because of the fact that she wanted to live with me.

10. Another time they went on holiday. They had a cruise holiday and because [Resident T] suffers from incontinence, she has no control and if she needs to go to the loo for a pee, she needs to go and that's it, and sometimes she has difficulty in walking long distances so obviously she needs a walking frame or a wheelchair to get about. On this occasion they had decided to get off the ship and have a walk around and [Resident T] had no means of support and she had to walk on her own. She was getting tired and said she needed to go to the loo and explained this to them and they told her "Come on [Resident T], we haven't got the time". Angelica and Michelle and a few others were on that cruise. I think Francis' brother was there as well, and also Michelle had her husband with her and nobody took any notice and they said [Resident T] is playing up. [Resident T] then said, that she felt tired and that her legs could not take any more, and she fell over. So they got annoyed with her, they grabbed her and took her back to the ship and left her in her room, on her own. This is what [Resident T] was telling me. From what [Resident T] said to me, I went down and told Michelle about it. She said "No no, don't take

this seriously, she over reacted on this thing. We never left her on her own." She had somebody there with her, workers from the ship who was looking after her. [Resident T] told her there wasn't. She turned to [Resident T] and said there was somebody there, and she named a person, I cannot remember the name, and they were looking in on her all the time, "Isn't that true?" And [Resident T] sort of gave in and said "Well yes, there was a woman there and she was looking after me." It was not until later that I realised that it was not true. It was a worker, a cleaner who just happened to be down there. So they left her on her own. [Resident T] was scared that facing up to them would mean repercussions later on, because, from what I can gather, [Resident T] later said to me that after I had left they would say to [her] "Don't talk to me because you have been a bad person," and they would send her to her room and nobody would speak to her, and every time they went past her they would ignore her. And if she asked for something they told her she would have to wait. She was punished for speaking up.

11. I know [Resident T] was punished on many occasions like when they used to go out on outings or go out for the day or the evening, she never used to want to go, which is unusual because she likes to get about, and when I asked they would say that she had come in late, that she was engrossed with the telly and that she didn't really want to come out. So obviously, not knowing what had happened I used [to] have a talk with her and say "[Resident T], what is wrong, you should get out, you should do your best the best medicine is to get out and enjoy yourself," and she said "Yea, no but I don't want to, I am quite happy to stay here". She never told me why it was she didn't go out.

12. All this had been happening prior to Joanna Hernandez going into [the Home]. [Resident T] seemed quite happy when Joanna Hernandez came in because she had somebody she could talk to. I asked her whether she had any problems and she said "Well no, just things in general," because she never actually came out in detail about things to me, but I know she was quite happy because she had somebody else to talk to, and I thought "Fine, that is good." She told me it was because in the Home you get used to the same people and you need to see new faces all the time.

13. It all came to light when Joanna Hernandez came in and the police was brought in and this was brought to my attention. Then, when I sat down with [Resident T] she came out with everything. So I asked her why she had not said anything before. She told me that she felt intimidated because of the fact that everybody who worked there was related to each other in one way or another either sister, brother, son-in-law, cousins and things like that so that if she complained about one of them the other one would cover up and say it was her imagination, and they would punish her in the sense of ignoring her and not wanting anything to do with her.

14. It went on for a while, obviously these people were interdicted and were off for about a year, and in that year I kept investigating and finding out what was happening, Joanna Hernandez was no longer there, and I rang a few people, but every time I went to the office there was a new person put in the post and I was speaking to all these different people, who, when I spoke to them said they did not know much about the case, they would have to find out and they would have to get back to me. It went on for ever and ever. I cannot remember everyone I spoke to but I spoke to Marie Gomez and she said there was no more news but she would let me know as soon as any development came along, and the other lady was ..... I cannot remember now. I spoke to Sharon Berini once, but other times I went to speak to her she was unavailable. She didn't really take anything up, no more than Michelle did. I did speak to five or six different people and all I kept getting was that they were new in the post that they had heard about it but that obviously they couldn't help me because it was private information that they could not divulge.

15. I kept investigating and they kept pushing me on to different people and they said that the records or the statements to the police and all the details were private and they could not divulge to me because it had to go through the proper procedure. I told them that I was her sister and I wanted to know what had been happening. I told them it wasn't as if she has been a naughty girl and she has been sent away. I said this is a serious matter. [Resident T] has been mentally and sexually abused – I said I was quite concerned about it. She has been left traumatised in the fact that she feels intimidated that these people, although they have been suspended, could be taken on at any time, and the fact that they would [be] taken on to Flat 1 would make no difference because the floor to Flat 1 is next to her bedroom. They told me that if they were taken back on

there would be somebody working with them, which I said made no difference because if one of them is taken ill, and one of the carers has to take them to hospital that leaves that person on their own, and maybe they would not physically abuse [Resident T] but they could easily mentally abuse her when there is nobody around. I said I could not take that chance. I said I wanted to know what was going on and what had been happening and they said they could not divulge and they wouldn't discuss anything with me. Eventually I spoke to the man who is in charge now [i.e. in September 2006], [Iain McNeil], and he was taken in new, and again I asked him if he knew what was going on. He told me he could not say anything because it was not his position or his job.... [She went on to say that she had consulted lawyers, Charles Gomez & Co, and that she had told them that she did not want Richard Muscat, Angelica Williams or Michelle Garro to continue working in the Home. She continued:] Eventually they were inducted and Richard did not like the idea and he moved out. Angelica handed in her notice, and Michelle went to the induction and got the job and now she is off sick.

16. I spoke to [Iain] and told him that I needed answers because I keep going and trying to find out information about [Resident T's] case and nobody has helped me. ....

17. In the Social Services I have been calling all these numbers that have been given to me and nobody is helping me. They are all passing the buck. I have spoken to Marie Gomez and so many other people, but every time there is somebody new in the post.

18. [Iain] told me he understood the situation and he sympathised but he really could not do anything for me because he said his hands were tied. .... [She went on to refer to Richard Muscat in the following terms:] Knowing the history of this Richard, how on earth could they employ somebody with a background like that. He is a drug user, selling drugs, taking drugs and it has also been known that he has been taking drugs from the [Home] for his own personal use. ....

19. ....

20. When Sharon came on the scene, and she took over, we made arrangements to speak to her on various occasions about complaints of what was happening in the [Home]. At first [Resident T] thought that Sharon was very nice because she appeared to be nice and sympathetic and listened to [Resident T] and advise[d] [Resident T]. And [Resident T] complained about things that were going on in the [Home], and Sharon told her that she would deal with it and that she was not to worry. But [Resident T] said nothing was ever done, nothing was ever stopped. She complained about Richard and about Michelle but things carried on the same. The team, Angelica, Michelle, Yvette [Borastero] and Richard, was always there."

In her oral evidence, Moira Elmer said that she usually visits Resident T about once a week, and that she has done so ever since Resident T became resident at the Home[1026].

She confirmed that she had never herself witnessed any incidents of bullying or abuse in relation to Resident T[1027], and that her evidence was based on what Resident T had told her[1028].

She said that when she complained to Michelle Garro, she was told that Resident T was "over-reacting", and that the reason why Resident T was "making up these stories" was because she wanted to live with her[1029]. She went on[1030]:

[1026] See Day 6 page 9 line 7ff.
[1027] See Day 6 page 12 line 24.
[1028] See Day 6 page 13 line 2.
[1029] See Day 6 page 15 lines 2-6.
[1030] See Day 6 page 16 line 18ff.

> "So I had assumed at the time that my sister was probably just trying to make excuses so that she could come and move back in with me. It wasn't until later on that it kept on persisting, then I realised that something was going on."

Later in her oral evidence, she said this[1031]:

> "I understand that my sister sometimes can be ... hard work, and she has ways, but obviously you have got to know how to react, and sometimes she might want to be excused to go to the loo. Because of her dystrophy she can't control herself, and sometimes she can become persistent that she needs to go and a lot of the time they said: "You can wait, you can wait." ... So of course ... she was ignored and left in the room a lot of the times. .... She might not want to go out with the rest of the residents, and she was made to go out. .... They had no patience for her to ... move at their own pace... She said they used to grab hold of her arm and pull her along, and a lot of times because of the balance she will fall over, and they say to her: "Oh, you are making it up." And they used to drag her up again and shout at her to move, and to get around."

She said that she had never spoken to either Isabella Tosso or Marie Gomez about her concerns with regard to Resident T[1032].

Counsel to the Inquiry put to her Charles Gomez & Co's letter dated 26 June 2006 (referred to earlier [**F/18/13**]) and asked her whether she was informed of the details of the "protection plan" referred to in that letter. Moira Elmer replied that she did try to inquire, through her lawyer. She went on[1033]:

> "He said that they wasn't getting a lot of information from the social care, they were keeping it a bit hush-hush, and as soon as he found out anything he would let me know. But obviously in the social care they weren't willing to open up to many things. They were doing their own investigation."

She said that she did not recall speaking to anyone in the SSA about the protection plan; and that she left it all in the hands of her lawyer[1034].

Asked by counsel to the Inquiry whether she was aware that the SSA had taken precautions to keep the three care workers, when they were reinstated, away from Resident T, she said that one of them had gone back to work in Flat 2, but that, when she had expressed concern about that, the care worker in question had been moved; and that the other two care workers did not return to the flat[1035].

She went on to say that no further incidents had occurred since 2006[1036].

Asked about the care currently being provided to Resident T[1037], she replied[1038]:

[1031] See Day 6 page 18 line 12ff.
[1032] See Day 6 page 22 line 24ff.
[1033] See Day 6 page 25 line 1ff.
[1034] See Day 6 page 25 line 16ff.
[1035] See Day 6 page 26 line 9ff.
[1036] See Day 6 page 27 line 1.
[1037] i.e. in October 2013.
[1038] See Day 6 page 27 line 4.

> "Fine. She is happy. They take her out, she needs to go – leave the facilities ... They are attentive. Mind you, her disability now is worse, but they are on top of her all the time. She is very happy."

Asked whether she considered that the level of care being given to Resident T was different to what it was, she replied that she found it to be "more professional"[1039].

Asked how she found the current managers of the Home, she replied[1040]:

> "Very helpful, very. ... I get informed of everything that is going on. If I've got a question I'll go and ask and it's dealt with straightaway. They ring me back ... if they don't know the answer ... and they keep me informed [of] everything that is happening."

Later in the course of her oral evidence, counsel for Yvette Borastero, Angelica Williams and Michelle Garro put it to her that when Resident T was first admitted as a resident, she (Moira Elmer) had informed Rose Seruya that Resident T had nearly caused the breakdown of her marriage[1041]. Moira Elmer agreed. She went on[1042]:

> "She accused [my husband] of wanting to kiss her, because she wanted me to fall out with him, because she wanted just me for herself."

She agreed with counsel that on that occasion Resident T had lied about sexual advances by her husband[1043].

As to Moira Elmer's evidence about what Resident T had told her about the way she was treated by carers, including Angelica Williams, on the holiday cruise (see paragraph 10 of Moira Elmer's witness statement quoted above), counsel put it to her that Angelica Williams did not go on that cruise. Moira Elmer replied that Resident T could be forgetful and nervous, and "she could have just mentioned the name"[1044]. When counsel put it to her that Resident T was not always truthful, she replied[1045]:

> "No, but none of us are always really truthful, but I know when she is lying and I know when she is telling the truth."

She went on to confirm once again that the entirety of her evidence in relation to the treatment of Resident T was based on what Resident T had told her.

I turn next to the evidence of Richard Muscat.

[1039] See Day 6 page 27 line 11.
[1040] See Day 6 page 27 line 13ff.
[1041] See Day 6 page 29 line 22ff.
[1042] See Day 6 page 30 lines 13-15.
[1043] See Day 6 page 31 line 7ff.
[1044] See Day 6 page 34 line 10.
[1045] See Day 6 page 34 lines 19-21.

Richard Muscat worked as a carer at the Home for some thirteen years[1046] until he left in mid-2006. As noted earlier, most of his time at the Home was spent working with Resident AE. He made a witness statement in the Inquiry [**E/60/1**], and he gave oral evidence.

In his witness statement, he says this [**E/60/2-3**]:

> "I have examined the various witness statements and reports which I have been presented with by the [Inquiry]. In some of these documents I have been accused of being an instigator of sexual acts between service users at the Home, ... and of being a drug addict and dealer. These allegations ... are not true and are unfounded. I firmly deny any wrong doing during my time as an employee of the Home.
>
> It is worth pointing out from the outset that during [the period from] 2003 [to] 2005[1047] I only worked in Flat two, which is where the alleged wrong doing took place, for a limited amount of time. During the majority of those three years I instead worked [night] shifts in respite and most of my time at work was spent in a single flat with a single service user, namely [Resident AE] in his flat ...
>
> [Resident T] was the last resident to join the [Home] during the time I worked there. She was never happy there and wanted to live with her sister, Moira Elmer. Her sister, who was her nearest relative, hardly visited her during my time there. [Resident T] didn't get on well with some service users especially [Resident AA] and [another resident]. Without being instigated by anyone, these two residents would always approach [Resident T], as well as any other person to greet, welcome, hug or talk. This behaviour was within their nature, within their own learning difficulties. [Resident T] used to on most occasions ignore them and at times be rude towards them, when crossing each other in the house. [Resident J] would at times sit in the room with [Resident T], [Resident AA] on these occasions used to want to join them and used to go into her room. On most occasions he was shouted at by [Resident T]. [Resident AA] didn't really understand he wasn't welcome. On some occasions [Resident T] and [Resident AA] hit each other after the whole situation had escalated. She used to complain constantly about her care plans making it difficult at times for staff to work with her and others around her. You could easily have a conversation with her and fewer were the times that it wasn't a happy one. She used to complain about how she would be treated at [St Bernadette's]. She used to complain and argue that she wasn't a little girl to have to go to school and complained about not enjoying a lot of the things she did there.
>
> [Resident AA] was a very friendly outgoing person who liked to laugh and joke with everybody. He was a much valued person within the [Home] environment, at times he claimed to be a staff member. Although he is a mature adult in age he does not act like one. By way of example, he used to sit staff down at times and used to pretend that he was the captain of the thunderbirds flying us all away into space. Due to his mental ability he has certain persistent traits that can be very annoying. For instance he repeats himself often whilst standing beside you. He is also very easily led and can be persuaded easily to change his mind.
>
> During my time at the Home I observed that [Resident T] had a lot of arguments with [Resident AA], they used to live in the same flat and their rooms were side by side. At times, [Resident AA] used to walk straight into [Resident T's] bedroom if she was there. This used to make [Resident T] very angry. [Resident T] had little patience for [Resident AA] as he never talked sense to her. Their disabilities were very different and did not go hand in hand with each other. [Resident AA] had to be prompted continually on some tasks he had to be aware of changing with an open door, had to always be encouraged to fold away his clothes and also about his personal hygiene. Although these were areas that he needed to improve, he was really slow in

[1046] In his witness statement he said that he worked at the Home for "over 9 years", but he corrected this in his oral evidence: see Day 11 page 80 line 19.

[1047] In his witness statement, he says "during 2003 and 2005"; but it is clear from his subsequent reference to "the majority of those three years" that he is referring to the period from 2003 to 2005.

> the process. Instead of folding his clothes he used to bundle and [roll] them up. He was very slow in learning. He had little concentration."

Later in his witness statement he turns to the witness statement of Moira Elmer (reviewed above).

As to paragraph 4 of Moira Elmer's witness statement, he says this [**E/60/4**]:

> "…. I totally deny these allegations made against me. [Resident AA], on most occasions needed to be told to do things twice. As a result no look whatsoever from me would be able to make him do any of [the things he is alleged to have done]. Moira mentions that I worked on night shifts when this happened. I would like to make clear that I never did a night shift in Flat 2 as only women did the night shifts due to the needs of female residents."

As to paragraph 5 of Moira Elmer's witness statement, he says this [**E/60/4**]:

> "Moira does not mention me directly but it can be implied that I am included in the word "they". She claims that [Resident AA] was told by these persons to lie on top of [Resident J] whilst she was getting ready to go to bed and claims this was done in a sexual manner and [Resident J] would be screaming. I totally deny being part of this if this in fact occurred. …. I never worked night shifts in flat 2 and could not therefore have been present."

Richard Muscat also denies all the allegations made by Moira Elmer in paragraph 15 of her witness statement. He suggests that if Moira Elmer really believed that he was guilty of abusing her sister as alleged, "it seems absurd that she would not want me dismissed from my job", rather than be given "an alternative one within the organisation" [**E/60/5**]. He goes on [**E/60/5**]:

> "... Moira says that when the interdicted employees came back that I left as I did not like the idea of being inducted (*sic*) by which I assume she means interdicted. Whilst I did not appreciate being interdicted having been accused of things which I have always denied, I totally deny that this is the reason for me leaving the [Home] after my interdiction. The reality is that after the interdiction, and as a result of it and my perceived unfairness about what had happened, I had lost enthusiasm for the job that I once loved. I no longer wanted to be part of an organisation in which I saw a lot of flaws. I decided to move on consequently."

As to the allegation in paragraph 18 of Moira Elmer's witness statement that he was a drug user and dealer and that he took drugs from the Home for recreational use, Richard Muscat says this in his witness statement [**E/60/5**]:

> "I totally deny these allegations which are again completely unfounded. I have never been a drug user and I have never been a drug dealer or ever stolen drugs. At the time I was undertaking a large amount of training. Further, I had been Gibraltar's road racing champion for 10 consecutive years and have represented Gibraltar more than a dozen times in athletics, triathlon, rowing and hockey at high levels. I was an active sportsman at the time of the allegations and the use of recreational drugs would have severely hampered my training and affected my performance. I simply did not take drugs."

As to paragraph 20 of Moira Elmer's witness statement, he says this [**E/60/5-6**]:

> "Moira states that [Resident T] complained to Sharon Berini about me. Sharon took over management of flat 2 once Michelle was interdicted. Please note that by that time I do not believe that I was working at the Home as I was interdicted at the same time as Michelle. Furthermore, if she complained to Sharon about me during that time, there must be a report about the complaints. In all the time I was working at the [Home] I do not recall ever seeing [Resident T's] sister visiting. I was never informed of any such complaint. I only saw Sharon[1048] [sic] a few times when [Resident T] arrived at the [Home] for the first time. She never visited her sister, unlike other families."

Richard Muscat then turns to Giselle Carreras' psychological reports [**E/60/6**].

At the outset, he denies that he ever told Resident AA to lie on top of Resident J, or that he ever encouraged him to do so. As to Resident T's description of incidents which occurred during the holiday cruise to Barcelona, he points out that he did not go on this trip [**E/60/7**]. He denies Resident T's allegations that he encouraged Resident AA to touch Resident T's genital area, or that he talked rudely to her about Resident AA's penis. He goes on [**E/60/7**]:

> "I never encouraged [Resident AA] to [make] any advances of a sexual or any nature to either [Resident T] or [Resident J], [nor] did I suggest to her that [Resident AA] would be good for her or [Resident J] in a sexual manner."

He goes on to deny that he and Angelica Williams used to pull down Resident AA's trousers and slap him across the face. He notes that, as recorded in the psychological reports, Resident AA had a propensity for lowering his trousers of his own accord. He also points out that during the time he was working in the Home he heard nothing of any such allegations. He goes on [**E/60/7**]:

> "Throughout my time working at the home I always had a very good relationship with [Resident AA]. As mentioned above, [Resident AA] was very valued in the home ... [N]ot once was there an occasion when [Resident AA] was uncomfortable in my, or the other carers' presence. He certainly was not scared of being in our presence and I am shocked that he would say this during his assessment. It is completely out of character in my mind and does not accurately reflect the good and caring relationship I had with [Resident AA]. We used to go out shopping for his clothes, for coffees in town whereby he had great fun; we even watched thunderbird [v]ideos on occasions. My role there at the home was so that [Resident AA] had a male carer he could relate to ..."

As to the references to Visitor X in Giselle Carreras' report dated 7 March 2005, Richard Muscat says that he has no recollection either of her or of the incidents in question [**E/60/8**]. He repeats his denial that he ever instructed or encouraged [Resident AA] to behave in the manner described in Giselle Carreras' reports. He says that had he been present when [Resident AA] had behaved in such a manner he would have reprimanded him.

As to his interview at the police station, he confirms that he was advised by his lawyer to make no comment on any questions asked of him. He says that he now regrets following that advice.

In the penultimate paragraph of his witness statement [**E/60/9**], he says this:

[1048] It appears that he is intending to refer to Moira Elmer, rather than to Sharon Berini.

> "I reiterate that the accusations made against me are unfounded and baseless. I have never done any of the various things which it is alleged I did do as an employee of the Home. I deny them in their entirety."

In the course of his oral evidence, he said this with reference to the allegations made by Resident T[1049]:

> "Well, I must say that since the very beginning when we were interdicted, I think the Manager at the time was Ms Hernandez, I never spoke to Ms Hernandez in my life. Actually I was doing night shifts in another place [from] where the whole thing apparently took place. .... Never did I speak to any social workers, never did I speak to any psychologist who actually made the report. So it's OK to be accused of doing something, but we felt very victimised ourselves."

Asked by counsel to the Inquiry about the letter dated 3 January 2006 [**M28/1/55**] offering reinstatement on certain conditions, he replied[1050]:

> "Well, for us it was in the sense agreed because it was good that we could go back, [but] for me it was a no go from the word – from the letter that I wasn't going back to work. .... I felt unsafe and obviously a job which I have loved for all my life had to be destroyed by something which was untrue. .... I think I left the same day that I went to the Home. .... I felt totally ... traumatised by the whole situation. You know, it was terrible for us. .... To be honest, I don't even remember reading this letter .... What I do remember is that obviously it was good that I was back and everything was acquitted in a way, and it was a stepping stone for me in a way that I could actually carry on with my life."

He went on to say that on return to work they felt they needed some support from the professionals, which they never received[1051]. No inquiry had ever taken place, and he had had no opportunity to put his side of the story to anyone[1052]. He summed up this episode by saying[1053]:

> "We were accused of something we didn't do, and that was it."

As to the suggestion that the three of them should undergo a form of induction, which (he said) "they wanted to make us go through", he felt that that was "totally inappropriate" given that he and Angelica Williams had worked in the Home for some thirteen years, and he decided to leave "there and then"[1054]. He went on to qualify this evidence by explaining that he and Angelica Williams went to see Iain McNeil (the then Manager) on the day when the induction was planned to take place: i.e. 12 June 2006, and that it was on that day that they both left the Home[1055].

Later in his oral evidence, he described Resident AA as follows[1056]:

[1049] See Day 11 page 84 line 15ff.
[1050] See Day 11 page 86 line 8ff.
[1051] See Day 11 page 88 line 3.
[1052] See Day 11 page 88 line 11.
[1053] See Day 11 page 88 line 5.
[1054] See Day 11 page 88 line 24.
[1055] See Day 11 page 90 line 19ff.
[1056] See Day 11 page 94 line 17.

> "[A] very ... funny person. He likes to make people laugh. Very outgoing, but ... can be very repetitive at times. And can molest people, if I can put it that way, because of his disability, maybe."

He went on to describe his relationship with Resident T and with the other residents at the Home as follows[1057]:

> "I can say that I got on well with her as well, but obviously she was not a very happy individual. .... She didn't want to be at the Home, she wanted to be with her sister. .... My relationship with all of the residents at the Home was quite a good one. I never had any problems with any of them."

I turn next to the evidence of Angelica Williams. She made a witness statement in the Inquiry [**E/66/1**], and she gave oral evidence.

In paragraphs 9 to 18 of her witness statement [**E/66/2-3**], she has this to say about Resident T's statements in interview with the police:

> "9. [As to Resident T's allegations that Richard Muscat and Angelica Williams encouraged Resident AA to make sexual approaches towards her:] The allegations ... are not true. Neither is the allegation afterwards that I told [Resident T] to be quiet. This incident never happened and I have never been in a situation like that. That entire scenario has been fabricated by [Resident T].
>
> 10. [As to Resident T's allegation that Resident AA used to hit her:] I have never seen [Resident AA] hit anyone since I have been working at the Home. If [Resident T] says that [Resident AA] has hit her in front [of] me, she has certainly never reported it.
>
> 11. [As to Resident T's allegation that Richard Muscat and Angelica Williams used to send Resident AA to beat her:] There has never been a point in time when I have worked only with Richard alone. Other people were always there as well and they would have seen and reported this alleged incident had it actually taken place.
>
> 12. [As to Resident T's allegations that Resident AA does what Richard Muscat and Angelica Williams tell him to do:] These allegations are completely untrue. [Resident AA's] lifestyle is centred around looking at the television show "Thunderbirds". That is all he does. He has certainly never been influenced by Richard or by me in any way and certainly not to act in any particular manner.
>
> 13. [As to Resident T's allegations concerning Visitor X:] [Resident T] has a friend, [Visitor X], a girl from downstairs [i.e. from St Bernadette's] who was employed elsewhere and used to go to St Bernadette's with [Resident T]. [Visitor X] used to bring a Shakira compilation tape with her and I remember that she used to come most afternoons and [Resident T] and her used to enjoy spending time together listening to that music. I would carry out my duties around the Home and I would see them listening to Shakira's songs, but I never encouraged them to dance and I certainly never laughed at them.
>
> 14. [As to Resident T's allegations concerning Resident J:] [Resident T's] allegations are not true. I would never have locked [Resident J] in a room nor encouraged her to dance. [Resident J] does whatever she wants to do as that is in her nature.
>
> 15. It appears to me as if [Resident T] is being coached to use the words she is using almost as though Giselle is egging her on. I have known and worked alongside [Resident T] for many years and these words do not seem like the kind of words [Resident T] would use, at least not the

[1057] See Day 11 page 95 line 1.

[Resident T] I know. Besides, if she is as well and as articulate as everyone says she is, then why does she need someone to help her with the interview?

16. [As to Resident T's reiteration of her allegations that Angelica told Resident AA to make advances of a sexual nature towards her and that Resident T should keep quiet:] Except for the fact that I was her designated Key Worker (i.e. the one who primarily looked after her and took her to the shops and other places whenever necessary), the allegations ... are untrue.

17. .... I have never worked with just Richard and there was always another person present. This may have been Rose Seruya, Kirsten Crawford or Jane Martinez. There was always an extra person as no two people would work a shift by themselves. Otherwise, if it was just Richard and myself, the situation would be very awkward as I would have to take care of all the female Service Users on my own and Richard would take care of the only male Service User, i.e. [Resident AA]."

18. .... I cannot understand how she can say that I worked on my own when there was always a third Support Worker present."

Turning to Giselle Carreras report dated 7 March 2005 (reviewed earlier), Angelica Williams says this (in paragraphs 20 to 28 of her witness statement [**E/66/3-4**]):

"20. [Visitor X] is the one who used to come with the Shakira cassette tape and wanted to dance in the Home. I have never told [Resident T] to dance with [Visitor X] or with [Resident AA]. In any event, [Resident AA] would not dance with anyone as those kinds of social interactions are taboo for him.

21. I do not understand why both [Visitor X] and [Resident T] have made these allegations about me and they are simply not true. I have never encouraged [Visitor X] to dance with [Resident AA] and I have never tried to get her to kiss him either. Besides, if the shocking allegations made by [Visitor X] are true, then one has to wonder why it is that [Visitor X] would visit Flat 2 almost every single day. Surely if we were doing all those things, the sensible thing to have done would have been to stay away but this was not the case.

22. ....

23. I do not make fun of people. If I do laugh when I am around Service Users it is because I am laughing with them, rather than at them or at the things they do. I would not be in my profession if I was the kind of person who would laugh at the expense of Service Users. My job at the Home was more of a vocation than a career and one has to be passionate about working there and helping others. This job is certainly not about monetary gain or selfish motives. I strongly reject these allegations as offensive and totally untrue.

24. None of the doors in Flat 2 have locks and I do not ever recall [Resident AA] opening a door while [Resident T] was changing.

25. I am assuming "Gerica" refers to me. I would never slap anyone as I do not believe in hitting anyone. I have never even slapped my own children, and I would never slap any Service User either as I consider them to be childlike themselves. I believe in responsibly disciplining individuals if necessary, but I would never slap anybody. This allegation is an outright lie.

26. There is only one bathroom which has a bathtub in Flat 2 of the Home, and that is specifically [Resident AA's] bathroom. [Resident T] would therefore always have a shower in the shower-room and there are no glass doors, just regular doors.

27. .... Service Users are simply not allowed to have keys and the keys are put on top of the architrave. Whilst we were not allowed to leave any keys in their locks, it is important to note that the bathrooms do not have keys in order to allow the Support Workers to enter freely in the event of an emergency or for any other genuine reason.

28. No one in Flat 2 of the Home would have burst into the bathroom in question. [Resident T] was typically the last person to have a shower in Flat 2 on any given day, but nobody would ever enter while she was doing so. The only ones allowed to enter were Support Workers and only to assist her if she fell, even though I do not remember a time when this ever happened."

Turning to Giselle Carreras' Evaluation, she says this (in paragraphs 35 to 42 of her witness statement [**E/66/5-6**]):

"[Resident J]

34. The allegations contained in [Resident J's] interview are denied. I would never condone or encourage such behaviour. I have known Richard since I was 4 years old and I do not believe that he would ever do something of this nature either.

35. I do not understand why [Resident J] has made these allegations. All I can offer by way of explanation is that [Resident J] has a cousin in Spain, and she has explained to me and other Support Workers that she has been sexually abused by him in the past.

[Resident T]

36. [Resident T] simply cannot be scared of me. If so, then in September 2004, before I was interdicted and after all these alleged incidents reportedly took place, why did [Resident T] specifically ask that I accompany her on holiday. In fact, she was insistent on it. If I was that bad to her and she was that scared of me, why would she insist on something like this?

37. I returned to work on 12th June 2006 and the morning that I returned, I stood in the foyer of the building for a short while and then made the decision not to return to work as the experience had been a painful one, particularly as [SSA] staff had threatened to walk out if Richard, Michelle and myself were reinstated. What I fail to understand is how this report, which is dated February 2006, refers to a decision to reinstate me and my other interdicted colleagues, when we ourselves were kept in the dark about their decision until late May 2006.

38. [As to Resident T's allegations that Angelica Williams told Resident AA to make advances of a sexual nature towards her:] I strongly deny the allegations ... I do not know why she has fabricated these allegations. I have never done anything like that or told [Resident AA] to do anything like that either. It simply did not happen and [Resident T] is lying.

39. [As to Resident T's allegations concerning a trip to the beach:] [We] used to go to a beach in Spain which had facilities which catered for special needs of the Service Users (e.g. a gentle slope to the shore, nearby showers, etc). [Resident T] always required the use of a walker which she used on the wooden platforms and we were right beside the showers. I never scolded her nor grabbed her [in] the manner she describes.

40. I did not go to the beach on the same occasions as Yvette as we did not share the same shift.

[Resident AA]

41. I do not understand how [Resident AA] has come up with these false allegations. In fact, I have known [Resident AA] for many years and I do not believe that these are [Resident AA's] own words as this is not his way of speaking. Once again I make the allegation that [Resident AA] is being encouraged or even forced by others to use these words as they are not part of his vocabulary.

42. [Resident AA] hardly ever spoke to [Resident T]. Whenever Richard was there, he would take [Resident AA] out of the Home and spend time with him. These events certainly never happened. Anything involving women is a taboo for [Resident AA] and ... has been ... ever since I have known him as a young child."

Turning to the evidence of Moira Elmer, Angelica Williams says this (in paragraphs 44 to 46 of her witness statement [**E/66/7**]):

> "44. I know that when [Resident T] first arrived at the Home, her sister Moira made it a point of telling everyone that when [Resident T] had previously lived with her, she had had lots of problems with [Resident T]. Moira had to hide because [Resident T] used to say that Moira's husband used to look at her inappropriately. Moira accused [Resident T] of being a compulsive liar.
>
> 45. It is not true that Moira spoke to me. Moira never once spoke to me in all the time that I worked at the Home.
>
> 46. [As to the allegations in paragraph 10 of Moira Elmer's 2006 witness statement regarding Resident T's treatment on the holiday cruise (quoted earlier):] The allegations against me in this paragraph are an outright lie as I never went on that cruise."

In the course of her oral evidence, Angelica Williams said that she used to get on very well with Resident T. She referred once again to the fact that in September 2004 Resident T had asked that she accompany her on holiday, saying this[1058]:

> "She could have gone on holiday with the other group, because there were two groups, but she said she wanted to go on holiday with her key worker, and share the room with her key worker, which was me."

She went on to repeat the denials which she had expressed in her witness statement[1059].

She said that Resident AA and Resident T did not get on very well with each other; and that while he was a "lively person", she was not[1060]. She said that they argued sometimes, but that she had never seen Resident AA touch or assault Resident T[1061], nor had she ever seen him burst into Resident T's room[1062]. She said that he could have gone into her room, although not when she was present[1063]. Asked whether the doors to the residents' bedrooms were locked, she replied[1064]:

> "Their rooms were not locked. .... They couldn't be locked. .... The keys were at the very top [of the door]. .... We couldn't have the residents locked inside their room, or they couldn't have their keys and be all day with their keys. .... Really the only one who could have asked [for her key] would have been [Resident T]: "I want to lock my room." But they didn't have their keys."

She went on to explain that the regime in relation to keys was a matter of policy based on the capacity of the residents[1065]; and that she was not talking of residents locking themselves in, but

[1058] See Day 8 page 190 line 16ff.
[1059] See Day 8 page 193 line 1ff.
[1060] See Day 8 page 194 line 21.
[1061] See Day 8 page 195 line 22.
[1062] See Day 8 page 195 line 24.
[1063] See Day 8 page 196 line 1ff.
[1064] See Day 8 page 197 line 8ff.
[1065] See Day 8 page 197 line 24ff.

rather of residents wishing to lock their rooms when they went out – but she said that no resident ever asked for that[1066].

As to Resident T's allegation that Resident AA burst into her room when she was changing and that Angelica Williams slapped him across the face, Angelica Williams said this[1067]:

> "First of all, when ... [Resident T] was changing, I wouldn't have been in the room. .... I would have only gone into the room if she would have wanted assistance, but I would never have gone into the room and hit Resident AA. No. .... I have never slapped any resident in the time I have worked in the [Home]. .... I don't even slap my own children, let alone ... slap a resident."

As to her encounters with Moira Elmer, she said that she had seen her in the Home once or twice, but had never really had a conversation with her[1068].
She said that until her police interview she was not aware of Resident T's allegations, or that such allegations had been made at Council Group Meetings; and that no such meetings had taken place in Flat 2[1069].

As to her resignation, she said this[1070]:

> "I was reinstated .... and I had to go back for ... an induction. I remember that day. I went into the part which was respite for my induction, and I was standing there in the corridor, and I was there for about three-quarters of an hour to an hour. Everybody was passing, and I was standing there, myself, Richard and Michelle, the three of us that were interdicted, and people used to walk up and down, and I made the decision. I said to Michelle: "I'm leaving. I'm going to resign". .... I had no problems with going back for an induction, but to be standing there, not even in a room. I was standing there in a corridor. I felt: what am I doing here?"

I turn next to the evidence of Michelle Garro.

Commenting on the transcript of Resident T's police interview, Michelle Garro says this (in paragraph 13 of her witness statement [**E/16/2**]):

> "[Resident T] was generally unhappy about most things as she never wanted to live in the Home in the first place. She made it clear from the outset that she wanted to live with her sister, Moira Elmer ... I therefore believe that all of these allegations are all lies she has created in an effort to try and have herself removed from the Home."

As to Resident T's allegations that Resident AA hit her, Michelle Garro says (in paragraph 14 of her witness statement [**E/16/2-3**]) that it was "simply not in [Resident AA's] nature" to hit Resident T.

As to Resident T's allegations concerning Resident J, Michelle Garro says (in paragraph 16 of her witness statement [**E/16/3**]) that no such incident was ever reported to her. She continues:

[1066] See Day 8 page 199 line 2.
[1067] See Day 8 page 200 line 9ff.
[1068] See Day 8 page 202 line 25.
[1069] See Day 8 page 206 line 6ff.
[1070] See Day 8 page 208 line 9ff.

> ".... I can understand how [Resident AA] could be perceived as being annoying at times by [Resident T] given that [Resident AA] tends to ask a lot of questions which I imagine would have irritated her."

As to Resident T's allegation that Resident AA lay on top of Resident J, Michelle Garro says this (in paragraphs 18 and 19 of her witness statement [**E/16/3**]):

> "18. I do not know anything about [Resident AA] having ever been on top of [Resident J] or any other girl within the Home in the manner in which [Resident T] describes. In any event, these incidents simply could not have happened without other workers in Flat 2 finding out. In addition to myself, there were ten to twelve Support Workers assigned to Flat 2 at any given period since I was employed there....
>
> 19. Flat 2 was always known to have a pleasant atmosphere in which Support Workers always interacted with each other harmoniously and in which we never had a problem with cover. As far as I was aware, [Resident AA] was not scared of any members of staff at the Home."

As to Resident T's allegation that Resident AA used to hug her, Michelle Garro says this (in paragraphs 20 and 21 of her witness statement [**E/16/3**]):

> "20. [Resident AA] would hug people and we used to ask him to either not hug them or to be more gentle with his hugs depending on the reaction of the person being hugged. I do not know if he used to hug [Resident T] at the time as she used to spend most of her time in her room.
>
> 21. [Resident AA] and [Resident T] used to have the odd argument mostly arising out of [Resident T's] dislike of [Resident AA's] behaviour towards her, but never about anything serious."

Commenting on the remainder of the transcript of Resident T's police interview, Michelle Garro says this (in paragraphs 22 to 36 of her witness statement [**E/16/3-5**]):

> "22. I am not aware that [Resident AA] has ever hit anyone in his life, and as far as I am aware, there are no incidents recorded in the Report Books at the Home in which he has hit anyone. [Resident T] may well have complained about [Resident AA's] behaviour, but there are no recorded complaints of hers to the effect that he actually hit her.
>
> .....
>
> 23. ... [I]t is likely that [Resident T] did argue with [Resident AA]. There were six adult Service Users who all lived together in Flat 2 and the odd argument was bound to ensue, but never anything serious.
>
> ....
>
> 24. Angelica never did night shifts and so there must have been other Support Workers attending to [Resident AA] during these alleged incidents as described by [Resident T], and which again I find hard to believe.
>
> ....
>
> 25. [Resident T] never made any reports to the Senior. In any event, I do not believe that these allegations are true.
>
> ....

26. [Visitor X] was a girl who used to attend St Bernadette's. She liked Shakira and brought a tape with her music, which she used to dance to. This does not mean we were laughing at her or the other Service Users who were enjoying the music, we were laughing with them. If [Visitor X] did not enjoy it, she would not have kept returning to the Home to play the music and dance along to it. We certainly would not have stopped her from doing so.

....

27. [Visitor X] would not have danced with [Resident AA] as she always danced on her own. Expressing any kind of sexual interest in women was a taboo to [Resident AA]. Whereas he did have a tendency to hug all those around him, including myself and other female Support Workers, I do not believe that he would have been comfortable with the idea of dancing with anyone in the manner in which [Resident T] describes.

....

28. It is true that Support Workers would only suggest that [Resident T] share things with other Service Users so that she would not be alone in her room by herself. She was never forced in the way she describes and she was never made to share her room with anyone.

....

29. As far as I am aware, [Resident T] never fell on the floor. [Resident T] had a walker, and with it she was able to move around without any significant issue. We understood that her sister Moira was in fact fed up of [Resident T's] habitual lying and the strain it was placing on her relationship with her own husband, and that is why Moira no longer wanted [Resident T] to live with her.

....

30. [Resident T] never reported to me that [Resident AA] touched her inappropriately. The only thing she reported to me was that he once hit her. And yet, I have worked in the Home for over 9 years, and I do not recall any actual fights having ever taken place between [Resident AA] and [Resident T], just verbal arguments. Besides, any physical fights that took place in the Home would have been recorded in a report.

....

31. [Moira] never spoke to me about these alleged incidents. We did contact Moira on occasion for miscellaneous matters in relation to [Resident T's] treatment, but never about these alleged incidents.

....

32. Manolita [Adamberry] would certainly have told [Resident T] to put her clothes away. Service Users are encouraged to do certain chores as these are designed to motivate them as long as it is within their capacity to do so.

....

33. It appears that [Resident T] complains about everybody and everything. In any case, the clothes matter was certainly not reported by [Resident T] either so it could not have been that serious.

....

34. The only bath in Flat 2 was used by [Resident AA]. [Resident T] would therefore never have had a bath and she always used the showers – [Resident T's] account of what happened is therefore factually impossible.

> 35. [Resident AA] would never have made an effort to kiss [Resident T] in the manner in which she describes as it is not in his nature.
>
> ....
>
> 36. [Resident T] was always in her bedroom at night and when she returned from the Day Centre, she did not integrate or share with any other Service Users."

Commenting on Giselle Carreras' Psychological Report dated 7 March 2005, Michelle Garro says this (in paragraphs 37 to 39 of her witness statement [**E/16/5-6**]):

> "37. Employees at the Home had reason to believe that [Resident T] was a compulsive liar based on what her sister Moira had previously told us. Notwithstanding that, I would have always told the Manager about [Resident T's] allegations had she shared them with me, even if I personally did not believe them.
>
> 38. Furthermore, if [Resident T] had been making these allegations at the time, I do not believe that her sister Moira would have decided to abandon the matter, regardless of whether or not she personally believed her sister. I believe that she would have taken the matter forward.
>
> 39. [Resident T] had an incident book of her own, and she could have used this to keep a record of these allegations had they actually taken place. [Resident T's] sister Moira has explained to me and other Service Workers in the past that [Resident T] is a habitual liar who has lied about incidents which allegedly took place whilst she was living with her."

Commenting on Giselle Carreras' Evaluation dated 22 February 2006, Michelle Garro says this (in paragraphs 47 to 58 of her witness statement [**E/16/7-8**]):

> "47. .... Sex is taboo for [Resident AA]. The only female person he looks at in that manner is the character "Penelope" from the television show "Thunderbirds". Knowing [Resident AA] as I do, I do not think that he would have behaved in the manner [Resident J] describes ...
>
> ....
>
> 48. [As to the holiday in Barcelona:] [Resident T's] allegations are taken out of context and are not true in certain places or not an accurate reflection of what actually happened on that holiday.
>
> 49. Whilst in the port of Barcelona, [Resident T] was moving at an unusually slow pace and I warned her that if we did not start walking faster and return to the ship in time it would leave without us. We told her by way of warning that we would call her sister if she did not cooperate.
>
> 50. [As to] the allegations in respect of [Resident T's] onboard sleeping arrangements, I am not aware of these allegations and her designated Service Worker at the time, Rose Seruya, would need to clarify the position. As far as I am concerned, these allegations are not true.
>
> 51. [Resident T] did not urinate in the manner [which she] describes in this report. [Resident T] had gotten annoyed because she wanted to sit down on a wheelchair during our stay in Barcelona. Prior to that date she had been very happy. In Barcelona we were all going to do a short walk to Las Ramblas. [Resident E] was a particularly awkward Service User to physically manage as she is heavily disabled, and so she had to use the only wheelchair we had available at the time. It took us so long to move everywhere that we did not even get a chance to see the interesting and famous parts of Barcelona.
>
> 52. It is true that we took [Resident T] to a church to use the toilet, but she refused to use it. We then tried to get her into the back of a taxi. [Resident AA] and [Resident J] got nervous as

they thought the police were going to take us away and they directed us to the church. We did not leave [Resident T] alone in Barcelona at any point.

53. I do not understand why [Resident T] has made these false allegations. Whilst everyone knows that [Resident T] sulks a lot and is usually very jealous of [Resident AA] who is very lovable, I always thought that my rapport with her was normally very good.

....

55. The Service Users used to go to [the] beach in Algeciras which had facilities which catered to their specific needs. [Resident T] used to go along with her walker and would throw herself on the ground on purpose. [Resident T] never went to the shore and in all the years I have worked I think she may have gone to the shower on one or two occasions, but never to the sea.

56. When it came to the beach trips, Yvette [Borastero] worked a separate shift to mine. She may have come to the beach but I cannot recall this as she only coincided with me if she was covering due to staff sickness.

....

57. [As to Resident AA's] statement that Richard Muscat and Angelica Williams pulled his trousers down, and that he reported that incident to Sharon Berini:] Nothing of that nature has ever been reported to me, although it is true that [Resident AA] and [Resident T] occasionally used to argue as a result of their individual habits. I do not know why [Resident AA] has said what he has said, perhaps only to implicate Sharon Berini. I find it hard to believe that [Resident AA] would recall those specific people as Sharon has never worked with [Resident AA].

58. What I would like to say about the [Evaluation] as a whole is that it is strange that the issues highlighted therein were only pursued and [brought] to light two years after the interdictions took place. Surely if there was a genuine cause for concern, steps should have been taken sooner to ensure that help would be provided to the Service Users in question."

Commenting on Moira Elmer's 2006 witness statement, Michelle Garro says this (in paragraphs 59 to 70 of her witness statement [**E/16/8-10**]):

"**Paragraph 4:**

59. [Resident AA] only used to go to [Resident T] when it was supper time. Otherwise [Resident T] never interacted with other Service Users. There must be [a] report in [Resident T's] individual diary or in the incident book, the medical book or the accident book. If the incident is not recorded in any of these books, it likely did not happen. It certainly was not reported to me.

60. Angelica having slapped [Resident AA] was never reported to me, and I personally doubt that ever happened.

Paragraph 6:

61. I would have written up a report. The allegation is false and this did not happen.

Paragraphs 8 and 9:

62. As set out earlier in this witness statement, Moira had reason to believe that her sister ... was a compulsive liar. Those were Moira's own words when she brought [Resident T] to the Home. [Resident T] wanted to live with her sister Moira and it is clear that most of these allegations are [Resident T's] way of ensuring that she leaves the Home.

63. If [Resident T] alleges that those things happened, she certainly never reported them to me. It is not true that Moira approached me on numerous occasions, or else I would have written a

report each time whilst explaining that she should discuss the matter with [the] Manager of the Home as well.

