Housing
Ombudsman Service

# Housing Ombudsman
# Special Report on
# Rochdale Boroughwide Housing

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# Contents

# Introduction

The Ombudsman makes the final decision on disputes between residents and member landlords. Our decisions are independent, impartial and fair. We also support effective landlord-tenant dispute resolution by others, including landlords themselves, and promote positive change in the housing sector.

This special report follows an investigation carried out under paragraph 49 of the Ombudsman Scheme, which allows the Ombudsman to conduct further investigation into whether there is a systemic failure.

Factors that may be indicative of a wider service failure may include, but are not limited to the following:

- a policy weakness,
- repeated points of service failure,
- service failures across multiple service areas,
- service failures across multiple geographical locations,
- failure to learn from complaints or,
- lack of oversight and governance to identify and act on repeated issues.

The Ombudsman's wider investigation was prompted by the inquest into Awaab Ishak's death from prolonged exposure to mould and our review of Rochdale Boroughwide Housing's open complaints. Additionally, we reviewed previous complaint determinations, and the landlord's response to our call for evidence for the Spotlight report on damp and mould report in 2021, which identified concerns with the landlord's approach to damp and mould reports as well as the respect afforded to residents when they made a service request.

This report provides insight to help the landlord strengthen its complaint handling and address the substantive issues giving rise to complaints, to help extend fairness to other residents and prevent complaints in future. This report forms part of our wider work to monitor landlord performance and promote learning from complaints.

## Scope and methodology

We reviewed the 20 complaints determined by the Ombudsman in the previous four financial years and up to the end of October 2022. There were nine live investigations into Rochdale Boroughwide Housing in December 2022 when this investigation was initiated following the coroner's report. The findings from those investigations have been set out on page two and incorporated into our review as case studies.

We also reviewed the complaints referred to us from November 2022 to date in order to ascertain the current situation and assess the efficacy of the changes and improvements the landlord is in the process of making. However, as these cases are pre-investigation and still within the landlord's procedure, they do not feature in the table of formal determinations.

We made an evidence request to Rochdale Boroughwide Housing in December 2022 for the following information, that was considered as part of our investigation:

- Relevant policies in place over the previous three years
- The void standard for the previous three years
- Information given to tenants at sign-up for the previous three years
- Relevant customer contact centre scripts for the previous three years
- Details of staff and relevant training for the previous three years
- Details of the cited changes and learning the landlord identified following Awaab's inquest
- The landlord's self-assessment against the 26 recommendations made in our Spotlight damp and mould report 'It's not Lifestyle'
- The landlord's self-assessments against the Complaint Handling Code since 2020 with details of the governance sign-off procedure
- Details of the relevant databases and relevant information held on them

# About Rochdale Boroughwide Housing

The landlord is a not-for-profit mutual housing society and registered provider of social housing which took ownership of homes previously owned by the local authority. As of March 2022, it owns 12,521 homes. There is a background of significant social challenges in the area and in 2022, the local authority reported that it had 7,801 households on the housing waiting list.

The landlord has proactively engaged with the Ombudsman during the investigation. This has included meeting with us to discuss the themes we identified and what actions they have taken or proposed to take. The landlord has also responded promptly to the extensive evidence requests and clarification points raised with them.

We particularly welcome the landlord's recognition of the need for these improvements and the new leadership's candour with us throughout the process.

Our investigations have highlighted that culture change, from top to bottom, is needed to rectify the situation and it is clear that the leadership is determined to lead from the front with the development of their recovery plan. This includes a focus by the governance and leadership teams on embedding change, as well as robust processes and strategies in place to ensure the problems experienced by Rochdale Boroughwide Housing residents are consigned to history.

# Investigation Findings

The Ombudsman's findings from the nine case investigations are set out in the table below.

The Ombudsman made 15 findings across these cases and found maladministration in 10 of them – a maladministration rate of 67%, including three findings of severe maladministration.

| Findings | Severe maladministration | Maladministration | Service failure | Redress | No maladministration |
|---|---|---|---|---|---|
| **202113713** | | • Responsive repairs – leaks / damp / mould | | | |
| **202119072** | • Responsive repairs – leaks / damp / mould | • Responsive repairs – leaks / damp / mould | | | |
| **202121470** | | | | | • Complaint handling<br>• Pest control - within property |
| **202122922** | | | • Noise | | |
| **202201509** | • Ending of tenancy<br>• Complaint handling | | | | |
| **202205227** | | • Anti-social behaviour handling | | | |

| | | | | | |
|---|---|---|---|---|---|
| **202207014** | | • Responsive repairs – general | | | |
| **202207288** | | • Anti-social behaviour handling | | • Responsive repairs – leaks / damp / mould | • Complaint handling |
| **202208649** | | | • Complaint handling | | • Responsive repairs – general |

# Themes Identified

When deciding if a failing is systemic, we look at whether the impact of maladministration is limited to a single area or is across different services and resident experiences. Although we have used the key areas of our Spotlight investigation on leaks, damp and mould to frame this investigation, other aspects of service provision have been considered.

We found a culture of 'othering' of the residents lies at the heart of the issues in Rochdale Boroughwide Housing. This is a pattern of exclusion and marginalisation based on identifies that are different to the norm. This pattern was exacerbated by an extremely poor data culture.

## Finding their silence

In an ideal world, every section of a community should feel safe and confident to raise their issues with their landlord. However, we know this is not always the case and there can be entire sections of society that do not raise issues, either because they are concerned about possible repercussions, or because their particular access and communication needs are not met by an organisation's systems.

In our damp and mould Spotlight report 'It's not lifestyle', we tasked landlords to 'find their silence' and to do more to find and help those members of the community who may otherwise struggle to access services. This is to ensure that groups of residents are not overlooked when decisions are made, that they are not being exposed to hazards and to ensure equality of service provision to all.

Our investigation has found that the landlord did not go far enough when finding its own silence, specifically relating to cases of damp and mould. The landlord did conduct an independent review in 2021 following Awaab Ishak's death but failed to find the damp and mould that a subsequent survey in late 2022 found throughout the estate that Awaab lived on – 80% of homes on the Freehold Estate in Rochdale suffered with damp and mould and 12 of the 380 properties surveyed were branded as Category 1 hazards under the Housing Health and Safety Rating System.

The disparity between the two responses raises concerns over the quality of the initial review, which appears to have been done by a leadership management company, focused solely on the Ilminster block on the Freehold Estate, and was conducted entirely by telephone because of the pandemic – the reviewer never visited the properties. The notes from the review often read as if the interviewer was 'leading the witness' – offering the members of staff answers to the questions they were asked, passing comments on the family 'it is likely they feel the cold of an English winter' and making suggestions, such as 'bucket bathing', based on what other members of staff had said – the reviewer later confirmed this in a statement to the inquest. We accept that the review was not legal in nature, but this raises serious concerns about the validity of some surveys which landlords undertake – offering false, or distorted, assurance on which actions and resource are based. Rochdale

Boroughwide Housing are unlikely to be the only landlord that has made crucial decisions based on flawed intelligence.

Our investigation further highlights the risk of relying on one method and one-off exercises – finding the silence is not easy and requires a range of methods, using skilled professionals, to be effective. The landlord is, as part of its recovery plan, conducting a review of the 2021 damp and mould enquiries to ascertain why so many properties with mould were missed and what blockages remain that obstruct residents from reporting damp and mould.

