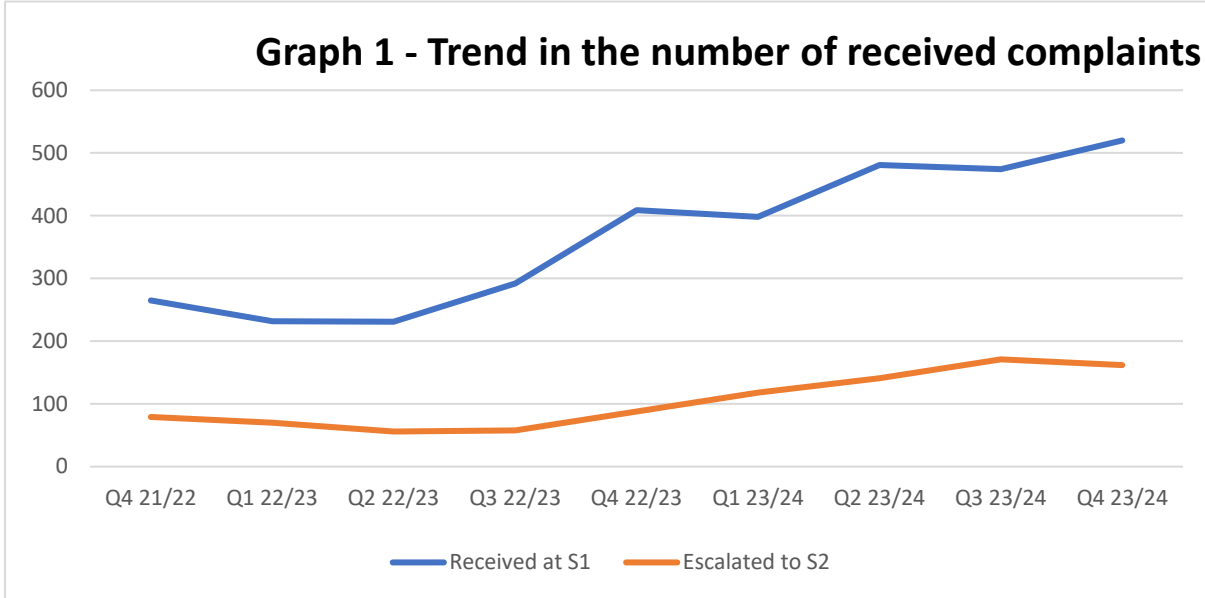


**SNH SNG Complaints report for Quarter 4 (01 January 2024 - 31 March 2024)**

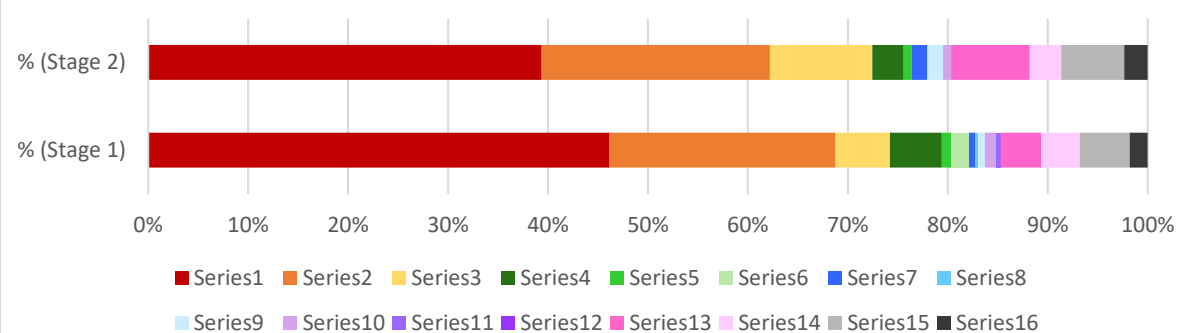


Quarter	Received at S1	Escalated to S2	Proportion of escalated complaints	Target
Q4 21/22	265	79	29.8%	10%
Q1 22/23	232	70	30.2%	10%
Q2 22/23	231	56	24.2%	10%
Q3 22/23	292	58	19.9%	10%
Q4 22/23	409	88	21.5%	10%
Q1 23/24	398	118	29.6%	10%
Q2 23/24	481	141	29.3%	25%
Q3 23/24	474	171	36.1%	25%
Q4 23/24	520	162	31.2%	25%

Graph 1 and the accompanying table shows Stage 1 and 2 complaints received covering the period 01 January 2024 - 31 March 2024. Comparison with the previous quarter a year ago Q4 22/23 shows an increase of 111 Stage 1 complaints (26% increase) and an increase of 74 Stage 2 complaints (85% increase).

It also shows an increase of 46 Stage 1 and decrease of 9 Stage 2 complaints when compared to the last quarter (Q3 2023/24), the stage 2 has dropped minimally from the last quarter but still overall a considerable increase on previous year. The stage 1 has increased again quarter on quarter and is expected to continue given the current climate within complaints.

**Graph 2 - Total Received Broke Down by Dept**



**By quarter**

	Total Received by Dept	Stage 1	Stage 2	% (Stage 1)	% (Stage 2)
<b>1</b>	Responsive Repairs	204	50	39.2%	30.9%
<b>2</b>	Planned Works, M & E	100	29	19.2%	17.9%
<b>3</b>	Leasehold Services	24	13	4.6%	8.0%
<b>4</b>	Neighbourhood - London	23	4	4.4%	2.5%
<b>5</b>	Neighbourhood - Hertford	4	1	0.8%	0.6%
<b>6</b>	Voids & Lettings - London	8	0	1.5%	0.0%
<b>7</b>	Voids & Lettings - Hertford	3	2	0.6%	1.2%
<b>8</b>	Income - Hertford	1	0	0.2%	0.0%
<b>9</b>	Income - London	3	2	0.6%	1.2%
<b>10</b>	Intermediate Rent	5	1	1.0%	0.6%
<b>11</b>	Older Persons	2	0	0.4%	0.0%
<b>12</b>	Supported Housing	0	0	0.0%	0.0%
<b>13</b>	SW9	18	10	3.5%	6.2%
<b>14</b>	Central Complaints	17	4	3.3%	2.5%
<b>15</b>	Development	22	8	4.2%	4.9%
<b>16</b>	Contact Centre	31	13	6.0%	8.0%
<b>17</b>	Estates Services	8	3	1.5%	1.9%
<b>18</b>	Miscellaneous	5	1	1.0%	0.6%
<b>19</b>	Damp and Mould	42	21	8.1%	13.0%
	<b>Total</b>	<b>520</b>	<b>162</b>		

A departmental breakdown of complaints received in the quarter is set out in graph 2 together with the accompanying table. Because of the nature of the work, they are involved in Asset Management accounts for 58.4% of the total complaints received at Stage 1. Asset Management is made up of Responsive repairs (39.2%) and Planned Works, M&E (19.2%) as shown in table above.

Responsive Repairs had 204 at Stage 1, 12 more than Q3 (2023/24), followed by 100 Stage 1 from Planned Works and M&E, which is an increase of 10 from Q3 (2023/24).

In this quarter there were 10,867 repairs raised for all responsive repair contractors. This is an increase 1,028 of repairs raised compared to the last quarter (9,838).

The repairs workforce is MCP our primary repairs contractor, plus our small new framework contractors, Close Brothers and R Benson (Roof repairs only).

There were 233 stage 1 complaints in the quarter for these responsive repair contractors 58 more than last quarter, approximately 2.1% of repairs lead to a complaint being logged. Below are tables which provide a full breakdown of the jobs raised for each contractor.

**Stage 1**

COMPLAINTS VS JOBS RAISED	<u>MCP</u>		
	Complaints	Jobs raised	%
<b>January</b>	66	3462	1.91%
<b>February</b>	53	3322	1.60%
<b>March</b>	66	2949	2.24%

COMPLAINTS VS JOBS RAISED	<u>R Benson</u>		
	Complaints	Jobs raised	%
<b>January</b>	9	202	4.46%
<b>February</b>	7	120	5.83%
<b>March</b>	2	291	0.69%