Paragraphs 10 and 11:

64. At the time we did not have a wheelchair available for [Resident T], only a walker. [Resident T] did not urinate on herself as Moira describes. [Resident T] never wore a nappy and she was not incontinent and perfectly capable of controlling her bladder.

65. Five Support Workers were present and [Resident T] had our full support. Another Service User required the use of the only wheelchair we had available to us and two Support Workers were walking alongside [Resident T] and supporting her at all times.

66. Furthermore, Angelica was not on the cruise holiday and I believe that Moira knew the Care Workers at Flat 2 well enough to know full well that Angelica had not gone on that holiday.

67. [Resident T] would occasionally throw the odd tantrum up by pretending to fall over at times and when put into the taxi she tried to throw herself back out as she was upset that she had not been given a wheelchair. None of this means that she had problems walking – far from it.

68. There was a specialist from the ship who worked with Special Needs. She offered to help out with looking after [Resident T] as she did not want to visit any more ports after Barcelona. So for the ports of Genoa and Marseilles, we would go on day trips and this lady would look after [Resident T] on board. This lady was not a cleaner.

69. If it was the case that she was punished and sent to her cabin in the ship, this would have meant that Rose Seruya would also have had a problem given that they were sharing the room.

70. When we returned from [the] cruise, we wrote a report ..."

The report in question [**E/16/16-18**] is dated 30 September 2002 and is in Michelle Garro's handwriting and signed by her, Rose Seruya and Yvette Borastero. It includes the following:

"[Resident T] welcomed the idea of going on a cruise this year for her holidays. Last year she had also seemed pleased to go to Marbella Atlantic Club. But once there she would not go in the pool, she was complaining all along, did not like anything, spoiling the other clients holiday.

This year on the 18th of September along with her peers and staff everyone left for our holidays on a weeks Mediterranean cruise. [Resident T] was pleased as punch on the first two days in the ship which were spent partying at sea. On Fri the 20th we arrived at the Port of Barcelona. [Two other service users] used wheelchairs, [Resident T] had a 2 to 1 carer supporting her on each arm. There was a 5 min walk from the Port to La Rambla [sic]. [Resident T] began to complain even though she was assured this was a small walk[;] there were cafes all along the street where she could sit down: there were no hills, steps etc. [Resident T] asked for toilet, supported by two carers made our way to look for w.c. [Resident T] said she would not walk & tried to drop herself whilst held by two carers one on each arm. Not being able to throw herself on the ground she began to shout that she would not move[.] The other clients began to get upset, seeing [Resident T] shouting and people stopping asking what was wrong. .... The police came up asking what was the matter and if the ambulance was needed. By this point [Resident AA] and [Resident J] were hysterical thinking the police were taking everyone away. [Resident T] refused to move, she refused the toilet etc. Finally she was told that her sister and brother-in-law would have to be phoned to pick her up because everyone had to return to the ship. A taxi was stopped for [Resident T] & two carers. As we were so near the ship the rest of [the] carers & clients returned walking. When [Resident T] was finally seated in the taxi still screaming [and] crying one carer walked around the other side of the car to get in. [Resident T] opened the door of the taxi and nearly threw herself on the street. She was caught just in time. Back in the ship [Resident T] would not walk at all and refused food at meal times. When we arrived at Genoa [Resident T] refused to leave the ship. I then spoke to the ship's Public Relations Officer. She then arranged for a lady carer to stay with [Resident T] for 3 hours on the 21st/Genoa and 4

> hours on the 22nd/Marseilles. [Resident T] with her negative attitude spoiled the holiday for everybody."

In paragraphs 72 to 81 of her witness statement, under the heading "Conclusion", Michelle Garro says this [**E/16/10-11**]:

> "72. [Resident T] has complained about what she says actually happened on the holiday to Barcelona which took place in 2002, and it is evidenced that she apparently only did so 4 years later after the event in 2006.
>
> 73. In September 2004, two years after the Barcelona holiday took place, the Home arranged another holiday to a beach club in Torremolinos. [Resident T] was offered the opportunity to go on the trip with another group headed by [another carer] and Manolita Adamberry. However, [Resident T] instead asked Sean Matto whether she would be able to go on holiday with Rose, Angelica and myself, and in that same telephone conversation she also made it clear that she wanted to share a room with her keyworker Angelica.
>
> 74. I therefore have reason to believe that her allegations as presented in the Psychological [E]valuation dated 22/02/06 by Giselle Carreras and Moira's witness statement are complete fabrications and not an accurate portrayal of what actually occurred or what she felt at the time and after the holiday that took place in Barcelona in 2002.
>
> 75. In December 2004 I was interdicted and it came as a surprise as I initially knew nothing of what was claimed and it later transpired that my interdiction was as a result of an alleged omission [on] my part as a Senior support worker.
>
> 76. Apparently [Resident T] had alleged that incidents of [a] sexual nature had been reported to me and I had done nothing about it.
>
> 77. Initially when I was asked to attend the police station I had to pay for legal representation at the interview and I instructed Mr Anthony McDonald.
>
> 78. As a Union member as a result of the allegations I attended the union and I was [designated] a lawyer, Mr Fabian Picardo, and all further correspondence was addressed by him.
>
> 79. On the 28th November 2005, nearly a year after my interdiction, my lawyer Picardo ... received a letter from the Police stating that after the matter had been referred to the AG's chambers the advice received was that no criminal proceedings would be instituted as there was No [sic] realistic prospects for a criminal conviction.
>
> 80. I was eventually reinstated on the 12th June 2006 further to a letter received by my lawyer from Ms Isabella Tosso dated 25th [M]ay 2006.
>
> 81. I find that it is very unfair that this matter has been brought up again by Joanna Hernandez. I was interdicted for a period of 18 months when I was subjected to a full Police Investigation followed by an internal investigation conducted by the Social Services and nothing incriminating resulted [from] the said investigations."

In the course of her oral evidence, Michelle Garro said that Resident T spent most of her time in her bedroom and "didn't get on well really" with the other residents[1071]. Asked to explain what she meant by that, she replied[1072]:

[1071] See Day 8 page 147 line 20ff.
[1072] See Day 8 page 148 line 7ff.

> "She preferred to keep to herself, sort of like knitting, she used to have her tea, when they all came up from [St Bernadette's] she used to have her tea in her bedroom, she used to knit, watch television. She loved watching Eastenders. She always kept to herself."

She went on to say that Resident T continually complained about Resident AA[1073]. As an example, she described how Resident T would go "ballistic" when Resident AA told her it was supper time[1074]. She said that Resident T was a sensitive person, and that Resident AA was "insistent" in that he would "keep on repeating himself"[1075]. She went on[1076]:

> "I wouldn't say [Resident] AA would wind her up. That was his way of being; he was like that with everybody."

She denied that the staff ever encouraged Resident AA to wind Resident T up, or to go into Resident T's room, or to kiss or touch her[1077]; or that they encouraged Resident T to dance or sing[1078].

She described Resident T as "a very unhappy woman", commenting that whatever the staff tried to do, she was never happy[1079]. She later confirmed that she was "quite a demanding person"[1080].

She said that when Resident T first came to the Home, Moira Elmer told her and Rose Seruya that Resident T had nearly ended her marriage because she used to say that Moira's husband had hit her and abused her[1081].

Michelle Garro was insistent that at the time Resident T did not inform her of any of the allegations which she later made[1082].

A number of other witnesses gave evidence relevant to this matter. I can refer to that evidence relatively briefly.

In paragraphs 6 and 7 of her second witness statement in the Inquiry [**E/70/2-3**], Marie Gomez says this in relation to the evidence of Giselle Carreras:

> "6. During her oral evidence Ms Giselle Carreras stated that she discussed particular concerns relating to Residents with management and defines management as Debbie Guinn, myself and Isabella Tosso .... I want to make it clear that she never reported or voiced any concerns to me at all. Ms Carreras herself was part of the management team and used to attend monthly meetings with other managers from across the [SSA]. When Douglas Rodriguez was still CEO she was constantly in his office practically forming part of his management team, why didn't she

[1073] See Day 8 page 149 line 12.
[1074] See Day 8 page 149 line 22.
[1075] See Day 8 page 150 line 12ff.
[1076] See Day 8 page 150 line 18.
[1077] See Day 8 page 150 line 25ff.
[1078] See Day 8 page 151 line 2ff.
[1079] See Day 8 page 156 line 17ff.
[1080] See Day 8 page 165 line 21.
[1081] See Day 8 page 157 line 17ff.
[1082] See Day 8 page 161 line 22.

> report this serious incident to him? .... I want to emphasise that she never reported or voiced any concerns to me at all. .... [I]f she had said how serious the situation was Isabella Tosso, Debbie Guinn or I would have certainly reacted as we have done to other allegations.
>
> 7. Ms Carreras further asserted that management namely, Isabella Tosso, Debbie Guinn or I requested her to attend at the police station with Joanna Hernandez and Resident T. .... Ms Carreras never reported anything to me and I did not request her to attend at the police station."

In the course of her oral evidence she was questioned at some length by counsel for Giselle Carreras as to why, if she was present at the Council Group Meetings referred to in Giselle Carreras' reports, she had taken no action in relation to Giselle Carreras' reports of Resident T's complaints and allegations[1083]. She responded by reminding the Inquiry that at that time she was "just the social worker"[1084]. She said that she could not recall the reports made by Giselle Carreras at Council Group Meetings in relation to the treatment of Resident T, but she was adamant that had she realised that these were serious concerns on the part of Giselle Carreras she would have done something about them[1085].

In paragraph 45 of her witness statement in the Inquiry [**E/68/7**], Debbie Guinn says that she was advised of the proposal to reinstate the three interdicted employees and was involved in identifying the best way to support and advise the Residents involved in the alleged incidents.

In the course of her oral evidence she confirmed that she had asked Giselle Carreras to "carry out psychological reports", and then to see "how best we could introduce those interdicted workers back into [the Home], because obviously the service users would have concerns"[1086].

Mandy Vallender was asked, in the course of her oral evidence, to comment on a handwritten report made by her relating to Resident T and dated 22 September 2006 [**M4/5/1-2**]. The report includes the following passage relating to the Mediterranean cruise to Barcelona:

> "[Resident T] started crying in the kitchen she was very upset so went to the office for a chat.
>
> Richard, Angelica, Michelle & Yvette did a lot of things to me, they upset me, and I still think about the boat[.] [T]hey locked me in my room and wouldn't let me watch the show, and then they brought me my dinner but I didn't eat it I only drank[.] I was hungry but I didn't want to eat because they wouldn't let me watch the show.
>
> Then when I went to [B]arcelona I wanted to do wee-wee and they said do it [in] your knickers, they wouldn't take me to the toilet.
>
> Then we went to the supermarket to take things back and then I said to [Resident AA] look there's a plane there on the shelf[.] [A]fter that I saw stripes on the floor and I fell backwards[.] [T]hey picked me up and I fell down again[.] [T]here was a policeman there and he said do you want me to take her to the hospital and they all said no and I had bruises on my arm[.] They [asked] the policeman if they could take me to the church[.] [T]hey didn't take me they dragged me[.] [T]hey left me there on my own and then they called the two husbands to take me to the boat[.] [T]hey pushed me down the stairs[.] I haven't told anybody this ...

[1083] See Day 14 page 80 line 11ff.
[1084] See Day 14 page 85 line 17.
[1085] See, in particular, Day 14 page 85 line 15 ff.
[1086] See Day 15 page 202 lines 10-14.

> The taxi wasn't going to take me but then he took me with the husbands.
>
> I fell on the floor near the taxi before I got in it and then they took me to the boat and asked a nurse to bring me a wheelchair and then the two husband[s] took me to my room and they left me there and went shopping.
>
> The next day they told me I had to get my own dinner[.] I was scared to fall the boat was moving and there was a man there who helped me take my food...."

Commenting on the above report, Mandy Vallender said[1087]:

> "I wasn't aware of [Resident T's] behaviour. .... I did this at that time because she was very upset... She was upset most of the day, most of that morning, and then I did this report, and when I handed it to whoever it was now, Liz Gallagher I think, she was the senior at the time, and she said to me: "I am not going to do anything about that. This was a while ago. She is very repetitive and [that] is what she is saying all the time".

Asked whether she regarded Resident T as reliable in the things she said, Mandy Vallender replied[1088]:

> "To answer honestly now, I don't think that she is reliable, no."

Yvette Borastero says this with reference to Giselle Carreras' Evaluation (in paragraphs 38 to 44 of her witness statement in the Inquiry [**E/4/6-7**]):

> "38. [Resident T] states that I had looked at her "con la vista sucia" [gave her a dirty look]. This is not the case. I never looked at anybody in that way.
>
> 39. In fact, when [Resident T] approached me that day it had been the first time in quite a while that I had actually seen her as I was no longer assigned to Flat 2. When she saw me she began to cry and explained that she wanted to come back [from Bishop Healy], that Joanna Hernandez had lied to her. I tried to be nice to her and comfort her because at the end of the day she is a Service User, but knowing what had happened with my sisters [i.e. Angelica Williams and Michelle Garro] and the fact they had been interdicted I decided after that to speak to Sharon Berini about it and write a report.
>
> 40. If I had in fact been looking at her "con la vista sucia" she would not have approached me and confided in me in the manner in which she had done so that day and as set out in my report.
>
> 41. [As to Resident T's account of what happened on a visit to the beach:] First of all, I have very rarely been on the same shift as my sisters Angelica and Michelle. Secondly, the beach where we would typically take Service Users has very good wheelchair access and has nearby shower and toilet facilities.... Also, if [Resident T] had in fact been kneeling on the wooden walkway she would have black knees other than white knees due to the accumulated dirt and sand which I know typically collects on the wooden boards.
>
> 42. With respect to her allegation that she was dunked under water, [Resident T] suffers from muscular dystrophy. This means that if [Resident T] were to be taken to the water, she would require the assistance of at least two people as she would not be able to walk on the sand on her own, even with the aid of her walker. If I had taken her down to the water, which I have not ever done in any event, then another Support Worker would have had to be present to assist us. No mention is made of another Support Worker being present.

[1087] See Day 10 page 152 line 8ff.
[1088] See Day 10 page 153 line 3.

> 43. Furthermore, on the occasions I have been to the beach with [Resident T] she has never gone down to the shore and every time that she has wanted water we have brought her a bucket containing water to cool her down as opposed to having to make the trip down to the shore.
>
> 44. Even if I had gone down to the water with [Resident T], and I had dunked her in the manner in which she alleges, I do not believe the other beach goers would have stood by and allowed me to behave in this manner. I also very much doubt the other Support Workers present would have condoned this behaviour. It simply did not happen and I do not know why this has been set out in [Giselle Carreras'] report."

Yvette Borastero exhibits to her witness statement the handwritten report dated 20 December 2004 [**E/4/9**] to which she refers in paragraph 39 of her witness statement. She reports that she went to Bishop Healy with Resident AE and two carers, and whilst there she saw Resident T[1089]. The report continues:

> "She [i.e. Resident T] was very happy to see me and she kissed and hugged me. [Resident T] began to cry, telling me she didn't want to be there and she wanted to go and live in Spain with her sister. I comforted [Resident T], telling her that she would be [coming] down to Flat 2 soon and spending Xmas with her sister. [Resident T] began to say that Joanna (Manager) had lied to her, forcing her to talk to the Police and moving her to Bishop Healy, asking me if I could help her as she wanted to tell me everything that had happened to her. ....
>
> I told [Resident T] to speak to Joanna and tell her how she was feeling as I was sure that Joanna would know how to deal with her problems as I could not interfere. I then told [Resident T] that I had to leave and she told me she missed Rose [Seruya], Michelle and myself very much. I reassured [Resident T] again telling her not to worry, that everything would turn out okay for her and then left."

Referring to the incident in her oral evidence, Yvette Borastero said this[1090]:

> "She actually approached me to say that she wanted to come down to [the Home], that she had been forced to give evidence, and she wanted to come down. So I was very surprised to see [the allegation that I looked at Resident T "con la vista sucia"], because [if] I looked at her with eyes that were not very nice, she wouldn't have approached me."

She goes on[1091]:

> "[Resident T was] always talking about wanting to go back home, and she wasn't happy, she didn't want to be there ... she used to like staying in her room, she didn't actually mix a lot with the other residents."

I turn next to the evidence of Sharon Peralta, Crown Counsel at the Attorney-General's Chambers. She made a witness statement in the Inquiry [**I2/1**], and she gave oral evidence.

In her witness statement she says that in March 2005 she met PS Adrian Bacarisa and DC (as she then was) Aldra Cerisola regarding the allegations made by Resident T; and that she and the two police officers subsequently attended a meeting with the Attorney-General, to whom the matter had been referred. In paragraphs 5 to 8 of her witness statement she says this [**I2/1/2-3**]:

[1089] It appears that Resident T was moved to Bishop Healy as part of the preparations for the reinstatement of the three interdicted carers.
[1090] See Day 11 page 60 line 14ff.
[1091] See Day 11 page 61 lines 3-6.

> "5. Consideration of the available evidence at the time revealed that the accounts of the victims could not be corroborated. Additionally, the officers could not obtain a statement from [Resident AA] given that at the time we were informed that he had the mental capacity of a 6 year old child. [Resident T] had provided a statement in the form of an interview but it was rambling and very hard to follow.
>
> 6. Our information was that the two alleged perpetrators[1092] had been suspended from work and were facing disciplinary proceedings. We were also provided with psychological reports from Giselle Carreras regarding the apparent incapacity of the victims to give cogent evidence at a subsequent trial.
>
> 7. Upon consideration of the available evidence and other material, I wrote to the Royal Gibraltar Police on the 10th June 2005 upon the instructions of the Attorney-General. This letter informed the Police that the Attorney-General was of the view that were the matter to proceed to trial, there would be no realistic prospect of conviction. [She then exhibits the letter, which is quoted earlier]
>
> 8. No criminal proceedings followed and the complaint was left to be dealt with by way of internal disciplinary proceedings."

In her oral evidence, she explained that oral advice to the above effect had been given to the two police officers in the course of the meeting with the Attorney-General, but that the police had subsequently asked that the advice be put in writing[1093].

I turn next to the evidence of Aldra Cerisola (she is no longer with the Royal Gibraltar Police). She made two witness statements in the Inquiry, and she gave oral evidence.

In her second witness statement [**H/20**], she addresses Joanna Hernandez' evidence that she told Joanna Hernandez that the police had been instructed not to investigate allegations of abuse in Gibraltar, saying this (in paragraph 4 of her witness statement [**H/20/1**]):

> "4. I can recall no such conversation where I would have stated what is alleged. I myself have been involved in investigations in relation to [the Home] and therefore it would be illogical, having first-hand knowledge of such investigations to have made a statement to the contrary...."

In the course of her oral evidence, she was referred to Joanna Hernandez' evidence (in paragraph 180 of her third witness statement, quoted earlier) that she had told Joanna Hernandez that the case against the carers "had been binned". She said this[1094]:

> "I certainly wouldn't have used the words "it had been binned" because I consider myself to be ... very professional and I would never have gone against my principles. I felt very strongly about this case and I certainly would never have said that it had been binned. Firstly, because those are not words which I would have used, and secondly because I don't think that would have been a professional manner in which to deal with it. .... [Thirdly], at the time I was a detective constable, I wasn't a sergeant then. I would have gone with my sergeant and most of the talking would have been done by my sergeant."

[1092] i.e. Richard Muscat and Angelica Williams.
[1093] See Day 17 page 27 line 13ff.
[1094] See Day 16 page 123 line 5ff.

Superintendent Emilio Acris of the Royal Gibraltar Police also gave written and oral evidence to the Inquiry.

In the course of his oral evidence, Superintendent Acris was asked by counsel for Joanna Hernandez to comment on Joanna Hernandez' evidence that DC Cerisola told her that the case against the carers had been "binned"; and that "she said ... words to the effect "in Gibraltar the police had been instructed not to investigate any cases of abuses"" (see paragraph 180 of Joanna Hernandez' third witness statement [**E/67/52**]). Superintendent Acris replied[1095]:

> "I can categorically say that in my time ... in the RGP ... nobody has instructed me not to investigate any case, not [just] of abuse, of any kind. The Royal Gibraltar Police is, I think, very independent. .... I am talking after 36 years in the service. .... I think this is outrageous ... that it is alleged that an officer, a serving officer at the time, would have said that. I know DC Cerisola, and I worked with her very closely within the CID and I don't think she would have said this ..."

Counsel for Joanna Hernandez then put it to Superintendent Acris that the fact that the police had suggested that an internal disciplinary process might be more appropriate "tied in" with Joanna Hernandez' assertions. Superintendent Acris replied[1096]:

> "No, I don't agree with you at all. Not to investigate? We did investigate. We investigated unfortunately, and this is my personal view, you know, because I am a very proud investigator, and when I do, when I carry out an investigation, I want to try and get to the bottom of it. Unfortunately the circumstances of this case that we are talking about were ... We did what we could under the circumstances, and we couldn't go any deeper than what we did, and that for me fully endorses the fact that we did carry out an investigation; and nobody, nobody ever, even, you know, intimated, insinuated or would have told me not to investigate any case."

I turn next to the evidence of Natalie Tavares. She is a Senior Social Worker at the Care Agency. She has worked as a qualified social worker for the SSA's predecessor, for the SSA, and subsequently for the Care Agency, since 1999. She has never worked at the Home[1097]. In 2009 she was working in the Children's and Families Team, which had responsibility for Resident L at Flat Bastion Road. She made a witness statement in the Inquiry, and she gave oral evidence.

In her oral evidence, she explained the approach of the Care Agency (and, previously, of the SSA) when faced with an allegation involving possible criminality by carers, saying this[1098]:

> "The first thing is that, when an allegation comes to me as a senior social worker of the team, I would call a strategy meeting with the police. That is regardless of who the child is, whether they are a looked after child ... or it's any other child. We would have a strategy meeting. .... We would then look at the information received, for the police to decide whether there is enough information to conduct their own investigation, if it does fall into the realm of criminal offence, and what then social services would need to be doing, and the reason for this is that neither of the two agencies would want to impinge on each other's investigation. .... We have very regular

[1095] See Day 16 page 93 line 19ff.
[1096] See Day 16 page 94 line 11ff.
[1097] See Day 16 page 39 line 12.
[1098] See Day 16 page 56 line 20ff.

> meetings [with the police] on a weekly basis. .... We have the strategy meeting format. .... It's a ... very formal structure. .... This goes back quite some time – 2003, thereabouts.
>
> The strategy meeting is very much to look at the actual information on an incident where referral comes in where a child has suffered some form of abuse, where it is felt that the threshold of significant harm has been met, and it seems that a criminal offence has been committed. And even when we are not too sure, because we work closely with the police, and ... there are times when we need to maybe conduct home visits with police officers from the Safeguarding Unit in order to look at what information, or any issues of the care that is presenting [sic] to children.
>
> So strategy meetings are the first port of call, and thereafter depending on the action points that may be decided, we may have a follow-up meeting to look at those action points, or go into a child protection case conference. So it very much depends on the information that is presented."

Lastly, so far as the witnesses are concerned, I turn to the evidence of the Attorney-General. He made a witness statement in the Inquiry, and he gave oral evidence.

In his witness statement [**I4/1**], the Attorney-General confirms that, having considered all the evidence in the case, and having been assured by the Royal Gibraltar Police that there was no further evidence, he came to the view that to prosecute either of the two interdicted employees in respect of whom a prosecution was under consideration[1099] would not be possible. He goes on (in paragraph 4 of his witness statement [**I4/1/1-2**]):

> "The test which we apply in Gibraltar when deciding whether or not to prosecute is the same test as that used by the Crown Prosecution Service. It is basically a 2-stage test in which the first stage is whether or not on the admissible evidence there is a realistic prospect of conviction and if there is, whether or not it would be in the public interest to prosecute. In this case had the evidential hurdle been overcome there would have been no doubt that it would have been in the public interest to prosecute given the appalling breach of trust alleged. I formed the view, however, that there was no realistic prospect of conviction in this case."

He goes on to enumerate the various matters which he had considered when coming to that view, viz: the fact that Resident AA had been unable to supply a witness statement; Giselle Carreras' view that Resident AA would be unable to give evidence in court; the Psychological Reports relating to Resident AA and Resident T provided by Giselle Carreras; and the transcript of Resident T's police interview.

In paragraph 5 of his witness statement [**I4/1/2**], he said this:

> "Having considered the psychological reports and the witness statements of [Resident T] [a reference to the transcript of her police interview] I came to the conclusion that any case based upon the evidence of [Resident AA] and [Resident T], would in the absence of any independent corroboration, be unlikely to provide a realistic prospect of conviction. It is also of note that at that time under the rules of evidence in force in Gibraltar, corroboration would be looked for as these were allegations of a sexual nature. It was thus, albeit with a sense of regret, that I made a decision that a prosecution should not take place, based upon the evidential test."

[1099] In his oral evidence he confirmed that a prosecution was being considered only in respect of two of the three interdicted employees (see Day 17 page 58 line 19): these must have been Richard Muscat and Angelica Williams.

In the course of his oral evidence, he was asked by counsel to the Inquiry to explain what he meant when, in paragraph 5 of his witness statement (quoted above) he used the words: "albeit with a sense of regret". He replied[1100]:

> "I think very often when one makes a decision on a prosecution, looking at the evidential test, it may be because one doesn't believe what's being said. In this case I thought that what was being said, having read the interviews of [Resident T], had a ring of truth."

He went on to say that he thought that there should have been internal disciplinary proceedings[1101]. He confirmed that the concern was that, absent a criminal prosecution, a vulnerable person would have no other means of recourse to any kind of redress[1102].

Having reviewed the evidence at considerable length, I can now set out my findings.

I turn first to the allegations against the carers. Self-evidently, the allegations that Richard Muscat and Angelica Williams prompted and/or encouraged Resident AA to make advances of a sexual nature towards other residents are of an extremely serious nature, as is the allegation that Michelle Garro knew of this abuse but did nothing about it. The Attorney-General was plainly right to describe these allegations, if true, as constituting "an appalling breach of trust". It follows that in order to prove them, cogent evidence is required[1103].

Given the accepted lack of capacity of Residents AA and J (see Giselle Carreras' Psychological Report on Resident AA dated 16 May 2005 [**M10/7.1/1-30**], and her oral evidence that Resident J's capacity was lower than that of Resident T, and that her credibility "can get confused", with "a mix and match of innocence and confusion going on"[1104]), the evidence of Residents AA and J, as recorded in Giselle Carreras' Evaluation, cannot be regarded as reliable. It follows that proof of the allegations must stand or fall by the evidence of Resident T, who claims to have witnessed the conduct alleged.

As to the evidence of Resident T, the first point to be made is that her allegations are uncorroborated by any reliable evidence.

Secondly, I bear in mind that (as those who knew him all agree) it was not in Resident AA's nature, given his mental and emotional age, to make advances of a sexual nature towards any female. Indeed, conduct of that kind was "taboo" to him. Hence it would have required a high degree of encouragement, not to say coercion, by his carers to cause him to indulge in a type of behaviour which he would otherwise have shunned.

[1100] See Day 17 page 62 line 23ff.
[1101] See Day 17 page 64 line 13.
[1102] See Day 17 page 73 line 20.
[1103] The relevant principle is that the more serious the conduct which is alleged, the less likely it is that such conduct took place; hence the stronger the evidence which is required to prove that it took place on a balance of probabilities.
[1104] See Day 5 page 58 line 1ff.

Thirdly, as I commented when reviewing Giselle Carreras' Evaluation, it would have been of assistance in assessing the credibility of Resident T's allegations to have had the opportunity to consider the manner in which, and the terms in which, Giselle Carreras elicited Resident T's quoted statements. Unfortunately, the Evaluation does not provide that detail. Again, I make it clear that I am not criticising Giselle Carreras in any way. She was following her instructions, and acting (among other things) as advocate for Resident T. The fact remains, however, that the lack of detail on that aspect inevitably impacts on the credibility of Resident T's quoted statements.

Fourthly, some of Resident T's quoted statements bear all the signs of exaggeration. Examples of this are her statement in her police interview that Resident AA "beats me, because he likes beating me" [**M27/44/5**], and her repeated assertions that Resident AA used to kiss her on the lips [e.g. **M27/44/9**] – conduct which, on the evidence of the experts, he would have never have willingly indulged in. The same applies with even greater force to her statement in her police interview that Resident AA used to say to Visitor X when dancing with her: "Come on, morena, kiss me on the lips" [**M27/46/3**]. Given the evidence as to his lack of capacity, I find it impossible to envisage Resident AA uttering those words, let alone dancing with Visitor X.

Fifthly, and most importantly, having carefully observed each of the carers involved (that is to say Richard Muscat, Angelica Williams, Michelle Garro and Yvette Borastero) when giving their oral evidence, I am fully satisfied that for them to have acted in the manner alleged by Resident T would have been entirely out of character.

Sixthly, as to Resident T herself, it is clear on the evidence that at the relevant time she was not happy in the Home and wanted to live with her sister. It is also clear that she did not get on well with the other residents; and that she objected to the innocent, but on occasion no doubt irritating, conduct of Resident AA – conduct which was no more than part of his nature and which was not directed particularly towards Resident T. She was also astute to complain about her treatment by her carers. Moreover, the fact that (on Moira Elmer's own evidence) she felt able to accuse her brother-in-law falsely of abusing her shows that her evidence may not always be reliable.

Seventhly, I have in mind the observation of Olga Sanchez[1105] that Resident T found no difficulty in communicating her situations and emotions, "but within her own reality".

Having anxiously considered the relevant evidence, and taking full account of the fact that I have not had the benefit of seeing and hearing Resident T give oral evidence, I find that the entirety of her evidence of misbehaviour, misconduct and abuse on the part of her carers is unreliable. I do not suggest that in making those allegations Resident T was doing anything other than describing the reality of the various alleged incidents, *as she saw it*. In other words I am satisfied that her evidence was, in the words of Olga Sanchez, "her own reality". That said, I find that it was not the true reality.

[1105] In her Psychosocial Report, quoted earlier [**M4/15/2**].

Resident T was described in evidence as a compulsive liar. However, I have no reason to think that in making her witness statement she had any intention to mislead the Inquiry.

Subject to that one qualification, I accept the evidence of Richard Muscat, Angelica Williams, Michelle Garro and Yvette Borastero in its entirety, and I exonerate them from each and every one of the allegations which have been made against them.

I turn next to the response of the SSA to those allegations.

In the first place it follows from the findings which I have already made that I reject Joanna Hernandez' assertion (in paragraph 179 of her third witness statement [**E/67/52**]) that the response of the SSA to the allegations was "a stark example of where senior members of the SSA had been aware of long term and repeated abuse of vulnerable residents, but had done nothing to protect those residents ...".

Turning to the factual history, I accept without qualification the evidence of Ernest Montado as to his participation in the matter of the reinstatement of the three carers by Isabella Tosso.

So far as Isabella Tosso is concerned, I have already found that it was for her, and not for the Gibraltar Government, to decide what action to take in the face of the allegations against the carers. As I have already recorded the SSA lost no time in interdicting the three carers. Plainly that was the right course to take given the serious nature of the allegations. However the SSA did not follow this up by arranging a disciplinary hearing. It was understandable that no disciplinary hearing should take place while the allegations were being investigated by the Royal Gibraltar Police, but once that investigation had run its course (i.e. by mid 2005) no time should have been lost in setting up a disciplinary hearing. In the event a disciplinary hearing was not scheduled to take place until December 2005.

In the meantime Isabelle Tosso appears to have procrastinated over whether, and if so when, to reinstate the three carers. As a result, Ernest Montado was faced with a delicate situation, in which he had to respect the competing interests of employees and residents. His compromise solution (reinstatement on conditions) was not an ideal solution; but, as he himself described it, he was doing his best to act as Solomon in difficult circumstances.

As to Marie Gomez, I accept her evidence that she did not regard Giselle Carreras' concerns about Resident T, as expressed at Group meetings from 2002 onwards, as sufficiently serious to justify her in taking action in respect of them. In this context I bear in mind in particular that she was not appointed as Adult Team Leader until June 2004.

I also accept the evidence of Natalie Tavares (quoted earlier) as to the close liaison between social workers and the Royal Gibraltar Police.

Lastly, I turn to the evidence of the police witnesses.

I accept without qualification the evidence of Superintendent Acris that the Royal Gibraltar Police has never been instructed by anyone not to investigate cases of abuse, or indeed any other type of case.

As to Aldra Cerisola, I also accept her evidence without qualification. In particular, I accept her evidence that she never told Joanna Hernandez (as Joanna Hernandez alleges in paragraph 180 of her third witness statement, quoted earlier) that the case against the carers "had been binned", or that the Royal Gibraltar Police had been instructed not to investigate cases of abuse. Having heard and seen her give evidence, I cannot envisage her using such language to Joanna Hernandez; nor can I see any reason why she should have told Joanna Hernandez something which she (Aldra Cerisola) knew to be untrue. I can only conclude that Joanna Hernandez' evidence in this respect is the product of some misunderstanding on her part, and/or of a faulty recollection.

Lastly, I consider the decision of the Attorney-General not to institute criminal proceedings against the carers to have been fully justified – if not inevitable, given the quality of the available evidence.

CHAPTER 14: Incidents involving medication at Flat Bastion Road (2008/9) – Resident L's allegations of physical and sexual abuse (2009)

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CHAPTER 14:
Incidents involving medication at Flat Bastion Road (2008/9) – Resident L's allegations of physical and sexual abuse (2009)

In the course of preparing for this Inquiry, the Inquiry team discovered that in October 2009 Resident L (who was almost sixteen years old and residing at a children's home in the UK[1106]) had made allegations to his carers in the UK of sexual abuse in Gibraltar by individuals named "Robert" and "Vicky". The Inquiry team accordingly brought these allegations to the attention of those who had cared for Resident L in Gibraltar and invited their comments on them. This led in due course to evidence being presented to the Inquiry of an allegation by Resident L of physical abuse by his carers while resident at Flat Bastion Road, of incidents relating to the control and storage of medication at Flat Bastion Road, and of earlier complaints in relation to Resident L's care whilst he was resident in Gibraltar.

The evidence presented to the Inquiry relating to these matters has established that while resident at Flat Bastion Road, Resident L was not a resident of the Home; rather, he was under the care of the Children's Services arm of the SSA (and subsequently of the Care Agency). Nonetheless, given that he had previously been a resident of the Home I considered that it was appropriate to investigate these matters.

Resident L (a male) was born on 29 October 1993. He suffers from Fragile X Syndrome, ADHD (Attention Deficit Hyperactivity Disorder) and autism (at the severe end of the spectrum). He became a resident of the Home in 1996. He was then aged about three. In 2005 he was moved to the flat at Flat Bastion Road as his behaviour was becoming increasingly challenging. A report by a Consultant Paediatrician dated 26 October 2005 [**M27/13/1**] referred to his behaviour as threatening, including throwing furniture, attacking staff, scratching and biting.

Returning to the matters to be considered in this Chapter, chronologically the story begins with the discovery, in October 2008, of an unused tube of rectal Diazepam in the flat at Flat Bastion Road. Diazepam was not prescribed medication for Resident L.

On 9 October 2008 Dr Cassaglia, a Consultant Paediatrician, wrote to Christopher Wilson (CEO of the Care Agency) concerning Resident L, saying this about the discovery of the Diazepam [**M27/15/1**]:

> "... [Resident L] is not on Diazepam. This is very serious and worrying and begs the question whether or not [Resident L] is being given Diazepam rectally in the night. If he is what is the purpose of this? I understand that this is being looked into by [Iain McNeil]. I take this development as something very serious and would like your reassurance that the matter is being

[1106] Valley House, Fillongley, Warwickshire.

> looked into and dealt with appropriately. Our primary concern is to ensure that [Resident L] remains safe and I would like some reassurance from you that everything is being done to ensure his safety."

Iain McNeil made a witness statement in the Inquiry, but declined to attend to give oral evidence. His witness statement is expressly limited to the above incident (see paragraph 3 [**J1/117/1**]).

In paragraphs 4 to 9 of his witness statement [**J1/117/1-3**], he says this:

> "4. I am not aware of any administration of unprescribed diazepam to [Resident L]. I am aware of the following incident. On or around October 2008 I was approached by [Sharron] Openshaw, a care worker employed by the SSA to look after [Resident L] at a residential unit in Flat Bastion Road, where [Resident L] lived by himself alongside his carers. Ms Openshaw was the manager at the flat. Ms Openshaw informed me that she had discovered an unused diazepam tube on top of a cupboard in the kitchen of [Resident L's] flat. This was alarming as I was aware that [Resident L] was not prescribed diazepam.
>
> 5. In normal circumstances [Maria] Elena Macias would be tasked with investigating matters of this nature. [Maria] Elena had experience in carrying out these investigations and it also meant that I would not be conflicted in sitting as a member of any disciplinary board that may be convened as a result of the investigation. However, on this occasion, for reasons that I cannot recall, I and not [Maria] Elena carried out the investigation.
>
> 6. I established that there were two possible methods I could adopt in order to try and establish how the diazepam had got into the flat. Firstly, I could try and work out where exactly the diazepam came from by tracking the serial number on the diazepam tube itself. In this instance this was not possible as the serial number on the diazepam was rubbed off which suggested to me that the drug was old. My only alternative was to try and establish how the diazepam got in the house by interviewing those who worked there at different times during the day.
>
> 7. I interviewed Flor Garcia, a care worker at the flat who recalled having cleaned the flat and on top of the cupboards a couple of days before and not having located the drug. This did appear strange to me at the time because Flor was a very meticulous cleaner. I interviewed [Sharron] Openshaw and Manolita Adamberry. I do believe, although I cannot be sure of this, that it was established that Manolita had not been in the flat between the period it had been cleaned by Flor and the discovery had been made by [Sharron] and so I discarded her as a possible wrongdoer.
>
> 8. Whilst I recall interviewing Flor, Manolita and [Sharron] I cannot be sure whether or not I interviewed anyone further. I do recall making statements of all the individuals I interviewed and leaving a file with my findings at the office that I left in Governors Parade when I departed to the United Kingdom.
>
> 9. I also recall that, having carried out the interviews it was impossible to establish how the diazepam had got into the flat. I did not believe that there had been an attempt to use it. On the basis that no evidence could be found the investigation came to an end and no disciplinary action was taken. I do believe that the Royal Gibraltar Police were informed of this incident but I cannot be sure of this. I also believe that this was discussed at a multidisciplinary meeting but again without sight of my notes and dates etc I cannot be absolutely certain of this. I would have informed the CEO, Chris Wilson, of this, although he would not have had any direct involvement in the investigating of this matter only to offer advice."

As Iain McNeil says in paragraph 4 of his witness statement, Sharron Openshaw was the Unit Manager of the flat at Flat Bastion Road. She was employed by the SSA from August 2007 until she resigned in May 2011. She is currently the registered manager of two children's homes in Wigan, in the North of England.

The matter of the unprescribed Diazepam reappears one year later in the minute of a meeting on 21 October 2009 attended by Maria Elena Macias, Nicole Viagas, Natalie Tavares and another member of staff. The minutes of that meeting [**J1/122/13**] include the following:

> "[Nicole Viagas] explained that on the 12.10.09 .... [Sharron Openshaw] informed her and NT [Natalie Tavares] that a rectal diazepam had been found at FBR [Flat Bastion Road]. She also pointed out that she had passed on this information to IMc [Iain McNeil] and that she never got any feedback on the investigation.
>
> MEM [Maria Elena Macias] was aware of this but FBR was not her responsibility. IMc [Iain McNeil] had been dealing with that flat.
>
> MEM asked SW [Social Worker, presumably Nicole Viagas] who then said that the rectal diazepam was still in her safe. She said that IMc has asked her to place it there.
>
> NT asked if the RGP had been informed about this. No one knew about this.
>
> MEM and NT read over the diary to find some indication of [Resident L's] medication.
>
> NT & NV spoke to Sgt Tunbridge re the medication.
>
> Decision made **to initiate [an] investigation. NV to write to the CEO and inform her about this**."

Nicole Viagas says this (in paragraph 3 of her witness statement [**J1/118/1**]):

> "3. I first became aware of the issue concerning unprescribed diazepam ... found in [Resident L's] flat on the 12th October 2009 whilst conducting a meeting where a senior care worker, Ms [Sharron] Openshaw, was being informed that she was being suspended pending an investigation following allegations relating to a separate incident which [Resident L] had made whilst in care in the UK."

She confirmed, in the course of her oral evidence, that she first became aware of the matter of the rectal Diazepam when Sharron Openshaw volunteered the information that she had found it and had handed it in[1107]. She went on[1108]:

> "What Sharron actually said was that she had found that some time ago and that she had handed it in to Iain McNeil ... and that she was wondering what was the outcome of the investigation, and that was the first time that I actually found out [about it]."

Nicole Viagas went on to explain that Sharron Openshaw was never called to account in relation to the rectal diazepam. As she put in oral evidence[1109]:

> "We called her in because of the medication that we found in Flat Bastion Road. We never ... called her in for the rectal diazepam."

[1107] See Day 16 page 4 line 9ff.
[1108] See Day 16 page 5 line 14ff.
[1109] See Day 16 page 7 line 9ff.

In due course, as I shall relate, the investigation by the Royal Gibraltar Police was closed without any charges being brought against any carer in respect of any of the matters involving Resident L mentioned above.

How the unused tube came to be in Resident L's flat must remain a mystery, given that Diazepam was not prescribed medication for Resident L. What is clear on the evidence, however, is that Sharron Openshaw acted entirely correctly in reporting the matter to Iain McNeil, who did his best, albeit unsuccessfully, to find out how it got there. There is no evidence that Sharron Openshaw was in any way at fault in relation to this incident.

The next relevant incident, chronologically, was the discovery on 26 March 2009 by Manuela Adamberry and Rose Robba (carers on the night shift at Flat Bastion Road) that Resident L had managed to get hold of two bottles of Calpol and a plastic bag containing 240 Risperidone tablets from the top of the wardrobe in the flat.

Manuela Adamberry and Rose Robba duly reported this discovery to the out-of-hours social worker. This in turn led to Maria Elena Macias, then a social worker in the Children's Residential Services Department of the Care Agency (now a Welfare Officer for the Human Resources Department of the Civil Service) being asked to investigate the incident. Maria Elena Macias interviewed a number of carers (including Manuela Adamberry, Rose Robba and Sharron Openshaw) and she reviewed the available documentation. In the course of her investigation it transpired that an entry had been made in the medication book which might have been back-dated, and a question arose as to whether Sharron Openshaw had made that entry following the alleged incident but had back-dated it to 22 December 2008.

In response to the allegations against her in relation to the medication, Sharron Openshaw wrote a report [**E/61/21-23**] in which she states that any excess medication for Resident L was stored in a locked filing cabinet; and that discontinued medication was also stored in the cabinet, before being returned to the chemist. The report goes on to say that she found it unlikely in practice that the medication in question had been found by Resident L on top of a wardrobe, and that she suspects that the allegation was a "set-up" by another carer.

In June 2009 Maria Elena Macias prepared a draft Report [**J1/122/7-11**] in which she suggested that Manolita Adamberry, Rose Robba and Sharron Openshaw be interviewed further. However, no further steps were taken to progress the investigation at that stage.

On 21 October 2009 a meeting took place attended by Maria Elena Macias, Nicole Viagas, Natalie Tavares and another member of staff. Following that meeting it was decided that Maria Elena Macias' investigation into the medication found in the flat at Flat Bastion Road should continue. In the event, it was only in June 2010, following completion of the investigation by the Royal Gibraltar Police (as related below), that Maria Elena Macias was in a position to interview Sharron Openshaw.

On 8 June 2010 Carmen Maskill (the CEO designate, in succession to Christopher Wilson) wrote to Maria Elena Macias asking her to interview Sharron Openshaw in connection with "the medication found in Flat Bastion Road" [**J1/121/20**].

Maria Elena Macias' interview with Sharron Openshaw took place on 1 July 2010. Following that interview, she produced a detailed Report [**J1/122/15-25**]. As to the alleged back-dated entry in the medication book, she reported [**J1/122/23**] that there was clear evidence that an entry bearing the date 22 December 2008 and made by Sharron Openshaw, in which staff were asked to return all unused medication to the chemist, must have been made after the incident of 26 March 2009; that "all staff [except one] say they had never seen the entry and that it was impossible for them to have missed it"; and that Sharron Openshaw had been unable to offer any explanation as to why the entry in question had not been signed as either read or actioned by anyone.

As to the matter of the medication which had been found in the flat, the Report noted [**J1/122/**24] that up to January 2009 the staff at Flat Bastion Road had been administering medication "without any training", albeit they had "procedures in place". It went on to note that Sharron Openshaw had asserted in interview that all medication was kept locked away, and that "unused medication would be stored in [the] medication cabinet and then returned to the chemist by either herself or a member of staff". The Report continued [**J1/122/24**]:

> "It is clear that there has been neglect around the storage of medication and the return of medication. In her undated report submitted in May 2009[1110] and during her interview in July 2010 Ms Openshaw states that she had assumed that the medication had been returned.
>
> There is a possibility that Ms Openshaw's claim that she was set up by a member of staff could be correct. It is something we will never resolve as instructions regarding medication were never made to one specific worker. For all intents and purposes whoever had taken responsibility for returning the meds [sic] could well have taken it home and then returned it to the flat.
>
> One important point to make however is that even if there had been a set up the recovered medication needed to have existed in the first place and Ms Openshaw just assumed that it had been returned. However if we are saying, and it is apparent from the evidence that the entry to return the unused medication was only put in the book after the incident[,] then the surplus medication must have been in the flat and neither safely stored or returned. It was according to staff interviewed not in any visible place in the flat and definitely not in the locked medication cabinet."

The Report went on to record that Maria Elena Macias felt that there was a strong case against Sharron Openshaw in relation to the alleged back-dated entry in the medication book. As to the medication left in the flat, she felt that although there was some evidence of negligence, it would be difficult to prove for the following reasons:

- "Staff were untrained in medication administration up until January 2009.
- Procedures in place up until the time when this training happened was [sic] somewhat sketchy in what needed to be recorded and procedures that needed to be followed.
- Ms Openshaw had raised these concerns.

[1110] This is a reference to the handwritten report exhibited to Sharron Openshaw's witness statement, reviewed later in this Chapter.