Ensuring the issues found in the Freehold Estate are addressed is imperative – the landlord committed in its recovery plan to have all Freehold Estate properties assessed and it completed those in March 2023 – but there are other estates and other families that need and deserve additional support.

It is clear that in the months following Awaab's inquest, most of the residents who got in touch with us to help them with their complaint about the landlord were calling from addresses in Middleton. While these are not cases that we have formally investigated, examples we have seen include a complaint where a resident reported concern after her young son developed chest problems which she believes is because of severe damp and mould in the property. The resident stated that the landlord sent inspectors to the property but at the time of her approaching this service no further action had been taken to rid her house of mould. In another complaint, which we have also not investigated formally, the resident has a doctor's note about the impact of the extensive mould on the entire family and the respiratory problems they are experiencing. Photographs sent to us show the extensive damp in the living room, kitchen and bedrooms, with a surveyor informing the resident that this is because of the leak through the chimney caused by a tree growing out of the mortar. The resident told us that when she asked where she was supposed to go during the extensive works required, the surveyor informed her that this was not part of his job.

We recognise the step-change in the landlord's engagement with residents under its new leadership. It is sending out personal letters from the new Chief Executive Officer encouraging residents to report damp and mould and providing updates on planned property works and resident engagement events. These letters contain an open offer to meet with residents to hear their concerns. The landlord is also holding drop-in surgeries on estates to provide residents an opportunity to report damp and mould and speak to the Chief Executive. Since January 2023, every visit to a resident's home has included a damp and mould inspection. We welcome these important steps.

There is now a banner across the landlord's website asking people to visit the dedicated page to damp and mould if they have concerns. Typing mould into the search function brings back 16 results, including multiple language versions of advice leaflets, as well as wider information about the landlord's response to the inquest. Following a recommendation from the inquest, the landlord has upgraded the resident portal to allow residents to submit their photographs from March 2023. Typing 'Rochdale Boroughwide Housing mould' into an internet search

understandably returns news coverage, but a result from the landlord's website is now the fifth return and is on the first page.

Although the landlord is planning a stock condition survey to cover all of their homes, given the severity and prevalence of mould identified in one estate alone, we would urge pace when rolling this out in order to find all the other places that it has a mould problem.

The diverse languages spoken by Rochdale Boroughwide Housing's residents has been recognised in the most recent damp, mould and condensation leaflet, with dedicated versions in Urdu, Farsi, Polish and Portugese. All three leaflets contain paragraphs in English, Farsi, Portuguese, Urdu and Polish explaining that the information is also available in Braille, audio and community languages. The website also has some accessibility features including a Google Translate option, along with the ability to change the contrast and the font size. Again, these are important and positive steps.

The landlord intends to conduct quarterly engagement with its tenant representative body to obtain feedback on the ease of access to the landlord for tenants who do not have English as their first language, vulnerable tenants and tenants with disabilities, reporting this back to the board. The landlord has, however, acknowledged that this tenant body has lapsed in recent years and that, because it is a mutual society, the body does not quite fit within a traditional governance structure.

## Proactive communication strategy

In our Spotlight report, we came across multiple examples of poor communication with inappropriate tone, unsuitable or impracticable advice. We urged landlords to review their advice, in consultation with residents, to ensure that blame language was removed, and they were accurate and effective. In our follow-up report a year on, we found that although landlords had removed the word 'lifestyle' from their literature, it was often replaced with euphemisms and the overall approach and tenant-blaming tone had not shifted.

We reviewed the communication Rochdale Boroughwide Housing has about how it is tackling damp and mould and found that, while the landlord has a webpage that contains details, it is a news article linked to the recovery plan area rather than being a specific webpage a resident can navigate to through the menus. The article can be found by searching for 'mould' on the website. The webpage's contents are scant and strike an uneasy balance between too little information and too much detail – the website tells residents how often the landlord will check in with them, once an issue has been fixed, but provides no information at all about how long it is likely to take to fix if it is not the most urgent of cases. There are general points made about what the landlord will do to resolve a mould report, but then quite specific instructions to the resident about what they should be doing to prevent condensation forming – the emphasis on precautionary measures remains squarely on the resident. It is likely that a resident is reading this webpage because they already have mould – no amount of guidance on how to prevent condensation at that point is going to help them. This information has limited benefit being on a webpage that should concentrate on telling residents what the landlord is doing to tackle damp and mould

and it should be in a separate area of guidance to residents on how to maintain a healthy home, either before mould develops or once the mould has been treated.

The landlord has also produced a leaflet on damp, mould and condensation that contains the same information. Providing more information to residents is positive, but more could be done to ensure this information is effective. For example, the leaflet states that condensation is the main cause of damp and mould, but it contains no pictures of what that looks like to allow people who cannot read English or those who require pictorial communications. It does, however, have pictures of examples of other types of water ingress – rising damp, penetrating damp (e.g. roof leaks) and plumbing faults, which may reinforce (even if unintentionally) the concept that only if these are present, is there an issue that the landlord is responsible for fixing. Combined with the extensive list of guidance to residents to prevent condensation, including guidance that may not be realistic in the current cost of living crisis, the leaflet may perpetuate misunderstandings around condensation and mould, as well as roles and responsibilities.

The landlord also had a booklet on condensation, damp and mould, last revised in 2022. It was, broadly, a more helpful document (albeit only written in English), with clear explanations of why the actions recommended will help manage condensation and how much water common household activities contribute to the air inside a home. However, the language did firmly put the onus on the resident and overtly mentioned ‘lifestyle’, ‘habits’ and ‘actions of residents’. The landlord has discontinued it as residents told them it was too big and contained too much information.

The landlord intends to produce a ‘Managing Condensation Guide’, which will include video, that will be left with a resident once mould has been treated and will also form part of the sign-up packs given out at the beginning of a tenancy – the landlord will want to consider including as much explanation of why these actions help with condensation management as possible.

We strongly encourage the landlord to further engage residents, as it has started to do, in the co-design of new, or revised, information to ensure it is accessible, impactful and effective. It should assure itself that the residents engaged reflect the full diversity of its population.

## Treat residents fairly

Everyone should be treated with respect, no matter their background, gender, race or nationality. Landlords hold professional relationships with some of our most vulnerable people in society and it is imperative they understand the importance of respect and the devastating impact it can have if not used. Our Spotlight report found that a resident’s lifestyle was often used as a reason to dismiss their concerns and apportion blame without any real focus on the limitations residents faced with modern day living – allowing landlords to dismiss legitimate problems that were outside of the resident’s control to remedy.

The landlord’s response to our call for evidence, submitted four months after Awaab’s death, was part of the evidence base for forming that conclusion. It asked:

*Q: What do you consider to be the main cause(s) of damp and mould?*

*A: Tenants lifestyle eg not heating the property adequately, insufficient use of ventilation provided, drying clothes and cooking in the home, not venting tumble dryers, ritual bathing.*

*Q: Are the root causes of damp and mould difficult to address? And if so, why?*

*A: For tenant lifestyle related issues this can be difficult to inform and educate the tenant in order to address the root causes. Some customers struggle to adequately heat their homes contributing to the causes of mould/damp. Cultural issues and language barriers.*

Most disturbingly, given it was only four months since Awaab's death, was the relevant part of the answer the landlord gave to the following question:

*Q: Has a **particular damp and mould situation*** [our emphasis] *led to significant changes in the way in which a landlord operates? If so, please provide details.*

*A: We are looking into the fitting of shower screens and are currently piloting this approach, particularly linked to ritual bathing.*

In the case of Awaab's family, when the mould issues were reported, the landlord focused entirely on the way his parents were using their home without considering if there was anything about the home that was contributing to the problems. The inquest heard evidence from staff that the family had a "lifestyle of boiling food in pans on the stove" and assumptions had been made, on the basis of seeing a bucket, that the family practiced ritual bathing. This assumption was based entirely on a member of staff's previous, irrelevant, interactions with other people in the same block of flats. There is no evidence that the family discussed their religious beliefs with the landlord or that member of staff, and this assumption appears to have been based entirely on the presence of a bucket, some water damage to the bath panel and that Awaab's family had ethnic similarities to the other people the member of staff had encountered who did ritual bathe.

