Housing Ombudsman Service

REPORT

COMPLAINT 202013956

Sovereign Housing Association Limited

8 December 2022

Our approach

The Housing Ombudsman's approach to investigating and determining complaints is to decide what is fair in all the circumstances of the case. This is set out in the Housing Act 1996 and the Housing Ombudsman Scheme (the Scheme). The Ombudsman considers the evidence and looks to see if there has been any 'maladministration', for example whether the landlord has failed to keep to the law, followed proper procedure, followed good practice or behaved in a reasonable and competent manner.

Both the resident and the landlord have submitted information to the Ombudsman and this has been carefully considered. Their accounts of what has happened are summarised below. This report is not an exhaustive description of all the events that have occurred in relation to this case, but an outline of the key issues as a background to the investigation's findings.

The complaint

1. The resident's complaint is about the landlord's handling of repairs to a leak in the roof of the property.

2. The Ombudsman has also considered the landlord's handling of the resident's complaint about this matter.

Background and summary of events

3. The Ombudsman notes that the resident has been represented by his sister in many of the communications about the matter. For ease of reference, unless necessary to specify for context, the Ombudsman has referred to "the resident" when his sister has made representation on his behalf.

4. The property is a one bedroom first floor flat. The tenant entered into an Assured Shorthold Tenancy with the landlord on 16 August 1999. The resident is a vulnerable adult, with physical and mental health challenges, who had lived in the property for a number of years. He is cared for by his mother and supported by his sister. The resident's vulnerabilities were recorded by the landlord.

5. On 14 February 2019 the resident reported a leak in the roof and property and that he was using a bucket to catch water. A "supervisor" from the landlord attended but found that a roofer was required.

6. On 3 or 6 September 2019 an inspection identified problems with the roof which needed repairs to stop leakage.

7. On 24 October 2019 a contractor reattended to further inspect and identify where scaffold needed to be placed.

8. In December 2019 the gas meter was replaced due to rain damage from the hole in the roof.

9. Scaffolding was erected on 13 February 2020. The landlord's notes from this date record "works completed".

10. A further leak was reported on 10 March 2020. A contractor attended and sent a report to the manager. It is not clear what the contents of that report was.

11. A contractor attended again on 1 May 2020 and found that they could not identify any problems with the roof and advised that scaffolding was needed again.

12. On 1 May 2020 the landlord indicated that the resident would be charged for the leak repair. The Ombudsman has been provided with limited evidence of the communication from the landlord about this and notes that it does not appear that this was suggested again.

13. On 7 September 2020 a contractor attended and reported back that there was no issue with the ceiling bowing. The resident subsequently reported to the landlord that this was not a thorough inspection and the contractor only looked at the roof from the ground.

14. In September 2020 the gas meter was replaced again due to damage.

15. On 23 September 2020 the resident's sister sent an email to the landlord strongly complaining about the situation. She stated that the landlord had been told in January that year that the gulleys/valleys needed replacing and queried why the property had again been inspected the day before when her view was that the landlord was aware of the works that were needed. She noted that the resident was having to empty buckets of water every time it rained and the situation was having a significant impact on the physical and mental health of the resident and their elderly mother who was his carer. The resident now felt unable to return to the property and was having to reside with his mother. On 24 September 2020 the landlord logged a new complaint about the roof leak in response to the email.

16. On 24 September 2020 the landlord noted that it had arranged for a contractor to visit and quote for the works. The landlord recorded its awareness that "a lot of water" was coming in when it rained with "buckets full".

17. On 29 September 2020 the resident told the landlord that he was very unwell and unable to return to the flat to empty out the buckets of water that continued to fill with rain. He noted that the landlord had done nothing to remedy the situation over the last year. The landlord noted internally that while there was an open complaint, “nothing seems to be getting done”.

18. On 30 September 2020 the resident called the landlord about the complaint.

19. On 2 October 2020 the resident advised the landlord that there was another hole in the roof and debris was in the bath of the property. The resident asked if anything had been done about the complaint and reiterated the significant impact this was having on him. The landlord responded that the email had been forwarded to the resolutions team to look into and provide an update.