- Improvements were apparent after training was delivered.
- The latter part of 2008 when medication was changed regularly was a very difficult year not only for the staff but especially for Ms Openshaw who was not only attempting to run the unit but also working hands on with [Resident L] and supporting the staff who were being assaulted on a daily basis. There were occasions when Ms Openshaw had to work around the clock.
- Due to staff shortages there was a time when Ms Openshaw was trying to run two units ...."

Sharron Openshaw was suspended in October 2009 pending an investigation into Resident L's allegations of physical abuse (as related below). However, in paragraph 13 of her witness statement [**E/61/2**] she says that at some point, "a long time" later, the SSA changed the reason for her suspension from the allegation of physical abuse to an allegation of a failure to adopt appropriate procedures in handling medication.

In the course of her oral evidence, Maria Elena Macias said this, with reference to the suggestion that Sharron Openshaw had backdated an entry in the medication book[1111]:

> "[Sharron Openshaw] was adamant she had written it at the time, ... but she did actually agree with me that it did look very, very suspicious. .... Mrs Openshaw and the rest of the staff were going through a terrible time in the flat. .... It was very, very difficult. This young resident was going into crisis continuously, his medication was being changed continuously, they were working round the clock because unfortunately because of this young resident's behaviour nobody wanted to work with him. So ... Mrs Adamberry, Mrs Openshaw, Mrs Robba, and maybe a couple of others, were the ones we could always rely on to work. And Mrs Openshaw was very, very dedicated ... I think what happened [was] that she was just caught up in all of this and she may have panicked. I don't know."

Sharron Openshaw eventually resigned, in circumstances which I shall relate, and no more was heard of the allegations in relation to the medication at Flat Bastion Road or to the alleged back-dated entry in the medication book.

It is impossible on the evidence presented to the Inquiry to make a final judgment as to the circumstances in which the Calpol and the Risperidone were left in Resident L's flat, and thus accessible to him, when they should have been locked away in the medication cabinet. All that can safely be said is that the procedures in place at the flat for the control of medication, as set out in Sharron Openshaw's handwritten note, were clearly breached in this instance. However, there is no evidence that Sharron Openshaw was responsible for that breach, save in the technical sense that she bore administrative responsibility for it in her capacity as Unit Manager.

Nor have I heard or seen sufficient evidence to justify a finding that she was guilty of backdating an entry in the medication book. I accordingly find that that allegation has not been established.

In the circumstances, I make no criticism of Sharron Openshaw in relation to these matters. In fairness to her, I should add that I fully appreciate that as Unit Manager she had an extremely demanding job on her hands (as Maria Elena Macias recognised in her oral evidence quoted

[1111] See Day 15 page 81 line 4ff.

above), and I have no doubt that she worked hard to discharge her responsibilities as best she could.

I can now turn to the allegations of sexual and physical abuse made by Resident L.

On 2 October 2009 (by which time Resident L was residing at Valley House, in the UK), Julie Sen, a social worker at the Care Agency, received a call from Cheryl Lester, the Manager at Valley House, concerning Resident L. Julie Sen's contemporary note of the telephone conversation [**J1/116/7**] reads as follows:

> "[Resident L] has made a disclosure of sexual abuse. The disclosure came about as a result of [Resident L] becoming very distressed after having wet the bed during the night. There were 2 male workers on duty and [Resident L] had not wanted to leave his room to use the toilet. [Resident L] told workers:
>
> - Robert put something in his bum.
> - Robert tried to put it inside him but it hurt.
> - Bad people in Gibraltar.
> - Robert threatened [Resident L] telling him he would throw his mum in the deep end (swimming pool?) and would punch [Resident L] in the face.
> - Robert is gay ([Resident L] has not used this word before).
> - Vicky and Robert put him down on the floor.
> - Sharon [i.e. Sharron Openshaw] said 'get in your room, get in the time out room'.
>
> [Resident L's] mother visited a few weeks ago with her brother, [Resident L's] uncle who is gay and according to staff, HIV + (this he disclosed to staff), and Uncle's friend. [Resident L] is said to be a little unsettled recently and following the disclosure has been extremely upset, sobbing and not eating.
>
> A Child Protection investigation has been instigated from Valley House."

Following that telephone call, Julie Sen set about ascertaining the identities of the "Vicky" and "Robert" mentioned by Resident L. She checked through Resident L's files, but could find no reference to individuals of that name with whom Resident L might have come into contact whilst residing at the Home. On 5 October 2009 Julie Sen emailed Cheryl Lester informing her that as yet she had been unable to identify "Vicky" and "Robert" **[J1/116/9**].

On 6 October 2009 Julie Sen emailed Marie Carmen Santos, the Human Resources Manager for the Care Agency, asking her to trace the names of carers who might have been in contact with Resident L [**J1/116/12**].

On the same day she received an email from Cheryl Lester [**J1/116/1**] attaching written confirmation from Warwickshire Child Protection Services of the child protection investigation which Cheryl Lester had mentioned in her earlier email. Paragraph 5 of that document set out Resident L's disclosures in the following terms [**J1/116/17**]:

> "[Resident L] appeared as anxious and upset since this morning. (2nd October 2009). At 12.20 [Resident L] was on the trampoline. Staff member Bindu Joseph was with [Resident L]. [Resident L] said to Bindu "I wants to go to toilet". Bindu said to [Resident L] you could go to toilet, come on. Then [Resident L] said to Bindu "no, I am scared, I am scared to go. It was

> horrible, Bindu it hurts, they are naughty people at [Gibraltar]. [T]hey put their things to my bum"[.] [Resident L] showed that part of his body, then he stopped talking, he took a deep breath, then punched the trampoline.
>
> After [a] couple of minutes [Resident L] started talking. "Bindu they tried to come into me, they put needles in my bum, they pulled my hair and put my face in toilet; Bindu I drank from toilet"[.] Then [Resident L] started stuttering and found it difficult to talk. [Resident L] then punched the trampoline threw stones at Bindu. [At] that moment Cheryl Lester (manager) came out to speak to [Resident L].
>
> [Resident L] said to Cheryl that he wants to go to toilet. Cheryl took [Resident L] to toilet. [Resident L] asked Bindu to come to toilet. Cheryl said to [Resident L] that we will wait outside. [Resident L] used toilet, came out and said to Cheryl he is hungry. Then [Resident L] had lunch with Staff. After lunch[,] [Resident L] said he would like to talk to Cheryl about what he said to Bindu. [Resident L] went to Cheryl and said to her "They are naughty in Gibraltar, they hurt my bum, they are gay"[.] Cheryl asked [Resident L] who hurt you. He said Robert and Vicky, then he said "I don't want them to come to [V]alley [H]ouse, they put my face down on the floor, they put needles in my bum["], he showed Cheryl by parting his buttocks and saying ["]it hurt me, Robert put his hands around my neck." [Resident L] became agitated when he said this, he was shaking his head, then [Resident L] said to Cheryl "Robert will throw my mum in the deep end and punch me in the face". [Resident L] became anxious again and stopped talking.
>
> At 16.30 Cheryl explained to [Resident L] that we have informed Julie Sen the manager at social services and read to him what he had said to staff. [Resident L] said ["]Put them in jail, we have to give them big sanction".
>
> Then Cheryl asked who are they, he said they are staff. Cheryl asked what are their names, then [Resident L] said Sharon, Rose, Monalita [sic].
>
> Then Bindu asked what had the staff done to upset him. [Resident L] then said they had held his head down the toilet. [Resident L] then said Robert tried to marry me, he put his tongue in my lips, Robert needs a big sanction, he must not come to Valley [H]ouse no more, no more Cheryl."

Also on 6 October 2009, Julie Sen spoke again on the telephone to Cheryl Lester confirming that she had received confirmation of the child protection investigation. In the course of the conversation, Cheryl Lester said that Resident L had referred to his "Uncle Robert", and said that he did not want him to visit Valley House again. Consequently, the view was formed that Resident L's uncle (who had visited him a few weeks previously) was likely to be the "Robert" to whom Resident L had referred. In her contemporary note of the conversation [**J1/116/23**], Julie Sen recorded Cheryl Lester as saying that Resident L was presenting as "much calmer and more relaxed since the disclosure".

On 8 October 2009 Marie Carmen Santos met with each of Rose Robba and Manuela Adamberry. The meetings were also attended by Carmen Maskill and Natalie Tavares, among others. At the meetings the two carers were told of the allegations which had been made against them by Resident L, and that they would be suspended with immediate effect pending an investigation [**J1/120/8-9**].

In paragraph 5 of her witness statement in the Inquiry [**J1/120/1**], Marie Carmen Santos recalls how "upset and shocked" each of them was on hearing of the allegations against them. In the course of her oral evidence she said that Rose Robba and Manuela Adamberry were "very, very

upset"[1112]. Carmen Maskill also confirmed in her oral evidence that they were "in complete shock" when told of Resident L's allegations[1113]. Natalie Tavares gave evidence to the same effect[1114].

The minutes of the meetings [**J1/120/8-10**] record Manuela Adamberry and Rose Robba as saying that their relationship with Resident L had always been good; that they had bought him a farewell gift; and that Manuela Adamberry had accompanied Resident L to the UK. Manuela Adamberry is recorded as saying that Resident L used to call her "Mum" (although she had explained to him that she was not in fact his mother); that the two carers who she believed were closest to Resident L were herself and Rose Robba; and that she was saddened that she, "who had contributed most to his care", should have found herself in this position. According to the minutes [**J1/120/10**], she went on to say that Rose Robba had also supported Resident L, and that they were the only carers who were not afraid of Resident L, indicating that Resident L felt secure with them. However, she said that other members of staff were not confident in dealing with Resident L; that they "had locked him in the room for long periods", with medication being passed to him through a small window "to avoid contact"; and that the unit manager (Sharron Openshaw) was aware of this but that no action had been taken.

On 8 October 2009 Marie Carmen Santos wrote formally to Rose Robba, Manuela Adamberry and Sharron Openshaw [**J1/120/4-6**] suspending them with immediate effect pending an investigation.

In the meantime, on 7 October 2009 Marie Carmen Santos responded to Julie Sen's request for information as to the carers with whom Resident L had been in contact in Gibraltar, saying [**J1/116/12**]:

> "Kirushka Compson, Manolita Adamberry have both worked for the two services [i.e. Residential and Respite]. Nigel Bassadone is no longer with us but he also worked for Dr G. and Respite.
>
> The supply staff are not normally used for both services. Each section have their own."

Julie Sen duly passed all this information to Natalie Tavares, a senior social worker in the Child Protection team, who in turn convened a strategy meeting on 8 October 2009 to consider the matter. The meeting was also attended by representatives of the Criminal Investigation Department of the Royal Gibraltar Police.

The minutes of the meeting [**J1/116/26**] record that it was agreed that the Royal Gibraltar Police would liaise with the Warwickshire police, and that Julie Sen would liaise with the UK Child Protection Social Services team. It was also agreed that Resident L would be interviewed by video in the UK; that, depending on what Resident L disclosed during that interview, a decision would have to be made as to whether Resident L should be medically examined; and that Resident L's mother, Elizabeth Elbrow, should not be informed about the allegations made

[1112] See Day 15 page 57 line 18.
[1113] See Day 14 page 109 line 24.
[1114] See Day 16 page 54 line 16ff.

against "Uncle Robert" lest that should hinder the investigation. Julie Sen duly reported to Cheryl Lester what had transpired at the meeting [**J1/116/34**].

However, a difficulty arose in relation to the proposed interview with Resident L in that his mother's consent to the interview was required, and in seeking her consent the reasons for the investigation would have to be disclosed to her. On 15 October 2009 Julie Sen raised this difficulty with DS Wayne Tunbridge, of the Royal Gibraltar Police [**J1/116/30**]. On 19 October 2009 she received a response from DC Soane saying that he had discussed the matter with DS Tunbridge, and that their suggestion was that, if necessary, the details should be disclosed to Resident L's mother.

In the light of that response, Julie Sen arranged to meet Elizabeth Elbrow, Resident L's mother. The meeting took place on 20 October 2009. Julie Sen's contemporary note of the meeting [**J1/116/32**] records that she informed Elizabeth Elbrow that her son had made allegations against care workers in Gibraltar (albeit without disclosing the names of the care workers or details of the allegations) and that the three care workers had been suspended pending an investigation; and that Elizabeth Elbrow duly consented to her son being interviewed. It also records that during the conversation Elizabeth Elbrow mentioned that her brother's name was not Robert; and that he had only met Resident L once, when he had visited Valley House a few weeks previously. The note goes on to record Julie Sen's comment on this disclosure, viz. that it seemed unlikely that Elizabeth Elbrow's brother was the "Uncle Robert" referred to by Resident L.

On 20 October 2009 Julie Sen emailed Cheryl Lester [**J1/116/34**] saying that "we have no idea who Robert is".

On 6 November 2009 Marie Carmen Santos wrote to each of the three suspended carers [**J1/120/12-14**] to tell them that the investigation into Resident L's allegations of sexual abuse was still ongoing in the UK, and that they would be informed of the outcome "as soon as the conclusions arrived at are made known to us".

On 9 November 2009, Resident L was interviewed by Warwickshire police. The interview was conducted by DC Hayley Reader.

On the following day DC Reader emailed DC Soane of the Royal Gibraltar Police [**M27/23/4**], reporting on the interview with Resident L. In the course of her email, she described the interview as follows:

> "The interview was very difficult as [Resident L's] concentration is not at all good, and he provided very little details about the offences, but [Resident L] did disclose that Rose, Sharon and Monalita [sic] (the carers from Gibraltar) had assaulted him by grabbing his arms and putting his arms up his back, and they put his head in the toilet and made him drink the toilet water."

In an email to Julie Sen dated 18 November 2009 [**J1/116/36**], DC Reader described the interview once again as "very difficult". She continued:

> "I didn't get half as much detail from [Resident L] as I would have like[d], but he has disclosed that that the carers in Gibraltar have assaulted him and mistreated him. It would seem that all of the offences have occurred in Gibraltar, so I am in the process of putting a package together to send to DC Soane, in Gibraltar, as he will be completing all of the investigations in this matter. ...."

In a further email to Julie Sen sent later that day [**J1/116/36**], DC Reader said this:

> "All [Resident L] would say during the interview about Robert was that "he had stuck needles in his bottom, kissed him and hit his face". I couldn't get any more details from [Resident L] about Robert during the interview, I do have two statements from Cheryl and Bindu from Valley House that say [Resident L] told them "the naughty people in Gibraltar put their things in my bum" and he said that "Robert put his hands around my neck, he tried to marry me and he put his tongue in my lips". We suspect that Robert may have been a carer that looked after [Resident L] some years ago, before [Resident L] lived in his own flat in Gibraltar[1115], but this isn't confirmed and enquiries will need to be completed by DC Soane to establish this, perhaps with assistance from yourself, as the police will need to look carefully through all of [Resident L's] [previous] care records.
>
> I am quite sure something has happened to [Resident L], he has consistently talked about "Robert" and the other females that cared for him, and isn't capable of making up lies, but it is so difficult to get any details from [Resident L] to help assist our enquiries."

On 23 November 2009 Julie Sen received a telephone call from Warwickshire police to the effect that their investigations were complete [**J1/116/39**].

As to the possibility of Resident L being tested for HIV, Julie Sen said in evidence that she had regarded it as up to Valley House to initiate an HIV test if they considered that to be appropriate[1116].

On 29 January 2010 a meeting of all the Team Leaders took place, chaired by Carmen Maskill. The minutes of the meeting with the Royal Gibraltar Police [**J1/121/12**] record that information in regard to the three suspended carers was "still on hold".

On 7 May 2010 a Management Board Meeting took place, chaired once again by Carmen Maskill. The minutes of the meeting [**J1/121/16**] record that the Royal Gibraltar Police had "completed all investigations", and that it was now for the Care Agency to take whatever disciplinary action was necessary.

On 7 June 2010 Marie Carmen Santos wrote to Rose Robba and Manolita Adamberry [**J1/120/16-17**] saying that the police investigations into Resident L's allegations had been concluded; that they (the carers) had been exonerated from any wrongdoing; and that they would accordingly be reinstated once they had completed a training course. A similar letter was not, however, sent to Sharron Openshaw at that stage, as she was still facing an investigation relating to the medication found in the flat at Flat Bastion Road.

[1115] A reference to the flat at Flat Bastion Road.
[1116] See Day 16 page 34 line 3ff.

On 8 June 2010 Carmen Maskill wrote to Maria Elena Macias informing her that the Royal Gibraltar Police had completed their investigation into the allegations made by Resident L and had concluded that there was no case to answer [**J1/121/20**].

On 14 June 2010 the suspensions of Rose Robba and Manuela Adamberry were lifted. Rose Robba returned to work in the Home, but Manuela Adamberry was at that time on sick leave and subsequently resigned. The suspension of Sharron Openshaw continued pending completion of the investigation in relation to medication at the flat at Flat Bastion Road.

On 22 June 2010 DC Soane reported in writing to the Commissioner of Police on the current state of the investigation into Resident L's allegations of abuse [**M27/10/16-19**]. His report, which was marked for the attention of DS Tunbridge, records (among other things) that Rose Robba, Manuela Adamberry and Sharron Openshaw had been interviewed under caution; that various search warrants had been executed at the Care Agency and at the hospital; and that a visit had been made to the flat at Flat Bastion Road. He went on to say that a statement had been obtained from Elizabeth Elbrow, who had said that "she did not know who "Robert" was nor had her son ever mentioned a "Robert" to her". DC Soane concluded his report by saying this [**M27/10/19**]:

> "At this moment in time the undersigned suggests that the investigation be drawn to a conclusion as all practicable lines of enquiry have now been completed. It cannot be ruled out that "Robert" is in fact a person that [Resident L] has met since living in the UK as no evidence has revealed any person who has had dealings with [Resident L] by the name of "Robert" whilst residing in Gibraltar."

On 5 July 2010 DC Soane submitted his report to the Attorney-General's Chambers seeking confirmation that the investigation could be closed [**M27/10/21**]. On 28 July 2010 Johann Fernandez, Crown Counsel, responded as follows [**M27/10/21**]:

> "Given the strength of the evidence it is submitted that should this matter proceed to [trial] there is no significant likelihood of conviction. Consequently I would suggest that no charges be preferred."

In the meantime as already noted, Maria Elena Macias' interview with Sharron Openshaw in relation to the medication incident took place on 1 July 2010. Following that interview, Maria Elena Macias produced a detailed Report [**J1/122/15-25**].

On 13 May 2011, Pat Brooks, the Human Resources Manager for the Agency, emailed Sharron Openshaw asking for confirmation that she would be available to attend a disciplinary hearing on 27 May 2011. Sharron Openshaw replied by letter dated 23 May 2011 [**E/61/25**]. In the course of her letter she said this:

> "As you are aware, I have been suspended from my position as Manager from 8th October 2009 to date. Despite the lengthy period of suspension, you have failed to keep me informed of the current status of your investigation throughout this period. However, I am aware that several other members of staff [who] were also suspended have returned to their duties long ago.

> The fact that I appear to be the only remaining person on suspension for these unfounded allegations and complaints has had a serious impact on my personal life and professional position.
>
> Whilst you failed to inform me of the position, I did contact the Royal Gibraltar Police in May 2010 to ascertain [their] position regarding the allegations and complaint made by [Resident L]. I was informed by the RGP that following their full investigation, which included communications with UK, that no charges were to be brought as there was no substance to the complaint and allegations made and that you had been fully [apprised] of their findings.
>
> I had anticipated that I would thereafter be returned to work. However, a year has passed and I have still not received notice to return to work.
>
> Recently, I have been alerted to the fact that other employees of the social services have been discussing me and the allegations and indeed defaming me to not only other employees, but also to the general public at large. This has caused me huge embarrassment and severe distress and will have a severe impact on my position and capabilities to perform my job. Indeed, such has been the effect of the gossip that I have sought medical assistance ... for stress and anxiety.
>
> Whilst attending upon the doctor, I received a telephone call from the office informing me that there was a letter for me to collect. I had anticipated that this would be the letter I had been waiting for, for quite some time, inviting me back to work. To my astonishment and dismay, this letter was not to invite me back to work, but to attend upon you to face a disciplinary meeting.
>
> In the light of this and the ongoing failure by social services to perform an investigation in a timely manner, or at all, I have had to consider my position carefully and it is with regret that I have come to the conclusion that I will not be able to return to the job which I have gained great satisfaction from, nor my position as a manager within social services.
>
> Therefore, as required by my contract of employment, I hereby give you 4 weeks' notice of my intention to leave my position as Unit Manager from the date of this letter. ...."

I now turn to the evidence of the witnesses in this Inquiry relating to Resident L's allegation of sexual and physical abuse.

I start with Elizabeth Elbrow, Resident L's mother. She made a witness statement in the Inquiry, and she gave oral evidence.

In paragraph 12 of her witness statement [**F/1/2-3**], she says this:

> "12. I have never spoken to my son when he made allegations of sexual abuse when in the UK against his maternal uncle Robert and physical abuse against three carers, namely [Sharron] Openshaw, Rose Robba and Manolita Adamberry. Prior to this, he has never raised this with me. I did however notice that my son used to get agitated when seeing certain individuals around the Home and I was suspicious as to the reasons for this."

In the course of her oral evidence, she said she was happy when a placement was found for Resident L in the UK, although she very much wanted him to return to Gibraltar[1117]. She confirmed that Resident L had told her nothing about the allegations, saying that she was shocked when she heard about them[1118].

Julie Sen says this (in paragraph 14 of her witness statement in the Inquiry [**J1/116/4**]):

[1117] See Day 6 page 138 line 19ff.
[1118] See Day 6 page 140 line 21ff.

> "14. To my knowledge the Care Agency has never requested that [Resident L] be tested for HIV as there has been no reason to do so. [Resident L] made his allegations whilst being cared for in the UK, and, having established that he had made no allegations against the uncle who is believed to be suffering from HIV, the Care Agency did not request that [Resident L] be tested. [Resident L] continues to be cared for in the UK and to the best of my knowledge he has not been tested there for HIV."

In the course of her oral evidence, she explained why Resident L was transferred to the UK, saying this[1119]:

> "When [Resident L] was brought into the Children's Services, because of his very complex needs we didn't have the facilities or the resources to meet his needs in Gibraltar, so a placement was found for him in the UK. .... [Valley House] wasn't known to me prior to visiting, but obviously once [Resident L] was placed there I did visit him sort of every couple of months. .... It's a small residential home specifically for children with complex needs such as autism...."

Marie Carmen Santos says this (in paragraphs 9 to 11 of her witness statement [**J1/120/2**]):

> "9. Manolita Adamberry submitted a number of medical certificates following [receipt of the letter informing her of her reinstatement], and did not in fact return to work at all.... Rose Robba returned to work following a training course offered to her ...."
>
> 10. My role throughout was to communicate the information passed on to me by Carmen Maskill, I was not involved in the investigation of the alleged incident.
>
> 11. As regards [Sharron] Openshaw, I was aware that she was not offered reinstatement when Rose Robba and Manolita Adamberry were, but as my colleague Pat Brooks[1120] was dealing with this particular employee, I was not involved in the process further."

Carmen Maskill says this (in paragraphs 7 and 8 of her witness statement [**J1/121/2**]):

> "7. Based on the communication from the RGP and their findings no disciplinary action in relation to [Resident L's] allegations were commenced. It was my view that the RGP had carried out an investigation of all the matters and on this basis it was decided that there was nothing further the Care Agency could investigate.
>
> 8. Manolita Adamberry and Rose Robba were subsequently both offered reinstatement. The third care worker that [Resident L] made allegations about, [Sharron] Openshaw, was not reinstated at the time as the matter concerning the medication found at Flat Bastion Road was pending...."

She confirmed that Rose Robba came back to work, but that Manuela Adamberry was initially absent through sickness and never returned to work in the Home[1121].

Maria Elena Macias says this (in paragraph 4 of her witness statement [**J1/122/1-2**]):

> "4. It was usual practice for the SSA/CA to internally investigate any allegations. Although strictly speaking these would be conducted parallel to RGP investigations, it was sometimes the case that internal investigations could not be carried out until after the completion of a police

[1119] See Day 16 page 18 line 3ff.
[1120] The Human Resources Manager for the Care Agency.
[1121] See Day 14 page 114 line 7ff.

> investigation, both because of evidence being seized by the police, and because internal investigations might impact on the police investigation. It might also be the case that no internal investigation would be carried out if the police investigation was believed to be conclusive. On other occasions, an internal investigation would be carried out in spite of the RGP concluding no criminal charges would be brought, on the basis that although there might be no criminal offence, there could be issues which ought to be dealt with via disciplinary proceedings."

In paragraph 6 of her witness statement [**J1/122/2**], she says this:

> "6. I should highlight that [Resident L] was resident in a flat at Flat Bastion Road under the care of Children's Residential Services ..., and not actually a resident of the Home."

In the course of her oral evidence, Maria Elena Macias agreed that the Care Agency's disciplinary code provided that disciplinary matters should be dealt with urgently and in the strictest confidence[1122]. She went on[1123]:

> "Sometimes there is some delay in carrying out the disciplinary investigation, because if the police have some of the evidence ... we have to wait for that to conclude; and sometimes ... when the police investigate ... and the outcome is conclusive there is no need for there to be a disciplinary investigation."

She went on to say that even if the police concluded that no further action should be taken by them, disciplinary proceedings could still be appropriate[1124].

Turning to Resident L's allegations of abuse, she confirmed that no internal disciplinary inquiry had taken place. Asked whether she recalled any discussion about that, she said this[1125]:

> "I can't remember. I know there was a discussion with social workers, I can't recall exactly. There must have been when it was decided that this was conclusive and it wouldn't be pursued. But we did decide that the inquiry which was started in March that same year [i.e. 2009] with regards to the medication that was found in the flat would be re-instigated."

Superintendent Richard Mifsud of the Royal Gibraltar Police made a witness statement in the Inquiry, and he gave oral evidence.

In the course of his oral evidence, he was asked about various references in the documentation to a police operation called "Operation Titan". He explained that it was an operation directed at the SSA generally; and that, so far as he could recall, it did not concern the Home[1126].

In her witness statement [**J1/119/1-3**] Natalie Tavares confirms the sequence of events set out above, in so far as those events involved her. I also bear in mind her evidence as to the close

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[1122] See Day 15 page 68 line 5.
[1123] See Day 15 page 67 line 23ff.
[1124] See Day 15 page 72 line 14ff.
[1125] See Day 15 page 73 line 20ff.
[1126] See Day 15 page 104 line 13, and the more detailed evidence of Chief Inspector Cathal Yeats, reviewed later in this Chapter.

liaison between social workers and the Royal Gibraltar Police in relation to cases involving children[1127].

In her oral evidence, she made clear that she was unable to recall the details of the discussions which had taken place concerning Resident L. She said that she had had no direct contact with Sharron Openshaw[1128], and that she could not recall the reasons why Sharron Openshaw had been suspended for so long[1129].

Chief Inspector Cathal Yeats of the Royal Gibraltar Police made a witness statement in the Inquiry, and he gave oral evidence. Since January 2013 he has been Staff Officer to the Commissioner of Police, Mr Eddie Yome CPM. Soon after taking up that post, he was asked by the Commissioner to give general assistance to the Inquiry by identifying and disclosing relevant information and documentation.

Chief Inspector Yeats exhibits to his witness statement [**H/16/1**] a timeline of the investigation carried out by the Royal Gibraltar Police in relation to the allegations of sexual and physical abuse made by Resident L [**H/16/14-16**]. The timeline is headed "Operation Margate". It sets out the chronology of events in relation to that investigation.

In the course of his oral evidence, Chief Inspector Yeats explained that the timeline had been reconstructed from documentation in the possession of the Royal Gibraltar Police[1130]. He agreed with counsel for the Attorney-General's description of it as a precis of such documentation[1131].

Chief Inspector Yeats confirmed that Operation Titan (mentioned by Superintendent Mifsud in the course of his evidence) was an umbrella investigation encompassing a number of separate investigations[1132]. He explained that Operation Margate was one of those investigations[1133]. He confirmed that Operation Margate was not an investigation into a complaint at the Home, and that its only connection with the Home was that it related to allegations made by a former resident of the Home[1134]. He went on to confirm that the investigation into the discovery of medication at the flat at Flat Bastion Road was another of the investigations covered by Operation Titan[1135].

Detective Inspector Wayne Tunbridge made two witness statements in the Inquiry, and he gave oral evidence. He is currently the Executive Coordinator of the Gibraltar Coordinating Centre

[1127] Quoted in Chapter 13. See Day 16 page 156 line 20ff.
[1128] See Day 16 page 68 line 22.
[1129] See Day 16 page 70 line 17.
[1130] See Day 17 page 13 line 1ff.
[1131] See Day 17 page 22 line 7ff.
[1132] See Day 17 page 8 line 15.
[1133] See Day 17 page 10 line 15.
[1134] See Day 17 page 10 line 21. When resident in his flat at Flat Bastion Road, Resident L was under the care of Children's Services.
[1135] See Day 15 page 16 line 19ff.

for Criminal Intelligence and Drugs. From May 2005 to September 2010 he was a Detective Sergeant in the Criminal Investigation Department of the Royal Gibraltar Police.

In his second witness statement in the Inquiry [**H/17/1**], and in his oral evidence, he confirmed the sequence of events set out above, in so far as they involved him.

I turn next to the evidence of the three carers, starting with Manuela Adamberry.

In paragraphs 32 to 56 of her witness statement, she says this [**E/1/5-7**]:

> "**Change of team and medication**
>
> 32. About a year after [Resident L] moved into the Flat[1136] [at Flat Bastion Road], a few members of his team were replaced. There was also a change to his medication.
>
> 33. From then on, [Resident L's] behaviour took a turn for the worse. His hyperactivity increased and his aggressive outbursts became much more frequent and intense. He developed a very pronounced tick and had a constant manic look in his eyes.
>
> 34. He did not get on with most of the new members of his team, especially [Sharron] Openshaw ... who by his own account he disliked intensely. He would regularly lash out at these new members of his team, both verbally and physically.
>
> 35. The new team found it impossible to keep [Resident L] under control, and eventually resorted to keeping out of his reach to avoid his unpredictable outbursts, during which he often hurt them. This did not happen to me, but I could sympathise with their reactions, as [Resident L] was a different boy when he was with them and his strength and total lack of control meant it must have been quite scary to be the target of his aggression.
>
> 36. Due to my close relationship with [Resident L] and the bond that we had, I never had any problem dealing with his [behaviour], although admittedly this became much harder after the change to his team and his medication. Because I knew and understood him so well, and was aware of the things that might spark an outburst, I sometimes tried to advise the new team members on the best way to deal with him. However, my colleagues appeared to resent this and did not heed my advice. There was a significant amount of tension between old and new members of [Resident L's] team.
>
> **[Resident L] leaves to the UK**
>
> 37. Eventually most care workers refused to work with [Resident L], which obviously posed a problem for Social Services.
>
> 38. A decision was taken to send him to Valley House in Coventry, where it was thought he would be taken better care of. This news came as a shock to me, as I had not considered that [Resident L] might one day be sent away from Gibraltar. He was a big part of my life and I was initially very upset at the decision.
>
> 39. However I came to realise that, for as long as Social Services could not cater for his needs, this was the best move for him. If he had stayed in Gibraltar, he would inevitably have ended up in KGV Hospital and this was something I would never have wanted for him.
>
> 40. When I heard that [Sharron] would be one of the group accompanying him to Coventry, I spoke to Maria Elena Macias ... to request permission to join them, as I knew that [Resident L]

[1136] i.e. in 2006/7.

would find [Sharron's] presence upsetting, which was to be avoided in what would inevitably be a highly stressful experience for him. Ms Macias granted my request.

41. The group accompanying [Resident L] to the UK consisted of myself, [Sharron] [and two others].

The trip to the UK

42. On the day we were leaving for the UK, Rose [Robba] and I took [Resident L] to the airport, stopping in town for breakfast on the way. We gave him a farewell gift that we had bought between us.

43. We had asked [Sharron] to keep out of sight at the airport and on the plane to avoid [Resident L] playing up until the last possible moment.

44. In the departure lounge, [Resident L] was injected with a sedative on the buttock in the usual way in preparation for the flight.

45. Once on the plane, he was seated between [Sharron] and myself. I was surprised because it was no secret that the mere sight of [Sharron] made [Resident L] play up. Upon seeing her, he immediately became unsettled and we had to restrain him between us. I eventually managed to convince him to behave by getting [Sharron] to swap seats with the male nurse who was in our group. This worked, although a light restraint was required throughout the flight, as [Resident L] was very anxious from then on.

46. During the car ride to Coventry, in which the whole group was present, [Resident L] was spitting, struggling and swearing and needed to be restrained throughout using the appropriate techniques. It was a very stressful journey for all involved.

47. When we got out of the car at Valley House, upon seeing his mother and Dean Lopez from Social Services, [Resident L] lost control completely and caused damage to the car by tearing off the wipers and throwing stones at it. When he went inside the house, he continued with his destructive behaviour, pulling at the tablecloth of a table set out for afternoon tea thereby smashing everything that had been laid on the table.

48. He was clearly very anxious and upset. I could not recall having ever seen him in such an agitated state, and I found it very hard to watch.

49. At this point I, along with the rest of the group, left Valley House. [Resident L] had lost control to such a point that I was not even able to say goodbye to him, which still saddens me to this day. I found it very hard to leave him behind and knew I would miss him a great deal.

50. We spent the night at a hotel and returned to Gibraltar the following day. I have not seen [Resident L] again.

Allegation by [Resident L] and suspension

51. A few months later, in October 2009, I was called to a meeting with Mrs Carmen Maskill ..., in which she told me that [Resident L] had made allegations of physical abuse against me and others, although she did not give me any specific details. At several points during the interview, Mrs Maskill reassured me that nobody believed these allegations to be true, but that they had to follow procedures.

52. I was subsequently suspended on full pay pending an investigation. .... As I recall, I only learned the specific details of [Resident L's] allegation from Rose [Robba].

53. At some point after this meeting, I was called to the police station for an interview. ....

54. I cannot recall everything that was said at the interview, which is probably due to the fact that it was a very stressful experience for me combined with the passage of time.

End of the investigation

55. I had no further contact with Social Services regarding the allegations or my suspension until I was eventually sent a letter ... on 7 June 2010 informing me that my suspension was over and that, upon completion of a course at Bleak House, I would be reinstated.

56. Although my intention was to return to work, I found that I was incapable of doing so. I had come to realise that I should never have allowed myself to become so close with a child in my care. [Resident L's] allegations were a real blow and I found it very hard to recover from this."

In the concluding section of her witness statement, headed "**My involvement in the Inquiry**", she says this (in paragraphs 60 to 65 [**E/1/8**]):

"60. [Resident L's] supposed allegations against me are ridiculous.

61. Firstly, it would have been physically impossible for me to overpower [Resident L]. Also, if it is true that he alleged that Rose, [Sharron] and I put his head in the toilet of the Flat, you would only have to see the bathroom to know that this is impossible due to the small size of the room. Furthermore, Rose and [Sharron] never worked together, and so saying that the three of us did this together makes no sense.

62. Apart from these obvious reasons, I would never hurt a child in my care. I loved [Resident L] as if he was one of my own grandchildren and as I have already mentioned was very protective towards him I would never have hurt him in any way. Even when he was being violent and aggressive, I would not even raise my voice to him. I was fully aware that his bad behaviour was not his fault.

63. According to the report from the Care Agency ... [Resident L] also accused his mother's brother Robert of abusing him sexually.

64. From what I understand, [Resident L's] mother does not even have a brother named Robert. However, there did used to be a boy named Robert in the care of Social Services who I believe had suffered sexual abuse before he was taken into care and my suspicion is that [Resident L] had overheard conversations about this. This would not be surprising coming from [Resident L], who as I have already mentioned, had difficulty keeping track of and rationalising his memories of events.

65. I am confident that [Resident L] has never accused me of abusing him. In all likelihood, his new carers in the UK have misunderstood what he was trying to say, which in fairness is easily done by someone who does not know him well."

In the course of her oral evidence (given through an interpreter), Manuela Adamberry was asked by counsel to the Inquiry whether Resident L was a child whose statements could be relied on. She replied[1137]:

"No. You couldn't believe him."

Later in her evidence, she was referred to an Assessment by the SSA of possible placements in the UK for Resident L [**M27/36/25-26**]. The assessment is undated, but it refers to Resident L

[1137] See Day 9 page 168 line 14.

as being 15 years old, so it must have been made in late 2008 or 2009[1138]. Under the heading "Background information", the Assessment reads as follows:

> "[Resident L's] behaviour has always been challenging. Recently [Resident L's] behaviour has become extremely problematic to a point where care staff have been finding it difficult to contain him. .... Fear and heightened anxiety due to any form of change however small or insignificant to others, was likely to be exacerbated during this period with rapid changes in mood occurring resulting in hitting, throwing and destructive behaviour. ....
>
> Staff are being hurt on a regular basis, one having suffered a detached retina following a physically aggressive incident, and [Resident L] has to be permanently medicated and regularly restrained to keep him and others around him safe.
>
> Triggers for his behaviour identified by [Resident L's] Carers include his obsessive relationship with his mother, recent changes in his mother's domestic arrangements which resulted in her not being able to see him so frequently (now resolved), negative associations within his current accommodation and a view of his carers as gaolers. These factors are primarily situational ... and they are exacerbated by the lack of knowledge, experience and expertise of the staff who are caring for him ...."

She was also referred to a Care Plan relating to Resident L dated February 2008 [**M27/36/27**] in which the following paragraph appears [**M27/36/30**]:

> "Historically, [Resident L] has been difficult to manage. He does not cope well with change and although for the most part we have tried keeping the same staff team supporting him, change is inevitable and new staff members have come in when others have left or been absent. There has always been concern regarding his behaviour: he can be aggressive towards the staff that care for him and he destroys items in his living area. Staff have been assaulted on many occasions and at times on a regular basis. He is of big build and can easily hurt others. There is a staff ratio of two to one, however even when calm the potential to escalate makes him a difficult service user to work with."

Manuela Adamberry confirmed that the above paragraphs accorded with her own experience[1139].

Asked about Resident L's allegation that he was grabbed and his head was put in the toilet, she denied it, saying[1140]:

> "No, no. This is impossible. First because the toilet was very small, and secondly because that would never have been done to him. No."

I turn next to the evidence of Rose Robba. She has worked as a carer in the Children and Families Team since 2002. She has never worked in the Home. She made a witness statement in the Inquiry, and she gave oral evidence.

In paragraph 23 of her witness statement [**E/62/4**], she says this about Resident L:

> "23. Although he was bright and could speak both English and Spanish well, he had communication difficulties. He would often get confused and, especially when recalling an earlier incident, speak very erratically, using only key words and actions. His chronology was

[1138] Resident L was born on 29 October 1993.
[1139] See Day 10 page 11 line 21.
[1140] See Day 10 page 13 line 21ff.

> often wrong, mixing up events from different times and he would often make up events or embellish events that had occurred. However, those of us who knew him well understood him and knew how to communicate with him. There were times when we would work out what he meant and others when it was impossible, even for us, to understand him fully."

In paragraphs 17 to 19 of her witness statement [**E/62/4**], Rose Robba says that she had a good rapport with Resident L, whom she describes as "a sweet, bright boy who was aware of the fact that his behaviour was often out of his control", albeit he was "a large boy and very strong for his age and ... was capable of overpowering [her] with ease". In paragraphs 26 to 30 of her witness statement [**E/62/4**], she echoes Manuela Adamberry's evidence as to the changes made to Resident L's team and to his medication. She goes on (in paragraph 35 of her witness statement [**E/62/5**]) to confirm Manuela Adamberry's evidence that the two of them bought Resident L a farewell present on his leaving for the UK and accompanied him to the airport.

In the concluding section of her witness statement, headed "**My involvement in the Inquiry**" [**E/62/6-7**], she once again echoes the evidence in the corresponding section of Manuela Adamberry's witness statement (quoted above), pointing out that she has never worked in the Home.

In the course of her oral evidence, Rose Robba confirmed that she had never worked at the Home[1141], and that she worked with Resident L from 2008 until he left for the UK in 2009[1142]. Asked by counsel to the Inquiry about her experience of working with Resident L during that time, she said this[1143]:

> "Well, it went very well all the time, I think. I rarely had any problems with him, because I kept with what Mrs Adamberry told me to do, and I didn't really have any problems with it."

Asked about Resident L's violent outbursts, she said this[1144]:

> "Well, with me, ... he hit me twice only really. Once wasn't meant for me and the other one he did for no reason at all, just as an impulse ... Then he used to cry and say "I'm sorry, I'm sorry" and he used to kiss me. In two years that's the only problem I had with him really. .... [When he was becoming aggressive] Mrs Adamberry used to tell me "Don't get near him". By the time she told me I had already backed off. .... Then when he calmed down we used to talk to him. I used to dance with him. From the beginning we had very good relationships. I didn't have any problem whatsoever. .... [On] summer nights we used to take him to the Med [a Gibraltar rowing club]."

She went on to confirm that Resident L could easily have overpowered her, and that about three carers were needed to control him when he became violent, because he was "really large, and he was very strong as well: he was a very strong boy for his age"[1145].

[1141] See Day 10 page 110 line 11.
[1142] See Day 10 page 111 line 13.
[1143] See Day 10 page 112 line 24ff.
[1144] See Day 10 page 113 line 11ff.
[1145] See Day 10 page 114 line 22ff.

Asked for examples of Resident L's confused and inaccurate accounts of what had happened to him, as described in paragraph 23 of her witness statement (quoted above), she said this[1146]:

> "When he used to come sometimes from his mother's house, [Resident L] explained to us that he had hit his sister there. He used to say that his mother's boyfriend would hit him, but it wasn't true. .... Or when [Resident L] had a fight, he used to mix everything up. And we knew it wasn't true. We know that it wasn't true. .... Knowing his mother, we knew it wasn't true. .... He used to get a lot of things mixed up, with names and people, and incidents. He used to combine two incidents together and make it one ...."

As to Resident L's allegations against her, she said this[1147]:

> "Well, when Carmen Maskill told me, I was shocked, and then I laughed because I said nobody had ... guts to get over him and put his head in the toilet. Anyway, the toilet was that small that when you had to get in the toilet you had to go actually in and then turn and then close the door. Anyway, I never worked with Sharron Openshaw... I was night staff and she was day staff. .... I never worked days."

As to Resident L's allegation about "Robert", she confirmed Manuela Adamberry's evidence that there had been a child in care called Robert who had suffered sexual abuse[1148].

I turn finally to the evidence of Sharron Openshaw.

In paragraph 8 of her witness statement [**E/61/2**] she says that when Nicole Viagas handed her the suspension letter dated 8 October 2009 referred to earlier, she was told not to contact anyone from Social Services and that the police would be in touch with her in due course. She goes on to say that she was interviewed by the police in about February 2010, and told that she would be contacted by Social Services on completion of the investigation. In paragraph 11 of her witness statement she says this [**E/61/2**]:

> "11. Having heard nothing for several months following my interview with the police and having been specifically told not to contact SSA, I contacted the RGP in May 2010 and was informed by them that the case had been closed months ago and they confirmed their investigation concluded that the allegations had no foundation. I did not receive any notice or contact from SSA."

In paragraph 24 of her witness statement [**E/61/4**], she confirms that on being advised of an imminent disciplinary hearing in connection with the alleged mishandling of medication she decided to resign.

In her oral evidence, Sharron Openshaw confirmed that Manuela Adamberry and Rose Robba were the regular night staff at the flat at Flat Bastion Road[1149].

[1146] See Day 10 page 116 line 5ff.
[1147] See Day 10 page 122 line 20ff.
[1148] See Day 10 page 126 line 2ff.
[1149] See Day 10 page 96 line 23ff.

She said that the letter dated 8 October 2009 from Marie Carmen Santos (referred to earlier) had come as a "bombshell" to her, as that was the first she had heard of Resident L's allegations against her[1150].

Having reviewed the evidence relating to Resident L's allegations of sexual and physical abuse, I now turn to the question: What findings can be made on that evidence?

In the first place, the evidence before the Inquiry cannot justify a finding of sexual abuse of Resident L by any individual. The "Vicky" and "Robert" mentioned by Resident L remain unidentified. Whether, in making that allegation, Resident L was recounting what he had heard from, or about, a former resident of the Home whose name was Robert must remain a matter for conjecture. What can be said, however, is that there was no evidence that Resident L was ever sexually abused by anyone at the Home, whether staff or resident.

I turn, then, to Resident L's allegation that Sharron Openshaw, Manuela Adamberry and Rose Robba subjected him to physical abuse by (among other things) putting needles[1151] in his bottom, pulling his hair, and forcing his head into the toilet.

I accept the evidence of Resident L's carers, and I find the allegations of physical abuse by them to be entirely without foundation.

The allegation in relation to needles in Resident L's bottom is plainly a reference to injections administered by his carers (an example being the injection of sedative described by Manuela Adamberry in her witness statement as part of the preparation for his flight to the UK). I reject the allegation that Resident L was ever abused by the administering of injections.

I also reject the allegation that his carers abused him by pulling his hair. I accept without qualification the evidence of Manuela Adamberry and Rose Robba as to their relationship with Resident L and as to the standard of care provided to him. Nor, as I am satisfied, would Sharron Openshaw have indulged in such conduct.

As to Resident L's allegations in relation to the toilet, these allegations echo a similar allegation made by Emilia Bruzon in relation to her grandson, Resident Z, some years earlier (an allegation which I have already rejected[1152]). I have no hesitation in rejecting this allegation too. Quite apart from what I find to be the physical impossibility of acting in the manner alleged (given the size of the toilet at Flat Bastion Road), I find it inconceivable that any of the three carers would have acted in that manner.

[1150] See Day 10 page 100 line 17ff.

[1151] In paragraph 5 of the document sent by Warwickshire Child Protection Services quoted earlier [**J1/116/17**], Resident L is quoted in the first subparagraph as saying: "They put things to my bum"; but in the following subparagraph he is quoted as referring to "needles in my bum".

[1152] See Chapter 7 of this Report.

