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The investigation of a complaint against Trivallis

A report by the
Public Services Ombudsman for Wales
Case: 202405250

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The name of the complainant and others have also been changed.

Summary

Mrs C complained about whether Trivallis ("the Association") responded appropriately to reports of damp and mould made by her between November 2023 and the present time.

The investigation found that the Association did not always respond appropriately to reports of damp and mould. Reports of issues in Mrs C's home were not always acted on promptly or line with relevant policies. Surveys have identified moisture in the same area of Mrs C's home but the Association has yet to definitively establish the cause. The way the Association communicated with Mrs C was also not always appropriate and I have seen no evidence that the Association considered the needs of disabled children living in Mrs C's home when responding to reports of damp and mould.

The Ombudsman was concerned that the failings identified in this case may be systemic, with opportunities missed to identify the issues in Mrs C's home. The failings identified in this case, particularly in relation to repair requests from vulnerable people, are ones from which other organisations can learn.

The Ombudsman made a number of recommendations which the Association accepted.

Within 1 month:

a) Provide evidence that the Association has acknowledged and apologised to Mrs C for the failings identified in this report.

b) Provide evidence that the Association has offered Mrs C a financial redress payment of £840. This includes £500 for the cost of a mattress, clothes and toys Mrs C has had to dispose of, £40 for the survey she arranged and £300 for the distress caused to her by the failings identified in this report.

c) After the next period of significant wet weather or when the tenant next reports any evidence of damp on the wall, to remove the plasterboard in the area where moisture has been recorded and undertake a full inspection of the wall. A copy of this inspection should be shared with Mrs C and this office.

Within 3 months:

d) Carry out any works determined as necessary as a result of the inspection of the wall.

e) Ensure all relevant staff receive training to identify and respond appropriately to vulnerable customers.

f) Ensure that a scenario based training programme is delivered to all relevant staff to ensure that lessons are learned from this case and staff take account of individual circumstances where prioritising repairs.

g) Develop a process to ensure that when a complaint of damp and mould is received, information gathered from sensors in properties belonging to the Association is regularly, analysed and reported accurately.

h) Share a copy of this report with the Association's Assurance Committee which should oversee and monitor the Association's compliance with these recommendations.

The Complaint

1. Mrs C complained about whether Trivallis ("the Association") responded appropriately to reports of damp and mould made by her between November 2023 and the present time.

Investigation

2. I obtained comments and copies of relevant documents from the Association and considered those in conjunction with the evidence provided by Mrs C. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Mrs C and the Association were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation and policy

4. The Renting Homes (Wales) Act 2016 ("the Act"). Part 4 of the Act places obligations on landlords regarding the condition of the homes that they let. These include ensuring a dwelling is both in repair and fit for human habitation:

- Section 92 of the Act states that a "landlord under a secure contract…must – keep in repair the structure and exterior of the dwelling".

- Section 97 of the Act states that a landlord's obligations under Section 92 do not arise until they become aware that repair works are necessary.

- Section 97 also states that a landlord has complied with the obligations of section 92 if it carries out the necessary works or repairs within a reasonable time.

5. Social Housing Conditions and Disrepair: Feedback to Social Landlords ("the Disrepair Feedback"), Welsh Government, February 2022. In relation to disrepair:

- "Think point 2" states that "Social landlords should have processes, systems and a culture of ownership to enable issues to be readily identified and easily escalated to the attention of the right people".

- "Think point 9" states that "Social landlords should ensure measures are in place to specifically identify and address reported issues with damp and mould". This should include "investigations/inspections by default, ensuring condensation and its causes are accurately diagnosed, rectifying any defects as promptly as possible and supporting tenants with help and advice".

6. The Welsh Housing Quality Standard ("the WHQS") 2023 (last updated in April 2024, implemented 2002) sets out the standards expected for social housing in Wales, against which landlords are measured. This requires homes to be "free from damp", including persistent condensation. All measures to upgrade the ventilation in a home must be taken, specifically in relation to ensuring adequate ventilation in kitchens and bathrooms. It requires that heating systems should be capable of heating the whole home to a comfortable level. It also states that homes should have adequate facilities to dry clothes.

7. The Association's Repairs Policy approved 10 October 2023 ("the Repairs Policy"). In a section titled "Timescales for undertaking repairs" the Repairs Policy states that mechanical extractor fans not working would be considered to be an urgent repair which should be completed within 7 working days. Kitchen and bathroom repairs are classified as routine repairs which should be completed within 20 working days. It also states that reasonable timescales for undertaking repairs will depend on factors such as the impact on the contract holder and the members of their household. It does not contain any further guidance on how to assess this impact. In a section titled "Equality, Diversity, and Inclusion Policy" it states that an Equality Impact Assessment was not deemed necessary for the Repairs Policy.

8. Tackling Fuel Poverty 2021 to 2035, Welsh Government, March 2021 ("the Fuel Poverty Strategy")[1], which defines a satisfactory heating regime for households that contain disabled person as 23 degrees Celsius in the living room and 18 degrees Celsius in other rooms achieved for 16 hours in a 24-hour period. The definition of vulnerable households includes those where occupants are aged under 16 and where occupants have a long-term illness or disability.

9. All public bodies, and other bodies which carry out public functions, must comply with the Human Rights Act 1998, which incorporated the European Convention on Human Rights ("the Convention") into UK law. Article 8 of the Convention provides individuals with the right to respect for private and family life.

10. The Equality Act 2010 ("the EA") gives people, with protected characteristics, such as a disability, general protection from discrimination. It defines disabled people as those who have a physical or mental impairment that has a "substantial" and "long term" adverse effect on their ability to do normal daily activities. It also imposes a public sector equality duty ("the equality duty") on public bodies and other bodies which carry out public functions. The equality duty requires them to have due regard to the need to eliminate conduct prohibited by the EA, to advance equality of opportunity between people who have a protected characteristic and people who do not, and to foster good relations between those individuals. Public bodies and other bodies which carry out public functions must routinely consider each of these equality duty aims when taking decisions, designing policies and delivering services.

11. It is not my function to make definitive findings about whether discrimination has occurred or whether an individual's human rights have been breached by actions (or inaction). However, I will comment on a public body's, and other bodies which carry out public functions, regard for human rights and the protection that the Equality Act affords while they are performing their functions when this is a relevant consideration.

[1] Tackling Fuel Poverty 2021 to 2035

Public Services Ombudsman for Wales ("PSOW") guidance and Thematic Report

12. The Ombudsman's Principles of Good Administration - issued by my predecessor [2], provides guidance for all public bodies in Wales to follow.

- Principle 2 is "Being Customer Focused" by dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.

- Principle 4 is "Acting Fairly and Proportionately" by dealing with people impartially and with respect, ensuring decisions are free from bias and have regard to individual circumstances.

- Principle 5 is "Putting Things Right" by acknowledging mistakes and taking prompt action to put things right.

Public Bodies in Wales must have regard to this guidance when discharging their functions.

13. Living in Disrepair – a thematic report about housing disrepair and damp and mould complaints to PSOW ("the Thematic Report")[3], Public Services Ombudsman for Wales, November 2024 which reported on complaints received regarding damp, mould and poor conditions in social housing. The Thematic Report also considered how housing providers respond to the needs of vulnerable occupants and recommended that repairs be properly prioritised in accordance with published policies. It also recommended that housing providers engage independent surveyors to inspect properties where damp is alleged, coupled with respiratory complaints. Whilst this report had not been published at the time these events relate to, the legislation and guidance it refers to was.

[2] Principles of Good Administration - Under section 34 of the PSOW Act 2019
[3] Living in Disrepair

The background events

14. Mrs C lives in a bungalow with family members, including her disabled granddaughters. The property was refurbished and adapted by the Association in **2021** specifically to meet the needs of Mrs C's granddaughters.

15. On 20 November **2023** Mrs C contacted the Association. She reported that there was black mould in a bedroom of her home which was used by her granddaughter, who has significant medical issues. Mrs C said that her granddaughter's asthma (a lung condition which causes breathing difficulties) had recently worsened and that she had to dispose of her medical mattress after mould had spread to it.

16. The next day a manager ("the First Manager") emailed a number of colleagues to make them aware of a post on social media that claimed a medical mattress in Mrs C's property had been damaged as a result of defects in her home. He said that Mrs C "could be irate and may post publicly misinformation". In response to a later email regarding Mrs C's home a senior manager ("the Senior Manager") wrote "this one's highly sensitive due to the health of 2 severely disabled children so need to be on guard. She's already put things over (social media)".

17. A surveyor ("the First Surveyor") visited Mrs C's home on 22 November. In an email to colleagues following that visit, he said that a stain on the wall in a bedroom had been caused by a lack of circulation due to a bed being up against it. He arranged for the wall to be washed in early January 2024. A small reading of water at skirting board level was found, so he proposed a further inspection using a borescope (an instrument for inspecting the inside of cavity walls). He also noted that an opening above the bathroom door required for a track hoist would allow moist air to migrate through Mrs C's home, and suggested that a larger extractor fan in the bathroom may be needed.

18. On 27 November another surveyor ("the Second Surveyor") attended Mrs C's home. He reported that insulation in the cavity wall of the bedroom was showing darker in some areas than others, indicating that there was possibly moisture in the cavity. In the areas where he had

drilled inspection holes the wall was dry, as was the dust and black mortar. Under a section of the report headed “Observation” it is recorded that moisture migrating from the bathroom could cause condensation in the bedroom. Photographs taken at that time show an area of staining to the wall above a skirting board. He also noted that fascia vents in the roof (which allow air to flow in and out of roof space, helping to regulate temperature and moisture) had a damp proof course fitted over them.

19. In an email responding to this report a senior surveyor (“the Senior Surveyor”) concluded that there was no water ingress and that the issue with mould was caused by moist air coming from the bathroom. He said there was a need for adequate ventilation and possibly work to reduce moisture migration from the bathroom by fitting something over the opening required for the track hoist.

