Housing
Ombudsman Service

Report of the Housing Ombudsman's Independent Reviewer of Service Complaints

For the period from 1 April 2025 to 30 September 2025

Housing Ombudsman Service

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Introduction

Background

The Housing Ombudsman's dispute resolution principles are: be fair; put things right; and learn from outcomes. The Ombudsman applies these principles internally to complaints about the service it has provided to its customers as well as externally. The appointment of the Independent Reviewer of Service Complaints is intended to enhance our learning with an independent perspective and demonstrate our openness through the publication of the Reviewer's reports.

Felicity Mitchell was appointed Independent Reviewer of Service Complaints in April 2025. This is her second report.

Service complaints during the period

This report covers service complaints closed during the period 1 April 2025 to 30 September 2025. The Ombudsman's approach to service complaints is to uphold them if there is any doubt over the service provided. During this period:

- The service investigated and closed 1003 service complaints at stage 1 and 26 at stage 2.
- It upheld or partially upheld 647 service complaints at stage 1 and 12 at stage 2.

The total of service complaints investigated and closed at stage 1 and stage 2 (1029) represents 4 per cent of the enquiries and complaints received by the Ombudsman during same period (23648).

Sample selection

The Ombudsman selects cases for review in each six-monthly period. For this review period, 12 random cases were selected that related to determinations rated as "high risk" during that period. This approach was used to provide insight into the Ombudsman's handling of service complaints relating to the highest priority cases for investigation.

Report

1. This is my second report since my appointment as Independent Reviewer. As before, I have reviewed a small sample of service complaints and I am satisfied that the service complaints process is operating effectively. My observation is that Service Complaint Investigators (SCIs) handle their investigations empathetically, sometimes in the face of very challenging correspondence.

2. I was given access to 12 service complaint files, which I have numbered 1 to 12 for ease of reference. In cases 8, 9 and 10, the stage 1 response was sent on 1, 3 and 6 October, respectively, and they were closed after 30 September 2025. Technically those cases fall outside the timeframe for this report. The review sample is ordinarily 10 cases, so I have decided to exclude cases 9 and 10 from my review, but to include case 8, which was closed on 1 October.

3. Cases 1 to 8 were closed at stage 1, and cases 11 and 12 were closed at stage 2. Four of the service complaints were upheld or partially upheld at stage 1, including the stage 2 complaints. Cases 1 and 6 were separate service complaints brought by the same resident. In every case (whether upheld or not) the resident was given an explanation of what had happened. In 4 cases, the Service offered an apology. The Service offered the resident compensation in one stage 2 case.

4. I raised several queries following my initial review of the service complaint files, and asked for some information from the landlord complaint file in 2 cases.

5. The cases selected for this period's review all related to landlord complaints that had been assessed as "high risk". All complaints received by the Service go through a risk assessment process at triage, and this process can be repeated at any stage. Guidance for case-handlers doing the initial risk assessment says that the assessment helps "prioritise cases based on any urgent housing issue and resident circumstances at the time the case is triaged". The assessment is based on the severity of the housing issue, whether or not the issue is ongoing (and for how long), and the resident's circumstances. Those three factors are given a rating from 0 to 4, and the ratings are added together to give an overall risk rating of 0 to 12. Cases with an overall rating of 9 or over are designated "high risk".

6. The risk assessment has an impact on the order in which cases are allocated to a case-handler, how they are investigated, and who can make the decision. I observe that the current expectation is that 90% of high-risk cases will be determined within 4 months from being Duly Made (i.e. confirmed within the jurisdiction of the Ombudsman) and 80% of all determinations within 12 months (i.e. including low- and medium-risk cases). These cases will already have waited some time for allocation and so these timeframes are very long for high- and medium-risk cases.

Analysis of cases

7. The service complaints were categorised on their case cards as follows (some complaints fell within more than one category):

   7.1. Case management: 7 cases, raising concerns about the handling of a service complaint, missed call-backs, processes not being followed, and delays

   7.2. Managing relations: 3 cases, raising concerns about staff conduct, understanding or professionalism

   7.3. Communication: 3 cases, raising concerns about the Service's published timescales and style of communication.

   7.4. Equality, Diversity and Inclusion (EDI), human rights, reasonable adjustments: 2 cases were categorised as EDI and human rights or relating to reasonable adjustments.