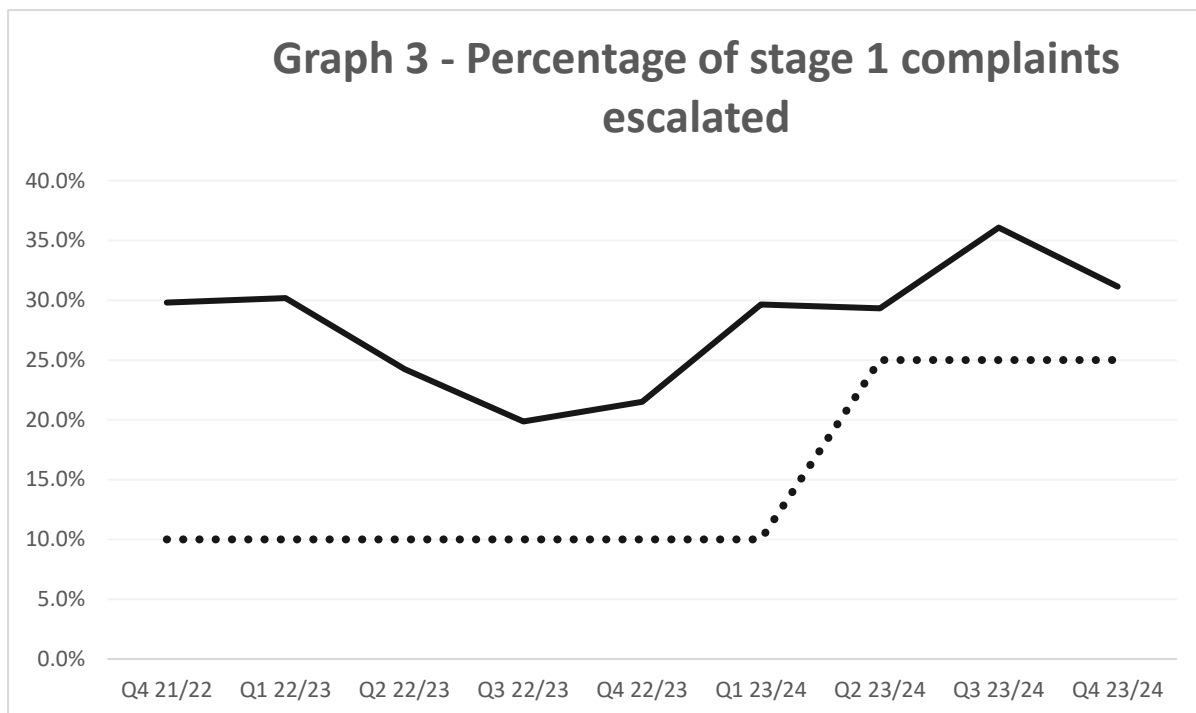
COMPLAINTS VS JOBS RAISED	<u>Close Brothers</u>		
	Complaints	Jobs raised	%
<b>January</b>	4	52	7.7%
<b>February</b>	3	71	4.2%
<b>March</b>	2	191	1.0%

COMPLAINTS VS JOBS RAISED	<u>Top Coat (TCL)</u>		
	Complaints	Jobs raised	%
January	1	60	1.7%
February	0	41	0.0%
March	0	62	0.0%

COMPLAINTS VS JOBS RAISED	<u>Other Contractors</u>		
	Complaints	Jobs raised	%
January	0	37	0.0%
February	0	5	0.0%
March	0	2	0.0%

COMPLAINTS VS JOBS RAISED	<u>Combined</u>		
	Complaints	Jobs raised	%
January	80	3813	2.10%
February	63	3559	1.77%
March	70	3495	2.00%
Quarter 4 total	233	10,867	2.1%

**Complaints that escalated from Stage 1 to Stage 2**



A total number of 530 Stage 1 complaints were received in Q4 2023/24, 56 more than Q3 2023/24 (474). There were 162 Stage 2 complaints logged, which was 9 less than Q3 2023/24 (171), although it has decreased it is still a high number.

**Performance - complaints responded to on time**

Performance decreased by 4% to 86% for Stage 1 Q4 2023/24. Meaning we are still failing to meet the target of 95% which can still be attributed to a high level of stage 1 complaints being received and resolved in the quarter, in a more challenging environment with a drive to improve quality opposed to issuing a response on time, no matter the cost.

SNG Stage 2 performance decreased by 7% to 88% which is our lowest since Q4 2021/22. This can be accredited to the increase in volumes of stage 2 received, as well as sickness and having to backfill positions, meaning for a period of six weeks the team’s capacity was reduced considerably.

Overall, SNG Complaints 547 out of 640 combined Stage 1 and Stage 2 complaints (85%) were issued on time, meaning the overall target of 95% was not achieved.

Overall, 29 out of 30 SW9 combined stage 1 and 2 complaints (97%) were issued on time.

Responsive repairs resolved 200 out of their 209 complaints on time showing 96%, which was an decrease of 2% on last quarter (Q3 2023/24) but still a very commendable effort. This is compared to Planned Works, Compliance and M & E who resolved 67 out of 90 of complaints on time with 74%. which is a 9% decrease on the last quarter (Q3 2023/24). During this time Planned Works, Compliance and M&E also had long term sickness and the need to backfill a complaints officer position which has contributed to this decline.

## Stage 1 and 2 Formal Decisions

### Stage 1

Month	Upheld	Not Upheld	Partially Upheld
January	87	48	17
February	104	65	29
March	81	49	34
<b>Totals</b>	<b><u>272</u></b>	<b><u>162</u></b>	<b><u>80</u></b>

Out of the 514 Stage 1 complaints above in Q4 we determined the outcomes as above. We upheld 68% of our Stage 1 complaints (including upheld and partially upheld).

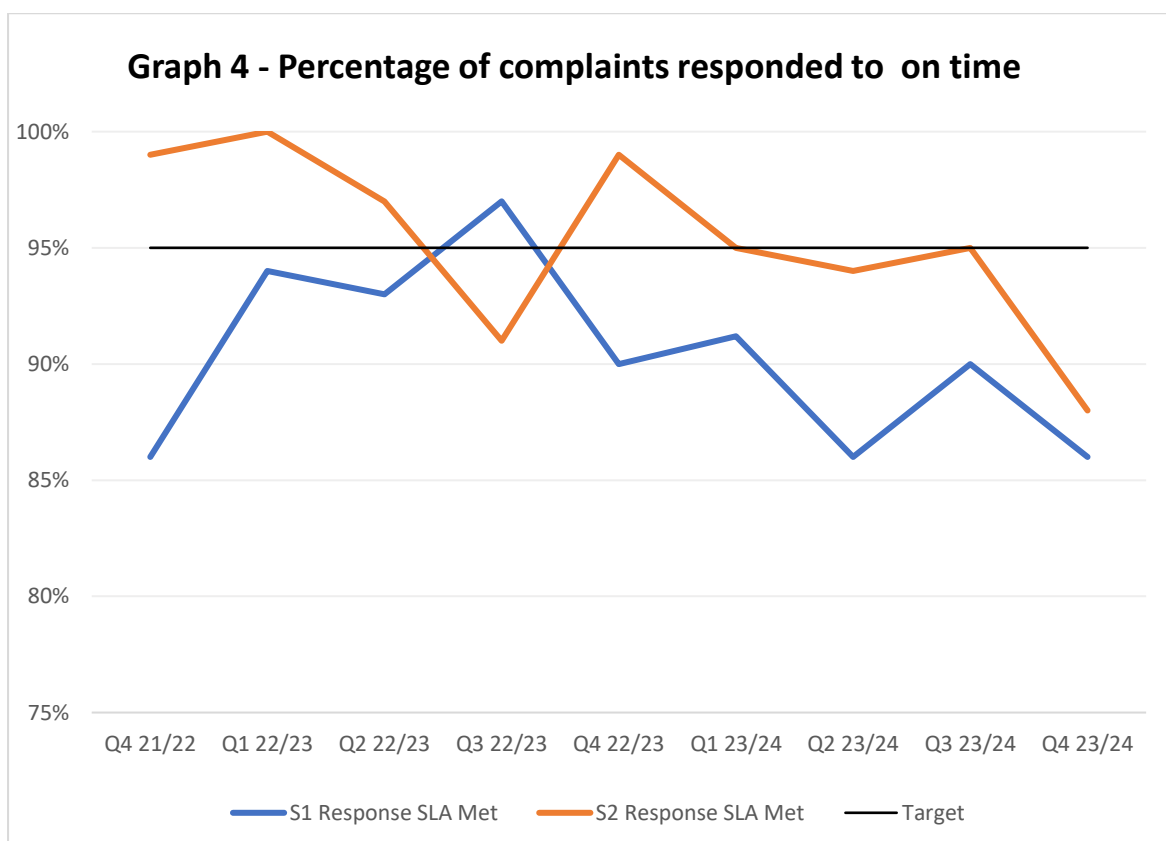
### Stage 2

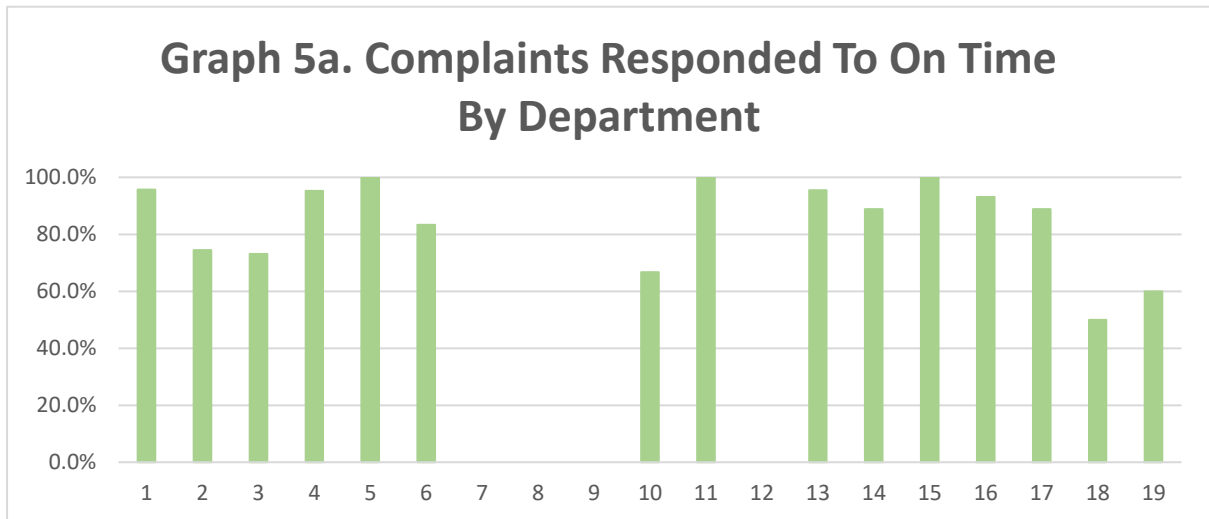
Month	Upheld	Not Upheld	Partially Upheld
January	28	11	12
February	21	7	10
March	33	16	12
<b>Totals</b>	<b><u>82</u></b>	<b><u>34</u></b>	<b><u>34</u></b>

Out of the 150 stage 2 complaints closed in Q4 we determined the outcomes as above. We upheld 77% of our Stage 2 complaints (including upheld and partially upheld).

