Housing Ombudsman Service

Learning from:

Severe Maladministration

Taking the key lessons from our severe maladministration decisions

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Introduction

Building safety is under scrutiny.

And every property manager knows the importance of complying with the ‘Big 6’ health and safety issues, ranging from gas to fire to lift safety. These are underpinned by a strong statutory framework, some of which stretches back decades. In some areas, such as gas safety, we know compliance rates are high.

Complaints can be an early indicator of problems.

The 23 cases in this report reveal obligations not always met or understood, processes mismanaged, and significant gaps in records.

By grouping these cases together under the ‘Big 6’ compliance areas, it is possible to map reoccurring points of service failure and identify areas for learning. The human cost of these failings can be acute. Children, who were the focus of our last report on damp and mould, can be exposed to potential harm.

For example, imagine living for 2 years with bin bags covering up a hole in the living room ceiling where asbestos may be present.

Or being the disabled woman being carried downstairs for almost 2 years because of a faulty lift.

Or the man resorting to bottled water because “black slime” comes out of his taps.

The financial hardship these conditions can create as well as the impact on mental health are constant experiences. In one case the resident’s health clearly made it challenging for the landlord to respond effectively, which no one would want to see.

The delays present in these cases can be staggering.

28 months without a functioning fire door. 2 years with a condemned gas boiler. 17 months with electrical safety issues unresolved. 2 years with asbestos after a ceiling collapse. 6 years with an unresolved drainage issue. 21 months with a lift out of action.

In several cases the issues should have been dealt with as emergencies, within hours or days but the risks remain unresolved for months or years.

So, how did this happen?

Landlords were often aware of the seriousness of the situation and did sometimes attend the property quickly. Where events become protracted, it may reflect difficulties resolving the issue, but effective action was sometimes impeded because inspections were either not done or done repeatedly without evidence of works being raised. When works are raised, they could be delayed, unsuccessful or never actually happen.

Often there is a failure to follow processes but in some cases a lack of procedure is highlighted. There could be a failure to do relevant assessments or shortcomings in staff training.

Occasionally, a failure to grasp obligations is apparent, including in relation to fire safety.

Extremely poor communication, both internally, with third parties or the resident, are commonplace.

The landlord may also be aware of the resident's circumstances but did not mitigate the risks where delays occurred. This includes failing to consider temporary moves and is unlikely to fulfil the requirements of Awaab's Law.

The interface between one hazard and wider disrepair can also be apparent, but a holistic approach can be absent.

But the most striking failure is one of omission – an absence of records or evidence of action.

Overall, these cases can provide vital intelligence for boards to seek assurance and the executive to deconstruct the case to learn lessons to improve services. Questions to explore include asking whether the case is isolated or not? Why the landlord didn't follow process? Or why it didn't have a process? Why didn't the landlord move the household from potential harm? Why did its actions not always align with its analysis? Why were there repeated and excessive delays? And why didn't the landlord put things right during its complaints process? Or why were the actions left outstanding until the Ombudsman intervened?

In several cases the senior management reviews are shown to be valuable tools for improvement and the efforts of many landlords to identify lessons is welcome.

These cases may also provide insight for policymakers as the evolving building safety regime embeds, such as the role of personal evacuation plans.

These reports also form part of our information sharing with regulators, primarily the Building Safety Regulator, part of the Health and Safety Executive (HSE), and Regulator of Social Housing. Our remit is to investigate the individual complaint, whether the landlord fulfilled its obligations to that resident, followed its policy and process, and put things right where they have gone wrong. It is for regulators' to consider overall outcomes against standards.

There is much to be proud of in the sector's approach to safety, but it must not be complacent because compliance rates are high in certain areas. These cases offer learning opportunities for landlords to prevent future service failure.

Richard Blakeway

Housing Ombudsman

The following report contains distressing references, including to suicide.

Samaritans contact details

When life is difficult, Samaritans are here – day or night, 365 days a year. You can call them for free on 116 123, email them at **jo@samaritans.org**, or visit **www.samaritans.org** to find your nearest branch**.**

Fire safety

Following the tragic events at Grenfell Tower, the sector has rightly focused on improving fire safety practices. While we are not responsible for inspecting buildings or enforcing fire safety regulations, there is much to learn from our casework.

Norwich Council

We made a severe maladministration finding for how **Norwich Council** (202307882) left a leaseholder without a functioning fire door for 28 months.

It would have been reasonable for the landlord to replace the resident's front door, which was also a fire door, and charge them for the repair. This would have ensured it was compliant with fire safety requirements.

The landlord attributed the delay to being unsure about the exact specification for fire doors under new legislation, although it could have replaced it with a door that met the regulations at the time. An outgoing contractor said there was a fire door waiting in its warehouse.

