Housing Ombudsman Service

REPORT

COMPLAINT 202216547

Sanctuary Housing Association

14 November 2023

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 complaint is about the landlord's handling of:

    a. The landlord's response to the resident's reports of a leak.

    b. The associated complaint.

Background and summary of events

Background

2. The resident lives in a one bedroom ground floor flat. The flat is owned by the landlord, a housing association. She has a sole, 6 year fixed term assured shorthold tenancy that began on November 2018.

3. The landlord informed this Service that the resident has no recorded vulnerabilities. The landlord's records show that the resident disclosed to the landlord she is a person living with autism and ADHD. She also reported experiencing a respiratory condition and exacerbation of her mental health during the course of the period under investigation.

4. In November 2020, the resident raised concern to the landlord of a leak in the wall behind her toilet. She reported hearing water passing behind the wall and the wall bubbling. The landlord completed an emergency inspection the same day and then a follow up visit in January 2021. It diagnosed the source of the issue and presenting damp as a defective extractor fan. The fan was removed. It did not complete an immediate replacement, noting it needed to complete asbestos testing to the wall. This left the resident with a gap into the wall. In the interim, the resident chased the work in February 2021. Her MP raised issue on her behalf in March 2021. The fan was replaced April 2021.

Scope of investigation

5. What we can and cannot consider is called this Service's jurisdiction. This is governed by the Housing Ombudsman Scheme ('the Scheme'). When a complaint is brought to this Service, we must consider all the circumstances of the case as there are sometimes reasons why a complaint will not be investigated.

6. In accordance with paragraph 42 of the Housing Ombudsman Scheme, this Service may not consider complaints that were not brought to the attention of the landlord as a formal complaint within a reasonable period. This is usually considered to be within 6 months of the matters arising. The complaint under consideration by this investigation report was made to the landlord in September 2022. The events raised by the resident's complaint dated back to November 2020. A significant gap in contact to the landlord fell between April 2021 and the resident's fresh reports in January 2022. Due to passage of time and noting the resident did not raise a complaint to the landlord across 2021, it is not considered reasonable to fully review events beginning in 2020. Although the 2020 and 2021 events fall outside of the period of investigation, they provide important background. They have been considered as relevant context.

7. The period of investigation has been determined from the resident's January 2022 reports. Within a short period of time and with some frequency thereafter, the resident expressed her dissatisfaction at the landlord's handling.

8. The resident has informed the Ombudsman that the landlord's handling of matters raised had a negative impact on her health and wellbeing. This Service is unable to look into and make a decision about the cause of, or liability for, any impact on health and wellbeing. This is in accordance with paragraph 42(g) of the Housing Ombudsman Scheme which says the Ombudsman will not investigate complaints which concern matters where the Ombudsman considers it quicker, fairer, more reasonable, or more effective to seek a remedy through the courts, a designated person, other tribunal, or procedure. Determinations about liability for any impact to health would more usually be dealt with as a personal injury claim through the courts. Nonetheless, consideration has been given to the general distress and inconvenience which the situation may have caused the resident.

Summary of events

9. On 22 January 2022, the resident contacted the landlord about a leak in the wall behind the toilet. She explained the area was subject to damp and raised concern for structural damage. The landlord raised an internal action for an operative to attend to investigate, trace and remedy the leak. The landlord

attended the same day. It noted follow on works were necessary to remove the toilet, boxing, find the leak and reinstate.

10. On 24 January 2022, the landlord booked remedial work in with the resident for 14 March 2022.

11. On 12 February 2022, the resident called the landlord and reported that the damp conditions in the bathroom had caused an infestation of drain flies. The landlord booked for a plumber to attend 2 days later to remove the toilet pan and boxing to source the cause of the leak or standing water.

12. On 14 February 2022, the landlord's operative attended the flat. The landlord's repair records noted there was 'no work to do' as treating flies was 'down to the tenant'. The resident subsequently reported that the operative was rude and abrasive, making derogatory comments about the condition of her home. The landlord's repair log said the resident was abusive towards the operative when told follow on work was necessary. The log noted as outcome for the investigation, 'job already booked in 14th march nothing else can be done'.

13. On the same day, the resident contacted the landlord and expressed dissatisfaction at the landlord's handling of the earlier visit and delay to repair of the leak. She requested to make a complaint. The landlord's call handler recorded advising her it would need to transfer her to a manager to make a complaint. The resident is noted saying she could not wait on hold and terminated the call.

14. The resident made further calls to the landlord that same date. She repeated her request to make a complaint. She advised that the leak issue was causing her 'to have a nervous breakdown'. The resident was placed on hold. The landlord noted on return to the phone, the call had been lost. The resident also spoke with the landlord's maintenance team. It was discussed whether the remedial work could be brought forward. The landlord liaised internally and offered the resident an appointment on 11 March 2022. The resident explained she was unable to meet this date due to work commitments.

15. On 16 February 2022, the resident wrote to the landlord to raise issue with its handling of the reported leak. The resident raised the following issues:

    a. Delay awaiting repair of water ingress in the wall space around the toilet.

    b. Ineffective diagnosis of damp in the bathroom.

    c. The wall was damp and mouldy. The unsightly conditions were worsened by the subsequent presence of drain flies and an unpleasant smell. This was causing her 'mental anguish' and difficulty managing their presence.

d. Concern about potential risks to the building and her health. She highlighted asthma that the damp living conditions could exacerbate. She was also concerned for risk of infection due to her recovering from surgery.

e. The unprofessional and abusive behaviour of the operative attending on 14 February 2022.

f. She lived with autism and ADHD and had particular communication needs. If unmet, she experienced difficulty processing information and this could lead to her becoming stressed and escalation to a ‘meltdown’.

g. The requirements of her job made waiting at home for visits difficult.

16. A series of contact took place on 21 and 22 February 2022 between the landlord and the resident concerning permissions for their family and or friends tact as advocates on her behalf. The landlord noted internally to action a call to the resident from a team manager.

17. On 23 February 2022, the resident made a phone call to the landlord. She advised of a further crack to the wall. She subsequently sent an email to the landlord expressing her dissatisfaction of its handling of her complaint. She raised issue that she had not been called back and was experiencing poor living conditions.

18. On 24 February 2022, the landlord called the resident. She updated that she was in hospital after suffering chest pain and an asthma attack. She raised concern that her ill health was linked to the mould in her flat. The landlord advised it would consider bringing forward the remedial work and would call her the next day. It liaised internally about a possible new work start date.