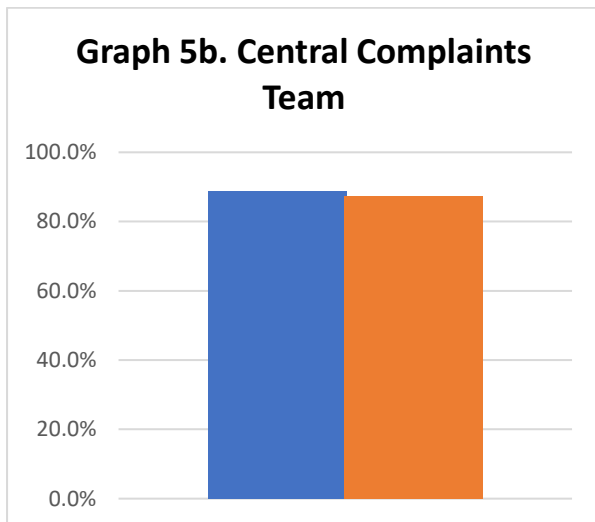
Quarter	S1 Response SLA Met	S2 Response SLA Met	Target
Q4 21/22	86%	99%	95.00%
Q1 22/23	94%	100%	95.00%
Q2 22/23	93%	97%	95.00%
Q3 22/23	97%	91%	95.00%
Q4 22/23	90%	99%	95.00%
Q1 23/24	91%	95%	95.00%
Q2 23/24	86%	94%	95.00%
Q3 23/24	90%	95%	95.00%
Q4 23/24	86%	88%	95.00%

Total Resolved by Dept	No. on Time	Closed	% On Time	No. on Time	Closed	% On Time
Responsive Repairs	200	209	95.7%	0	0	N/A
Planned Works, M & E	67	90	74.4%	0	0	N/A
Leasehold Services	19	26	73.1%	0	0	N/A
Neighbourhood - London	20	21	95.2%	0	0	N/A
Neighbourhood - Hertford	2	2	100.0%	0	0	N/A
Voids & Lettings - London	5	6	83.3%	0	0	N/A
Voids & Lettings - Hertford	3	3	N/A	0	0	N/A
Income - Hertford	0	0	N/A	0	0	N/A
Income - London	2	3	N/A	0	0	N/A
Intermediate Rent	2	3	66.7%	0	0	N/A
Older Persons	2	2	100.0%	0	0	N/A
Supported Housing	0	0	N/A	0	0	N/A
SW9	21	22	95.5%	8	8	100.0%
Central Complaints	16	18	88.9%	124	142	87.3%
Development	20	20	100.0%	0	0	N/A
Contact Centre	27	29	93.1%	0	0	N/A
Estates Services	8	9	88.9%	0	0	N/A
Miscellaneous	3	6	50.0%	0	0	N/A
Damp and Mould	27	45	60.0%	0	0	N/A
<b>Total</b>	<b>444</b>	<b>514</b>	<b>86.4%</b>	<b>132</b>	<b>150</b>	<b>88.0%</b>





Please note that SW9 complete their own Stage 2 complaint responses and all SNG (formerly Network Homes) are completed by the Central Complaints Team.



**Compensation.**

**Stage 1**

Compensation can be awarded where, following an investigation, it is identified that our actions or lack of action had a significantly adverse effect on the resident. At Stage 1 £70,747 shown in graph 6 (below) with a comparison to previous quarters. This is an increase of £19,218 on the last quarter (Q3 2023/24). This continued increase is due to the increase of stage 1 complaints received and resolved, and the Ombudsman highlighting compensation shortfalls within their determinations, we would prefer to get it right and not have to award compensation, but where there is a failure, we are ensuring the compensation policy is applied fairly and reasonably and in line with Ombudsman expectations.

Once again delay was the highest payment with £25,023.50 compensation paid out. Distress was £21,973.50. This is shown in graph 7 along with the rest of the breakdown of categories in the table overleaf.



## Stage 2

We are now reporting on Stage 2 compensation, whilst in the whole this can be seen as addition to all Stage 1 compensation awarded, in some respects it will be new compensation (as none was awarded at Stage 1). Currently we have no way of cross referencing this but gives a good indication of where we are. As the quarters go on there will be more comparable data at Stage 2 same as with Stage 1.

Compensation was awarded at Stage 2 at a total cost of £54,678 £58,639 this was a decrease of £3,961 on Q3 2023/24 shown in graph 7 along with the table. Stage 2 follow suit as per Stage 1 with Delay and Distress taking up most of the total amount.

Stage 2 has reduced due less Stage 2 complaints compared to Q3 2023/24 and aligning with commentary above, Complaints Officers investigators at stage 1 awarding more compensation, bridging any difference between the two Stages of investigation/compensation review.

The statement in the last quarterly report: *"Compensation is something that is currently under scrutiny, with the Ombudsman awarding more compensation than ever. We are waiting on an update from the Ombudsman in respect of their own spotlight on Compensation, so we can review and update our Compensation Policy Document to align with their rationale on awarding compensation.*

*It does feel however, that although overall the level of compensation is continuing to increase quarter on quarter, year on year we are still falling short of the Ombudsman's expectations".*

This message continues/remains unchanged.

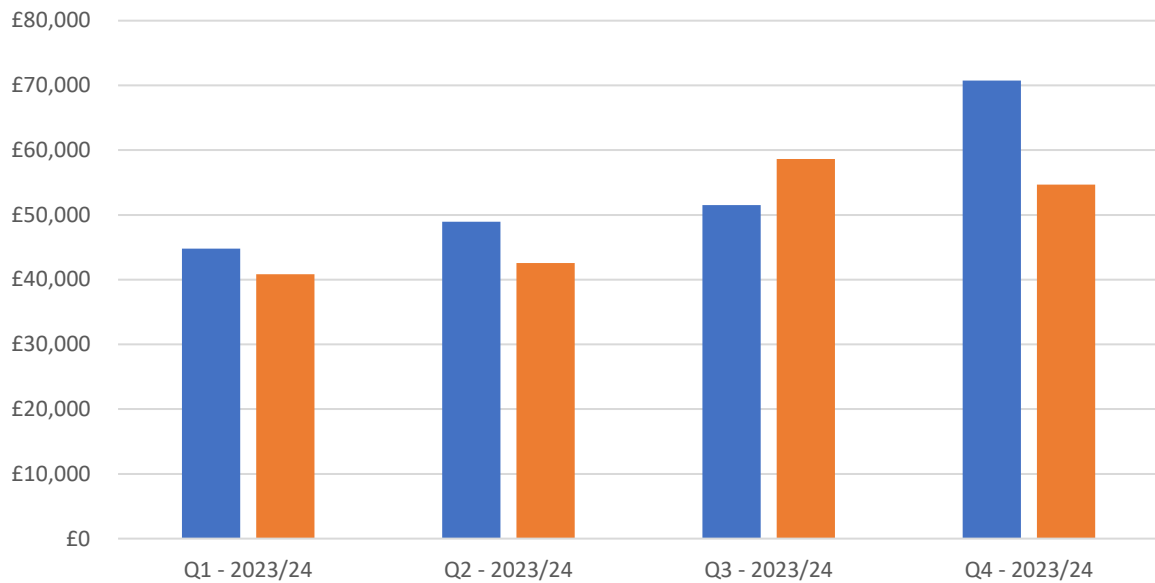
### **Regaining costs from contractors**

Each month our repairs team track the amount awarded in complaints and request this money back from our contractors. In this quarter (01 January 2024 to 31 March 2024 ) we are claiming back £56,977.17 worth of compensation so far. Full breakdown below.

This figure accounts for both complaints **and** non-complaints related compensation recharged to a contractor.

