Alison Mutch, HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

By e-mail
Copy of response sent to Thomas Teague KC - HM Chief Coroner

11th September 2023

Dear Madam

Re: Regulation 28, Report to Prevent Future Deaths – Report into the death of Sylvia Pollitt

We acknowledge the Regulation 28 report to Prevent Future Deaths and your comments contained therein.

We thank you for highlighting the areas of concern in the process both during the inquest and in your report, and we wish to provide assurances that we have taken very serious regard of these and have carefully considered and commenced implementing the steps that are required to be taken to seek to prevent such circumstances occurring again.

We also confirm that we also took immediate action following the inquest and prior to the report in self-referring ourselves to the Regulator for Social Housing in order to formally track our mitigating actions.

Action taken to prevent future deaths

We acknowledge the two main concerns raised in your report, being the Housing Association (L&Q) had –

1. No audit system which enabled it to know if this issue of non-escalation by Liberty was a one off or a frequent issue. They had only become aware of the non-contact in this instance following Sylvia Pollitt's death.

2. No system where they captured/monitored the outcome of each referral to their subcontractor e.g. non-contact, successful attendance.

We confirm that we have undertaken a full and thorough robust review and aim to show how we have mitigated these concerns and others raised by ourselves through the process.

To provide some context, we would like to highlight that Mrs Pollitt's death occurred during a transition phase for L&Q and the previous Trafford Housing Trust ("THT"), this was as the two entities were integrating, a process which completed on 31st March 2023. The processes in place at the time were those of THT. This is not intended to avoid any ownership of the incident on our part, it is to provide the context. We have since aligned the L&Q property services and building compliance policies and processes, which includes the gas safety and contractor management processes. This shall, as we will hopefully demonstrate, now provide greater control and will prevent future deaths from these incidents occurring.

With respect to your concern 1 –

As soon as we were aware of the incident and the inquest, we immediately reviewed every other gas repair request which had been closed by Liberty outside of the agreed SLA and without reference back to L&Q.

We took note of your comments regarding us 'not knowing what we did not know' and ensured that this review of the gas repair process included identifying 'what we did not know'. This included a review of calls received by L&Q and transferred to Liberty, calls received with Liberty, tracing of jobs through Liberty and the L&Q system, and consolidation of the records held by each. Through this we were able to confidently identify all repair cases including those that had been closed both with or without direct reference back to L&Q and were able to identify reasons for all closures. No similar issues to Mrs Pollitt's situation were identified.

Gas safety in L&Q and THT had recently been audited by our independent auditors Mazars in April 2023, which included the process of alignment of the contractual arrangements and a thorough audit of the gas repairs process. This, together with regular contract management meetings confirmed that the circumstances of Mrs Pollitt's case - where a repair had been aborted by Liberty without any escalation back to L&Q and where L&Q had not subsequently identified the repair - were not and had not been replicated elsewhere.

With respect to your concern 2 –

Following the inquest and prior to your formal recommendations contained within this Regulation 28 Prevention of Future Deaths report, we had immediately put in place additional processes and checks. This included aligning the process of the former THT with that of L&Q where all calls of this nature are recorded by and within the central call centre prior to being passed to contractors, ensuring that a comprehensive record of all repairs is tracked and managed through our internal housing management system. The previous THT process was to transfer the resident call directly to the contractor, in this incident Liberty.

This ensures that no longer can any calls of this nature 'fall through the gaps' and there is a clear auditable trail for every repair.

That notwithstanding, we have subsequently instituted weekly meetings with Liberty to review every single job raised to trace all those in progress, overdue, completed and requested to be aborted. A full Work In Progress (WIP) report is produced by Liberty which is reconciled against the list held by L&Q and is reviewed by the Gas Compliance Manager weekly to ensure every single repair is accounted for. No jobs are permitted or are possible to be aborted directly by Liberty without reference back to L&Q and the report records all reasons for no access and dates of escalation back to L&Q.

All cases of incomplete and requested aborted jobs are automatically followed up by the L&Q gas team to make contact with the resident and if this is unsuccessful, they are immediately passed to the housing management team to make an in-person welfare check.

With respect to the ongoing relationship with Liberty, their contractual arrangements are currently under review.

We, again, re-iterate that we have taken this very seriously and have welcomed the opportunity to improve. We have personally expressed our condolences to Mrs Pollitt's family and our regret and remorse for the incident.

Yours faithfully

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[redacted]

Executive Group Director, Property Services
For and on behalf of London & Quadrant Housing Trust