The resident refused a temporary door, preferring to wait for a permanent replacement as that was measured for 2 months previously.

Once the landlord became aware of the situation, it should have reoffered the temporary replacement, outlining the reasons for it and given the resident an estimated timeframe for a permanent replacement.

This would have allowed the resident to make an informed decision and the landlord to make sure it was complying with fire safety requirements.

Overall, the landlord measured the space for the door 4 times and received 3 different quotes for the works. While it was prioritising replacing fire doors in its high-risk buildings first, it could still have honoured the agreement with the resident to replace this door.

On several occasions the landlord or its contractor told the resident someone would contact him, but this did not happen. It also failed to respond to the resident's phone calls and emails on several occasions which resulted in him spending a significant amount of time and trouble pursuing the complaint.

When the landlord did communicate with the resident it often gave him inaccurate, contradictory, or misleading information.

In its learning from this case, the landlord says it has restructured its property services department and made significant improvements in both its repairs service and complaints handling.

Peabody

We made 2 findings of severe maladministration in 2 different **Peabody** cases (**202307894** and 202204476) following failings around risk assessments, Personal Emergency Evacuation Plans (PEEP) and cladding.

Case 202307894

In **202307894**, Peabody failed to put in place suitable arrangements for a resident with mobility issues to escape a fire. The landlord did not have an appropriate procedure in place for assessing the fire safety risks present in this case which resulted in an unreasonable delay in agreeing to complete an assessment which took into account the resident's circumstances.

Further delays occurred due to the landlord passing the case between internal teams for 6 months, while not updating the resident on what was happening. The landlord itself raised concerns it did not have the correct training or knowledge about these assessments. And later it said the local authority had to undertake an occupational therapist assessment instead of it completing the previously agreed fire risk assessment.

There is no evidence the landlord progressed the resident's fire safety concerns until its final complaint response, in which it told the resident it would not fit a fire escape but would complete a PEEP. This was 17 months after it first considered the fire risk assessment. This caused time and trouble to the resident in pursuing a response as well as distress.

Case 202204476

In case 202204476, **Peabody** provided a poor response to a resident about the risk and remediation works for the cladding on their building. There had been no identifiable progress in completing any remediation 2 years following a fire risk appraisal report. Nor evidence to suggest why.

The landlord failed to manage expectations in relations to the works or updates, simply repeating "as soon as possible" to the resident. It failed to provide meaningful and regular updates and failed to update its website despite saying that it would.

While the landlord told us it was reasonably prioritising higher risk buildings it did not show the communications it had with the developer, whether it had considered undertaking the works itself, or that it has a plan. Nor was the landlord able to provide any evidence of any progress being made towards completing the remedial works needed to be able to issue an EWS1 (External Wall System form).

This caused significant distress to the resident who was still waiting for the EWS1 with no timeframe for one when we completed our investigation.

We ordered the landlord to write to all residents in the block providing an update, as well as updating the information on its website.

In its learning from these cases, the landlord says it has reviewed how it communicates with residents during remediation works and how it prioritises work on buildings that need fire risk assessments.

L&Q

In case 202221775, **L&Q** did not provide a PEEP for over 16 months or seal a door and resolve a closer issue for about 2 years. This exposed the resident to an immediate risk in the event of fire.

The resident raised concerns about her mobility issues as she was unable to use the stairs independently from the third floor to the ground level. This meant for medical appointments she had been carried down the stairs by 3 people. There is no evidence that the landlord had taken any action in response to these concerns.

The resident also said she had to request a fire safety visit from the Fire Brigade Society (FBS) because of her fear of a potential fire. Despite this visit, the landlord did not complete a Person-Centred Risk Assessment (PCRA) for over 2 months and when it did so, it contained inaccurate information. There was no evidence this was corrected after the resident raised concerns, but it was updated after the FBS identified that the fire box was empty and there was no personal evacuation plan for the resident.

The resident explained on multiple occasions the worry and the mental health concerns her circumstances were causing her and, on a few occasions, she expressed her thoughts of self-harm. While the landlord took some safeguarding measures, it failed to acknowledge the impact the situation had on a vulnerable resident.

The landlord did consider temporary accommodation, but did not take this further due to perceived availability of suitable properties. The landlord should have been proactive in finding an option to minimise the fire risk for the resident.

In its learning from this case the landlord says it has started a wide-ranging programme of service improvements following our **special investigation**. This includes overhauling its approach to complaints handling and record keeping, investing in additional staff and training, prioritising efficiency and good communication, and embedding learning from complaints in its processes.

The landlord is also in the third year of a 15-year, £3bn home investment programme to upgrade residents' kitchens, bathrooms, windows and roofs.

