Housing Ombudsman Service

Learning from: Severe Maladministration

Taking the key lessons from our severe maladministration decisions

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Introduction

Welcome to the Housing Ombudsman's first 'learning from severe maladministration' publication.

Due to the increasingly high number of complaints we are receiving, it means that we are also seeing a rise in severe maladministration.

As the number of these severe maladministration cases rise, we are concerned landlords could switch off to the severity of the detriment these issues cause residents and the significant amount of learning that each case has within it. We know that within most cases we see, there are multiple opportunities to make things right and to rebuild trust with the resident. But too often these opportunities are missed, or landlords feel the issue has gone on too long and therefore let it drift further. In this new publication, we want to prevent repeated failings in these areas and show where the key learning points are.

Because we know there are common and repeated reasons for severe maladministration. This could be because the landlord does not have an adequate framework in place for handling issues in the first place, or their practice deviates significantly from its policy and obligations. Or that escalations did not happen as they should; that multiple delays compounded the detriment; that there was poor internal or external communication exacerbated by poor records and information management. And, fundamentally, the individual circumstances of the household, especially where any physical or mental needs present, were not recognised and the complaints procedure did not recover the situation or provide reasonable redress.

This report aims to pinpoint these failings across the range of issues we handle, from anti-social behaviour to repairs, and the learning the landlord involved has undertaken since determination, in order to help landlords answer this question: what would we have done differently?

With the important role that social housing has to play in giving safe and secure housing to millions, the learning in these reports should help landlords provide effective services that protect this aspiration.

There are 2 sections to this report – the first being where we feel there is significant and key learning around a set theme, and then a second section rounding up some other cases, pulling out vital lessons from those. In some instances, where a landlord has multiple severe maladministration findings, we will publish these together. Where possible, we will present these reports thematically; either by issue (repairs, ASB), failing (complaint handling, records); obligations (Landlord and Tenant Act, hazards); or size, type or geography of the landlords involved.

We want to demonstrate within this document where we see consistent failings, whether that is on a particular theme such as communications or damp, or whether it is on a particular policy such as complaint handling or compensation. We hope you engage positively with this report and share the learning throughout your organisation. You'll see dotted throughout this, and future publications, there will be resources from our Centre for Learning. These are invaluable and will help you to provide an improved service for your residents.

I am often asked what makes a finding severe rather than maladministration, and while each case depends on the individual circumstances, the impact and extent of the failings, as well as the period of time, can be central to these cases. There is also invaluable learning for landlords across all our findings, and all our casework is available online.

In the coming months, alongside this report, we will also be doing more to highlight where landlords are being found as having 'no maladministration' in cases, so that the Ombudsman can share learning wherever it may appear.

Richard Blakeway

Housing Ombudsman

Key cases this month

This month we are highlighting 3 cases that speak to themes from our recent **Spotlight report on attitudes, respect and rights (PDF)**. Every month we highlight either different themes, regions or landlords to focus on and showcase the learning from this as part of our commitment to help deliver better services for residents. You can read the full investigation reports on our website.

Plus Dane Housing

In case **202204372**, the Ombudsman made a finding of severe maladministration and ordered £6,400 in compensation after **Plus Dane Housing** left a resident and his young children in damp and mould for 5 years due to failure in dealing with a leak.

The landlord was aware of the leaks prior to the resident moving in, who also raised it when he visited the property a year later, but it was not recorded. He reported that the walls were "wet to touch" just 2 days after moving in and that water was dripping onto the floor.

It took 33 months for the landlord to take real ownership of the issue and find out the landlord of the neighbouring property to resolve the issue, leaving the resident with a leak to the front bedroom and no plan of how to resolve it.

Various health professionals notified the landlord regarding serious concerns over exposure to mould and the health and safety of the resident's young children. There was significant concern given the respiratory condition of the resident's son in particular. Having seen the news about Awaab Ishak, the concern from the resident only heightened.

The resident believed he was being "treated differently" due to a lack of action and no temporary decant and raised a concern about discrimination. The landlord said the family's religious beliefs played a part in the delays; however, the Ombudsman believes this is not reasonable. The resident had been clear and reasonable in his requests around appointments and notice periods for them, and it was unreasonable

that the landlord commented that delays in completing remedial works were in some way linked to the resident's religious beliefs.

The Ombudsman made an order for an independent team to investigate any claims of discrimination and to report this back to the governing body.