During the 2021 review, members of staff were recorded by the reviewing team as saying the following:

*"The lifestyle choices likely to be relevant here are ritual bathing…"*
*"…style of cooking by boiling food…"*
*"…bucket bathing is quite common on the Illminster Estate…"*
*"when people come to this country and go through the asylum process…everything is done for them in terms of cleaning and so they expect it when they are moving into accommodation and that they can call housing services to come a*[nd] *clean the place for them."*
*"the issue appeared to be the style of cooking…and the style of bathing."*
*"the family used a style of bathing known as bucket bathing which is common to their culture as it is part of their culture and practice."*
*"The life style choices were likely to be bucket bathing and the Tenant's cooking practices…"*

*“...dealt with a great many similar claims… maybe Tenants with such ritual practices…”*

These are all othering statements that demonstrates the family were not ‘seen’ at all – their entire treatment was based on assumptions as to who they were and how they lived. Combined together, it paints a disturbing picture of residents being judged entirely by staff members’ held prejudices, lazy assumptions and an attitude towards asylum seekers and refugees that is wholly unacceptable.

We also received a report from former staff that “residents complained about mold *[sic]* and living conditions…regularly…raised it with her manager…was told it’s ok and acceptable. Most of residents were refugees and she was told they are lucky they have [a] Roof over head”.

The 2021 review also showed a propensity by staff towards making the residents responsible for the situation – there were discussions about trickle vents on the new windows that could become blocked if not cleaned regularly and another member of staff offered to check gas and electricity usage to see if the family were heating the home sufficiently, before the reviewer pointed out that the home’s temperature and humidity had been high. At the inquest it transpired that the bathroom fan had not been fully functioning for the previous two years and that the family had reported that. The professional assessment of the property in December 2020 after Awaab died found that the toilet was leaking because of defective plumbing and continuously discharging (and was the cause of the damage to the bath panel and the leak into the flat below), there was no ventilation in the kitchen, no extractor fan, there were no secure external drying options for clothing and the report made specific comment that no excess lifestyle was noted.

The staff who were involved in handling the mould reports all state they would have taken more action had they known a child resided at the property. It ought to have been part of any risk assessment of the situation to ascertain who lived there and whether there was an increased risk from the mould.

One staff member reported Awaab’s visibly pregnant mother as being visibly upset and distressed when he attended and yet, he did not refer the situation to the ‘Eyes Wide Open’ programme – a programme for “identified safeguarding such as disability, frailty or illness, domestic abuse and concern for welfare or any other identified need” – because he considered the mould was “a standard repair”. A month later, Awaab had died because of it and it was finally declared a Category 1 health hazard by a professional. Even if the staff member had honestly held a belief that the extent of the mould was “standard”, it is highly questionable how embedded and effective that initiative is for staff not refer a pregnant woman in significant distress to a safeguarding programme specifically designed to identify and help people in distress.

It is evident from our recent investigations that the dismissive and discriminatory attitude towards residents revealed at Awaab Ishak’s inquest was not restricted to his family’s experience. In case 202119072, members of staff visited the home in September 2021 to assess it after a report of damp and mould and reached unprofessional decisions that the mould was caused by the number of people living

in the home (it was a two bedroom flat with a family of five) and lifestyle, the quantity of mould was only small and it was only being reported because they were frustrated that they had not yet been allocated a bigger home. The landlord kept advising the resident to move their bed away from the wall, despite the fact that there were also two cots in the same room and there was no space to do so. The landlord viewed the lack of adherence to this advice as the resident being awkward and irresponsible. There had been work two years previously to fix repairs in the property and this appears to have led to the landlord developing the view that the family were now solely raising mould issues in a bid to get a bigger house. The email sent internally after the September 2021 inspection read:

*There is a small amount of black mould in the property however, this is due to lifestyle and the number of people in the property. There are 3 children and 2 adults living in the 2 bed home. So, that is the cause of the problem. Their frustration is that they want a bigger home and cant* [sic] *get one.*

Residents should not be viewed as challenging or uncooperative because they outgrow the originally assigned property. While there will be significant pressures around available homes given the housing crisis, it is also unrealistic of landlords to expect their tenants' circumstances to remain the same and the landlord should be working with them to come up with realistic solutions. Landlords should always avoid inferring blame on an expanding family.

We found numerous other instances where a resident had experienced disrespect or a dismissive attitude when trying to engage with the landlord to address their concerns. In 202002793 a resident queried whether he could have work done to his garden, given that his neighbour was having fences erected, paving put down and a garden gate hung. He was told that he was not entitled to these as “RBH don’t do gardens” without any further explanation. The resident told us that he felt discriminated against, highlighting that his neighbour was white and he was Black Asian. He also cited unnotified visits from the landlord’s staff that he had previously asked them to stop doing, including one during Eid.

In case 202122922 the resident had suffered a brain injury and stated that she felt bullied and intimidated by the landlord when it failed to respect her requests for specific contact methods. She also told us that they responded to her reports that someone was in the empty flat upstairs by suggesting that she “must be hearing things” because of her brain injury.

This strongly indicates that unsympathetic, inappropriate, or even heavy-handed behaviour towards residents are present throughout the landlord’s interactions, not only when responding to reports of damp and mould. The landlord’s training records show that all staff were provided with ‘Respect’ training at induction but there is no evidence this is repeated during their career. Although we recognise that the number of staff involved in the inquest was relatively small, and long service does not in itself result in such behaviours, there would appear to be a direct correlation between the length of service with the landlord and the level of ‘othering’ and disrespect shown in the evidence submitted to the inquest.

This is a significant concern and requires a comprehensive and sustained focus on shifting behaviour and culture at the landlord. This must be a priority for the new leadership. The recovery plan set by the landlord does acknowledge it needs to rebuild trust and confidence in key stakeholders and staff. It is clear that the new interim Chief Executive is determined to address the culture issues evidenced with an entire section of the recovery plan dedicated to changing the culture to being customer focussed and ensuring that diverse needs are met. Clearly the recovery plan needs to be given enough time to achieve results.

It does, however, remain a concern that this identification and acknowledgement of a deep-rooted problem with the landlord's culture has only surfaced once the issues surrounding Awaab's death were aired in a public forum, two years subsequent, and it is only now being addressed by senior management. It is imperative that the governing body oversees a programme of education and training on staff engagement with residents, with a particular focus on refugees.

**Case Study – 202119072**

Mr H lives in a two-bedroom flat with his partner and three young children. They had issues with rising damp when they first moved in and the landlord put in a damp proof course. The issues continued and the landlord carried out further works. Regardless, the damp and mould was now affecting the carpets and furniture, and Mr H raised concerns about the impact it was having on his young children, including one being prescribed an inhaler. He reported the family were now sleeping in one room. The resident submitted an application for rehousing and was provided a B and C for medical priority.