20. On 5 October 2020 the resident advised the landlord that he and his mother had to go to the flat to empty buckets of water for the last three days. The landlord responded that this had been passed on to the resolutions team.

21. On 9 October 2020 the resident emailed the Chief Executive Officer (CEO) of the landlord with his complaint, emphasising the detrimental impact this was having on him and that the landlord had been aware since January that the gulleys/valleys needed replacing. The landlord indicated internally that as a result of this it would contact the resident and advised the resident that the case owner would contact him “as soon as possible”.

22. The landlord raised a job for scaffolding works on 9 October 2020 following the email to the CEO. The internal notes for the landlord record that the job to erect the scaffolding was given a priority of “ROUTINE”.

23. On 16 October 2020 the landlord told the resident that it needed to erect a scaffold to further investigate the issue and this would happen on 26 October. The landlord could then "go from there" to arrange the repairs.

24. On 18 October 2020 the resident told the landlord that he had been told that scaffolding would be going up the week after the 9 October but this had not happened and he was now being told the 26 October. The resident stressed that he was living full-time with his mother at the moment which was a difficult situation and now did not want to return to the property. He noted that he had applied for a transfer and hoped that in the circumstances he would be considered a priority.

25. On 20 October 2020 the landlord apologised to the resident that it had not “stuck to its word” regarding the scaffolding and said that 26 October was “the earliest date”. It asked for the resident to provide photos of the damage inside the flat so that it could “start making a plan” to sort those issues. It said that it “cannot organise for a transfer at the moment but will speak to Housing and

make them aware of this situation and see if they can help [him] with anything relating to a move".

26. On 21 October 2021 the resident sent an email to the landlord stating that he and his mother had attended the flat to empty buckets of water. He noted it was normally three buckets of water every time it rains and they had been doing so for over a year. He attached photos that showed two holes in the roof where the water was coming in.

27. On 24 October 2020 the resident sent a photo of lumps of roof tiles that were starting to fall through the roof. He noted that the flat now smelt and was very damp and uninhabitable. He queried about alternative accommodation.

28. On 26 October 2020 the landlord queried whether the resident could stay with his mother and stated that a temporary decant to a hotel would be a "last resort".

29. On 26 October 2020 the resident advised that he was okay to stay at his mother's place. He noted his concerns with the dampness of the property and requested a dehumidifier. He noted that after a year of dealing with it, he was very unhappy being in the flat and it was not clear that he would be happy to return. The landlord responded that the email had been passed on to the complaint owner.

30. On 27 October 2020 the resident advised that the water board had visited and the stopcock could not be located and the landlord's input was needed to tell them where the stopcock was. He queried why the matter could not be attended to earlier given its urgency and the impact on him and his mother.

31. The landlord responded that day advising the resident that it had "tried to pull forward" the work but 3 November was the earliest date. It "apologised for the inconvenience". It advised that a dehumidifier would be dropped off the next day which "would hopefully help with the damp". It stated that "once all the repairs are completed [the resident] will be expected to move back to the flat and we would not move him out unless the property cannot be repaired". It advised the resident that if he was unhappy in the flat it "would suggest that he registers on Homehunt to see if he is able to do a mutual exchange".

32. On 29 October 2020 a contractor attended the property and found that the property was "in a bad way". The contractor observed that, as a result of the leak, the gas meter was off so there was no heating. The notes record that "the flat is damp and ice cold and not in great state. I would say unliveable, maybe worth sending someone to visit as a duty of care".

33. The resident emailed the landlord on 2 November 2020 noting that he had expected to hear from the landlord but had not. It noted that the resident was

required to visit the flat the next day to locate the stop cock despite being exhausted. He reiterated the impact on his and his mother's wellbeing. He asked if a property inspector was available to check the habitability of the flat as at the moment it was uninhabitable. He reiterated that the landlord had first been contacted in 2019 about the leak and the condition of the flat had deteriorated since then. The impact on his physical and mental health had been significant.