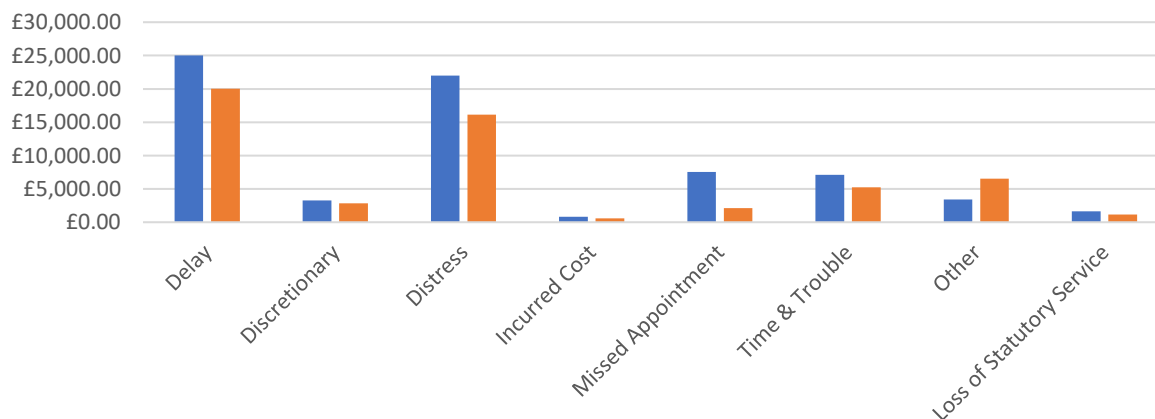
<b><u>MCP</u></b>	<b><u>Alternative contractors</u></b>
January 2024 - £17,350	January 2024 - £891
February 2024 - £15,665.50	February 2024 - £4,715
March 2024 – £15,723.67	March 2024 – £2,632
<b>Total for Q4 – £48,739.17</b>	<b>Total for Q4 – £8,238</b>

### Graph 6 - Quarterly Compensation Comparison (Stage 1 & Stage 2)



	Stage 1	Stage 2
<b>Q1 - 2023/24</b>	£44,804	£40,840
<b>Q2 - 2023/24</b>	£48,964	£42,555
<b>Q3 - 2023/24</b>	£51,529	£58,639
<b>Q4 - 2023/24</b>	£70,747	£54,678

### Graph 7 - Quarterly Compensation Comparison (Stage 1 & Stage 2) by Type



	<i>January</i>	<i>February</i>	<i>March</i>	<b>Total</b>
<b>Award</b>	<b>Stage 1</b>			
Delay	£6,661.00	£8,325.00	£10,037.50	£25,023.50
Discretionary	£290.00	£160.00	£2,801.10	£3,251.10
Distress	£5,250.00	£7,500.00	£9,223.50	£21,973.50
Incurred Cost	£585.00	£0.00	£240.23	£825.23
Missed Appointment	£1,990.00	£2,970.00	£2,580.00	£7,540.00
Time & Trouble	£1,784.00	£2,585.00	£2,716.50	£7,085.50
Other	£2,445.00	£280.00	£710.00	£3,435.00
Loss of Statutory Service	£860.00	£680.00	£73.00	£1,613.00
<b>Total</b>	<b>£19,865.00</b>	<b>£22,500.00</b>	<b>£28,381.83</b>	<b>£70,746.83</b>

	<i>January</i>	<i>February</i>	<i>March</i>	<b>Total</b>
<b>Award</b>	<b>Stage 2</b>			
Delay	£8,027.00	£4,345.00	£7,659.00	£20,031.00
Discretionary	£832.00	£805.00	£1,217.00	£2,854.00
Distress	£5,410.00	£4,405.00	£6,320.00	£16,135.00
Incurred Cost	£103.10	£221.00	£271.98	£596.08
Missed Appointment	£1,080.00	£570.00	£480.00	£2,130.00
Time & Trouble	£1,672.00	£1,934.00	£1,649.00	£5,255.00
Other	£1,554.00	£2,924.00	£2,065.00	£6,543.00
Loss of Statutory Service	£140.00	£654.00	£340.00	£1,134.00
<b>Total</b>	<b>£18,818.10</b>	<b>£15,858.00</b>	<b>£20,001.98</b>	<b>£54,678.08</b>

<b>Award</b>	<b>Total S1 and S2</b>
Delay	£45,054.50
Discretionary	£6,105.10
Distress	£38,108.50
Incurred Cost	£1,421.31
Missed Appointment	£9,670.00
Time & Trouble	£12,340.50
Other	£9,978.00
Loss of Statutory Service	£2,747.00
<b>Total</b>	<b><u>£125,424.91</u></b>

In closing on compensation and looking forward we still looking at completing adhoc/retrospective reviews on compensation payments over £500. This will help ensure learning and consistency on how and when compensation should be awarded. This is dependent on resource being available and not yet something we have been able to consider beyond identifying proactive measures to monitor compensation which has increased considerably in recent years.

### **MP and Cllr Enquiries**

73 MP and Councillor enquiries were received in this quarter (Q4 2023/24), 10 more than as in Q3 2023/24. 59 out of 80 (due for response within the quarter) were closed on time which is 74% which was an increase of 18%.

This percentage figure on time has increased but is still needs to improve to align with our target of 95%. This was due to staff sickness and backfilling positions within the central complaints team.

(Table overleaf).

<b>Total Received Broke Down by Dept</b>	<b>Enquiries Received</b>	<b>% (Enquiries)</b>	<b>No. on Time</b>	<b>No. Closed</b>	<b>% On Time</b>
Central Complaints Team	6	8.2%	5	6	83.3%
Development - Aftercare	0	0.0%	0	0	N/A
Energy Project	0	0.0%	0	0	N/A
Estates Services	0	0.0%	0	1	0.0%
Fire Safety	0	0.0%	0	0	N/A
Income - London	2	2.7%	0	1	0.0%
Income - Hertford	0	0.0%	0	0	N/A
Leasehold Services	7	9.6%	4	5	80.0%
Neighbourhood - Hertford	2	2.7%	3	3	100.0%
Neighbourhood - London	16	21.9%	12	15	80.0%
Older Persons	0	0.0%	0	0	N/A
Planned Works, M & E	9	12.3%	6	10	60.0%
Mental Health	0	0.0%	0	0	N/A
Responsive Repairs	16	21.9%	17	22	77.3%
Voids & Lettings & Handy Person - Hertford	1	1.4%	1	1	100.0%
SW9	0	0.0%	0	0	N/A
Building Safety	0	0.0%	0	0	N/A
Contact Centre Management	1	1.4%	1	1	100.0%
Intermediate Rent	1	1.4%	1	1	100.0%
Legal Services/Disrepair	5	6.8%	3	5	60.0%
Development - Construction	1	1.4%	1	1	100.0%
Dampness Project Team	6	8.2%	5	8	62.5%
<b>Total</b>	<b>73</b>	<b>45.2%</b>	<b>59</b>	<b>80</b>	<b>73.8%</b>

<b>Received</b>	73
<b>Closed</b>	80
<b>On Time</b>	59
<b>Percentage on time</b>	74.0%
<b>Open on 23/04/2024</b>	14

### **Housing Ombudsman activity and Decisions**

23 formal investigation requests and 19 formal determinations were received in Q4 2023/2024.

Out of the 19 determinations received in the quarter some had multiple determinations, there were 45 decisions in total. These were made up of:

- 13 service failure
- 7 maladministration
- 4 Reasonable Redress
- 11 No maladministration
- 1 Severe maladministration
- 9 Outside of Jurisdiction

Below is a breakdown of the 19 determinations.

#### **Ombudsman Determination 1 - Reasonable Redress and Out of Jurisdiction**

The complaint was about our provision of information relating to parking and snags and defects.

##### **Outside of jurisdiction for parking**

The residents complaint is that they believe they were misinformed by us, regarding the parking arrangements prior to signing their lease. The property sales process is a legal one. There are rules and regulations about the information provided to prospective buyers, and solicitors play an important role in advising and guiding their clients in the process.

Allegations of impropriety, such as the ones made by the resident, are serious matters, and ones which, ultimately, can only be resolved by the courts. The courts can cross examine and call expert witnesses and can make legally binding judgements on the parties involved in the sale. The Ombudsman does not have the authority or remit to make such judgments. Because of that, in line with paragraph 42(f) this matter is better suited for the courts and is not one the Ombudsman will investigate.

##### **Reasonable redress for Snags and defects**

The Ombudsman states we appropriately acknowledged that we should have done more when the resident first reported issues in February 2022 and that there was a small delay in responding to their emails. We also took steps to put things right for the resident and furthermore said that as a result of their complaint, it would carry out a review of the current process which shows that it was actively looking to learn from the outcome.

These were appropriate steps for us to take and the Ombudsman has made an order for us to share a copy of its review as it would not be reasonable for it to take the position that residents could not report snagging issues once they had moved into the property. The Ombudsman would expect to see a clear policy, procedure and/or guidance which details how long a resident has to report any snagging issues, which are not classed as a defect, and what steps we will take to address them.

In determining whether £50 compensation was a fair and reasonable offer of compensation, they consulted their own remedies guidance which states that where there has been service failure, which may include distress and inconvenience, time and trouble, and delays in getting matters resolved, payments of between £50 and £100 are recommended. Therefore, they were satisfied that there has been reasonable redress.

### **Ombudsman decision 2 - Reasonable Redress**

The complaint is about our handling of the resident's reports of vermin in their property.

The Ombudsman said the total time to complete the work was approximately 37 weeks since the first report on 1 July 2022. This was a long timeframe by any reasonable measure. Some of it was not in our control (including the lack of access in August 2022), but there is no clear explanation for the rest of the time taken.

Pests, including rodents, are classed as a hazard under the Housing Health and Safety Rating System and the resident's concerns about the ongoing problem were wholly understandable. Given their nature, there should have been a sense of urgency by us in resolving the rodent problem, and no evidence of such urgency has been seen in their investigation.

We acknowledged providing a poor service in both our complaint responses. But failed to act promptly in completing these repairs even the after the first complaint response. We offered a total of £565 compensation. They state this was reasonable and in line with their own complaints policy.

### **Ombudsman decision 3 - Reasonable Redress and Service Failure**

The complaint was about our response to maintenance responsibilities for the hedge at the front of the property.

And the Ombudsman also considered our complaint handling.

#### **Reasonable redress hedge maintenance responsibilities**

The resident had said to the Ombudsman that we should have considered replacement of the hedge so there was little to no maintenance. As explained by HOS, they did not need to apply for permission to trim the hedge as this was considered routine. However as stated in the tenancy agreement, if they wanted to make alterations, they would have required permission. There is no evidence the resident proposed alterations to the hedge area, therefore they cannot state we failed to consider this.