The landlord sent a technical officer to review the property who recommended "a bit of paint". When Mr H made contact again, the landlord put the situation down to "overcrowding" and having a bed against the wall, having sent a non-specialist to assess the mould. The landlord referenced that "yet again" he had mould and held the view that Mr H was frustrated because he wanted a bigger home but could not get one. The landlord placed total responsibility on the resident, telling him to move beds and cots and clean the mould himself.

The landlord's complaint responses emphasised the resident's "lifestyle", "living conditions", and the "number of people". It pre-judged the motivation behind reporting the mould and adopted a dismissive attitude towards his continued concerns. When Mr H questioned the qualifications of the people sent to assess his home, the landlord did not give details and asserted that they were appropriately qualified.

The landlord failed to recognise the challenge that some homes were not designed with modern living in mind, and occupancy factors should not be used to absolve it of responsibility to deal with reports of damp and mould. This service found severe maladministration by the landlord in respect to reports of damp and mould and maladministration with its record keeping. The landlord was ordered to provide a payment of £2,710 to Mr H, send a qualified surveyor to review the home and review its handling of reports of damp and mould.

**Case Study - 202201509**

Ms G is a vulnerable adult who is helped by a social worker and supported by a representative. Ms G had reported serious criminal behaviour happening in some of the flats in her building. She assisted the police with their investigations and was relocated to temporary accommodation for her safety while the police took action. Once the risk had subsided, the landlord, despite knowing that she was not living there, called her landline twice and sent a letter telling her that her tenancy may be at risk.

Ms G's representative let the landlord know that Ms G was still in temporary housing and the landlord told her representative that it was now safe for her to return and her property would start to accrue rent arrears. The social worker spoke to Ms G and, because she intended to stay at the temporary accommodation, suggested that the landlord conduct a multidisciplinary team meeting to ensure the situation was explained to her. The landlord did not arrange this meeting.

The landlord then informed both the representative and social worker that it again was unable to reach Ms G and had since changed the locks on her property. There is no evidence the landlord had asked for previous messages to be passed on to Ms G or advised them that it had started the Notice to Quit process.

The representative made a formal complaint on behalf of Ms G as the landlord had terminated her tenancy, disposed of her belongings and had not made her aware of the Notice to Quit. They also complained that the landlord was classing Ms G as "untraceable" when it was aware the representative was in touch with her. It stated the landlord had not shown compassion, knowing Ms G had been assisting police and that the landlord had ignored the request for a multidisciplinary meeting. They also state the landlord was aware Ms G did not have a working telephone at her current accommodation.

The Ombudsman found that the landlord's attempts to contact Ms G were inadequate as it had not made 'every attempt to make contact' as outlined in its Notice to Quit process. It had also not taken the opportunity to arrange a meeting with all parties, despite knowing of her vulnerabilities and need for a wider support network. The landlord's failure to follow its policies correctly, and its failure to take the complainant's circumstances into account, caused her significant detriment, and amounted to severe maladministration in the circumstances. An additional finding of severe maladministration was made in relation to its communication and overall treatment to Ms G.

An order was made for compensation of £4,000, half for the landlord's repeated failure to effectively communicate its intention to end the tenancy and dispose of her possessions, and £2,000 for its heavy handed and unsympathetic approach, and for its failure to demonstrate any consideration of her vulnerabilities. It was also ordered to apologise to her for its repeated failings and to review staff training.

## Record keeping - know your residents, know your homes

Our upcoming Spotlight report focusses on knowledge and information management. A key part of this is record keeping which is an important and integral part of a landlord's responsibilities. Many hours are wasted, appointments cancelled, and questions left unanswered due to poor record keeping and it is a key theme running through Rochdale Boroughwide Housing's complaints – missing repairs records, different systems holding different information, repairs information logged against the wrong address, key details being stored on individual staff computers are just some examples.

Our investigation has also seen instances of repairs being logged through the official systems only for staff to then email their recommendations for work needed to individuals outside of that system. The use of individual email accounts to manage repairs is exacerbating these problems and must be reviewed, as the risks involved in someone missing the email, being on annual leave or long-term absence are unacceptable and undermine the entire purpose of a central database.

In late 2020, the landlord migrated its computer system and emails to new software and lost the majority of previous emails from their servers forever – destroying any audit trail for cases wrongly handled by email completely. Prior to that, emails were automatically deleted after two years and only backed up emails for six weeks because of space constraints. Over reliance on this method to appropriately manage services to residents is undoubtedly one of the reasons service delivery successes are ad-hoc at best.

The lack of synchronisation between multiple databases had profound consequences for Awaab and his family. The CRM database that contained all the information about the tenancy and the service requests made about the flat listed his father as the sole tenant/occupant. However, the database for managing reallocation requests contained details of his mother, her pregnancy and of Awaab's presence in the family home. It was also through this channel that the midwife raised her concerns about the mould's impact on Awaab and his mother – that information never reached the repairs department. Effective record keeping is an area of concern for many landlords, and there are urgent lessons for other landlords from the practices of Rochdale Boroughwide Housing that must be heeded. The risk of another landlord repeating similar errors are apparent.

Applications for (re)housing are now handled by Rochdale Borough Council. This increases the probability that information disclosed in that process, as with Awaab's family, will not be linked to the landlord's records. The landlord intends to put a protocol in place with Rochdale Borough Council by end of April 2023 to ensure that any reported concerns relating to damp and mould are sent to the landlord for actioning.

The landlord sets out in evidence to us that it has implemented a red/amber/green priority system when addressing damp and mould which it uses in conjunction with its vulnerability criteria – the household composition, whether young children are present and if there are any long-term health conditions. However, this is only done when a report of damp and mould has been made and there is nothing to indicate

that it intends any broad exercise to ascertain who its residents are. The landlord has recently told us it intends to undertake tenancy audits and we would urge the landlord to prioritise this and for the governing body to monitor its implementation.

The family stated at the inquest that they had reported the bathroom fan as broken two years previously. There is nothing on the repairs records for 196 Illminster to indicate that this report was made, and it certainly was not acted upon. Another repair record for 196 Illminster had been incorrectly recorded against 186 Illminster and it is therefore entirely likely that this report of the broken fan was either not recorded at all or was recorded against an incorrect address.

Our casework illustrates other areas where the landlord's knowledge and information management can be weak. In case 202215329 the resident was given the wrong end date for her tenancy. The landlord had actually realised that it had given her the wrong date but did not contact her to let her know. She had partially moved out and returned to remove the remaining belongings to find the landlord had changed the locks and had removed and disposed of her belongings, including her parents' ashes. The landlord had kept no records of what they had removed and relied on assertions that they would have kept things like ashes to one side.

In 202114274 a resident moved into a property with a driveway that flooded when it rained and was a trip hazard. When she raised this with the landlord, it stated it would not do any work on the driveway and she should not have put the driveway in as it was not part of her tenancy. The resident had to resort to using a Google Map image to prove that the driveway had been there, and in that condition, when she moved in.

Rochdale Boroughwide Housing is taking steps to encourage a culture shift to updating live documents in the databases, including reviewing the permissions to ensure document integrity. It is training staff to ensure that a CRM entry is created for every resident contact. It also intends to review the data quality, integrity and governance processes to ensure that there is only one version of the truth, and that version is accurate and complete.