20. On 20 December the Association wrote to Mrs C and said that “we have identified the source of the problem and taken necessary steps to address it”. It said that an inspection had found the wall to be dry with no sign of damp. Extra moisture in the air was as a result of the opening required for the track hoist and that a survey would be carried out to install both a mechanical extract ventilation fan and a positive input ventilation system (“PIV” – a system which draws in fresh air from outside and reduces the likelihood of condensation forming). These were subsequently installed in February 2024.

21. On 31 January **2024** a technical surveyor (“the Technical Surveyor”) emailed colleagues including the Senior Manager and the Senior Surveyor. He had attended Mrs C’s home regarding making adaptations for her granddaughters. During the visit he identified several potential problems which he believed could be causing damp in Mrs C’s home. These included vents being covered and issues with the roof felt and guttering. He said that Mrs C’s home also appeared to be inadequately heated and recommended that an evaluation be carried out into the adequacy of the radiators. He also raised concerns regarding a retaining wall (where the external ground level is higher than the internal floor level).

22. The Senior Surveyor replied to this email on 1 February. He said that damp and mould issues had been investigated the previous November and that there was no sign of water ingress. He said that he assumed "development carried out all the necessary checks" in respect of whether heating and radiators in Mrs C's home met relevant standards.

23. On 11 March Mrs C contacted the Association to request a heating survey be carried out as she was concerned radiators in her home may be undersized. A survey was carried out later that month which found that most of the radiators installed in Mrs C's home, when it was developed, were undersized. The radiators were replaced in May 2024.

24. On 19 March Mrs C emailed the Senior Manager. She said water damage had re-occurred in the bedroom and that her daughter and granddaughter were unable to use the room as it was having a negative impact on their health. She also said that possessions had been damaged. I have seen no evidence that Mrs C received a response to this email.

25. On 16 April Mrs C sent an email of complaint to the Association stating that it had not addressed reports she had made of water damage to a bedroom in her home. She said this was having a negative impact on the health of her and her family, including her disabled granddaughters.

26. The Senior Surveyor visited Mrs C's property on 26 April and reported slight condensation above a skirting board in the bedroom. In respect of the bathroom, he wrote that when it was not in use it was being utilised as a drying room, meaning the area was always high in humidity. Photographs taken during that visit show children's clothes drying on a clothes horse. He said that he was looking to fit a PVC strip curtain to prevent moist air migrating through the space required for the hoist.

27. On 29 April a manager ("the Second Manager") sent the Senior Surveyor an email including data collected by sensors in Mrs C's property. These had been installed when the property was developed but prior to this point no data from them had been collected or analysed. He said that new fans and a PIV system were managing humidity effectively, and that moisture migrating to cool surfaces in Mrs C's home was likely causing any reported condensation. He suggested that Mrs C be

provided with a residents “app” so that she could view data for herself and adjust her behaviour if necessary. Mrs C was not offered this app.

28. The Second Manager attached a number of charts to the email. This included a graph showing relative humidity in the bedrooms of Mrs C’s home from July 2022 to the current date. This showed that the average relative humidity in the bedrooms of Mrs C’s home over that period was 64.12%, and that the latest relative humidity was 61%. Whilst there were drops in the humidity level in Mrs C’s home between January and May in both 2023 and 2024 the relative humidity level of bedroom 3 was consistently above the recommended maximum of 60%. A chart showing the damp and mould score in the bedrooms recorded occasions where the score reached 100 in all bedrooms, the maximum possible score. This included in November 2023, when Mrs C first reported mould. The temperature was only shown for the bedrooms in Mrs C’s home, but this showed an average daily temperature of 20 degrees Celsius and a current temperature of 18 degrees.

29. On 31 May Mrs C arranged for a private company to carry out a survey of the wall where she was reporting damp. The survey found low wood moisture level readings but did notice some staining to the plasterboard. They noted that this was a retaining wall and that this could be a cause of damp. It recommended the plasterboard in this area be removed to test the wall and apply damp proofing treatment if needed.

30. Mrs C complained to the Ombudsman on 17 June. This complaint was settled on the basis that the Association would carry out work to reduce the migration of moist air from the bathroom by 20 August. It was also agreed that the Association would monitor the situation for 2 months after the work was completed and consider further options should they be necessary.

31. On 5 July a carpenter attended Mrs C’s home to fit PVC curtains to the opening required for the hoist, but they were not suitable. On 22 July the Senior Surveyor sent an email to a senior manager. He wrote that: “Im [sic] a little frustrated with development. I have discussed the issue with the vapour migration with them. Only to fine [sic] out last week that they have used sourced doors to reduce this issue on another job”.

32. On 23 August Mrs C contacted my office to report that the Association had not carried out the agreed works. The Association said that the Second Manager had reviewed data from the sensors in Mrs C's home and found that humidity levels were high.

33. Officers from the Association attended Mrs C's home on 17 September to carry out works to reduce moisture migration but had to re-schedule as they were unable to carry out the works due to not having the correct materials. A further appointment was cancelled by the Association for 1 October for the same reason. As a result of the ongoing failure by the Association to complete the agreed works my Office commenced an investigation of Mrs C's complaint. The works were eventually completed on 20 November.

34. On 12 December Mrs C spoke with a complaints co-ordinator from the Association. Mrs C said that water damage had returned and that she suspected it was as a result of damp, rather than condensation. As a result, the First Surveyor attended Mrs C's home on 19 December. They found no signs of mould and found the wall to be dry. On 17 January **2025**, the Association told Mrs C that it would not remove plasterboard to conduct further investigations as a camera survey conducted previously had confirmed the cavity was dry.

35. On 7 February Mrs C contacted my office as she felt that works to reduce moisture migration had not resolved the issue with damp. As 2 months had passed since the completion of works, the Association was asked what the results of its monitoring had been and if it proposed to take any further action. In response it referred to the letter of 17 January. As this letter referred to monitoring that had been undertaken less than a month after the completion of works the Association agreed to arrange a further survey by an independent surveyor.

36. On 19 March an independent Chartered building surveyor ("the Chartered Surveyor") visited Mrs C's home. Areas where Mrs C had previously reported damp and mould were found to be dry, with the exception of a section of skirting board that was shown as being wet. They found humidity readings to be within acceptable levels, with the

exception of the bathroom after the shower had been run. This situation was exacerbated as the extractor fan to the bathroom had been disconnected.

37. To the exterior of Mrs C's home, the Chartered Surveyor noted issues with the guttering that may cause water to spill behind it in heavy rain. They also raised concerns about a retaining wall. They found dark staining beneath the lead, adjacent to where issues with damp had been reported internally and that silicone beading in this area was in poorer condition than other areas of the property. The Charted Surveyor considered that if the retaining wall lacked suitable tanking or membrane, then this could be the cause of dampness in Mrs C's home. They found no current issues with dampness and felt that the bedroom was suitable for use. They recommended that the extractor fan be re-connected, repairing the silicone beading and clearing the guttering. They also recommended that the Association monitor the area closely and re-inspect it in 6 months, and that further, more intrusive checks may be needed if Mrs C continued to report issues. The Association has since carried out work to repair the silicone beading and guttering and re-connect the extractor fan.

Mrs C's evidence

38. Mrs C said that she had made repeated reports of mould in a bedroom used by her granddaughter, and that despite numerous visits to her home by the Association the issue had yet to be resolved.

39. Both Mrs C's granddaughters have life limiting disabilities. She said that they were unable to use the bedroom whilst the issue remained unresolved due to the impact on their health. This meant that they were having to share beds, with some family members sleeping in the living room. This was a source of great stress to her, and Mrs C said that as a result she had begun having anxiety attacks and had been referred for counselling.

40. Mrs C said that she wanted the Association to address the issues with moisture in the bedroom so that her grandchildren could use it again.

The Association's evidence

41. The Association said that it had carried out appropriate investigations and established that there was no penetrating damp. It believed that the issues reported by Mrs C were caused by moist air migrating from the bathroom. As such it would not be undertaking any further investigation of the wall. It said that it had put in place a number of measures to attempt to reduce water vapour migration from the bathroom. The Association said that when the bathroom was not in use it was utilised as a drying room, which would mean that the area would always be high in humidity, but it did not supply any details of the current moisture level in Mrs C's home.

Analysis and conclusions

Whether the Association responded appropriately to reports of damp and mould made by her between November 2023 and the present time

42. The Association did not always respond appropriately to reports of damp and mould. When Mrs C first reported mould, the Association responded quickly and carried out appropriate investigations. This led the Association to conclude that the issue was due to condensation caused by moist air migrating from a bathroom. Despite this, a new extractor fan was not installed to the bathroom until over 2 months later. This is contrary to the Association's repair policy. The first attempt to cover the space needed for the hoist was not made until over 7 months later. The Disrepair Feedback states that defects causing condensation should be rectified as promptly as possible. In this case it was a year until the issue the Association considered to be the cause of the condensation, was addressed. The Association has made repeated references to the wall being dry. This is despite the First Surveyor finding evidence of water and the Second Surveyor finding indications of moisture in the cavity.

43. When the Technical Surveyor raised concerns about the adequacy of radiators in Mrs C's home, no action was taken as the Senior Surveyor assumed checks would have been carried out when the property was developed. I have seen no evidence that the Senior Surveyor sought to establish if this was the case. When a survey was carried out after Mrs C contacted the Association 2 months later, most of the radiators were found

to be undersized. It was a further 2 months before the radiators were replaced. I do not consider that the Association responded to Mrs C's concerns about the inadequacy of the radiators with sufficient promptness, especially given that the Technical Surveyor had identified shortcomings some 2 months previously.

44. Despite the installation of a mechanical extractor fan and PIV system Mrs C continued to report issues with water damage. The First Surveyor and Second Surveyor had previously found that an area of the wall was wet. The Technical Surveyor had reported issues in Mrs C's home that he considered could be causing damp. A private survey arranged by Mrs C recommended further investigation of the wall. Despite this, the Association undertook no further investigations. This is contrary to the Disrepair Feeback which states that investigations should be undertaken by default. The Chartered Surveyor found an area of the wall was wet. This was the same area of wall identified as being wet by the First Surveyor in November 2023. They also raised similar concerns as the Technical Surveyor regarding a retaining wall and guttering. The Association has not committed to undertake any further investigation of this wall.