The Resident wanted to discuss maintenance responsibilities on 21 October 2022 after we advised them it was their responsibility. As they had not received a response (to discuss this matter further), they submitted a formal complaint on 26 October 2022. This was not responded to until our stage 1 complaint response of 29 November 2022. This would no doubt have been frustrating for the resident as they had no acknowledgment from it until 3 November 2022 where we requested, they

send pictures. However, it was positive to see that we had recognised this failing and awarded a total of £50.

This demonstrated our willingness to put things right and identified learnings which included the delay and the time and trouble. This was in line with HOS' compensation policy, factoring the impact on the resident.

Overall, it was clear from the evidence provided that we acted in line with our relevant policies and procedures and explained our reasoning and decision making to the resident.

### **Service failing complaint handling**

We failed to answer a part of the complaint regarding pests. The Ombudsman said we had the opportunity to provide clarity on the steps to take regarding pests. Yet the resident was still questioning this when the complaint was referred to this Service. Although the pests were not inside the property, it was unreasonable for us not have considered or assessed a response to this part of the complaint. Therefore, we were not able to assess the impact this had on the resident and their ability to maintain the hedge. Our delay impacted our ability to assess the risk to the resident and too much time has passed since then.

Due to our complaint handling failures identified and the cumulative effect this would have had on the resident, the Ombudsman makes a finding of service failure and ordered we pay an additional £100.

### **Ombudsman decision 4 - No Maladministration, and No Maladministration, and Out of Jurisdiction**

The complaint was about our response of the resident's reports of:

- Mechanical ventilation issues.
- Various repairs.
- Staff conduct.
- Allegations of antisocial behaviour (ASB)

They also considered our complaint handling.

### **Outside of jurisdiction Allegations of antisocial behaviour (ASB)**

This Ombudsman was aware that the resident made a secondary complaint in relation to a letter received from our solicitors.

After careful consideration, this part of the complaint had been ruled outside of jurisdiction as there was no evidence of the complaint being escalated to the final stage of our complaint's procedure.

### **Mechanical ventilation issues no maladministration**

The Ombudsman said the evidence shows that when carrying out the inspections, we and our operatives did not report experiencing any of the same symptoms as those of the resident and had not received reports of a similar nature from neighbouring residents.

Due to this we concluded that there was no requirement to undertake any further investigations as there was no evidence that our services were causing chemical burns, or that the ventilation systems

were not working as they should. This Service considers this to be a reasonable and proportionate response.

While the resident expressed concern that the investigation was not satisfactory, we were entitled to reply upon the opinions of qualified members of staff which indicated that it was focused on providing the resident with independent opinions on the matter. And we were open to reviewing any findings if the resident wished to instruct her own independent survey of the property.

#### **Various repairs no maladministration**

The Ombudsman said they reviewed our repair records, specifically in relation to the windows and fire alarm and confirmed that the issues had not been raised previously, or within the resident's initial complaint. Therefore, it was appropriate to advise that it needed the opportunity to put things right, before investigating as a complaint.

We arranged for replacement window handles and accepted responsibility for not addressing all the relevant repairs required to the bin store. The Ombudsman was satisfied that we took reasonable steps to investigate the repair issues. Although there were some delays in completing non-urgent repairs to the bin store, we provided a reasonable explanation and carried out interim repairs while waiting for a specialist team to replace parts to the bin store.

This Ombudsman were unclear if the beeping from the neighbouring fire alarm had been resolved, and therefore recommended that we followed this up, if we had not already done so.

#### **Staff conduct no maladministration**

The Ombudsman said the resident notified us on numerous occasions that they did not consent to a member of staff contacting them. Explaining that they found the correspondence deliberately upsetting, obstructive and offensive. The resident requested a reasonable adjustment on the grounds that they was deliberately worsening their condition. The resident was not able to substantiate the allegations, because of this there were limited steps we could take to investigate the reports.

The resident reported the staff member to the police for harassment, the matter was considered by our solicitors, and the resident was provided a letter which set out our final position on the matter on 24 September 2021. It confirmed that the allegations were unsubstantiated and without foundation. We appropriately appointed a new single point of contact (SPOC), which satisfied the resident's reasonable adjustment request and managed the communication in accordance with our habitual complaints policy.

#### **Complaint handling no maladministration**



The Ombudsman said although there was a slight delay in acknowledging the complaint, in their opinion, the resident was not significantly impacted as a result, and the complaint response was issued within ten days of acknowledging the complaint.

They appreciated that the situation had been upsetting for the resident, but our actions had focused on mitigating any detriment to the resident and provided them with sufficient explanations to support our findings.

#### **Ombudsman determination 5 - Out of Jurisdiction**

This complaint was about our handling of the resident's rent account, and the resulting legal action due to rent arrears.

The Housing Ombudsman Scheme sets out the Ombudsman's jurisdiction to consider complaints brought before their Service. Paragraph 42(e) of the Scheme states that the Ombudsman will not investigate complaints which, in the Ombudsman's opinion concern matters where a complainant has or had the opportunity to raise the subject matter of the complaint as part of legal proceedings.

This means that the Ombudsman will not consider a complaint where, in the Ombudsman's opinion, the court can handle all the matters now complained of to this Service. This is because the Ombudsman ought not to make decisions on matters which are already subject to findings and orders of the court.

It is evident the resident submitted a defence ahead of the hearing. Therefore, the resident had the opportunity to raise their concerns about our handling of their rent account, and their concerns about our approach, ahead of the court hearing. So, in accordance with paragraph 42(e) of the Housing Ombudsman Scheme our handling of the resident's rent account, and the resulting legal action due to rent arrears, is outside of the Ombudsman's jurisdiction to investigate.

#### **Ombudsman determination 6 - No Maladministration, No Maladministration, and Service Failure**

The complaint was about our handling of the resident's:

- Reports of water damage to the kitchen ceiling.
- Reports of damage to the bathroom ceiling from a leak.
- Request for a new kitchen.

#### **Repairs to kitchen ceiling no maladministration**

The Ombudsman said the resident's tenancy agreement states that it is their responsibility to keep the interior of the premises properly decorated and painted to our satisfaction. Our repairs policy outlines that it is responsible for repairs to ceilings but not for painting or decorating. Therefore, it was appropriate for us to repair the damage to the ceiling but not to paint any parts of the ceiling that had not been repaired.

As part of our stage 2 response, we offered £30, as a goodwill gesture, for the resident to buy paint. Our actions were appropriate in repairing the ceiling in a timely manner and advising the resident of their responsibility to decorate.

#### **Repairs to bathroom ceiling service failure**

The Ombudsman said we contacted the resident on 16 September 2022 to advise that we could not complete works in his bathroom as we had arranged an intrusive investigation to identify leaks in the property above. Our decision to postpone works was reasonable while investigations were continuing.

Our failures to then complete these bathroom ceiling repairs led to the resident completing the repairs themselves. Our repairs policy states that we will provide residents with an estimated completion date for a complex repair, but it aims to complete planned repairs within 90 days. However, we failed to comply with this timescale.

The Ombudsman would have expected us to update the resident with a date for repairs as it stated in our stage 2 response, or to have provided a reason for further delays. We failed to award compensation for this service failure, and the ombudsman ordered we pay £100 for this failure.

### **Request for new kitchen no maladministration**

The Ombudsman said we emailed the resident on 19 January 2023 and confirmed that the kitchen was due for an upgrade between 2035 and 2040. The dates differed from the date provided in our stage 1 response on 23 August 2022. Our responses were not consistent, and a recommendation was made for us to confirm the proposed replacement date to the resident.

We also asked the resident to send photographs of the kitchen to consider earlier replacement. The response was reasonable and demonstrated that we were willing to consider the resident's request further.

### **Ombudsman determination 7 - No Maladministration, No Maladministration, No Maladministration**

The complaint was about our handling of:

- The resident's reports of antisocial behaviour.
- The resident's reports of cracks in the wall.
- The resident's reports of repairs required to the communal front door.

### **Antisocial behaviour no maladministration**

The Ombudsman said our ASB policy states that in ASB cases, it will complete an action plan, identify any vulnerabilities, and complete risk assessments. It states that it will share the action plan with the resident and provide progress updates to the resident on an agreed frequency. We were proactive in our communications in providing updates to the resident as previously noted. We produced an action plan and risk assessment document which was dated 30 November 2021. There is a lack of evidence to confirm that the document was updated and whether we revised its risk assessment in light of each of the resident's new reports of continued ASB. It does not provide any details of what it would do to further support the resident in light of escalating events and does not note any steps taken, neither informal nor legal action.

We provided an additional action plan to the Ombudsman. The action plan provided was not dated and had 'active' tasks listed but it had confirmed to the resident that the ASB case was closed as of 5 August 2022. It is unclear why the tasks therefore remained 'active' and outstanding, and it suggests that we did not update this during the ASB case. It was a shortcoming of us to have not evidenced that it re-assessed the risks towards the resident and the household after each report of new ASB

incidents occurring. By not doing this, we may have missed opportunities to provide further support to the resident, as this could have been identified by speaking to the resident and updating the living risk assessment.

While this would have been appropriate, there is no evidence to suggest that this had any impact on the resident. We demonstrated that we took numerous steps to update and communicate with the resident, including the opportunities this communication gave the resident to raise any new concerns. Our proactive communication with the resident and consideration of the impact of the ASB considering their mental health concerns and previous trauma was appropriate and fair in the circumstances. There is no evidence to suggest that the resident was disadvantaged by the lack of these actions being completed or updated by us.