Lastly, I note the evidence that carers who replaced Manuela Adamberry and Rose Robba at Flat Bastion Road found it difficult to deal with Resident L. This, again, is not a matter for this Inquiry. I merely comment that Resident L was on any view an unpredictable and sometimes dangerous resident. Consequently it is not altogether surprising if replacement carers who did not have the same experience and expertise as Manuela Adamberry, or for that matter the same degree of affection for Resident L as she clearly has, tended to keep him at arm's length where possible.

CHAPTER 15: The care provided in the Home from 2006 to date

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CHAPTER 15:
The care provided in the Home from 2006 to date

There was general agreement amongst those witnesses who were in a position to give evidence about the period from 2006 to date that structures and standards in the Home improved gradually over that period, to the point where there was general approval by those witnesses of the current state of affairs in the Home. There was also unanimous praise for the efforts and contribution of Carlos Banderas (I consider his evidence later in this Chapter).

The only seriously discordant note was sounded by Gayle Everest, who gave evidence to the effect that there was no alcohol policy in place in the Home when she left in about 2011[1153], and that residents were not allowed an appropriate degree of independence[1154]. I have already rejected that evidence[1155], which is in any event contrary to the evidence of Carlos Banderas, reviewed later in this Chapter.

General approval

The following references give a flavour of the generally favourable views of the witnesses.

In paragraphs 47 to 52 of her witness statement [**E/68/7**], Debbie Guinn says this:

> "**Current management**
>
> 47. I am of the opinion that standards within [the Home] have continued to improve over the past few years as a result of the tenacity of the dedicated staff teams, changes to systems and more effective communication between different professionals, the service users[']families and significant others.
>
> 48. Adaptations and reforming of the physical building has taken [place] and has greatly improved the physical environment within the different flats.
>
> 49. Carlos Banderas is a dedicated, pro-active manager who has set down a number of systems to ensure best practice takes place within the [Home], working policies and procedures are introduced. There is open and effective communication between the different stakeholders and social workers are encouraged to actively participate in setting down the policies and working practices within the flats.
>
> 50. All workers are required to attend a rolling programme of training on a regular basis to include training specific to the service.
>
> 51. Qualified nurses are also present, providing support and ensuring workers [have] access to management on a 24 hour basis.

[1153] See Day 11 page 16 line 10.
[1154] See paragraph 32 of her witness statement [**E/13/6**] and Day 11 page 33 line 13ff.
[1155] See Chapter 7 of this Report.

> 52. The social workers and I meet the various managers and workers within [the Home] on a regular basis to ensure the best interests of the service users remain paramount and any issues arising are quickly resolved."

In the course of her oral evidence, Debbie Guinn was asked for her general impressions of how things were in the Home from 2006 to March 2011, when Carlos Banderas took over the management of the nursing team at the Home. She gave the following assessment[1156]:

> "I think things did move forward inasmuch as ... more policies and procedures were being put in place, that a rolling training programme was put in place, so there was more of a commitment to training within [the Home], and people were freed up to make sure that they could participate in the training. I think Iain [McNeil] did a lot of work looking around at personalised care-centred approach to people. I think it had been moving forward ... in the time when I was actively involved[1157]."

Asked whether it would be correct to say that her impression was that things gradually improved after 2006 to the point where, under the present management, things were functioning pretty well, she replied[1158]:

> "Yes. I think lots of things were implemented, like we had the admin workers[1159]. [The Home] had admin support, the senior support workers were able to have access to computers, whereas before they hadn't got access to computers, which made it very difficult for effective communication with ... the social workers .... Different systems were put in place, some on the recommendations which were made in the reports[1160]. A lot of the work the social workers did was collated and used in the business Plan which Iain [McNeil] put forward[1161]. I don't think it was ever implemented, but a lot of the suggestions were actually implemented. So that moved it forward to a degree as well."

She said[1162] that the improvement in care standards in the Home over the last few years was due to:

> "... the tenacity of the dedicated staff teams, it's not just the manager but the fact that everybody wants to drive the service forward, and the culture has definitely changed within [the Home]."

She went on[1163]:

> "My belief is [that] the culture has changed significantly, as people have left and new people have joined, because everybody has a very thorough induction, so new workers now understand what the working practices are, so they have more power within the systems."

In his oral evidence, Sean Matto was asked how things were in the Home as of today. He replied[1164]:

[1156] See Day 15 page 196 line 10ff.
[1157] i.e. prior to 2009.
[1158] See Day 15 page 196 line 25ff.
[1159] i.e. administrative assistants.
[1160] A reference to the reports of the social workers reviewed in Chapter 11 of this Report.
[1161] See Chapter 11 of this Report.
[1162] See Day 15 page 195 line 5ff.
[1163] See Day 15 page 195 line 9ff.
[1164] See Day 7 page 210 line 6ff.

> "Things are probably ten times better than they were in the past. Resources are much better, there is much better structure, it's much more professional. .... In the past ... they [i.e. the staff] all tried their best. They weren't very good at it, some of them, but they tried their best and you could see they tried their best."

In paragraph 24 of her witness statement in the Inquiry [**F/2/7**], Jennifer Poole says this:

> "24. I am more satisfied now with the kind of care being provided to the residents since Carlos [Banderas] has been working there. The management of the Home is more effective. The residents have more activities which are organised for and appropriate for them and they go out more."

Maurice Valarino also expressed a high opinion of Carlos Banderas in paragraph 22 of his witness statement in the Inquiry [**G/6/5**], saying that he is extremely happy with the work Carlos Banderas is doing in the Home, adding that he is "really helping and improving the Home and Goole House" (where Resident X resides).

He was somewhat less complimentary about Goole House itself, saying (in paragraph 20 of his witness statement [**G/6/5**]) that there was on occasion a lack of communication between relatives and staff. On the other hand he went on to say that the care of Resident X is of a better standard than it was in the Home and that his move to Goole House was beneficial to him.

Gina Llanelo was generally less complimentary. In paragraph 13 of her witness statement in the Inquiry [**F/20/3**], she makes the general comment that many things have been promised in terms of progress and advancement in the Home throughout the years but that "nothing has ever come to fruition". She goes on to say that things have been attempted by various individuals but that mountains cannot be moved by a single person. However, she acknowledges that some improvements have been made. By way of example, she notes that each parent is now allocated a social worker; a development which she regards as "very helpful and beneficial."

I feel sure that Gina Llanelo did not intend her comment that "nothing has ever come to fruition" to be taken as a general comment on the state of affairs in the Home: indeed, it is contradicted by her subsequent acknowledgment that some improvements have been made, as well as by the evidence of other witnesses. Rather, I take it as meaning that not every attempt by individual managers to improve respite care met with success, on the basis that, as she rightly says, mountains cannot be moved by a single person.

Frederick Becerra ends his witness statement in the Inquiry [**G/1/2**] by saying this:

> "I am of the opinion that the Home has however improved since Milbury left. There is better communication between parents and staff now and we even engage in monthly meetings (coffee mornings) where all issues and procedures are discussed.

> I am happy with the work the current staff is doing at the Home and have no complaints about the current treatment of my daughter, [Resident O]."

I refer next to evidence relating to specific aspects of the operation of the Home during the period from 2006 to date.

Increased input of social workers

In paragraphs 23 to 27 of her witness statement [**E/68/4**], Debbie Guinn says this:

> "**Roles**
>
> 23. The key worker system was set down in the Home and a key worker and social worker were appointed to each service user. A system of Annual Reviews and Individual Planning Meetings for each service user with the social workers and family representation where possible was also set down in line with UK systems. Clear objectives were to be set and then reviewed at the next meeting to see if they had been met thus highlighting a clear indication of progress being achieved.
>
> 24. The social worker's role was to act as the main link between the Home and a service user's family and they were responsible for setting up any services required outside the [Home], for example attendance at a work placement. The key worker was responsible for [the] setting down of any activities or appointments required by the person on a day to day basis.
>
> 25. I was very keen to formalise all services being provided by the Adult Team to include clear pathways to services both within the community and service users and daycare settings. Marie Gomez, Team Leader and the social workers were very supportive of all these suggestions although they were aware of the increase these changes would make to workloads as they were all raising concerns. Multi-agency case conferences were also set up in order to be able to share information, raise concerns about individual people and set down clear plans.
>
> 26. Iain [McNeil] also continued to instigate the formalisation of different system[s] on his promotion to Head of ... Residential Services but reported he met at times with some difficulties due to his workload and areas of responsibility.
>
> 27. After Iain [McNeil] left and the Team Leader for Disability was created under the Care Agency, Marie Gomez spent larger amounts of time in [the Home] and St Bernadette's. She was eventually based in St Bernadette's on a permanent basis until her retirement. Elizabeth Harrison also spent a period of time based in St Bernadette's and spent time in [the Home] in order to provide extra support and assistance."

As already noted, Gina Llanelo found the increased input of social workers to be "very helpful and beneficial".

Care plans

In paragraph 16 of her witness statement [**E/68/3**], Debbie Guinn says that following her transfer to Adult Services (in July 2005) she initiated a system to ensure that every service user had a comprehensive assessment of needs completed in conjunction with their families and carers: i.e. a care plan. She goes on:

> "This document outlined important areas of the person's life that could be used to ensure their individual needs were identified and met. The system of reviewing services within the Home was also set down via Individual Planning Meetings."

In paragraph 19 of her witness statement in the Inquiry [**F/2/6**], Jennifer Poole says this:

> "19. .... One of [Iain McNeil's] tasks was to set up a system of individual plans for each resident and this did happen. Care plans, risk assessments, personal information, "day in my life" documentation is all now in place."

Training of staff

With reference to the training of staff in the period after Joanna Hernandez had left, Debbie Guinn said that "everybody had at least an intensive two-week training programme"[1165]. She continued[1166]:

> "We did ... a rolling programme for people within the Home where we would go at the end of a team meeting and do a particular topic, and on a few occasions we did a half-day programme on different things."

In the course of her oral evidence, Jennifer Poole said that when the Care Agency was formed (in 2009) a core generic training programme was introduced whereby all employees had to go through a two-week induction programme of basic training covering "all the core topics" and involving working with service users. She described the programme as follows[1167]:

> "It's a two-week induction programme with at least all the core topics that need to be covered in terms of awareness [of] abuse, medication training, manual handling, first aid, things that before weren't even offered at all. After that there is obviously a period where they are shadowing other workers as well and they are supervised on site. In comparison to what there was, it's miles ahead."

She went on to say that prior to the introduction of the core induction training programme there were induction programmes in place but they were of a less extensive nature[1168].

She said, in relation to training of staff, that she was satisfied that "we are moving in the right direction"[1169].

With reference to the training of staff, Sean Matto said this[1170]:

> "The turning point of the care in Gibraltar, in my opinion, was when the NVQs really took off[1171]. .... I was very much involved ... We were actually supported by the Union and in fact

[1165] See Day 15 page 117 line 18.
[1166] See Day 15 page 118 line 8ff.
[1167] See Day 5 page 139 line 20ff.
[1168] See Day 5 page 140 line 11.
[1169] See Day 5 page 119 line 16.
[1170] See Day 8 page 50 line 13ff.

> even higher management and I presume Government, that's why it was funded, and thereafter ... the standards considerably improved."

In the course of her oral evidence, Gina Llanelo said that staff training was "much, much better"[1172].

Recruitment of staff

With reference to the recruitment of staff from 2005 until the Care Agency took over in 2009, Debbie Guinn said this[1173]:

> "We had a very formal interview process which involved a group exercise to actually see how people worked as part of a team. We had an interview, and also because at the time Finance were raising that there were major issues around the petty cash being correct, ... we also got each worker to do a very brief little task adding up about six receipts and filling in the imprest to try and get away from that problem."

She went on to say that after the Care Agency took over she was no longer actively involved in recruitment[1174].

In paragraph 16 of her witness statement, Jennifer Poole says this, with reference to the recruitment of staff [**F/2/5**]:

> "16. .... [R]ecruitment for Home employees used to be undertaken by the SSA in conjunction with the Home Manager. Advertisements were placed in the Gibraltar and Spanish English language newspapers because all documentation at the Home has always had to be completed in English. Workshops and interviews followed. Now, I think that recruitment is undertaken by the Care Agency for all of its organisations. The final selection process is now based on an interview only. Everyone is now CRB checked[1175] here and in Spain and if an employee is [a] Spanish resident he has to provide updates."

Independence of residents

Asked by counsel for the Gibraltar Disability Society whether progress had been made since 2005 in enabling service users to become more independent, Debbie Guinn replied[1176]:

> "Yes, definitely."

[1171] In his evidence, Sean Matto made clear that he was talking about 2007/8: see Day 8 page 50 line 22.
[1172] See Day 4 page 15 line 6.
[1173] See Day 15 page 193 line 18ff.
[1174] See Day 15 page 194 line 5.
[1175] i.e. screened for a criminal record.
[1176] See Day 15 page 205 line 20.

Staff shortages

As to the perennial problem of staff shortages, Gina Llanelo says (in paragraph 8 of her witness statement in the Inquiry [**F/20/2**]) that "staffing levels at the Home have always been very poor and still to this day remain poor, albeit somewhat better".

Yvette Del Agua said that so far as she could recall the recommendations in Rod Campbell's report[1177] in that respect were duly implemented[1178]. That is consistent with the fact that (as Carlos Banderas demonstrated in his evidence, reviewed below) the problem has been addressed to the point where it is no longer so pressing.

No doubt additional staff will always be welcome in an organisation such as the Home, but with the present complement of staff in the Home, coupled with the fact (noted in Chapter 1 of this Report) that the number of permanent residents has remained relatively constant since 2005, the pressures and stress on individual members of staff are significantly less than in previous years and the standard of care which the staff are able to offer is consequently higher.

Relationships between members of staff

Gina Llanelo says (in paragraph 18 of her witness statement in the Inquiry [**F/20/4**]) that there are no longer two factions among the staff in the Home, and that the staff now show a "more united front"; a development which she describes as "constructive for both management and service users".

Medication

As to medication, Jennifer Poole said that following her report in December 2005[1179] arrangements had been made for medication to be administered by nurses[1180]. This is confirmed by Elizabeth Harrison in paragraph 24 of her witness statement [**F/6/5**].

Gina Llanelo says (in paragraph 16 of her witness statement in the Inquiry [**F/20/4**]) that she has never had problems with nurses administering Resident AC's medication, noting that "medication procedures have been tightened over the years".

[1177] See Chapter 11 of this Report.
[1178] See Day 12 page 90 line 24ff.
[1179] See Chapter 11.
[1180] See Day 5 page 124 line 4.

Physical facilities

As to the physical facilities, Jennifer Poole says this in paragraph 23 of her witness statement in the Inquiry [**F/2/7**]:

> "23. .... [I]n 2005, the Home was not particularly disability friendly. Wheelchair users could not reach the kitchen worktops, for example, and the bathrooms were not custom designed so that the baths were not accessible by all residents. There was also a lot of wear and tear. The condition was not appalling but it did reflect the budget restraints imposed on the Home at the time. Now there have been refurbishments and the facilities are in a much better condition."

Elizabeth Harrison says in paragraph 23 of her witness statement [**F/6/5**] that in 2009 new baths were installed, which (as she puts it) "drastically improved the facilities at the Home".

This is confirmed by Albert Bruzon. In paragraphs 99 to 101 of his witness statement [**J1/1/24**], he says this:

> "99. In early 2005 [Gibraltar Joinery & Building Services Ltd] were contracted again to improve the bathroom facilities at Flats 1, 2 and 3 of the Home ....
>
> 100. On 30th March 2007 [an occupational therapist] stated, after having assessed each resident at the Home, that there was an essential need for major adaptations to all of the bathroom areas at the Home to make them safer and more homely for service users ... This was echoed by Elizabeth Gallagher in a report dated 14th July 2008 ... which added further issues to those identified by [the occupational therapist] ... Proposal drawings and an estimated value of the works were sought and obtained from the Technical Services Department on 17th July 2008.
>
> 101. A letter from Carmen Maskill to [Gibraltar Joinery & Building Services Ltd] dated 3rd December 2009 shows that a meeting was held on 2nd December 2009 and works to refurbish the bathrooms were agreed to commence on 17th January 2010 ... Respite service users were moved out of the Home to Merlot House and/or to Tangier View[1181] in the meantime ... [T]hese works were on-going on 26th March 2010. The works were completed by 26th April 2010 ..."

Administrative structures

In the course of her oral evidence, Alison Baldachino[1182] was asked whether administrative structures in the Home had improved since 2004. She replied[1183]:

> "Yes, as far as I know things had been improving ever since I started ... there [have] always been improvements. [Things are] a lot better than what they used to be."

Alison Baldachino's evidence (as set out above) was confirmed by Marie Carmen Santos in the course of her oral evidence, when she said that the administrative problems in the Home pre-

[1181] Properties belonging to the SSA, but not part of the Home.
[1182] Alison Baldachino has been employed by the SSA (and subsequently by the Care Agency) for the last 11 years as an administrative officer. She worked at the Home for some three to four months in 2005 to assist with administration.
[1183] See Day 5 page 183 line 5ff.

2006, and in particular the problems with rotas and completion of overtime sheets, were finally resolved when the Home was provided with administrative support[1184].

Petty cash

As to the problems concerning petty cash referred to earlier in this Report, Natalie Fortuna said in the course of her oral evidence that the financial systems at the Home eventually improved, although it took "years"[1185]; and that from 2005 onwards, there were no more incidents of petty cash going missing and record-keeping improved.

Also, Craig Farrell said in the course of his oral evidence that whereas until three or four years ago the petty cash was kept in a tin with a lock on, it is now kept in a safe[1186].

The respite service

Gina Llanelo says (in paragraph 11 of her witness statement in the Inquiry [**F/20/3**]) that relatives of respite users have never been fully introduced to the carers who look after their family members, although she goes on to say that "this has got slightly better but usually we know little more than the carer's first name."

However, in paragraph 19 of her witness statement [**F/20/4**] she strikes a more positive note, saying:

> "19. .... Our routine with the Home is a lot more settled now than it was in 2006. If [Resident AC] cannot be looked after at the Home for any reason when he is due to enter for respite we are advised of this well in advance to allow for alternative arrangements to be made."

In paragraph 24 of her witness statement Gina Llanelo says this [**F/20/5**]:

> "24. I am now much happier with the respite regime in place but will say that the staffing problems are still a very prevalent issue. The Home has improved a lot since Carlos [Banderas] has been put in charge and he should be given credit for the work he has [been] and is doing. I would also commend carers such as Nathan Santana and Craig [Farrell] who have contributed to [Resident AC's] advancement and development over the years."

In the course of her oral evidence, she acknowledged that things had been improving gradually[1187]. She said that before Carlos Banderas arrived there had been a slight improvement over the years[1188], but that he had made great improvements, adding that "if you have any

[1184] See Day 15 page 63 line 4.
[1185] See Day 4 page 45 line 1ff.
[1186] See Day 9 page 57 line 5ff.
[1187] See Day 4 page 13 line 25.
[1188] See Day 4 page 14 line 22.

complaints he will actually see it through and tell you the results"[1189]. She went on to say that communication between relatives and staff had also improved during the last two or three years[1190]. She said that she was generally content with the care which Resident AC is currently receiving[1191].

Elizabeth Featherstone gave oral evidence to broadly the same effect as Gina Llanelo, saying that things were improving all the time[1192]. She noted in particular the fact that relatives were allocated a social worker, and that there was better communication between relatives and staff[1193].

Violet Sullivan also gave evidence to broadly the same effect.

In the concluding paragraph of her witness statement in the Inquiry she says this [**F/12/7**]:

> "35. I would however like to set out that I am happy with the work that the current staff is doing at the Home. Carlos Banderas is a credit to himself and a very helpful and enthusiastic person. I would also add that Nathan Santana, who dealt with [Resident I] for many years, was a great carer."

In her oral evidence, Violet Sullivan described Carlos Banderas as "a breath of fresh air for us"[1194].

As mentioned above, Frederick Becerra was also satisfied with the current state of the respite service. Asked by counsel to the Inquiry whether he was happy with the care which Resident O had received since 2002, he replied[1195]:

> "Yes, and it's getting better. .... There is more communication between parents and [the Home], and we have an excellent Manager."

Finally, so far as the respite service is concerned, I note that in her letter to Chris Wilson dated 22 January 2008 [**M5/4/1**] Carmen Dixon-Pritchet said this:

> "The respite service is of [a] high standard, the carers are excellent and professional. Most important of all is that [Resident AD[1196]] loves going there."

[1189] See Day 4 page 14 line 9.
[1190] See Day 4 page 15 line 14.
[1191] See Day 4 page 15 line 19.
[1192] See Day 3 page 8 line 8.
[1193] See Day 3 page 7 line 24ff.
[1194] See Day 4 page 97 line 2.
[1195] See Day 3 page 60 line 16ff.
[1196] Resident AD became a permanent resident in 2010.

Other issues

In her witness statement in the Inquiry, Jennifer Poole addressed a number of other issues, as follows [**F/2/5-9**]:

> *Organisation and appraisal of staff*[1197]
> "17. .... I recall that Chris Wilson at one time did try to start appraisals, ... however they did not continue. Staffing ratios at the Home [have] always been an issue. There have always been very high sickness absence levels and little relief cover. Until quite recently, 18 employees were out. Cover would often have to be provided by other full time employees already working at the Home which would result in burn out. The Inquiry has resulted in higher levels of stress absence in those working at the Home. There is also the inevitable tension between the carers views on how many of them are needed – ideally, this would be on a one-to-one basis for optimum quality of life for residents – and the economic constraints of the service. In respect of supervision, carers are supposed to be supervised by the unit managers for each flat, but unfortunately they are not always there, particularly at night. In addition, there is however at night a nurse who "floats" between the flats. Presently, unit managers are required to give formal monthly supervision to all carers. This was not the case before. However, I am not sure how much formal supervision is actually taking place."
>
> *Procedures for internal reporting and record-keeping*[1198]
> "18. .... Probably as a result of Elizabeth's and my reports, record-keeping since Iain [McNeil]'s time as manager has been much better."
>
> *Working relationships between staff and residents*[1199]
> "20. .... In 2005 there was a very good atmosphere within the Home between the care workers and the residents. As in most organisations, there was not such a good atmosphere between management and the care workers. It could possibly be said that the care workers were too relaxed and tended to treat the flats like their own homes. They used to all have breakfast together when they arrived at work, for example. .... This does not happen [any more]. Some carers went, some still do, go above and beyond in their care for residents ...."
>
> *Care of younger residents and residents of differing genders*[1200]
> "21. .... I think that appropriate arrangements were made for the care of younger residents and residents of different genders. The 2 child residents at the time, [Resident Z] and [Resident L], were cared for in the community by carers from the Home because they had the necessary expertise and experience in their conditions. In relation to toilets, there were appropriate arrangements for the care of residents of differing genders. There were separate toilets and each resident had a routine, so this did not pose any problems."
>
> *Communication between staff and relatives*[1201]
> "22. .... I would say that, if anything, there was too much ease of access for the residents' family members. People were always wandering in and out of the flats, both residents' and employees' relatives, and not always signing in. This has now changed and so far as I am aware does not occur [any more]. Since [Iain McNeil]'s time, family members are always informed as soon as possible of an injury and/or a hospitalisation. Care workers inform parents of other incidents involving their family members if/when this was indicated by the resident's care plan."
>
> *Code of conduct for staff*[1202]
> "33. .... [M]anuals were introduced by Milbury. Later on, [Iain McNeil] introduced information packs. I think that a staff handbook is now being prepared."

[1197] Issue (4) in the List of Issues .
[1198] Issue (5) in the List of Issues.
[1199] Issue (7) in the List of Issues.
[1200] Issue (8) in the List of Issues.
[1201] Issue (9) in the List of Issues.
[1202] Issue (21) in the List of Issues.

I accept all the above evidence. Overall, it paints a healthy picture of the current state of affairs in the Home: a picture which is confirmed by the evidence of Carlos Banderas, to which I now turn.

The evidence of Carlos Banderas

Carlos Banderas is a Registered General Nurse and has been employed by the Care Agency (and by its predecessor the Elderly Care Agency) since 2002. In 2004 he was appointed nurse in charge/team leader of a 35-bed floor at Mount Alvernia, the residential home for elderly residents in Gibraltar. In 2007 he was transferred to the Jewish home as nurse in charge/team leader, where he managed the residential and respite services. In March 2011 he took over the management of the nursing team at the Home. He worked at the Home until December 2011, when he was appointed team leader of Disability Services in an acting capacity. At that point he returned to Mount Alvernia until July 2012, when he was asked to manage the disability service and to assist in implementing numerous policies designed to improve the running of the Home and the care offered to residents.

Carlos Banderas made two witness statements in the Inquiry, and he gave oral evidence.

In paragraph 5 of his first witness statement in the Inquiry [**J1/124/2**], he describes the Home as it is today, as follows:

> "5. .... The Home is a residential facility [consisting] of five flats..., each with a bedroom for each service user, a fully equipped kitchen and bathroom/wet room facilities, and [their] own communal lounge. The Home currently accommodates 13 permanent residents with a wide spectrum of conditions largely consisting of a mix of learning disabilities, mental health problems and Down Syndrome. The Home also provides respite services...."

In paragraph 7[1203] of that witness statement [**J1/124/2**], he describes to Goole House as follows:

> "7. In addition there is also one supported living home in the community at ... Goole House.... This property is outside of the Dr Giraldi complex, but management from Dr Giraldi is responsible for the day to day running of this flat. Goole House is used by vulnerable adults who have a learning disability or who are recognised as being on the Autistic Spectrum. At present there are two permanent residents in this accommodation."

In paragraphs 8 and 9 of that witness statement [**J1/124/2**], he says this:

> "8. Both the Home and Goole House operate 24 hours a day, 7 days a week to provide care and support to its residents. ....
>
> 9. I am concerned that it seems that there are some service users whose disability has not been properly diagnosed. This is a concern that is shared by the social workers. As a result, the Care Agency (the adult team of the social services department and myself) are liaising with the

[1203] There is no paragraph numbered 6.

> [Gibraltar Health Authority] with a view to engaging a specialist doctor to assess all residents/service users with a view to providing a detailed diagnosis."

In the next section of his first witness statement, Carlos Banderas sets out details of the current staffing arrangements in the Home. In paragraph 12 of his witness statement he sets out the allocation of the staff members as between the various flats, as follows:

- In Flat 1 there are 6 permanent residents (including Resident T) with an age range of between 34 and 60. They are cared for by a Unit Manager, 14 full-time care workers and 2 part-time care workers.
- In Flat 2 there are 4 permanent residents (including Residents AA and J). They are cared for by a Unit Manager and 14 full-time care workers.
- In Flat 3 (the respite flat) there is one permanent resident (Resident I). The flat also offers respite and sitting services for 11 respite users from 4pm to 9pm. There is one Unit Manager, 6 full-time care workers and 6 part-time care workers.
- In Flat 4 there is one permanent resident (Resident AD). This flat shares a Unit Manager with Flat 5. There are 11 full-time care workers allocated to this flat.
- In Flat 5 there is one permanent resident (Resident AE). In addition to the shared Unit Manager, this flat has 10 full-time care workers.
- In Goole House there are two permanent residents (Residents A and X). There is a Unit Manager, 5 full-time care workers and 1 part-time care worker.

He goes on to say that arrangements are also being made for the introduction of a behavioural support officer, with a view to the development of behavioural care plans in the Home.

As to development and training, Carlos Banderas says (in paragraphs 14 and 15 of his first witness statement [**J1/124/3-4**]) that all members of staff are now required to undergo, within the first three months of their employment, a comprehensive Core Training Programme comprising the following elements:

- an introduction/induction to the Agency;
- an introduction to personal development;
- the principles of safeguarding and protection in health and social care;
- an introduction to the role of the health and social care worker and duty of care;
- equality and inclusion;
- contributing to health and safety, food safety and infection control in health and social care;
- values, attitudes and beliefs workshop;
- professional boundaries workshop;
- introduction to communication in health and social care;
- handling information and data protection training;
- implementing person-centred approaches in health and social care;

- fire safety, EVAC chair[1204], Anglia blanket and basic life support;
- manual handling;
- conflict resolution – level 1;
- drug and alcohol awareness;
- customer care (i.e. placing the needs of service users first);
- meeting the needs of service users;
- practical skills; and
- emergency first aid at work.

The Core Training Programme is delivered over the course of three weeks, and applies to all Care Agency employees.

In the next section of his first witness statement, comprising paragraphs 17 to 26 [**J1/124/7-8**], Carlos Banderas turns to training and courses specific to the Home, saying this:

> "17. In addition to the core training described above, on entering the Home, all new employees will spend a full day with me and my management team. Thereafter they shadow a senior care worker/unit manager, who is tasked with mentoring the new employee for two weeks. As part of this mentoring process the new employee will be shown around the Home, will be taught about the workings of the Communication Books, the philosophy of care, the dress code and the general workings of the Home.
>
> 18. All care workers at the Home need to attend theoretical training in how to administer medicines safely and how to recognise adverse reactions to medication. This training is provided by Dr [Margaret] Williams who was a tutor at the School of Health Studies at the Gibraltar Health Authority .... Care workers are then assessed by a qualified nurse in the safe administration of medicines .... [A]lthough this policy was in place before I took up my role at the Home, I have ensured that all staff adheres to it.
>
> 19. In addition, it is currently proposed that every year one of the unit managers at the Home will attend a training course leading to a recognised management qualification. At present, one of the Unit Managers is undertaking the course and is due to complete this in October 2013 when a further member of staff will commence the course.
>
> 20. The fact that some residents present challenging behaviour means that employees are required to attend Dignified Care and Responsibility Training. Whilst the initial response to challenging behaviour is always to try and de-escalate the situation, staff also need to be able to identify any possible risks and to have the know how to deal with this should the need arise. All staff who deal with persons with disabilities (both at the Home and St Bernadette's) are required to attend Dignified Care and Responsibility Training Level 1. In the past this training has been carried out by a private company and the employees receiving the training were only those who worked with service users who had challenging behaviour. This changed in December 2012 when four employees received the necessary training (Dignified Care and Responsibility Training Level 2 and 3) to be able to train all staff at the Home themselves.
>
> 21. This initiative of providing staff with the necessary training so that they can go on to become in house trainers has also occurred in the following areas:
>
> - Manual handling: 4 members of staff attended a course in March 2013 and will now be providing refresher training to existing staff who have done this core training and a full day of training to new entrants.

[1204] This is a device which assists people with physical disabilities to go up and down stairs.

- Basic life support training: One person attended a course in Bleak House and is now giving basic life support sessions to all care workers at the Home.

The fact that staff members[s] have received this high level of training so that they can become trainers has proved to be a morale booster.

22. In March 2013, the Care Agency occupational therapist, who is ... a strategy coordinator and specialist in learning disabilities, begun giving care workers training in managing behaviour and calming techniques as well as a course on completing behavioural incident forms. This individual originally used to work at St Bernadette's but her work has [now] been extended so that she provides her services to the Home. In addition, the occupational therapist has been providing certain residents [with] sessions relating to practical skills for improving their independent living, this has included budgeting skills and time management skills. Further, the occupational therapist has also been providing some residents with anxiety alleviating sessions.

23. In addition to the food safety course that all Care [A]gency staff receives during their Core Training Programme, the majority of the staff at the Home have also attended more specialist training in Food Safety. This course was given to staff by the Environmental Agency. In keeping with the healthy lifestyle ethos which is promoted at the Home a dietician from the [Gibraltar Health Authority] has, since 2013, been coming to [the Home] in order to promote awareness of healthy eating habits.

24. There are some residents/service users who use Makaton sign language as a means of communication. These residents/service users would have learnt Makaton whilst in school. However, the difficulty we had at the Home was that generally the staff did not know how to communicate in this manner. Since February 2013 most staff members have received Makaton training. I also arranged for some of the parents/guardians of the residents/service users who use Makaton to attend an up-to-date training session so that they can update their knowledge. All of this training is delivered by the [Gibraltar Health Authority].

25. In February 2013 three staff members received additional training on Safeguarding Vulnerable Adults and have become Safeguarding Adults at Risk Lead Managers. As people with specific training in identifying suspected abuse, their role is to report any matter that they feel needs investigating to the safeguarding adult coordinator. This does not in any way prevent any member of staff from reporting suspected abuse to their line manager. The aim of this is to ensure that there are people trained to identify inappropriate conduct which may not be obvious to other staff members. Further, all the residential managers, unit managers and registered nurses have been trained in safeguarding adults at risk. This training has been provided by some members of the Safeguarding Adults at Risk Committee which consists of the team leader of the Adults team of the social services department of the Care [Agency], a member of staff from the [Gibraltar Health Authority], a member of staff [from] the Elderly Care Services and me.

26. In March 2013 all staff at the Home attended an autism conference in Gibraltar organised by the training department of the Care Agency. In November 2013, the British Institute of Learning Disabilities will be providing a one-day course on understanding learning disabilities. I am aware that further training on disability has been organised and will take place later in the year and Dr Giraldi staff will be attending."

In paragraph 28 of his first witness statement [**J1/124/9**], in a section headed "Policies and Procedures relating to the Home", Carlos Banderas exhibits a 227-page Manual entitled "Policy and Procedure Guidance Manual For Staff". He describes it as a working document, the aims of which are to provide up-to-date information and guidance to staff, to establish safe working practices, and to set out the standards of conduct and care which are expected of members of staff. The Manual covers a wide range of topics, including:

- recognising abuse;

- how to raise concerns about abuse;
- dealing with aggressive behaviour;
- restraint policy and procedure;
- accidents and reporting;
- first aid and basic life support;
- misuse of drugs;
- alcohol policy;
- raising and reporting concerns regarding bad practice; and
- medication policy.

As to the medication policy, Carlos Banderas says this in paragraphs 29 and 30 of his first witness statement [**J1/124/10**]:

> "29. The Medication Policy is regularly updated, and a new version was produced in January 2013 ... This deals with the process which must be followed by Care Agency staff when administering medicines. In particular, it is Care Agency policy that the administration of medication must be performed by two members of staff, one of whom must be a Registered Nurse; the care workers are also involved, to ensure that in the event of an outing, without a Registered Nurse present, they are familiar and able to safely and correctly administer any medication. All Registered Nurses are assessed by Dr Williams on a yearly basis. If mistakes in the administration of medication occur repeatedly, Dr Williams is recalled to reassess the relevant Registered Nurse or [provide] any extra training. The policy also covers audits of medication, the Medicine Administration Record and the procedure to follow in the event of errors or adverse reactions to medication. Audits and stock control are carried out by the duty registered nurse or the Home Manager. Keys for the medication cupboard are only held by the registered nurse on duty. At the end of each shift, the medication book must be checked by the outgoing and incoming staff members. Stock is checked on every night shift. Staff are assessed annually on their competence in assisting in the administration of medicines in the Home.
>
> 30. In early 2013 medication cupboards were placed in all of the flats in the Home, prior to this date there were only medication cupboards in three of the flats. This has ensured that each resident has their medication in their own flat and reduces the chances of mistake. A medical fridge was also purchased in April 2013. In order to support those [administering] medication, we have recently placed laminated leaflets explaining the contents and possible side effects of each of the medication that residents/service users take. The Medicine Administration Record ("MAR") sheets, which note what medication has been prescribed and administered to each resident/service user has also been amended recently to ensure that there are two signatories to this document meaning that there are now proper checks and balances in place. In March 2012 photographs of the relevant resident/service user were added to the covers of all "MAR" sheets, this means that it is now easier to identify which MAR sheet relates to which resident/service user .... In February 2013, a Medication Audit was implemented. This sets out a list of requirements relating to the MAR sheets and the administration of medication which all staff must comply with."

Carlos Banderas goes on to say (in paragraphs 32 and 33 of his first witness statement [**J1/124/11**]) that regular residential environmental audits of the flats are carried out so as to ensure that appropriate standards are maintained in each flat; and that a policy has been put in place which is designed to allow residents to achieve "an optimum level of independence in managing their financial affairs". In paragraphs 35 and 36 [**J1/124/11-12**] he notes that care workers are bound by a code of practice which sets the standards of professional conduct and

practice required of care workers, and points out that their performance is regularly reviewed. In paragraph 37 [**J1/124/12**] he summarises the current disciplinary procedures.

In paragraphs 40 to 45 of his first witness statement [**J1/124/13-14**], under the heading "Daily Care", he says this:

> "40. Apart from strict adherence to the policies, staff members are expected to ensure that each resident enjoys the benefit of a personalised care plan .... The care plans are prepared with the resident's/service user's allocated social worker and other relevant professionals, with the views of relatives also being considered. Since October 2011 residents also have, amongst other things, a Health Plan, Daily Care Plans, Risk Assessments and, for those with special communication needs, a Communication Plan. A Transition Plan ... has recently been drafted between the occupational therapist and me. This is a new initiative which aims to have an organised and non-traumatic transition from St Martin's, St Bernadette's and the Home. ....
>
> 41. Daily Diaries are kept for each resident, and staff work on a shift pattern which allows a complete handover to take place; the day staff work from 9am to 9.30pm and the night staff work from 9pm to 9.30am. This ensures a physical handover between staff coming in on a new shift, which takes place in a quiet room, away from service users to allow confidential information to be discussed. A clear written report on each service user will also be handed over at the end of each shift. Staff are required to complete a newly devised shift planner that is flat specific, ... Each resident has an action plan in place, ... Since June 2013, a monthly "Documentation Audit" has been introduced ... ensuring that all policy books and records are properly completed for each resident and allowing corrective action to be taken promptly in the event of any discrepancies ... Following the implementation of this monthly audit, a new document dealing with documentation and record keeping was introduced and specific training on this issue has also been delivered to all residential managers, unit managers and Registered Nurses. ....
>
> 42. Daily routines at each flat depend on the needs of the residents/service user[s], but generally meals will be prepared by the care workers for each flat and residents will carry out an activity either at home or outdoors, and usually enjoy a trip out of the Flat each day. Each resident/service user will have an activity planner in order to allow for consistency.
>
> 43. There are also social trips and events organised for residents, in accordance with the "Outings Policy" ... which ensures that venues for outings are appropriate to the service user, that adequate records are kept and that escorts include a person who has attended at least the 1 day Emergency First Aid training. Recent outings include day trips to a spa, zoo visits, visits to public gardens, bowling, attending the Gibraltar fair, the Gibraltar International Music Festival, National Day festivities and cinema sessions.
>
> 44. Activities include weekly drama sessions at Bayside Comprehensive School, mixed skill dance sessions, swimming and pottery classes. Two residents are supported in work placements, one of which is paid, the other voluntary. Another has participated in the production of an International Down Syndrome short film promoting jobs for people with Down's syndrome.
>
> 45. Residents also go on holiday, and in order to ensure that these are properly co-ordinated, holiday forms are completed. Service users from [the Home] support Gibraltar's environmentally friendly initiative to re-cycle rubbish. They also contribute to the community by organising fundraising events."

In the final section of his first witness statement, headed "Refurbishments and works" [**J1/124/14**], Carlos Banderas lists a number of improvements which have recently been made to the premises, including the installation of bath thermometers, improved ventilation, improved lift access, the purchase of a tilt mobile shower chair, the installation of CCTV cameras in the external areas, and the installation of an attack alarm system. He goes on to say that "the much

needed refurbishment of Goole House was completed in August 2013", in the form of the installation of a new kitchen, bathroom, stairway and air-conditioning system.

In the course of his oral evidence, he confirmed that a qualified nurse is on the premises all the time[1205].

Asked whether having residents of differing genders living in the same flat gave rise to a problem, he replied[1206]:

> "No, absolutely not, because at the end of the day we are very lucky to have two bathrooms or one bathroom and a wet room, and a toilet as well in [the] ... large flats. So at the end of the day there is never a problem with regards to gender ...."

Asked about relations between service users, he said this[1207]:

> "Well, some service users ... get on better with ... other service users ... At the end of the day, they are living together so we are trying to promote the activities, we are trying to get them to be [as] independent as possible. We are trying to get them ... doing [more] activities [on] their own, not to do as a group. .... What we have been trying to do is ... to promote individualised activities for each service user, so then they are trying to get all these activities always [on] their own with a carer or with one or two other service users, but from different flats."

When I put to him that the impression I had gained from his evidence so far was that he and the staff were doing their best to make the place feel like home for the residents, he replied[1208]:

> "Absolutely. All the flats are decorated with their own pictures. We are trying [to ensure] that each room of each service user has their own things, what they like, the type of pictures that they want, the theme of anything that they like, for example we have [one] service user who likes "Thunderbirds" [and] there is a lot of decoration of his flat with "Thunderbirds"[1209]. We have also other service users who like Disney, and they have a lot of things with themes of Disney. Or we have other service users when they come for respite that, for example, he likes "Superman", so we have things for him whilst he is going to be with us, so he tries to feel more comfortable."

He went on to say (contradicting the evidence of Gayle Everest, referred to above) that one of the main aims the Home is to promote integration of service users into society[1210].

As to care plans, he said this[1211]:

> "It is essential that each service user has a care plan where we have identified what are all their problems, what are their objectives. .... What we try to do is to evaluate these aims and objectives, trying to make sure that we try to meet them. .... But at the end of the day we are still trying to improve and increase the independence of each service user. .... Care plans are

[1205] See Day 1 page 57 line 19ff.
[1206] See Day 1 page 60 line 24.
[1207] See Day 1 page 61 line 7ff.
[1208] See Day 1 page 62 line 7.
[1209] A reference to Resident AA.
[1210] See Day 1 page 62 line 22ff.
[1211] See Day 1 page 69 line 11ff.

> completed in a multi-disciplinary [process] and it's done ... with the social workers, the key worker, or care workers, staff from St Bernadette's ..."

In relation to medication, he reiterated the evidence in his first witness statement, quoted earlier[1212].

Asked about the training of staff, he said this[1213]:

> "Training is one of the main essential things that we have improved in [the Home] recently. .... The Care Agency has increased the complement for training. They have now three people that ... are participating in the training. .... In all our work what we need from our staff is that they – we have to trust them, and they have to trust management. .... It's essential that they know what [is meant by a] professional relationship with service users; they need to know all the time that they are not their friends, that they are there to support them at all times. It's essential about a professional relationship that they understand how important it is, the way that they communicate with the service users. .... The other part that is essential is about confidentiality. In Gibraltar it is a small community, the carers sometimes know the relative who lives next to them. .... So it's important that they understand what is confidentiality...."

Asked by counsel to the Inquiry whether in his experience at the Home there had been incidents of abuse of residents, he referred to an incident which he characterised as "neglect"[1214]. Counsel for Joanna Hernandez invited him to enlarge upon this response. He explained that he had in mind an incident where (as he described it[1215]):

> "... a care worker who didn't think that it was necessary to assess a service user who was lacking his balance. That happened, that a service user, he was moving from one side to the other, and he thought that it was not important. The following day, this person had to go to the hospital, and because he had high blood pressure, and that was really bad for him. .... That was the neglect, because this specific member of the staff should have investigated what had happened, should have recorded some observations, check his blood pressure, check how he was feeling, ask him, but this specific person didn't do anything about it until the following day."

Asked whether, in general terms, he had come across any other categories of abuse, he replied[1216]:

> "Apart [from] that, I haven't been – or any type of financial abuse, I have never witnessed that, nothing sexual. It's been more that kind of neglect [by] the carers, the lack of training."

Prompted by oral evidence given by Gayle Everest as to the lack of a policy in the Home in relation to alcohol consumption[1217], Carlos Banderas made a second witness statement in the Inquiry [**J1/124.1/1**] and he agreed to be recalled to give further oral evidence.

In his second witness statement, he says that the Care Agency has a "zero tolerance policy" with regards to alcohol consumption by any employee of the Home", and he refers to the relevant

[1212] See Day 1 page 73 line 23.
[1213] See Day 1 page 77 line 6ff.
[1214] See Day 1 page 74 line 16.
[1215] See Day 1 page 80 line 25ff.
[1216] See Day 1 page 82 line 11ff.
[1217] See Chapter 2 of this Report, and Day 11 page 16 line 7.

procedure manual where that policy is set out. In consequence, he says, any employee suspected of having consumed alcohol will be sent home pending a disciplinary hearing.

As to consumption of alcohol by service users, in paragraph 8 of his second witness statement [**J1/124.1/**3] he describes the policy of the Home as follows:

> "8. The policy of the Home is that whilst our residents have a range of disabilities and conditions they are adults and in as much as they are able to express a choice we promote and allow them to do so and this extends to any of them expressing the wish or preference to consume alcoholic beverages. This does not mean that the Home encourages service users to drink alcohol, quite the opposite. We operate a policy of discouraging such consumption and when residents express a wish to consume alcohol we try to steer them towards a non-alcoholic alternative. Also consumption of alcohol by residents is only permitted for those residents where such consumption does not interfere with any medications. ...."

He goes on to give examples of how that policy is applied in the cases of particular residents.

In his further oral evidence, he was adamant that when he arrived at the Home in 2011 alcohol was not available in the Home in the manner suggested by Gayle Everest[1218]; and that at least from that time it was not permitted for members of staff to consume alcohol whilst on duty[1219].

Counsel to the Inquiry also put to him Gayle Everest's evidence to the effect that residents had no privacy or independence[1220]. He responded as follows[1221]:

> "Well, at the end of the day we are in a dynamic process ... where we try to find out what are the goals and objectives for each service user. Of course ... we can get better, and that's our aim. .... I have to disagree with the content of [Gayle Everest's] statement, because if we follow the care plans that have been done in conjunction with all the professionals, then that doesn't mean that we are not getting the best [out] of each service user."

He went on to make it clear that he recognised that there was always room for improvement[1222].

Later in his oral evidence, I asked him again whether he was aware of any deliberate acts of abuse by any member of staff or anyone else during his time at the Home. He replied[1223]:

> "Let me think. Well, I know of a care worker, that he shaved the back of a service user. That was dealt with, discussed with the care worker ... and we spoke with the relative. She said she did not want to put any complaint, but she was completely informed about this. .... I think he had a problem about the body hair of the service user[1224]."