19. The following day the landlord conducted an assessment as to whether the property was ‘habitable’. It recorded making contact with the resident and the most recent attending operative; both were noted to have said it was. It completed a referral to its wellbeing team in view of the health issues raised. This internal service tracked remedial work and maintained resident contact. The wellbeing team declined the referral the same day, noting that the resident would ‘not benefit’ from its service.

20. The landlord referenced the wellbeing refusal on 28 February 2022, noting the case was not appropriate for the service. It commented ‘I don’t understand how a leak can affect the tnts asthma’. The landlord decided it would seek more information about the resident’s health to inform which service would monitor the case. That afternoon, the landlord offered the resident an appointment for the works. The resident advised she was not immediately available. It was agreed she would be contacted in case of any further cancellations. Following the call, the landlord raised a further internal request to its wellbeing service.

21. On 1 March 2022, the landlord's wellbeing team contacted the resident to introduce its service. The landlord advised it would continue to track the case to see if the works could be reprioritised.

22. On 2 March 2022, the landlord noted that the attending operative's account of the visit of 14 February 2022 was in dispute with the resident's and it would take no further action. It recorded providing this update to the resident. A copy of the call log or correspondence has not been made available. It also offered and paid the resident £75 to account for its delays and lack of response to her complaint. The landlord noted learning points from delays to repairs and for the operative to be respectful of the resident's needs.

23. The landlord's wellbeing service reviewed the case on 7 and 10 March 2022. It sent a text message to the resident on 10 March 2022 to advise it was not currently able to bring the repairs appointment forward and would make contact on 15 March 2022 to check completion of the works.

24. On 14 March 2022, the landlord's repairs log recorded the remedial works with completed status. The notes of the job refer to the need for further works. The operative logged cutting out the wall, completing a temporary repair and observing 'leaking, dripping' in the wall, with possible cause being the 'stack' higher up. It was suggested to access the flats above. The resident described the operative having affixed tape to a pipe as a temporary repair and advised her of a likely issue above.

25. On 15 March 2022, the landlord left a voice message for the resident. The following day it spoke with her by phone. It recorded her confirming 'it is all complete' and noted closure of its case.

26. On 12 May 2022, the resident contacted the landlord and reported that the temporary repair was leaking and dripping and highlighted the need to look at the stack from above.

27. On 20 June 2022, the landlord inspected the resident's flat. It noted 'no apparent leaks' from inside and the resident's reminder that there may be leaking from the above flats. The landlord tried to access the above flats to inspect. They were unable to gain access that on that day.

28. The landlord's records noted an operative attending one of the 2 flats above the resident on 5 September 2022 and finding no leak.

29. On 18 September 2022, the resident wrote to the landlord to raise a complaint that:

a. The landlord had failed to complete effective repair(s) to a leak causing damp in her home for 2 years, The work completed in March did not fix the problem and the landlord had not fixed the suspected problem from above.

b. She had repeatedly made contact with the landlord to chase progress.

c. Her living conditions were unpleasant, describing the drain fly infestation and the leaking water created a foul smell. She had to repeatedly deep clean and redecorate the areas affected by damp and mould.

d. The issues had negatively impacted her physical and mental health.

e. She had suffered financial loss due to being absent from work so that she could try to address the issue with the landlord and falling unwell. She had bought a dehumidifier and this was costly.

f. She requested an apology with an explanation, all remedial work completed in 30 days and compensation.

30. The resident attached to her email photographs of damp within the corner of the bathroom at low level, crumbling plaster and disintegrating skirting. Other photographs displayed brown staining to the wall adjacent to the toilet at low level. Over the damp area, black mould spores were visible.

31. On 23 September 2022, the landlord contacted the resident and arranged an appointment for a surveyor to inspect the flat on 28 September 2022. The landlord also sent details of the complaint to its insurance advisor. It cautioned against issuing a response until it had received further advice.

32. The surveyor reported back to the landlord following their inspection of 28 September 2022 by a brief email. They noted the need for access to the 2 flats above the resident to repair leaks. Remedial work to treat and redecorate areas in the bedroom and bathroom damaged by damp was listed as required once the leak(s) had been fixed.

33. The landlord received advice from its insurance advisor on 4 October 2022.

34. On 6 October 2022, the landlord sent a text to the resident providing notice that works were booked for 22 November 2022. The resident called the landlord for confirmation of what had been booked in and to what exactly this related.

35. On the same date, the landlord emailed the resident and provided the following update:

a. It acknowledged receipt of her complaint at stage 1 of its complaints process. It would be in touch on or before 20 October 2022.

b. Its surveyor had identified remedial work from their recent inspection and further works were required to the properties above to 'inspect and repair any identified works'. It noted leaks within her home had been repaired.

c. The resident was advised to submit details about the stated impact to her health to its insurers and given guidance on making a claim.

d. The landlord requested evidence of the damage mentioned in her complaint and costs incurred.

36. On 17 October 2022, the resident emailed the landlord advising that the leak was causing damage to her bedroom carpet, having penetrated through the bathroom wall. She described the floor as wet and requested compensation.

37. The resident advised this Service that in October 2022 she submitted a claim to the landlord's insurers with medical evidence. She told this Service she has received no reply to date.

38. On 28 October 2022, the Ombudsman wrote to the landlord asking that it respond to the resident's stage 1 complaint by 4 November 2022.

39. On 3 November 2022, the landlord provided its stage 1 complaint response to the resident. It:

a. Outlined actions taken in response to the resident's reports and relayed the findings of the recent survey inspection. It confirmed that the remedial work recommended had been ordered for 22 November 2022.

b. Apologised for a lack of action after 20 June 2022 and the inconvenience caused to the resident.

c. Responded to the resident's proposed redress:

i. It was unable to consider loss of earnings, due to 'policy and procedure'.

ii. It would redecorate the areas affected as part of the remedial work booked in November.

iii. Regarding damage to the carpet, it had found no visible damage at the inspection or from the evidence provided.

iv. It offered £350 'goodwill' comprised of £200 for the time and trouble to the resident and delays and £150 for its delayed complaint response.

40. The resident sent an email in response to the landlord on the same date, requesting escalation of her complaint. She raised the following:

a. The landlord was not doing enough to rectify her concerns. The damp was worsening and she believed there was an ongoing leak. The proposed make good works were ineffective if the landlord did not repair the cause.

b. The complaint response failed to acknowledge the fuller history of her reports.

c. The landlord had failed to consider the impact to her health or the photographs she had sent.

d. The damp on her carpet had worsened over time.