34. On 4 November 2020 the landlord wrote to the resident advising that the roof repair had been raised and once this was done the internal damage would be repaired. It stated that if the resident was not happy to return once the repairs were finished it would advise him to "register with HomeHunt". It told the resident that if there was significant rainfall it "would like" the resident to empty the buckets if he was able to. It said that it would ask a contractor to remove roof tiles which were in the bath.

35. Scaffolding was erected and the roof was mended on 6 November 2020. It took one day.

36. On 12 November 2020 the landlord confirmed to the resident that it was waiting for a quote back from the contractor for the internal remedial works following the roof repair. An internal note by the landlord from the same date noted that it was "still waiting on the quote for the works, the leak has now stopped, the place is drying out…this should be wrapped up within the next 4 weeks".

37. On 19 November 2020 the landlord spoke to the resident and confirmed that the ceiling would be plastered on 25 November 2020 and the painting works completed on 30 November 2020.

38. On 25 November 2020 internal works were undertaken.

39. On 27 November 2020 the resident's mother wrote to the landlord with an information request. She confirmed that the resident was staying with her - he was very unwell and the flat had contributed to his illness. She noted that the resident had been emptying buckets for a year while suffering from mental and physical vulnerabilities.

40. On 30 November 2020 the resident waited at the flat for a contractor who did not arrive.

41. On 1 December 2020 the resident confirmed that the roof had been fixed and the flat was dry, however he felt that no attempt had been made to resolve the complaint itself. He stated that the landlord had not addressed the issue of what he felt was neglect by the landlord. He asked for a final response so that he may refer the matter to the Ombudsman.

42. On 3 December 2020 the resident sent an email to the landlord further setting out the detrimental impact the matter has had. He noted there were issues with the roof insulation which did not appear to be planned to be sorted.

43. The resident sent an “urgent” complaint to the landlord on 3 December 2020 stating that there were two crucial issues that needed to be addressed before closing the complaint. Firstly, the serious impact that the matter has had on the resident and his mother, who is his carer. The resident noted that at that stage he did wish to move back in but requested that, if this was too traumatic for him, he be rehoused as a matter of urgency within three months of making such a request. Secondly, the need for the landlord to be accountable and structural changes should be made. At the very least, the resident stated, a permanent officer responsible for vulnerable residents should be appointed. The resident stated that the landlord’s treatment of a resident with known vulnerability was a scandal.

44. On 7 December 2020 the landlord responded to the resident stating that if the resident decided that he did not wish to remain at the address he would need to contact the Housing Response Team who can help with vulnerable residents. The landlord could not agree that the resident would be moved within three months. The landlord further stated that it was not able to implement new roles but it understood that its Housing Response Team had the resources to assist more vulnerable residents and said that someone from that team could contact the resident.

45. The landlord told the resident on 16 December 2020 that it was going to close the complaint.

46. The landlord reopened and escalated the case to stage two of its complaints procedure on 16 March 2021, following an intervention from this service.

47. The landlord sent a stage two response on 18 March 2021. In this response the landlord apologised for the time taken to resolve the issues and the distress which this had caused the resident. The landlord set out that the roof and internal damage had been repaired in November 2020. It also installed a dehumidifier in November 2020 and paid a reimbursement of £139.84 in February 2021 for the cost of running this. The landlord stated that it did not have a record of a new gas meter being fitted due to water damage, however it did have a record of paying a reimbursement of £130 in February 2021 to cover an increase in gas bills. The landlord further noted that there was an “open job” for loft insulation, which was on hold due to the Covid restrictions and would take place when these were lifted. The landlord acknowledged the impact that the matter had had on the resident’s mental health. It noted that it was pleased that it had found a new flat for the resident to move into within a few weeks. It acknowledged that the leak had not been repaired in a timely

manner when there had been multiple requests from the resident and his family. It stated that, as a result of its investigation, seven recommendations for process improvement had been put forward and approved at Director level. It ended by advising the resident that the complaint would now be closed.

Assessment and findings

48. The landlord has acknowledged that there were failings in its handling of this matter. The crux of the resident's position is that the landlord has failed to acknowledge the extent of the impact on him and his family. The resident is also concerned that the landlord has not been held "accountable" and that necessary systemic changes have not been made.