45. The Association also suggests that Mrs C may be contributing to the high humidity levels by not opening windows and drying washing indoors. The Second Manager recommended that Mrs C be offered an app that would allow her to see how the way she used her home impacted humidity levels. If the Association believed that lifestyle factors were causing increased humidity in Mrs C's home, then this would have been an effective way of addressing this with her. Mrs C was not offered the app until after this investigation began. The Association has not provided an explanation for this.

46. Sensors monitoring environmental conditions in Mrs C's home were installed in 2022, but the Association said that no analysis of the data was conducted until April 2024. When the data was analysed, I am concerned that it was not reported accurately. The Second Manager reported that new fans and a PIV system were managing humidity effectively. The data relating to humidity shows no significant difference from the same period

the previous year, when enhanced ventilation had not been installed. Following Mrs C's contact with my office in Augus,t the Association said that sensors had shown that humidity in her home was high.

47. The way that the Association communicated with Mrs C was not always in accordance with the Principles of Good Administration. I have seen no evidence that Mrs C received a response to her email of 19 March 2023. The Association has not shown that it had regard to Mrs C's individual circumstances, particularly the needs of her disabled granddaughters. Mrs C's initial concern was not dealt with sensitively, with internal emails from the First Manager and the Senior Manager focusing on posts made on social media rather than the potential impact on Mrs C and her family. The email from the First Manager also refers to Mrs C potentially posting misinformation. This was before an inspection had been carried out to establish if defects had caused the issue she had reported. This is contrary to Principle 2 which requires public bodies to be customer focused and Principle 4 which states that public bodies should act fairly and proportionately. Not acknowledging that there was continued moisture in the wall of Mrs C's home and not taking prompt action to address this is also not in accordance with Principle 5 which relates to public bodies putting things right.

48. Our Thematic Report: Living in Disrepair which I recently issued, makes specific reference to the needs of vulnerable people. In Mrs C's case, despite her reporting a worsening of her granddaughter's asthma, no independent survey was carried out until the intervention of my office. The Repairs Policy also contains no guidance on how and when repair requests made by vulnerable people should be prioritised.

49. These are failings which amount to maladministration. They are an injustice to Mrs C and her disabled granddaughters who had to live with outstanding repairs in their home for a significant period of time. By not keeping Mrs C's home in repair the Association also did not comply with its duties under the Act. I therefore **uphold** Mrs C's complaint.

50. I am concerned that this investigation has identified systemic issues within the Association. Whilst sensors were installed in Mrs C's home, no action has been taken to analyse the data they provided. This represents

a significant missed opportunity to identify issues in Mrs C's home. If no routine monitoring of data is being undertaken similar failings may also have occurred in other properties owned by the Association. It also seems that information was not always shared effectively between different teams, which led to a delay in issues reported by Mrs C being addressed.

51. I acknowledge that there is a degree of technical uncertainty regarding what is causing the issues in Mrs C's home. That said, the issues identified during this investigation are significant. Four separate surveys have identified moisture in the same area of a bedroom wall, but the Association did not take any action to investigate this further. Despite the Technical Surveyor raising concerns that Mrs C's home was inadequately heated, the Association took no action until Mrs C made contact 2 months later. At this point, 3 years after the property had been developed, it was found that inadequately sized radiators had been installed.

52. The issues are also ongoing. The Association has yet to definitively establish what is causing the moisture to the skirting board.

53. I also consider that the failings identified in this case are ones from which other organisations can learn. There were missed opportunities to undertake an earlier independent survey. I have seen no evidence that the Association considered the needs of Mrs C's granddaughters, or that during this time it had a policy regarding repair requests from households containing vulnerable people. It is for these reasons I consider this report to be of wider public interest.

54. Article 8 of the Convention requires public bodies, and other bodies which carry out public functions, to have respect for the homes and family lives of individuals. Respect can include ensuring homes are maintained in a good state of repair and listening and taking appropriate action when issues arise. I consider that Article 8 was engaged by the circumstances of this complaint, as the Association did not respond appropriately to Mrs C's repair reports or the findings of its own surveys. As such a situation arose where the right of Mrs C to have her home and family life respected may have been compromised.

55. The WHQS requires homes to have adequate facilities to dry clothes. What is adequate will depend upon the specific needs of individual households. When it was noted that Mrs C was drying clothes indoors, I am concerned that no steps were taken to establish if there were adequate drying facilities to meet the needs of Mrs C's disabled grandchildren. The Fuel Poverty Strategy sets out what is considered a satisfactory level of heating for households containing a disabled person. I have seen no evidence that the Association took this into account when assessing the adequacy of the heating in her home. Whilst data shows that the bedrooms meet the required levels, both the Technical Surveyor and Mrs C raised concerns about the temperature of other areas of her home. Failing to consider the needs of Mrs C's household in responding to repair requests is also contrary to the Repairs Policy.

56. The Association knew at the time Mrs C made her complaint that her granddaughters were disabled. The EA protects disabled people from being treated less favourably because they have a disability. It is not for me to make a definitive determination regarding whether a body has complied with the terms of the EA, but I can consider if an organisation has had due regard to its obligations. The failure to consider the needs of Mrs C's grandchildren suggests the Association may not have paid due regard to its duties under the EA.

Recommendations

57. I **recommend** that within **1 month** of the date of the final report the Association should:

a) Provide evidence that the Association has acknowledged and apologised to Mrs C for the failings identified in this report.

b) Provide evidence that the Association has offered Mrs C a financial redress payment of £840. This includes £500 for the cost of a mattress, clothes and toys Mrs C has had to dispose of, £40 for the survey she arranged and £300 for the distress caused to her by the failings identified in this report.

c) After the next period of significant wet weather or when the tenant next reports any evidence of damp on the wall, to remove the plasterboard in the area where moisture has been recorded and undertake a full inspection of the wall. A copy of this inspection should be shared with Mrs C and this office.

58. **I recommend** that within **3 months** of the date of the final report the Association should:

d) Carry out any works determined as necessary as a result of the inspection of the wall.

e) Ensure all relevant staff receive training to identify and respond appropriately to vulnerable customers.

f) Ensure that a scenario based training programme is delivered to all relevant staff to ensure that lessons are learned from this case and staff take account of individual circumstances where prioritising repairs.

g) Develop a process to ensure that when a complaint of damp and mould is received, information gathered from sensors in properties belonging to the Association is regularly, analysed and reported accurately.

h) Share a copy of this report with the Association's Assurance Committee which should oversee and monitor the Association's compliance with these recommendations.

59. I am pleased to note that in commenting on the draft of this report **Trivallis** has agreed to implement these recommendations.

Michelle Morris

Michelle Morris 23 October 2025
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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Ymchwiliad i gŵyn yn erbyn Trivallis

Adroddiad gan
Ombwdsmon Gwasanaethau Cyhoeddus Cymru
Achos: 202405250

Cynnwys	Tudalen

Cyflwyniad

Cyhoeddir yr adroddiad hwn o dan adran 23 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019.

Rydym wedi cymryd camau i gelu pwy yw'r achwynydd ac eraill, cyn belled ag y bo modd. Mae enw'r achwynydd ac eraill wedi cael eu newid hefyd.

Crynodeb

Cwynodd Mrs C ynghylch a oedd Trivallis ("y Gymdeithas") wedi ymateb yn briodol i adroddiadau am leithder a llwydni a wnaed ganddi rhwng mis Tachwedd 2023 a'r presennol.

Canfu'r ymchwiliad nad oedd y Gymdeithas bob amser yn ymateb yn briodol i adroddiadau am leithder a llwydni. Nid oedd y Gymdeithas yn ymateb yn brydlon bob amser i adroddiadau am broblemau yng nghartref Mrs C nac yn unol â pholisïau perthnasol.

Mae arolygon wedi nodi lleithder yn yr un ardal o gartref Mrs C ond nid yw'r Gymdeithas wedi sefydlu'r achos yn bendant eto. Nid oedd y ffordd yr oedd y Gymdeithas yn cyfathrebu â Mrs C bob amser yn briodol chwaith ac nid wyf wedi gweld unrhyw dystiolaeth bod y Gymdeithas wedi ystyried anghenion y plant anabl sy'n byw yng nghartref Mrs C wrth ymateb i adroddiadau am leithder a llwydni.

Roedd yr Ombwdsmon yn bryderus y gallai'r methiannau a nodwyd yn yr achos hwn fod yn systemig, gyda chyfleoedd wedi'u methu i nodi'r problemau yng nghartref Mrs C. Mae'r methiannau a nodwyd yn yr achos hwn, yn arbennig mewn cysylltiad â cheisiadau am atgyweiriadau gan bobl agored i niwed, yn rhai y gall y sefydliadau eraill ddysgu ohonynt.

Gwnaeth yr Ombwdsmon nifer o argymhellion a dderbyniwyd gan y Gymdeithas.

O fewn 1 mis:

a) Darparu tystiolaeth bod y Gymdeithas wedi cydnabod ac ymddiheuro i Mrs C am y methiannau a nodwyd yn yr adroddiad hwn.

b) Darparu tystiolaeth bod y Gymdeithas wedi cynnig taliad iawndal ariannol o £840 i Mrs C. Mae hyn yn cynnwys £500 ar gyfer cost matres, dillad a theganau y mae Mrs C wedi gorfod eu gwaredu, £40 am yr arolwg a drefnodd a £300 am y gofid a achoswyd iddi gan y methiannau a nodwyd yn yr adroddiad hwn.

c) Yn dilyn y cyfnod nesaf o dywydd gwlyb sylweddol neu pan fydd y tenant yn adrodd unrhyw dystiolaeth o leithder ar y wal, tynnu'r bwrdd plastr yn yr ardal lle adroddwyd lleithder a chynnal archwiliad llawn o'r wal. Dylid rhannu copi o'r archwiliad hwn gyda Mrs C a'r swyddfa hon.