Riverside

In case **202317333**, **Riverside** failed to undertake various repairs, with a particular concern around the fire safety related repairs, which were not completed for 9 months.

A damaged fire alarm call point was hanging out of the wall, exposing the wires. It took the landlord 3 months to carry out this emergency repair, demonstrating a worrying response by the landlord to a key fire safety issue.

The landlord took no action to carry out the repairs which included emergency help buttons in both lifts being out of service, a faulty lift call button, faulty capping and missing carpeting on communal stairs. This was a concerning approach by the landlord to risk management in this complaint.

The landlord also failed to follow its fire safety management policy because it did not take corrective and remedial action or maintain its fire safety equipment. We therefore ordered the landlord to look at the impact this could be having on other residents.

In its learning from this case, the landlord says it has created a new team with a one-stop shop model to manage all communal repairs in a single team across building safety and estate management. It has also invested in and improved its complaints model, including creating a dedicated building safety team.

Learning from fire safety

We expect landlords to take issues of fire safety seriously. Any resolution should include looking at how to minimise safety risks for residents.

Landlords should have a process for regular and timely property inspections to identify defects and a mechanism to follow up on repairs, in relation to health and safety, including fire safety.

Staff should be adequately trained where appropriate to deal with fire safety issues, provide up to date information or progress any works where needed. Whenever issues occur, effective communication is vital due to the extremely sensitive nature of the topic. This should be clear and manage expectations, providing regular updates where possible.

Landlords should adhere to fire safety legislation and put in place policies that will make sure they are able to meet these in practice. This could include on fire doors, EWS1 forms, fire risk appraisals and PEEPs.

In its response to the phase 2 Grenfell Tower Inquiry report, the government has also announced that secondary legislation will be introduced later this year for Residential Personal Emergency Evacuation Plans (RPEEPs).

Where residents have chased the landlord for information or action, it should consider the time and trouble as well as the impact on the resident, when handling a complaint.

Gas safety

Complying with gas safety regulations is a core component of many maintenance teams' operations. While thousands of checks will be carried out successfully each week, failings can present considerable risks to residents as well as being a potential breach of regulatory standards.

Southend Council

We made a severe maladministration finding for **Southend Council** (**202234512**) after it exposed a resident to the risk of carbon monoxide poisoning following a dangerous boiler.

The boiler was categorised as immediately dangerous, disconnected, and then labelled “danger do not use”. It should have completed a detailed risk assessment with clear records. However, there is little evidence to show the landlord took substantial action to seek out the source of the gas leak.

The landlord should have also reported the incident to the Health and Safety Executive as a dangerous occurrence in a domestic premises. The landlord did not make this referral.

It was also dismissive of the resident’s reports despite the serious risk posed to the resident because of the boiler. She had told the landlord that she had been exposed to levels of carbon monoxide that put her life at risk. The landlord did not address these concerns in its complaints response but did offer compensation.

In its learning from this case, the landlord says it has enhanced staff training, overhauled record-keeping practices, centralised complaints handling, and introduced a healthy homes team to address damp, mould, and asbestos issues.

Camden Council

In this case 202217728, **Camden Council** failed to sort a gas connection issue that was identified during the void inspection before reletting the property. This meant the landlord did not consider the home was fit for human habitation before it was let.

The landlord failed to act when it realised the supply was not connected nor is there evidence the landlord told the resident when he moved in about arranging this.

As the issue remained unresolved and headed into winter months, the landlord said it would provide more heaters but went back on this promise and only supplied one.

This had a significant impact on the resident over a period of 5 months. Our compensation took into account the additional costs incurred by the resident for personal care, laundry and food as well as the additional energy costs from the fan heater.

Our investigation noted that the landlord identified lessons from the complaint during its own handling, and shared these with the resident, saying that properties would in future not be signed off as complete without a gas meter. This demonstrated encouraging learning from complaints.

In its learning from this case, the landlord says it has also implemented new procedures so that homes are no longer handed over with no heating or hot water. This involves officers from the council working closely with external utility providers on behalf of residents to make sure this happens.

Clarion

We found severe maladministration for **Clarion** (202314634) after it failed to replace a boiler for 2 years after it was identified as do not use.

The landlord's records show that the appliance was left on at the resident's request, despite the gas safe certificates relating to both years stating the appliance should not be used.

There was a lack of proactive investigation or action in relation to the safety of the boiler and flue. It gave no warning or advice to the resident regarding the unsafe appliance and there was no evidence provided that the landlord arranged any urgent repairs.

The landlord should have made greater efforts to communicate with the resident and that he understood what the classification of risk meant.

It should have completed a detailed assessment of the risk, with clear records.

There is no evidence that the landlord completed any risk assessment or offered an alternative option or a schedule of repairs to mitigate risk and impact upon the resident.