49. The Ombudsman finds that there have been a number of failings by the landlord over an extended period of time. The resident first reported the leak on 4 February 2019 and it was not successfully repaired until 6 November 2020. The leak itself took one day to repair – it was not a significant piece of work, although the Ombudsman acknowledges that it required scaffolding which requires additional time to erect. Even after the roof had been repaired, it took until the end of November 2020 to finalise the internal works. It is clearly unreasonable that the landlord took 21 months to successfully complete a simple repair to the roof. While there were some contractor visits, the evidence does not indicate that there were any reasonable reasons for the delay in the repair. By the time the repair was successfully undertaken, a contractor for the landlord itself observed that the property had become uninhabitable. The Ombudsman finds that there was a significant ongoing failure by the landlord to fulfil its basic duty to maintain the property in good repair.

50. The Ombudsman would find this to be a serious failing in any circumstance. In this case, the seriousness of the landlord's failings were exacerbated by the resident's vulnerability – of which the landlord was aware. The landlord should have been alert to the fact that the resident could find problems with the property particularly distressing and challenging to deal with and taken steps to prioritise the matter and communicate effectively with the resident, taking into account his individual vulnerabilities. The evidence indicates that the landlord did not take any substantive additional effort to take into account and respond to the resident's individual circumstances because of his vulnerability.

51. The resident's sister submits that at least 37 phone calls were made to the landlord between February 2019 and October 2020 about the leak. The resident's sister has herself undertaken a review of the documents she has had access to on the matter and submits that from 14 February 2019 onwards in landlord communications there were references to:

i. the existence of the leak on at least 48 days;

ii. the fact that the resident was having to empty between one to three buckets of water every time it rained on at least 28 days;

iii. the vulnerability of the resident on at least 24 days.

52. She further submits that between 1 May 2020 and 30 September 2020 the landlord was told that the ceiling had fallen in on at least 12 days, and that the flat was cold and damp on at least 13 days. Between 6 September 2020 and 30 November 2020 she submits that the landlord was told that the resident was without gas, heating and hot water on at least 5 days. The Ombudsman acknowledges the resident's submissions about the number of times the landlord was notified and agrees that this demonstrates that the landlord was on reasonable notice about the problem and the extent of the negative impact on the resident.

53. The Ombudsman considers that the landlord was quite clearly on notice that the matter was having a significantly detrimental impact on the resident and the matter was urgent from 23 September 2020 at the very latest – when the resident's sister made a detailed complaint. However, as late as 9 October 2020 the landlord gave the works a priority of "ROUTINE". The landlord was aware that, at great personal inconvenience and distress, the resident and his mother were returning to the property to empty buckets of water and there is no indication that it took steps to relieve the resident of this ongoing work. The Ombudsman would expect all ongoing maintenance work resulting from the leak to be undertaken by the landlord, particularly in this situation where the resident was clearly experiencing such distress. The Ombudsman considers that the landlord failed to treat the matter with the urgency which it required when it became clearly apparent how bad the condition of the property was and how much distress this was causing to the vulnerable resident and his family.

54. The Ombudsman also finds that there were failings in the way in which the landlord responded to the resident's concern about his ongoing occupation of the property given the distress he had suffered. The landlord's recommendation to the resident on 27 October 2020 that he register for a mutual exchange if he was unhappy to continue to live in the property was a reasonable option to refer to. However, it being the only option referred to, in a an undetailed and cursory fashion, was an inappropriate and unhelpful response to his understandable concerns about returning to the property. The resident clearly required more substantive support. Fortunately, by March 2021 the landlord had found the resident alternative accommodation. The Ombudsman understands that the resident continued to reside with his mother until moving to the new property and it is not clear if the resident ever returned to the property to live in before moving to the alternative property.