The landlord has told us that it is obtaining independent assurance on the condition of its properties by commissioning stock condition surveys across the entirety of its homes. This will include an assessment of whether the home is meeting the Decent Homes Standard. It also intends to review the data that it does hold to identify homes that have made multiple reports of mould, homes more vulnerable to mould growth (e.g. those with no external ventilation in the bathroom) and 'hot spot' areas where a lot of mould has been reported in the same estate. It will also be reviewing the missed appointment data on damp and mould inspections and getting in touch with those residents to check if work is required.

These are important actions, and we would encourage other landlords, in line with the recommendations of The Better Social Housing Review, to consider what actions should be taken to ascertain the condition of all properties within their responsibility.

**Case Study – 202207014**

Ms P reported damage to the rear boundary fence that backed on to a busy main road with a lot of foot traffic. The landlord's responsive repairs policy confirms that fencing jobs had a target timescale of 90 calendar days but it advised Ms P it would try to complete the work within five months, explaining it had 743 fencing jobs outstanding.

Ms P began to complain about the length of time it was taking to replace the fence. She felt she had no privacy because of the number of people able to see into her garden and she was not comfortable with her grandchildren playing in the unsecured garden near a main road. She also reported potential security issues as people had begun to use the gap in the fence as a cut through to the surrounding area.

The landlord was provided with all necessary information from the resident to identify that her repair was a priority. It showed no consideration of the fact the delay compromised her security or enjoyment of her home and that, as a minimum, it should have taken temporary measures to assist Ms P with the security risk.

We found no evidence that this individual factor of the complaint had been considered, resulting in a finding of maladministration and a compensation payment.

## Damp and Mould Strategy and net zero plans

The landlord does not have a dedicated damp and mould strategy at present, though it has told us that it intends to have a damp and mould policy in place by April 2023. The current responsive repairs policy does not explicitly list out where damp and mould would belong in the priority assessment grid (below).

Given the damp and mould leaflet says the most urgent cases will be handled within 24 hours, it is apparent that the most serious mould cases would be graded priority 2. It will be important for the landlord to ensure that actions are clear and aligned across its policies.

**Responsive Repairs priority assessment grid**

| Priority level of Job | Timescale (Current) | Timescale (New) | Sample Job types |
|---|---|---|---|
| 1 or 2 | 2 hours / 24 hours | P1 – same day<br>P2 – 24 hours | • No heat or hot water<br>• No electrics<br>• Uncontrollable leak<br>• Home insecure<br>• Major Health and Safety risk |
| 3 | 15 days | 60 calendar days | • Routine Electrical<br>• Roof repairs<br>• Routine joinery |
| 4 | 12 months | 90 calendar days | • Fencing and gates<br>• Plastering<br>• Gutter cleans & renewals<br>• Internal joinery jobs which take over 30 mins<br>• Internal plumbing jobs which take over 30 mins |

The landlord installs openable windows with trickle vents as standard and will, whenever possible, install mechanical ventilation in both the kitchen and the bathroom. It also considers the installation of a whole house ventilation unit if necessary. There is, however, no mention in their New Home Service Standard that they give to new residents, of anything that they will have done in the void period to inspect for and/or treat mould or susceptibility to mould such as an unventilated bathroom.

A damp and mould taskforce was set up in December 2022, comprising of seven inspectors. The landlord also requires all repair team members to check for any mould in the home that they have attended and there are a series of questions they must answer prior to being able to close-down a job ticket. The landlord has also placed an obligation on any visiting member of staff to visually inspect the home and ask the tenant if there is any mould that needs reporting – a new app sends the report directly to a dedicated inbox.

The taskforce has been provided with training on damp and mould. However, the training records suggest this is the same e-learning course on damp, condensation and mould awareness other staff have received. We are concerned that the level of training given to this taskforce may not be specialist enough.

The landlord has outlined to us how it will now go back to a property six, 12 and 18 months after mould has been treated to check that it has not returned. The residents who moved into the address where Awaab and his family lived reported a leak into the flat, from above in October 2021, and again in March 2022. They also reported mould problems in March 2022 – 15 months after the mould present when Awaab's family occupied the home, had led to Awaab's death.

The landlord is exploring the installation of humidity sensors in homes that have repeated reports of mould or damp and it is also considering supplying hygrometers to residents to allow them to monitor and address humidity in their homes. It also assesses ventilation. Landlords should consider how they will ensure that any planned insulation activity for the purposes of net zero will not create further opportunities for condensation creation and continuously review this as new technology and approaches emerge.

We have considered in detail the landlord's Mould Treatment Flowchart in place at the time. It includes a priority system for assessing how long a mould repair could take, ranging from 10 to 90 days depending on severity. The low/medium/high rating is based on the number of rooms affected by mould – low priority is based on no more than two rooms being affected, and medium priority is no more than three rooms. This does not sufficiently recognise the severity of the mould, nor whether the location is critical, only on how relatively wide-spread it is. Nor does it consider the number of rooms as a ratio of the number of potential rooms it could be affecting. 196 Illminster had four rooms – a kitchen, a bathroom, a lounge and one bedroom – all leading off a small hallway. It had mould present in three of those four rooms – all except the lounge, as well as the hallway, at the time of Awaab's death.

The flowchart relies on the assessment of the individual who attends on the day and there does not appear to be any quantifiable assessment – e.g. what percentage of the rooms, what percentage of the walls are covered etc. This allows for the possibility that poor communication with the resident (Awaab's mother did not speak English and there was no translator there – there was no opportunity for her to explain just how wide-spread the mould was and what impact it was having on their lives), time pressures or human error could lead to the wrong priority being given. The landlord states it has now created a new flowchart for prioritisation of mould reports.

The mould flowchart document also detailed the process should the Technical Officer not be able to gain access, once it is decided that there will be attendance. This process has now changed, following legal advice, but at the time the process was that the landlord will try to make contact with the resident twice by telephone to arrange an appointment and then will attend unannounced and leave a calling card if necessary. If no response is received to that card within a week, the inspection ticket is closed. The resident is then sent a letter setting out that they had tried to gain access. If no response is received to that a second letter is sent and then, if no response is received to that within a week, legal proceedings to gain access to the property will be commenced. However, the landlord's self-assessment against the Spotlight report and our discussions with the landlord's senior management have made it clear that the landlord did not regularly pursue non-response to mould inspections through to obtaining access via legal proceedings.

## Empower staff

Our investigation has found that the landlord's staff did not have the sufficient training to explore reports of damp and mould with residents, make the right decisions on how to handle damp and mould reports nor the empowerment to

challenge appropriately if they did not consider the proposed response to be the appropriate one.

One member of staff who spoke to the media was quoted as saying that the culture at Rochdale Boroughwide Housing is ‘toxic’ and contact centre staff were told to ‘fob people off’ by giving them standard and ineffective advice to handle their reports of damp and mould. They go on to report that ‘there was a total disregard for the residents and cost-cutting was obvious and really sad’. The flowchart for mould reports in place in 2020 required the call handler to ask if there was a leak and if not, the next set of questions moved straight to lifestyle-orientated questions:

- drying clothes?
- not ventilating/heating?
- not using extractor fan?

The contact centre exists for residents to raise their issues with their landlord. The contact centre needs to fully explore the issue being reported by the resident to ensure that it is truly understood, and the right decision is made on the priority and the actions required to remedy the situation. The average person is unlikely to have specialist knowledge of damp and mould and will use the word “damp” as common parlance to describe the presence of moisture in their home – this does not necessarily mean that what they are reporting is rising or penetrating damp and it should be standard practice to ask exploratory questions. The landlord intends to set up training programmes centred around diagnostic and problem-solving skills. The landlord has also reviewed its contact centre capacity, staffing and skill sets as well as the scope and delivery of the out-of-hours service. It aims to have a new service supplier in place by the end of June 2023.