41. The resident attached to her escalation request photographs of the wall/ floor at low level within a carpeted room. These showed visible signs of damp at low level adjacent to the floor, with brown mould on the wall and skirting.

42. On 21 November 2022, the landlord raised works for the soil stack to the properties above the resident's flat. The next day, the resident called the landlord to query whether the booked appointment was going ahead. She explained having spoken with an operative at the block the day prior who told her they had been unable to access one of the above flats. The landlord confirmed it had not been able to access either property above and would need to rearrange the remedial works in due course.

43. On 6 December 2022, the landlord's recorded the resident's complaint as closed. It noted, 'no response from tenant to final response sent'.

44. On 12 December 2022, the Ombudsman sent correspondence to the landlord explaining it was aware the resident had escalated her complaint but not received a reply. It required a response to her no later than 19 December 2022.

45. Later that day, the landlord emailed the resident. It acknowledged the approach from the Ombudsman and advised having reviewed its records. It said her complaint was closed on 6 December 2022 as it did not receive a reply to its stage 1 response. It noted she remained dissatisfied and updated having re-opened her complaint at stage 2. It stated she would be provided with its findings within 20 working days.

46. On 13 December 2022, the resident sent an email to the landlord reminding it that she had replied to its stage 1 response by her email of 3 November 2022. She forwarded a copy. She raised dissatisfaction that on 22 November 2022, she had taken time off work to be at home for the arranged remedial work appointment. She asked the further delay be noted as part of her complaint. She advised the leak was continuing to cause damage to her home.

47. The landlord replied the same day. It apologised that the resident had received no reply to her 3 November 2022 email. It noted her comments and assured her these would be passed to the officer investigating her complaint at stage 2.

48. On 16 December 2022, the landlord acknowledged by email to the resident that her complaint was being reviewed under stage 2 of its complaints procedure. It advised its response would be sent no later than 12 January 2023.

49. On 19 December 2022, the landlord called the resident. It updated that it was contacting her above neighbours and once it had done so, would be in touch following their investigation.

50. On 9 January 2023, the landlord raised an internal request for the investigations of the above flats to be rebooked. The investigations were arranged for 15 February 2023.

51. On 12 January 2023, the landlord provided the resident its stage 2 complaint response:

    a. It acknowledged a longer history of reports than considered by its stage 1 response, acknowledging the first report of a leak in November 2020. It also considered the associated reports of a drain fly infestation and apologised to the resident for the attendance of 14 February 2022.

    b. Considering the further chronology, it apologised for the inconvenience caused and stated it was not the standard of service it expected to provide. It accepted if it had taken appropriate action in November 2020 and June 2022, it could have resolved the repair sooner.

    c. It explained being unable to access the above 2 flats as no appointments had been confirmed with the residents. These had been arranged for 15 February 2023 and once the above soil stack was repaired, it would treat and redecorate the affected areas in the resident's bedroom and bathroom, including replacement of the damaged skirting.

    d. It accepted failings in its complaint handling at stage 1. It admitted having failed to acknowledge or respond to her escalation request. It promised to feedback its findings at a senior level to prevent recurrence.

    e. It advised it could not directly compensate the resident's loss of earnings in line with its complaints policy but would recognise her individual circumstances with an increased financial offer. It offered £935 compensation broken down as follows:

        i. £400 for time, trouble and inconvenience.

        ii. £75 for the inconvenience of failed appointment on 21 November 2022.

        iii. £300 for complaint handling.

        iv. £100 for unclear records and poor communication.

        v. £60 contribution towards carpet cleaning.

Post-complaint events

52. On 20 January 2023, the resident accepted the landlord's compensation offer. The landlord replied explaining steps it was taking to gain access to the above flats on 15 February 2023.

53. The landlord stated to this Service that its records indicated work to the above flats was completed across February. The provided logs were unclear, the works completed cannot be deciphered. The landlord's records of 8 March 2023 said its operatives 'repaired above properties' and the resident reported that her bathroom remained wet and the walls stained. Other logs provided suggest work to the above flats on 13 April 2023 and another on 26 May 2023. The resident recalled to this Service that the landlord completed redecoration of her bathroom on 26 May 2023.

54. On 26 May 2023, the landlord logged a call by the resident expressing concern about the work completed by the landlord that day. She raised issue that the skirting board was still rotten and was painted over instead of being replaced or first treated. Her concerns were followed up in a web complaint submission. She highlighted having to chase the work promised to her home in April, leading to the appointment in May. She described the issues causing her 'mental health problems' and feeling ignored.

55. On 29 May 2023, the landlord replied and apologised for delay, quality of works and inconvenience. It offered compensation of £200 as 'goodwill', increased to £225 by the date of sending in June 2023 due to delay making the payment.

56. On 4 July 2023, the landlord logged on its repairs system the need for works to be completed to the resident's bathroom, 'to stop escalation of complaint'. It noted the bathroom had been assessed and the cause of mould found to be 'numerous leaks coming from the soil stack from above flats'. It listed a number of items for work including renewal of the flooring and wall lining. The work was initially booked for 23 August 2023 but later brought forward to 8 July 2023.

57. The resident's account to this Service described a series of visits to her home and the flats above towards the end of June 2023. She detailed at length the work undertaken by attending operatives to cut an inspection hatch into the wall to diagnose the issue from above. She was informed during the course of the June 2023 visits that the leak from above had been fixed on those dates. She confirmed that on 8 July 2023 the landlord completed full treatment and redecoration of the affected areas of her bathroom. She was recommended to allow her bedroom wall to dry out. The resident has advised no longer wishing for redecoration by the landlord to this area to avoid disruption.

58. On 9 August 2023, a senior member of the landlord emailed the resident. They apologised that the resident had need to pursue a complaint to the Ombudsman and sought to check if matters had been put right. The resident replied on 11 August 2023 to confirm that the work had been resolved.

59. On 27 September 2023, the landlord replied to a query raised by this Service about their repair logs. It updated that works to one of the above flats remained outstanding and had been requested for urgent completion.

Assessment and findings

60. The Ombudsman's Dispute Resolution Principles are:

    a. be fair

    b. put things right

    c. learn from outcomes.