The resident told the landlord he was worried about the risk to his health, citing anxiety and distress. There is little evidence the landlord took this concern seriously or handled it with empathy.

Lack of timely action meant this was needlessly prolonged and forced the resident to choose between his safety or access to hot water and heating in periods of cold weather.

The landlord also appeared to provide inaccurate information after misunderstanding the safety certificate.

In its learning from this case, the landlord says it has continued to review all actions that arise and proactively review any exceptions and unresolved matters to ensure it is delivering the service level required.

Soho Housing

In this case 202309829, **Soho Housing** did not take urgent action following the report of a potential carbon monoxide leak.

It failed to provide any evidence that it had robust processes in place to ensure proper record keeping and that it followed its processes. Consequently, our investigation could not establish that the actions the landlord had taken were reasonable.

This case contained 4 severe maladministration findings, with others linked to leaks and repairs. The landlord also failed to respond to our evidence request or provide a stage 2 response to the resident. These issues were not isolated to this case and is something which the landlord has now sought to put right.

In its learning from this case, the landlord says it has appointed a dedicated complaints officer and rolled out extensive staff training on complaint handling and compensation payments. It has also launched a new repairs policy and procedure backed by a dedicated customer service team.

Key learning from gas safety

Residents should live in a safe environment. With the importance of gas in some resident's homes for daily activities from heating to eating, it is vital timely action is taken where concerns are reported.

Landlords are responsible for the gas supply from the gas meter to the appliances it supplies as well as maintenance and repair of the appliances to provide heating and hot water. This reflects the obligations in section 11 of the Landlord and Tenant Act 1985.

Landlord operatives should understand key legislation around gas safety, including on boilers and flues. This also includes provisions around carbon monoxide, in which the alarm itself should not be used as a substitute for the proper installation and maintenance of gas equipment by a Gas Safe registered engineer. This follows guidance from the Health and Safety Executive.

An unresolved carbon monoxide leak has the potential to cause serious harm or even be fatal. Landlords should treat any report of potential carbon monoxide within a property as an urgent or emergency matter. This would remain the case even where there is an operational carbon monoxide alarm in the property.

Where complaints about gas safety or leaks are made, landlords must consider the resident's fuel costs when calculating compensation where relevant. This can be important to make sure the landlord's communication is empathetic to help rebuild trust with the resident.

Electrical safety

Landlords have a statutory duty under section 11 of the Landlord and Tenant Act 1985 to keep the installations for the supply of electricity in good repair.

Landlords are responsible for ensuring properties are fit for human habitation, with electrical hazards listed as one of the 29 hazards under the Housing Health and Safety Rating System (HHSRS). This duty means it is required to repair any issues it is responsible for within a reasonable time.

L&Q

We ordered a senior review by **L&Q's** management of this case (202226880) because it failed to undertake repairs relating to electrical safety that left a resident with tripping electrics.

The review looked at how the landlord should have responded under its obligations compared to how it did. As well as its record keeping processes and systems, encouraging better record keeping behaviours amongst employees.

While the resident believed the landlord failed to conduct the proper tests during a mutual exchange, there was evidence of an electrical installation condition report.

However, due to the tripping electrics, the resident had difficulties cooking, washing and drying clothes. Her cooker was disconnected, and she was reliant on an air fryer for herself and her children.

Due to poor records, it is unclear what happened when the landlord inspected the property, although its timing indicates the landlord only inspected the kitchen 6 months after the first report of the issues. There was evidence that a contractor said there was a need for at least 14 plug sockets to be isolated due to safety concerns.

Poor records meant it was not possible to verify if any of this work was completed or what supply of electricity the resident had been left with in her kitchen.

This was a significant failure by the landlord given that the resident had raised concerns about the safety of the electrics and lack of access to adequate cooking facilities.

The landlord stated the kitchen was rewired, but again due to the lack of adequate records, it was not possible to verify this, or whether the kitchen was now safe through the provision of an inspection report or installation certificate.

In its learning from this case the landlord says it has, started a wide-ranging programme of service improvements, following our special investigation. This includes overhauling its approach to complaints handling and record keeping, investing in additional staff and training, prioritising efficiency and good communication, and embedding learning from complaints in its processes. The landlord is also in the third year of a 15-year, £3bn home investment programme to upgrade residents' kitchens, bathrooms, windows and roofs.

Barking and Dagenham Council

In case **202311480**, **Barking and Dagenham Council** poorly handled an electrical safety hazard following a leak in a home.

The resident reported having no electricity in her bathroom during the leak, with operatives attending and noting that the lights were full of water, but the landlord's response to these concerns was delayed.