### **Crack in the wall no maladministration**

The Ombudsman said our repairs policy states that we are responsible for plasterwork but that the resident is responsible for minor cracks to the plaster.

When the resident reported cracks, we booked an appointment for a surveyor to attend who deemed the cracks were decorative. Due to this we were entitled to rely on the opinions of our surveyor when determining that the cracks were decorative, and not caused by a structural issue. We ultimately took responsibility for the repair and filled in the cracks, although it is unclear when this occurred. Due to this there was no maladministration.

### **Repairs required to the communal front door no maladministration**

The Ombudsman said our records showed that the job for the doorframe repair was completed on 31 March 2022. We took the decision to repair instead of replacing because of the age of the property. And confirmed that the works were completed to a good standard and that it took the decision to repair the doorframe because it would have been considered major works to replace it.

Our response was reasonable given the practicality of completing such a task. The resident has not disputed our repairs method and has confirmed to the Ombudsman that there were no further issues with the door after March 2022.

### **Ombudsman determination 8 – Maladministration and Service Failure**

The complaint was about our response to the resident's reports of damp, mould, and water ingress.

The Ombudsman has also considered our complaint handling.

### **Damp, mould, and water ingress maladministration**

The Ombudsman said the compensation of £3,313, offered for delays, distress, and time and trouble was in line with our compensation policy. However, the offer of redress fell short of recognising the full impact of the delays, and the fact the resident was unable to enjoy full use of the property for over a year and a half. Due to the cumulative impact of our failings, the Ombudsman has made a finding of maladministration and will order us to pay additional redress. This is in recognition of delays, distress and time and trouble resulting in the resident not being able to properly use his living room for a period we had acknowledged to be 21 months.

They ordered we pay £4,725 for the loss of use of the living room calculated as 30% of the property. In recognition of the fact that the resident is a 25% shared owner, we have calculated the loss of amenity to be 22.5% when calculating the rent paid in relation to this area.

### **Complaint handling service failure**

The ombudsman found 3 points where we failed.

We did not offer compensation at stage 1.

We stated we would use the case a learning opportunity but did not specify how.

We put some of the delays on the resident.

They ordered we pay £100 for this failure.

### **Ombudsman determination 9 - No Maladministration, No Maladministration, Service Failure**

The complaint was about our response to:

- Reports of antisocial behaviour (ASB) within the block.
- Items being dumped in the bin store.
- Concerns about communal cleaning not being completed.

### **ASB no maladministration**

The ombudsman said we reasonably attempted to address cannabis use within the block using letters and texts to all residents. Due to the perpetrators being unidentified there were no reasonable lines of enquiry we could follow to take further action at the time of complaint. We established that children causing nuisance within the block were not linked to any of its residents and gave appropriate advice about reporting this to police.

### **Items dumped in bin store no maladministration**

The Ombudsman said we took reasonable steps to persuade, advise, warn, and enforce against dumping of items in the bin store and removed items in reasonable time after they were dumped. We showed consideration of how it could improve identification of perpetrators and invited residents to contribute to solutions to the issue.

### **Cleaning service failure**

The Ombudsman said we had not provided evidence that we addressed the issue of the bin store being repeatedly missed, or the cleaning missed entirely on 6 May 2022, until a complaint was raised. Although our position of accepting a 'make up' clean by our contractor was reasonable, we did not appropriately communicate this to affected residents. Hence a service failure.

### **Ombudsman determination 10 - Out of Jurisdiction**

The complaint was about our handling of reports of damage to the property and belongings, following a ceiling collapse connected to a leak.

The ombudsman said the information on this case showed the complaint was referred just over 27 months after the final response. The Ombudsman considers it important that complaints are brought to both landlords and this service as quickly as possible. As more time passes it becomes increasingly difficult to effectively investigate cases as records may be deleted and people's accounts of events become less accurate.

Similarly, it is not reasonable or a fair use of this service's resources to open investigations about issues which occurred a long time ago. This service considers 12 months a reasonable timeframe within which to refer a complaint, this timescale reflects those provided by similar services. This complaint was not referred to this service within a reasonable timeframe. Therefore, this complaint was outside the jurisdiction of the Housing Ombudsman.

### **Ombudsman determination 11 - Severe Maladministration and Maladministration**

The complaint was about our handling of reports of damp and mould and complaint handling.

#### **Damp and mould Severe Maladministration**

The Ombudsman found that there was severe maladministration as we failed to fully address the impact its delays have had on the resident. We failed to resolve the water ingress or complete repairs to resolve the issues present in the property. We did not act with a sense of urgency and did not consider whether the property was habitable in view of the vulnerability of the occupants.

We also did not effectively manage the repairs and failed to keep the resident updated throughout. We did not recognise the severity of the impact the issues had on the resident. Whilst we acknowledged some of our failings, our compensation offer was insufficient given the circumstances of the case.

In deciding an appropriate level of redress in this complaint, the Ombudsman has considered the resident's level of rent, our failures and the inconvenience and distress caused.

The Ombudsman will order increased compensation to put things right for the resident based on the information seen.

They awarded £4,300 which is around 25% of the rent for the period and £700 for the distress and inconvenience caused.

#### **Complaint handling maladministration.**

The Ombudsman said the complaints procedure was not used as an effective tool in resolving the substantive issue for the resident. Our stage 1 and 2 responses were inadequate and did not demonstrate we had taken full ownership of the problems experienced by the resident. We listed repairs each time but did not demonstrate how we planned to resolve the wider issues.

They deemed we did not consider the household vulnerabilities highlighted by the resident. It would have been appropriate for us to consider the impact on the resident and their family. We missed opportunities to remedy the substantive issue, address and resolve the wider aspects of the

resident's complaint, show empathy, and improve the relationship. They ordered we should pay the resident £250 for these complaint handling failures.

### **Ombudsman determination 12 - No Maladministration, Service Failure, Out of Jurisdiction, and Out of Jurisdiction**

The complaint was about:

Our response to the resident's security concerns.

Our handling of repairs to the block the resident lives in and to communal areas.

Our handling of repairs to blocks on the estate other than the one the resident lives in.

Our handling of the resident's reports of a trespasser.

#### **Security concerns No maladministration**

The Ombudsman said It is not clear from the evidence provided when the resident first requested that a chain and padlock be put on the gate to the communal garden. However, we confirmed in our stage 2 response of 7 January 2023 that it had installed a chain and combination padlock on 29 December 2022. There is no obligation under the tenancy agreement for us to have installed this and so this installation was beyond what we were required to do.

The Ombudsman does not consider there to have been maladministration as we implemented a security service which has proven to be effective, and other residents told us any change to this would not represent value for money. Whilst we could have gone through a formal consultation process with residents on an upgrade to the CCTV system, given the effectiveness of the security service, it was appropriate that we did not do this. And, whilst we have now installed a chain and padlock to the gate, we were not required to do this. We also carried out estate inspections in line with our policy, which gave all residents regular opportunity to discuss matters of concern.

#### **Handling of internal repairs Service failure**

The Ombudsman said we have not provided a copy of our repair logs, showing exactly when each repair issue was raised with it, and when each job was completed. This does not demonstrate we had a robust knowledge and information management system in place.

Overall, based on the timescales set out in the stage 2 response of most of the jobs were completed within the timeframes set out in our repairs policy for these types of repairs. We provided reasonable explanations for the repairs that took slightly longer than expected. However, not all of the repairs had been completed at the time the stage 2 response was sent.

The Ombudsman considers that there was service as we failed to provide evidence of when each repair was reported, or that all of the repairs were completed. Whilst we did offer compensation of £100 to recognise the time and trouble the resident went to in order to raise these issues, this did not do enough to recognise the distress and inconvenience caused to the resident by its delays and failures to keep them updated.

Due to this they ordered we pay further compensation of £100.

#### **Handling of external repairs outside of jurisdiction**

The Ombudsman said according to paragraph 42(n), the Ombudsman may not consider complaints which concern matters which, in the Ombudsman's opinion, do not cause significant adverse effect to the complainant.

The resident's property is in a block on an estate with multiple blocks. Some of the issues the resident has raised in the complaint relate to problems in the other blocks.

The Ombudsman appreciates that hearing about issues in other blocks may have been frustrating for the resident, given the number of issues raised about their block and communal areas. However, the Ombudsman does not consider that issues in blocks would have a significant adverse effect on their occupation of the property.

For the above reason these repairs fall outside the Ombudsman's jurisdiction.

### **Handling of trespassers outside of jurisdiction**

The Ombudsman said according to paragraph 42(a) of the Scheme, the Ombudsman may not consider complaints which, in the Ombudsman's opinion, are made prior to having exhausted a member's complaints procedure.

On 23 August 2023 the resident told this Service they had provided us with many police reference numbers for trespassing incidents, with the name and the address of the offender, but we had not put a banning order in place. The first crime reference number was from November 2022, just before they raised the complaint, however the remainder of these incidents took place from February 2023 onwards, which was after we had concluded our internal complaints process on 10 January 2023.

The Ombudsman has not seen evidence that the resident raised this as a formal complaint and so has not exhausted our internal complaints process. For this reason the trespasser issue falls outside of the Ombudsman's jurisdiction.

### **Ombudsman decision 13 – Maladministration and Service Failure**

The complaint was about:

- Our handling of identification of a leak in her bathroom.
- Our handling of a request for a bath to be installed.
- Our response to a loss of heating in their living room.
- Our contractor's conduct towards her.