    This Service will apply these principles when considering whether any redress is appropriate and proportionate for any maladministration or service failure identified.

The landlord's obligations

61. The tenancy agreement required the landlord to keep in repair the structure of the property including pipework and the walls. This mirrored its repairing obligation at section 11 of the Landlord and Tenant Act 1985. A repair must be completed within a reasonable period of time. A landlord is also required to make good damage caused to decoration from its failure to do repairs.

62. The operation of the Homes (Fitness for Human Habitation) Act 2018 implied a term into the resident's tenancy agreement from 20 March 2020 that the landlord must ensure its dwelling was fit for human habitation. The existence of a hazard as defined by the Housing Health and Safety Rating System is one of the factors that may be considered when assessing fitness. Hazards arise from faults or deficiencies that could cause the occupant(s) harm and include damp, high moisture and hygiene risks. Relevant case law held that a property is not reasonably fit for habitation if the state of repair means an occupier might experience injury to health as a result of their ordinary use of the property.

63. This Service published in October 2021, its spotlight report on damp and mould. This repeated findings from NHS data that residents living in homes with damp and mould may be more likely to have respiratory problems. It stated that landlords should recognise such issues can have an ongoing detrimental impact to the health and wellbeing of the resident and should therefore be responded to in a timely manner.

64. The landlord's repairs and maintenance procedure set service timescales for its expected response to report of a repair issue:

    a. 'Emergency' repairs were to be attended to within 24 hours to make safe the property. These were defined as those necessary to 'remove a serious threat to the health and safety of the service user, members of their household, visitors, or the structure and fabric of their home'. It gave an example of a water leak coming through a ceiling.

    b. 'Appointed' repairs were non-urgent to be completed in 28 days.

65. This repairs procedure said the landlord would ensure its repairs service would consider both the needs of vulnerable service users and the severity of their situation on a case by case basis to inform the potential need for flexibility to job priority or services. The landlord's repairs policy expressed a stated aim to provide a repairs service tailored to meet individual needs and to regularly update its customer on the progress of their repair by proactive communication.

66. The landlord's wellbeing process guidance concerned additional measures put in place where a customer was adversely affected by an outstanding repair. This allowed for ownership and tracking of the repair until completion, alongside keeping the resident informed and checking their wellbeing.

67. In accordance with its complaint's procedure, the landlord's response to the resident's' complaint at stage 1 was required within 10 working days of the complaint and the stage 2 response in 20 working days. The complaints policy set out matters to be considered by separate processes, including personal injury claims that it would ordinarily pass to its insurers. Its policy also detailed the need for reasonable adjustments when made aware a customer had particular needs and signposting to other organisations for support where appropriate. The associated reasonable adjustments guidance said the landlord would review a complainant's file to identify needs on receipt of a complaint.

68. The landlord is required to have regard to a complainant's disability in line with its obligations under the Equality Act 2010. Where on notice, it must consider when making decisions and providing a service whether its decision making/ actions could place the person at a particular disadvantage due to their vulnerabilities. The landlord is also required to make reasonable adjustments taking into account a known disability.

69. The landlord had compensation guidance covering factors it should consider when assessing financial redress if it identified failings and guideline rates.

The landlord's response to the resident's reports of a leak

70. The resident reported signs of water ingress continuing to affect her home in January 2022. As at the landlord's final response to her complaint almost a year later, the leak was ongoing. From review of the landlord's records, 2 principal common features are noted as contributing to this delay:

    a. Failure to sufficiently priortise the investigations and works it identified.

    b. Works and investigations recorded as required were not followed through.

71. The evidence showed the landlord on occasions assigning appropriate emergency level priority to the resident's reports. However, after completing initial attendances and despite logging the need to source the leak, insufficient priority was given to follow on and investigatory works. By way of examples:

    a. The landlord noted evidence of a leak requiring further investigation at its visit of January 2022. The work to investigate the wall and diagnose the issue was not diarised until mid-March.

    b. At the visit on 14 March 2022, the landlord identified the potential cause of water ingress coming from the flats above and noted the need for investigation. Attempted visits to the above flats were not made until 20 June and 21 November 2022. On both occasions, no evidence was provided that the residents had been placed on reasonable notice of access being required to their homes. In the interim, multiple further inspections of the resident's home confirmed the need for assessment of the above flats.

    c. Inspections to the above flats were diarised in early January for 15 February 2023.

72. The landlord's failure to sufficiently priortise work left the resident living with the consequences of worsening damp for an extended period. It would appear there were systemic delays to appointed works. On each occasion the works were booked outside of the landlord's own repairs timescale.

73. The landlord was noted in February 2022 to have completed a form of risk assessment leading to the case being tracked for potential prioritisation by its wellbeing service. However, outside of this period and despite the same facts recurring with reports of worsening conditions and photographic evidence of mould, there is no evidence of any other risk-based approach or assessment. A number of factors should reasonably have indicated to the landlord the potential for risks presenting in this case. These include that it was a longstanding issue first reported in Nov 2020, repeated reports, latterly a failed attendance and stated impacts on the resident's day to day life, physical and mental health, some described in severe terms. The landlord's failure to adopt a consistent risk-based approach is likely to have contributed to its failure to assign

appropriate priority and give sufficient impetus to completion of necessary remedial actions.

74. Outside of the period of monitoring of the works by the landlord's wellbeing service, there is little evidence of a service taking ownership for completion or devising a strategy for resolution. Almost each time the resident re-reported the issue to the landlord, a new job was logged by the landlord back into its queue and multiple further inspections booked. It seems the landlord was unable to hold a full picture of the ongoing nature of the matter and this could be explained by a failure in the way it holds and manages its data. There was a failure by the landlord to recognise the recurrent reports as part of one ongoing issue and accordingly formulate an appropriate strategy to remove barriers to resolution. The implementation of the recommendation of this Service by its damp and mould spotlight report of a risk based approach and specific framework or policy to tackling such issues may reasonably have helped to avoid this failing.

75. Some months passed during which there is no evidence of any progression or work booked in. For example between mid-March to mid-May 2022. It is unclear if this was an issue of capturing jobs in the landlord's systems or a failure of effective monitoring or implementation.