Given the leak ran into the light fitting and affected the bathroom electrics, the landlord should have identified it as a health and safety hazard and raised a priority job for the leak to be resolved so that the electrics could be reinstated. Records do not show it completed any follow-on works for several months to address the water running into the light fitting, presenting a hazard to the resident and her family.

This would have compromised the family's use of the bathroom and affected the resident for a longer period than the landlord's assertion of a few weeks and we ordered £3,500 compensation.

In its learning from this case, the landlord says it has continued to place its efforts into improving services and reviewing how it manages its role in remedying damp and mould.

Lambeth Council

We found severe maladministration for **Lambeth Council** (202302135) after it failed to make electrics safe for 4 months in a resident's kitchen or restore the power for 8 months.

When the resident reported that she had no power, the landlord attended the same day as it should. It restored power to the home apart from the kitchen. This remained the case throughout her complaint and still was unresolved when we issued our decision.

The landlord should have reattended the kitchen as an emergency due to the potential safety implications, as well as the significant inconvenience the situation was causing the resident. Despite regular chasing from the resident, the landlord delayed arranging an appointment.

The resident reported that she ran an extension lead to the kitchen to allow her to cook which the landlord had seen during visits. The landlord did not consider alternative arrangements, including an alternative power source or a temporarily move from the property.

In its learning from this case, the landlord says it is taking measures to ensure timely repairs, improving complaint handling, enhancing communication with residents, and establishing clear guidelines for compensation.

Richmond Housing Partnership

In this case 202414659, we made multiple findings of severe maladministration for **RHP**, including not dealing with electrical safety issues for 17 months.

The resident first reported issues with his electrics a month after he moved in, but there are no records to suggest the landlord took action. A couple of months later the resident reiterated his concerns and said an inspection identified that the home needed rewiring.

An Electrical Installation Condition Report (EICR) was conducted 5 months later, which stated the electrics were in a satisfactory condition and identified no repairs. Despite this, the resident consistently reported the same problems with the electrics. This included concerns that the electrics would cause a fire, and that it had caused his TV to blow.

The landlord's records in relation to a further inspection were poor. The records state that an operative attempted to replicate the problem of tripping electrics but was unable to do so. It is not clear from the evidence provided what happened, whether further investigation was needed or whether the operative was appropriately qualified.

We ordered the landlord to carry out a further inspection because of the lack of records. The issues with the electrics were unresolved when we made our decision.

In its learning from this case, the landlord says it has reviewed its internal processes and implemented changes to improve its approach, making sure it continues to learn and enhance services for the future.

Birmingham City Council

We made a severe maladministration finding for how **Birmingham City Council** (202313362) failed to deal with electrical safety following a leak, which left a family with a young child and health issues without power over Christmas.

After every report from the resident, the landlord instructed an electrician to disconnect and restore the power to the affected rooms, focusing only on the electrical issues without resolving the source of the leak.

By failing to address the cause of the problem, the landlord neglected its duty to maintain the resident's property in a safe and functional condition as expected under the Landlord and Tenant Act 1985. This failure likely caused inconvenience to the resident, leaving him without reliable lighting in his property for an extended period.

It also left the leak unresolved, increasing the risk of further damage to the property and other potential safety hazards for the resident.

One visit from an electrician found water running into the lights and sockets, indicating a serious safety hazard. The electrician made the electrics safe and provided temporary lighting, addressing the immediate electrical issues.

However, the landlord failed to arrange an inspection for 52 days. This left the resident relying on temporary lighting solutions, and living with the disruption of an ongoing leak

In its learning from this case, the landlord says it has established a working group to specifically target issues with leaks from above. Particularly where there are issues with accessing leaseholder properties preventing repairs from being carried out. It is also reviewing its approach to identifying properties of concern and taking early and effective enforcement action where access is a barrier to the resolution of repairs. It will be implementing a no access policy to confirm its commitment to resolving issues at the earliest opportunity.

Key learning from electrical safety

If a landlord is unable to meet the emergency timescales required around electrical safety, it must consider what alternative arrangements it can offer the resident. This may include an alternative power source or temporarily being moved from the property.

Considering temporary moves is especially important depending on the time of year and circumstances of the household, especially where children or health conditions are present.

It is appropriate to make the electrics safe before dealing with the root causes of the issue. In doing so, landlords must maintain clear communication with the resident during what can be a stressful and anxious time, especially if the household contains children.

Hazards and wider issues with a property's condition can interlink. A landlord failing to deal with a leak for a long period could cause new problems with electrics and create further damage to the living environment. It is also important for landlords to listen to the resident and their experience of living in the home, to make sure landlords do not miss issues or dismiss valid concerns about electrical safety.