Plus Dane Housing learning statement

We have made significant changes to our structures and processes over the last 18 months and since this determination in July 2023, to prevent the same or similar issues reoccurring including:

• Completed a complaints taskforce, making a fundamental change to our complaint handling model.

• Completed a damp and mould taskforce reviewing our approach to the management of instances of damp and mould in our homes.

• Restructuring operational teams to create better opportunities for collaboration across different teams so internal barriers do not impact customers.

• We are undertaking a significant review of our customer experience and repairs services.

• Following feedback from the customer, we commissioned an external EDI expert to help us understand if we can do anything differently in the future.

In our **Spotlight report on attitudes, rights and respect (PDF)**, we found investigating claims of discrimination when they are reported and explaining what has been found is an effective response. A reluctance to investigate these claims only adds to the feelings of discrimination. We recommend in the report that landlords should establish and enforce a clear process for how complaints about discrimination should be handled. Failure to do so can erode trust or faith in the landlord and therefore lead to a breakdown in relationship.

Northwest Leicestershire Council

Another key theme from the Spotlight report was staff conduct. That is what the Ombudsman found severe maladministration for in case **202222635** involving **Northwest Leicestershire Council**.

The Ombudsman ordered the landlord to instruct a senior member of staff to investigate and seek to address any potential workplace culture that could have led the repairs operative to believe that his behaviour was acceptable.

In this case the repairs operative was sending inappropriate messages to a resident living in a warden-controlled accommodation with a traumatic personal history, which she had disclosed to the landlord. The operative attempted to misuse the resident's personal information to establish a relationship. This was not only against safeguarding policies and employee code of conduct, but also not in keeping with protecting personal data.

After reporting the issue, the landlord set up a meeting with HR and, subsequently, the operative wrote a letter that the landlord felt was reasonable for the resident to accept and to move on.

However, on 2 occasions in the letter, the repairs operative described the inappropriate messages he had sent as "banter". He stated that he had "good professional relationships" with many residents, and he often used this sort of "friendly banter" with them. The letter referred to a "misunderstanding" and said the messages had "come across wrong". The wording in the letter suggested the problem did not lie with the repairs operative's behaviour but instead with the resident's perception of his behaviour.

In a following meeting, the landlord admitted it took a "firm and assertive" approach to ensure it had control of the meeting. This was inappropriate in these circumstances and left the resident so distressed she had to leave multiple times due to the upsetting nature. She also said she felt bullied into accepting the apology. Before one of the meetings, the repairs operative greeted her in the office which the landlord said he did out of "respect".

The landlord also said it did not appreciate how much of an impact this had on the resident due to her history. This was unreasonable, as they were fully aware. As soon as the resident reported the issue, the landlord should have ensured no further contact could be allowed to happen until the resident was fully satisfied with the outcome, especially as there were known vulnerabilities and history of personal trauma. If the landlord had taken this robust approach on first reporting, it would have saved its resident significant distress.

Northwest Leicestershire Council learning statement

We are incredibly sorry for the distress that has been caused to one of our tenants – both in the way our staff member behaved and for our failures in the way we handled the complaint.

We have learned from this incident and have set in motion a significant programme of customer focus within our housing service, making sure all our staff are absolutely clear about the standards that we and our tenants require of them and challenging times when this falls short of expectations.

We are committed to making sure nothing like this happens again, with staff training and embedding an ethos of putting the customer first.

One of the key recommendations from our **Spotlight report (PDF)** was for landlords to accept complaints about staff conduct.

Trident Housing

In the third case in this group, case **202013105** involved severe maladministration for how **Trident Housing** responded to an anti-social behaviour complaint in which a resident was physically assaulted and their home vandalised, and how it handled that complaint.

After the resident reported the assault, the landlord spoke to the resident the next day but failed to carry out any form of risk assessment, action plan or vulnerability assessment. The police had made an arrest due to the assault.

A few days later, the resident reported that someone came to the house and smashed the windows. The matter was recorded as criminal damage by the police but once again in the interaction with the landlord there was no evidence of any action plan, risk assessment or vulnerability assessment.

There was also no evidence the landlord considered the impact it would have on the children in the household, or its safeguarding responsibilities.

The landlord said it worked with the police to get a priority move for the resident, but records show it was the resident who had to put the effort in to get this. There was also no evidence of any meetings with the perpetrator and when presented with Anti-Social Behaviour (ASB) footage on the resident's phone, the landlord did not seem to take any steps to record it as evidence.