8. Some cases categorised under "communication" and "managing relations" were in reality about the length of time the Service was taking to investigate the landlord complaint, to reply to correspondence, or to follow up compliance with orders and recommendations. Case 1 is categorised as "managing relations – staff conduct/understanding", but it is essentially a complaint about failure to implement reasonable adjustments. The case categorisation is reviewed when the service complaint is closed, which is a sensible quality check.

9. These categories have since been reviewed and updated, and I understand that work is underway to produce guidance for staff on which category to select in

different scenarios. As this work is in progress, I make no further recommendations.

Timelines

10. I am pleased to say that in 9 cases, the timeframes set by the Service Complaints Process were met. In case 4, the stage 1 outcome was issued 1 day late, but after two extensions. In case 12, the stage 1 outcome was sent several days late, after two extensions. The stage 2 outcomes were both sent late.

11. In several cases, the SCI wrote to the resident when they realised that they were not going to meet the timeframe for issuing the service complaint outcome, asking for an extension of time. For example, in case 4, the SCI writes:

    “I would like to kindly request a short extension and will endeavour to provide you with my response within the next 5 working days."

    Whilst it is good practice for SCIs to notify residents that they will not be able to meet the timeframes set in the procedures, asking for permission in this way may be a little misleading. It is not clear what would happen if the resident refused the request.

12. In cases 1 and 12, the date of the stage 1 outcome has been incorrectly entered on the case card. This data is quality checked (by sample). It is used by the Service to monitor performance against the timeframes set out in the service level agreements which, in turn, could impact decisions on resourcing.

13. In case 12, the resident sent 4 chasing emails before their request to escalate their service complaint to stage 2 was actioned. These emails were all sent to the general casework email address instead of to the service complaints email address, but each had the words "Stage 2 request” in the subject line, and were addressed to the customer insight team. This led to a delay of 9 days before the SCT received it, and meant that the SCT missed the timeframe for accepting the stage 2 complaint. The stage 1 outcome letter sets out that the resident can request escalation to stage 2, but not how to do so. This wording has since been amended to include instructions for how to escalate the complaint to stage 2. It would be helpful to add the SCT email address to that wording.

14. The Service has recently introduced new processes that will speed up decisions on whether a complaint (or all of the complaint) can be investigated. This means that residents know at an early stage if they will need to raise a new complaint with their landlord before the Service can consider it. The new process would no doubt have avoided some of this resident's frustration with the Service.

15. **Recommendation 1: I recommend that SCIs are reminded of the importance of accurately recording dates (and other information) on the case record.**

Communication and managing relations

16. It is always disappointing to see complaints about staff understanding or professionalism. However, I would expect to see complaints of this nature in the context of these cases, because they arise from high-risk complaints. The residents bringing these complaints are likely to have been significantly affected by a severe housing issue, possibly for a long time. There is evidence in each of the 10 complaints that I reviewed that the residents are under very considerable stress, and that affects how they communicate with the Service. Several of the residents experience mental health problems that they believe have been aggravated by the stress of complaining. Two have declared health conditions or impairments affecting how they communicate. In almost every case I reviewed, the resident had already made at least one service complaint to the Service – sometimes about the same issues. Often emails from residents were extremely impatient (reflecting the frustration that many felt), rude and even abusive. For example, in case 5, the resident said:

"I am abhorred by this ombudsman. You are reckless, you are dangerous to the wider public in the UK, you are unfit to exist. You are extremely biased in favour towards the freeholders, to the point that you are happy to KILL PEOPLE."

"The conversation with [case-handler] was nonsensical , as before. [Case-handler] caused me EXTREME LEVELS OF FRUSTRATION and DEEP PSYCHOLOGICAL TRAUMA. It was like talking to a NON-INTELLIGENT ROBOT, who would NOT accept FACTS , EVIDENCE AND the HORRENDOUS

LETHAL CONDITIONS CAUSED BY THE freeholder. The conversation with [case-handler] WAS TOTALLY ILLOGICAL and therefore NONSENSICAL."

17. In case 11, the resident said:

"You previously upheld my complaint about exactly the same thing a few weeks ago, i.e. not replying and drivelled on about how you're sorry etc. and now you've done it again so you're not sorry and you simply can't do your job, that's the truth of the matter."