O fewn 3 mis:

ch) Gwneud unrhyw waith y penderfynwyd eu bod yn angenrheidiol o ganlyniad i'r archwiliad o'r wal.

d) Sicrhau bod pob aelod o staff perthnasol yn derbyn hyfforddiant i nodi ac ymateb yn briodol i gwsmeriaid agored i niwed.

dd) Sicrhau bod rhaglen hyfforddiant sy'n seiliedig ar sefyllfaoedd yn cael ei darparu i bob aelod o staff perthnasol i sicrhau bod gwersi'n cael eu dysgu o'r achos hwn a bod staff yn ystyried amgylchiadau unigol wrth flaenoriaethu atgyweiriadau.

e) Datblygu proses i sicrhau, pan dderbynnir cwyn am leithder a llwydni, bod gwybodaeth sy'n cael ei chasglu o synwyryddion yn yr eiddo y mae'r Gymdeithas yn berchen arnynt, yn cael ei dadansoddi a'i hadrodd yn gywir yn rheolaidd.

f) Rhannu copi o'r adroddiad hwn gyda Phwyllgor Sicrwydd y Gymdeithas, a ddylai oruchwylio a monitro cydymffurfiaeth y Gymdeithas â'r argymhellion hyn.

Y Gŵyn

1. Cwynodd Mrs C ynghylch a oedd Trivallis ("y Gymdeithas") wedi ymateb yn briodol i adroddiadau am leithder a llwydni a wnaed ganddi rhwng Tachwedd 2023 a'r presennol.

Yr Ymchwiliad

2. Derbyniais sylwadau a chopïau o ddogfennau perthnasol gan y Gymdeithas ac ystyriais y rhain ochr yn ochr â'r dystiolaeth a ddarparwyd gan Mrs C. Nid wyf wedi cynnwys pob manylyn yr ymchwiliwyd iddynt yn yr adroddiad hwn, ond rwy'n fodlon nad oes unrhyw beth arwyddocaol wedi'i anwybyddu.

3. Rhoddwyd cyfle i Mrs C a'r Gymdeithas i weld a rhoi sylwadau ar y copi drafft o'r adroddiad hwn cyn cyhoeddi'r fersiwn derfynol.

Deddfwriaethau a pholisïau perthnasol

4. Deddf Rhentu Cartrefi (Cymru) 2016 ("y Ddeddf"). Mae Rhan 4 of y Ddeddf yn gosod rhwymedigaethau ar landlordiaid ynghylch cyflwr y cartrefi y maent yn eu gosod. Mae'r rhain yn cynnwys sicrhau bod annedd mewn cyflwr da ac yn addas i bobl fyw ynddi:

- Mae Adran 92 y Ddeddf yn datgan "rhaid i'r landlord o dan gontract diogel…. - cadw'r strwythur a'r tu allan i'r annedd...mewn cyflwr da".

- Mae Adran 97 y Ddeddf yn datgan nad yw rhwymedigaethau'r landlord o dan Adran 92 yn codi hyd nes bod y landlord yn dod i wybod bod angen gwaith atgyweirio.

- Mae Adran 97 hefyd yn datgan bod landlord yn cydymffurfio â rhwymedigaethau adran 92 os yw'n gwneud y gwaith neu'r atgyweiriadau angenrheidiol o fewn cyfnod rhesymol o amser.

5. Cyflwr a Diffyg Atgyweirio Tai Cymdeithasol: Adborth i Landlordiaid Cymdeithasol (“yr Adborth Diffyg Atgyweirio”), Llywodraeth Cymru, Chwefror 2022. Mewn cysylltiad â diffyg atgyweirio:

- Mae “Pwynt meddwl 2” yn datgan: “Dylai fod gan landlordiaid cymdeithasol brosesau, systemau a diwylliant o berchenogaeth er mwyn i broblemau allu cael eu nodi a’u huwchgyfeirio’n hawdd at sylw’r bobl iawn, gan gynnwys eu cyrff llywodraethu, os bydd angen cymryd camau ar frys.”

- Mae “Pwynt meddwl 9” yn datgan: “Dylai landlordiaid cymdeithasol sicrhau bod mesurau ar waith i nodi’n benodol problemau sy’n ymwneud â lleithder a llwydni y rhoddwyd gwybod amdanynt a mynd i’r afael â nhw. Dylai hyn gynnwys cynnal ymchwiliadau/archwiliadau yn ddiofyn, gan sicrhau bod anwedd a’i achosion yn cael eu hadnabod yn gywir, unioni unrhyw ddiffygion cyn gynted â phosibl a rhoi cymorth a chyngor i denantiaid, gan gynnwys cyngor ar dlodi tanwydd”.

6. Mae Safon Ansawdd Tai Cymru (“SATC”) 2023(diweddarwyd diwethaf ym mis Ebrill 2024, gweithredwyd 2002) yn nodi’r safonau a ddisgwylir ar gyfer tai cymdeithasol yng Nghymru, y mae landlordiaid yn cael eu mesur yn eu herbyn. Mae hyn yn ei gwneud yn ofynnol i gartrefi fod yn “rhydd o leithder”, gan gynnwys anwedd parhaus. Rhaid cymryd pob mesur i uwchraddio’r dulliau awyru mewn cartref, yn benodol mewn perthynas â sicrhau awyru digonol mewn ceginau ac ystafelloedd ymolchi. Mae’n ei gwneud yn ofynnol i systemau gwresogi allu gwresogi’r cartref cyfan i lefel gyfforddus. Mae hefyd yn nodi y dylai fod gan gartrefi gyfleusterau digonol i sychu dillad.

7. Polisi Atgyweiriadau’r Gymdeithas cymeradwywyd 10 Hydref 2023 (“y Polisi Atgyweiriadau”). Mewn adran o’r enw “Amserlenni ar gyfer gwneud atgyweiriadau”, mae’r Polisi Atgyweiriadau yn nodi bod angen ystyried ffaniau echdynnu mecanyddol nad ydynt yn gweithio fel atgyweiriad brys y dylid ei gwblhau o fewn 7 diwrnod gwaith. Mae atgyweiriadau cegin ac ystafell ymolchi wedi’u dosbarthu fel atgyweiriadau arferol y dylid eu cwblhau o fewn 20 diwrnod gwaith. Mae hefyd yn nodi y bydd amserlenni

rhesymol ar gyfer gwneud atgyweiriadau yn dibynnu ar ffactorau fel yr effaith ar ddeiliad y contract ac aelodau eu haelwyd. Nid yw'n cynnwys unrhyw ganllawiau pellach ar sut i asesu'r effaith hon. Mewn adran o'r enw "Polisi Cydraddoldeb, Amrywiaeth a Chynhwysiant" mae'n nodi nad ystyriwyd bod Asesiad o'r Effaith ar Gydraddoldeb yn angenrheidiol ar gyfer y Polisi Atgyweiriadau.

8. Trechu Tlodi Tanwydd 2021 i 2035, Llywodraeth Cymru, Mawrth 2021 ("y Strategaeth Tlodi Tanwydd")[1], sy'n diffinio system wresogi foddhaol i aelwydydd â pherson anabl fel 23 gradd Celsius yn yr ystafell fyw a 18 gradd Celsius mewn ystafelloedd eraill am 16 awr mewn cyfnod o 24 awr. Mae'r diffiniad o aelwydydd agored i niwed yn cynnwys y rhai y mae eu deiliaid o dan 16 oed ac mae gan y deiliaid salwch neu anabledd hirdymor.

9. Rhaid i bob corff cyhoeddus, a chyrff eraill sy'n cyflawni swyddogaethau cyhoeddus, gydymffurfio â Deddf Hawliau Dynol 1998, a oedd yn ymgorffori'r Confensiwn Ewropeaidd ar Hawliau Dynol ("y Confensiwn") yng nghyfreithiau'r DU. Mae Erthygl 8 y Confensiwn yn darparu hawl i unigolion i fywyd preifat a theuluol.

10. Mae Deddf Cydraddoldeb 2010 yn rhoi diogelwch cyffredinol i bobl â nodweddion gwarchodedig rhag gwahaniaethu. Mae'n diffinio pobl anabl fel y rhai sydd â nam corfforol neu feddyliol sy'n cael effaith andwyol "sylweddol" a "hirdymor" ar eu gallu i gyflawni gweithgareddau arferol o ddydd i ddydd. Mae hefyd yn gosod dyletswydd cydraddoldeb y sector cyhoeddus ("y ddyletswydd cydraddoldeb") ar gyrff cyhoeddus a chyrff eraill sy'n cyflawni swyddogaethau cyhoeddus. Mae'r ddeddf cydraddoldeb yn ei gwneud yn ofynnol iddynt roi sylw dyladwy i'r angen i ddiddymu ymddygiad a waherddir gan y Ddeddf Cydraddoldeb, er mwyn hybu cyfle cyfartal rhwng pobl â nodweddion gwarchodedig a phobl heb y nodweddion hyn, ac i feithrin cysylltiadau da rhwng yr unigolion hynny. Rhaid i gyrff cyhoeddus a chyrff eraill sy'n cyflawni swyddogaethau cyhoeddus ystyried pob un o'r nodau dyletswydd cydraddoldeb hyn wrth wneud penderfyniadau, cynllunio polisïau a chyflenwi gwasanaethau.

[1] Trechu Tlodi Tanwydd 2021 i 2035

11. Nid fy swyddogaeth i yw gwneud canfyddiadau pendant ynghylch a yw gwahaniaethu wedi digwydd neu a yw hawliau dynol unigolyn wedi cael eu torri gan gamau gweithredu (neu ddiffyg gweithredu). Fodd bynnag, byddaf yn gwneud sylwadau ar barch corff cyhoeddus, a chyrff eraill sy'n cyflawni swyddogaethau cyhoeddus, at hawliau dynol a'r amddiffyniad y mae'r Ddeddf Cydraddoldeb yn ei roi wrth iddynt gyflawni

Canllawiau ac Adroddiad Thematig Ombwdsmon Gwasanaethau Cyhoeddus Cymru ("OGCC")

12. Mae Egwyddorion Gweinyddu Da yr Ombwdsmon - a gyhoeddwyd gan fy rhagflaenydd[2], yn darparu canllaw i bob corff cyhoeddus yng Nghymru eu dilyn.