A lack of communication throughout the complaint's handling left the resident feeling anxious, unsupported, and undermined his confidence in the landlord to the extent that he told the landlord that he would be contacting a solicitor to seek advice.

Eventually, the Ombudsman had to issue a Complaint Handling Failure Order to force the landlord to respond to the complaint appropriately.

Our Spotlight report on attitudes, rights and respect outlines very clearly what landlords should be expected to do around sensitive cases and with residents' that may be considered as vulnerable. At the heart of the report is taking a "human centric" approach to provision and that should have been the case here, as well as following the correct policy and procedure.

Trident Housing learning statement

We are sorry for our customer's experience. Our CEO apologised personally to them. There has been significant learning based on their experience, including:

• Creating a new Community Safety Team.

• Improving Complaints and ASB handling including dedicated modules on our housing system.

• A more robust approach to case management and risk assessment.

• Implementing a weekly complaints meeting.

• Investing in training.

We accept the findings and are determined to learn from the mistakes made. Our customers rely on us to support them when they need us the most, and we need to make sure we get things right.

Key lessons from these cases

Throughout these cases, there were missed opportunities for landlords. Actions could have been taken at the start of the process. Cases could have been prioritised with due regard to the impact of the situation on the resident. Coordination with third parties could have been more effective. Complaints about staff conduct could have been handled with the gravity that such allegations merit. Communication throughout all of these cases was poor; so poor that for one resident, it led them to believe that he was being discriminated against.

Centre for Learning resources

Damp and mould e-learning and workshops (log in required)

Damp and mould key topic page (containing reports, podcasts, guidance)

Attitudes, respect and rights e-learning and workshops (log in required)

Attitudes, respect and rights key topics page (containing reports, podcast, guidance)

Complaint Handling Code

Complaint Handling Failure Order reports

Other cases highlighted this month

In this section we include a summary review of severe maladministration cases we've determined recently and include one or two key aspects to each case, with the key learning that has come from it. In future editions, these cases may also speak to the main theme above, or round up significant learning from a particular landlord or issue.

Peabody

In case **202117288**, the Ombudsman ordered **Peabody** to undertake a wider asbestos review into a sample of homes to ensure that issues uncovered in this case did not impact other residents.

The landlord failed to ensure the asbestos was managed properly, failed to engage appropriately with the resident's concerns and mismanaged the situation. It also failed to offer appropriate compensation, with the Ombudsman awarding the resident £10,650.

The independent review the landlord commissioned into the management of asbestos confirmed there were no areas of high risk, significant failures, or breach of legislation.

In its learning from this case, the landlord says it has developed an action plan around the specifics of the issue, as well as making improvements to its complaint handling including forming a specialist, centralised complaints handling team and introducing a new centralised system for improved record keeping.

Key learning for the sector

Where asbestos is present, a timely inspection needs to take place. Where there is a need to remove it, the resident should be informed of the options and whether there is a need for a move. A management plan should be made, as well as regular reviews taking place. Strong record keeping is needed in these cases, to ensure the landlord can be confident it is meeting all relevant legislation and regulation.

Landlords have multiple obligations under health and safety regulation and legislation to keep their homes safe for residents.

Centre for Learning resources

Spotlight report on knowledge and information management

Asbestos guidance from Health and Safety Executive

Two Rivers Housing

In this case **202017334**, the Ombudsman found severe maladministration for how **Two Rivers Housing** handled its record keeping throughout an Anti-Social Behaviour (ASB) case. The original investigation could not find any evidence of ASB logs and it was only at review stage that the landlord was able to provide them, which shows a lack of strong record keeping.

This delay in evidence added further distress to the resident and delayed redress.

In its learning from this case, the landlord said it accepts that its delays in providing this information impacted the resident.

In terms of its ASB, the landlord has also delivered additional training to all frontline staff, reviewed how ASB cases are recorded, introduced a triage system for incident reporting and strengthening the link between the manager overseeing ASB and the safeguarding lead.

Key learning for the sector

As set out in the Ombudsman's Spotlight report on knowledge and information management, landlords should be keeping effective records to ensure it can confidently call upon evidence to inform its decisions.

Centre for Learning resources

Spotlight report on knowledge and information management

Knowledge and information management key topic page (containing podcasts, guidance and case studies)

Knowledge and information management e-learning and workshops (log in required)

Metropolitan Thames Valley

The Ombudsman found severe maladministration for how **Metropolitan Thames Valley 202208487** failed to replace a back door for 2 years.