"However, with respect, it's the same old guff I got last time I complained about no reply, so it's just meaningless lip service; you're not going to improve, you can't do your jobs and you're incompetent. Your organization is simply not fit for purpose; it's a made up quango, looks good, sounds good, but is completely incapable of even replying to an email enquiry, within 15 working days. Which is of course, absurd."

18. I was pleased to see that SCIs' communications with residents were always polite and empathetic. For example, the SCI replied to the resident in case 11:

"I am truly sorry that no one contacted you. I understand why this would be extremely frustrating. Especially with your previous service complaint about the same issue."

19. In cases 1, 2, 3, 6 and 12, SCIs took great care to provide explanations for what had gone wrong, and appropriate steps to improve the service for the resident.

20. In only one of the cases I reviewed (case 2), the resident had been warned under the Service's Managed Behaviour Policy. The policy sets out examples of unacceptable behaviour and unreasonable demands and levels of contact, and explains how the Service manages such behaviour. The policy is on the Service's website, under "Corporate Information/policies/dispute resolution", and under the banner, "These are our internal policies and guidance for staff published on our website for transparency".

21. Finding a way to manage challenging behaviour is the silver bullet every ombuds scheme seeks. It can be effective to have a more public-facing webpage that sets out how residents can help the service to investigate their complaint. This could

include letting the service know that they need help or support, responding to the service as quickly as possible, not sending in personal information about other people, keeping the service informed about any changes to contact information or other circumstances, and being patient! The behaviour policy can then be framed as a last resort, to be referred to if the resident's behaviour is starting to have a negative impact on the service's work or staff.[1]

22. The Service's Managed Behaviour Policy is very formal and directed at staff members rather than the public. Re-wording the policy for an external audience might help residents to understand, and therefore to accept, expectations around behaviours. It can also make it easier for case-handlers to refer residents to the policy, so that they can see how their behaviour might have negative consequences for the Service's ability to review their complaint, before the behaviour reaches the stage where the policy needs to be invoked. I have seen good examples of "easy read" behaviour policies[2].

23. **Recommendation 2: I recommend that the Service considers producing a public-facing behaviour policy, in straight-forward language, to which any individual engaging with the service can be referred**.

24. In case 2, one of the resident's service complaints was that they had "tried to speak to [their adjudicator] and email them numerous times". The SCI did not uphold this part of the complaint and provided a detailed and helpful account of communications between the adjudicator and the resident. The SCI noted that the adjudicator had taken time to go through the determination with the resident over the phone and had tried to liaise between the landlord and the resident regarding payment of compensation. The stage 1 outcome letter included a summary of actions taken by the Service each month. This was a helpful way to address some of the resident's concerns, and drew the resident's attention to the warning that they had been given because of the high level of contact.

25. Case 4 related to correspondence the resident had sent to the casework team over a 4-month period, after the determination on their complaint had been

[1] See, for example, How you can help us to review your complaint - OIAHE
[2] See for example customer-contact-policy-easy-read-hi-res-v1.pdf

issued. The resident received a standard autoreply which promised a reply within 15 days.

They also called and were told that a call back would be arranged within 5 days. It was not explained to the resident that correspondence after the file was closed would not receive a reply and the resident took the autoreply text at face value, expecting to hear from the Service within 15 days.

26. The resident's post-determination correspondence raised concerns about the landlord's compliance with the order made on their landlord complaint, issues that might have amounted to a new complaint. It would have been good practice for someone to have considered the resident's correspondence so that they could be pointed in the right direction.

27. The stage 1 outcome says:

"while auto-acknowledgement emails will be sent in response to any email contact, the actual email itself will not be reviewed until the case is assigned to a new caseworker. In your situation, as your case had been closed all further information you sent to us would've only been added to the case. This is because there isn't anything further the caseworker can do as I've explained above. I am sorry this was not made clear to you."

28. Case 11 also related to a failure to respond within 15 days to a request for an update. This was the resident's second complaint about the same issue. The stage 1 outcome says:

"I am truly sorry that no one contacted you. I understand why this would be extremely frustrating. Especially with your previous service complaint about the same issue.