#### **Maladministration for leak, bath to be installed and loss of heating.**

##### **Shower**

The Ombudsman said we told the resident on 16 March 2023, not to use the shower in the property until they were decanted – which did not occur until 24 April 2023. Although this instruction is not documented within records supplied by either us or the resident. Our stage 2 complaint response did not dispute this and offered compensation of £125 for the resident being unable to use the shower. However, this amount did not represent reasonable redress for the inconvenience cause to the disabled resident by being unable to bathe in their own home for such a prolonged period.

One month after being decanted we had also not provided any update on the repairs, or even collected the keys to access the property. Temporary decants upend a resident's home life and can cause significant distress and inconvenience.

Although the Ombudsman does not dispute our position that leaks can be difficult to detect, or consider it unreasonable that we initially believed issues to be caused by flooding from the shower. However, our contractor missed the opportunity to identify the leak significantly earlier by failing to carry out the replacement of the flooring in accordance with our instructions. Although we did acknowledge and offer some redress for the resident being unable to shower at the property for an extended period, this did not reasonably reflect the inconvenience caused. This represents maladministration.

## **Bath**

The Ombudsman said we confirmed on 26 April 2023, that we were able to install a bath and would do so as part of the decant works. This means that the resident lived in the property for a period of approximately 2 years during which we failed to appropriately assess or complete the adaptation recommended by the occupation therapist (OT). The resident told us that this had "caused years of complications and pain with their disability".

Our 'Aids and Adaptations Policy' contains the option for it to carry out a "feasibility assessment" following an OT report to establish "the feasibility of the adaptation in relation to the layout and structure of the property". Had such an assessment been appropriately carried out in relation to the request for a bath, a great deal of distress and inconvenience for the resident could have been avoided over the subsequent years.

In summary, we incorrectly advised the resident that it was not possible for it to install a bath via environmental health (EH) in the property as recommended by the OT. However, this was subsequently found to be incorrect, meaning the resident experienced several years of distress and inconvenience in using the shower which could have been avoided. This represents maladministration.

## **Loss of heating**

The Ombudsman said it is unclear from the information available exactly when the storage heater fell off of the living room wall in the resident's property, but they advised that this occurred in 2018. This was the only source of heating within the room and ceased to function.

Our records indicate that we arranged for an electrician to inspect all storage heaters in the property on 13 January 2022. But we had provided any outcome in relation to this inspection, however it is apparent that the living room storage heater was either not raised as an issue, or not appropriately followed up on.

The issue was identified by a surveyor during our inspection on or around 11 August 2022, as confirmed by EH in the email of 1 September 2022. However, the matter had still not been resolved at the point that the resident was decanted from the property, some 8 months later. We had not provided any explanation for this unreasonable delay.

In summary, our lack of action meant the resident was left without heating in their living room for over a year after the issue should have first been identified and resolved (within the timeframe considered by the ombudsman investigation). This represents maladministration.



### **Contractor conduct service failure**

The Ombudsman said the resident also expressed dissatisfaction that the contractor left the property on 9 February 2023 without informing that it would not be returning. The contractor's notes indicate that it left due to the resident's behaviour, which it is reasonably entitled to do. However, it would have been reasonable to expect either it, or we communicated this to the resident – even if this was via a phone call after they had left the property. The resident has advised that this alleged behaviour was not discussed with them by us at any point, and they remained confused as to why the contractor withdrew.

We reviewed "a number of the more recent jobs" that our contractor had carried out at the resident's property as part of our stage 2 complaint investigation. We confirmed that these supported the resident's complaint that they were not always contacted in advance of appointments as required under the terms of the tenancy agreement. We offered an appropriate apology for this.

In summary, our contractor's failure to effectively communicate internally led to it repeatedly attempting to collect the dehumidifier and caused the resident "major distress". Us and the contractor also failed to appropriately make clear to the resident that the contractor had withdrawn from the property due to their alleged behaviour, and to raise this with them and give them a right of reply. Although we acknowledged and apologised for some failings, in our contractor attending unannounced, we did not recognise the full extent of the issues, or the distress and inconvenience caused.

They ordered us to pay £1,435 in compensation for our maladministration and service failures.

### **Ombudsman determination 14 Reasonable Redress and Service Failure**

The complaint was about:

- Our response to the resident's concerns that we removed personal items belonging to the resident without their knowledge or consent.
- Our response to the resident's reports about damage to their bicycle.
- The Ombudsman has also considered our complaint handling.

### **Removal of personal items reasonable redress**

The Ombudsman had considered the residents claim, that they had stored a bicycle in the car parking bay for 20 years without challenge. While this is of concern, it is also reasonable to assume that the resident's bicycle was not usually in the car park during our typical working hours, as it was routinely used for commuting purposes.

The Ombudsman accepts the timing of the resident's belongings being removed on 7 March 2023, coincided with our communal area clearance. However, none of the items described by the resident were visible in any of the photographs taken by us prior to and following the clearance. The CCTV does not cover this area and there were no witnesses to support the resident's view that the our contractor removed the items. Therefore, the Ombudsman is unable to determine based on fact from the evidence seen, that the items described by the resident were removed by us. This is the same for their bicycle.

In summary, our communications were inadequate, and we did not provide a timely response to the resident's concerns. Our apology and offer of compensation were reasonable.

### **Damage to bicycle reasonable redress**

The ombudsman said it is not in dispute that there were delays in responding to the resident's initial enquiries about damage to their bicycle. We apologised for the delay in responding and offered compensation which was reasonable.

### **Complaint handling service failure**

The Housing Ombudsman's Complaint Handling Code (the Code) states that where residents raise additional complaints during the landlord's investigation, these should be incorporated into the stage 1 response where they are relevant, and the stage 1 response has not yet been issued. However, where this would unreasonably delay the response, the landlord should log a new complaint. In view of the timing of the resident's communication, logging a new complaint would have been a reasonable approach.

Despite the resident clearly stating several times that the bicycle had been fully removed without warning, we said our complaint handlers had not realised the bicycle had been removed until after it issued our stage 2 response. This would have left the resident uncertain as to how their complaint was being resolved. It was also likely to have restricted the resident's ability to progress the potential theft of the bicycle with the police and their insurance company in a timely manner. But it is encouraging that we accepted there had been a failing in our complaint handling, apologised, and appropriately directed the resident to escalate his complaint to the Ombudsman.

We agreed to arrange a review of our complaint handling by senior management and issue a follow-on stage 2 response. This was in keeping with our complaint policy and showed that we were open to learning from complaints. In the Ombudsman's opinion, the resident was not unduly disadvantaged by our decision to investigate the matter past issue of the stage 2 response. But we should have considered making an additional award of compensation to reflect the failure we had identified in our complaint handling.

When considered cumulatively, the Ombudsman finds service failure in our complaint handling. They ordered that we pay £50 compensation.

### **Ombudsman determination 15 – Maladministration and Service Failure**

The complaint was about our handling of:

- Reports of outstanding repairs to the property, resulting in condensation, damp and mould.
- Associated formal complaint.

### **Damp and mould maladministration**

The Ombudsman spotlight report on damp and mould, published October 2021, provides recommendations for landlords which set out 26 recommendations which included:

The Ombudsman empathises that the delays in completing repairs caused frustration and distress to the resident and their family. Our delays were not appropriate or in line with our repairs policy or damp and mould policy principles. We failed to recognise our obligations under HHSRS or empathise that the continued delays in completing repairs impacted the resident's mental health and their son's asthma. We failed to keep the resident informed of what actions we were taking or adhere to any timescales given. We repeatedly inspected the property and failed to resolve the repairs issues identified.

The Ombudsman concludes that we failed to provide reasonable redress to the resident's complaint and finds maladministration in our handling of the resident's reports. It must be reiterated that this finding and consequent orders are with respect to events occurring up to 20 March 2023 as the resident's complaint about events since September 2023 are the subject of her more recent complaint.

They ordered we pay additional £600 compensation to the £854 already offered at stage 2.

### **Complaint handling service failure**

The ombudsman said we operate a 2-stage complaints process. Complaints are acknowledged within 5 working days of being received. Stage 1 complaints are responded to within 10 working days and stage 2 complaint within 20 working days.

The resident raised a formal complaint on 19 January 2023. We responded on 6 February 2023, 18 working days later and 8 days outside of our complaints policy timescale.

The resident escalated their complaint on 10 February 2023, however in our stage 2 response we stated that she had escalated the complaint on 17 February 2023. We responded on 20 March 2023, 38 working days later, and 18 working days later than our complaints policy timescale. While they were not significant delays in our complaint handling, we failed to respond within our policy timescales and therefore the ombudsman finds service failure in our handling of the resident's complaint.

### **Ombudsman determination 16 - No Maladministration and Maladministration**

The resident's complaint is about our handling of:

- Antisocial Behaviour ("ASB") by her neighbour
- Their complaint.

### **ASB No maladministration**

The Ombudsman said we took several steps to address ASB by the neighbour and the resident. We considered information provided by the police. This information did not indicate that the resident was at risk, and it was reasonable for us to decline a management transfer request. We also communicated in an appropriate way with the resident.

### **Complaint maladministration**

The Ombudsman said we provided a stage one complaint response to the resident on 24 October 2022. The resident responded on 2 November 2022 asking for their complaint to be escalated. We responded stating that it required details of the reasons she was dissatisfied with the complaint

response. The resident's response was that they were dissatisfied with "everything". We did not escalate the complaint at that time. The Ombudsman finds this to be a failing. The resident clearly asked for the complaint to be reviewed at the second stage. It was not reasonable for us to require that the resident provide a detailed critique of the stage one complaint response.