The landlord has improved its approach to damp and mould within its publications but putting the changes into practice will be vital. The landlord has stated it is putting practices in place to help its staff recognise and support residents in need. This includes training staff who carry out home assessments to recognise damp and mould, including taking photographs and visits to set out what is/is not an acceptable level. The landlord has now provided an e-learning course on damp, condensation and mould awareness, but this occurred in December 2022, after the inquest. There is no evidence that the landlord recognised that there was a gap in its staff’s knowledge as a result of critical incident debriefs in 2021. The repairs team attended a seminar from a legal firm on disrepair in 2021. The precise content is unknown, but it is likely to have focussed on disrepair claims and the technical requirements on a landlord when a claim has been submitted. It was clear from the evidence submitted to the inquest that any damp and mould inspection done as a result of a disrepair claim was done solely to identify if there was a leak, rising damp or penetrating damp and was done through the lens of assessing whether the landlord needed to concede liability – the disrepair claims culture had entirely overtaken any customer service culture.

In our casework, we saw instances where it was not even a member of the repairs team who was sent to inspect the reported damp and mould. We also saw instances where the wrong specialist was deployed. In case 202113713 the resident’s home was experiencing drainage issues which had historically affected the entire block.

The landlord had access to the previous repair jobs and should have realised which skill set was required. The landlord sent a plumber who confirmed what had been apparent from the records – a drainage team was needed instead. The delay in sending the correct specialism meant that the resident's home was flooded by bathroom wastewater.

It is apparent from the evidence submitted to the inquest that the landlord operated within a culture of not necessarily progressing repairs if a resident had made an associated disrepair claim, in addition to conducting damp and mould assessments through the lens of what the landlord was legally liable for, rather than what action was necessarily required to resolve the issue.

Ostensibly, this was because authorisation of the proposed repairs had to go through the legal department to be sent to the disrepair solicitors for approval, incurring a time delay. This is not what the policy actually said should be done when considering the priority of the work required. Regardless of any ongoing legal claim, the landlord has a legal duty of care towards its residents to act to prevent injury or damage to property caused by defects in the home. It is essential that no landlord delays or fetters access to the repairs process in the event of a complaint or claim, and landlords must also ensure they have a clear and effective approach where both a claim and complaint are open.

After the November 2020 inspection, the internal email listed all the repairs needed, including replacing the bathroom fan, installing a kitchen fan and possibly a ventilation unit, as well as treating the ‘severe’ mould, but acknowledged that none of these would be ticketed for action because of the disrepair claim. The email further acknowledges that Awaab’s mother might have been unaware of ‘what she had signed up to’ when taking out the disrepair claim because English wasn’t her first language, but without any associated recognition that this was a further reason to refer the situation to the ‘Eyes Wide Open’ campaign or to action repairs.

That internal email prompted a check as to whether the solicitors had replied to the July 2020 report that was sent to them, but when it was established that no reply had been received, nothing further was done and the solicitors were not chased. The solicitors had actually closed their file in September 2020 but had not told the landlord – there was nothing preventing the landlord from actioning the required repairs with the urgency they required. Two months after Awaab’s death, the landlord was criticised in another disrepair court case for not taking any action on the repairs needed for nine months while the claim was ongoing, and the resident was refusing access. The landlord now sends chasing letters to solicitors within 14 days and, if they still receive no reply, will consider actioning the repairs, provided they can get access to do so.

The landlord has commissioned an external body to do a wholesale review of its repairs service to ensure that it starts to provide an efficient, quality, right first-time approach and value-for-money service. This review is due to be completed by the end of March 2023. The review will cover:

- initial repair requests to understand the financial cost of repeat requests and repeat call outs

- the planning function to ensure staff resources are used efficiently
- productivity rates to compare with similar sized landlords.
- the capacity within the empty homes team

During our investigation, we have been approached by members/former members of staff from Rochdale Boroughwide Housing who wanted to share their experiences and opinions on the landlord's attitude towards residents. It is also clear some staff did not feel comfortable raising their issues through the whistleblowing process in place within the landlord.

The landlord intends to regularly communicate its whistleblowing policy to encourage a culture of 'calling out' where staff have concerns, and it is also providing specific Equality and Diversity training that includes confidence building to empower staff to challenge when they feel policies or procedures and a process-driven culture has overtaken doing what is right.

## Organisational learning

Until the inquest, the landlord did not show a strong ability to learn from its mistakes or take opportunities to improve from them. As outlined throughout the body of this report, the landlord did not take the appropriate actions from the tragedy of Awaab Ishak's death and had an obligation to find the silence where the potential lay for another tragedy to occur.

Our investigation examined the learning identified by the landlord at the coroner's inquest and at the end of 2022, to ascertain whether this is sufficient. The learning review conducted and submitted to the coroner in July 2022 identified the following:

- the management structure for the disrepair was too cumbersome and there were too many reporting lines that had to be followed when escalating a report
- there was a lack of inter-team communication across the teams involved in disrepair cases (e.g. legal, customer contact centre and the repairs team)
- the need for video calls when conducting a conversation via a translator to ensure that body language, facial expression and gestures can be included in the translation
- an improved induction programme for call handlers with improved quality assurance, including peer support
- an improved translation offering
- the customer relationship management (CRM) system, which records all contact into the contact centre, was not widely used because it had not been implemented well
- the CRM system was not used as the central database for recording all information given to the landlord about their residents – for example, a change in the household's composition
- the landlord had 16 generic officers covering the entire geographical spread of their homes and have now increased that to 20 dedicated neighbourhood housing officers, each assigned a specific area
- there were two separate contact centres – one exclusively for rent payments and the other for everything else.

The review concentrates entirely on barriers to information sharing and knowledge retention – it is entirely focussed on how to improve the process, with limited lessons on how to improve customer service and no recognition of the duty of care it failed to provide Awaab's family. This reflects the prevailing culture that we have found throughout our investigation of the landlord – a process-orientated culture that has completely lost sight of the people at the heart of the service it provides.

There was a further learning review conducted in November 2022 after the conclusion of the inquest and it became clear that the coroner considered the landlord's lack of actions on the mould to be responsible for Awaab's death. Only then did the landlord look at what more it could do to support the people reporting mould to them and what it needs to do to remove the blame language from the conversation. In that learning review, it acknowledges the current subjectivity issues surrounding the mould hazard risk assessment, including the individual operative's perception bias. This is also the first time that the landlord acknowledged that wholesale, proactive, works to address ventilation issues are required.

This review also finally looks at the prevailing culture perpetuated by management structures. In 2019, all roles pertaining to customer relations and learning from complaints sat under the Head of Transformation, a vacant role that did not sit within 'business as usual' but under a specific transformation area of the business. A dedicated Head of Customer Experience role was created within the main area of the business with the portfolio for:

- Customer Contact
- Customer Insight
- Customer Engagement/Involvement
- Customer Feedback
- Learning from Complaints

As well as learning from critical incidents, complaints are an opportunity to learn and turn a mistake into an opportunity to improve and it is reassuring that there is now a dedicated role to delivering learning from complaints. There does, however, remain further work that the landlord needs to do to ensure that it has the appropriate infrastructure and procedures in place to allow access to the complaints system for efficient and effective handling of complaints to generate that learning.