Asbestos management

Asbestos legislation, policies, and procedures are designed to protect everyone and should be strictly adhered to. Any deviation must be taken seriously and thoroughly investigated. Social landlords can be particularly exposed to asbestos due to the age of housing they own and manage.

Hyde Housing

We made a severe maladministration finding for **Hyde Housing** (202302504) after it failed to adhere to health and safety protocols over asbestos, putting a resident at potential risk.

The failure led to inconvenience for the family due to spending almost a month in confined hotel rooms with 2 young children. They returned home 27 days later to a leaking ceiling, with no carpets, no towels, limited bedding and limited clothing due to the damage.

The resident was financially disadvantaged due to having to pay money upfront to replace essential items, pending the landlord's decision on his compensation request and his subsequent challenge to this.

During repairs to a pipe, a panel broke off in the plumber's hands who realised it could be asbestos. Instead of excluding all persons from the immediate area when this was suspected, the operative carried it in 2 parts down stairs and through the house. He sealed and bagged it outside. This did not follow the landlord's policy.

The area should only be cleared of the asbestos by a licenced asbestos removal contractor. The operative who brought the panel outside and then bagged it was not a specialist asbestos contractor.

The landlord's own procedures say work must stop where suspect material is found and may only continue following consultation with the asbestos register and relevant surveys. No enquiries were made by the landlord with the operatives to satisfy itself that appropriate action took place at the time.

Later the landlord did take some appropriate action such as securing the site and arranging for specialists to test the panel for asbestos. It also arranged for an environmental clean to be carried out and extended the resident's temporary move to allow this to happen. The incident was referred to a health and safety manager who instigated an internal post-incident investigation into how the asbestos was disturbed in the first place. A serious incident report form was completed, and senior management notified.

However, in its post-incident investigation it failed to gather statements from all witnesses, including none from the resident or operatives. Therefore, it was only informed about the sequence of events from one perspective. It also failed to put this investigation into writing for the resident.

In its learning from this case, the landlord says its staff are fully trained in potential hazard handling techniques, which are aligned to legislative guidelines.

A2Dominion Group

In case **202304843**, while we recognise some of the resident's behaviour was challenging for **A2Dominion Group** to handle, the issues with the property condition exacerbated the situation.

Following an asbestos check, the resident paid to move appliances out of her kitchen so that works could start. However, no one from the landlord turned up on the day and she was forced to move those appliances back in on her own, in which she reported injuring her back.

The resident mentioned self-harm due to the ongoing issues at the home, which afterwards the landlord contacted its mental health team. The landlord also referred the resident to the local authority's safeguarding adults' team.

An action was created for the landlord to confirm the timeframe and date of works to the resident. However, there is no evidence this was actioned.

Works were postponed by the landlord following the resident's allegation of theft. The resident later called to say her kitchen had been ripped out and that the contractors refused to return due to her mental health. The housing team had been asked to arrange for the resident to sign a behaviour agreement for works to commence. Under the circumstances this was reasonable and in line with its repairs policy. However, there is no evidence that the landlord progressed this request.

An entry on the safeguarding chronology contains copies of emails from the resident. She explains the distress caused to her by the ongoing situation, including the impact on her mental health. The landlord contacted the mental health team to seek an update. The notes say the safeguarding officer received emails from the senior social worker at the Multi Agency Safeguarding Hub (MASH), however the evidence provided by the landlord during this investigation was limited.

In its learning from this case, the landlord says it has implemented enhanced training for staff on record-keeping, new reporting measures to identify and support vulnerable households, and improvements in the timeliness of its complaint responses.

Lambeth Council

We made a severe maladministration finding for how **Lambeth Council** (202220339) exposed a resident and her family to potential asbestos for 2 years.

The ceiling collapsed 2 days after the resident complained about a leak, but 2 months after the resident first reported the issues. There is no evidence of any action taking place during this time.

The landlord raised a repair for the ceiling to be made safe the next day, with a note to say it may need to be tested for asbestos.

The landlord's records do not indicate whether anyone attended to make the ceiling safe or if there was asbestos in the ceiling.

Under the HHSRS, the landlord should have identified the location of any asbestos in the property, assessed how vulnerable it was to damage, and identified any current damage or potential fibre release. The landlord's own notes stated this should have been an urgent assessment due to the damage already caused to the ceiling. However, the landlord did not provide any evidence that it considered the safety of the resident and her children during the incident.

The resident created a makeshift cover for the ceiling with black bin bags which was in place for 2 years. We ordered an urgent inspection and asbestos survey.

In its learning from this case, the landlord says it is underlining the importance of timely and effective responses to repair requests, the need for accurate and comprehensive record-keeping to ensure proper tracking and resolution of issues, and the value of proactive measures, such as risk assessments and interim solutions.