The resident followed their escalation request up on 28 December 2022. Following further communications between the parties, the resident confirmed that they wanted the complaint escalated in an email on 17 January 2023. We made an administrative error and did not acknowledge the email or instigate the escalation process until 29 March 2023. The second stage complaint response was sent on 5 April 2023. This was a clear further failure.

The Ombudsman therefore finds that there has been maladministration with respect our complaint handling. This reflects the importance of the escalation stage and that there were two failings which lead to considerable delay in the escalation of the complaint.

They awarded we pay £250 in compensation.

### **Ombudsman determination 17 - Service Failure and Service Failure**

The complaint was about:

- Our handling of the resident's application, on behalf of their son, for our next generation scheme.
- Our handling of the resident's complaint.

#### **Next generation scheme service failure**

The Ombudsman said in early January 2023 the resident contacted us for an update on her next generation application. On 20 January 2023 we contacted the resident by phone informing them that the scheme had closed and it would not be able to rehouse their son. This was the first time the resident had been informed that their son would not be rehoused and was 9 months after the scheme had closed. This was unreasonable and caused a detriment to the resident specifically the resident has said they were heartbroken to have wasted the previous 9 months when they could have been looking for alternative accommodation for their son.

The resident submitted a formal complaint the same day which said that she was told their son would be rehoused under the scheme. We provided our final response to the complaint on 20 March 2023. We concluded that applicants could wait between 6-18 months to be rehoused under the next generation scheme and we should not have accepted the resident's application knowing the scheme would close on 4 April 2022. We confirmed a total of 50 applications were outstanding when the scheme closed, and no further lettings were completed. We offered the resident £150 compensation in recognition of its poor communication.

Whilst our apology and offer of compensation went some way to resolving the complaint it didn't put it fully right. We didn't fully recognise the distress caused to the resident. And gave the resident false hope their son would be rehoused and failed to inform them of the end of the scheme for 9 months. As such this amounts to service failure.

#### **Service failure complaint handling**

The Ombudsman said on 20 January 2023 the resident contacted us to submit a formal

complaint. We responded to the resident acknowledging her complaint on 24 January 2023 and said a response would be received by 6 February 2023. This was in-line with our complaints policy which. However, we did not respond to the resident until 10 February 2023. This was 4 days outside of our agreed timescale and there is no evidence we informed the resident of the delay. This was a failing in our complaint handling.

As part of the escalation request the resident raised concerns that inaccurate information had been provided in the stage one response. Specifically, the resident has said they were not contacted by email on 23 March 2022 as outlined at stage 1. We acknowledged this failing as part of the stage 2 response and confirmed that no email was sent on 23 March 2022. This was an appropriate response given the error.

As part of the resident's complaint, they also outlined that they were told during a telephone call with us that making a complaint "wouldn't make a difference". We acknowledged, as part of our final response, that this comment should not have been made. We accepted that the comment was assumptive and not in line with our complaints process. We said that a full investigation of the application should have been completed before any determination was made. This was an appropriate response; however, we had not considered any impact our complaints handling may have had on the resident or offered redress. As such, this amounts to service failure and an of order of £300 compensation was made for us to pay.

### **Ombudsman determination 18 – Maladministration, Service Failure, Service Failure, and Service Failure**

The complaint was about our handling of the resident's reports concerning:

- Fire safety following a fire in the building.
- A request to be rehoused.
- Smoke damage to the furniture and soft furnishings.
- The associated complaint.

#### **Fire safety maladministration**

The Ombudsman said the resident was unhappy that we had delayed seeking consent from the local council to undertake works to the fire doors as required by the fire service's notice of deficiency to provide a minimum of 30 minutes fire resistance in the event of a fire. Our stage one complaint response to the resident of 24 January 2023 indicated that we had undertaken a Section 20 consultation due to there being leaseholders within the building. We advised that it needed to seek planning permission as the building was in a conservation area. We confirmed to the resident that the plans were submitted to the local council in March 2023. The resident provided an extract of the our later response to this Service, however, this was not dated.

The council's planning consent letter of 26 May 2023 stated that the planning application had been received on 18 January 2023. This again indicated that our record keeping was insufficiently robust as we were unaware of when the planning application was made, and we gave incorrect information to the resident.

We recognised that we would be unable to proceed to carry out works to the doors without the necessary planning consent which was not provided until 26 May 2023. Additionally, a Section 20 consultation would require a consultation period for leaseholders to comment on the plans prior to any work being commissioned.

However, it would be expected that we kept all the residents informed of the progress of the planning application and the timing of the works. The Ombudsman has not seen evidence that we kept residents suitably informed. The lack of updates would have caused distress to the resident as there were identified deficiencies in the fire stopping. The resident had the inconvenience, along with the time and trouble in pursuing updates in respect of the outstanding work which was unreasonable.

Due to these failings, there was maladministration in our handling of the resident's reports concerning fire safety in the building following a fire. They awarded £500. £200 compensation for our failure to undertake actions required by our fire risk assessment within the required timescale, failure to update our fire risk assessment by the date specified and in line with our fire safety policy. It includes a further £200 in recognition of the overall distress, inconvenience and time and trouble caused to the resident by our failings, and £100 compensation for failing to provide the resident with regular updates on the status of the outstanding work that required planning consent.

### **Service failure rehoused**

The Ombudsman said there was service failing we did not evidence we had reasonably considered the resident's request for rehousing in line with our allocations and lettings policy above. We failed to communicate to the resident the reason why this request fell outside of the allocations policy in our complaint responses which we needed to do given the resident had mentioned that this was a remedy being sought. This caused inconvenience and distress to the resident. It caused additional time and trouble in pursuing us for a reasonable response.

They awarded £100 compensation to reflect the distress and inconvenience caused to the resident by our failings.

### **Service failure smoke damage to property**

The Ombudsman said we responded in respect of the insurance claim on 4 May 2023 to advise that the insurance company had not found fault and it was therefore unable to replace the damaged items. It is not known when we were informed of the insurance company's response, however, it is recognised that the delay was not entirely our fault as our insurer would have needed to investigate the resident's claim and we could not control how long this took.

However, we could have been more proactive in updating the resident on the claim, and only provided the final response after the resident chased this up. This would have caused unnecessary inconvenience to the resident. There was therefore a failing as it did not do this. We changed our position in respect of the damaged items following the end of the internal complaints process. and offered at this point to pay up to £200 for the resident to arrange to clean the smoke damaged items and be reimbursed. We also offered compensation of £345 as there had been delay in sorting out the works that it had agreed to do with regard to the cleaning and decorating. But the ombudsman said It would have been more appropriate for us to consider this offer as part of the complaint response in order to resolve things for the resident sooner.

An order of paying further compensation of £100 was made.

### **Complaint handling service failure**

The Ombudsman said our complaints policy was non-compliant with the Complaint Handling Code

(The Code). We updated complaints policy which postdates the resident's complaint is also non-compliant with the Code which is a statutory requirement.

Our revised policy states that a response at stage 2 will be sent within 20 working days of a stage 2 request being accepted and acknowledged. It also cites reasons, as with the previous policy, such as the need to resolve repairs as to why it may not escalate a complaint to stage 2 which would not be reasonable. We should therefore pay particular attention to the complaint stages when we conduct a self-assessment of our complaints policy.

They awarded £100 compensation for this failure.

### **Ombudsman determination 19 - Out of Jurisdiction, Out of Jurisdiction, Out of Jurisdiction, and Maladministration**

The complaint was about:

- A request to carry out an asbestos survey.
- Access to the resident's property.
- Termination of the resident's tenancy.
- Handling of electrical testing appointments, including its communications and response.

#### **Electrical testing maladministration**

The Ombudsman said in summary we did carry out further investigations at stage 2 of the complaints process. We identified the error that had been made by the contractor and acknowledged the confusion that this had caused. We apologised to the resident and increased our offer of financial redress as a result of its findings.

While this was an appropriate response our offer of financial redress was not proportionate to the failings identified. As we did not consider our poor complaint handling at stage 1, or have easily accessible records or detail from our contractor to check to see if the resident's property was due to have an electrical test carried out. In not doing this we missed the opportunity to resolve the resident's complaint at the earliest opportunity.

As a result, they found maladministration in the handling of the electrical testing appointments, including its communications and response. They ordered us to pay £170 calculated below.

- £50 for complaint handling.
- £50 for record keeping.
- £50 for the distress and inconvenience caused to the resident.
- £20 for the appointments arranged that were not required.

**A request to carry out an asbestos survey outside of jurisdiction**

**Access to the resident's property outside of jurisdiction**

**Termination of the resident's tenancy outside of jurisdiction**

The ombudsman said that paragraph 42(a) of the Scheme notes as follows. The Ombudsman may not investigate complaints which, in the Ombudsman's opinion are made prior to having exhausted a member's complaints procedure unless there is evidence of a complaint handling failure and the Ombudsman is satisfied that the member has not taken action within a reasonable timescale.

The resident reported concerns to the Ombudsman about us having made a request for us to be able to carry out an asbestos survey their property, our behaviour around accessing their property, and the termination of their tenancy. However, there had been no evidence seen by the ombudsman to show that the resident had raised their concerns with us or that we had recorded the resident's concerns as formal complaints in line with our complaints process.

They deem the complaint about our request to carry out an asbestos survey, access to the resident's property, and the termination of their tenancy are outside of the Ombudsman's jurisdiction.

**Report completed by**

James Mahaffy, Central Complaints Manager and Adam Tolhurst, Central Complaints Officer