55. The Ombudsman also considers that there were failings in the way in which the landlord handled the resident's complaint. The resident sent an email on 23 September 2020 clearly setting out his complaint. It does not appear that a specific complaint response was given to this. The resident contacted the landlord about the complaint on 30 September 2020. Following further communications, the resident again clearly articulated his complaint on 9 October 2020. It does not appear that the landlord gave a specific complaint response to the resident. Whilst it communicated with the resident about the progress of the work, this is different to providing a complaint response. The Ombudsman does not consider that the landlord's email dated 7 December 2020 – in which the landlord apologised to the resident and stated that his comments "would be feedback" is sufficient to be considered a proper complaint response. The brief follow up email sent by the landlord on 16 December 2021 advising the resident that it was closing the complaint does not appear to refer to the resident's rights to use this Service.

56. It appears that the landlord did not then escalate the matter to stage two until this Service intervened. It provided a stage two response on 18 March 2021. This did include referral details to this service. The Ombudsman notes that the resident has indicated that he did not receive the stage two complaint response on 18 March 2021, however we are satisfied that that it is more likely that this was sent to the resident.

57. The resident's narrative of the impact on him and his family is distressing to read. The resident reports that as a result of the state of the flat he fell into a deep depression, which in turn led to him leaving his voluntary job and has had implications for his physical health. The matter has also had a significant impact on the resident's mother, who is in her eighties, who acts as a carer for him. The resident reports that the detrimental impact on him has continued even after he has moved into the new property.

58. Taking into account the length of the matter that the time was ongoing, the number of opportunities the landlord had to address the issue and its failure to respond to the serious impact on a vulnerable resident, the Ombudsman considers that there was severe maladministration by the landlord.

59. The Ombudsman has considered whether the landlord has already provided reasonable redress to the resident for this. In its second response letter in March 2021 the landlord set out that it:

    i. had paid a reimbursement of £139.84 in February 2021 for the cost of running a dehumidifier;

    ii. had paid a reimbursement of £130 in February 2021 to cover an increase in gas bills.

iii. stated that it acknowledged the impact that the matter had on the resident's mental health

iv. stated that as a result of its investigation seven recommendations for process improvement had been put forward and approved at Director level. It did not state what those recommendations were.

60. The Ombudsman acknowledges that the landlord has gone some way to addressing the impact of its failings. Rehousing the resident in particular was a significant step which the Ombudsman welcomes. However, the Ombudsman does not consider that the steps which the landlord took can be considered to be reasonable redress which reflects the serious impact which the matter has had on the resident.

61. The Ombudsman notes that the landlord did not pay the resident compensation. The Ombudsman has referred to the landlord's Compensation Policy. This states that "for most problems, a genuine apology and putting things right straight away is where it ends … Sometimes, if it's taken us longer than it should have to get something sorted … we may offer a small gesture of goodwill…As a charitable organisation, we rarely offer compensation unless the customer has suffered financial loss … The things that we will look at will be: how much the customer has been disrupted, how long it's taken to put right, if there's been significant distress". The landlord distinguishes between "goodwill gestures" and compensation which it characterises as being solely for financial loss. These goodwill gestures appear to be £25 vouchers, flowers or gestures of a similar nature. It does not appear that in this case the landlord gave the resident one of these goodwill gestures.

62. The Ombudsman draws the landlord's attention to section six of the Housing Ombudsman Complaint Handling Code, which sets out what the Ombudsman considers are the best practice principles of "putting things right" where there have been failings. This includes the principle that any remedy offered by a landlord "must reflect the extent of any service failures and the level of detriment caused to the resident". The Ombudsman does not consider that the landlord's blanket policy of not giving compensation for distress and inconvenience, and limiting "goodwill gestures" to small amounts, is consistent with this. The landlord's corporate structure as a charity is not a reason for the landlord to not pay compensation where its failings have caused significant distress and inconvenience to a resident.

63. In assessing an appropriate level of compensation, the Ombudsman takes into account a range of factors including any distress and inconvenience caused by the issues, the amount of time and effort expended on pursuing the matter with the landlord, and the level of detriment caused by the landlord's acts and/or omissions. It considers whether any redress is proportionate to the

severity of the failing by the landlord and the impact on the resident. The Ombudsman also takes into account the evidence that has been provided. Ultimately the Ombudsman considers what would be fair and proportionate. The aim of compensation is not to be punitive but to provide redress for the impact of any failings by the landlord on the resident. In the case of compensation for distress and inconvenience, we are not able to quantify a definitive loss and the intention of such an award is to recognise the overall distress and inconvenience suffered by the resident.