76. Instead of appropriately progressing the investigatory work identified in January 2022 to the above flats, the landlord repeatedly re-inspected the resident's flat only to draw the same conclusion. It is understandable that as the issue progressed, the landlord would seek to update itself of the reported conditions and obtain further expertise from a surveyor. However, the landlord's notes show these attending had to be reminded by the resident of previous findings. This is suggestive of a record keeping failure or a failure by staff to review notes of previous attendances. This issue is also consistent with the on-the-day attempt to inspect the above flats in June, made without notice to the occupants and impacting the landlord's chances of gaining entry.

77. Investigatory works were unnecessarily prolonged and added to the disruption caused to the resident who advised of taking unpaid days off work only to be no further forward. The very circumstances cited by the landlord's repairs procedure to be avoided, i.e., wasted efforts through unnecessarily repeated inspections occurred in this case.

78. The landlord's delay of almost a year taking effective steps to seek to remedy the reported water ingress was unreasonable. An effective repair was still outstanding at the point of the landlord's final response. The delay was contrary to the landlord's legal repairing and fitness obligations and out of compliance with its own policy and procedure.

79. This delay led to water ingress continuing to impact the resident's home and in turn caused impact to the resident. The resident reported increasingly unpleasant and unsightly living conditions consistent with the photographic evidence she provided. This included: mould spores, brown staining on walls, damp patches, crumbling and rotting plasterwork and rotting skirting boards. Over time, as the issue was left untreated, the effects spread to her bedroom and the mould spores worsened. She also made the landlord aware of an infestation of drain flies and provided video footage of the flies. It is clear the resident endured conditions that were unpleasant and worsened during the periods of inaction and ineffective action by the landlord. She was also put to time and trouble making arrangements to repeatedly stay at home for inspections that drew the same repeated conclusion. The landlord's delay is noted to have led to a seriously detrimental impact upon the resident, principally owing to the length of time that the circumstances continued.

80. Added to the detriment caused by its delay, the landlord on a number of occasions acted in a way that was inconsistent with its previous assurances to the resident. It advised the resident in February 2022 after she reported worsening conditions at her home that it would attend her home to complete works on 14 February 2022. At the visit she was then informed no works could be completed and further informed the fly infestation reported as linked to damp conditions was her responsibility. The records display a lack of evidence to support the advised finding or any details of how this conclusion was reached. The resident raised her severe distress following this visit in immediate response, describing the issue causing her to 'have a nervous breakdown'. The resident's expectations were not effectively managed ahead of the visit of 14 February 2022 and the attending operative acted contrary to or in ignorance of the landlord's existing knowledge of a leak. This mishandling exacerbated the detriment including distress experienced by the resident.

81. The resident was provided in September an appointment of 22 November 2022 for remedial work. The evidence does not provide any facts or context to explain why such delay to works occurred. In any event, and after the resident had waited for a further 2 months, it was only the day prior to her appointment that the landlord's system logged the need for work to the properties above. The landlord was not able to access the above flats. The consequence to the resident of failing to complete this work to stop the cause of water ingress does not appear to have been identified. The landlord did not take any proactive step to update the resident that the make good decorative work would no longer go ahead the following day. The resident accordingly took a day off work, only to be informed when chasing confirmation that it would no longer be attending. The failed visit exacerbated the detriment to the resident who was left with disappointment and distress that she was once again no further forward.

82. This incident is also an example of the poor communications displayed by the landlord to the resident throughout the period of investigation. The records show an almost consistent pattern of the resident's contact driving progress of the case and the provision of updates.

83. The landlord's wellbeing service had involvement in the case for a period of several weeks leading up to the attendance to her home of 14 March 2023. The proactive communication and updating to the resident during this short period is in marked contrast to the rest of the timeframe under review. Outside of those few weeks, there are significant gaps in the landlord's contact with the resident, at times for periods of months, even though it was aware work was outstanding and water ingress ongoing.

84. It is noted on occasion to have communicated notice of remedial works appointment by text only, sending standard notification of works booked. Against the history of the case and its awareness of the resident's vulnerabilities, this was inappropriate handling of its message. It failed to provide an accessible explanation of what works it had arranged to the property or how these would resolve the issues experienced. The resident was put to further inconvenience calling the landlord seeking an explanation of the work due that should reasonably have been communicated to her. It failed to apply any reasonable adjustments that this Service would expect to see, the landlord being on notice of the resident's communication vulnerabilities.

85. Outside of the short term handling by the wellbeing service, there is no evidence a particular service took responsibility or had adopted a clear strategy for ensuring proactive and consistent communication with the resident. The landlord's poor communications were contrary to the stated aim within its repairs policy to regularly update its customers on the progress of their repair and to proactively communicate. Communications relied on the resident reporting matters or chasing update that placed her at significant time and trouble. It is noted the resident advised the landlord that communications presented her with challenges owing to her vulnerabilities. That the landlord's ineffective communication placed additional burdens on a resident in these circumstances is an aggravating factor to the detriment caused by the landlord's mishandled contact.

86. The landlord is shown from its records to have given little regard to the detrimental impact to health as reported by the resident. It is acknowledged the landlord appropriately identified and took account of risk factors at the end of February 2022. Prior to this however, the resident had already told the landlord the issues were taking a serious toll on her mental health and presented in acute distress over the phone. She had raised concern of respiratory issues and her recovery from surgery. There is no evidence the landlord completed a needs or risk based assessment until the point she cited hospitalisation due to

respiratory related illness. This belated recognition was inconsistent with the early recognition of potential risks recommended by the Ombudsman's spotlight report. It is also contrary to the landlord's repairs policy that required it to take into account service users' needs.

87. The comments made by the landlord regarding a link between the resident's respiratory issues and damp conditions were noted with concern. While the wellbeing referral was later accepted owing to internal persistence, this opinion showed a lack of consistent understanding of the well documented potential health related risks that may arise from damp living conditions and a lack of consistency of approach to assessing residents' needs.

88. The wellbeing service support was terminated when the landlord recorded completion of works on 15 March 2022. Although the landlord allocated this additional service to the resident due to her identified vulnerabilities, there is no evidence these were considered at potential closure or whether signposting was required for follow on assistance. The landlord's internal wellbeing process guidance provides no details as to how the landlord assesses withdrawal of support or its decision making. This omission at a key stage of process is out of line with the landlord's commitment to consider resident needs. The withdrawal of an adjustment to service to account for health related issues without any updated reference to the resident's needs is also out of line with the requirements of the Equality Act 2010.