This is not the level of service we want to provide. Our aim is to respond to emails within 15 working days, in line with our service level agreements. Unfortunately, this is becoming increasingly difficult when a case is waiting to be assigned to a caseworker. This is because of the high demand for our Service. …

I do acknowledge that we need to make our communication about response times much clearer. This will help us manage expectations as early as possible."

29. The resident's exasperated response (see paragraph 17, above) was, perhaps, predictable.
The explanation given to the resident in the stage 2 response was as follows:

"To give you more context and for future reference, when a case is passed from one case stage to another, it is placed in a queue to be picked up in date order. While it sits in this queue, it does not have a named caseworker. So, while auto-acknowledgement emails will be sent in response to any email contact, the actual email itself will not be reviewed until the case is assigned to a new caseworker."

"The content of the auto-acknowledgement has been raised as feedback at this moment. We're not meeting the timeframes we have stated in it which is causing frustration for residents like you. This is due to the volume of enquiries the service receives, as well as cases waiting for allocation to a caseworker. … The content of the standard acknowledgment email may not change immediately – it will be monitored as the service takes necessary steps to reach the standard of service it wants to provide to it users."

30. In my view it is not good practice to leave correspondence unread for lengthy periods while cases are "queuing" at different stages of the process, especially where the complaints have been assessed as high-risk. There is a real risk that important and urgent information will be missed. This could lead to safeguarding concerns. The current text of the automated reply, which leads residents to believe that they can expect a reply within 15 days, without qualification, risks exacerbating the underlying issue. It is inevitable that this will generate service complaints when the timeframe is not met.

31. In my previous report, I recommended that the Service "Consider what steps can be taken to better support residents during the periods of inactivity before their complaint is allocated for investigation." I am aware that the Service is already working on improving communications with residents while they wait for their complaint to be assessed and allocated. This includes improving the way that emails are sorted and prioritised, and better use of webforms.
Recommendation 3: I now recommend that, if this has not already been done, the Service reconsiders the wording of its current automated

responses to ensure that they do not mislead residents to believe that they will receive a response when they will not.

Issues relating to health conditions or impairments

32. The risk assessment factors in a resident's vulnerabilities, as well as the severity of the impact of the housing issue on the resident. Therefore, it is not surprising that many of the high-risk cases I reviewed involved residents experiencing long-term mental health problems, health conditions, or physical impairments. Three of the cases I reviewed (cases 1, 6 and 7) were about reasonable adjustments put in place for a resident.

33. Cases 1 and 6 were brought by the same resident – I believe the resident has made at least 6 different service complaints. The resident's case card records that they needed to use voice-detect software, and that they should be contacted by phone, using email only for updates and for arranging calls. I understand these adjustments were put in place following an earlier service complaint (or complaints). Case 1 relates to a call this resident made to a customer adviser about an earlier service complaint. The resident asked for the Stage 1 service complaint to be escalated to Stage 2. The customer adviser said they would need to email the customer insight team.

34. The SCI's investigation included listening to the phone call. The SCI notes that the resident directed the customer adviser to the reasonable adjustments agreed for him, and explained that it would likely take him over an hour to put together an email. But the customer adviser was adamant that the resident needed to email the SCT, because "that's our process".

35. This incident became a service complaint in its own right (case 1), which was handled very well. It was thoroughly investigated, and the SCI phoned the resident with the outcome, following this up with an email. The SCI upheld the complaint, acknowledging that the resident's reasonable adjustments had not been applied. The SCI also took steps to progress the previous service complaint, and assisted the resident by taking down their reasons for wanting a

review of the landlord complaint. So the outcome of this service complaint resolved one issue, and progressed two others.

36. Unfortunately, the resident then had cause to complain again (case 6), when their request for a review of the landlord complaint was refused. The SCI upheld this part of the service complaint and agreed that the resident could provide further information in relation to their review request. A note on the service complaint file says,

"R asked for a call from the Adjudicator to explain the review process. This didn't happen, and on that basis I'm upholding the complaint. If we had called R as we should have done, this situation would probably not have arisen."