Key learning from asbestos

Asbestos is a hazard under the HHSRS, which along with other legislation contributes to a landlord's overall duty to manage asbestos in its properties. This includes identifying if asbestos is present in a property and making sure the correct survey is carried out. The survey should identify the location of any asbestos in the property, assess how vulnerable it is to damage, and identify any current damage or potential fibre release.

If asbestos is present, this does not automatically mean that the property is in disrepair. Asbestos can often be safely managed by landlords in situ provided it is covered, in good condition, and unlikely to be damaged or disturbed. Landlords must however keep accurate records in relation to all locations of the asbestos and keep its condition under review.

Landlords are required by various statutory provisions to make sure that tenants, staff and contractors are protected from exposure to asbestos fibres. Where work is required and it is known or suspected that asbestos is present, only individuals with sufficient competency and training should be involved in carrying out the work.

Landlords should explore what staff training is needed and how it can get assurance of an effective response in practice with modern, integrated systems to facilitate it.

When related to repairs, the presence of asbestos may turn a routine repair into an emergency, requiring nimble triaging where appropriate.

As with all safety and hazard-related topics, open communication and providing accurate information to the resident living in the home is essential as the household could be particularly concerned where children or health conditions are present.

Where resident behaviour is unreasonable, landlords may need to take action to manage the behaviour in accordance with its policies without losing sight of the need to resolve the potential hazard.

Legionella (water hygiene)

When considering how to deal with water safety issues, there are many aspects that landlords need to think about. From the cause of the issue itself, to how that manifests itself, from contaminated water to leaks that can cause other significant issues.

Home Group

In this case, we made a finding of severe maladministration for **Home Group** (202230230) after it failed to deal with black sludge coming from a vulnerable resident's taps. Leaving no drinking water available in the house.

While the landlord repeatedly attended when the resident reported the issue, it failed to take a holistic approach, proposing the same resolution which proved ineffective.

Some jobs were not followed up or were marked as abandoned. There were also some appointments the resident was not available for and therefore no access was provided.

The landlord described the issue as nothing it had seen before but failed to take further action.

The resident was reluctant to drink the water from the tap which frequently had black slime coming out of it. The resident was now buying bottled drinking water, which he reported causing him financial hardship, but the landlord did not appear to consider this in its complaint handling.

The landlord was also aware of the resident's mental health, as it was noted in its repair logs, which compounds the failings in this case.

In its learning from this case, the landlord says it has brought its repairs in house and has developed a new operating system which has created greater visibility, collaboration, and cohesiveness between departments.

It has helped with better tracking and monitoring of jobs through to completion; more focus on joint working and using data holistically rather than focusing on tasks, to put the customer up front and centre; widened system access to ensure better visibility of customer and property related issues.

Lewisham Council

We found severe maladministration for **Lewisham Council** (202331984) following sewerage leaks in the toilet which spread onto the bathroom floor remaining for 11 months, despite this needing to be an emergency repair and with children in the house.

On the initial reporting of the issue, the landlord said it attended as an emergency repair but was unable to show what actions it took.

The longest period the repair to the toilet should have remained outstanding was 20 working days.

At the time the landlord said the toilet needed to be replaced, it was outstanding for 183 working days. These timescales were significantly beyond the landlord's repairs policy and left the resident feeling she had been "disregarded". When we made our decision, the repair remained outstanding.

The landlord did not evidence it considered the resident's reports of health and safety concerns. Or that she had said there was sewage leaking on the bathroom floor especially with 3 young children living in the property.

In its learning from this case, the landlord says it has revamped its complaints process and introduced a robust system for recording and monitoring complaints. Its repairs service has also commissioned an upgrade to its operational control system which will improve its data management and help overcome the shortcomings in monitoring and oversight within its repairs service.

L&Q

In 2 cases, we made severe maladministration findings for **L&Q** (202230978 and **202306931**) as it failed to deal with a drainage issue for 6 years in a house where a resident with pneumonia and another case where it was unable to make assurances over safe drinking water.

Case 202230978

In case 202230978, the landlord said it would erect a manhole and rectify the u-bend in the drainage pipework. It said both were completed but 2 years later the issues were still ongoing.

Repairs logs show the landlord raised a job following toilet and sinks backing up and marked these as complete despite no notes to evidence it. The landlord also failed to communicate effectively with the resident throughout which caused further frustration.

The draining issue also caused damp and mould in her home, which she was worried about due to her daughter's recent hospitalisation with pneumonia.

She was concerned how the conditions in the property might impact her daughter as the winter approached. The landlord's tenancy notes indicated it spoke with its contractor, who was waiting on a third party before it could arrange an inspection.

The landlord took 9 months to carry out any works to the resident's drainage in the basement.