64. The Ombudsman has first considered the distress and inconvenience suffered by the resident as a result of the landlord's failure to attend to the repair in a timely manner, its failure to treat the matter with the appropriate urgency as the matter progressed and its failure to acknowledge and account for the resident's vulnerabilities and its poor communication. In this case the Ombudsman considers the distress and inconvenience suffered by the resident to have been very significant and over an extended period of time. In recognition of the severity of the resident's distress, the Ombudsman considers it appropriate to require the landlord to pay the resident £1,200 compensation for distress and inconvenience caused by the landlord's failure to attend to the repair in a timely manner, its failure to treat the matter with the appropriate urgency as the matter progressed and its failure to acknowledge and account for the resident's vulnerabilities and its poor communication.

65. The Ombudsman has also separately considered the impact on the resident of not being able to live at the property for an extended period of time and ultimately having to move from the property that had been his established home since 2009. The resident has clearly articulated that having a safe and established residence was important for the effective management of his vulnerabilities. The impact on the resident's mother, as he lived with her for an extended period, was also a significant source of concern for the resident.

66. There was also a financial impact on the resident. The parties have not referred to rent being refunded and it appears that the tenancy continued to be treated as ongoing throughout the matter. Whilst the landlord made a contribution to some of the resident's increased gas bills due to the matter, it appears that the resident remained liable for the costs of utilities to the property when it was uninhabitable. The parties have not referred to moving costs, however it is to be expected that there would have been costs associated with the residents move to the new property.

67. Whilst in many instances a tenant would be expected to continue to pay rent while repairs are undertaken (even where the resident has been decanted), in this case the Ombudsman considers it unreasonable that the landlord did not consider a rent refund whilst the property was uninhabitable. The Ombudsman also considers that it was unreasonable that the tenant appears

to have remained liable for utilities and other associated costs in maintaining the property. In coming to this view, the Ombudsman has taken into account that the landlord does not appear to have made any effort to ensure the property was still habitable and indeed was aware that the resident was continuing to return to the property to empty buckets of water but was unable to live there. Further, whilst the landlord made a reference to offering alternative accommodation, this was presented as a “last resort”. Although the resident had alternative accommodation with his mother, the landlord was clearly on notice of the significantly detrimental impact this was having both on the resident and his elderly mother.

68. The Ombudsman has not been provided with exact dates, however it appears that from sometime around September 2020 onwards the resident had moved to his mother’s property to live permanently. Before this it appears that the resident was staying intermittently with his mother. By March 2021 the landlord had found the resident alternative accommodation. The Ombudsman understands that the resident continued to reside with his mother until moving to the new property and it is not clear that the resident ever returned to the property to live in before moving to the alternative property.

69. When the tenancy was first entered into in August 1999 the rent was £50.93 per week. The Ombudsman has not been provided with the rent that was charged at the time of this matter, however it would be expected that it would have increased over the lengthy period the resident lived in the property. When considering the amount of compensation that should be paid to the resident, the Ombudsman has therefore referred to the annual statistical data return that Registered Providers (including this landlord) submit to the Regulator of Social Housing. Data published from these returns includes average rents. The relevant table for the area that the resident lived in records the average housing association rent for a one bed property in 2021/22 as being just under £94 per week. The Ombudsman has also not been provided with evidence of utilities or the additional expenses that the resident and his mother incurred.

70. The Ombudsman recognises that some time has passed since the events and it would cause a notable burden on the parties, and in particular the resident, to identify and collate comprehensive evidence of the financial impact on the resident. The Ombudsman therefore does not consider it appropriate to make a specific order for financial reimbursement for the actual costs incurred by the resident. Rather, the Ombudsman considers it appropriate to require the landlord to make a further payment of compensation for distress and inconvenience which recognises the financial impact on the resident, including that rent was still charged for the flat, the impact of his temporary relocation and the loss of his long term home.