- Egwyddor 2 yw "Canolbwyntio ar y Cwsmer" drwy ddelio â phobl yn gymwynasgar, yn brydlon ac yn sensitif, gan ystyried eu hamgylchiadau unigol.

- Egwyddor 4 yw "Gweithredu'n Deg ac yn Gymesur" drwy drin pobl yn ddiduedd a gyda pharch, gan sicrhau bod penderfyniadau yn rhydd rhag rhagfarn a'u bod yn ystyried amgylchiadau unigol.

- Egwyddor 5 yw "Gwneud Pethau'n Iawn" drwy gydnabod camgymeriadau ac ymddiheuro lle bo hynny'n briodol.

Rhaid i Gyrff Cyhoeddus yng Nghymru ystyried y canllawiau hyn wrth gyflawni eu swyddogaethau.

13. Byw mewn Cyflyrau Difrifol – adroddiad thematig am dai gwael a chwynion am damprwydd a llwydni i OGCC ("yr Adroddiad Thematig")[3], Ombwdsmon Gwasanaethau Cyhoeddus Cymru, Tachwedd 2024 a oedd yn adrodd ar y cwynion a dderbyniwyd am leithder, llwydni a chyflyrau difrifol mewn tai cymdeithasol. Roedd yr Adroddiad Thematig hefyd yn ystyried sut mae darparwyr tai yn ymateb i anghenion deiliaid agored i niwed ac yn argymell bod angen blaenoriaethu atgyweiriadau yn unol â pholisïau

[2] Egwyddorion Gweinyddu Da – O dan adran 34 Deddf OGCC 2019
[3] Byw mewn Cyflyrau Difrifol

cyhoeddedig. Roedd hefyd yn argymell y dylai darparwyr tai ddefnyddio arolygwyr annibynnol i archwilio eiddo yr honnir bod lleithder ynddynt, ynghyd â chwynion anadlol. Er nad oedd yr adroddiad hwn wedi'i gyhoeddi ar yr adeg y mae'r digwyddiadau hyn yn berthnasol iddi, roedd y ddeddfwriaeth a'r canllawiau y mae'n cyfeirio atynt.

Y digwyddiadau cefndir

14. Mae Mrs C yn byw mewn byngalo gydag aelodau ei theulu, gan gynnwys ei hwyresau anabl. Cafodd yr eiddo ei adnewyddu a'i addasu gan y Gymdeithas yn **2021**, yn benodol er mwyn cyflawni anghenion wyresau Mrs C.

15. Ar 20 Tachwedd **2023** cysylltodd Mrs C â'r Gymdeithas. Dywedodd bod llwydni du yn ystafell wely ei chartref, sy'n cael ei defnyddio gan ei hwyres, sydd â materion meddygol sylweddol. Dywedodd Mrs C bod asthma ei hwyres (cyflwr yr ysgyfaint sy'n achosi anawsterau anadlu) wedi gwaethygu'n ddiweddar a'i bod wedi gorfod cael gwared ar ei matres meddygol ar ôl i'r llwydni ymledu iddo.

16. Y diwrnod canlynol, anfonodd rheolwr ("y Rheolwr Cyntaf") neges e-bost at nifer o gydweithwyr i'w hysbysu am bostiad ar y cyfryngau cymdeithasol a oedd yn honni bod matres meddygol yn eiddo Mrs C wedi'i ddifrodi o ganlyniad i ddiffygion yn ei chartref. Dywedodd y gallai Mrs C "fod yn flin iawn ac y gallai bostio camwybodaeth yn gyhoeddus". Mewn ymateb i neges e-bost ddiweddarach ynglŷn â chartref Mrs C, ysgrifennodd uwch reolwr ("yr Uwch Reolwr") "mae hyn yn sensitif iawn oherwydd iechyd dau blentyn ag anableddau difrifol felly mae angen bod yn ofalus. Mae eisoes yn rhoi pethau ar draws (y cyfryngau cymdeithasol)".

17. Ymwelodd syrfëwr ("y Syrfëwr Cyntaf") â chartref Mrs C ar 22 Tachwedd. Mewn neges e-bost at gydweithwyr yn dilyn yr ymweliad, dywedodd bod staen ar y wal mewn ystafell wely wedi'i achosi gan ddiffyg awyriad oherwydd bod gwely yn ei erbyn. Trefnodd i'r wal gael ei olchi ddechrau mis Ionawr 2024. Canfuwyd darlleniad bychan o ddŵr ar lefel y sgertins, felly cynigiodd archwiliad pellach gan ddefnyddio borosgop (cyfarpar a ddefnyddir i archwilio y tu mewn i waliau ceudod). Nododd

hefyd y gallai agoriad uwchben drws yr ystafell ymolchi, sydd ei angen ar gyfer trac teclyn codi alluogi i aer gwlyb symud drwy gartref Mrs C, ac awgrymodd y gallai fod angen ffan echdynnu fwy yn yr ystafell ymolchi.

18. Ar 27 Tachwedd ymwelodd syrfëwr arall ("yr Ail Syrfëwr") â chartref Mrs C. Dywedodd bod deunydd inswleiddio yn wal geudod yr ystafell ymolchi yn ymddangos yn fwy tywyll mewn rhai mannau nag eraill, gan ddangos bod lleithder o bosibl yn y ceudod. Yn y mannau lle'r oedd wedi drilio tyllau archwilio roedd y wal yn sych, oherwydd roedd llwch a morter du. O dan adran "Arsylwadau" yr adroddiad, cofnodwyd y gallai lleithder sy'n mudo o'r ystafell ymolchi fod yn achosi anwedd yn yr ystafell wely. Mae ffotograffau a dynnwyd ar y pryd yn dangos ardal o staenio ar y wal uwchben y sgertin. Nododd hefyd bod deunydd cwrs atal lleithder wedi'i osod dros fentiau ffasgia yn y to (sy'n galluogi i aer lifo i mewn ac allan o ofod y to, gan helpu i reoleiddio tymheredd a lleithder) .

19. Mewn e-bost yn ymateb i'r adroddiad hwn, daeth uwch syrfëwr ("yr Uwch Syrfëwr") i'r casgliad nad oedd dŵr yn dod i mewn a bod y broblem gyda llwydni wedi'i hachosi gan aer llaith yn dod o'r ystafell ymolchi. Dywedodd fod angen awyru digonol ac o bosibl gwaith i leihau lleithder yn mudo o'r ystafell ymolchi trwy osod rhywbeth dros yr agoriad sydd ei angen ar gyfer y trac teclyn codi.

20. Ar 20 Rhagfyr ysgrifennodd y Gymdeithas at Mrs a dweud "rydym wedi canfod ffynhonnell y broblem ac wedi cymryd camau angenrheidiol i fynd i'r afael â hi". Dywedodd bod archwiliad wedi canfod bod y wal yn sych heb arwydd o leithder. Roedd y lleithder ychwanegol yn yr aer yn cael ei achosi oherwydd yr agoriad sydd ei angen ar gyfer y trac teclyn codi ac y byddai arolwg yn cael ei gynnal i osod ffan awyru echdynnu mecanyddol a system awyru mewnbwn cadarnhaol ("PIV" - system sy'n tynnu awyr iach ffres o'r tu allan ac sy'n lleihau'r tebygolrwydd y bydd anwedd yn ffurfio). Gosodwyd y rhain ym mis Chwefror 2024.

21. Ar 31 Ionawr **2024** anfonodd syrfëwr technegol ("y Syrfëwr Technegol") e-bost at eu cydweithwyr, gan gynnwys yr Uwch Reolwr a'r Uwch Syrfëwr. Ymwelodd â chartref Mrs C ynglŷn â gwneud addasiadau ar gyfer ei hwyresau. Yn ystod yr ymweliad nododd sawl problem bosibl y credai y

gallent fod yn achosi lleithder yng nghartref Mrs C. Roedd y rhain yn cynnwys fentiau wedi'u gorchuddio a materion gyda ffelt y to a chwteri. Dywedodd ei bod yn ymddangos nad oedd cartref Mrs C wedi'i wresogi'n ddigonol ac argymhellodd y dylid cynnal gwerthusiad o ddigonolrwydd y rheiddiaduron. Mynegodd bryderon hefyd ynglŷn â wal gynnal (lle mae lefel allanol y ddaear yn uwch na lefel fewnol y llawr).

22. Atebodd yr Uwch Syrfëwr i'r e-bost hwn ar 1 Chwefror. Dywedodd bod y materion lleithder a llwydni wedi'u hymchwilio yn y mis Tachwedd blaenorol ac nad oedd unrhyw arwyddion o ddŵr yn dod i mewn. Dywedodd ei fod yn tybio bod y "datblygiad wedi cynnal yr holl wiriadau angenrheidiol" o ran a oedd y system wresogi a'r rheiddiaduron yng nghartref Mrs C yn cyflawni'r safonau perthnasol.

23. Ar 11 Mawrth cysylltodd Mrs C â'r Gymdeithas i ofyn i arolwg gael ei gynnal o'i system wresogi am ei bod yn poeni y gallai'r rheiddiaduron yn ei chartref fod yn rhy fach. Cynhaliwyd arolwg yn ddiweddarach y mis hwnnw a ganfu bod y rhan fwyaf o'r rheiddiaduron a oedd wedi'u gosod yng nghartref Mrs C, pan gafodd ei ddatblygu, yn rhy fach. Gosodwyd rheiddiaduron newydd ym mis Mai 2024.

24. Ar 19 Mawrth anfonodd Mrs C e-bost at yr Uwch Reolwr. Dywedodd bod y difrod dŵr wedi digwydd eto yn yr ystafell ymolchi ac na allai ei merch a'i hwyres ddefnyddio'r ystafell am ei bod yn cael effaith negyddol ar eu hiechyd. Dywedodd hefyd bod eiddo wedi'i ddifrodi. Nid wyf wedi gweld unrhyw dystiolaeth bod Mrs C wedi derbyn ymateb i'r e-bost hwn.