37. Case 6 also included this resident's complaint about their application for a subject access request in relation to a phone call they had made to the Service that had not been actioned, because it was filed on the wrong service complaint. The Information Governance (IG) officer had sent a lengthy and complicated email to the resident asking for proof of their identity, even though the Resident had already provided proof of identity to that team. In view of the adjustments in place for this resident, the IG team's email was not appropriate. The resident responded:

"The continued failure to abide the reasonable adjustments i have is one example of your abuse.

As with past SAR it's to support my service complaint against the Housing Ombudsman if a manager from the service complaint team would call me the disclosure would not be necessary as they could listen to the recording and take action with the service complaint"

38. The SCI took care to establish the sequence of events leading to the complaint and listened to the call in question. However, the SCI accepted the IG team's explanation for not calling the resident, when they asked for a call:

"They didn't say they wouldn't call R, but they thought R was unhappy at being asked for ID again when has provided it previously. Came back to R to say that they were able to proceed based on ID provided before. Didn't feel call was needed. IG will call residents when agreed as a RA [reasonable adjustment]."

In this case, phone calls were an agreed adjustment. Even if the IG team believed they had resolved the resident's concern, it would have been good practice to phone the resident to make sure. The resident decided not to pursue this part of the service complaint, notably, after a phone call with an SCI.

39. In my view, these two service complaints could and ought to have been avoided had staff in the different teams been more willing to speak to the resident over the phone. Receiving 6 service complaints from one individual ought to be avoidable if appropriate care is taken and steps are put in place to manage the resident through the process from end to end. This proliferation of service complaints itself gave rise to confusion, and minor issues were allowed to snowball, and become something much larger. Having one named individual to shepherd this resident through the process from end to end might have avoided the service complaints. Although it is a resource-intensive way to manage complaints, it would undoubtedly have saved a lot of other individuals' time and might well have resulted in the resident's landlord complaint being resolved more quickly.

40. It may be that case-workers in some areas of the Service do not often need to make calls to residents, and therefore do not have much experience of calling residents who may come across in writing as challenging. It is very common for people to be a nervous of phone calls, especially if they do not often have to make them. Regular call training across the organisation can give people confidence in dealing with challenging calls.

41. In my previous report,I recommended that the Service should consider "whether further steps might be taken to expedite a complaint where the resident has made a service complaint that has been upheld, has made multiple landlord complaints, or is otherwise likely to absorb considerable resource…." and "what steps can be taken to better support residents during the periods of inactivity". I am aware that the Service has since streamlined and simplified the process leading up to allocation to a case-handler for determination, which means that fewer people are involved during these early stages, and periods of inactivity are kept to a minimum. The Service has also introduced a new Risk and Allocation Policy that allows for cases to be prioritised: if the resident has been disadvantaged by errors in case handling that have led to unreasonable delays;

and if the resident has complex needs and is likely to be caused significant detriment if the usual allocation timescales are applied. These changes will undoubtedly bring improvements.

42. **Recommendation 4: I now recommend that, building on work that is already underway, the Service considers whether, in exceptional cases, it would be proportionate to provide a named single point of contact, or other specific resource, for the duration of the landlord complaint, as a reasonable adjustment for residents who are finding it difficult to engage in a constructive way with the Service because of a disability.** This would not necessarily mean that the case-handler remained the same throughout the process. The point of contact could be a specialised role outside of case-handling.

43. **Recommendation 5: I recommend that, if it is not already in place, a regular and tailored programme of call training is rolled out across the organisation. It may be that this can be done in conjunction with the review of the behaviour policy.**

The resident's problems with the landlord are ongoing

44. Cases 1, 5, 6 and 12 were service complaints from residents who had ongoing difficulties with their landlords. In my previous report I reflected on three cases where the resident's problems with the landlord were ongoing. Given the long-term relationship between the resident and the landlord, this must be a very common issue for the Service.

45. In case 5, the resident's landlord complaint related to a leak at their leasehold property. The complaint was first raised in 2023, but a further leak (or a repeat of the same leak) was discovered after the landlord's final decision on the complaint. The leaks damaged the ceilings to the resident's flat and disrupted asbestos. The Service did not include the asbestos damage in their determination of the complaint because, it said, the landlord had not had an opportunity to investigate a complaint about it. I note, however, that the landlord refers to

asbestos damage in its final decision letter. Given the delay in the Service's investigation – which was not concluded until a year after the landlord's final decision – I can understand why the resident was frustrated to be told that they would need to raise a new complaint about the asbestos damage which they believed had been caused by the landlord's ongoing failure to tackle the leaks at the property. In response to my enquiries about this case, the casework team told me that the asbestos issue was the subject of an insurance claim, because the resident was a leaseholder. That is why it was not considered as part of the resident's complaint to the Service.