71. In the circumstances, the Ombudsman considers it reasonable to require the landlord to pay the resident a further £3,500 compensation. This figure has been calculated on the basis of £500 per month for the period of around seven months from September 2020 when the resident moved to his mother's until March 2021 when he moved to alterative accommodation. The figure of £500 per month has been based on the current average rent level being around £400 per month, plus a further £100 per month for other costs. Whilst the Ombudsman acknowledges that this is not a precise calculation, this is considered to a be a fair and reasonable amount of compensation taking all of the circumstances into account.

72. The Ombudsman also considers that the landlord's complaint handling failings caused additional distress to the resident. They exacerbated the resident's feelings that he was not being heard and meant that opportunities were missed to deal with the matter more appropriately in a quicker timeframe. The Ombudsman therefore considers it appropriate to require the landlord to pay the resident an additional £300 compensation for complaints handling failings.

73. The Ombudsman notes that the landlord has advised that seven recommendations for process improvement had been put forward and approved at Director level. The Ombudsman has not been advised what these were and it is not clear if the issues surrounding the landlord's management of vulnerable residents was addressed. The Ombudsman therefore requires that the landlord review its approach to the treatment of repairs for vulnerable residents and its management of communications and escalations for vulnerable residents. The Ombudsman's order regarding this is set out below.

74. The Ombudsman also requires that the landlord review its approach to compensation for distress and inconvenience and its complaints handling approach. The Ombudsman requires that the landlord provide the Ombudsman with the outcome of this review within twelve weeks of the date of this decision. The Ombudsman's order regarding this is set out below.

75. The Ombudsman understands that the resident feels that his distress has not been adequately recognised. The Ombudsman requires that a written apology is given to the resident from a Director level representative of the landlord.

Determination (decision)

76. In accordance with section 52 of the Housing Ombudsman Scheme there has been severe maladministration by the landlord with respect to its handling of repairs to a leak in the roof of the property.

77. In accordance with paragraph 52 of the Housing Ombudsman Scheme there was maladministration by the landlord in its handling of the resident's complaint about this matter.

Reasons

78. The landlord took approximately 21 months to successfully complete a relatively minor repair to the property. The landlord's failure to successfully undertake the repair in a timely manner led to the property becoming uninhabitable and caused significant distress and inconvenience to the vulnerable resident. When the landlord was made aware of the significance of the detrimental impact the situation was having on the resident, it failed to act with appropriate urgency. Whilst the landlord took some steps to address the impact of its failings – most notably rehousing the resident – these were not sufficient redress for the seriousness of the impact which the matter had on the resident.

79. The landlord failed to properly engage with the complaint at stage one and it appears that it did not escalate the matter to stage two until this service intervened. The landlord's blanket policy of not providing compensation for distress and inconvenience is unreasonable.

Orders

80. The Ombudsman requires that the landlord pay the resident a total of £5,000 compensation for distress and inconvenience. This amount is comprised of

    i. £1,200 in recognition of the distress and inconvenience caused by its failure to attend to the repair in a timely manner, its failure to treat the matter with the appropriate urgency as the matter progressed, its failure to acknowledge and account for the resident's vulnerabilities and its poor communication.

    ii. £3,500 in recognition of the significant period of time the resident was unable to live in the flat whilst continuing to pay rent, the additional expenses that were incurred due to his living in the alternative accommodation provided by his mother and the distress and inconvenience specific to his temporary and then permanent relocation.

    iii. £300 in recognition of the further distress and inconvenience caused by failings in the landlord's complaint handling.

81. The Ombudsman requires the landlord to undertake a review of the outcomes of this investigation and produce an action plan for service improvement which should be shared with this Service within twelve weeks of the date of this determination, including updated polices. This action plan should include

progress updates on the seven process improvements the landlord identified itself. It should also, if these are not covered already, ensure that it reviews -

(i) its approach to the treatment of repairs for vulnerable residents

(ii) its management of communications and escalations for vulnerable residents.

(iii) its approach to compensation for distress and inconvenience.

(iv) its approach to complaint handling.

82. The Ombudsman requires that a written apology is given to the resident from a Director level representative of the landlord. A copy should be provided to this Service, within four weeks of the date of this determination.