Currently, there is no complaint policy on the landlord's website and instead, it is 'available upon request'. The landlord provided the Ombudsman with a complaint policy dated February 2022 for the purposes of this investigation and we have assessed that, and the accompanying self-assessment.

The policy is not as thorough as we would expect and does not include aspects as outlined in the Housing Ombudsman's Complaint Handling Code (the Code) such as an emphasis around equality playing a part in complaints. The landlord briefly mentions the induction training for all staff on respect, but there does not appear to be any dedicated intention to ensure equality is considered when addressing complaints. As many of the issues we have identified in our investigation concern the fair treatment of residents, particularly those with protected characteristics, we are

concerned that the complaint policy does not sufficiently address how it will put equality at the heart of its complaint handling. The landlord has told us it is reviewing the policy.

The complaint policy incorrectly states that a complaint may progress immediately to stage 2 if it is considered to be a serious complaint. This is not what is required by the Code – all complaints must be given two stages of handling. If the landlord wishes to appoint someone more senior to handle a more serious complaint, it can do so, but the initial handling of a complaint will always be a stage 1 complaint and the resident must always have the right to escalate their complaint to a second stage review to ensure another member of staff can examine it. Having a more serious complaint only have one stage of handling goes completely against the culture of fair and equal treatment that the Code seeks to cultivate.

We are also concerned that these two issues have not been identified in the self-assessment, which states that the policy is fully compliant with the Code. This might suggest that the ethos underpinning those two particular requirements – that every resident gets fair and equitable treatment and active steps are taken to ensure that – have not been fully grasped by the landlord. This would be entirely in keeping with our wider findings on service provision by the landlord.

The landlord also has an Unreasonable Behaviour (Complaints) Policy in place with a lengthy annex that outlines examples of what the landlord considers unreasonable behaviour. These include ‘refusing to accept the decision’ and ‘repeatedly arguing points with no new evidence’. This is not unreasonable behaviour. That is a resident exercising their right to challenge and question the outcome of their complaint. In many of the cases we have reviewed, the outcome the landlord reached on the evidence given was found to be incorrect. It is therefore entirely reasonable for a resident to be arguing the outcome without needing to provide new evidence. The landlord needs to keep separate its reasons not to accept a complaint into the system again, such as: the complaint has had due process applied; it has been escalated through the stages and; has had the right to take the complaint to the Ombudsman, from its reasons to restrict or manage contact which needs to focus entirely on behaviour that is unacceptable to staff on the receiving end, such as abusive or grossly excessive contact.

The policy also states that all records of unreasonable behaviour will be kept for six years. Six years appears excessive – there is a risk that residents will not be dealt with fairly because of a perception bias based on how they conducted themselves in the past, particularly given that the policy currently cites refusing to accept a decision as unreasonable behaviour.

**Case Study – 202208649**

Ms F is a wheelchair user and the landlord knew this as it had carried out repairs and adaptations at the property previously. It was also in discussions with the local authority's social care department about widening the front door to make wheelchair access easier, although the front door was not widened or replaced and the landlord's records do not explain why.

Five years later Ms F had issues with the lock on the existing door and was unhappy that she had been charged a fee to fix it. Her reasoning was that the door had been faulty for a number of years and had been due to be replaced and widened for the last five years.

In its complaint response, the landlord advised that the lock charges are the resident's responsibility in line with its chargeable repairs policy. It did not reply in relation to the residents points about the promised door replacement.

This service agreed that it was reasonable for the landlord to initially recharge the cost of the lock but once Ms F disputed the charge because of the outstanding repairs to the door, the landlord should have investigated the issues raised.

The Ombudsman determined the landlord had shown poor record keeping on the door works that had originally been planned, as well as poor complaint handling, and found service failure. It ordered the landlord to pay compensation to the resident and to contact her about the outstanding door issues.

# Compliance

## Orders and recommendations

In the nine cases monitored, we ordered the landlord to apologise to five residents and pay more than £8,000 in compensation to residents. More significantly, we made several orders and recommendations to try to prevent the same problems happening again.

### Proactive communication strategy

In case 202119072 we ordered the landlord to:

- Remove and update the information provided on its website relating to damp and mould.

### Treating people fairly

In cases 202122922, 202201509 and 202205227 we ordered the landlord to:

- Review its service and complaint handling, to ensure that it communicates more clearly to residents in respect to its actions and basis for any positions;
- Review its policies to ensure that all proper consideration to a resident's vulnerabilities and circumstances are given when taking any action;
- Review its ASB policy with a view to improving its explanation as to its assessment and residents' recording of ASB.

### Damp and Mould Strategy

In case 202119072 we ordered the landlord to:

- Consider the failings identified in the report, identify what changes will be made to reduce the risk of the failings happening again. The review must also include consideration of the Ombudsman's Spotlight Report on Damp and Mould. The landlord should report the outcome of this review to its appropriate governing body;
- Devise a policy and procedure for responding to reports of damp and mould within its housing stock as part of its review of its approach to damp and mould. The policy and procedure should include reference to monitoring of and adhering to agreed timescales, completing work to appropriate standards and keeping residents informed.

### Record keeping

In cases 202119072 and 202207014 we ordered the landlord to:

- Review its record keeping practices for repairs and maintenance, in particular for cases where damp and mould is reported. This is to ensure that accurate and accessible records are kept and maintained, both of inspections and surveys carried out, and of works raised and completed. As part of its review, the landlord should consider whether a record management policy and staff training are required;

- Review its repairs logging practice to ensure that target timescales are in alignment with its responsive repairs policy.

### Empowering staff

In case 202207288 we ordered the landlord to:

- Give training to all staff dealing with ASB cases to strengthen their knowledge and confidence on when a referral should be made for enforcement action.

In cases 202113713, 202201509 and 202205227 we recommended that:

- The landlord review learning from the case for how it responds to claims related to its repairs service, in accordance with its policy and the Ombudsman's guidance on insurance;

- The landlord review whether any learning or staff training is required on issuing a diagnosis from repairs reports;

- The landlord undertake staff training to ensure its staff are aware of the contact requirements in its Notice to Quit procedure.

- Review its staff's training needs on:

  - Applying tenancy agreement conditions
  - Remedies with regard to ASB and pet nuisance
  - Its ASB policy's provisions on specialist support for vulnerabilities.

### Use complaints system to learn

In case 202208649 we recommended that:

- The landlord reviews its staff training requirements for complaint handling, to ensure that all points of the complaint are addressed.

# Conclusion

Our investigation found that the root cause of service failure within Rochdale Boroughwide Housing was a propensity to dismiss residents and their concerns out of hand, with staff believing that they knew better and that the expectations of their residents were unreasonable. Rochdale Boroughwide Housing is a mutual society – it is co-owned by its residents and its employees – making this attitude and the endemic 'othering' of its residents even more difficult to countenance. That attitude was then further exacerbated by a poor standard of customer service, when they did accept that action was required, because of databases that did not share information, extremely poor record keeping and the use of incorrect methods (email) to manage the service response.

Condensation is a very real problem facing residents living modern lives and it is not their fault, particularly when the ventilation in the home is demonstrably inadequate. The advice available to residents in Rochdale Boroughwide Housing on maintaining a healthy home is still simplistic and broad-brush and is not tailored to the type of property, or type of family, that a household might be. Given the widespread presence of serious mould in just one estate, it is inevitable that there are more of the landlord's residents living with serious mould and more support needs to be offered than superficial actions.