46. It seems to me that it was reasonable for the resident to expect their complaint to the Service to investigate the landlord's responsibility for the leaks, and the consequences of those leaks. If the damage was caused by the landlord's failings, I would have expected the landlord to put right the consequences of those failings, whether or not the resident had a potential insurance claim. In my view, a better way to have approached this would have been to ask the landlord whether they would agree to include all the outstanding issues in the Service's review of the resident's complaint – and give them the opportunity to provide any further evidence. Wrapping up the issues in one complaint would have made it easier for the landlord and the Service to manage, as well as providing a better service for the resident.

47. The Service has recently introduced new processes that will speed up decisions on whether a complaint (or all of the complaint) can be investigated. This means that residents know at an early stage if they will need to raise a new complaint with their landlord before the Service can consider it. The new process would no doubt have avoided some of this resident's frustration with the Service. As it was, the resident made several service complaints and sent frequent and highly charged correspondence, which demonstrated graphically their frustration (see paragraph 16, above), and which should perhaps have been managed under the Managed Behaviour Policy.

48. A rigid insistence that issues arising after the landlord's final decision must be considered as new complaints is difficult to sustain where the Service's timescales have been so protracted, and when correspondence has gone

unanswered for several weeks. It is inevitably difficult for a resident to accept that they must start again in those circumstances. Where the Service is still investigating a complaint, it ought to be possible to bring in complaints about further incidents of the same nature into the same investigation, by inviting the landlord to agree and to provide any further response they would like to provide (effectively accepting that their internal processes had concluded), while the complaint is awaiting allocation. In my view, the Service is not prevented from doing this by the Scheme under which it operates.

49. In case 12, the resident had made a total of 7 landlord complaints, some of which related to antisocial behaviour dating back to 2021. The resident's service complaint related to delays in handling 3 of their landlord complaints, and differences in the 3 risk assessments. They drew attention to a previous landlord complaint, also about antisocial behaviour, in which their chronic illness and the vulnerability of their housemate are documented.

50. One complaint about antisocial behaviour was initially assessed as low risk, apparently because there was limited information on the file to inform the assessment. This was changed to high risk 10 months later, after the resident had provided some further information about the impact the complaint was having, and following the service complaint. Another complaint was initially assessed as medium risk but increased to high risk 5 months later (and 4 months after the first case).

51. The resident received compensation of £100 for a delay of about 6 months to the investigation of their landlord complaint resulting from the risk being initially assessed as low risk. The stage 1 outcome also resulted in a reassessment of their other complaints – although there was a delay of 3 months before one was reassessed as high risk.

52. The resident asked for the complaints to be dealt with together. In my view, there are significant advantages to allocating complaints about similar issues to the same case-handler, to be investigated simultaneously. This grouping of complaints might mean expediting a later complaint, or putting on hold an earlier complaint so that the later complaint can catch it up. It does not necessarily mean

that the complaints have to be merged. Having one case-handler means that the resident does not have to explain things multiple times. It also avoids duplication of effort in the investigation of the complaints, confusion between different cases, and the risk that important information is overlooked because it is on the "wrong" case. It also means that case-handlers have a full picture of a pattern of complaints, and reduces the risk of inconsistency in decision-making. The Service has a manual process in place to try to identify and group linked cases and this could form the basis for a more structured approach to grouping.

53. In my previous report, I made recommendations about the risk assessment process, and about supporting residents with ongoing issues. The Service has completed a review of the process, and put in place a new Casework Risk and Allocation Policy in January 2026. The new policy says that, at the initial assessment stage, if there is not enough information on the file to assess the risk level, "we'll make reasonable attempts to contact the resident for further information to inform the score." It includes the following: "Our approach to risk is also dynamic, allowing for re-evaluation at any time during our casework process following known changes in case circumstances when brought to our attention." These changes would likely have resolved the issue that arose in case 12. When the policy is next reviewed, I suggest that it includes a mechanism for reviewing related cases to ensure consistency of approach to the risk assessment process across those cases.