25. Ar 16 Ebrill anfonodd Mrs C e-bost i gwyno at y Gymdeithas yn datgan nad oedd wedi mynd i'r afael â'r adroddiadau a wnaeth ynglŷn â'r difrod dŵr mewn ystafell wely yn ei chartref. Dywedodd bod hyn yn cael effaith negyddol ar ei hiechyd hi ac iechyd ei theulu, gan gynnwys ei hwyresau anabl.

26. Ymwelodd yr Uwch Syrfëwr ag eiddo Mrs C ar 26 Ebrill ac adroddodd am ychydig o anwedd uwchben bwrdd sgertin yn yr ystafell wely. O ran yr ystafell ymolchi, ysgrifennodd pan nad oedd yn cael ei defnyddio ei bod yn cael ei defnyddio fel ystafell sychu, sy'n golygu bod

llawer o leithder yn yr ardal bob amser. Mae ffotograffau a dynnwyd yn ystod yr ymweliad hwnnw yn dangos dillad plant yn sychu ar hors ddillad. Dywedodd ei fod yn edrych i osod llen stribed PVC i atal aer llaith rhag mudo trwy'r gofod sydd ei angen ar gyfer y teclyn codi.

27. Ar 29 Ebrill anfonodd rheolwr ("yr Ail Reolwr") e-bost at yr Uwch Syrfëwr a oedd yn cynnwys data wedi'i gasglu gan synwyryddion yn eiddo Mrs C. Roedd y rhain wedi'u gosod pan gafodd yr eiddo ei ddatblygu ond cyn y pwynt hwn nid oedd unrhyw ddata wedi'i gasglu ohonynt na'i ddadansoddi. Dywedodd bod y ffaniau a'r system PIV newydd yn rheoli'r lleithder yn effeithiol a bod lleithder a oedd yn mudo i arwynebau oer yng nghartref Mrs C yn debygol o achosi unrhyw anwedd a adroddwyd. Awgrymodd y dylai Mrs C dderbyn "ap" preswylwyr er mwyn iddi allu gweld y data ei hun ac addasu ei harferion pe byddai angen. Ni chynigiwyd yr ap hwn i Mrs C.

28. Roedd yr Ail Reolwr wedi atodi nifer o siartiau i'r e-bost. Roedd y rhain yn cynnwys graff yn dangos y lleithder cymharol yn ystafelloedd gwely cartref Mrs C o fis Gorffennaf 2022 hyd at y dyddiad presennol. Dangosodd hyn fod y lleithder cymharol cyfartalog yn ystafelloedd gwely cartref Mrs C dros y cyfnod hwnnw yn 64.12%, a bod y lleithder perthynol diweddaraf yn 61%. Er bod lefel y lleithder yng nghartref Mrs C wedi gostwng rhwng Ionawr a Mai yn 2023 ac yn 2024, roedd y lefel o leithder cymharol yn ystafell wely 3 yn gyson uwch na'r uchafswm a argymhellir, sef 60%. Roedd siart yn dangos y sgôr lleithder a llwydni yn yr ystafelloedd gwely yn cofnodi achlysuron lle cyrhaeddodd y sgôr 100 ym mhob ystafell wely, y sgôr uchaf posibl. Roedd hyn yn cynnwys ym mis Tachwedd 2023, pan adroddodd Mrs C am lwydni gyntaf. Dim ond ar gyfer yr ystafelloedd gwely yng nghartref Mrs C y dangoswyd y tymheredd, ond dangosodd hyn dymheredd dyddiol cyfartalog o 20 gradd Celsius a thymheredd cyfredol o 18 gradd.

29. Ar 31 Mai trefnodd Mrs C i gwmni preifat gynnal arolwg o'r wal lle'r oedd wedi cofnodi lleithder. Canfu'r arolwg lefel lleithder isel yn y pren ond sylwodd ar rywfaint o staenio i'r bwrdd plastr. Nodwyd bod y wal hon yn wal gynnal ac y gallai hyn fod yn achosi'r lleithder. Argymhellwyd y dylid tynnu'r bwrdd plastr yn yr ardal hon er mwyn profi'r wal a gosod triniaeth atal lleithder pe byddai angen.

30. Cyflwynodd Mrs C gŵyn i'r Ombwdsmon ar 17 Mehefin. Cafodd y gŵyn hon ei setlo ar y sail y byddai'r Gymdeithas yn gwneud gwaith i leihau'r aer llaith a oedd yn mudo o'r ystafell ymolchi erbyn 20 Awst. Cytunwyd hefyd y byddai'r Gymdeithas yn monitro'r sefyllfa am 2 fis ar ôl cwblhau'r gwaith ac yn ystyried opsiynau pellach pe byddai eu hangen.

31. Ar 5 Gorffennaf aeth saer coed i gartref Mrs C i osod llenni PVC i'r agoriad a oedd ei angen ar gyfer y teclyn codi, ond nid oeddent yn addas. Ar 22 Gorffennaf anfonodd yr Uwch Syrfëwr e-bost at uwch reolwr. Ysgrifennodd: "Rydw i'n teimlo ychydig yn rhwystredig gyda'r datblygiad. Rwyf wedi trafod y mater o anwedd yn mudo gyda nhw. A chanfod yr wythnos ddiwethaf eu bod wedi defnyddio'r drysau ar gyfer lleihau'r broblem hon mewn lleoliad arall".

32. Ar 23 Awst cysylltodd Mrs C â fy swyddfa i ddatgan nad oedd y Gymdeithas wedi cyflawni'r gwaith yr oedd wedi cytuno i'w wneud. Dywedodd y Gymdeithas bod yr Ail Reolwr wedi adolygu'r data o'r synwyryddion yng nghartref Mrs C ac wedi canfod bod y lefelau lleithder yn uchel.

33. Ymwelodd swyddogion o'r Gymdeithas â chartref Mrs C ar 17 Medi i wneud gwaith i leihau lleithder sy'n mudo ond bu'n rhaid ail-drefnu'r gwaith am nad oedd ganddynt y deunyddiau cywir. Gohiriwyd apwyntiad pellach gan y Gymdeithas ar gyfer 1 Hydref am yr un rheswm. O ganlyniad i fethiant parhaus y Gymdeithas i gwblhau'r gwaith y cytunwyd i'w wneud, dechreuodd fy Swyddfa ymchwiliad i gŵyn Mrs C. Cwblhawyd y gwaith yn y pen draw ar 20 Tachwedd.

34. Ar 12 Rhagfyr siaradodd Mrs C gyda chydlynydd cwynion o'r Gymdeithas. Dywedodd Mrs C fod y difrod dŵr wedi dychwelyd a'i bod yn amau mai lleithder oedd yn gyfrifol am hyn, yn hytrach nac anwedd. O ganlyniad, ymwelodd y Syrfëwr Cyntaf â chartref Mrs C ar 19 Rhagfyr. Ni chanfuwyd unrhyw arwyddion o leithder a bod y wal yn sych. Ar 17 Ionawr **2025**, dywedodd y Gymdeithas wrth Mrs C na fyddai'n tynnu bwrdd plastr er mwyn cynnal ymchwiliadau pellach oherwydd bod yr arolwg camera a gynhaliwyd yn flaenorol wedi cadarnhau bod y ceudod yn sych.

35. Ar 7 Chwefror cysylltodd Mrs C â fy swyddfa am ei bod o'r farn nad oedd y gwaith i leihau'r lleithder rhag mudo wedi datrys y broblem tamprwydd. Oherwydd bod 2 fis wedi bod ers i'r gwaith gael ei gwblhau, gofynnwyd i'r Gymdeithas beth oedd canlyniadau ei gwaith monitro ac a oedd yn cynnig cymryd unrhyw gamau pellach. Mewn ymateb i hyn, cyfeiriodd at lythyr 17 Ionawr. Gan fod y llythyr hwn yn cyfeirio at fonitro a oedd wedi'i wneud lai na mis ar ôl cwblhau'r gwaith, cytunodd y Gymdeithas i drefnu arolwg pellach gan syrfëwr annibynnol.

36. Ar 19 Mawrth ymwelodd syrfëwr adeiladau Siartredig annibynnol ("y Syrfëwr Siartredig") â chartref Mrs C. Canfuwyd bod ardaloedd lle'r oedd Mrs C wedi adrodd lleithder a llwydni yn y gorffennol yn sych, ac eithrio'r rhan o'r sgertin y dangoswyd ei bod yn wlyb. Canfuwyd bod y darlleniadau lleithder o fewn lefelau derbyniol, ac eithrio'r ystafell ymolchi ar ôl i'r gawod fod ymlaen. Gwaethygwyd y sefyllfa hon gan fod y ffan echdynnu i'r ystafell ymolchi wedi'i datgysylltu.

37. Y tu allan i gartref Mrs C, nododd y Syrfëwr Siartredig broblemau gyda'r cwteri a allai achosi i ddŵr ollwng y tu ôl iddo mewn glaw trwm. Mynegwyd pryderon hefyd ynglŷn â wal gynnal. Canfuwyd staeniau tywyll o dan y plwm, ger lleoliad y problemau tamprwydd a oedd wedi'u hadrodd yn fewnol a bod y rhimyn silicon yn yr ardal hon mewn cyflwr gwaeth nag mewn ardaloedd eraill o'r eiddo. Ystyriodd y Syrfëwr Siartredig, os nad oedd gan y wal gynnal danc na philen addas, y gallai hyn fod yn achos lleithder yng nghartref Mrs C. Ni chanfuwyd unrhyw broblemau cyfredol gyda lleithder ac roeddent yn teimlo bod yr ystafell wely yn addas i'w defnyddio. Argymhellwyd y dylid ailgysylltu'r ffan echdynnu, gan atgyweirio'r gleiniau silicon a chlirio'r cwteri. Argymhellwyd hefyd y dylai'r Gymdeithas fonitro'r ardal yn agos a'i hail-archwilio ymhen 6 mis, ac y gallai fod angen gwiriadau pellach, mwy ymwthiol pe bai Mrs C yn parhau i adrodd am broblemau. Ers hynny mae'r Gymdeithas wedi cynnal gwaith i atgyweirio'r gleiniau silicon a'r cwteri ac maent wedi ailgysylltu'r ffan echdynnu.