Case 202306931

In case **202306931**, we ordered nearly £9,000 in compensation after it failed to deal with possible contamination of drinking water. The landlord had identified most of the compensation award through its own complaint handling.

The landlord recorded that there was possible contamination of drinking water via the boiler.

It arranged an urgent job for its gas contractors who could find no contamination from the boiler to the cold-water supply. The matter was referred to a specialist.

The risk assessment and management action plan which followed noted there was an elevated overall risk, and the property had been recorded as “medium”.

Although the report noted that there appeared to be minimal risk of bacteria growth, the assessment highlighted that the landlord’s monitoring records were not available, nor up to date. The report concluded that that “medium risk requires action as soon as it can be conveniently included in the work schedule”.

However, it was not clear what the work schedule would include, and the outcome was not shared with the resident.

The resident had to chase updates. She said she was “mentally exhausted” and that her anxiety was severe.

Other than reassuring the resident it would reimburse her with bottled water costs, the landlord did not demonstrate sufficient empathy towards her situation.

It failed to set out what it was doing to investigate the issue, and it was delayed in referring her to further support.

The water failed to be tested again for a while and evidenced 2 failed samples, which caused additional stress. It was unclear what caused these to fail. The landlord did not provide the resident with sufficient reassurance, and it did not share its plan of action with her. By not doing so, it failed to demonstrate that it had considered what other measures it could put in place to safeguard her whilst it addressed the issue.

The contractor noted it was baffled by the results and that there was a need for major works. However, there is no evidence that the landlord discussed a possible temporary move with the resident after it had come to this conclusion, which was inappropriate.

In its learning from these cases the landlord says it has, following on from our special investigation, started a wide-ranging programme of service improvements. This includes overhauling its approach to complaint handling and record keeping, investing in additional staff and training, prioritising efficiency and good communication, and embedding learning from complaints in its processes. The landlord is also in the third year of a 15-year, £3bn home investment programme to upgrade residents' kitchens, bathrooms, windows and roofs.

Norwich Council

We made a finding of severe maladministration for **Norwich Council** (**202316688**) after the water supply to the home was not connected when the resident started the tenancy, causing disruption for 5 days.

The landlord had a legal obligation to make sure the property had a supply of water before the start of the tenancy, attending to the job as an emergency when it realised it was not running, and taking mitigating action when it realised it could not be immediately fixed.

Due to a lack of adequate records, it is not possible to verify whether any checks were carried out during the voids process.

In its learning from this case, the landlord says it has restructured its property services department and made significant improvements in both its repairs service and complaint handling.

Key learning from legionella

Landlords should make sure there is a safe and clean water supply to a property before occupancy. Where issues occur, including with sanitation, landlords need to make sure they investigate and respond, including considering whether it is an emergency.

In some cases, the causes can be complex. This means the landlord may need to consider appropriate mitigations, including avoiding financial hardship for the household or a temporary move. Especially where the household's circumstances present greater risks.

Communication is also key with the resident but also between the different parties involved to resolve to issues.

LOLER (Lifting Operations and Lifting Equipment Regulations)

A2Dominion Group

In this case, we made a severe maladministration finding for **A2Dominion Group** (**202233103**) after it left a lift out of action for 21 months, with a disabled resident forced to have a family member carry her down the stairs. It also disrupted her treatment for an ongoing bowel condition, as she did not know if she would have access to a bathroom if she left the building and could not access her home.

The resident was also moved temporarily on at least 8 occasions and the landlord failed to engage on a PEEP. It attempted to repair the lift 8 times but did not provide repair records or how it categorised the repairs.

The landlord said delays were due to parts or having to refer to the manufacturer based in Italy.

While we recognise that complex repairs may require additional time to complete, the landlord should have kept in regular communication with the resident and updated them on progress. The evidence provided by the landlord shows that this was not always the case.

The landlord eventually agreed to replace the lift, but this was after it delayed far too long, causing distress to the resident. It should also have considered whether a more extensive assessment may have been required.

This could have mitigated the resident's complaint and the impact on her in relation to the frequency of the outages of the lift.

The landlord had not replaced the lift at the time we made our decision.

In its learning from this case, the landlord says it has appointed 2 new contractors to service and maintain all passenger lifts and is trialling remote monitoring equipment to improve performance and identify issues quicker.

Key learning from LOLER

Landlords should assess any underlying cause of lift outages to see whether more than a repair is needed and provide clear communication to residents throughout this time. This can be complex and therefore communication is even more important.

Centre for Learning resources

Knowledge and information management key topics page containing reports, podcasts and case studies.

Knowledge and information management eLearning and workshops available on the Learning Hub.

Decants key topics page containing reports, podcasts and case studies.

Attitudes, respect and rights key topics page containing reports, podcasts and case studies.

Spotlight report on cladding

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