54. Recommendation 6: I recommend that the Service continues to give consideration to its approach to complaints about ongoing issues, for example:

54.1. **Merging a new complaint with an existing complaint from the same resident about related issues that is awaiting allocation, provided the landlord agrees and has the opportunity to respond.**

54.2. **Developing further their process for grouping complaints about similar issues for simultaneous investigation by the same case-handler.**

I am pleased to note that the new Risk and Allocation Policy (see paragraph 41, above) also allows for cases to be prioritised so that they can be

investigated at the same time as older, linked cases, and where the substantive issue with the landlord remains unresolved.

Conclusions

55. This sample of service complaints has been challenging for me to review, and I can see that they have been difficult for the Service to manage. Cases assessed as high-risk are likely to involve individuals who are under considerable emotional stress, and whose frustration with a process is taking a long time plays out in their communications. Nevertheless, this small sample demonstrates that the service complaints process is operating effectively, SCIs handle their investigations empathetically, sometimes in the face of very challenging correspondence, and outcomes are generally reasonable. I have made several recommendations that I hope will help the Service to manage high-risk complaints more effectively.

Housing Ombudsman Service

Recommendations, actions and responses

No.	Recommendation		Action	Owner(s)	Delivery date
1	SCIs are reminded of the importance of accurately recording dates (and other information) on the case record.	Accepted in full	Ensure WorkPro data accuracy is part of quality assurance checks and quality control checks for service complaints.	Head of Quality and Customer Insight	QA part of business as usual QC by 30 September 2026
2	The Service considers producing a public-facing behaviour policy, in straight-forward language, to which any individual engaging with	Accepted in full	Review our existing Managed Behaviour Policy and make relevant changes to make sure the policy and key messages within it are understandable and accessible for customers. Review the accessibility and presentation of the policy on our website.	Head of Dispute Support - Enquiries	By 30 September 2026 (aligned with review of connected Reasonable Adjustments Policy).

	the service can be referred.				

3	(If this has not already been done) The Service reconsiders the wording of its current automated responses to ensure that they do not mislead residents to believe that they will receive a response when they will not.	Accepted in full	Review standard automated email acknowledgement templates to ensure these are transparent to customers around expectations.	Head of Dispute Support - Enquiries	No later than 30 September 2026
4	The Service considers whether, in exceptional cases, it would be proportionate to provide a named single point of contact, or other specific resource, for the duration of the landlord complaint, as a reasonable adjustment	Accepted in part The potential provision of a Designated Point Of Contact (DPOC) is part of the current	Consider the provision of points of contact as part of the DPOC / SLA process rollout and post-implementation review.	Head of Quality and Customer Insight/Head of Dispute Support - Enquiries	No later than 30 September 2026

	for residents who are finding it difficult to engage in a constructive way with the Service because of a disability.	Reasonable Adjustments policy, in place from December 2024. There may be multiple points of contact throughout the customer journey due to the skills and knowledge required at each stage.			
5	If it is not already in place, a regular and	Accepted	Training needs analysis to be completed to determine the appropriate scope and	Head of People	30 September 2026

	tailored programme of call training is rolled out across the organisation.		delivery methods for such training before its roll-out.		
6.1	The Service continues to give consideration to its approach to complaints about ongoing issues, for example: Merging a new complaint with an existing complaint that is awaiting allocation, provided the landlord agrees and has the opportunity to respond.	Accepted within the parameters of the Scheme	Provide further guidance on para 42a to give clarity on scenarios where we would consider post complaint procedure events which closely relate to the same issue that has been through internal complaint procedure and make a version of this accessible to external audiences.	Head of Dispute Resolution	By 30 September 2026
6.2	The Service continues to give consideration to its approach to complaints	Accepted	Review our internal procedures, guidance and allocation approach to ensure these	Head of Casework	30 September 2026

	about ongoing issues, for example: Grouping complaints about similar issues for simultaneous investigation by the same case-handler.		are clear about scenarios for and handling of linked customer cases. In the longer term, ensure that need for automated recognition of linked cases informs our technology change programme requirements.	Assessment and Support Head of Casework Assessment and Support	31 March 2027