Tystiolaeth Mrs C

38. Dywedodd Mrs C ei bod wedi gwneud adroddiadau dro ar ôl tro am y llwydni yn yr ystafell wely a ddefnyddiwyd gan ei hwyres, ac er gwaethaf

ymweliadau niferus â'i chartref gan y Gymdeithas, nid oedd y mater wedi'i ddatrys eto.

39. Mae gan ddwy wyres Mrs C anableddau sy'n cyfyngu ar fywyd. Dywedodd nad oeddent yn gallu defnyddio'r ystafell wely am nad oedd y broblem wedi'i datrys oherwydd yr effaith ar eu hiechyd. Roedd hyn yn golygu eu bod yn gorfod rhannu gwelyau, gyda rhai o aelodau'r teulu yn cysgu yn yr ystafell fyw. Roedd hyn yn creu llawer o straen iddi, a dywedodd Mrs C ei bod wedi dechrau cael pyliau o orbryder o ganlyniad i hyn a'i bod wedi'i hatgyfeirio ar gyfer cwnsela.

40. Dywedodd Mrs C ei bod eisiau i'r Gymdeithas fynd i'r afael â'r problemau gyda lleithder yn yr ystafell wely er mwyn i'w hwyresau allu ei defnyddio unwaith eto.

Tystiolaeth y Gymdeithas

41. Dywedodd y Gymdeithas ei bod wedi cynnal ymchwiliadau priodol ac wedi sefydlu nad oedd unrhyw leithder treiddiol. Credwyd bod y problemau a adroddwyd gan Mrs yn cael eu hachosi gan aer llaith yn mudo o'r ystafell ymolchi. O'r herwydd, ni fyddai'n cynnal unrhyw ymchwiliad pellach o'r wal. Dywedodd eu bod wedi rhoi nifer o fesurau ar waith i geisio lleihau'r anwedd dŵr a oedd yn mudo o'r ystafell ymolchi. Dywedodd y Gymdeithas, pan nad oedd yr ystafell ymolchi yn cael ei defnyddio, ei bod yn cael ei defnyddio fel ystafell sychu, a fyddai'n golygu y byddai llawer o leithder bob amser yn yr ardal, ond ni ddarparodd unrhyw fanylion o'r lefel bresennol o leithder yng nghartref Mrs C.

Dadansoddiad a chasgliadau

A ymatebodd y Gymdeithas yn briodol i adroddiadau am leithder a llwydni a wnaed ganddi rhwng Tachwedd 2023 a'r presennol.

42. Nid oedd y Gymdeithas bob amser yn ymateb yn briodol i adroddiadau o leithder a llwydni. Pan adroddodd Mrs C y llwydni y tro cyntaf, ymatebodd y Gymdeithas yn gyflym a chynhaliodd ymchwiliadau priodol. Yn sgil y rhain, daeth y Gymdeithas i'r casgliad mai anwedd a

achoswyd gan aer gwlyb yn mudo o ystafell ymolchi oedd yn gyfrifol am hyn. Er gwaethaf hyn, ni osodwyd ffan echdynnu newydd yn yr ystafell ymolchi hyd at dros 2 fis yn ddiweddarach. Mae hyn yn groes i bolisi atgyweirio'r Gymdeithas. Ni wnaed yr ymgais gyntaf i orchuddio'r gofod oedd ei angen ar gyfer y teclyn codi tan dros 7 mis yn ddiweddarach. Mae'r Adborth ar y Diffyg Atgyweirio yn nodi y dylid cywiro diffygion sy'n achosi anwedd cyn gynted â phosibl. Yn yr achos hwn, aeth blwyddyn heibio cyn mynd i'r afael â'r broblem a ystyriai'r Gymdeithas yn achos yr anwedd. Mae'r Gymdeithas wedi cyfeirio dro ar ôl tro at y ffaith bod y wal yn sych. Mae hyn er gwaethaf y ffaith bod y Syrfëwr Cyntaf wedi dod o hyd i dystiolaeth o ddŵr a'r Ail Syrfëwr yn canfod arwyddion o leithder yn y ceudod.

43. Pan gododd y Syrfëwr Technegol bryderon ynghylch digonolrwydd rheiddiaduron yng nghartref Mrs C, ni chymerwyd unrhyw gamau gweithredu oherwydd bod yr Uwch Syrfëwr wedi tybio y byddai gwiriadau wedi'u cynnal pan ddatblygwyd yr eiddo. Nid wyf wedi gweld unrhyw dystiolaeth bod yr Uwch Syrfëwr wedi ceisio cael cadarnhad bod hynny'n wir. Pan gynhaliwyd arolwg ar ôl i Mrs C gysylltu â'r Gymdeithas 2 fis yn ddiweddarach, canfuwyd bod y rhan fwyaf o'r rheiddiaduron yn rhy fach. Cymerodd 2 fis arall cyn i reiddiaduron newydd gael eu gosod. Nid wyf o'r farn bod y Gymdeithas wedi ymateb yn ddigon prydlon i bryderon Mrs C ynglŷn â digonolrwydd y rheiddiaduron, yn arbennig o ystyried bod y Syrfëwr Technegol wedi nodi diffygion tua 2 fis yn flaenorol.

44. Er bod ffan echdynnu fecanyddol a system PIV wedi'i gosod, roedd Mrs C yn parhau i adrodd problemau gyda difrod dŵr. Roedd y Syrfëwr Cyntaf a'r Ail Syrfëwr wedi canfod yn flaenorol bod ardal o'r wal yn wlyb. Roedd y Syrfëwr Technegol wedi adrodd problemau yng nghartref Mrs C a allai fod yn achosi damprwydd. Argymhellodd arolwg preifat a drefnwyd gan Mrs C bod angen ymchwiliad pellach o'r wal. Er gwaethaf hyn, ni chynhaliodd y Gymdeithas unrhyw ymchwiliadau pellach. Mae hyn yn groes i'r Adborth Cyflwr Difrifol sy'n datgan y dylid cynnal ymchwiliadau ar sail ddiofyn. Canfu'r Syrfëwr Siartredig bod ardal o'r wal yn wlyb. Dyma'r un ardal o wal a nodwyd fel un wlyb gan y Syrfëwr Cyntaf ym mis Tachwedd 2023. Codwyd pryderon tebyg hefyd gyda'r Syrfëwr Technegol ynghylch wal gynnal a chwteri. Nid yw'r Gymdeithas wedi ymrwymo i gynnal unrhyw ymchwiliad pellach i'r wal hon.

45. Mae'r Gymdeithas hefyd yn awgrymu y gallai Mrs C fod yn cyfrannu at y lefelau uchel o leithder drwy beidio agor ffenestri a sychu dillad y tu mewn. Argymhellodd yr Ail Reolwr y dylid cynnig ap i Mrs C a fyddai'n ei galluogi i weld sut roedd y ffordd yr oedd yn defnyddio ei chartref yn effeithio ar lefelau lleithder. Os oedd y Gymdeithas yn credu bod ffactorau ffordd o fyw yn achosi mwy o leithder yng nghartref Mrs C, yna byddai hyn wedi bod yn ffordd effeithiol o fynd i'r afael â hyn gyda hi. Ni chynigiwyd yr ap i Mrs nes ar ôl i'r ymchwiliad hwn ddechrau. Nid yw'r Gymdeithas wedi darparu esboniad am hyn.

46. Gosodwyd synwyryddion a oedd yn monitro amodau amgylcheddol yng nghartref Mrs C yn 2022, ond dywedodd y Gymdeithas na chynhaliwyd unrhyw ddadansoddiad o'r data tan fis Ebrill 2024. Pan gafodd y data hwn ei ddadansoddi, rwy'n pryderu na chafodd ei adrodd yn gywir. Adroddodd yr Ail Reolwr fod ffaniau a system PIV newydd yn rheoli lleithder yn effeithiol. Nid yw'r data sy'n ymwneud â lleithder yn dangos unrhyw wahaniaeth sylweddol o'r un cyfnod y flwyddyn flaenorol, pan nad oedd system awyru well wedi'i gosod. Ar ôl i Mrs C gysylltu â fy swyddfa ym mis Awst, dywedodd y Gymdeithas bod y synwyryddion wedi dangos bod y lefelau o leithder yn ei chartref yn uchel.

47. Nid oedd y ffordd yr oedd y Gymdeithas yn cyfathrebu â Mrs C bob amser yn unol ag Egwyddorion Gweinyddu Da. Nid oes gennyf unrhyw dystiolaeth bod Mrs C wedi derbyn ymateb i'w neges e-bost dyddiedig19 Mawrth 2023. Nid yw'r Gymdeithas wedi dangos ei bod wedi rhoi ystyriaeth i amgylchiadau unigol Mrs C, yn benodol anghenion ei hwyresau anabl. Nid aed i'r afael â phryder cychwynnol Mrs C mewn ffordd sensitif, gyda negeseuon e-bost mewnol gan y Rheolwr Cyntaf a'r Uwch Reolwr yn canolbwyntio ar bostiadau a wnaed ar y cyfryngau cymdeithasol yn hytrach nac ar yr effaith bosibl ar Mrs C a'i theulu. Mae'r e-bost gan y Rheolwr Cyntaf hefyd yn cyfeirio at y posibilrwydd y gallai Mrs C fod yn postio camwybodaeth. Roedd hyn cyn i archwiliad gael ei gynnal i sefydlu a oedd diffygion wedi achosi'r mater a adroddodd. Mae hyn yn groes i Egwyddor 2 sy'n ei gwneud yn ofynnol i gyrff cyhoeddus ganolbwyntio ar y cwsmer ac Egwyddor 4 sy'n datgan y dylai cyrff cyhoeddus weithredu mewn ffordd deg a chymesur. Mae peidio cydnabod

bod lleithder yn parhau yn y wal yng nghartref Mrs C a pheidio gweithredu'n brydlon i fynd i'r afael â hyn hefyd yn groes i Egwyddor 5, sy'n gysylltiedig â gweithio i wella.