89. Despite the resident continuing to report adverse impacts to her physical and mental health that she attributed to conditions at her home after March 2022, there is no evidence the landlord considered the resident's vulnerabilities during the rest of its course of contact with her. There is no record that the landlord acknowledged or responded to the mental health concerns she stated were connected to the outstanding repairs eg by offering relevant support. Appropriate signposting of potential support was specifically referred to within the landlord's complaints policy and its commitment to making reasonable adjustments. Actions in line with its policy were not taken.

90. The landlord's wellbeing service was not further contacted, despite the conditions for referral from its process guidance being clearly met. The landlord's failure to re-refer the resident to its appropriate service was unreasonable and contrary to its guidance. The involvement of the service was previously noted to have ensured communication with the resident, considerate of her needs. This failure represented a missed opportunity by the landlord to minimise the impact of its further mishandling.

91. The resident told the landlord in February 2022 that she was a person living with autism and ADHD with communication needs. The landlord is noted to have appropriately noted these needs at that time and made assurances of the

account it would take moving forward by its contact on 2 March 2022. However, as found above, its ineffective handling of communications placed her as a person with communication related vulnerabilities at undue additional detriment.

92. The landlord failed to engage reasonably over the course of a significant period with its awareness of the resident's known disability and specific representations of vulnerabilities. This was a failure by the landlord across the course of this period to have regard to its duties under the Equality Act 2010. It failed to actively engage in conversations with the resident that would have enabled it to understand her needs and make relevant reasonable adjustments. This represents additional detriment experienced by the resident.

93. While the landlord's repairs procedure and policy contained provisions requiring it to consider the needs of its vulnerable service users, these were limited in scope. The wellbeing process did not engage in real substance with the resident's vulnerabilities and appeared primarily aimed at monitoring repairs and the service time/task limited. There is no evidence the landlord had sufficiently detailed policies or procedures to guide consistent identification, assessment and response to customer vulnerabilities across its services.

94. The above identified failings in the landlord's handling of the resident's reports of a leak were serious, ultimately leading to a delay of almost a year taking effective action to resolve the cause of water ingress. The landlord's final complaint response of 12 January 2023 sought to put matters right. It apologised to the resident and acknowledged the fuller history of the issue. The apology was communicated in a clear way and presented as sincerely given. It was reasonable that the landlord acknowledged failings in its approach to handling her reports, accepted the service provided fell below expectation and that it could have resolved the issue at an earlier stage.

95. However, the response did not identify and acknowledge adequately the failings identified by this report, nor did the compensation offered provide proportionate redress in consideration of the level of its failings and detriment caused to the resident. It did not give appropriate consideration to the individual detriment cause to the resident, particular in view of her vulnerability. Further, it did not assess the impact to the resident in line with its room loss allowance guidance. While it suggested having assessed learning points and made promises of works it would complete, it did not take appropriate further steps to address the issue. The assurances made in the final response did not lead to an effective response. Concerningly, from the landlord's most recent correspondence to this Service, works to remedy the leak from one of the above flats are even now still unresolved. The landlord's failings amount to severe maladministration, taking in account the impact to the resident. It is ordered that compensation be paid to the resident to account for the detriment

caused. The compensation already paid to the resident of £935 is to be taken off the amount awarded below.

96. The landlord's previously offered compensation appropriately identified that the inconvenience and time and trouble caused to the resident was at a high level. This led to it offering the maximum figure for this form of detriment in line with its compensation guidance. However, this Service considers appropriate discretion was not exercised to consider the full level of detriment caused in this particular case with reference to the resident's individual circumstances,

97. The Ombudsman's remedies guidance suggests financial redress of between £600 to £1,000 where a severe maladministration finding is made but where the impact was significant but not severe and long term. The vulnerability of the resident and the time and trouble to which she was accordingly placed repeatedly communicating her circumstances is considered an aggravating factor. Compensation is ordered at the higher end of this band.

98. Although the landlord gave appropriate account for a number of decorative items, it failed to consider a significant aspect of the particular detriment caused in line with its compensation guidance, the impact of the affected areas to the resident's enjoyment of her home. It did not offer any compensatory sum with reference to its room loss allowance, despite accepting repair failings. This Service considers it would have been appropriate for the landlord to do so. While the resident was able to use the rooms, her experience at home was adversely impacted. She lived for many months amongst unpleasant conditions. The affected areas were directly next to her toilet and her bed, forcing her to come into close proximity with damp conditions.

99. Compensation is additionally ordered to address this loss of enjoyment of home with reference to the resident's rent in line with the landlord's compensation guidance. As the bathroom was an essential room containing crucial sanitary installations, a starting percentage of 30% for the room is appropriate. This is in line with the maximum proportion for this room in the landlord's guidance. This figure is lowered to 15% given that the room remained usable but enjoyment of the area substantially curtailed. The period of calculation for loss of enjoyment of the bathroom has been taken to begin 28 days after the resident's report in January 2022. This 28 days mirrors the landlord's own repair timescale as a reasonable period of time in which the landlord was able to progress effective remedial works.

100. Similarly, the resident's use of her bedroom was affected. This was a more discrete impacted area but there was evidence of damp, mould and staining. The resident further reported experiencing a wet carpet, consistent with evidence of other damp in the affected area. Given the small area impacted but noting that this was in the room where the resident slept and therefore

unavoidable, the appropriate percentage is identified as 10%. The period of calculation is assessed from September 2022, when the landlord first noted the presence of water ingress in the bedroom.

101. The calculations for loss of amenity are set out below:

Affected room	**Room allowance based on rent**		**Totals**
	April 2021 rent £86.76 pw	April 2022 rent £90.51 pw	
Bathroom – 15%	£78.08 (6 weeks- 19.02.22-31.03.22)	£549.85 (40.5 weeks- 01.04.22-12.01.23)	£627.93
Bedroom- 10%		£203.65 (15 weeks- 28.09.22-12.01.23)	£203.65
			£831.58

102. This Service orders additional compensation to address the ongoing impact to the resident in the further period during which the landlord failed to fulfil the specific actions promised by its final response of 12 January 2023. The landlord's records show its remedial actions to address, at least in part, the cause of water ingress to the resident's home and decorative work were not completed until 8 July 2023. The landlord is ordered to compensate the resident for loss of enjoyment to her home during this further period using the loss of amenity figures identified above as consistent with its own compensation guidance and as set out below.