Counsel to the Inquiry then referred him to a document setting out the relevant policies in relation to abuse [**J1/124/49-60**], and identifying six categories of abuse of a service user,

[1218] See Day 13 page 7 line 9ff.
[1219] See Day 13 page 11 line 20.
[1220] See Day 11 page 33 line 10ff.
[1221] The service user in question was Resident I.
[1222] See Day 13 page 22 line 7.
[1223] See Day 13 page 31 line 3ff.
[1224] The service user in question was Resident I.

ranging from neglect, through financial and institutional abuse, to emotional, physical and sexual abuse. He confirmed that the incidents which he had described were not deliberate, and that they did not fall within the more serious categories of abuse as set out in that document[1225].

I accept Carlos Banderas' evidence without qualification. I found him to be a most impressive witness, and I can fully understand why he is universally so well regarded. Through his drive and dynamism, coupled with the dedication and hard work of his colleagues in management and of the care workers (both full-time and part-time), several of whom have given many years of service to the Home, the Home is now in a better state than it has been at any time during the period with which this Inquiry is concerned.

[1225] See Day 13 page 33 line 19.

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CHAPTER 16:
Conclusions and Summary of Findings on the List of Issues

In preceding chapters of this Report I have extensively reviewed the documentary and oral evidence before the Inquiry. I have also made a number of findings. This chapter groups those findings under each of the twenty-two issues that the Inquiry identified it would examine following its preliminary hearings[1226]. For detailed discussion of each finding, reference should be made to the earlier chapters. For convenience, cross-references to particular passages in earlier parts of this Report are identified in footnotes. In this chapter, to the extent not set out in earlier chapters, I also set out some additional findings and further observations in relation to some of the issues. Lastly, I set out some concluding remarks to the Report after my comments on the twenty-two issues.

THE ISSUES

(1) Did the SSA provide sufficient support for senior management at the Home?

The statutory framework of the Care Agency, and its predecessor the SSA, is explained in the Introduction and Chapter 1 of this Report. In short, the CEO of the SSA reported to the Minister for Social Services, with Team Leaders being assigned specific responsibilities for different areas within the responsibility of Social Services. One of the Team Leaders was responsible for the Home. The Manager of the Home reported to the relevant Team Leader. The same system continued when the Care Agency was formed. The Home has seen a succession of Managers since 2002.

As to the period when Joanna Hernandez was Manager of the Home, it was not the case that (as she alleges) she was "completely unsupported"[1227] by the SSA's senior management. The evidence of Marie Gomez and Sean Matto in particular establishes that support was offered to Joanna Hernandez by both management and staff to the extent she wished to avail herself of it.[1228] See also my consideration of the evidence of Nicole Viagas in that respect.[1229]

Yvette Del Agua was the Minister for Social Services during the time Joanna Hernandez was Manager. I accept Yvette Del Agua's evidence that she took her ministerial responsibilities in relation to the Home extremely seriously, and that she did all she could to discharge those responsibilities promptly and effectively. That being so I have no doubt that she was well aware

[1226] See the List of Issues: Annex 2 to this Report.
[1227] Chapter 8/page199 ("C8/199" – references to chapters and page numbers of the Report will follow this format throughout this Chapter).
[1228] C8/199.
[1229] C8/216-217.

in the autumn of 2004 that there were staffing problems and shortcomings in the operation of the Home, and that she would have referred to those issues when speaking with Joanna Hernandez.[1230]

The documentary evidence does not support Joanna Hernandez' assertion that she did not get a hand-over of any value.[1231] I have no doubt that Elizabeth Harrison put her fully in the picture as to the responsibilities she would have to discharge as Manager.[1232] I reject Elizabeth Harrison's evidence that Marie Gomez' support of Joanna Hernandez lasted "only for a week."[1233] I accept Marie Gomez' description of her relationship with Joanna Hernandez and her evidence as to what she was being told by Joanna Hernandez at the time.[1234] I am satisfied that neither Marie Gomez nor Sharon Berini told Joanna Hernandez to "shut up" or otherwise she would lose her job.[1235] I am also satisfied that Joanna Hernandez was not "warned" about Sharon Berini by Marie Gomez or Isabella Tosso.[1236]

I accept the evidence of Marie Gomez that she supported Joanna Hernandez and was not aware of any instructions 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.[1237] I find that any such instruction must have been issued by Isabella Tosso shortly after Joanna Hernandez' June 2005 "investigation."[1238]

I do, however, accept (bearing in mind the attendance note of the meeting held on 18 December 2006 in the context of the Industrial Tribunal proceedings) that by that stage the SSA had reached the general conclusion with the benefit of hindsight that it had not supported Joanna Hernandez sufficiently. That said, I am satisfied that Marie Gomez, Sharon Berini and Sean Matto and indeed the rest of staff at the Home tried their best to support Joanna Hernandez at least until relations were poisoned by her June 2005 "investigation."[1239]

I reject the contention that the June 2005 "investigation", in which members of staff were approached to prepare statements against Sharon Berini and Nigel Bassadone, was authorised by Isabella Tosso.[1240] The process which Joanna Hernandez embarked upon cannot be described as a disciplinary process. Joanna Hernandez' reliance on what was said by Isabella Tosso at an earlier meeting is an attempt by Joanna Hernandez to justify, ex post facto, a process she well knew at the time was unjustifiable and unfair.[1241] I reject her evidence that she was bullied or intimidated by any member of staff or management. I also reject her evidence that she was given

[1230] C8/204.
[1231] C8/205.
[1232] C8/205.
[1233] C8/207.
[1234] C8/215-216
[1235] C8/214, 217 & 218.
[1236] C8/218, 220 & 221.
[1237] C8/238-240.
[1238] C8/239.
[1239] C8/239-240.
[1240] C10/310.
[1241] C10/311.

"no support whatever."[1242] I accept Yvette Del Agua's evidence that Joanna Hernandez' assertion that she (Yvette Del Agua) put pressure on Isabella Tosso and/or Marie Gomez so that she would lose her job was an "outright lie."[1243] Isabella Tosso's observations in relation to the June 2005 "investigation" were entirely justified.[1244] That said, Isabella Tosso's handling of the "investigation" left much to be desired in that she should have taken a stronger line in support of Sharon Berini, who had been victimised.[1245]

There was little criticism of lack of support on the part of senior management in the years following 2005. As in any public service, there will from time to time be pressures on the Home's management due to budgetary restrictions; but that is not equivalent to lack of support by management While additional resources will always be welcome, the current position (as it appears from the evidence) is that management is generally satisfied with the support it receives from the Care Agency.

(2) Did the SSA and senior management provide sufficient support for social service workers working at the Home?

As was the case under Issue (1), the evidence on this issue focused on the period of Joanna Hernandez' tenure as Manager.

There was evidence of lack of supervision for senior care workers and other staff. A number of witnesses gave evidence of that from different standpoints. Some carers expressed the view that they felt unsupported from time to time and specifically in relation to personal proposals or ideas (e.g. Jonathan Teuma). Jennifer Poole, Elizabeth Harrison and Sean Matto considered that there was little support by way of supervision. Marie Gomez also expressed concerns that there was insufficient supervision within the Home. This concern was confirmed by Debbie Guinn in so far as the period before 2006 was concerned.

In 2004-5 there were staff shortages compounded by high levels of sick leave. This was a delicate situation which cried out for a careful and sensitive approach by management and by Joanna Hernandez in particular as Manager. However she signally failed to adopt such an approach. Her decision to embark on an "investigation" in June 2005, following the breakdown of her relationship with Sharon Berini, only served to exacerbate the situation.[1246] I find that the breakdown in that relationship can be traced back to a staff meeting held in April or May 2005.[1247] I reject Joanna Hernandez' account of that meeting to the extent that it conflicts with the evidence of Sharon Berini, Sean Matto and Nigel Bassadone.[1248] I am satisfied that the conduct of those present at the meeting in reacting to Joanna Hernandez' proposed changes was

[1242] C10/312.
[1243] C10/313.
[1244] C10/314.
[1245] C10/315.
[1246] C8/213.
[1247] C8/219.
[1248] C8/220.

nothing other than professional.[1249] Joanna Hernandez' own emotional reaction to the expression of contrary views affected her subsequent conduct towards them and impacts upon the reliability of her evidence.[1250]

Joanna Hernandez' June 2005 "investigation" 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 to have them both sacked. As such it was nothing short of a disgrace. I agree with Sharon Berini's description of that "investigation" as a "witch-hunt".[1251]

To the extent that there was an "us and them" culture amongst the staff during Joanna Hernandez' time as Manager, 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. Moreover, her June 2005 "investigation" was calculated to aggravate the situation by promoting just the kind of "us and them" culture about which the makers of the June 2005 statements complained. It can only have further damaged relations between members of staff.[1252]

I find – see below generally and in particular under Issue (11) – that there were significant shortcomings identified in the reports by Jennifer Poole and Elizabeth Harrison in late 2005 and the report by Debbie Guinn in 2006 in respect of staff morale, communication, staffing, medication etc (see Chapter 11). Those shortcomings were addressed in a significant manner after 2005.

(3) Was there an adequate recruitment process in place for social service workers working at the Home?

To the extent that this issue touches upon levels of staffing I describe my findings on the aspect of staff shortages in greater detail below (see Issue (11)).

There was evidence that in the past not all care workers were proficient in English, and that this led to communication difficulties, especially when handing over at the end of a shift. The extent to which these difficulties could have been reduced by recruiting personnel proficient in English is a matter beyond the scope of this Inquiry, as it necessarily depended on the pool of applicants for vacancies. In addition, there was evidence that many of the residents preferred to use Spanish as a first language.

[1249] C8/220.
[1250] C8/220.
[1251] C10/306.
[1252] C10/310.

Debbie Guinn noted that there were issues as to the recruitment process before 2005, but these were at that stage improved with, for example, the writing of proper job descriptions and short-listing of applications.[1253]

(4) Were the staff at the Home sufficiently (a) trained, (b) organised, (c) supervised and (d) appraised?

I accept the view of Gina Llanelo that in past years carers needed to be more highly trained. This view was shared by a number of other witnesses including Elizabeth Featherstone, Violet Sullivan, Maurice Valarino, Matthew Turnock, Sharon Berini and Michelle Garro.[1254]

Carlos Banderas (whose evidence I accept) gave evidence of a comprehensive Core Training Programme now followed by the Care Agency. All members of staff are required to follow this programme within the first three months of their employment. The programme contains various elements including an induction to the Agency, principles of safeguarding and protection in health and social care, equality and inclusion, introduction to communication in health and social care, health and safety, data protection, manual handling, drug and alcohol awareness, practical skills and emergency first aid.[1255] In addition to the Core Training Programme, new employees spend a day with Carlos Banderas and the management team and thereafter shadow a senior care worker for two weeks. This allows initial monitoring of the new employee and gives the new employee the opportunity to be shown around the Home and taught about, amongst other things, the communications books and the philosophy of care. Additionally, carers are trained in the safe administering of medication and in recognising adverse reactions. Carlos Banderas also explained that it is currently proposed that every year one of the unit managers at the Home will attend a training course leading to a recognised management qualification. (One of the unit managers is currently undertaking such a course.) Carers are also trained in the handling of challenging behaviour. In 2012 and 2013 carers received training to be able themselves to become trainers in the handling of challenging behaviour, manual handling and basic life support. Since February 2013 most staff members have received Makaton sign language training, which assists communication with those residents who use Makaton.

Further evidence was given by Carlos Banderas of ongoing training opportunities for staff in, for example, food safety, safeguarding vulnerable adults, autism and understanding learning disabilities.[1256]

A number of witnesses gave evidence of a lack of supervision and appraisal of staff. This was manifested by, for example, lack of formal supervision sessions and also by insufficient support of individual carers on ongoing work or stand-alone initiatives (such as the one taken by Jonathan Teuma in relation to Resident Z). Issues as to insufficiency of supervision and

[1253] Day 15/193.
[1254] C7/181.
[1255] C15/528-529.
[1256] C15/528-532.

appraisal were also raised in the reviews conducted by Debbie Guinn, Jennifer Poole and Elizabeth Harrison in 2005-6: see Chapter 11 and below under Issue (11).

(5) Were there sufficient procedures in place in respect of internal reporting and record keeping at the Home?

Many witnesses gave evidence of problems in earlier years in relation to paperwork going missing and files being misplaced. This was a matter of importance, and procedures should have been put in place and implemented to ensure that valuable time of both staff and relatives was not wasted in replicating earlier paperwork.[1257] Missing paperwork was a real and continuing problem. This affected residents' files and other paperwork specific to the care of individual residents as well as policies at the Home and, at a wider SSA level, documentation including copies of the Council Group Minutes of meetings with Home residents taken by Giselle Carreras. No doubt the frequent changes of management personnel were a contributing factor.[1258]

I accept the evidence of a number of witnesses (Mandy Spencer, Natalie Fortuna, Kirushka Compson, Maurice Valarino, Jordan Davis and Sean Matto) as to the problems in accounting of petty cash.[1259] I also accept the evidence of Marie Gomez that the responsibility for ensuring that petty cash returns were correct lay with the Manager for the time being, and that there were continuing problems with this.[1260] I reject Joanna Hernandez' evidence that she succeeded in resolving that problem. I accept the contrary evidence of Natalie Fortuna.[1261] While both Joanna Hernandez and Natalie Fortuna tried to resolve this problem, it continued to be a matter of "great concern" during the period Joanna Hernandez was Manager.[1262]

Issues as to whether on one occasion a file was deliberately removed, and whether there were deliberate efforts to undermine management of the Home, are addressed below under Issue (7).

The issue as to the availability of policies relating to the operation of the Home, and as to the general awareness of those policies on the part of members of staff, is addressed under Issue (21).

Steps were taken primarily after 2005/6 to address the problems and introduce a series of financial and administrative changes to improve matters – see under Issue (11).

[1257] C7/173.
[1258] C7/181 & 187.
[1259] C7/173, 178-179.
[1260] C7/174 & 187.
[1261] C8/201.
[1262] C8/202.

(6) Were there proper care plans for those using the service provided by the Home, whether on a permanent, temporary, or respite basis (together, "residents")?

It became clear during the oral evidence heard by the Inquiry that there were some differences of opinion between witnesses as to the proper definition of a "care plan", although there was broad agreement that the care plans currently in place are more comprehensive than those which were in place when, for example, Joanna Hernandez was Manager. Nonetheless, while it was only later that more comprehensive care plans were drawn up for each resident and respite user, policies in relation to care plans were in place during the Milbury era and continued in place when the SSA took over.[1263]

There were, however, significant concerns about the form of and preparation of care plans, especially up to 2006, as explained in the findings and evidence under Issue (11), as well as their safekeeping.

Currently, staff members are "expected to ensure that each resident enjoys the benefit of a personalised care plan"[1264] which is prepared with relevant professionals. Since October 2011 residents have also had a Health Plan, Daily Care Plan, Risk Assessments and (if necessary) a Communication Plan. Daily diaries are kept for each resident to allow a log of care for each resident and facilitate handovers between staff changing shifts.[1265] Since June 2013 a monthly Documentation Audit has been introduced to ensure that all policy books and records are properly completed for each resident. Each resident also has a daily activity planner. There is also an Outings Policy governing social trips and events organised for residents.[1266]

(7) Were the working relationships between members of staff at the Home satisfactory in relation to:

a. the provision of adequate care for residents; and/or

b. the efficient performance of their allocated duties.

As indicated by the social workers' reports prepared in 2005/6, the issue of staff morale was a concern at that time. Among the causes of low staff morale were the shortcomings identified in those reports, together with Joanna Hernandez' June 2005 "investigation". Working relationships between various members of staff at that time would inevitably have been significantly affected by that "investigation": see also under Issue (2).

In relation to specific instances:

[1263] C7/175.
[1264] C15/532.
[1265] This is not an innovation. The evidence before the Inquiry establishes that this has been the case for several years and from the start of the period to be investigated by the Inquiry.
[1266] C15/532.

- I accept the evidence of Richard Muscat and Nigel Bassadone that if Mandy Spencer's passport was in truth misappropriated by staff members, they had nothing to do with it.[1267]
- As to Joanna Hernandez' allegation that Sharon Berini had removed a report from her office, I accept Sharon Berini's denial that she did so.[1268]

I find that there was no rational justification for Joanna Hernandez' mistrust of Sharon Berini.[1269] Sharon Berini 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 reject Elizabeth Harrison's suggestion that there was some form of conspiracy among members of staff to "make a fail", so far as Joanna Hernandez was concerned.[1270] I also reject Joanna Hernandez' conspiracy theory, and I regard her allegation that members of staff were undermining "the working of the Home and to suppress any criticism of themselves" as a distortion of the truth.[1271]

There was no evidence that the care of residents suffered in any significant way as a result of problems between individual members of staff.

(8) Were appropriate arrangements made for the care of younger residents and residents of differing genders?

Jennifer Poole gave evidence that in her view appropriate arrangements had been made for the care of younger residents and residents of different genders. She explained that the child residents (e.g. Residents Z and L) were for a period "cared for in the community by carers from the Home because they had the necessary expertise and experience in their conditions.[1272] In relation to toilets, there were appropriate arrangements for the care of residents of differing genders. There were separate toilets and each resident had a routine so this did not pose any problems".[1273] I accept her evidence. Similar evidence in relation to residents of different genders was given by Carlos Banderas, whose evidence I also accept[1274].

There was also evidence before the Inquiry that following "unitisation" (i.e. the conversion of the Home into separate flats) Milbury allocated residents to flats on a mixed gender basis, and that that system has since continued. There was no evidence that this gave rise to any major problem.

[1267] C7/171.
[1268] C8/222-224.
[1269] C8/223 & C10/300 *et seq.*
[1270] C8/236 & 239.
[1271] C9/295.
[1272] C15/526-527.
[1273] C15/526-527.
[1274] C15/536.

(9) Was there sufficient communication between members of staff and relatives of residents?

Although communication between relatives and staff (including management) was sometimes difficult, and relatives sometimes felt frustrated, there was communication nonetheless.[1275]

While it was understandable in the context of the demands on the service that there were times when relatives felt that they were being told what they wanted to hear, particularly by Sharon Berini, I find that Sharon Berini was doing her best to ensure the best possible care for respite users.[1276] I accept Gina Llanelo's criticism that Marie Gomez was not as efficient as she could have been in dealing with missing paperwork and in taking minutes of meetings with relatives.[1277] However I find Gina Llanelo's description of Marie Gomez as "not there to help" relatives to be unfair.[1278]

There was a complaint by Violet Sullivan that she was not allowed to look at the communications book. However, as Sharon Berini explained, the communications book contained information solely for staff members between shifts.[1279]

There were instances of failures of communication, for example when there was confusion between Resident X's relatives and care workers as to whether permission had been granted for Resident X to be taken on an outing to Morocco.[1280] Moira Elmer also complained of insufficiency of communication as to the investigation concerning her sister, Resident T.[1281] In her report in 2005/6 – see under Issue (11) – Debbie Guinn noted that unreasonable demands were sometimes made on carers by relatives.[1282] Equally, Jennifer Poole thought there should be a protocol on access to the Home.

The evidence pointed to a number of improvements in communication between staff and relatives in the period from 2006 to date – see Chapter 15 and under Issue (11).

(10) Were the physical facilities at the Home satisfactory?

The Home consisted initially of one large property with a number of self-contained rooms. Following the process of "unitisation" carried out by Milbury (see above), the Home was converted into a series of flats within which there are a number of individual rooms.

[1275] C7/183.
[1276] C7/180-181.
[1277] C7/181.
[1278] C7/181 & 187.
[1279] C7/184.
[1280] C4/109-110.
[1281] C13/442
[1282] C11/348.

I am satisfied that, as a matter of policy, succeeding managements attempted to achieve improvements to the physical facilities at the Home, consistently with the level of resources available from time to time.[1283]

I accept Joanna Hernandez' evidence that the fire alarm system was faulty and that she succeeded in having a new fire alarm system installed in the Home. However, I reject her evidence that Yvette Del Agua refused to take account of safety considerations. I have no doubt that safety considerations were uppermost in Yvette Del Agua's mind in any discussion about upgrading the fire alarm system at the Home.[1284]

As explained in greater detail under Issue (11), there is evidence that the facilities were improved, especially after 2006. More recently, a number of further improvements have been made to the Home, including the installation of bath thermometers, installation of CCTV in external areas, improved lift access, installation of an attack alarm system and a number of improvements at Goole House.[1285] In his witness statement, Albert Bruzon (whose evidence I accept) summarised the programme of refurbishments which has been undertaken. In particular there has been a major overhaul of bathroom facilities. Carlos Banderas did not think major refurbishment issues currently exist.

Bishop Healy House (the old children's home) was used as temporary accommodation for a relatively short period in 2003 when the Home was flooded. I accept the evidence of Elizabeth Harrison that the physical facilities for residents and respite users at Bishop Healy were inadequate. Similar evidence was given by other witnesses (Mandy Vallender, Violet Sullivan, Maurice Valarino).[1286] On the other hand, I find that the facilities within Flat 3 were adequate[1287], as they were in the other flats within the Home.

As to the state of the Merlot House flat in which Resident Z lived, I prefer the evidence of Jessica Perez to that of Joanna Hernandez.[1288]

As to the flat at Flat Bastion Road, I accept that the facilities could have been improved. That said, the wider criticisms made by Joanna Hernandez as to the state of the flat were rejected by the relevant carers, and I accept their evidence.

(11) Was the care provided to residents of a satisfactory standard with regard to their mental and physical health and their social development?

The issue of staffing was a serious and chronic problem in the Home.[1289] This was echoed by a number of witnesses including Gina Llanelo, Sharon Berini, Gayle Everest, Elizabeth

[1283] C9/292.
[1284] C9/292.
[1285] C15/532.
[1286] C7/107, 109 & 166.
[1287] C7/181.
[1288] C9/276-279.
[1289] C7/176.

Featherstone, Violet Sullivan, Moira Elmer, Carmen Dixon-Pritchet and Matthew Turnock.[1290] I endorse that view. At the same time, I bear in mind that employing more staff would have involved greater expenditure of public funds, and that budgetary priorities may have militated against that. As explained in the Introduction to this Report, that was a matter for Government: it is not a matter for this Inquiry. What can be said, however, is that it is clear on the evidence that the presence of a larger and better trained staff in the Home would have benefited residents, respite users and staff alike.[1291]

The issue of staff shortages was also a constant theme in the evidence of Elizabeth Harrison, Jennifer Poole and Debbie Guinn in respect of the period 2004-5, and is reflected in the contemporary documentation.[1292] Whilst this affected standards of care, I am satisfied that the basic needs of residents and respite users were met. This was achieved through the commitment and hard work of the staff, albeit it was undoubtedly a struggle to achieve that. There can be no doubt that with greater numbers of staff a higher standard of care could have been provided.[1293]

Changes of managerial personnel on a frequent basis inevitably also disrupted the smooth running of the Home. This was compounded by the fact that prior to the arrival of Joanna Hernandez handovers between Managers were carried out in a relatively perfunctory fashion, if at all.[1294] It was also the case that the widespread use of supply workers added to the difficulties of setting rotas.[1295]

On the other hand, Jordan Davis' descriptions of the operation of the Home as "disgraceful", and of the management as "unprofessional", are not borne out by the evidence.[1296]

I accept the evidence of Sharon Berini that she, initially as carer and later as Deputy Manager, together with other dedicated members of staff, worked hard to overcome the many challenges presented by the service, including staff shortages, lack of training of staff, inadequate facilities at Bishop Healy and frequent changes of Manager.[1297] I also accept Matthew Turnock's favourable assessment of her.[1298]

The general picture that emerges from the evidence as a whole is of a dedicated and caring staff doing their best in difficult circumstances to provide as high a standard of care as possible for residents and respite users.[1299] The staff did their best to create as normal a family atmosphere as was possible in the circumstances.[1300] I was impressed by the evidence of Michelle Garro as

[1290] C7/182.
[1291] C7/181-182.
[1292] C8/209-214.
[1293] C8/214.
[1294] C7/182.
[1295] C8/208.
[1296] C7/179.
[1297] C7/187.
[1298] C7/187.
[1299] C7/174.
[1300] C7/176.

to the atmosphere of a "big family" that the staff were trying to create within the Home. I also accept Matthew Turnock's detailed and balanced account of the operation of the Home.[1301] I find on the totality of the evidence that the staff were doing their best to foster a family atmosphere in the Home. They deserve considerable credit for that, rather than the unfounded and in many cases offensive criticisms to which they have, regrettably, been subjected.[1302]

For reasons given (see in particular Chapters 2-7), I accept that the task facing Joanna Hernandez when she was appointed as the new Manager of the Home was a difficult and challenging one; and that there were a number of aspects of the operation of the Home which required to be improved.[1303] I also accept that she worked hard to try to improve conditions at the Home.[1304] I do not, however, accept her description of the Home as a "chaotic working environment."[1305] I find that throughout her evidence she manifested a tendency to exaggerate the challenges she faced as Manager, and to depict the Home and the conduct of the staff in the worst possible light.[1306] I have no doubt that that tendency stems from her resentment at the SSA's refusal to renew her contract.[1307] Her desire to make good her allegations against, and her criticisms of, the operation of the Home and some of her colleagues led her, in giving her evidence, to resort to emotive and on occasion lurid language, and to make allegations in the course of her oral evidence which did not appear in her written evidence.[1308] I find her allegation that staff 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.[1309]

I have seen no evidence of children at the Home "in a terrible state" or "clearly suffering from negligence" as asserted by Joanna Hernandez.[1310] I similarly reject her evidence that on her arrival as Manager she found the Home to be in "virtual chaos". I also reject her evidence that in the Home there was a culture of "institutionalised historic malpractices"[1311], save only to the extent that in his evidence Sean Matto referred to the problem of staff shortages, and to its effect on standards of care, as "institutional abuse"[1312]. I am satisfied that neither Sharon Berini nor Sean Matto would have allowed any sexual, physical, verbal or emotional abuse of residents and respite users to take place in the Home.[1313] The minutes of the management meeting of 8 December 2004 reveal that Joanna Hernandez made no complaint about such matters at that stage.[1314] Whilst it is the case that in November 2004, when Joanna Hernandez took up her

[1301] C7/188.
[1302] C7/188.
[1303] C7/188.
[1304] C8/199.
[1305] C8/199.
[1306] C8/199-200.
[1307] C8/200.
[1308] C8/200.
[1309] C8/200.
[1310] C8/203.
[1311] C8/206.
[1312] C8/206.
[1313] C8/206.
[1314] C8/208.

appointment as Manager, there were a number of shortcomings in the operation of the Home, they were far less serious than Joanna Hernandez now maintains.[1315]

As to the October 2005 "service audit" report[1316] prepared by Joanna Hernandez, I note that nowhere in that report does she acknowledge any shortcomings in her own performance as Manager of the Home, still less does she acknowledge any responsibility for the bleak picture which she painted in that report. Her criticisms of Sharon Berini were clearly coloured by her irrational mistrust of Sharon Berini. As to her criticisms of systems and practices at the Home as at October 2005, I accept those criticisms only to the extent that they reflect a continuation of the shortcomings identified in Chapters 2-9 of this Report when she took up her appointment as Manager, as corroborated by Debbie Guinn in her evidence. To the extent Joanna Hernandez' criticisms go beyond that, I regard them as a further 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.[1317]

Similarly, I consider it necessary to treat the evidence of Simy Herbert with caution, for the reasons explained in Chapter 11.[1318] I reject her assertions that residents were not treated as human beings[1319], or that the Home was "chaotic" after Joanna Hernandez had left.[1320]

In October 2005, at Isabella Tosso's request, Debbie Guinn was asked to supervise a review of working practices at the Home. The review was conducted, under Debbie Guinn's supervision, by Elizabeth Harrison and Jennifer Poole. I find that Debbie Guinn was justified in listing a number of issues arising from this in her email of October 2005 to Marie Gomez.[1321] Among those issues were staff shortages; high levels of sickness and annual leave; absence of care plans; little ongoing training; lack of supervision; the fact that a number of workers felt threatened by the introduction of changes in systems; concerns from workers as to inconsistent approaches to individual workers; lack of documentary records; problems in relation to the completion of medication records and the administering of medication; the recording of medical appointments; the fact that the management appeared unclear as to their roles and job descriptions; and the fact that the Manager and Deputy Manager could rarely leave their offices resulting in a lack of monitoring of practice and procedures. I have no doubt that those shortcomings existed in October 2005.[1322] On the other hand, Debbie Guinn also noted a number of improvements, including the introduction of structures allowing contact between social workers and residents; the fact that workers felt themselves to be supported and no longer working in isolation; the fact that excellent work had been carried out in setting down guidelines and behavioural programmes; improvements to communication; and reports from Managers that workers felt

[1315] C8/209.
[1316] C10/316-317.
[1317] C10/320.
[1318] C11/338-362.
[1319] C11/358.
[1320] C11/361.
[1321] C11/327-328.
[1322] C11/327-328.

part of a team and valued. I accept this list of improvements as correct.[1323] A number of suggestions were also included in the email.

Jennifer Poole's Report of findings of operational problems within Dr Giraldi Home dated 26 October 2005 was divided into ten sections dealing with meetings, visitors' book, medication, acting, reporting of incidents, health and safety, procedure for allegations, communication problems, seniors' role and transport.[1324] It identified a number of shortcomings which I accept as accurate. This was followed by a Report dated 12 December 2005 prepared by Elizabeth Harrison. The main issues which she identified were staff shortages, high sick leave rates and high turnover of staff. I accept both Reports as accurately reflecting the shortcomings within the Home at the time.[1325] Jennifer Poole also prepared reports on Flats 1 and 2 on 12 December 2005 after spending some time monitoring practices there.[1326] I find that these reports represented an accurate, thoughtful and constructive response to Isabella Tosso.[1327]

Elizabeth Harrison also monitored Flat 2, as well as Flat 3, and submitted an undated report and a report dated 7 February 2006 respectively.[1328]

A Report was also commissioned by the Minister (Yvette Del Agua) from Rod Campbell (Head of Operations of Milbury). This was delivered on 12 January 2006 and dealt with, among other things, staffing and absenteeism at the Home. Rod Campbell made certain recommendations as to the increase of staff. As indicated earlier, I accept that staff shortages and absenteeism were continuing problems.[1329]

Following receipt of the reports from Jennifer Poole and Elizabeth Harrison, and by way of an overview of those reports, Debbie Guinn wrote reports on all the Flats in February or March 2006. As to Flat 1, she made a number of recommendations as to handovers,[1330] absenteeism and sickness policy,[1331] communication,[1332] staffing,[1333] care-plans,[1334] health and safety[1335] and working practices.[1336] As to Flats 2 and 3, her reports followed a similar format and identified broadly similar shortcomings.[1337] She elaborated on the reports in her oral evidence to the Inquiry.[1338]

[1323] C11/328.
[1324] C11/329.
[1325] C11/333 & 335.
[1326] C11/336-340.
[1327] C11/340.
[1328] C11/340-342.
[1329] C11/340.
[1330] C11/342.
[1331] C11/343.
[1332] C11/343.
[1333] C11/343.
[1334] C11/343-344.
[1335] C11/344.
[1336] C11/344-345.
[1337] C11/345-346.
[1338] C11/347-349.

I accept the findings and conclusions of Debbie Guinn in her Reports, based as they were on her own experience and on the Reports prepared by Elizabeth Harrison and Jennifer Poole. I also accept her oral and written evidence without qualification. Her evidence and her Reports gave a comprehensive and accurate picture of the operation of the Home in late 2005 and early 2006. The general picture which they present is of an operation bedevilled by a shortage of staff (aggravated by a high level of sick leave) with committed workers struggling to deliver the best possible care to service users, some of whom presented with challenging behaviour.

Isabella Tosso was aware of and wished to resolve those problems as far as possible.[1339] She instructed Iain McNeil to draw up a Business Plan in relation to standards of care in the Home. The final version of the Business Plan (which was dated July 2006) was co-authored by Sharon Berini. It is an impressive document. It covers aspects of the service in exhaustive detail, setting standards and identifying points of action. It sets out 43 standards/aims, and to each is appended an action list.[1340] I summarise the standards/aims in Chapter 11 of this Report.[1341] I regard the Business Plan as a significant and constructive attempt by Iain McNeil and Sharon Berini to chart the course of the Home for the future.[1342]

There was general agreement among the witnesses that structures and standards at the Home improved gradually from 2006 to date.[1343] This covered areas as diverse as the physical state of the premises, training, communication, systems to improve best practice, the engagement of qualified nurses, the role of social workers in the Home, the introduction of policies and procedures and the recruitment of administrative support staff.[1344] Witnesses varied in how complimentary they were about the gradual improvements.[1345]

The problem of staff shortages has now been addressed to the point where it is no longer such a pressing problem. Table A in Annex 6 to this Report reveals a significant increase in staff since 2005. No doubt additional staff will always be welcome in an organisation such as the Home, but with the present complement of staff in the Home the pressures and stress on individual members of staff are significantly less than in previous years and the standard of care which the staff is able to offer is consequently higher.[1346]

Relationships between members of staff have improved and medication procedures have been tightened.[1347]

Concerns were, however, expressed by Maurice Valarino about communication at Goole House, although he did say that Resident X's care had improved.[1348] The administrative support and

[1339] C11/350.
[1340] C11/351.
[1341] C11/351-355.
[1342] C11/355.
[1343] C15/516.
[1344] For example, the evidence of Debbie Guinn: see C15/516-517.
[1345] Evidence of Gina Llanelo – C15/518.
[1346] C15/522.
[1347] C15/522.

financial systems have improved and there was no evidence of petty cash being unaccounted for since 2005. The respite service has also improved gradually since 2006, although some relatives still expressed certain concerns.[1349]

There was widespread acknowledgment that Carlos Banderas had helped to introduce a number of further improvements following his appointment as Acting Team Leader.

For his part, Carlos Banderas expressed concern that some residents have not had their disability properly diagnosed. He gave evidence that the Care Agency is working with the Gibraltar Health Authority with a view to engaging a specialist doctor to assess all residents' needs and to provide detailed diagnoses.[1350] Details of the staff employed within the Home and their allocation are set out in a schedule exhibited by Carlos Banderas to his first witness statement.[1351] Regular environmental audits of the flats are carried out to ensure appropriate standards are in place and a policy has been introduced designed to allow residents an optimum level of independence in maintaining their financial affairs.[1352] I accept the totality of Carlos Banderas' evidence.

In relation to specific instances of care in relation to various Residents, as raised in evidence, and which I have not dealt with elsewhere:

Resident C

- I reject the evidence of Mandy Spencer that the way in which Sean Matto dealt with an incident when Resident C fell out of bed showed lack of concern for his welfare.[1353] I similarly reject the allegations of Stacey McKay in relation to Resident C, and I accept the contrary evidence of Sean Matto.[1354]

Resident AE

- I am satisfied that the carers of Resident AE dealt with AE's weight problem in a sympathetic and professional way.[1355] A number of additional allegations in respect of the care of Resident AE were made by Joanna Hernandez, in particular in paragraphs 259-280 of her third witness statement. I accept the evidence of Craig Farrell (Resident AE's carer) without qualification and reject as untrue the evidence of Joanna Hernandez wherever it conflicts with his evidence.[1356] I also reject Elizabeth Harrison's criticism of

[1348] C15/518.
[1349] C15/524-525.
[1350] C15/527-528.
[1351] C15/528.
[1352] C15/531.
[1353] C7/172.
[1354] C7/180.
[1355] C7/172.
[1356] C9/291.

Craig Farrell.[1357] Craig Farrell was an excellent carer who had built up a very good relationship with AE.[1358]

Resident L

- In respect of Joanna Hernandez' evidence about an incident when she was called to St Martin's School where Resident L was displaying violent behaviour when under the care of Nigel Bassadone, I prefer the evidence of Nigel Bassadone. This incident provides 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.[1359]

Resident Z

- Having carefully considered all the evidence in relation to Resident Z, I accept the evidence of Jessica Perez and Jonathan Teuma, both as to the condition of Resident Z's flat in Merlot House and as to the standard of care provided for him at different times. I find the evidence of Joanna Hernandez on these issues to be exaggerated to the point of being seriously misleading.[1360]
- I reject the allegation that Sharon Berini was responsible for a decision to take Resident Z off his medication.[1361]

Resident X

- While handovers of Resident X could have been carried out more sympathetically, the ability of carers to spend time in handing over respite users to their relatives was limited given the pressures under which they were working.[1362] I consider the statement of Carmen Dixon-Pritchet in 2008 to the effect that the respite service was failing "its clients" to be an unfair exaggeration which failed to recognise the efforts of staff to operate the service, when it was running, as efficiently and effectively as possible in difficult circumstances. I accept the evidence of Maurice Valarino in this respect.[1363]
- Jonathan Teuma was right to accept that an incident that took place in 2005 while Resident X was under his care was a serious lapse on his part from the standard of conduct expected of any member of the public, let alone a carer acting in the course of his employment. Nonetheless, 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.[1364]

[1357] C11/341.
[1358] C11/341.
[1359] C8/232.
[1360] C9/284.
[1361] C7/172.
[1362] C7/183.
[1363] C7/186.
[1364] C9/284.

General Findings

- I am satisfied that the health needs of residents were adequately met, including arranging for medical and dental treatment whenever such treatment was reasonably required.[1365]
- As to the practice of taking residents or respite users to carers' homes, I am satisfied that this was done because at the time it was considered in their best interests. I do not question the decision to discontinue the practice, but I also note there was no evidence of any harm to a resident or respite user as a result of that practice.[1366]
- I found no evidence that carers were stealing food provided for residents or respite users. Rather, members of staff brought their own food into the Home for themselves and (sometimes) residents.[1367] 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 reoccur. There is no evidence of any Manager having failed to do so.[1368]
- I accept Marie Gomez' denial that she ever told Joanna Hernandez that some night staff locked residents in their room and went drinking in Casemates. I found no evidence in that regard.[1369]

(12) Was appropriate provision made for the safety of residents?

Lack of security at the Home was a legitimate concern for Joanna Hernandez on her appointment as Manager, and according to social workers this remained a concern in early 2006 (after Joanna Hernandez had left).[1370]

In Jennifer Poole's 2005 Reports a number of health and safety concerns were noted, including doors to flats being left open, staff not asking visitors to identify themselves, staff not knowing where other staff members were, keys left unattended, and ceiling tiles being liable to fall down. I accept this as a fair and accurate account of shortcomings which then existed.[1371]

The concerns as to the fire alarm systems are dealt with under Issues (10) and (11). Issues in relation to the bathrooms are addressed under Issue (10).

[1365] C9/292.
[1366] C7/183 & C9/296.
[1367] C7/183.
[1368] C9/292.
[1369] C8/218.
[1370] C9/292.
[1371] C11/331.

(13) Was there a satisfactory regime in place at the Home with regard to the control and administering of medication?

As to the allegation that Resident C was over-dosed, I accept the evidence of Elizabeth Featherstone that a mistake in administering medication was made, in that he was given a repeat dose by a carer who had not checked whether he had already had his medication.[1372] I also accept the evidence of Violet Sullivan that there were two occasions when Resident I was either under- or over-medicated, and that on one occasion prescribed medication for Resident I was returned to Violet Sullivan without explanation.[1373] There was also evidence concerning the finding of medication in the flat occupied by Resident L in Flat Bastion Road (reviewed in Chapter 14).

Those incidents demonstrated the need, at the times in question, to tighten existing procedures in relation to the administering of medication. This view was echoed by a number of witnesses, including Mandy Spencer, Matthew Turnock, Violet Sullivan and Maurice Valarino. I am satisfied that such procedures should have been improved, and that there were problems in this respect during the period prior to 2006.[1374]

These problems were described in detail in Jennifer Poole's Report dated 26 October 2005.[1375] There were further recommendations in Elizabeth Harrison's Report[1376] and in Debbie Guinn's Report referred to under Issue (11).

I accept Simy Herbert's evidence as to the administering of medication only to the extent that it is corroborated by the evidence of Jennifer Poole and Debbie Guinn.[1377]

The introduction of a qualified nurse to oversee the administering of medication was an improvement in this respect.[1378]

Carlos Banderas gave evidence as to the current medication policy. This policy is regularly updated. The administering of medication is now carried out by two members of staff, one of whom must be a registered nurse. Care workers also ensure that if a registered nurse is not available to accompany them on an outing with a resident, the care workers concerned are aware of, and are familiar with, the medication which needs to be administered. Nurses are assessed by a clinician on an annual basis. The policy also covers audits of medication, procedures to follow in the event of errors or adverse reactions to medication, and stock control. In early 2013 medication cupboards were placed in all the flats in the Home. Prior to this there were only medication cupboards in three of the flats. This ensures that medication for each resident is kept in the flat where he or she lives. A medical refrigerator has also been purchased. The

[1372] C7/182.
[1373] C7/184.
[1374] C7/182.
[1375] C11/329.
[1376] C11/333.
[1377] C11/355-361.
[1378] C7/184.

Medication Administration Record sheets have also been amended to require two signatories and to incorporate photographs.[1379]

(14) Was the standard of hygiene at the Home satisfactory?

There was some evidence of inadequacy of facilities which also impacted on issues of hygiene – for example the evidence of "rats" having been seen at Bishop Healy.

In respect of Merlot House, for the most part I reject allegations (made principally by Joanna Hernandez) that the standards of hygiene were inadequate. I accept the contrary evidence of other witnesses.

There was little evidence touching upon the standard of hygiene within the Home itself, save for a historic letter sent by Violet Sullivan which complained about Resident I's personal hygiene (among other matters).

(15) Were there any instances of abuse of or cruelty towards residents, including punishment?

The Care Agency's definition of abuse is set out in its Manual presented to the Inquiry. Six classifications of abuse are given namely, physical abuse; neglect; sexual abuse; emotional abuse; institutional abuse; and financial abuse[1380].

A number of relatives and carers gave evidence that they had never seen any act of abuse at the Home. In so far as more recent times are concerned Carlos Banderas gave evidence of a few instances of behaviour which he classified as "neglect" due to lack of training. However, he confirmed that apart from that he had not seen any sexual or other serious abuse within the six categories of abuse defined by the Care Agency.[1381]

The so-called "punishment room"

I find on the basis of the totality of the evidence in relation to the possible existence and use of a "punishment room" in the Home that at some point in or about 1999/2000, either during or following the "unitisation" process carried out by Milbury, a room in Flat 3 was designated 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. Nor was there a "punishment room" in any of the other premises in which the Home operated.[1382]

[1379] C15/531.
[1380] C15/535-536.
[1381] C15/535-536.
[1382] C9/265.

Specific Residents

As to alleged incidents involving specific residents my findings are as follows:-

Resident Z

I find that the incident when Resident Z was made to stand with books on his hands was an act of abuse by an inexperienced carer who was rightly reprimanded, and who subsequently apologised. I am satisfied that Nigel Bassadone did not authorise such treatment.[1383]

I find that the allegation that Resident Z's head had been put in a freezer was unfounded and that the alleged incident never occurred.[1384]

While Resident Z may from time to time have been given cold showers, I reject the implication that this constituted abuse or misconduct. I find the allegation that he was abused in this manner to be based on unfounded rumour.[1385]

I accept Mandy Spencer's evidence concerning an incident when Resident Z was placed on a jet ski, and her evidence that there had been no re-occurrence of this.[1386]

In January or February 2005 Joanna Hernandez proposed changes in Resident Z's team of carers. There was a stark contrast in evidence as to the reasons for this, and as to the responses of the team. The contrast was between the evidence given by Joanna Hernandez and the contents of a contemporaneous letter written by Jonathan Teuma, one of Resident Z's carers. I accept Jonathan Teuma's version as true. I conclude that Joanna Hernandez has once again resorted to unacceptable hyperbole, and that she has presented a view of Resident Z's care which is grossly distorted.[1387]

Resident N

I find the evidence of Denise Hassan that she had witnessed an alleged incident in which a carer had mimicked a sexual act with Resident N to be untrue.[1388]

Resident AE

I also reject Denise Hassan's uncorroborated evidence that Resident AE used to be locked in a time-out room at Merlot House.[1389]

[1383] C7/172.
[1384] C7/173 & 177.
[1385] C7/173.
[1386] C7/173.
[1387] C9/269.
[1388] C7/177.
[1389] C9/262.