The landlord is planning large-scale improvements to its data culture and the databases to deliver that culture change, but installing new systems only provide the functionality – what will be key to the success of these systems is good and embedded training, quality assurance processes and exception reporting aligned to performance management. This is a significant lesson for other landlords, given the problems we see in record keeping across the sector.

The landlord also cannot rely on one-off retrospective exercises to improve its datasets once a tragedy has occurred. Rolling stock survey programmes should be viewed as an investment – a chance to identify the issues and take immediate action, thus prolonging the life of the property and preventing significantly more costly remedial action and/or legal action later down the line.

People's lives and welfare depend on the landlord knowing who they are, what home they live in, and what has been done previously – this information must be reviewed regularly and updated through a tenancy audit or similar method.

Offering relevant training and ensuring it is embedded is a start but more needs to be done to move the culture back towards a focus on customer service and seeing the resident. The resident is turning to the landlord for help and the dehumanisation of residents because of deadlines, targets, waiting lists or personal bias has no place in a modern social housing sector.

The landlord's stated values are:

**Collaboration** - *We are stronger together. We must be active listeners and partners, who respect diversity and tackle stigma. This empathy and deep collaborative ethos is the source of our strength and power.*

**Democracy** - *We are democratic. Our democracy is rooted in our mutual status and evidenced in our governance through our Representative Body and Board. Our tenants, employees and communities have voice and power over what we do, and how we operate.*

**Equity** - *We seek fairness and equality. This is how we think and operate as a mutual Society, and why we strive for greater inclusion and equality within RBH, in our communities, and in the wider economy and society of Rochdale borough and elsewhere.*

**Pioneering** - *We innovate. We have pioneered mutuality and cooperation within the housing sector and wider. We will continue to strive to champion new innovations in creating excellent homes, a sustainable environment, and a just economy for our communities.*

**Responsibility** - *We build mutual respect. We have a responsibility to create great homes, communities and be a good employer, and we are rightly held accountable on that. We also care about and are responsible for each other and act with individual and collective integrity building mutual respect.*

Recruiting the right staff, using values-based recruitment methodology, coupled with an organisation-wide culture programme that encourages and supports staff to report inappropriate attitudes, is essential.

The weakness in policies, repeated failures and failure to learn from complaints has led the Ombudsman to a conclusion of wider service failure by the landlord, particularly in the handling of damp and mould, record keeping and communication.

Our investigation into Rochdale Boroughwide Housing has found reoccurring instances of residents being treated in dismissive, inappropriate or unsympathetic ways. In some instances the language used was derogatory. It is highly unlikely that this endemic behaviour of 'othering' is isolated to a single landlord and the social housing sector as a whole should consider whether they also need to turn over the stone and do a deep-dive into their culture and whether they are living their social purpose.

# Recommendations

Within three months of this report, the landlord should publish and provide the Ombudsman with details of the following:

## 2023 lessons learned review

- The outcome of the 2023 lessons learned review that will examine:
  - The events that led to and followed from Awaab Ishak's death relating to the governance, risk, control and assurance processes and practices in place during this period
  - Why the initial review of stock and data that was carried out after Awaab's death in 2021 did not identify the damp and mould issues identified in 2022
- The action plan arising from that review.

## Damp and mould strategy

- A dedicated strategy for handling damp and mould, including:
  - Proactive prevention works that fully consider future Net Zero plans
  - How disrepair claims will be handled within the existing framework
  - Formal hazard assessments for every mould inspection
  - A nuanced assessment framework for grading the severity of the mould found during an inspection that takes into account the proportion and the nature of rooms affected
  - How damp and mould identified during the void process will be managed – this should be echoed in the void standard and policy
  - Consideration of when a management move or transfer to alternative accommodation may be required, whether permanently or on a temporary basis whilst work is undertaken – this should be included in the relevant policy.

## Guidance

- Separation of guidance to residents on how to report mould from guidance on how to maintain a healthy home
- Specific guidance to residents about how to access the complaints system and what the complaints system can do for residents as opposed to pursuing a disrepair claim, alongside targeted awareness raising of the complaints procedure

- Review of guidance on maintaining a healthy home by a damp, condensation and mould specialist, in conjunction with residents, to ensure actions are realistic and achievable

- Consideration of additional community events and open surgeries to discuss condensation management methods, these should not just focus on estates where there are known damp and mould issues.

## Resident engagement

- A training programme of re-education for staff on courtesy and respect with regular refresher sessions

- An education programme about asylum seekers and refugees with regular refresher sessions

- Implementation and refresher management monitoring for these programmes

- Quality assurance processes to evaluate and ensure the learning from these programmes has made an impact and elicited change

## Performance management

- A programme of exception reporting to management on data quality, including the data provided to the landlord by the local authority from (re)homing applications

- Feedback mechanisms for possible disciplinary action where record keeping is found to be at fault, either through a complaint or through exception reporting

- Explicit reporting on follow up inspections in line with the landlords six-, 12- and 18-month inspection process – this should identify properties where appointments have not been kept, the reasons and any measures taken to resolve this – this information should be reported to senior management and actions taken where required.

## Knowledge

- Prioritising a survey of all residents/tenancy audit to establish who is living in the homes, vulnerabilities and the presence of children

- The outcome of the stock conditions surveys and resulting action plan

- Plans put in place to frequently revisit this information, review and update it

## Empowering staff

- A review of the ‘Eyes Wide Open’ campaign to be clearer on the triggers for reporting households to the campaign
- An addition to the objectives of maintenance operatives to proactively note who is living in the homes, signs of financial, emotional or physical distress and whether there are stock condition issues in evidence
- A review, including an anonymous staff survey, of the usage of the whistleblowing policy in the past five years to identify areas that are not being reported and why staff do not feel safe to raise their concerns
- A review of the job descriptions for all front-facing staff to ensure that customer focus and the landlord’s stated values are present throughout
- A review of the recruitment process for all front-facing staff to ensure that customer focus and the landlord’s stated values form the backbone of the testing process.

## Complaints handling

- An updated and Code compliant complaint policy
- Alignment of the planned governance reporting to our guidance note
- Creation of a Managing Unacceptable Behaviour policy that aligns with the Ombudsman’s guidance on our website.
- An updated self-assessment responding to all sections
- Accessible versions of the policies directly downloadable from the website.

# Rochdale Boroughwide Housing statement

We would like to thank the Ombudsman service for its very thorough and balanced report. The findings in the report are sobering but not unexpected. There has been significant learning from the tragic death of Awaab Ishak, which highlighted key areas of concern within RBH.

We have recognised that too often damp and mould was not seen as a serious issue and was attributed to a resident's lifestyle.

At RBH we have taken significant steps since December 2022 to tackle this across our homes. But it is fair to say that this work should have started much sooner and that the scale of the issue in our homes means it will take us time to complete.

The report also highlights concerns with the way in which residents were treated. Our residents have the right to be treated with respect and listened to and too often this wasn't happening. We will put this right and have begun a culture shift programme across the organisation.

There are wider lessons that we need to act upon, around the investment in our existing homes, and how this is balanced against the desperate need for more homes. Issues of overcrowding in homes have a detrimental effect in a lot of areas and is a significant issue within Rochdale but also across the country, with insufficient family homes to move people into. However, this should not excuse us from trying to find solutions, investigating the root cause of the damp and mould and taking action to treat it.