Affected room	**Room allowance based on rent**		**Totals**
	April 2022 rent £90.51 pw	April 2023 rent £98.65 pw	
Bathroom – 15%	£149.34 (11 weeks- 13.01.23-31.03.23)	£207.17 (14 weeks- 01.04.23-08.07.23)	£365.51
Bedroom- 10%	£99.56 (11 weeks- 13.01.23-31.03.23)	£138.11 (14 weeks- 01.04.23-08.07.23)	£237.67
			£594.18

103. The landlord is also ordered to compensate the resident for the additional distress and inconvenience experienced and the further time and trouble to which she was put during the period 12 January to 8 July 2023. This Service has noted the resident's contact to the landlord in May 2023 of the emotional distress caused by its continued failure to complete works promised by its

complaint response. There is evidence in further period that the resident was put to further unnecessary efforts having to inform the landlord it had not completed works promised and chasing compliance with its offered complaint resolution. An additional award that addresses the further detriment to which the landlord placed the resident by delaying compliance has been added to the compensation ordered.

104. This Service is unable to quantify the detriment arising from the landlord's outstanding works past 8 July 2023. It is clear from the resident's account and the nature of works recorded completed on this date that the subsequent adverse impact to use of her home was significantly lessened. She reported being unaware of any further visible impacts of water ingress from July 2023. However, the landlord's update to this Service of 27 September 2023 confirmed some associated remedial work remained outstanding. This Service has insufficient information to assess the further impact of this outstanding work. There is no evidence the landlord notified the resident it still had work to complete and the resident was unaware by her account.

105. Should the outstanding work be linked to that promised by the landlord in its final complaint response, the landlord is ordered to review appropriate further compensation to the resident. The sum to be offered should take into account the additional further delay to completion of work promised by its complaint response, lack of notice to the resident and have regard to any associated distress caused by the resident becoming aware it further failed in its assurances to her.

106. It is noted that the landlord's compensation guidance recommends financial award of £2 per day for use of a dehumifider. The resident's complaint included a request for compensation for the purchase and use of a dehumidifier, however no specific consideration was given within the landlord's responses. The resident supplied evidence of and the landlord itself confirmed the presence of damp conditions subsequently shown to have been caused by its failure to repair. It is reasonable that the landlord provide specific redress for this additional cost to the resident. On receipt of evidence of purchase of the dehumidifier from the resident, the landlord is ordered to assess reasonable reimbursement to the resident for the item and an award for use in line with the daily rate from its own compensation guidance.

107. This Service has considered the landlord's publicised response to this Service's damp and mould spotlight recommendations. It is noted that the response is undated, however the positive measures detailed were not observed in this particular case. The spotlight report suggested that landlords consider an overall framework or policy to specifically address damp and mould and ensure reports are treated consistently and given appropriate priority. A wider order

under paragraph 54(f) of the Scheme has been issued to the landlord as part of case 202224898 that focuses on the landlord's response to such reports.

108. Concerning the resident's claim to the landlord's insurers, it is considered reasonable that the landlord directed the landlord to their separate process in line with its policy. This Service has not seen evidence of the resident notifying the landlord that she did not hear back from to place it on alert that it might try to support her efforts. The landlord is recommended to take all reasonable steps to support the resident with her claim and to seek a status update from its insurer.

The landlord's handling of the resident's complaint

109. Although the landlord's complaints policy appropriately defined a complaint as 'an expression of dissatisfaction, however made, about the standard of service, actions or lack of action..', it failed to treat a number of clear earlier complaints by the resident in line with its formal policy.

110. The resident attempted to log a complaint on 14 February 2022. It is unclear why she was told it had to be raised with a manager and could not be registered by the call handler. This appeared to present an unnecessary obstacle to her raising complaint out of line with the landlord's policy or accessibility. The written complaint subsequently received by the landlord on 16 February 2022 does not appear to have been handled in line with the landlord's complaints procedure. There is evidence of a payment of £75 being offered to the resident on 2 March 2022 in acknowledgement for service delays. However, there is no copy record of a complaint acknowledgement or a full stage 1 complaint response. There is no evidence accordingly that the landlord demonstrated to the resident it had carefully investigated her concerns and provided reasoning on its findings. Importantly, by the lack of a detailed response as required, the resident was left without written explanation of the landlord's identified failings. This prevented full transparency and accountability to the resident. This handling of earlier complaints was contrary to the landlord's own complaints policy and the requirements of the Ombudsman's Complaint Handling Code ('the Code').

111. The resident sought the support of this Service to require the landlord's complaints responses at both stages one and 2 of its complaints policy. At stage 1, the landlord's response ran outside of its standard response timescale before it informed the resident it needed an extension of time. Contrary to the terms of the Code, although the extension brought the response time beyond 20 working days, it did not try to agree the extension with the resident. The extension date came and went without the resident receiving an update, request for further extension or any acknowledgement that the landlord required a further period. Its silence accordingly led to the resident incurring

time and trouble seeking external assistance by this Service and prompted its first intervention of 28 October 2022.

112. The landlord's response of 3 November 2022 came almost 7 weeks after the resident submitted her complaint. While liaison with the landlord's insurers would reasonably lead to short delay on specific associated matters, there is no mitigating circumstances evident that explain the level of delay or why the landlord did not keep the resident updated. In the circumstances where the landlord was already aware of the resident's level of distress, her communication challenges and that she was living with a delayed repair, the failings in its engagement during complaint handling show a lack of regard for the resident's experience or needs.

113. The landlord received the resident's escalation request by email on 3 November 2022 but failed to acknowledge receipt or start an investigation in accordance with its process at stage 2 or the requirements of the Code. It then prematurely closed the complaint case on 6 December 2022, noting in error that there had been no response to its stage 1 response. The resident's request for further consideration of her complaint failed to be acknowledged or responded to. The landlord's failure to issue a stage 2 response was brought to its attention by this Service's second intervention of 12 December 2022. The landlord's immediate response wrongly advised of not receiving an escalation request. This placed the resident once again at further time and trouble sending further copy to the landlord. It is evident that her complaint escalation of 3 November 2022 had failed to be appropriately logged or recorded as received.

114. The landlord's failure to action the complaint escalation request led to its stage 2 response being issued outside of the standard response time of 20 working days as stated by its policy. It was issued 10 weeks after the landlord received the resident's request.

115. It is of concern that following the first intervention by this Service, the resident was put to further time and trouble of re-referring the matter at stage 2 and that a more proactive and accountable approach was not taken by the landlord to ensure resident experience of complaint handling improved. The need for multiple interventions by this Service to require responses to the resident's complaint are serious failings.