Resident X

The incident where a carer slapped Resident X, witnessed by his parents, was an act of abuse for which the carer was subsequently dismissed.[1390] Whilst I cannot say whether similar incidents occurred on other occasions – because it is impossible for the Inquiry to investigate the behaviour of every carer on every shift throughout the relevant period – I saw no evidence of the existence of a culture among staff whereby similar incidents would have been tolerated and not dealt with appropriately.[1391]

Resident L

I reject the allegation that Mandy Vallender slapped Resident L. I am satisfied that for her to have abused Resident L in that way would have been totally out of character. I accept her evidence that the alleged incident never occurred.[1392]

I accept Violet Sullivan's evidence that on one occasion she saw Resident I locked in his bedroom in the dark. This was an inexcusable lapse by the carer, but was "stopped."[1393]

The finding, in 2008, of a rectal diazepam tube in the flat at Flat Bastion Road (where Resident L lived) led to an investigation. Diazepam was not a prescribed medication for Resident L, and concerns were expressed by a Consultant Paediatrician in respect of this discovery.[1394] How the unused tube came to be in Resident L's flat must, on the evidence, remains a mystery. However, Sharron Openshaw (the Unit Manager at the time) acted entirely correctly in reporting the matter to Iain McNeil, who did his best, albeit unsuccessfully, to find out how it came to be there. There is no evidence that Sharron Openshaw was in any way at fault in relation to this incident.[1395]

On 26 March 2009 Manuela Adamberry and Rose Robba discovered that Resident L had managed to get hold of two bottles of Calpol and 240 Risperidone tablets from the top of the wardrobe in the flat. This discovery led to a formal investigation by Maria Elena Macias.[1396] It is impossible, on the evidence presented to the Inquiry, to make a final judgment as to the circumstances in which the Calpol and Risperidone were left in the flat, and thus accessible to Resident L when they should have been locked away in the medication cabinet. All that can safely be said is that the procedures in place at the flat for the control of medication were clearly breached in this instance. However there is no evidence that Sharron Openshaw was responsible for that breach, save in the technical sense that she bore administrative responsibility for it in her capacity as Unit Manager. Nor have I heard or seen sufficient evidence to justify a finding that she was guilty of backdating an entry in the medication book, which was an

[1390] C7/184.
[1391] C7/184-185.
[1392] C8/240-244.
[1393] C9/265.
[1394] C14/490.
[1395] C14/493.
[1396] C14/493-496.

allegation which arose in the course of the investigation into the incident. I accordingly find that suspicion that she may have done so is not established. In the circumstances I make no criticism of Sharron Openshaw in relation to these matters.[1397]

In the course of preparing for the Inquiry, the Inquiry team discovered that in October 2009 Resident L (who was then aged 16 or thereabouts, and residing in a children's home in Warwickshire, UK) had made certain allegations to his carers there of sexual and physical abuse suffered whilst in Gibraltar. The sexual abuse allegations implicated, primarily, an individual referred to by Resident L as "Robert", together with another individual referred to by Resident L as "Vicky".[1398] Resident L also made allegations of physical abuse against three carers namely Manuela Adamberry, Sharron Openshaw and Rose Robba. The three carers were duly suspended pending an investigation. The matter was passed to the Royal Gibraltar Police who in turn liaised with Warwickshire police. The police investigation concluded in May 2010. The Attorney General recommended that no prosecution should be brought in relation to the allegations of abuse, because given the state of the evidence there was no real likelihood of a conviction and in any event no-one of the name of "Robert" could be identified.[1399]

Manuela Adamberry and Rose Robba were in due course offered reinstatement. Reinstatement was not offered to Sharron Openshaw at that stage because of the pending investigation in relation to the medication referred to earlier. Evidence was given by a number of witnesses, including all three carers, in relation to the relationship of the carers with Resident L, and in relation to the specific allegations he had made.[1400]

Having regard to all evidence before the Inquiry, a finding of sexual abuse of Resident L by any individual could not be justified. The "Robert" and "Vicky" referred to by Resident L remain unidentified. Nor is there any evidence that Resident L was sexually abused by anyone at the Home.[1401]

I also find Resident L's allegations that Sharron Openshaw, Manuela Adamberry and Rose Robba subjected him to physical abuse to be entirely without foundation. I accept without qualification the denials of Manuela Adamberry and Rose Robba that the alleged incidents ever occurred, and their evidence as to their relationship with Resident L and the standard of care provided to him. I am also satisfied that Sharron Openshaw would never have indulged in such conduct.[1402]

[1397] C14/495.
[1398] C14/496.
[1399] C14/501.
[1400] C14/506-512.
[1401] C14/512.
[1402] C14/512.

(16) Were there any instances of members of staff instigating or encouraging inappropriate behaviour between residents?

In December 2004 a number of allegations came to light in relation to the conduct of carers towards Residents J, AA and T.[1403] This led to the suspension of three members of staff namely Angelica Williams, Richard Muscat and Michelle Garro. A police investigation was also launched.

On 7 March 2005 Giselle Carreras produced a Psychological Report on Resident T which referred to meetings at which concerns had been raised in 2002 and 2003.[1404] Following an investigation by the Royal Gibraltar Police and advice from the Attorney General it was decided that there should be no prosecution in relation to these allegations.[1405] Disciplinary proceedings were initiated, but were not prosecuted to a conclusion. After a substantial delay, the three members of staff were offered reinstatement.

Resident T made a witness statement in the Inquiry (following a Psychosocial Report dated 26 September 2013[1406]), as did her sister Moira Elmer. Moira Elmer also gave oral evidence. In their evidence to the Inquiry all three members of staff (Richard Muscat, Angelica Williams and Michelle Garro) denied the allegations against them.

The allegations made by Resident T are serious. If true, they amount to what the Attorney General rightly described in his oral evidence as an "appalling breach of trust."[1407] It follows that in order to prove them cogent evidence is required.

On the evidence available to the Inquiry it is clear that Residents AA and J lacked capacity, and that their accounts could not and cannot be regarded as reliable. As to the evidence of Resident T herself, this was uncorroborated by any reliable evidence. I have also carefully considered the evidence in respect of Resident AA's nature, the way the Psychological Evaluation of Resident T by Giselle Carreras in 2005 had been carried out, the contents of Resident T's police interview, the oral evidence of the relevant carers, the fact that Resident T was not happy in the Home at the time and had previously felt able to make false accusations against her brother-in-law, and the evidence of the Psychosocial Report in September 2013.[1408] I also take account of the fact that Moira Elmer accepted in evidence that she did not witness any abusive conduct herself, and that her account was based entirely on what Resident T had told her.[1409]

[1403] C13/420 *et seq.*
[1404] C13/425-427.
[1405] C13/433.
[1406] C13/443.
[1407] C13/482-483.
[1408] C13/483-484.
[1409] C7/186 & C13/458.

I accept Marie Gomez' evidence that she did not regard Giselle Carreras' concerns about Resident T, as expressed by Resident T in Group Meetings from 2002 onwards, to be sufficiently serious as to justify her taking action in respect of them.[1410]

Having considered all the evidence, I find Resident T's evidence of misbehaviour, misconduct and abuse on the part of carers to be unreliable. I accept the evidence of Richard Muscat, Angelica Williams and Michelle Garro (together with that of Yvette Borastero) in its entirety and exonerate them from each and every one of the allegations which have been made against them by Residents T, J and AA. In particular, I accept Richard Muscat's denial that he was involved in any incident of the kind described by Moira Elmer in relation to Residents J and AA.[1411]

A relatively minor allegation was also made in relation to Resident J: viz. an allegation to the effect that carers would provoke her by saying "mimosin dice que no" in order to annoy her. There was evidence before the Inquiry, which I accept, that the matter was investigated at the time. There was no direct evidence supporting the allegation.

(17) Were there any instances of misconduct by members of staff in the form of (a) sexual misbehaviour, (b) unlawful consumption of drugs (c) alcohol abuse (d) bullying of residents or other members of staff, (e) misappropriation of medication, (f) theft of petty cash or (g) sleeping while on duty?

(a) ***sexual misbehaviour***

There was an allegation of sexual misconduct between carers on a trip to Lourdes. I am satisfied that no such incident took place. I also accept the evidence of Manuela Adamberry that, contrary to Mandy Spencer's assertion, she never informed Mandy Spencer that she had witnessed such an incident.[1412]

I have already dealt with the allegation in connection with Resident N under Issue (15).

(b) ***unlawful consumption of drugs***

Generally there was no evidence of the unlawful consumption of drugs at the Home, save for a reference to an isolated incident when a carer was disciplined for apparently having a partly-smoked reefer in her possession. On another occasion a carer, accompanying a resident, was arrested at the border when he was found to be in possession of a small quantity of cannabis. He subsequently left the employment of the SSA.

As to an incident which was said to have occurred on 27 January 2002, I accept the evidence of Nigel Bassadone (supported by the documentary evidence of witness statements taken at the time and the disciplinary process undertaken by the SSA in 2002) that he was neither high on drugs nor has he undergone drug rehabilitation. I regard the evidence of Denise Hassan in

[1410] C13/485.
[1411] C7/186.
[1412] C7/171.

relation to this incident, and to an incident where she was allegedly told by other carers that they had to dispose of cocaine left by Nigel Bassadone in a flat, as fundamentally unreliable.[1413]

(c) ***alcohol abuse***

Nigel Bassadone accepted that on 27 January 2002 he was present at the Home when under the influence of alcohol. He explained that this was as a result of mixing alcohol with prescribed medication. He was disciplined for that incident.

I also heard evidence about an incident said to have occurred on 15 May 2005 when Nigel Bassadone arrived at Bishop Healy in the early hours. I accept Nigel Bassadone's evidence about this incident, namely, that there was no misconduct on his part.[1414]

Mandy Spencer also referred in her evidence to an incident of alcohol abuse which occurred during the Milbury period, following which the carer in question (the then Deputy Manager) was dismissed.

(d) ***bullying of residents or other members of staff***

For the reasons set out in Chapter 7 I reject Mandy Spencer's allegations of bullying and/or manipulation by staff. I find that in her evidence to the Inquiry she described staff and their behaviour in extreme and unjustified terms.[1415] In particular, I reject her allegations against Sharon Berini, Sean Matto, Nigel Bassadone and Richard Muscat.[1416] I am satisfied that their conduct towards Mandy Spencer was never anything other than professional.[1417] I also reject the suggestion that staff were unwilling to report incidents for fear of repercussions.[1418] To the extent that junior members of staff may have been apprehensive about doing so, it was for the Manager to rectify that situation by dispelling any atmosphere of mistrust or suspicion which gave rise to such apprehension. In the case of Joanna Hernandez, I find that by her June 2005 "investigation" she did precisely the opposite.[1419]

I also reject Gabrielle Llambias' allegations of bullying by Sharon Berini. I also reject the allegations of favouritism and bullying on the part of Sharon Berini made in the June 2005 statements of Emily Dempsey, Maria Gonzalez, Rose Seruya, Christian Santos, Nicholas Hassan and Stacey McKay. As stated earlier, I am satisfied that Sharon Berini acted fairly and professionally throughout. I consider the criticisms made in the June 2005 statement of Jackie Palma to be inconsequential for present purposes.[1420]

[1413] C7/172 & 177.
[1414] C8/225-226.
[1415] C7/170.
[1416] C7/170-171.
[1417] C7/171.
[1418] C7/171.
[1419] C9/295.
[1420] C7/179.

There was no evidence before the Inquiry that cliques or "factions" among the staff (to the extent that they may have existed) impacted to any material degree on the care provided to residents and respite users.[1421]

I accept Michelle Garro's denial of the allegations made by Jonathan Dalrymple.[1422]

I reject Joanna Hernandez' allegations that Craig Farrell, Nigel Bassadone, Sharon Berini and/or Sean Matto were undermining the management of the Home, bullying their teams and dragging down the standard of care at the Home.[1423]

(e) ***misappropriation of medication***

The incident relating to a missing Ritalin tablet was investigated by the Royal Gibraltar Police, but it was found to be impossible to identify the culprit. I make no finding of criminal conduct in respect of this matter.[1424] In particular, I find the suspicion expressed in Jonathan Dalrymple's June 2005 statement to the effect that Nigel Bassadone had something to do with the missing tablet to be unfounded.[1425]

(f) ***theft of petty cash***

There is no credible evidence that any carer used residents' petty cash for his/her benefit or otherwise misappropriated it.[1426]

(g) ***sleeping while on duty***

There was evidence, unsurprisingly, of isolated occasions when carers fell asleep whilst on duty, but this appears to have been relatively uncommon; and any such incident was dealt with as a disciplinary matter.

(18) What complaints were made to the senior management concerning alleged incidents at the Home?

A number of complaints were brought to the attention of senior management by relatives. To the extent that such complaints were brought to the attention of senior management, they were investigated.

(19) What complaints were made to the SSA, to Ministers, to the Royal Gibraltar Police and/or to the Attorney General's Chambers (together "the Authorities") concerning alleged incidents at the Home?

Various matters were brought to the attention of (some or all of) the Authorities:

[1421] C7/181.
[1422] C7/187.
[1423] C8/233 & 239.
[1424] C7/172.
[1425] C7/179.
[1426] C7/174 & C8/201.

1. The matters in the statements collated by and on behalf of Joanna Hernandez as part of her June 2005 "investigation";
2. Certain individual complaints by relatives in relation to isolated incidents, as described in the Chapters reviewing the evidence on this aspect (Chapters 2-8). Elizabeth Featherstone also complained to the Chief Minister about cancellations in respite services;
3. Allegations raised in the witness statements filed by Joanna Hernandez in the Industrial Tribunal proceedings, as described in the Chapters reviewing the evidence on this aspect (Chapters 2-8);
4. Specific allegations of the existence of a punishment room: see Chapter 9;
5. Specific allegations in respect of Residents T, J and AA: see Chapter 13 and Issue (16);
6. Specific allegations in respect of Resident L: see Chapter 14 and Issue (15);
7. In her evidence to the Inquiry, Simy Herbert stated that she also brought various matters to the attention of the Minister. Yvette Del Agua's evidence is in sharp contrast, highlighting the lack of evidence shown to her. I accept the entirety of Yvette Del Agua's evidence as to her dealings with Simy Herbert.[1427]

(20) How did the Authorities respond to, or otherwise conduct themselves in relation to, any such complaints?

This Report reviews at length how the Authorities responded to the matters listed in points 1-7 of Issue (19).

In respect of the June 2005 statements (i.e. the statements received by the CEO of the SSA in June 2005 following Joanna Hernandez' "investigation") Yvette Del Agua made clear in her evidence that all the allegations contained in those statements had been investigated, save for the references to a punishment room: an allegation of which she had previously been unaware, and which was investigated at her request.

In so far as Resident T's allegations are concerned, I reject Joanna Hernandez' assertion that the response of the SSA to the allegations was "a stark example of where senior members of the SSA had been aware of long term and repeated abuse of vulnerable residents, but had done nothing to protect those residents…".[1428]

I find that it was for Isabella Tosso as CEO of the SSA, and not for Government, to decide whether disciplinary proceedings should proceed against the suspended employees in that case. I find that she delayed those proceedings for no good reason, and then also procrastinated over whether, and if so when, to reinstate the carers.[1429] I accept without qualification the evidence of Ernest Montado as to his participation in the matter of reinstatement of the three carers by Isabella Tosso.[1430] Ernest Montado was faced with a delicate situation in which he had to

[1427] C11/363.
[1428] C13/485.
[1429] C13/485.
[1430] C13/485.

balance the competing interests of employees and service users. His compromise solution (reinstatement on conditions) was not an ideal solution, but he was doing his best to act as Solomon in difficult circumstances.

Joanna Hernandez alleged that one of the police officers involved in investigating the allegations (DC Aldra Cerisola)[1431] had told her that the police had been instructed not to investigate allegations of abuse in Gibraltar, and that she had been told that the then Chief Minister (The Hon. Sir Peter Caruana KCMG QC MP, as he now is) had given such instructions.[1432] In evidence to the Inquiry, such allegations were rejected both by Aldra Cerisola and by Superintendent Acris.[1433] I accept without qualification the evidence of Superintendent Acris that the Royal Gibraltar Police has never been instructed by anyone not to investigate cases of abuse or indeed any other type of case.[1434] I also accept the evidence of DS Aldra Cerisola without qualification. In particular I accept she never told Joanna Hernandez that the case against the carers in the Resident T case had been "binned", or that the Royal Gibraltar Police had been instructed not to investigate cases of abuse.

I also consider the decision of the Attorney General not to institute criminal proceedings against the carers in the Resident T case to have been fully justified – if not inevitable given the quality of the evidence.[1435]

I find that the Royal Gibraltar Police investigated all matters brought to its attention. Indeed the Inquiry was shown papers of a wide-ranging police operation into social services cases entitled Operation Titan. Few of the cases under the umbrella of Operation Titan concerned the Home or its residents, but to the extent that they did they were clearly and vigorously investigated by the Royal Gibraltar Police, and where necessary advice on prosecutions was sought.

The implication of the evidence of The Hon. Joe Bossano MP was that there was a possibility that the conduct by Government in its defence of the Industrial Tribunal proceedings brought by Joanna Hernandez and the prosecution of various procedural appeals was simply an attempt to delay matters, to prevent the hearing and/or to obstruct the emergence of evidence in the case.[1436] He also considered it "peculiar" that Joanna Hernandez' case had not been funded by her trade union.[1437] Whilst Joe Bossano made clear that he was merely voicing suspicions for which he had no direct evidence, I considered it necessary, given the nature of those suspicions, to investigate whether they were justified on the evidence presented to the Inquiry.[1438]

[1431] C13/420 & Issue 16 above.
[1432] C13/446.
[1433] C13/480-481.
[1434] C13/486.
[1435] C13/486.
[1436] C12/370-373.
[1437] C12/371.
[1438] C12/374.

No evidence has been presented to the Inquiry to support Joe Bossano's suspicion in relation to the decision of Joanna Hernandez' trade union not to fund her case.[1439]

As to his wider suspicion, I accept without qualification the evidence of Yvette Del Agua, The Hon. Jaime Netto MP and Sir Peter. I find that there was no conspiracy by anyone in Government, or indeed anyone else, to delay or obstruct the hearing of Joanna Hernandez' claim in the Industrial Tribunal, or to stifle it by prolonging the proceedings.[1440]

(21) Did the SSA promulgate a code of conduct for members of staff at the Home and, if so, were copies readily available to staff?

In her evidence Joanna Hernandez complained that on her arrival as Manager she was unable to locate any staff policies or procedures.[1441] However, the minutes of a management meeting of 8 December 2004 record that Isabella Tosso stated that as from 22 November 2004 the SSA was following the Milbury policy and procedures, and that each member of staff would be provided with a copy of the policy.[1442] I find that by the end of December 2004, if not earlier, Joanna Hernandez was fully informed as to the policies and procedures of the Home.[1443]

I reject Gayle Everest's evidence that there was no policy in relation to the consumption of alcohol by residents and respite users.[1444] I am satisfied that consumption of alcohol by residents and respite users was properly monitored by staff, having regard to the health and welfare of those who wished to consume alcohol and the rights of all other residents and respite users.[1445]

Albert Bruzon gave evidence of the policies operated by Milbury and thereafter by the SSA. The Milbury manual itself was nearly 500 pages long. However, the evidence establishes that amongst SSA staff there was a degree of unawareness of policies, procedures and guidelines. Witnesses who gave evidence to that effect included Mandy Spencer, Giselle Carreras, Kirushka Compson, and Mandy Vallender. On the other hand, Sean Matto made clear that in his view the applicable policies had been in place since the Milbury days. I also note that in a memorandum dated 15 July 2009 and sent to all Care Agency staff, Carmen Maskill (then CEO) instructed all departments to keep a file of policies and required line managers to make staff aware of the same; and that a memorandum was sent on 13 August 2010 by Mary de Santos to Unit Managers requiring staff to read and sign an acknowledgment form confirming awareness of existing policies[1446].

[1439] C12/374.
[1440] C12/407-408.
[1441] C8/205.
[1442] C8/207.
[1443] C8/208.
[1444] C7/176.
[1445] C7/176.
[1446] [J1/1/20]; [J1/73/1];[J1/74/1].

Carlos Banderas gave extensive evidence of the policies introduced by the Care Agency, including a 227-page Policy and Procedure Manual Guidance for Staff[1447] (which covers a range of topics including recognising abuse, misuse of drugs, alcohol policy, medication policy and dealing with aggressive behaviour).[1448] The policies are updated from time to time. Regular environmental audits of the Flats are carried out to ensure appropriate standards in the flats. Care workers are bound by a code of conduct and disciplinary procedures regulate their behaviour.[1449]

(22) Were disciplinary procedures adequate to deal with proved misconduct or breaches of the code of conduct (if promulgated)?

I have seen no evidence to suggest that lack of disciplinary procedures was a significant issue during the period under review. So far as the available evidence is concerned all matters requiring disciplinary action were duly dealt with.[1450]

The disciplinary process operated by the SSA was presented in evidence to the Inquiry.[1451] Disciplinary investigations were conducted by the SSA whenever matters were reported to it which called for investigation. To the extent that matters so reported raised the possibility of criminal action, those matters were first investigated by the Royal Gibraltar Police. In some cases the SSA suspended its own internal disciplinary investigations in order to ensure that there was no conflict of investigations. The only disadvantage of this course, however, was the prospect of delay before the internal disciplinary investigation could be concluded.

Epilogue and General Conclusions

Finally, following my extensive review of the evidence presented to the Inquiry and my detailed findings on that evidence, I set out below a number of general conclusions based on that evidence. They are necessarily expressed in summary form, and reference should be made to the relevant Chapters of the Report for an understanding and appreciation of the factual background to them.

My general conclusions are as follows:

1. There were some instances of mismanagement, misconduct and malpractice (including abuse) at the Home, but they were infrequent and at the lower end of the scale of seriousness. Many families had no complaints about the services provided by the Home, and some were complimentary about them.

[1447] C15/530-534.
[1448] C15/531.
[1449] C15/531-532.
[1450] C7/179-180.
[1451] J1/57/51.

2. Many of the allegations in the witness statements filed on behalf of Joanna Hernandez in the Industrial Tribunal in 2006 (see paragraph 1(a) of the Inquiry's Terms of Reference) were untrue, grossly exaggerated or unsubstantiated by credible evidence. As identified in the Report the same was also the case in respect of some allegations raised in more recent witness statements filed by certain individuals for the purposes of the Inquiry.

3. To the extent that such allegations were established on the evidence, the incidents in question were largely historic and infrequent, and had been dealt with at the time by management at the Home, and/or by the SSA.

4. In any event, allegations of serious misconduct or abuse were investigated by management, the SSA and the relevant authorities (including the Royal Gibraltar Police) as the case may be. There was no conspiracy to prevent such allegations being investigated or being put into the public domain. The decisions taken by the relevant authorities (including the Royal Gibraltar Police) in relation to such allegations were justified.

5. Ongoing issues relating to the operation of the Home were investigated and dealt with as they arose, in accordance with current protocols and disciplinary procedures.

6. There were issues as to management and as to the provision of facilities that needed tackling. Shortage of staff was also a continuing problem. However the Home has gradually improved during the period under review and especially after 2005/6 in terms of staffing, procedures, working practices and impact on care. Resources can always be improved but that is a matter for the Government and not for the Inquiry;

7. The efforts of staff in working in difficult and often challenging conditions to provide care to residents (including respite users) deserves to be recognised. With few exceptions (which have been dealt with), they have done sterling work in the past and continue to do so.

This Inquiry has ranged over an extensive factual area covering a lengthy period of time. Numerous incidents, or alleged incidents, have been investigated – a large proportion of which happened, or allegedly happened, many years ago. On a positive note, however, I can report that the Home is now in much better order, and is better run, than it has been at any time during the period which the Inquiry has had to investigate. From relatively modest beginnings, it is now a much more efficient and professional operation.

I end by expressing the hope that the fact that the Inquiry has, perforce, focused to a large extent on negative issues regarding the Home will not serve to obscure the importance of the continuing work carried on at the Home for the benefit of its residents and respite users, and hence for the benefit of Gibraltar.

THE DR GIRALDI HOME INQUIRY REPORT

Annexures

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Annex 1

TERMS OF REFERENCE OF THE INQUIRY

1. To inquire into:

(a) allegations of mismanagement, misconduct and malpractice (including abuse) at the Dr Giraldi Home contained in witness statements intended to be relied on by Ms Joanna Hernandez in connection with her claim of unfair dismissal by the Social Services Agency; and

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

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

3. To find the relevant facts.

4. To report on the above.

Annex 2

LIST OF ISSUES

List of Issues considered by the Inquiry in the form finalised and agreed at the second preliminary hearing of the Inquiry held on the 23rd of July 2013

1. The Inquiry will investigate the issues listed in paragraph 4 below (being issues which derive from allegations contained in the witness statements referred to in paragraph 1(a) of the Inquiry's Terms of Reference and/or from documentary material which the Inquiry has examined) and the Terms of Reference are accordingly widened pursuant to paragraph 2 thereof to the extent necessary to include such issues.

2. The Inquiry will limit its investigations to the period since November 2002, which was the date at which the Social Services Agency ("the SSA") assumed operational management of the Dr Giraldi Home ("the Home") save that the Inquiry will also investigate the specific allegations made in witness statements by Ms Mandy Spencer which relate to an earlier period.

3. Generally, the Inquiry reserves its position as to any further extension of the Terms of Reference.

4. The issues:
   (1) Did the SSA provide sufficient support for senior management at the Home?
   (2) Did the SSA and senior management provide sufficient support for social service workers working at the Home?
   (3) Was there an adequate recruitment process in place for social service workers working at the Home?
   (4) Were the staff at the Home sufficiently (a) trained, (b) organised, (c) supervised and (d) appraised?
   (5) Were there sufficient procedures in place in respect of internal reporting and record keeping at the Home?
   (6) Were there proper care plans for those using the service provided by the Home, whether on a permanent, temporary, or respite basis (together, "residents")?
   (7) Were the working relationships between members of staff at the Home satisfactory in relation to:
      a. the provision of adequate care for residents; and/or
      b. the efficient performance of their allocated duties.
   (8) Were appropriate arrangements made for the care of younger residents and residents of differing genders?
   (9) Was there sufficient communication between members of staff and relatives of residents?

(10) Were the physical facilities at the Home satisfactory?
(11) Was the care provided to residents of a satisfactory standard with regard to their mental and physical health and their social development?
(12) Was appropriate provision made for the safety of residents?
(13) Was there a satisfactory regime in place at the Home with regard to the control and administering of medication?
(14) Was the standard of hygiene at the Home satisfactory?
(15) Were there any instances of abuse of or cruelty towards residents, including punishment?
(16) Were there any instances of members of staff instigating or encouraging inappropriate behaviour between residents?
(17) Were there any instances of misconduct by members of staff in the form of (a) sexual misbehaviour, (b) unlawful consumption of drugs (c) alcohol abuse (d) bullying of residents or other members of staff, (e) misappropriation of medication, (f) theft of petty cash or (g) sleeping while on duty?
(18) What complaints were made to the senior management concerning alleged incidents at the Home?
(19) What complaints were made to the SSA, to Ministers, to the Royal Gibraltar Police and/or to the Attorney General's Chambers (together, "the Authorities") concerning alleged incidents at the Home?
(20) How did the Authorities respond to, or otherwise conduct themselves in relation to, any such complaints?
(21) Did the SSA promulgate a code of conduct for members of staff at the Home and, if so, were copies readily available to staff?
(22) Were disciplinary procedures adequate to deal with proved misconduct or breaches of the code of conduct (if promulgated)?

Annex 3

LIST OF WITNESSES WHO GAVE EVIDENCE AT THE HEARING OF THE INQUIRY

No.	Witness	Date gave Evidence
1.	Carlos Banderas	30th September 2013 – Day 1 Recalled – 18th October 2013 – Day 13
2.	Joanna Hernandez	1st October 2013 – Day 2
3.	Elizabeth Featherstone	2nd October 2013 – Day 3
4.	Emilia Bruzon	2nd October 2013 – Day 3
5.	Denise Evaristo	2nd October 2013 – Day 3
6.	Frederick Becerra	2nd October 2013 – Day 3
7.	Maurice Valarino	2nd October 2013 – Day 3
8.	Gina Llanello	3rd October 2013 – Day 4
9.	Natalie Fortuna	3rd October 2013 – Day 4
10.	Violet Sullivan	3rd October 2013 – Day 4
11.	Simy Herbert	3rd October 2013 – Day 4
12.	Giselle Carreras	7th October 2013 – Day 5
13.	Jennifer Poole	7th October 2013 – Day 5
14.	Jessica Perez	7th October 2013 – Day 5
15.	Alison Baldachino	7th October 2013 – Day 5
16.	Moira Elmer	8th October 2013 – Day 6
17.	Elizabeth Harrison	8th October 2013 – Day 6
18.	Javier Millan	8th October 2013 – Day 6
19.	Elizabeth Elbrow	8th October 2013 – Day 6
20.	The Hon. Joe Bossano MP	9th October 2013 – Day 7
21.	Denise Hassan	9th October 2013 – Day 7
22.	Nigel Bassadone	9th October 2013 – Day 7
23.	Sean Matto	10th October 2013 – Day 8
24.	Sharon Berini	10th October 2013 – Day 8
25.	Jennifer Garrett	10th October 2013 – Day 8
26.	Michelle Garro	10th October 2013 – Day 8
27.	Angelica Williams	10th October 2013 – Day 8
28.	Craig Farrell	14th October 2013 – Day 9
29.	Kirushka Compson	14th October 2013 – Day 9
30.	Manuela Adamberry	14th October 2013 – Day 9
31.	Jonathan Teuma	15th October 2013 – Day 10
32.	Sharron Openshaw	15th October 2013 – Day 10
33.	Rose Robba	15th October 2013 – Day 10
34.	Mandy Vallender	15th October 2013 – Day 10
35.	Gayle Everest	16th October 2013 – Day 11
36.	Yvette Borastero	16th October 2013 – Day 11
37.	Richard Muscat	16th October 2013 – Day 11

38.	Mark Isola QC	16th October 2013 – Day 11
39.	Chris Wilson	16th October 2013 – Day 11
40.	The Hon. Sir Peter Caruana KCMG QC MP	17th October 2013 – Day 12
41.	The Hon. Yvette Del Agua	17th October 2013 – Day 12
42.	The Hon. Jaime Netto MP	17th October 2013 – Day 12
43.	Detective Inspector Wayne Tunbridge[1452]	17th October 2013 – Day 12
44.	Police Sergeant Adrian Bacarisa	17th October 2013 – Day 12
45.	Marie Gomez	18th October 2013 – Day 13
46.	Carmen Maskill	21st October 2013 – Day 14
47.	Mandy Spencer	21st October 2013 – Day 14
48.	Marie Carmen Santos	22nd October 2013 – Day 15
49.	Maria Elena Macias	22nd October 2013 – Day 15
50.	Police Officer Richard Mifsud	22nd October 2013 – Day 15
51.	Debbie Guinn	22nd October 2013 – Day 15
52.	Nicole Viagas	23rd October 2013 – Day 16
53.	Julie Sen	23rd October 2013 – Day 16
54.	Natalie Tavares	23rd October 2013 – Day 16
55.	Inspector Peter B Finlayson	23rd October 2013 – Day 16
56.	Police Superintendent Emilio Acris	23rd October 2013 – Day 16
57.	Louis Wink	23rd October 2013 – Day 16
58.	Aldra Cerisola	23rd October 2013 – Day 16
59.	Chief Inspector Cathal Yeats	24th October 2013 – Day 17
60.	Sharon Peralta	24th October 2013 – Day 17
61.	Johann Fernandez	24th October 2013 – Day 17
62.	Attorney General – R. Rhoda QC CBE	24th October 2013 – Day 17
63.	Ernest Montado CBE	24th October 2013 – Day 17

[1452] Ranks of the Royal Gibraltar Police Officers are as stated at the time of the filing of their Witness Statements with the Inquiry

Annex 4

SUMMARY OF THE PROCESS FOLLOWED IN RESPECT OF THE TAKING OF EVIDENCE FROM RESIDENTS

From the outset the Inquiry has been keen to assess whether residents were capable and willing to give evidence. The Inquiry has also been conscious of the special need to protect the rights of residents and their families in so doing.

The following note sets out an overview of the process followed by the Inquiry in assessing whether residents were capable of giving evidence and whether they wished to do so.

During the period May to September 2013 the Inquiry underwent a phase in which it took and received witness statement evidence from numerous people many of whom would, in due course, also give oral evidence at the Inquiry hearings.

On 4th June, 2013, the Inquiry's solicitors wrote to the Care Agency (and its solicitors) in the following terms:

> "The Inquiry Chairman has indicated that if there are any residents of the Home who might be able to assist the Inquiry and who wish to contribute evidence that he would like to hear from them as part of the Inquiry. We appreciate that where this is possible or desired it may be that such persons would need to give evidence under special conditions. Before we turn to such questions, it is first necessary to have some assessment of the issue of capacity to give evidence. We would like to discuss this further with you and with the current Home occupational psychologist (or equivalent relevant professional) in a meeting. We are hoping that it may be possible for the psychologist to provide us with an assessment of whether any of the residents who may have been affected by any of the matters which the Inquiry is investigating are capable of giving reliable evidence to the Inquiry and in what circumstances (e.g. by live evidence to the Inquiry with perhaps an interpreter, by witness statement prepared with one of our lawyers and if necessary an appropriate medical professional, by (dictated) letter, by recorded interview a transcript of which could be taken, or by such other means that we could discuss. We are mindful for example that (Resident T) did provide certain evidence to Police as part of their investigation of a particular matter. We are unclear whether there are other service-users/residents who may be equally capable."

As is evident from that email the Inquiry was focussed on the desired outcome of obtaining evidence from residents but sensitive that this should be done in accordance with their wishes and interests.

Residents suffer from a range of diagnosed disabilities some of which are extremely severe in nature and extent[1453]. It was self-evident from the evidence in the possession of the Inquiry that not all residents would be able to give evidence and that, in fact, it was likely that there would only be a small number who could.

[1453] See [J1/112/3].

On 2nd July 2013, the solicitors for the Care Agency wrote to the Inquiry identifying a small group of residents who, in the Care Agency's view, could potentially meet the "minimal standard threshold towards competency to provide any evidence." It was made clear in that e-mail that the Care Agency:

> "are concerned by the anxiety and stress that these individuals are likely to suffer should they be required to give evidence to the Inquiry. Ms Carreras [the Agency Psychologist] has explained that when internal investigations have been carried out by investigating bodies at the Home in the past, the levels of stress amongst the service users has been seen to increase dramatically and if any of the service users are going to give evidence in one form or another the situation has to be appropriately managed."

The Care Agency also made the point in its e-mail that:

> "Given the concerns raised by the Clinical Psychologist, we are keen to ensure that, if evidence is going to be taken at all, those individuals that (1) are capable and (2) wish to provide evidence are not caused anxiety and/or stress in so doing. Further, we would need to ensure that, in the event that a service user were to provide the Inquiry with evidence, that individual's next of kin/guardian was involved in the process as a means of ensuring that the service user has the necessary support structure he or she may require at that end."

A meeting was held on the 10th July, 2013, between the Inquiry's solicitors, the Care Agency's solicitors and Carlos Banderas and Giselle Carreras to discuss all these matters. A five-step process was identified that could lead to residents giving evidence to the Inquiry namely:

(1) there would be an assessment by the Care Agency Psychologist (Giselle Carreras) as to whether particular residents were, in principle, capable of giving evidence.[1454] That would identify a number of residents that could, if they were willing, provide evidence;

(2) those residents would then be approached sensitively to assess whether they wished to give evidence;

(3) if they were willing to give evidence an independent opinion on capacity would also need to be obtained to provide formal and independent support on this question;

(4) the family members of the particular residents would be informed as they might have views on the issue and in any event to provide support to the resident;

(5) the resident if willing and capable would give evidence albeit if necessary under special conditions.

There was a discussion about the learning difficulties of the various residents who had been identified in the email of 2nd July 2013 as possibly being able to give evidence. Subsequently the

[1454] It was agreed that Ms Carreras was the relevant clinician with the most knowledge and experience of residents and best suited to give this preliminary opinion on in-principle capacity.

Clinical Psychologist gave a preliminary opinion that a small number of residents could be capable of giving evidence.[1455]

It was agreed that Mr Banderas and Ms Carreras would meet with the residents identified as possibly capable and assess whether they were willing to explore the possibility of giving evidence. This was a process to be undertaken with the consent of families. If residents opposed such an idea there would be no need to proceed further.

On the 15th August, 2013, the Inquiry's solicitors received an e-mail from the Care Agency's solicitors confirming that informal conversations with residents had taken place and that they had individually been asked if they wished to participate in the Inquiry. Of those only one (Resident T) had expressed a willingness to provide evidence and only then on condition that Mr Banderas was involved in the process. Resident T's Family member had expressed opposition to her giving evidence. Despite this, Resident T expressed a wish to do so, as confirmed in an email received from the Care Agency's solicitors on 23rd August 2013.

A report on capacity was then commissioned from an independent psychologist (Ms Olga Puertas Sanchez). This can be found within the Inquiry's documents at **[M4/15/1]**.

A meeting was held between the Inquiry's solicitors and Resident T (with Mr Banderas and Resident T's sister also in attendance) at which Resident T maintained her willingness to provide a written statement to the Inquiry. She did not wish to give oral evidence to the Inquiry. A statement was obtained and this was included in the Core Documents of the Inquiry **[F/19/1]**.

The background to this process was explained in summary by counsel to the Inquiry in opening.[1456] Mr Englehart QC stated:

> "I should say a brief word about one matter. The Inquiry has carefully considered the possibility of obtaining evidence from residents of the Dr Giraldi Home but it would be well appreciated there is a need for special sensitivity in the treatment of such residents and any such evidence importantly had to be voluntary and also subject to professional advice on the capacity of anyone to give evidence. In the event it is right to say that one resident has expressed a wish to provide evidence in written form – I stress written form not orally – to the Inquiry and a witness statement has been taken following independent clinical advice".

Concerns were raised by counsel for Joanna Hernandez in respect of the process followed by the Inquiry. Mr Enright suggested that residents and users of the home had not been adequately involved in the Inquiry because they had not provided evidence to the Inquiry.

In oral closing submissions, Mr Enright for Ms Hernandez stated (see for example Day 19 page 21 line 7):

> "The first issue is the absence of the victims. At its heart, this Inquiry is an inquiry into … alleged abuse and ill treatment of vulnerable residents and the complete absence of those

[1455] At that stage five residents were so assessed.
[1456] Day 1 Page 18 line 23

> residents and users of the Home from the Inquiry… are serious matters that the Inquiry will have to grapple with. It's an obvious point that readers of the Inquiry's report will wish to understand that - why were the alleged victims not here to give evidence? Because it's right that they are given a place at the very heart of the Inquiry. You pointed out this morning sir that it was being felt that it was not in their best interests and it might distress them but it is also worth highlighting that the residents and users were not independently represented by counsel, who would be only concerned with their best interests and who could speak on their behalf. I also want to emphasise that at no time did Ms Hernandez or myself suggests that residents should be compelled to give evidence in writing or in person. But it was submitted that they deserved to know that the Inquiry was going on in their name and to be given the opportunity should they so wish, to give evidence."

In lengthy submissions submitted to the Inquiry in November 2014 following provision to Ms Hernandez of extracts of the draft Report, Mr Enright stated:

> "As far as we are aware, Ms Hernandez is the only person to raise this serious issue i.e. the consequences that flow from failing to involve and engage with the victims and alleged victims at all, or in any meaningful way…..
>
> … the almost complete absence of the most affected persons from the Inquiry, combined with the failure to provide those individuals with independent legal representation, renders the Inquiry and its report fundamentally flawed, of no practical use and a flagrant breach of the rights of the alleged victims."

However, as can be seen from the above, a detailed process had been followed by the Inquiry to assess whether residents wished to give evidence and their capacity to do so; and the interests of all residents were at all times represented and protected by counsel appointed by the Disability Society.

As conceded on her behalf in Mr Enright's submissions (above), Ms Hernandez was the only party – from among the numerous represented parties – who made such submissions (probably because everyone else understood that in fact it would have been a breach of the fundamental rights of the residents to have attempted to compel them to give evidence against their wishes or disregarded the issue of capacity). This was not a course of action supported by families of residents in any event.

Counsel for the Care Agency during closing submissions stated:[1457]

> "the first issue that I wanted to raise as a matter of fairness is the allegation that the residents have not been involved in the process at all. Whilst acknowledging that it certainly was a matter that counsel to the Inquiry raised and it was a matter for counsel to the Inquiry to determine I think it would be very unfair of us not to make a statement to the effect that the Care Agency was very much involved in the process together with counsel to the Inquiry of ascertaining issues concerning the capability of the various residents and also the willingness of those residents to give evidence. In as much as it is within our knowledge, the level of involvement and indeed the sensitivity and care that was taken in that process in line with needless to say not only the role that counsel to the Inquiry plays but also in line with the fact that the Care Agency also has a duty of care to the residents, we were keen to ensure that matters were done appropriately. So far as we are concerned the exercise was undertaken and the outcome is the outcome that ended up being before you which is essentially that there was only one resident who was indeed competent and willing to be able to assist the Inquiry and that is indeed the position."

[1457] Day 18 page 151 line 17.

The Disability Society represents the interests of residents and families of residents. Counsel for the Disability Society also made clear that the Disability Society's view was that it concurred with the submissions made by the Care Agency on this subject[1458].

[1458] Day 19 page 10 line 7; and see also the description of her submissions in the Introduction to this Report.

Annex 5

LIST OF COUNSEL INSTRUCTED IN THE INQUIRY

Counsel	Firm	Representation
Robert Englehart QC	Blackstone Chambers	The Inquiry
Keith Azopardi QC Ms Gabrielle O'Hagan Ms Cristina Linares Nicholas Bottino Esq.	Triay Stagnetto Neish	The Inquiry
Gillian Guzman QC Darren Martinez Esq.	Hassans	The Care Agency
Christian Rocca Esq. James Montado Esq.	Isolas	The Royal Gibraltar Police
Robert Fischel QC Karl Tonna Esq.	Attorney General's Chambers	Attorney General
David Enright Esq.	Howe & Co	Joanna Hernandez (represented Ms Hernandez from Aug 2013)
Chris Finch Esq.	Lexicon Legal	Joanna Hernandez (represented Ms Hernandez until end July 2013)
Charles Gomez Esq. Ms Lydia Jackson	Charles Gomez & Co	Kirushka Compson; Craig Farrell
Nicholas Cruz Esq. Ms Christina Wright	Cruz & Co	Marie Gomez
Suresh Mahtani Esq. Nicholas Borge Esq.	Veralls	Yvette Borastero; Michelle Garro; Angelica Williams
Christopher Miles Esq.	Veralls	Gabrielle Llambias
Ms Kathryn Moran	Litigaid Law	Gayle Everest; Sharron Openshaw
Kenneth Navas	Kenneth Navas & Co	Manuela Adamberry; Rose Robba; Jonathan Teuma; Matthew Turnock
Charles Salter Esq. Andrew Cardona Esq.	Phillips & Co	Giselle Carreras

Ms Anne Balestrino	Phillips & Co	Disability Society; Emilia Bruzon; Elizabeth Featherstone; Denise Evaristo
Ray Pilley Esq.	Triay & Triay	Mandy Vallender
Robert Vasquez QC	Triay & Triay	Sharon Berini; Melissa Hales; Sean Matto; Richard Muscat
Christopher Pitto Esq.	Bullock & Co (subsequently Attias & Levy)	Mandy Spencer; Simy Herbert.

Annex 6

LIST OF RESIDENTS AND STAFF ORGANOGRAMS

Compiled from documentation provided by the Care Agency

- List of Permanent Residents
- List of Respite Users
- Staff Organograms[1459]

Dr Giraldi Home – Permanent Residents

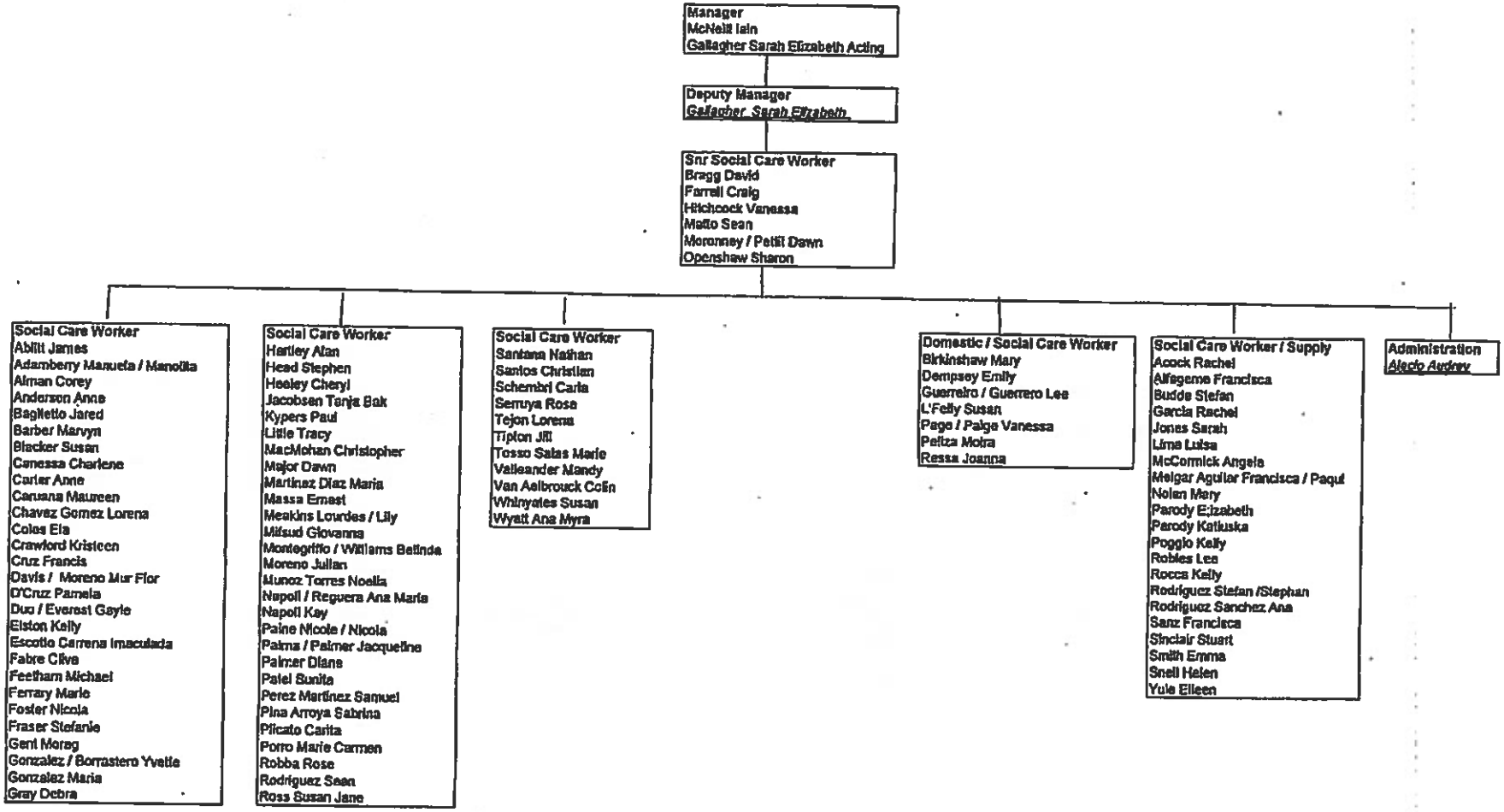
	Resident	Flat Number and Date of Admission to the Dr Giraldi Home
1	Resident B	Flat 1 Admitted: 17.06.1994
2	Resident U	Flat 1 Admitted: 13.01.1995
3	Resident N	Flat 1 Admitted: April 1994
4	Resident K	Flat 1 Admitted: 02.01.1997
5	Resident T	Flat 1 Admitted: 2002
6	Resident F	Flat 1 Admitted: 18:02:2006
7	Resident J	Flat 2 Admitted: 10.01.1994
8	Resident AI	Flat 2 Admitted: 10.01.1994
9	Resident AA	Flat 2 Admitted: 2000
10	Resident E	Flat 2 Admitted: 10.01.1994
11	Resident I	Flat 3 Admitted: 1998
12	Resident AD	Flat 4 Admitted: 14.03.2010
13	Resident AE	Flat 5 Admitted: 25.11.1996
14	Resident A	Goole House Admitted: 10.11.1996
15	Resident X	Goole House Admitted: February 2003

[1459] In the original form supplied by the Care Agency to the Inquiry.