48. Mae ein Hadroddiad Thematig: Byw mewn Cyflyrau Difrifol a gyhoeddwyd yn ddiweddar, yn cyfeirio'n benodol at anghenion pobl agored i niwed. Yn achos Mrs C, er ei bod wedi adrodd bod asthma ei hwyres wedi gwaethygu, ni chynhaliwyd arolwg annibynnol nes i fy swyddfa ymyrryd yn y mater. Hefyd, nid yw'r Polisi Atgyweiriadau yn cynnwys unrhyw arweiniad ar sut a phryd y dylid rhoi blaenoriaeth i geisiadau am atgyweiriadau gan bobl agored i niwed.

49. Mae'r rhain yn fethiannau sydd gyfystyr â chamweinyddiaeth. Maent yn anghyfiawnder i Mrs a'i hwyresau anabl y bu'n rhaid iddynt fyw gydag atgyweiriadau i'w cwblhau yn eu cartref am gyfnod sylweddol o amser. Drwy beidio cadw cartref Mrs C mewn cyflwr da, ni wnaeth y Gymdeithas gydymffurfio chwaith gyda'i dyletswydd o dan y Ddeddf. Rwyf hefyd yn **cadarnhau** cwyn Mrs C.

50. Rwyf yn bryderus bod yr ymchwiliad hwn wedi nodi materion systemig yn y Gymdeithas. Er i synwyryddion gael eu gosod yng nghartref Mrs C, ni chymerwyd unrhyw gamau i ddadansoddi'r data maent yn ei ddarparu. Mae hyn yn cynrychioli cyfle arwyddocaol a gollwyd i nodi problemau yng nghartref Mrs C. Os nad oes gwaith monitro data yn cael ei wneud yn rheolaidd, mae'n bosibl bod methiannau tebyg wedi digwydd mewn eiddo eraill sy'n eiddo i'r Gymdeithas. Ymddengys hefyd nad oedd gwybodaeth bob amser yn cael ei rhannu'n effeithiol rhwng gwahanol dimau, a arweiniodd at oedi cyn mynd i'r afael â materion a adroddwyd gan Mrs C.

51. Rwy'n cydnabod bod rhywfaint o ansicrwydd technegol ynghylch yr hyn sy'n achosi'r problemau yng nghartref Mrs C. Serch hynny, mae'r materion a nodwyd yn ystod yr ymchwiliad hwn yn sylweddol. Mae pedwar arolwg unigol wedi nodi lleithder yn yr un ardal o wal mewn ystafell wely, ond ni chymerodd y Gymdeithas unrhyw gamau i ymchwilio ymhellach i hyn. Er bod y Syrfëwr Technegol wedi codi pryderon nad oedd cartref Mrs C yn cael ei wresogi'n ddigonol, ni chymerodd y Gymdeithas unrhyw

gamau gweithredu hyd nes i Mrs C gysylltu â hwy 2 fis yn ddiweddarach. Ar y pwynt hwn, 3 blynedd ar ôl i'r eiddo gael ei ddatblygu, canfuwyd bod rheiddiaduron o feintiau annigonol wedi'u gosod.

52. Mae'r materion hefyd yn rhai parhaus. Nid yw'r Gymdeithas wedi sefydlu'n bendant eto beth sy'n achosi'r lleithder i'r sgertin.

53. Rwyf hefyd o'r farn bod y methiannau a nodwyd yn yr achos hwn yn rhai y gall sefydliadau eraill ddysgu ohonynt. Bu cyfleoedd a fethwyd i gynnal arolwg annibynnol cynharach. Nid wyf wedi gweld unrhyw dystiolaeth bod y Gymdeithas wedi ystyried anghenion wyresau Mrs C, neu fod ganddynt bolisi yn ystod y cyfnod hwn ynghylch ceisiadau am atgyweiriadau gan aelwydydd sy'n cynnwys pobl agored i niwed. Am y rhesymau hyn rwy'n ystyried bod yr adroddiad hwn o ddiddordeb cyhoeddus ehangach.

54. Mae Erthygl 8 y Confensiwn yn ei gwneud yn ofynnol i gyrff cyhoeddus, a chyrff eraill sy'n cyflawni swyddogaethau cyhoeddus, barchu cartrefi a bywydau teuluol unigolion. Gall parch gynnwys sicrhau bod cartrefi'n cael eu cynnal a'u cadw mewn cyflwr da a gwrando a chymryd camau gweithredu priodol pan fydd problemau'n codi. Rwy'n ystyried bod Erthygl 8 wedi'i hysgogi gan amgylchiadau'r gŵyn hon, am nad ymatebodd y Gymdeithas yn briodol i adroddiadau atgyweirio Mrs C nac i ganfyddiadau ei harolygon ei hun. O ganlyniad, cododd sefyllfa lle gallai hawl Mrs C i gael ei chartref a'i bywyd teuluol wedi'i barchu fod wedi'i chyfaddawdu.

55. Mae'r SATC yn ei gwneud yn ofynnol i gartrefi gynnwys cyfleusterau digonol ar gyfer sychu dillad. Bydd yr hyn sy'n ddigonol yn dibynnu ar anghenion penodol aelwydydd unigol. Pan nodwyd bod Mrs C yn sychu dillad y tu mewn i'r tŷ, rwy'n bryderus na chymerwyd unrhyw gamau i sefydlu a oedd cyfleusterau sychu digonol i gyflawni anghenion wyresau anabl Mrs C. Mae'r Strategaeth Tlodi Tanwydd yn nodi'r hyn a ystyrir yn lefel foddhaol o wresogi ar gyfer aelwydydd sy'n cynnwys person anabl. Nid wyf wedi gweld unrhyw dystiolaeth bod y Gymdeithas wedi ystyried hyn wrth asesu digonolrwydd y system wresogi yn ei chartref. Er bod data yn dangos bod yr ystafelloedd gwely wedi cyflawni'r lefelau gofynnol, roedd y Syrfëwr Technegol a Mrs C wedi codi pryderon ynglŷn â thymheredd

ardaloedd eraill o'i chartref. Mae methiant i ystyried anghenion aelwyd Mrs C wrth ymateb i geisiadau am atgyweiriadau hefyd yn groes i'r Polisi Atgyweiriadau.

56. Roedd y Gymdeithas yn gwybod pan wnaeth Mrs C ei chwyn bod ei hwyresau yn anabl. Mae'r Ddeddf Cydraddoldeb yn diogelu pobl anabl rhag triniaeth lai ffafriol oherwydd bod ganddynt anabledd. Nid fy lle i yw gwneud penderfyniad pendant ynghylch a yw corff wedi cydymffurfio â thelerau'r Ddeddf Cydraddoldeb, ond gallaf ystyried a yw sefydliad wedi rhoi sylw dyledus i'w rwymedigaethau. Mae'r methiant i ystyried anghenion wyrion Mrs C yn awgrymu nad yw'r Gymdeithas o bosibl wedi rhoi sylw dyledus i'w dyletswyddau o dan y Ddeddf Cydraddoldeb.

Argymhellion

57. Rwy'n argymell, o fewn **1 mis** o ddyddiad yr adroddiad terfynol, y dylai'r Gymdeithas:

a) Darparu tystiolaeth bod y Gymdeithas wedi cydnabod ac ymddiheuro i Mrs C am y methiannau a nodwyd yn yr adroddiad hwn.

b) Darparu tystiolaeth bod y Gymdeithas wedi cynnig taliad iawndal ariannol o £840 i Mrs C. Mae hyn yn cynnwys £500 ar gyfer cost matres, dillad a theganau y mae Mrs C wedi gorfod eu gwaredu, £40 am yr arolwg a drefnodd a £300 am y gofid a achoswyd iddi gan y methiannau a nodwyd yn yr adroddiad hwn.

c) Yn dilyn y cyfnod nesaf o dywydd gwlyb sylweddol neu pan fydd y tenant yn adrodd unrhyw dystiolaeth o leithder ar y wal, tynnu'r bwrdd plastr yn yr ardal lle adroddwyd lleithder a chynnal archwiliad llawn o'r wal. Dylid rhannu copi o'r archwiliad hwn gyda Mrs C a'r swyddfa hon.

O fewn **3 mis**:

ch) Gwneud unrhyw waith y penderfynwyd eu bod yn angenrheidiol o ganlyniad i'r archwiliad o'r wal.

d) Sicrhau bod pob aelod o staff perthnasol yn derbyn hyfforddiant i nodi ac ymateb yn briodol i gwsmeriaid agored i niwed.

dd) Sicrhau bod rhaglen hyfforddiant sy'n seiliedig ar sefyllfaoedd yn cael ei darparu i bob aelod o staff perthnasol i sicrhau bod gwersi'n cael eu dysgu o'r achos hwn a bod staff yn ystyried amgylchiadau unigol wrth flaenoriaethu atgyweiriadau.

e) Datblygu proses i sicrhau, pan dderbynnir cwyn am leithder a llwydni, bod gwybodaeth sy'n cael ei chasglu o synwyryddion yn yr eiddo y mae'r Gymdeithas yn berchen arnynt, yn cael ei dadansoddi a'i hadrodd yn gywir yn rheolaidd.

f) Rhannu copi o'r adroddiad hwn gyda Phwyllgor Sicrwydd y Gymdeithas, a ddylai oruchwylio a monitro cydymffurfiaeth y Gymdeithas â'r argymhellion hyn.

58. Mae'n bleser gennyf ddatgan, wrth roi sylwadau ar fersiwn ddrafft yr adroddiad hwn, bod **Trivallis** wedi cytuno i weithredu'r argymhellion hyn.

Michelle Morris

Michelle Morris 23 Hydref 2025
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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