116. It was appropriate that the landlord provided apology to the resident for failing to acknowledge or respond to her escalation request. It also acknowledged concerns about the way the resident's complaint was handled. However, it did not identify or address the level of failings detailed above or acknowledge the impact of these to the resident. In particular, it showed no regard to the particular difficulties she experienced when communicating and how these may have exacerbated the detriment caused by her repeat efforts she incurred

simply to have her voice heard. These efforts were only made necessary due to the landlord's non-compliance with its own policies and the Code. The apology did not go far enough.

117. It is noted that the landlord offered to the resident compensation for poor complaint handling at the highest end of its guided banding for this category of service failure. It was appropriate that the landlord recognised the resident had been subjected to higher level of failings. However, the £300 offered was not, in the view of this Service, a proportionate figure to redress both the level of failings or their associated detriment to the resident. The figure did not take sufficient account of the resident's experience throughout the series of complaint handling failures and how these would have particular impacted her as a person who could find communications challenging due to her disabilities.

118. The accumulation of failings in the landlord's complaint handling amount to severe maladministration. The Ombudsman's remedies guidance suggests financial redress of between £600 to £1,000 where a severe maladministration finding is made but where the impact was significant but not severe and long term. Owing to the level of time and trouble to which the resident was placed and the evident distress caused to a vulnerable resident, compensation is ordered within this band.

Review of policies and practice

119. The Ombudsman has found maladministration (including severe maladministration) following several investigations into complaints raised with the landlord involving leaks, damp and mould. As a result of these; a wider order has been issued to the landlord under paragraph 54(f) of the Scheme. This is for the landlord to review its policy or practice in relation to the service failures identified, which may give rise to further complaints about the matter.

120. The landlord has been ordered to carry out a review, within 12 weeks, of its practice in relation to responding to requests for repairs due to leaks, damp and mould. Some of the issues identified in this case are similar to the previous cases and so the learning from this complaint should be incorporated into the wider review, ordered as part of case 202224898. In addition to this, we have not made any orders or recommendations as part of this case, which would duplicate those already made to landlord as part of the wider order.

Determination (decision)

121. In accordance with paragraph 52 of the Housing Ombudsman Scheme, there was severe maladministration in the landlord's handling of the resident's report of a leak.

122. In accordance with paragraph 52 of the Housing Ombudsman Scheme, there was severe maladministration in the landlord's handling of the resident's complaint.

Reasons

123. As at the point of the landlord's complaint response and almost a year after the resident re-reported water ingress to the landlord, remedial work to fix the problem was outstanding. The landlord's response was subject to significant and unreasonable delay, contrary to its own policy, procedures and legal obligations. The landlord poorly handled its communications with the resident, whose proactivity drove its updates and progress despite challenges she faced as a person living with communication difficulties. The landlord had little regard to the detrimental impact to health reported or the resident's vulnerabilities, inconsistent with its legal obligations and policy commitments. The detriment to the resident was significant. She was left living with the consequences of worsening damp for an extended period and put to substantial time and trouble chasing progress.

124. The landlord's complaint handling was subject to a series of failings. It failed to treat a number of clear expressions of dissatisfaction as complaints contrary to its policy and the Code. Its responses at both stages of the complaint process were delayed and it failed to appropriately communicate delay to the resident. It was only after the intervention of this Service at both stages 1 and 2 of its complaint process that the landlord provided its required formal responses. This placed the resident at significant detriment and occurred in circumstances where the landlord was aware of the resident's communication vulnerabilities. It showed a lack of regard for her resident's experience throughout the complaint process. Although the landlord provided apology for aspects of its complaint handling and offered financial redress, it did not go far enough to recognise its failings in or the particular difficulties these caused the resident.

Orders and recommendations

Orders

125. Within 4 weeks of the date of this decision, the landlord is ordered to:

    a. Arrange for an apology in writing to the resident from its Chief Executive for the failings identified in this report.

    b. Pay the resident £2,290.76 compensation. This figure is net of the £1,135 total compensation already paid to the resident. It is comprised of:

        i. £1,425.76 loss of amenity in line with its compensation guidance (room allowance) to account for loss of amenity during delay to works.

ii. £1,350 distress, inconvenience and time and trouble.

iii. £650 complaint handling.

(minus £1,135 already paid)

c. Conduct a review as to whether, on the basis of the findings of this report, further compensation is due for loss of enjoyment of home, further delays, distress and inconvenience and time and trouble after 8 July 2023. The landlord's decision is to be signed off by the senior member of staff carrying out the below ordered review. The landlord is to then to write to the resident and this Service to confirm its position with explanation.

d. On receipt of evidence of purchase of a dehumidifier from the resident, the landlord is ordered to assess reasonable reimbursement and an award for use in line with the daily rate from its own compensation guidance.

e. Complete the outstanding remedial work to the above flat impacting the resident's home and confirm to the resident and this Service in writing. If issues arise concerning access, the further work is to be re-diarised with emergency priority in line with the landlord's repairs timescale and the resident kept updated of progress in a timely manner.

126. In accordance with paragraph 54(f) of the Housing Ombudsman Scheme, the landlord is ordered to carry out a review of the failings identified above in its response to the resident's vulnerabilities as follows:

a. The review should be conducted by a team independent of the service area responsible for the failings identified by this investigation.

b. The review should include but not be limited to consideration of:

i. How it assessed or failed to identify the resident's particular needs.

ii. How it responded to notice by the resident of her needs or cited adverse impact to health.

iii. The formulation of a policy/ procedure that covers responding to customer vulnerabilities.

c. The review team should prepare a report setting out its findings and learning and the actions recommended to prevent recurrence of similar failings. A copy of the report is to be provided to the Ombudsman within 8 weeks of the date of this determination.

d. The landlord may combine this review with the wider review being undertaken ordered as part of case 202224898, subject to the prior approval of this Service. Should the landlord wish to combine reviews, it must:

i. Ensure the assessment of its approach to handling customer vulnerabilities is not confined only to cases relating to damp and mould;

ii. Outline to this Service for approval within 4 weeks of the date of this decision the proposed terms of reference for incorporating this review into the wider review.

Recommendations

127. It is recommended that the landlord support the resident to obtain a status update on her claim to its insurers and if issues are encountered with progression, take appropriate action to request prioritisation of her claim.