Dr Giraldi Home – Respite Service Users

	Resident
1	Resident O
2	Resident C
3	Resident AF
4	Resident D
5	Resident P
6	Resident AC
7	Resident M
9	Resident AG
10	Resident Q
11	Resident AH
12	Resident R

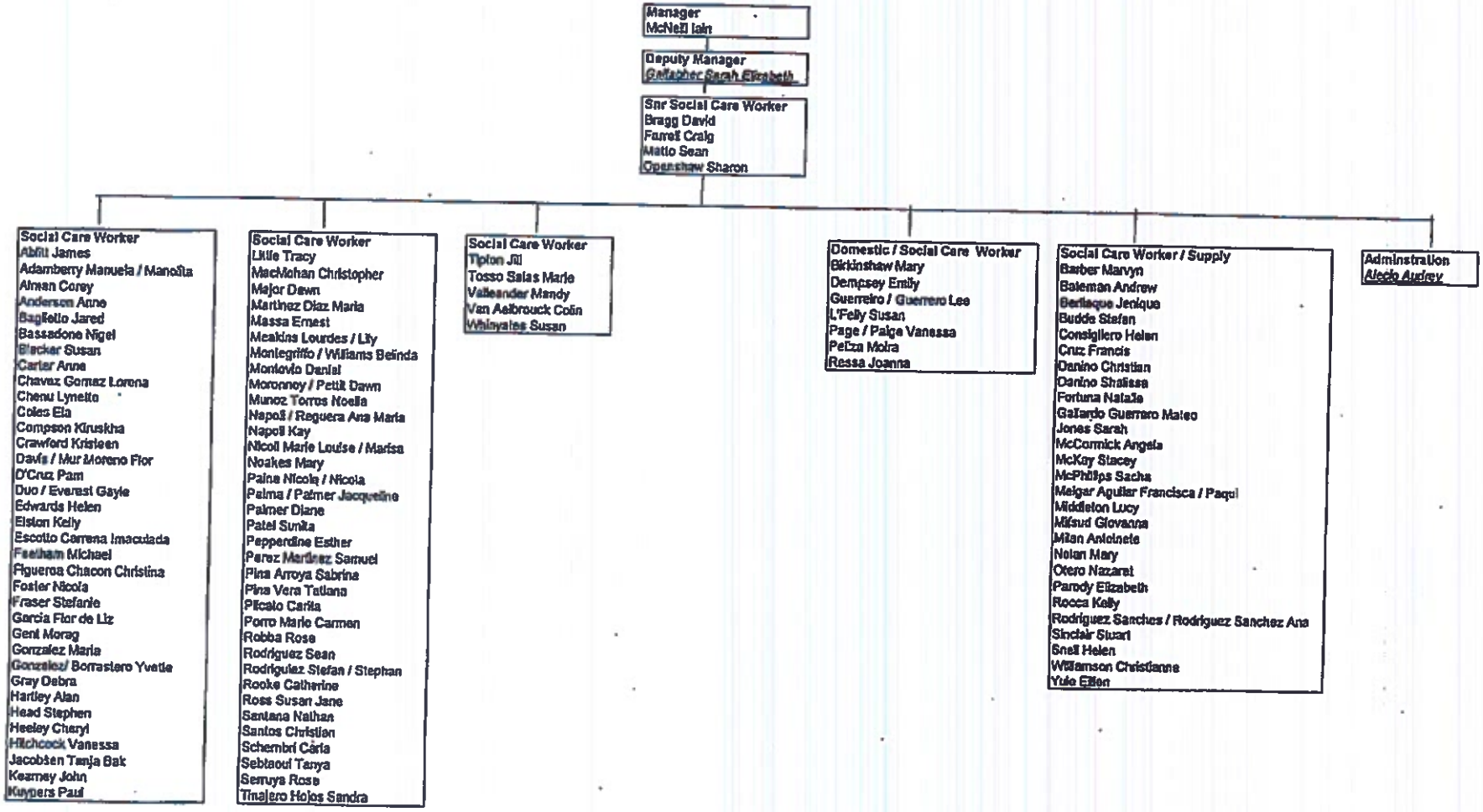
Dr. Giraldi Home Staff 2009/2010



Note:

Italics & Underlined: Proof of employment identified but not of grade/post.

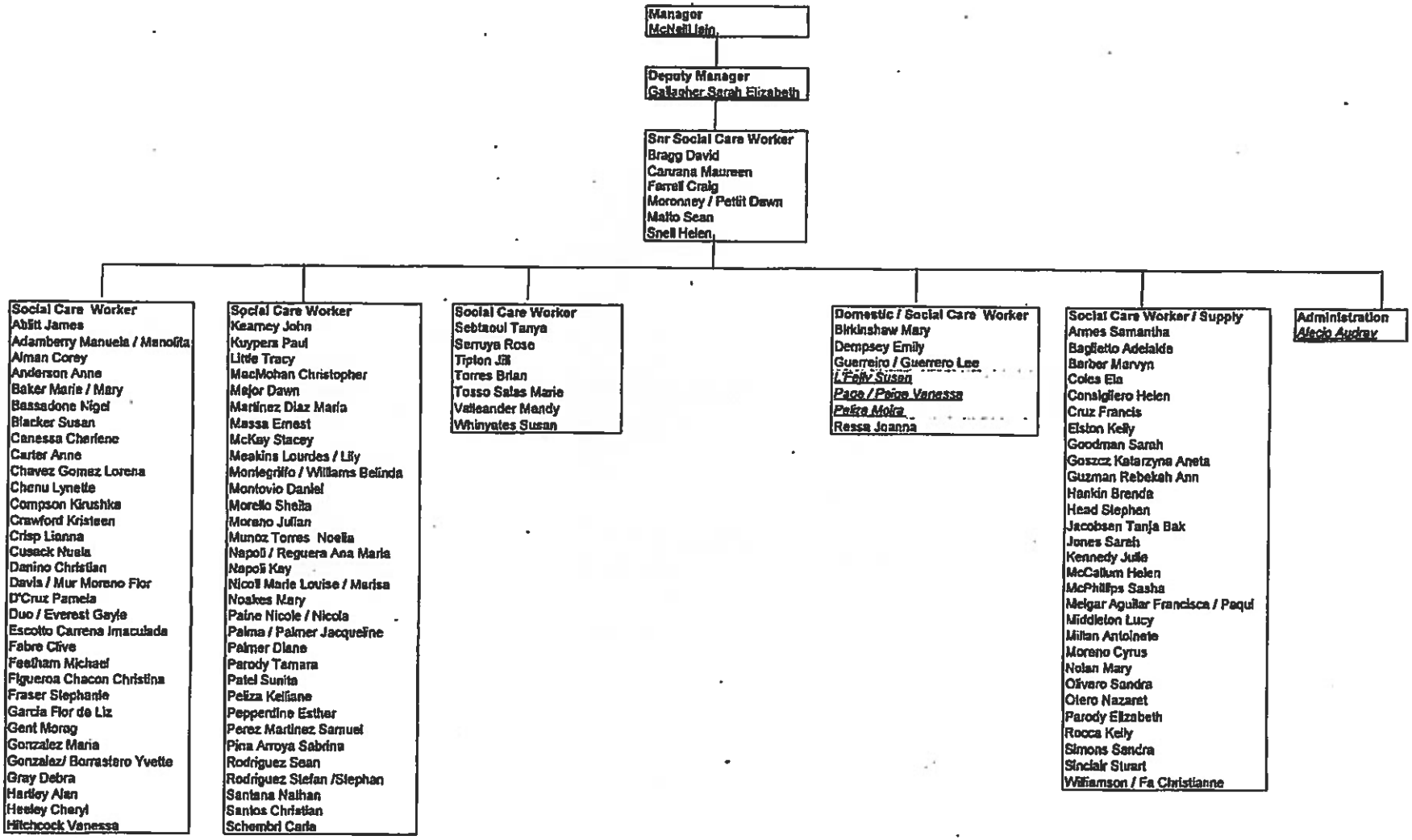
Dr. Giraldi Home Staff 2008/2009



Note:

Italics & Underlined: proof of employment identified but not of grade/post.

Dr. Giraldi Home Staff 2007/2008

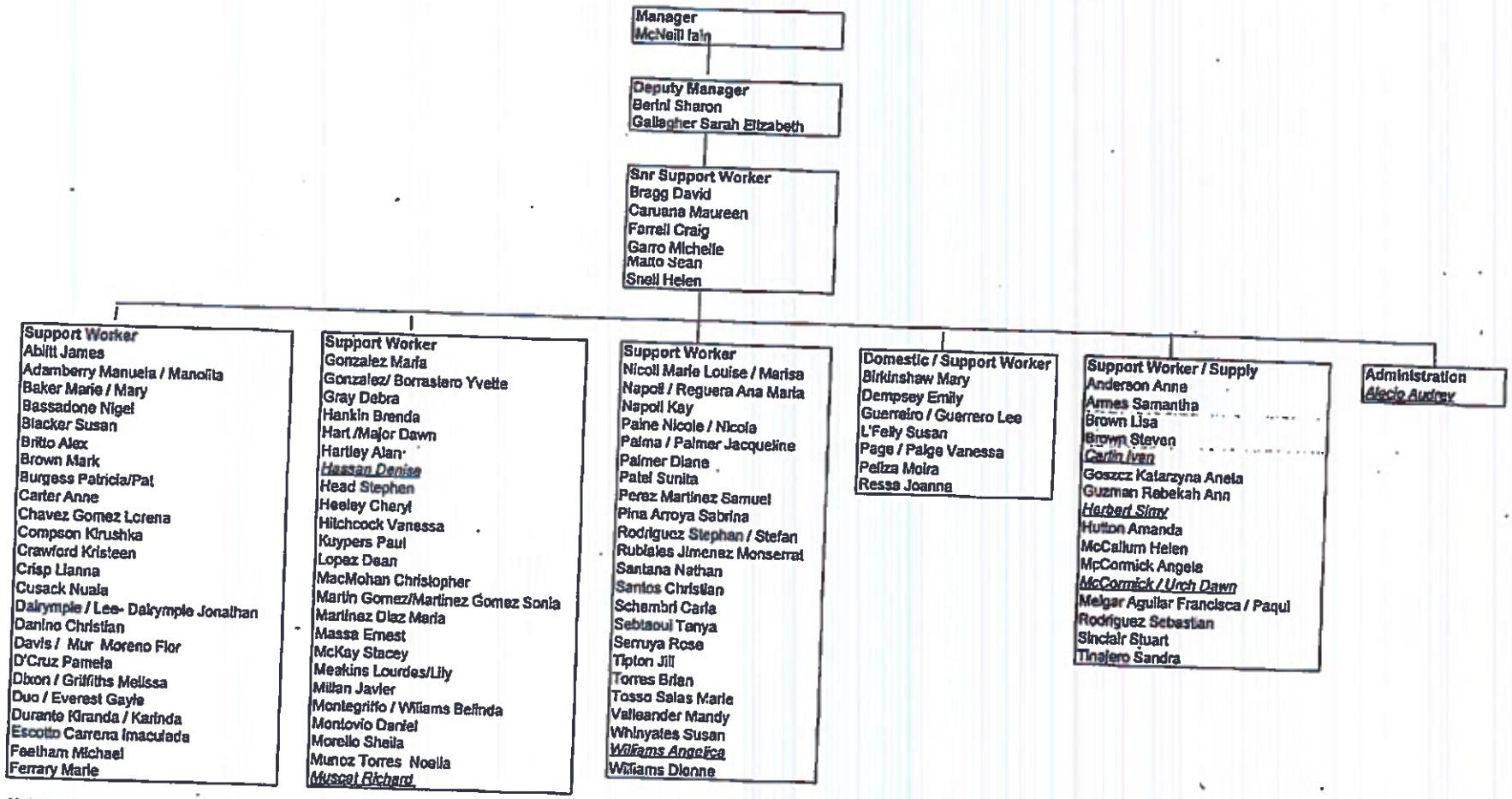


Note:

Italics & Underlined: Proof of employment at Dr Giraldi Home identified but not of grade/post and/or location.

Italics, Highlighted & Underlined: Proof of employment within Social Services Agency identified, included on the basis of fact knowledge from previous and subsequent financial years.

Dr. Giraldi Home Staff 2006/2007

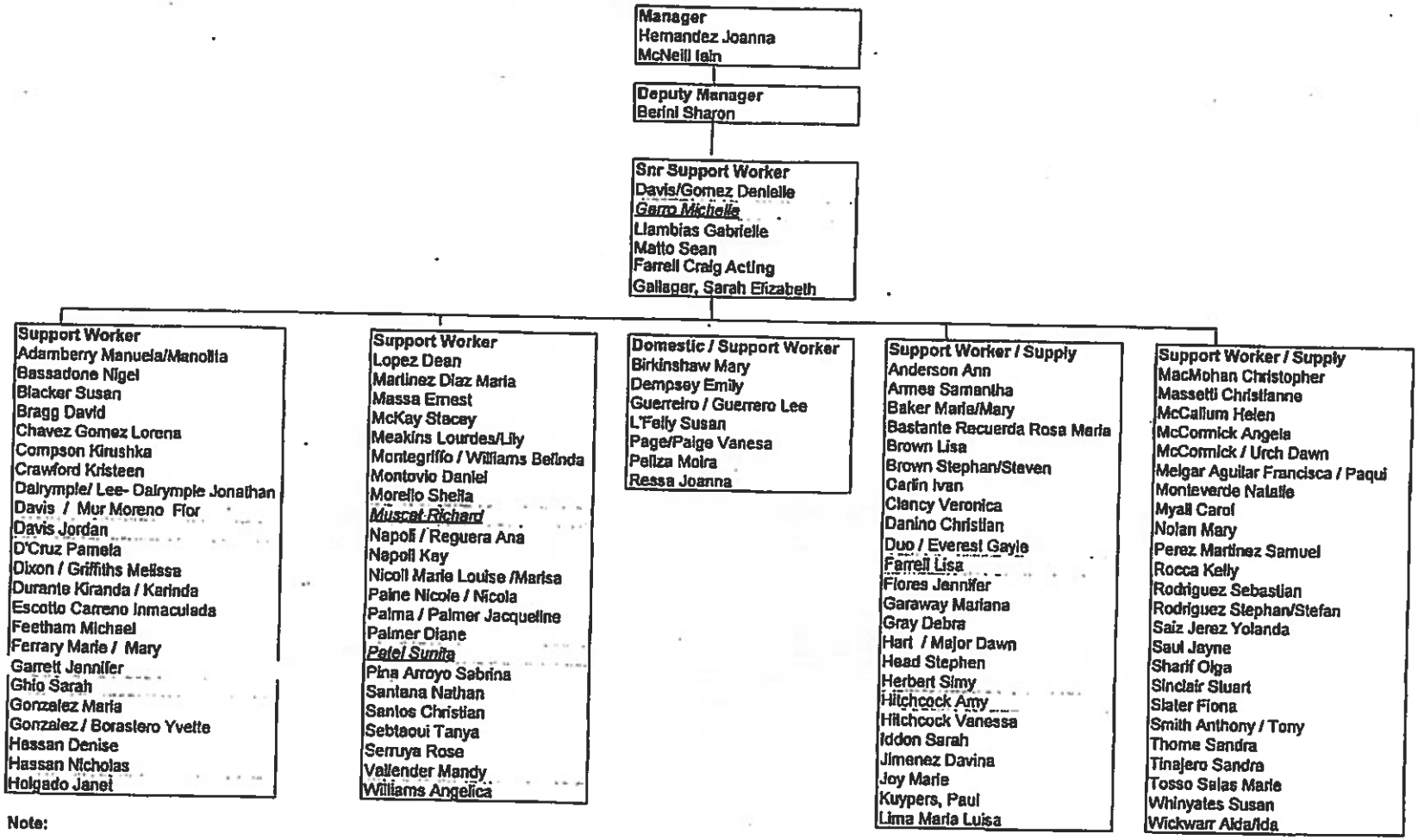


Note:

Highlighted Entries: Names submitted by the Care Agency; no documentary evidence found to date to substantiate proof of employment.

Italics & Underlined Entries: Proof of employment identified but not of grade/post and/or location.

Dr. Giraldi Home Staff 2005/2006



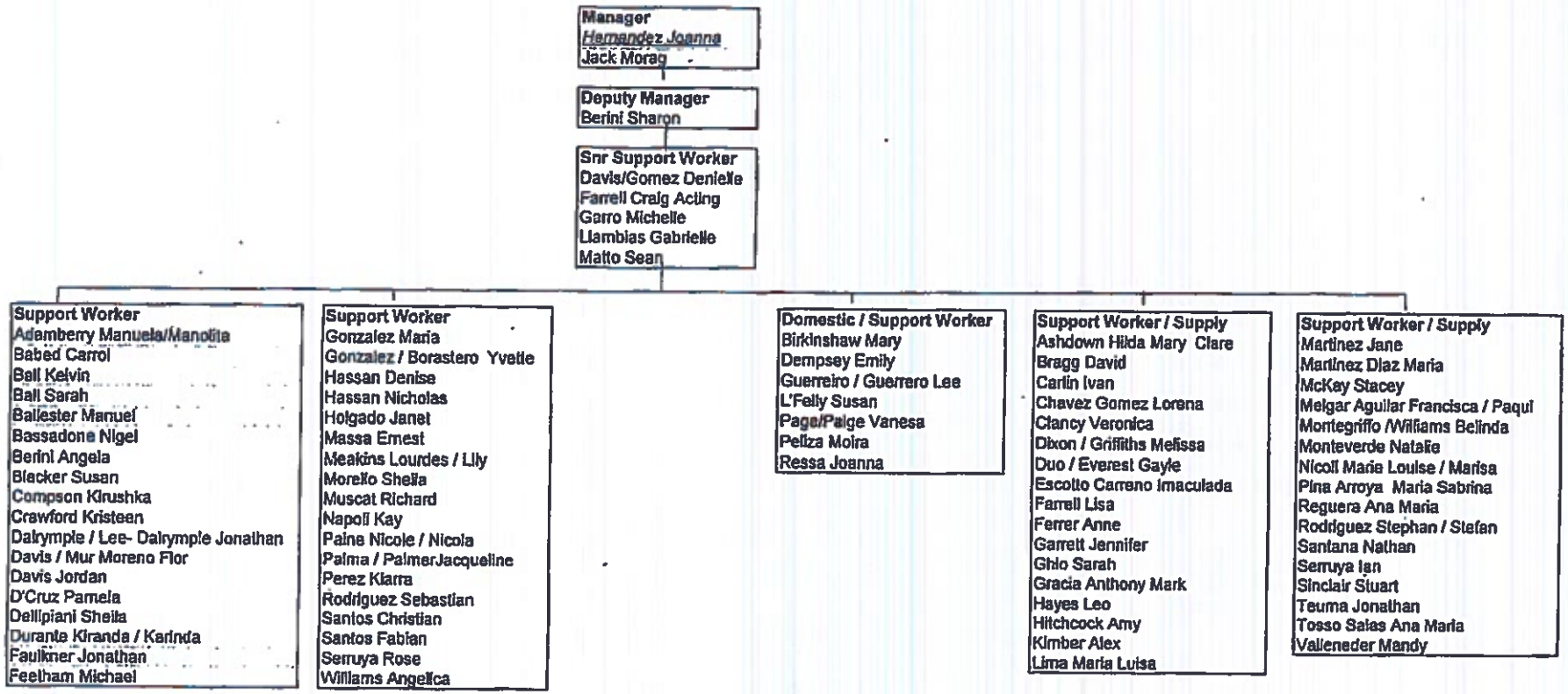
Note:

Highlighted Enteries: Names submitted by the Care Agency; no documentary evidence found to date to substantiate proof of employment.

Italics, Underlined & Highlighted Enteries: Names submitted by Care Agency as working at Dr Giraldi Home, proof of employment at Social Services Agency identified but not of grade/post and/or location.

Bold: Information submitted by Care Agency

Dr. Giraldi Home Staff 2004/2005

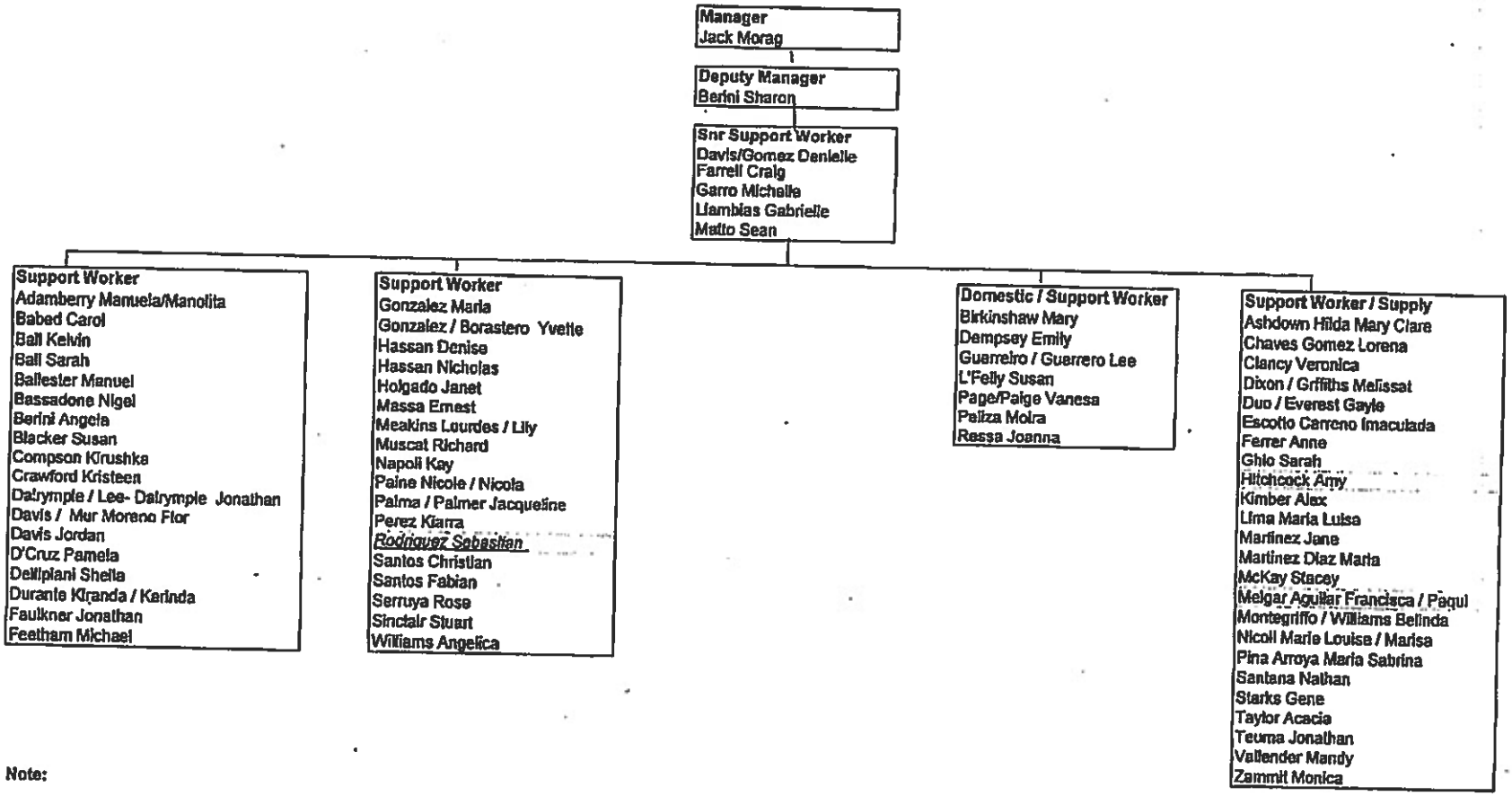


Note:
Below listed are the students employed under the Stay & Play Scheme who worked at Dr Giraldi Home during summer 2004.
Aidasani Silvan Ashou
Clancy Veronica
D'Amato Elaine
Masseti Chrisanne
McMahon Melissa Jane
Muscat Francis
Rodriguez Joleen Kelly
Rodriguez Stephanie
Sivers Aimee L
Suarez Fabian

Highlighted Entories: Names submitted by the Care Agency; no documentary evidence found to date to substantiate proof of employment.

Italics and Underlined: Proof of employment found but not of grade/post and/or location.

Dr. Giraldi Home Staff 2003/2004



Note:

Highlighted Entries: Names submitted by the Care Agency; no documentary evidence found to date to substantiate proof of employment.

Italics, Underlined & Highlighted Entries: Names submitted by Care Agency , proof of employment at Social Services Agency identified but not of grade/post and/or location.

Annex 7

TABLE A - RESIDENTS 1994-2004 AND SITUATION AT SEPTEMBER 2013

Compiled from evidence provided by the Care Agency

	Total Permanent Residential & Respite	Total Permanent Residential (excluding Respite)	Flat 1	Flat 2	Flat 3	Flat 4	Flats	Merlot House	Bishop Healey	Goole House	Respite
1995/6[1460]	**10**	**7**	-	-	-	-	-	-	-	-	**3**
1997[1461]	**42**	**13**[1462]	-	-	-	-	-	-	-	-	**29**[1463]
2002[1464]	**29**	**13**	**7**	**6**	**-**	**-**	**-**	**-**	**-**	**-**	**16**
2003[1465]	**32**	**16**	**U**[1466]	**U**[1467]	**-**	**-**	**-**	**-**	**-**	**-**	**18**
2004 (April)[1468]	**-**	**18**	**7**[1469]	**6**[1470]	**-**	**-**	**-**	**2**[1471]	**3**[1472]	**-**	**-**
2004 (Nov)[1473]	**29**	**17**	**7**[1474]	**6**[1475]	**1**[1476]	**-**	**-**	**1**[1477]	**2**[1478]	**-**	**12**[1479]

[1460] Bruzon, Para 82 [J1/1/21] drawn from letter sent by Mgr. Caruana, the Dr. Giraldi Home Trust Chairman to the Chief Minister in late 1995/early 1996.
[1461] Bruzon, Para 13 [J1/1/4] drawn from a Review of Community Care in Gibraltar by Milbury Care Services in 1997
[1462] 12 Adults; 1 Child – [J1/106/4]
[1463] 11 Adults; 18 children – [J1/106/4]
[1464] Bruzon, Para 83 [J1/1/21] drawn from Insurance cover document of 2002.
[1465] Bruzon, Para 84 [J1/1/21] drawn from information prepared for parliamentary answer in 2003. The information provided is for the end of 2002 – see [J1/176/1] and [J1/76/2].
[1466] Unspecified.
[1467] Unspecified.
[1468] Bruzon, para 85 [J1/1/21] drawn from Memo 5th April 2004 from Sharon Berini to Douglas Rodriguez, CEO/SSA.
[1469] Residents W, K, U, A, N, B & V.
[1470] Residents J, E, T, AI, AA & S.
[1471] Residents AE & Z.
[1472] Residents L, AB & I.
[1473] Bruzon, Para 87 [J1/1/21] drawn from memo 18th November 2004 from Sharon Berini to Isabella Tosso – see [J1/9/1].
[1474] Residents N, K, A, W, V, B & U.
[1475] Residents AI, J, E, T, AB & AA.
[1476] Resident AE.
[1477] Resident Z.
[1478] Residents L & I.
[1479] Residents X, C, G, AD, AH, AG, O, M, R, Y, AC & AF.

2013 (Sept)[1480]	**27**	**13**	**6**[1481]	**4**[1482]	**1**[1483]	**1**[1484]	**1**[1485]	**-**	**-**	**2**[1486]	**14**[1487]

TABLE B - STAFF NUMBERS 1999[1488] TO 2010

Compiled from evidence provided by the Care Agency

	Manager	Deputy Manager	Senior Care Workers[1489]	Care Workers (full & part-time)	Supply Care Workers	Domestic Cook & Handyman	Others
1999[1490]	**1**	**-**	**1**	**17**	**2**	**5**	**1**
2002 April)[1491]	**1**	**1**	**3**	**22**	**13**	**Not Specified**	**3**
2002 (Sept)[1492]	**1**[1493]	**1**[1494]	**3**	**20**	**9**	**4**	**3**
2003 (Oct)[1495]	**1**[1496]	**1**[1497]	**4**	**34**	**22**	**4**	**3**
2004-5[1498]	**1**[1499]	**1**[1500]	**5**	**36**	**33**	**7**	**-**
2005 (Oct)[1501]	**1**	**1**	**4**	**40**	**Not Specified**	**7**	**-**
2005-6[1502]	**1**[1503]	**1**[1504]	**6**	**46**	**48**	**7**	**-**
2006 (Oct)[1505]	**1**	**1**	**2**	**52**	**Not Specified**	**7**	**1**[1506]

[1480] Banderas Para 12 [J1/124/3].
[1481] Residents B, F, K, N, T & U.
[1482] Residents AA, AI, E & J.
[1483] Resident I.
[1484] Resident AD.
[1485] Resident AE.
[1486] Residents A & X.
[1487] Excludes weekends for which numbers vary – see Banderas [J1/124/3]. The figure of 14 individual respite residents at September 2013 is obtained from information supplied to the Inquiry by the Care Agency in March 2014.
[1488] The earliest list of staff in evidence was that of February 1999 – Bruzon, Para 30 [J1/1/9]
[1489] The terminology initially in the staff lists is "Support Worker" or "Senior Support Worker"
[1490] Bruzon Para 31 [J1/1/9] & [J1/20/2]
[1491] Bruzon Para 32 [J1/1/9] & [J1/21/1] and for a division of workers into the three flats at the time See [J1/22/1]
[1492] Bruzon Para 33 [J1/1/10] and [J1/22/1]
[1493] Mandy Spencer
[1494] Sharon Berini
[1495] Bruzon Para 38 [J1/1/11] – based on memo from Sharon Berini (Deputy Manager) to Douglas Rodriguez (CEO) of SSA 30th October 2003 [J1/26/1]
[1496] Morag Jack
[1497] Sharon Berini
[1498] Bruzon, Para 39 [J1/1/12] based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1499] Morag Jack and Joanna Hernandez
[1500] Sharon Berini
[1501] Bruzon, Para 31 [J1/1/13] – breakdown prepared by SSA for parliamentary answer in October 2005 [J1/27/5]
[1502] Bruzon, Para 40[J1/1/12] based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1503] Joanna Hernandez/Ian MacNeil
[1504] Sharon Berini
[1505] Bruzon, Para 43 [J1/1/13] – information prepared in October 2006 by SSA for parliamentary answer [J1/28/4]
[1506] Administration Officer (Part-time)

2006-7[1507]	**1**[1508]	**1**[1509]	**6**	**71**	**16**	**7**	**1**[1510]
2007-8[1511]	**1**[1512]	**1**[1513]	**6**	**71**	**29**	**7**	**1**[1514]
2008-9[1515]	**1**[1516]	**1**[1517]	**4**	**75**	**27**	**7**	**1**
2009-10[1518]	**1**[1519]	**1**[1520]	**6**	**67**	**21**	**7**	**1**
2013 (Sept)[1521]	**1**	**-**	**4**	**69**[1522]	**Not Specified**	**6**	**7**[1523]

[1507] Bruzon, Para 42 [J1/1/13] based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1508] Ian MacNeill
[1509] Sharon Berini/Elizabeth Gallagher
[1510] Administration Officer
[1511] Bruzon, Para 44 [J1/1/13] – based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1512] Ian MacNeill
[1513] Elizabeth Gallagher
[1514] "Administrator" – as described from 2007 onwards
[1515] Bruzon, Para 45 [J1/1/14] – based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1516] Ian MacNeill
[1517] Elizabeth Gallagher
[1518] Bruzon, Para 46 [J1/14] - based on organogram prepared by Social Services Ministry in 2013 for purposes of the Inquiry (Annex 5)
[1519] Ian MacNeill/Elizabeth Gallagher
[1520] Elizabeth Gallagher
[1521] Banderas, Paras 10-13 [J1/124/2] – information of staffing levels at September 2013 supplied by Care Agency to the Inquiry
[1522] While Banderas states at Para 11 that there are 65 care workers as part of the complement it is unclear whether that includes the flat in the community at Goole House. The flat by flat breakdown at Para 12 evidences that the staff complement (including Goole House) is 70 of which 69 posts were filled at September 2013, which we consider is more accurate. See also the table at [J1/124/17] which supports that conclusion
[1523] Administrator and 6 Registered Nurses

Annex 8

DRAMATIS PERSONAE

Persons mentioned in the Chairman's Report and/or at the hearing of the Inquiry

Acris	Emilio	Police Superintendent Royal Gibraltar Police. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Adamberry	Manuela	Began in 1995 as a volunteer care worker at the Home and thereafter employed as a care worker until 2010. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Allison	Jennie	Clinical Standards and Compliance and in March 2012, Care Agency Acting CEO.
Azopardi QC	Keith	Of Triay Stagnetto Neish. Counsel to the Inquiry.
Bacarisa	Adrian	Police Sergeant, Royal Gibraltar Police, Interviewing Officer during the police interview of a Resident of the Home in 2004.
Baldachino	Alison	Administrative Officer since 2003. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Balestrino	Anne	Of Phillips. Counsel for the Disability Society, Emilia Bruzon, Denise Evaristo and Elizabeth Featherstone.
Ball	Kelvin	Former supply care worker at the Home. Ex-husband of Mandy Spencer.
Banderas	Carlos	Acting Team Leader (Disabilities), Care Agency. Took over the management of the nursing team at the Home in 2011. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Barr	David	Barrister, in 2006, of 1 Temple Gardens, London. Advised the Social Services Agency in connection with Joanna Hernandez-Industrial Tribunal action.
Barton	Frank	In 2005, Sergeant, CID, Royal Gibraltar Police. Provided a Witness Statement to the Inquiry.
Bassadone	Nigel	Care worker at the Home from 1997 to 2008. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Bear	Fr Paul	Trustee of the Dr Giraldi Home Trust.
Becerra	Frederick	Father of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Beguelin MB RS	Dr Rene A.	General Medical Practitioner and also from time to time Acting Locum Consultant Psychiatrist, KGV Hospital, GHA. In 2005 provided an assessment of a Resident's ability to cope with a police interview.

Beiso	M. A.	Mother of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Berini	Sharon	Deputy Manager of the Home from 2002 to July 2006. Acting Manager of the Home for much of 2004. Provided a Witness Statement for the SSA in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Borastero	Stuart	Teacher at Notre Dame First School. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Borastero	Yvette	Care worker at the Home since 1996. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Borastero-Porter	Francis	Of FBP Solicitors. Counsel for Nigel Bassadone and Jennifer Garrett.
Bossano MP	The Hon. JJ	Former Chief Minister from 1988 to 1996. Member of Parliament since 1972. Current Minister for Economic Development, Telecommunications & the GSB (at the time of the Inquiry hearing was, Minister for Enterprise, Training and Employment). Briefly represented and assisted Joanna Hernandez in the Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Bottino	Nicholas	Of Triay Stagnetto Neish, Solicitors to the Inquiry.
Brooks	Pat	Human Resources Manager of the Care Agency.
Bruzon	Albert	Present Acting Chief Executive Officer, Care Agency. Provided a Witness Statement to the Inquiry.
Bruzon	Emilia	Grandmother of a Resident of the Home. Provided a joint Witness Statement with her daughter, Denise Evaristo, in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Carreras	Giselle	SSA/Care Agency employee from 2002. Presently, Care Agency Psychologist and Team Manager for the Therapeutic Service. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Caruana (deceased)	Mgr Charles	Former Bishop of Gibraltar. Trustee of the Dr Giraldi Home Trust.
Caruana KCMG QC MP	The Hon. Sir Peter	Chief Minister 1996 to 2011. Gave evidence at the hearing of the Inquiry.
Cassaglia MRCPCH	Dr Daniel	Consultant Paediatrician, St Bernard's Hospital, GHA.
Celecia	Rafael	Father of a Resident of the Home. Provided a Witness Statement to the Inquiry.
Cerisola	Aldra	In 2004, Detective Constable, CID, Royal Gibraltar Police. Provided Witness Statements to the Inquiry and gave evidence at the hearing of the Inquiry.
Clark	Dr Bruce	In 2003, Specialist Registrar to DR BW Jacobs, Consultant Child & Adolescent Psychiatrist, Bethlem Royal Hospital,

		South London and Maudsley NHS Trust.
Compson	Kirushka	SSA/Care Agency employee from 2000; care worker from 2001 to 2012. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Costa MP	The Hon. Neil	Member of the Opposition 2007 to 2011. Current Minister for Business, Employment and Skills (At the time of the Inquiry was Minister for Tourism, Public Transport and the Port).
Crawford	Kirsten	St. Martin's School nurse and former care worker at the Home.
Cruz (née Ryan)	Jordana	In 2004, Administrative Officer at the Home.
Cruz	Nick	Of Cruz & Co. Counsel for Marie Gomez.
Dalrymple	Jonathan	Senior care worker at the Home until 2007. Provided one of the twelve June 2005 statements to Joanna Hernandez.
Davis	Jordan	Care worker at the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
de Santos	Mary	Manager of the Home from January 2010 to September 2011.
Del Agua	The Hon. Yvette	Minister for Social Services from 2000 to 2007. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Dempsey	Emily	Domestic worker at the Home from 2000. Provided one of the twelve June 2005 statements collated by Joanna Hernandez.
Dixon-Pritchett	Carmen	Mother of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Elbrow	Elizabeth	Mother of a Resident of the Home. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Elmer	Moira	Sister of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Englehart QC	Robert	Of Blackstone Chambers. Counsel to the Inquiry.
Enright	David	Of Howe & Co. Counsel for Joanna Hernandez from August 2013.
Evaristo	Denise	Mother of a Resident of the Home. Provided a joint Witness Statement with her mother, Emilia Bruzon, in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Everest	Gayle	SSA/Care Agency employee since November 2003, presently as a care worker. Provided one of the twelve statements collated by Joanna Hernandez in June 2005. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Farrell	Craig	Care worker at the Home since September 2003; since 2006/7 as Unit Manager. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Featherstone	Elizabeth	Mother of a Resident of the Home. Provided a Witness

		statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Feetham MP	The Hon. Daniel	Former Minister of Justice from 2007 to 2011. Presently Leader of the Opposition. Represented Joanna Hernandez prior to the Industrial Tribunal action.
Fernandez	Johann	Crown Counsel, Attorney-General's Chambers. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Figueras MBE RD*	Dennis	Secretary to the Inquiry.
Finch	Chris	Of Lexicon Legal. Counsel for Joanna Hernandez until July 2013.
Finlayson	Peter Brian	Inspector, Royal Gibraltar Police. In 2009, Detective Sergeant, Financial Crime Unit. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry
Fischel QC	Robert	Crown Counsel, Attorney -General's Chambers.
Fortuna	Natalie	SSA/Care Agency Finance Officer. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Gallagher	Elizabeth	Deputy Manager of the Home in 2006/07; Manager of the Home from 2006 to December 2011, from time to time in an interim capacity.
Galloway	Dr A	General Practitioner with the Gibraltar Health Authority, prescribed medication to several Residents of the Home and involved in numerous aspects of Residents access to healthcare. Assessed Resident T for the purposes of giving evidence in Court proceedings.
Garcia	Flor	Also known as Flor Davis/Davies. Care worker from 2003.
Garrett	Jennifer	Former care worker at the Home from 1999 to 2005. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Garro	Michelle	Former care worker at the Home from 1994 to September 2006. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Gomez	Charles	Of Charles Gomez & Company. Counsel for Kirushka Compson and Craig Farrell.
Gomez	Denielle	Former senior care worker at the Home from January 2002 to April 2005. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Gomez	Marie	Acting CEO of the SSA from October 2004 to April 2005; previously Adult Team Leader. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Gonzalez	Ave	SSA/Care Agency employee for almost 20 years. Team Leader until March 2005. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.

Gonzalez	Maria	Care worker at the Home. Provided one of the twelve statements collated by Joanna Hernandez in June 2005.
Guinn	Debbie	SSA/Care Agency Social Worker within the Children and Families Team since 2002. In July 2005, promoted to Senior Social Worker within Adult Services (transferred in October 2005). Team Leader of Adult Services since 2009. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Guzman QC	Gillian	Of Hassans. Counsel for the Care Agency.
Hales	Melissa	SSA administrative clerk in 2006. Provided a Witness Statement to the Inquiry.
Harrison	Elizabeth	Presently employed as a Care Agency unqualified Social Worker. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Hassan	Denise	Care worker at the Home from 1999 to 2005. Provided one of the twelve statements collated by Joanna Hernandez in June 2005. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Hassan	Nicholas	Care worker at the Home in 2004. Provided one of the twelve statements collated by Joanna Hernandez in June 2005.
Herbert	Simy	Care worker at the Home from August 2005 to February 2006. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Hernandez	Joanna	Manager of the Home from November 2004 to November 2005. Claimant in the Industrial Tribunal action and provided a Witness Statement. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Higgs	Dr Steven	In 2005, consultant paediatrician, GHA.
Ignacio	Joseph	Father of a Resident of the Home. Provided a Witness Statement to the Inquiry.
Ismail	Dr	In 2005, consultant paediatrician, GHA.
Isola QC	Mark	Of Isolas. Counsel for the SSA in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Jack	Morag	Manager of the Home from November 2002 to January 2004.
Joaquin	Rosemarie	Mother of a Resident of the Home. Provided a Witness Statement to the Inquiry.
Jones	Duncan	Adult Team Leader from November 2002 to June 2004.
Joseph	Bindu	Staff member at Valley House (in the UK) where a former Resident of the Home presently resides.
Kennedy	Sir Paul	Court of Appeal President, who gave leading judgment in an appeal from the decision of Schofield CJ arising from the Joanna Hernandez Industrial Tribunal action.
Lester	Cheryl	Manager at Valley House (in the UK) where a former Resident of the Home presently resides.
Linares	Cristina	Of Triay Stagnetto Neish, Solicitors to the Inquiry.
Llambias	Gabrielle	Acting Deputy Manager of the Home in April 2005. Provided

		one of the twelve statements to Joanna Hernandez in June 2005. Excused by the Chairman from participating in the Inquiry at the first preliminary hearing.
Llanelo	Gina	Mother of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Lombard	Louis	Trustee of the Dr Giraldi Home Trust.
Lopez	Dean	SSA employee from October 2004; as a care worker at the Home since February 2005; and as a Social Worker since December 2006. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Lopez	Elizabeth	Mother of a Resident of the Home. Provided a Witness Statement to the Inquiry.
Lopez	John	Father of a Resident of Home. Provided a Witness Statement to the Inquiry.
Lucas	Angela	Head Teacher of St Martin's Special School
Macias	Marie Elena	SSA/Care Agency Social Worker from late 1999/2000 to September 2012. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Mahtani	Suresh	At the time of the hearing of the Inquiry, of Verralls. Counsel for Yvette Borastero, Michelle Garro and Angelica Williams
Martinez	Jane	Former care worker at the Home in 2003/04.
Maskill	Carmen	Presently, head of Elderly Care Services Care Agency. CEO of the Care Agency from March 2009 to March 2012. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Matto	Sean	Acting Manager of the Home since October 2012. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
McDonagh	Sarah	Manager of the Home from September 2011 to September 2012.
McDonald	Anthony	Previously of Isolas. Counsel for Michelle Garro during her police interview in 2005.
McGrail	Ian	Superintendent Royal Gibraltar Police. In 2007, Detective Chief Inspector of the Crime Unit. Provided a Witness Statement to the Inquiry.
McKay	Stacey	Care worker at the Home. Provided one of the twelve statements to Joanna Hernandez in June 2005.
McNeil	Iain	Manager of the Home from November 2006 to 2009. Presently resides in the UK. Provided a Witness Statement to the Inquiry.
Mifsud	Richard	Superintendent, Royal Gibraltar Police. Chief Inspector Operations and acting Superintendent Operations in 2007. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Miles	Christopher	Of Verralls. Counsel for Gabrielle Llambias.

Millan	Javier	SSA/Care Agency employee since 2004. Presently, Manager of the Challenging Behaviour Unit of the Children's Home. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Montado CBE	Ernest	Chief Secretary to the Government between 1986 and 2007. Gave evidence at the hearing of the Inquiry.
Montiel	The Hon. Luis	In 2005, District Officer for the Transport and General Workers' Union. Subsequently Minister for Employment 2007-2011.
Moran	Kathryn	Of Litigaid Law. Counsel for Gayle Everest and Sharron Openshaw.
Muscat	Richard	Care worker at the Home until December 2004. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Napoli	Maurice	Inspector Royal Gibraltar Police. Provided a Witness Statement to the Inquiry.
Navas	Kenneth	Of Kenneth Navas Barristers & Solicitors. Counsel for Manuela Adamberry, Rose Robba, Jonathan Teuma and Matthew Turnock.
Netto MP	The Hon. Jaime	Minister for Social Affairs 2007 to 2011. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
O'Hagan	Gabrielle	Of Triay Stagnetto Neish, Solicitors to the Inquiry
Openshaw	Sharron	SSA/Care Agency Unit Manager from August 2007 to May 2011. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Paine	Nicola	Care worker at the Home. Provided one of the twelve statements to Joanna Hernandez in June 2005.
Palma (deceased)	Jackie	Care worker at the Home and Acting Unit Manager in 2009. Provided one of the twelve statements to Joanna Hernandez in June 2005.
Peralta	Sharon	Crown Counsel, Attorney-General's Chambers. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Perez	Jessica	SSA/Care Agency Social Worker for the Home from September 2004 to March 2007. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Perez	Roy Francis	Inspector Royal Gibraltar Police. Provided a Witness Statement to the Inquiry.
Picardo QC MP	The Hon. Fabian	Chief Minister 2011 to date. Briefly represented Joanna Hernandez at the time of the Industrial Tribunal proceedings.
Pilley	Ray	Of Triay & Triay. Counsel for Mandy Vallender.
Pitto	Christopher	Of Attias & Levy. Counsel for Mandy Spencer and Simy Herbert.
Poole	Jennifer	SSA/Care Agency Senior Social Worker for Adult Services. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.

