Senior Management Review of a Housing Ombudsman Complaint

Summary of Findings and Service Improvements – review undertaken in June 2025

1. Introduction

The Council accepts the findings of the Housing Ombudsman in full and acknowledges that the service provided fell below the expected standard. We sincerely apologise for the impact that this had on the resident and, in recognition of this, the Director of Housing for the London Borough of Hammersmith and Fulham met with the resident to formally apologise and discuss their experience.

In response to the findings made on this case, the Council undertook both a comprehensive root branch review of this case and a broader review of other pest control cases from 2024 to the date of the determination. This wider review did not identify evidence of any cases with similar failings or evidence of systemic failures across services. It did highlight areas where processes, coordination between services and managerial oversight could be strengthened.

The review identified that a number of improvements had already been implemented prior to the Ombudsman's determination as part of the Council's ongoing commitment to improving services for our residents.

Further targeted actions have since been introduced as a result of this review to strengthen processes and further reduce the risk of similar failings occurring in the future.

Following the comprehensive review, and since this determination, the Council has created a new Housing and Neighborhoods directorate to improve standards, enhance cross-team collaboration and communication and improve outcomes for residents.

This report summarises the findings from this review, the learning identified and the actions taken to improve the Council's service delivery.

2. Scope of Review

The review was led by senior officers across Housing, Public Protection and Complaints services and included;

• The Council's end-to-end management of pest reports and escalation processes

• Assessments of property habitability in cases of pest infestation, including communication with residents regarding requests for temporary relocation (decant).

• Review of other pest control cases received between 2024-25 up to the determination date, including actions taken.

3. Wider review

As part of this review the Council undertook a re-examination of other pest-related cases. This review considered the frequency and outcomes of pest control treatments, escalation and coordination between the Council's Public Protection and Housing directorates, resident requests for additional support and complaint handling quality and timeliness. Where any cases were identified to have had multiple pest control visits or there were identified vulnerabilities in the household, the Council's Housing teams made proactive contact with the residents to ensure that matters had been resolved.

This review did not identify any evidence of a systemic failure across services. Case management showed a high level of compliance in line with processes and satisfactory outcomes being achieved within reasonable timeframes.

The Council still identified improvements that could be made and these fed into the wider review and improvement actions identified.

4. Key Findings from the case

4.1 Pest Infestation Management

Though the resident's reports were responded to and multiple treatments were undertaken, ultimately these did not resolve the issue, and there was no formalised escalation process between pest control services and housing management. As a result, alternative treatment options were not fully explored. Communication with the resident was inconsistent and practical support and reasonable adjustments weren't adequately considered.

4.2 Habitable Conditions and Temporary Moves

The impact on the property's habitability was not fully assessed. Requests for temporary relocation were also not fully considered, and no formal risk assessment was carried out, meaning additional support measures were not proactively identified.

4.3 Complaint Handling

The Council's complaint responses did not fully address all of the issues raised, or fully reflect the impact on the resident, and the compensation offered was not proportionate to the service issues experienced. Delays occurred due to incorrect escalation timelines and agreed actions were not consistently monitored, indicating a need for greater oversight.

5. Service Improvements and Actions

5.1 Governance and Oversight

Lessons learnt from this case have been shared across services through all-staff forums and training sessions.

In addition, since the Council's consideration of this complaint, improvements have been made to strengthen oversight of complaints handling. The Council also has an established Complaints Learning Board to review trends and drive improvements.

5.2 Pest Control and Cross-Service Working

Prior to the Ombudsman's determination work had been undertaken to strengthen collaboration between services. This included the development of a centralised data dashboard to track pest control treatments and identify unresolved cases. A review of resident guidance relating to pest control was also in progress to ensure that this was clear and accessible and the use of specialist pest control contractors had been expanded where it was identified that alternative treatment methods were necessary.

Building on this the Council has established a specialist cross-departmental pest control taskforce to provide ongoing oversight on joint working arrangements and complex cases. A formal pest control policy has been developed in line with Ombudsman guidance, ensuring our approach is clear for staff and residents. In addition, escalation processes between services have been improved to enable more proactive engagement with vulnerable residents to support early intervention.

5.3 Complaint Handling

Prior to the Ombudsman's determination complaints handling processes had been strengthened through the introduction of strengthened triaging of complaints to support early identification of high-priority cases, mandatory

manager quality checks on responses and clearer accountability and improved monitoring for the completion of actions.

The Council has also introduced additional training aligned with the Housing Ombudsman Complaint Handling Code and periodic mandatory refresher sessions. A complaints learning framework is also in place to capture resident feedback and use it to improve service delivery.

6. Conclusion

This case highlighted significant service failings and the impact that this had on the resident. Though the wider review undertaken alongside this investigation provided assurance that these issues were not systemic, it did identify clear opportunities to strengthen service delivery, ensuring a more consistent, responsive, and resident-focused approach. The Council has taken these findings seriously and, as a result, implemented clear and measurable improvements across services.

The Council remains committed to learning from complaints and ensuring that residents receive a responsive, consistent and resident focussed service. This is supported by a wider improvement agenda, supported by a culture change and leadership framework aimed at reinstating values, behaviours and ways of working, to ensure services across housing become more dynamic, collaborative and outcome focused for residents.

Through improved coordination, stronger oversight, and a continued focus on resident experience, the Council is working to ensure services are responsive, empathetic, and effective, both in resolving issues at the earliest opportunity and in handling any complaints effectively if they arise.