The landlord told the residents that it would have to wait until the planned works cycle, which was incorrect. It also did not respond to requests for a side gate to be fitted. The residents therefore fitted a security gate and alarm system themselves. The landlord acted appropriately by reimbursing the residents for this gate, but by the time of the determination, the landlord still had not replaced the back door, requiring the Ombudsman to order its replacement.

In its learning from this case, the landlord said it has reviewed its processes so that when an incident occurs like this, it can override a major works plan to be fixed before that planned works is being undertaken. The landlord has also enrolled its staff on complaint handling training including how to take, log or escalate a complaint.

Key learning for the sector

The landlord had multiple opportunities over the 2 years to replace the back door but failed to do so. The longer the complaint went on, the more the landlord and resident relationship would have broken down. Landlords also need to be clear about their repair obligations and respond in an appropriate timeframe when future works are planned. Landlords also need to be clear about their repair obligations and respond in an appropriate timeframe when future works are planned. Clear communications about timeframes would have been an effective way to deal with this complaint, on top of a timely replacement to reduce the security fears the residents had.

Centre for Learning resources

Spotlight report on attitudes, respect and rights

Attitudes, respect and rights e-learning and workshops (log in required)

Attitudes, respect and rights key topics page (containing reports, podcast, guidance)

For Housing

In case **202202552**, **For Housing** left a resident in long term detriment after failing to deal with damp and mould, as well as pests, for a significant period of time. The age and vulnerability of the resident should have seen the works completed with more urgency.

After an initial survey on the damp and mould, works were identified but those did not adequately deal with the pest infestation problem. It took nearly 2 years after the first report of this issue for the final repair to be carried out.

This is despite the residents being decanted for a period of time.

In its learning from this case, the landlord said it has made changes to improve the customer focus of its repairs contracts and introduced processes for identifying and dealing with damp and mould cases. The landlord says it has also invested more resources to support pest control and is working with the local authority on this.

Key learning for the sector

The landlord should have identified early on that the residents were vulnerable and tailored their response to those vulnerabilities. It should have also taken ownership of the pest infestation issues which it took too long to do. The last 2 cases involved timescales that far exceed those proposed in the consultation on Awaab's Law or indeed the landlord's own policy. Landlords therefore need to use complaints to understand where repairs are not being delivered in line with their policy, including emergencies, and what steps are required for it to meet any future obligations.

Centre for Learning resources

Spotlight report on attitudes, respect and rights

Attitudes, respect and rights e-learning and workshops (log in required)

Attitudes, respect and rights key topics page (containing reports, podcast, guidance)

Pest infestation key topics page

Spotlight report on knowledge and information management

Knowledge and information management key topic page (containing podcasts,

guidance and case studies)

Knowledge and information management e-learning and workshops (log in required)

Damp and mould e-learning and workshops (log in required)

Damp and mould key topic page (containing reports, podcasts, guidance)

Hastoe Housing

The Ombudsman found severe maladministration in case **202113581** involving **Hastoe Housing.** The landlord unreasonably refused a management move due to lack of medical evidence, despite the previous overwhelming evidence.

The landlord had previously provided written commitments of the move and did not manage expectations in this regard. The landlord did not organise an Occupational Therapist (OT) until it was too late, and others had already taken the priority homes, not giving the resident a fair chance of a move. The resident ended up paying for his own private OT assessment.

The resident's doctor and immediate family wrote to the landlord, explaining that the resident was at risk of taking their own life, partially because of the current living situation. This lack of move also meant 4 children of different sexes were sharing the same bedroom. There is no evidence to suggest the landlord ever investigated these concerns.

In its learning from this case, the landlord says it has since made good on its promise to move the resident and has learned from this experience and made improvements, updated policies and procedures and paid compensation to the resident.

Key learning for the sector

The landlord should have investigated the issues raised by the resident and its healthcare professionals as soon as they were aware of any concerns. The landlords handling of third-party evidence was inconsistent and unreasonable, and this also contributed to expectations being less effectively managed.

Whilst we recognise that moves are hard to facilitate, landlords must communicate effectively about options and expectations.

Centre for Learning resources

Spotlight report on attitudes, respect and rights

Attitudes, respect and rights e-learning and workshops (log in required)

Attitudes, respect and rights key topics page (containing reports, podcast, guidance)

All landlord staff are able to register with our Centre for Learning. To register, please **visit our Learning Hub**.

Housing
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