Resident A[1524]		Resident of the Home from October to June 2006. Diagnosed with Down syndrome.
Resident AA		Admitted in 2001. Diagnosed as having the intellectual emotional and education capacity of a three year old, scoliosis, left retinal detachment and left cataract.
Resident AB		Admitted 2003. Diagnosed with epilepsy, diabetes and Down syndrome.
Resident AC		Respite User since 1998. Diagnosed with learning disabilities, impaired hearing and autistic tendencies.
Resident AD		Admitted in February 2010. Diagnosed with autism, anxiety and challenging behaviour.
Resident AE		Admitted in November 1996. Diagnosed with low level concentration, autistic spectrum, psychosis, schizophrenic and bi-polar disorder.
Resident AF		Respite since 2009. Diagnosed with profound and multiple learning disabilities, severe autism, grommets and epilepsy.
Resident AI		Admitted in January 1994. Suffers from learning disabilities, fits and severe osteoporosis.
Resident AJ		Care provided at his Home. Now deceased. Diagnosed with cerebral palsy, tuberous sclerosis & epilepsy.
Resident B		Admitted in June 1994. Diagnosed with mental retardation, epilepsy and obsessive compulsive tendencies.
Resident C		Admitted in 2006. Diagnosed with Febrile convulsions, cerebral palsy, limited speech and epilepsy.
Resident D		Respite User. Suffers from seizures caused by epilepsy and displays autistic features.
Resident E		Admitted in January 1994. Diagnosed with down syndrome, diabetes and hypothyroid.
Resident I		Admitted in 1994. Diagnosed with learning disability, brain damage, hemipliegia on right side and epilepsy.
Resident J		Admitted in January 1994 from KGV. Learning disabilities and poor sight.
Resident K		Admitted in January 1997. Diagnosed with mild learning disability and asthma.
Resident L		Admitted to the Home in July 1996. Diagnosed with Fragile X syndrome.
Resident M		Respite user since 2007. Diagnosed as mentally retarded.
Resident N		Admitted in 1995. Diagnosed with down syndrome, gout and hypothyroid.
Resident O		Respite User, diagnosed with cerebral palsy and chronic epilepsy.
Resident P		Respite user since 1999 for 13 months. Diagnosed with cerebral palsy. Wheelchair user.
Resident Q		Respite user since 2010. Diagnosed with learning disabilities stemming from brain damage, also suffers from epilepsy.
Resident S		Resident of the Home from 1995 to 2004. Deceased.

[1524] The description of the clinical condition of residents is taken from information supplied to the Inquiry by the Care Agency.

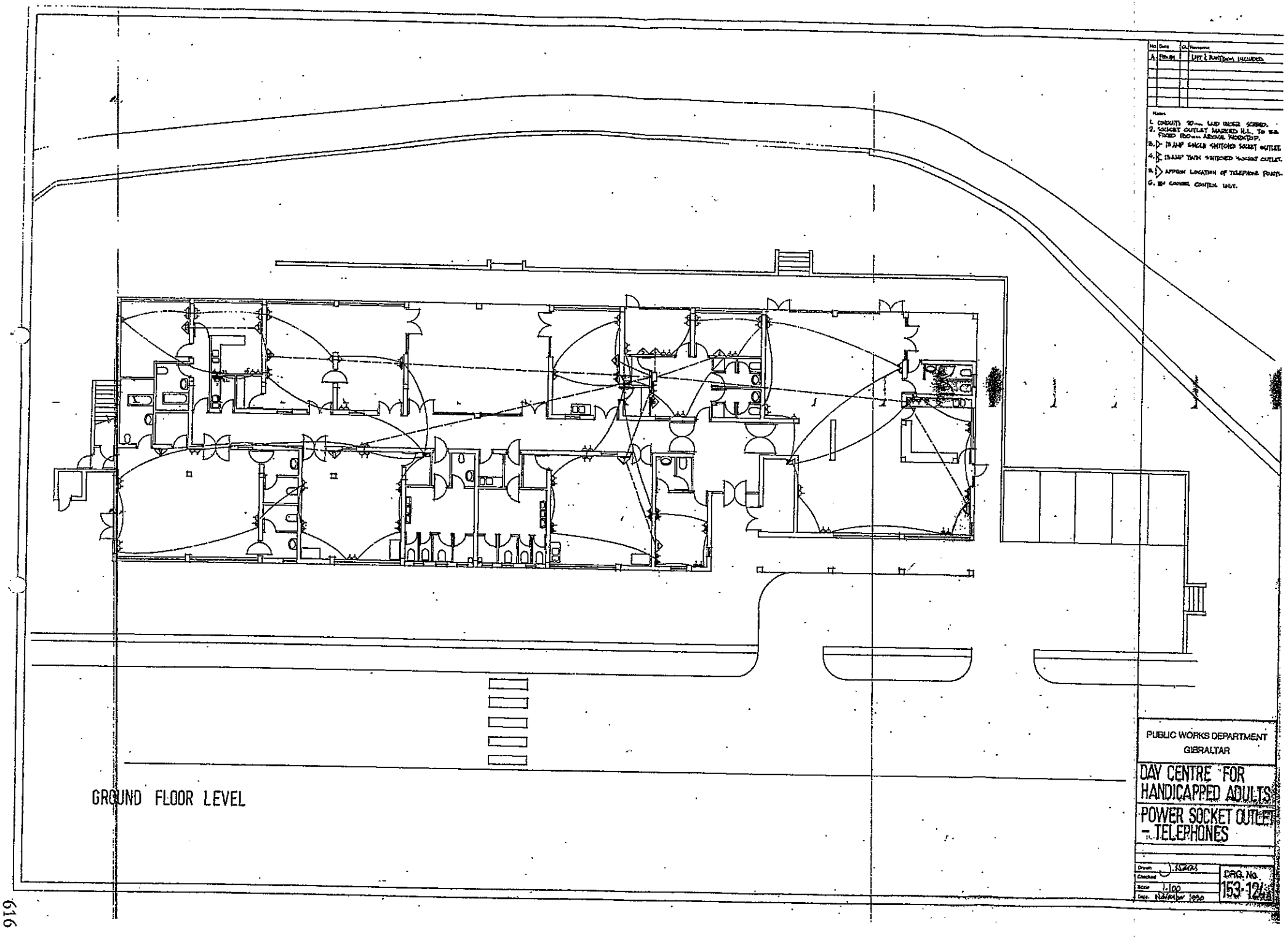
Resident T		Admitted in 1998. Diagnosed with global development delay, muscular dystrophy, osteoporosis, droopy eye syndrome and mytonic dystrophy.
Resident U		Admitted to the Home in January 1995. Diagnosed with cerebral palsy, paraplegic, epilepsy, depression and vascular dementia.
Resident V		Admitted in 2003. Diagnosed with learning difficulties, mental health problems and bi-polar disorder.
Resident W		Admitted in January 1994. No diagnosis as to mental state. Diagnosed with diabetes.
Resident X		Resident of the Home since 2003, respite user prior to that. Diagnosed with learning disabilities.
Resident Y		Unknown date of admission. Diagnosed as suffering from epilepsy, non-verbal communication and poor mobility.
Resident Z		Admitted in July 1996. Diagnosed with Lennox-Gastraut Syndrome, learning disabilities, behavioural difficulties.
Reyes	John	In 2005, Private Secretary (Legal) to the then Chief Minister.
Rhoda QC CBE	Ricky	Her Majesty's Attorney General for Gibraltar. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Risso	Annie	Manager of St. Bernadette's Occupational Therapy Centre.
Risso	Maruchi	Trustee of the Dr Giraldi Home Trust.
Robba	Rose	Care worker at the Home since 2002. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Rocca	Christian	Of Isolas. Counsel for the Royal Gibraltar Police.
Rodriguez	Douglas	Former CEO of the SSA; retired in October 2004. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Salter	Charles	Of Phillips. Counsel for Giselle Carreras.
Sanchez	Olga	Speech therapist with academic training relating to people with intellectual disabilities. Prepared a psychological report in relation to a Resident of the Home regarding giving evidence in proceedings.
Santana	Nathan	Care worker at the Home.
Santos	Christian	In 2005, care worker at the Home. Provided one of the twelve Joanna Hernandez June 2005 statements.
Santos	Marie Carmen	Retired Government of Gibraltar Executive Officer; seconded to the SSA/Care Agency from March 2004 to April 2013. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Schofield CJ	Derek	Former Chief Justice.
Sen	Julie	SSA/Care Agency Social Worker since December 2002. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Seruya	Rose	Care worker at the Home. Provided one of the twelve June 2005 statements to Joanna Hernandez.

Sisarello	Charles	Former Branch Officer of the Transport and General Workers' Union.
Soane	Cavalo	Detective Constable, Royal Gibraltar Police.
Spencer	Mandy	Manager of the Home from November 2000 to November 2002. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Stagnetto QC (deceased)	Augustus	Trustee of the Dr Giraldi Home Trust.
Sullivan	Violet	Mother of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Tavares	Natalie	SSA/Care Agency Social Worker since 1999. Presently, Senior Social Worker in the Child Protection Team. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Tavares	Robert	Father of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action.
Teuma	Jonathan	Supply care worker from 2001 to 2002 and then full time care worker until 2005. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Tornay	Audrey	Mother of a Resident of the Home. Provided a Witness Statement to the Inquiry.
Tosso	Isabella	CEO of the SSA from April 2005 to January 2007. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal Action.
Tunbridge	Wayne	Inspector, Royal Gibraltar Police. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Turnock	Matthew	Former respite user of the Home and subsequently former receptionist at St. Bernadette's Occupational Therapy Centre. Provided a Witness Statement to the Inquiry.
Turnock	Maurice	In 2005, Counsel (of Hassans) for Richard Muscat at his Royal Gibraltar Police interview.
Valarino (deceased)	Agnes	Mother of a Resident of the Home. Wife of Maurice Valarino.
Valarino	Maurice	Father of a Resident of the Home. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Vallender	Mandy	Care worker at the Home from late 2002. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Vasquez QC	Robert	Of Triay & Triay. Counsel for Sharon Berini, Melissa Hales, Sean Matto and Richard Muscat.
Viagas	Nicole	SSA/Care Agency employee since 2000. Provided a Witness Statement in the Joanna Hernandez Industrial Tribunal action. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.

Visitor X		A lady with learning difficulties who would visit Resident T at the Home.
Williams	Angelica	Also referred to as "Gerica". Employed as a care worker at the Home between September 2000 and December 2004.
Wilson	Christopher	Interim CEO of the SSA from February 2007 to March 2009. Presently, director of Human Resources for the GHA. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.
Wink	Louis	Commissioner, Royal Gibraltar Police, between April 2006 and April 2012. Provided Witness Statements to and gave evidence at the hearing of the Inquiry.
Yeats	Cathal	Chief Inspector, Royal Gibraltar Police. Staff Officer to the Commissioner of Police since January 2013.
Yome	Edward	Commissioner, Royal Gibraltar Police. Between December 2007 and May 2008 was Superintendent of Operations. Provided a Witness Statement to and gave evidence at the hearing of the Inquiry.

Annex 9

1990/1 PLANS OF DGH



No.	Date	Ch.	Remarks
A	Feb 84		List 2 Amendments included

Notes

1. CONDUITS 20mm. LAID UNDER SCREED.
2. SOCKET OUTLET MARKED H.L. TO BE FIXED 150mm ABOVE WORKTOP.
3. 13 AMP SINGLE SWITCHED SOCKET OUTLET.
4. 13 AMP TWIN SWITCHED SOCKET OUTLET.
5. APPROX LOCATION OF TELEPHONE POINT.
6. 30 CHANNEL CONTROL UNIT.

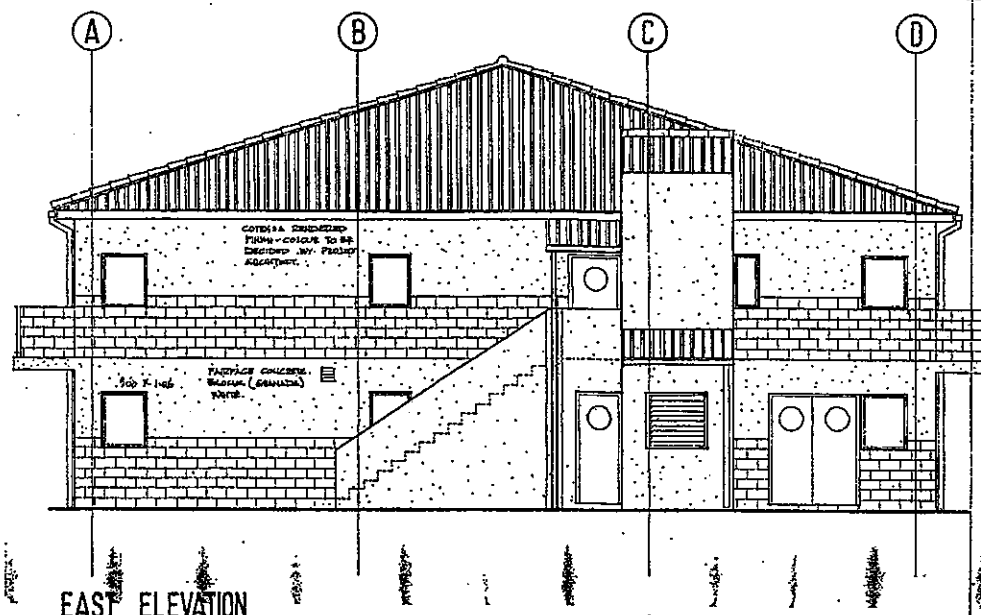
PUBLIC WORKS DEPARTMENT
GIBRALTAR

DAY CENTRE FOR HANDICAPPED ADULTS

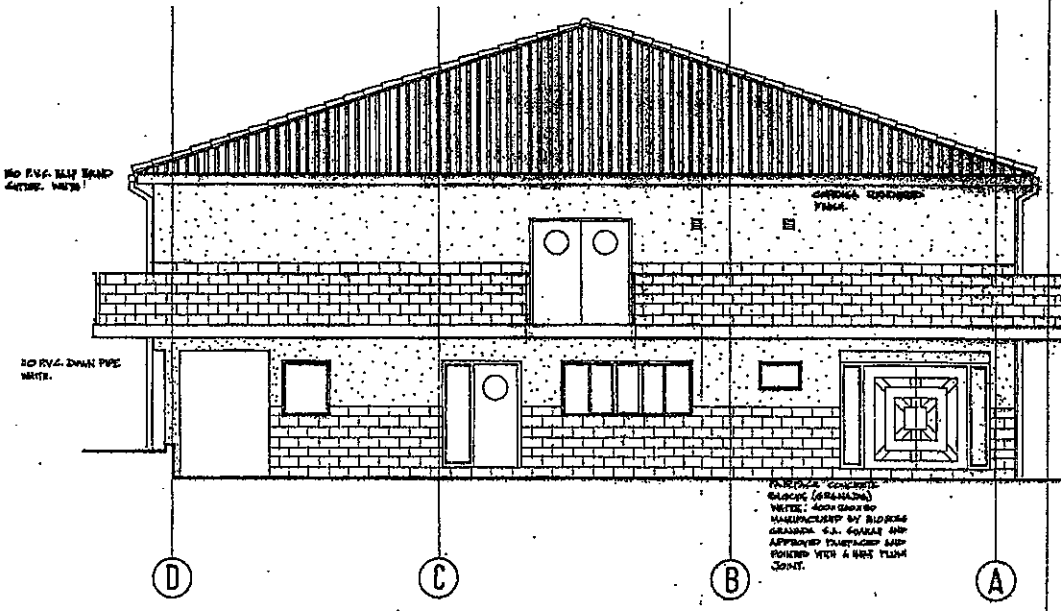
POWER SOCKET OUTLETS - TELEPHONES

Drawn	K.Rivas
Checked	
Scale	1:100
Date	November 1983

DRG. No. 153-12/...



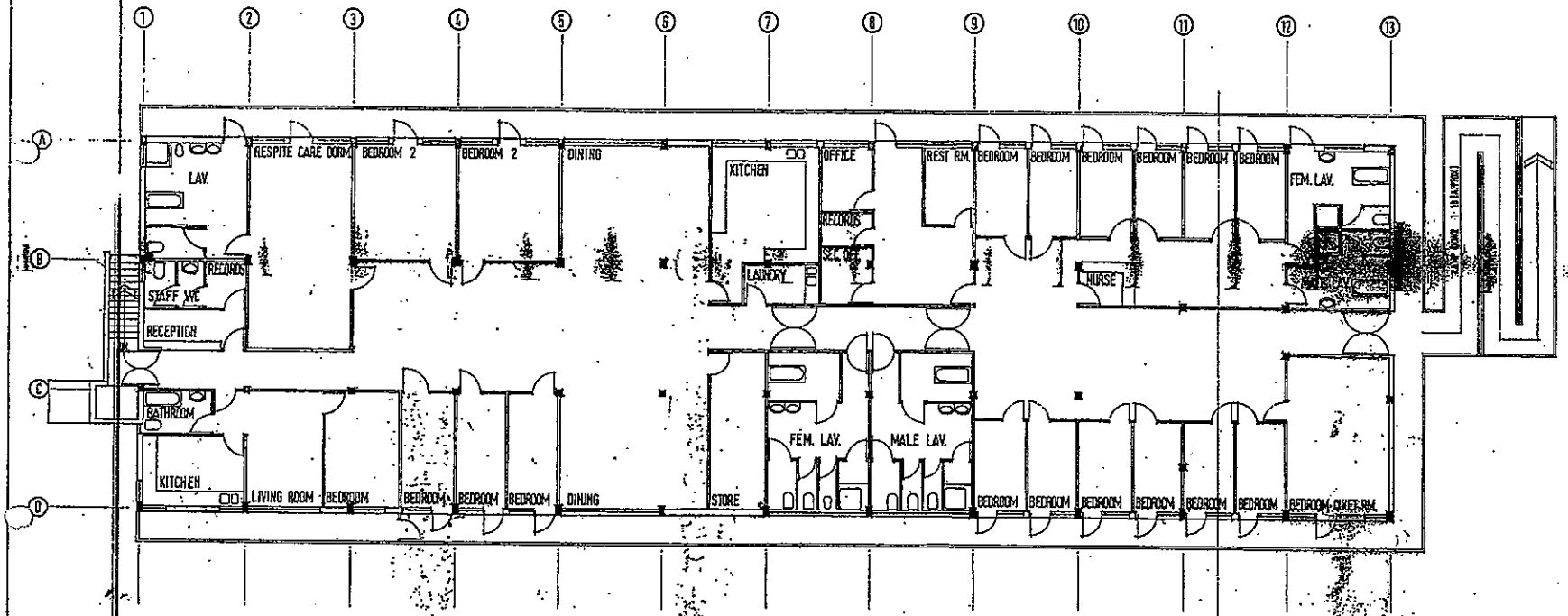
EAST ELEVATION



WEST ELEVATION

PUBLIC WORKS DEPARTMENT
GIBRALTAR

DAY CENTRE FOR HANDICAPPED ADULTS
REVISED EAST & WEST ELEVATIONS



FIRST FLOOR LEVEL

PUBLIC WORKS DEPARTMENT
GIBRALTAR

DAY CENTRE FOR HANDICAPPED ADULTS

REVISED FIRST FLOOR PLAN (C)

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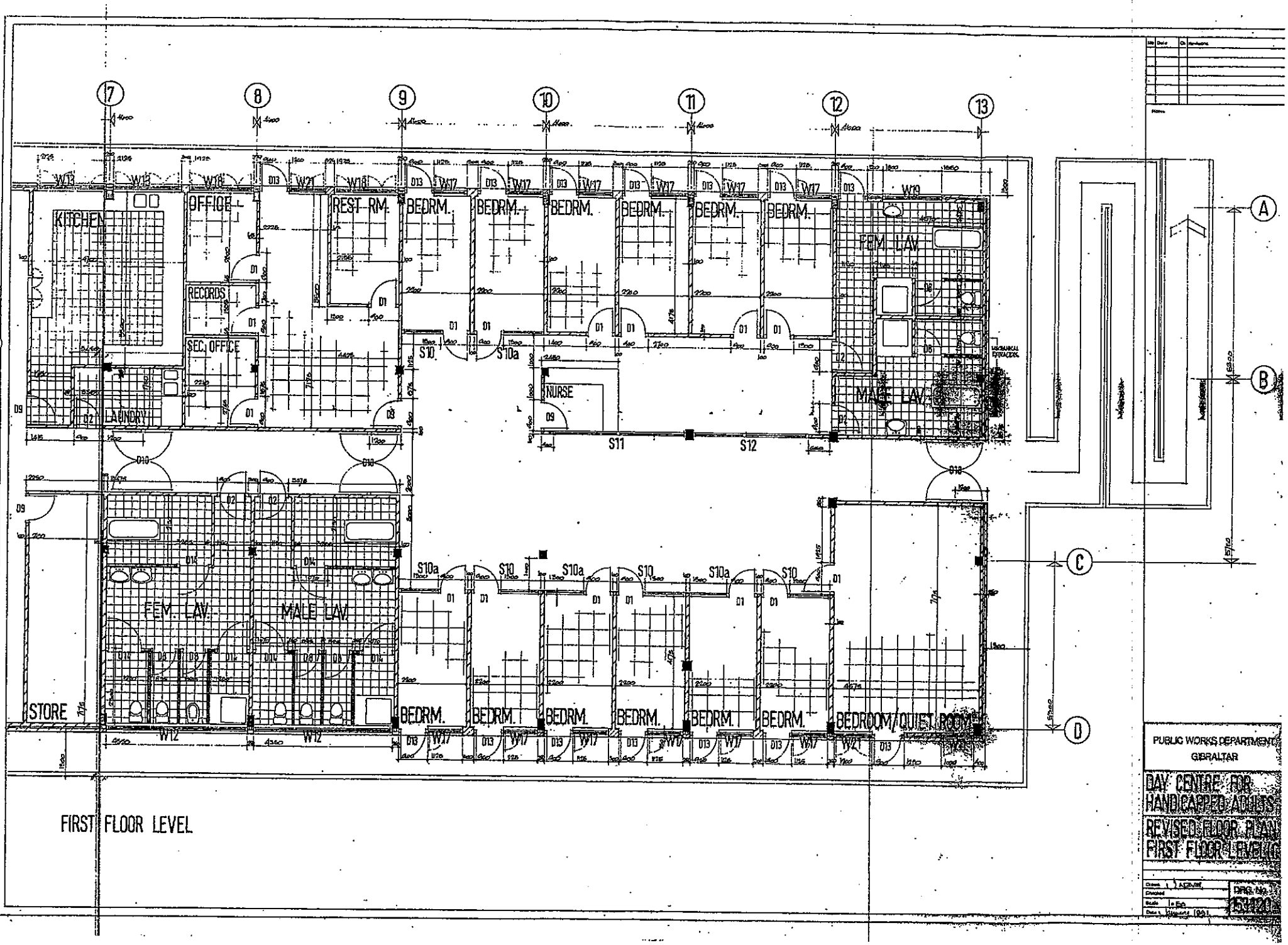
Scale: 1:100
Date: March 1991

DRG. No. 15313

618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A
B
C
D
KITCHEN
OFFICE
REST RM.
RECORDS
SEC. OFFICE
LAUNDRY
BEDRM.
NURSE
FEM. LAV.
MALE LAV.
STORE
BEDROOM/QUIET ROOM
S10
S10a
S11
S12
W13
W15
W16
W21
W18
W17
W19
W12
D1
D2
D3
D4
D5
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D10
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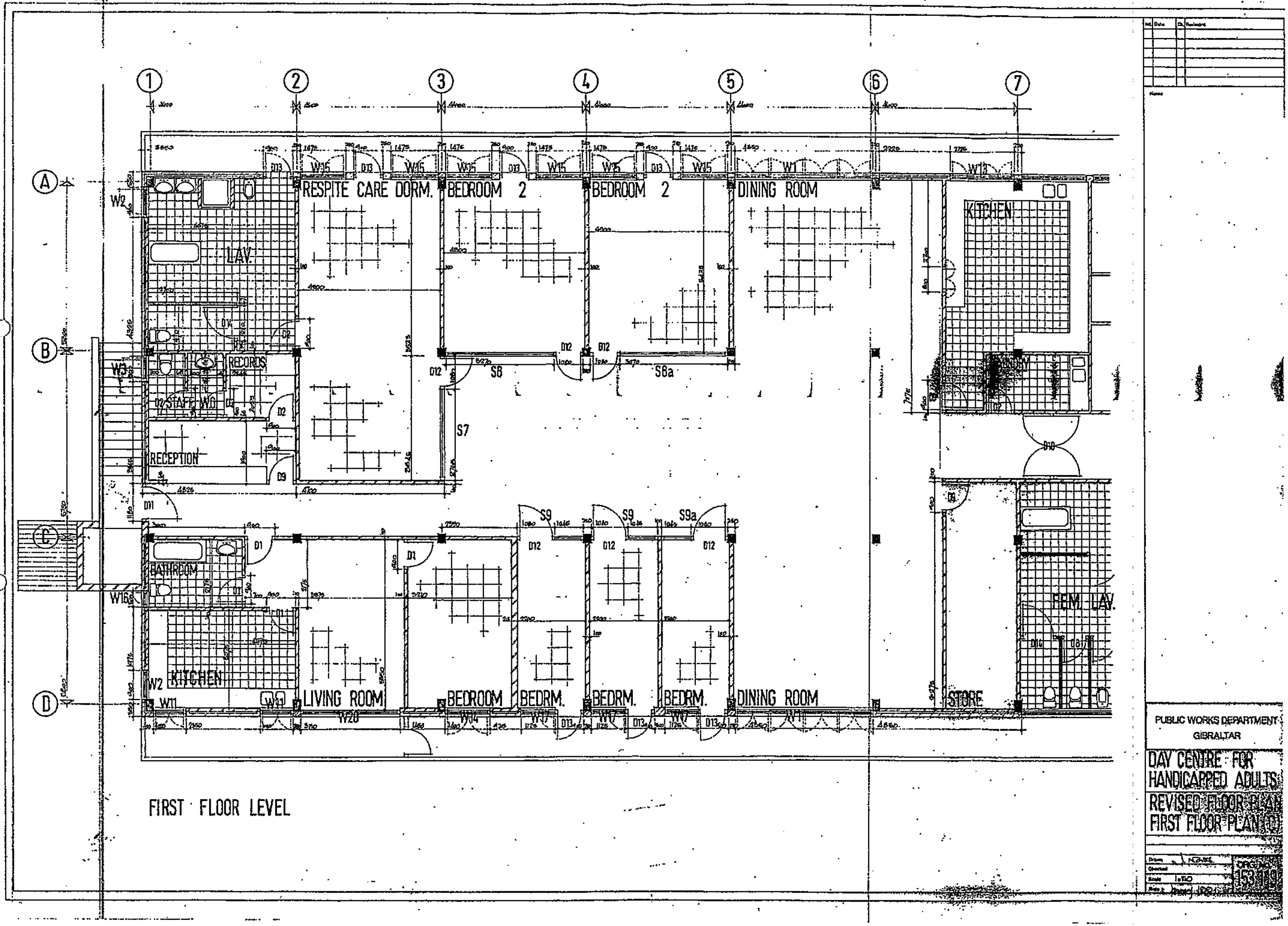
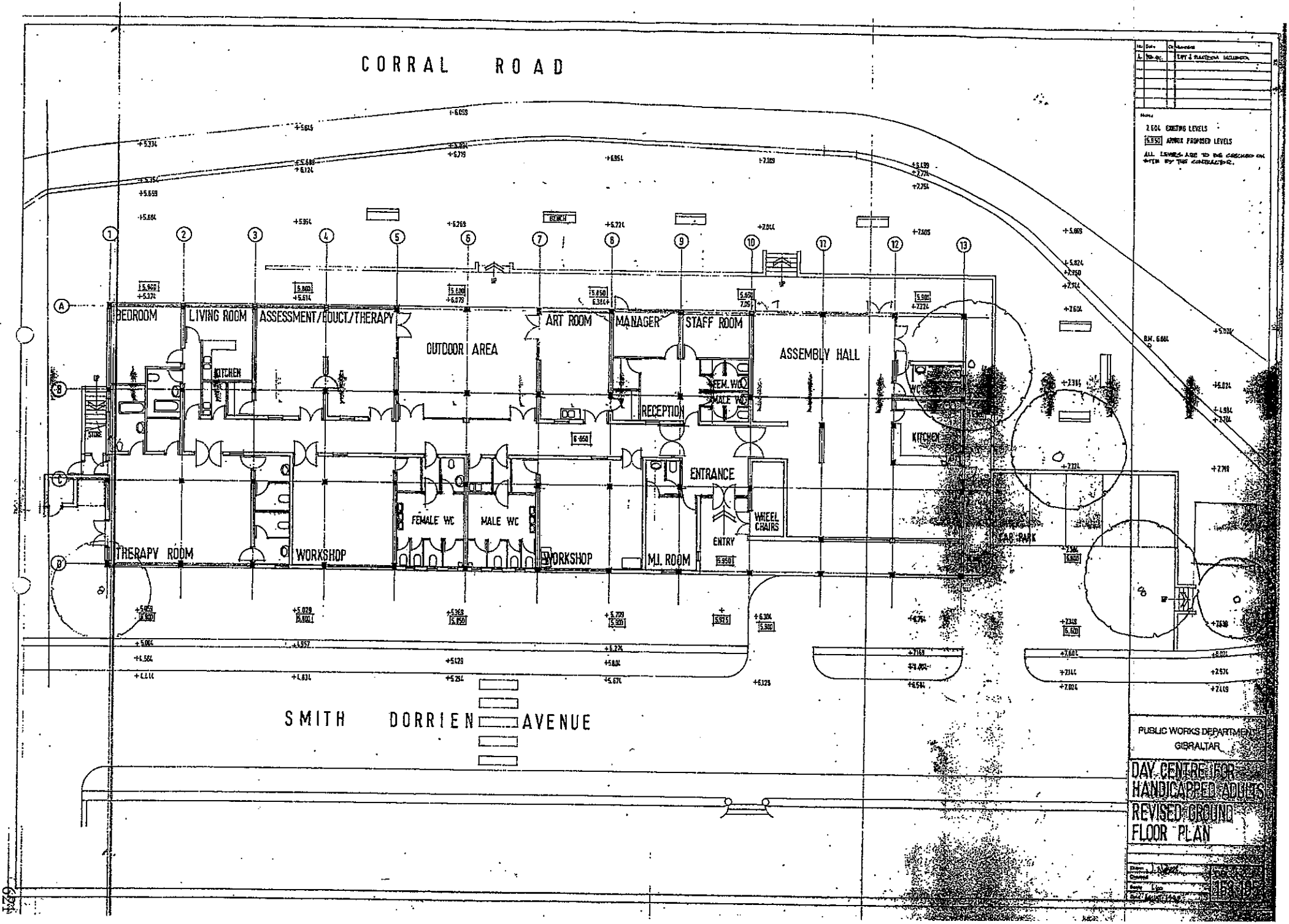
D14
FIRST FLOOR LEVEL
PUBLIC WORKS DEPARTMENT
GIBRALTAR
DAY CENTRE FOR HANDICAPPED ADULTS
REVISED FLOOR PLAN
FIRST FLOOR LEVEL
DRG. No.
150120


RESPITE CARE DORM.
BEDROOM 2
BEDROOM 2
DINING ROOM
KITCHEN
LAV.
RECORDS
STAFF WC
RECEPTION
BATHROOM
KITCHEN
LIVING ROOM
BEDROOM
BEDRM.
BEDRM.
BEDRM.
DINING ROOM
STORE
FEM. LAV.
FIRST FLOOR LEVEL
PUBLIC WORKS DEPARTMENT
GIBRALTAR
DAY CENTRE FOR
HANDICAPPED ADULTS
REVISED FLOOR PLAN
FIRST FLOOR PLAN (C)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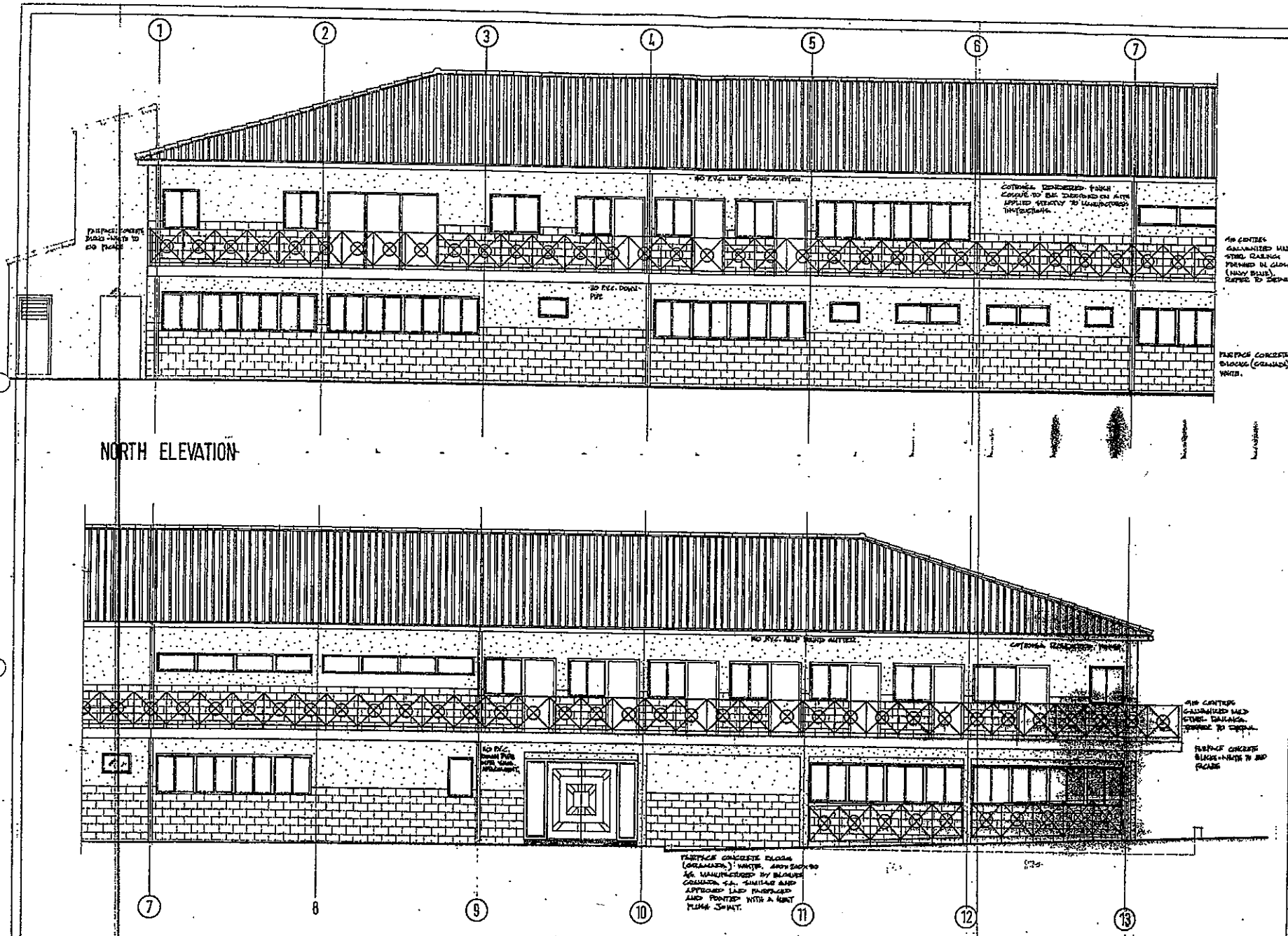
SMITH DORRIEN AVENUE
BEDROOM
LIVING ROOM
ASSESSMENT/EDUCT/THERAPY
KITCHEN
OUTDOOR AREA
ART ROOM
MANAGER
STAFF ROOM
FEM. WC
MALE WC
RECEPTION
ASSEMBLY HALL
WC
KITCHEN
ENTRANCE
WHEEL CHAIRS
ENTRY
FEMALE WC
MALE WC
THERAPY ROOM
WORKSHOP
WORKSHOP
M.I. ROOM
CAR PARK
BENCH
STORE
2.604 EXISTING LEVELS
5.950 APPROX PROPOSED LEVELS
ALL LEVELS ARE TO BE CHECKED ON SITE BY THE CONTRACTOR.
PUBLIC WORKS DEPARTMENT
GIBRALTAR
DAY CENTRE FOR HANDICAPPED ADULTS
REVISED GROUND FLOOR PLAN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NORTH ELEVATION
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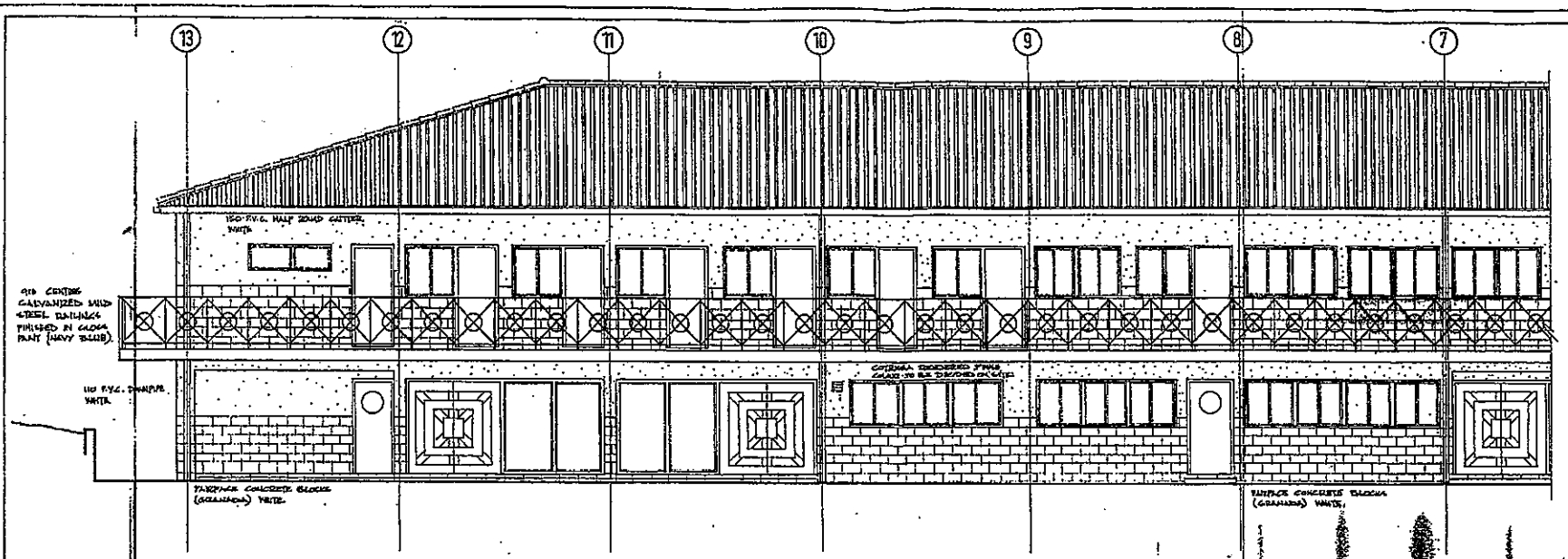
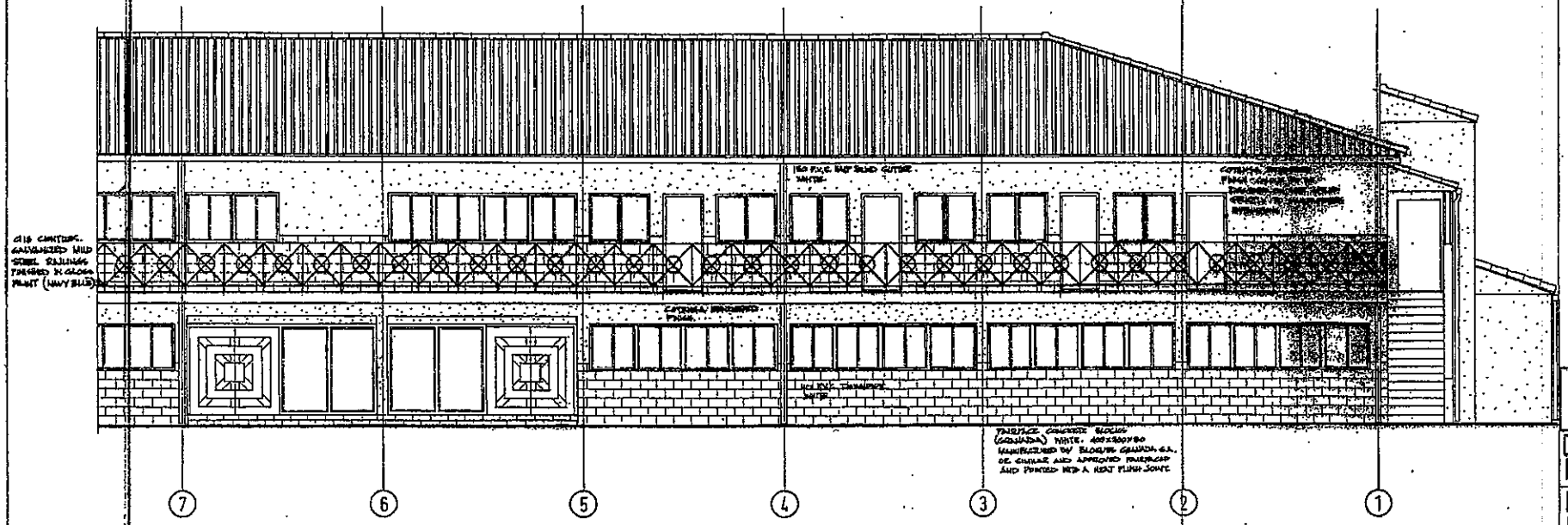
NORTH ELEVATION
PUBLIC WORKS DEPARTMENT
GIBRALTAR
DAY CENTRE FOR HANDICAPPED ADULTS
REVISED NORTH ELEVATION
Drawn J. Nichols
Checked
Scale 1:50
Date January 1991
DRG. No. 1539/10





No.	Date	By	Revisions
A.	Jul. 91.		FIRST FLOOR INCLUDED.
B.	Feb. 92.		LIFT & PLANT ROOM INCLUDED.
C.	Dec. 92.		GRADED CENTRE - RAMPS TO MAINTAIN

PUBLIC WORKS DEPARTMENT
GIBRALTAR

DAY CENTRE FOR HANDICAPPED ADULTS

REVISED SOUTH ELEVATION

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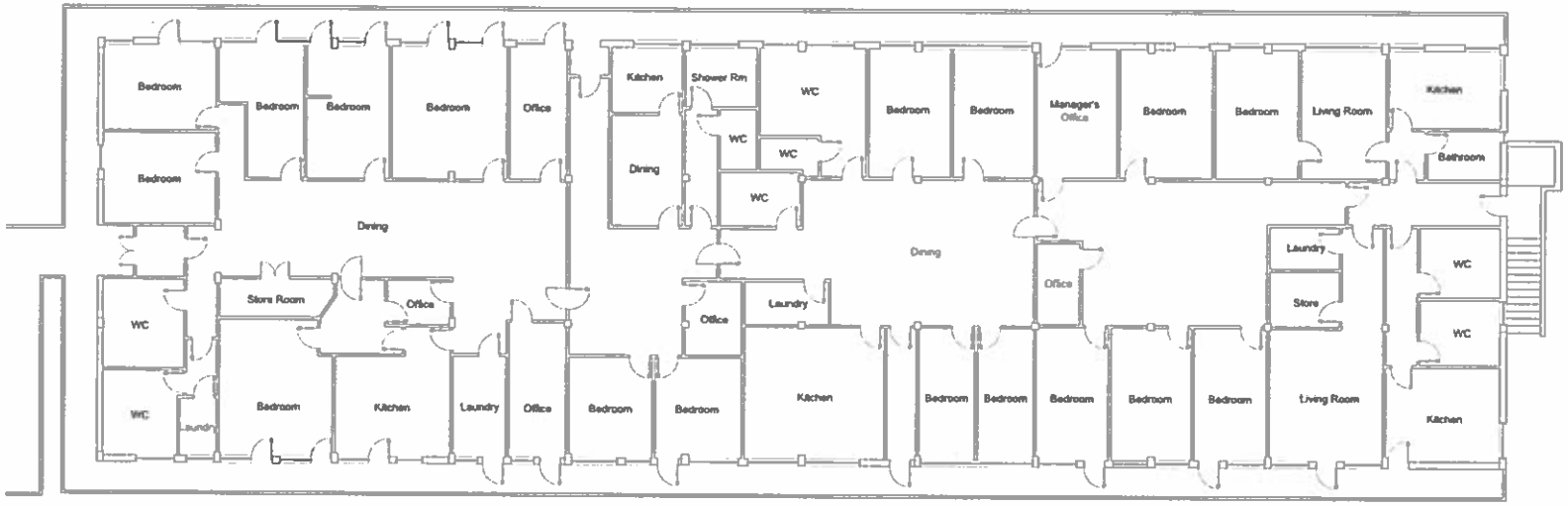
Scale	1:50
Date	August 1991
ORG. No.	153/11

Annex 10

2014 PLANS OF DGH



NOTES:
ALL DIMENSIONS MUST BE CHECKED ON SITE AND NOT SCALED FROM THIS DRAWING.

PLEASE NOTE THAT DRAWING REFLECTS SURVEY CARRIED OUT ON 03/03/2014

H.M.Government of Gibraltar
Technical Services Department
Joshua Hassan House
Secretary's Lane
Gibraltar

Job Title

Dr Giraldis Home

Drawing Title

Layout as Existing

Drawn	Checked
SL & KD	IM
Date	Scale (at A1)
04/03/2014	1:100
Drg. No. 153/203	Rev. -

625

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