Publication-Ready Case Review

**Internal audit review of Housing Ombudsman Determination 202437916 (24/12/2025)**

**Report dated: 16 January 2026**
Senior Management Case Review – Summary
This report sets out the findings of a senior management case review completed following a Housing Ombudsman determination which found severe maladministration. The review considered the landlord's handling of reports of damp, mould and mould mites within a household, alongside associated complaint handling.

The purpose of the review was to identify learning, assess compliance with expected standards, and confirm what improvements have been made to prevent similar issues occurring in future. The review was undertaken independently of the service area involved.

**Scope of Review**
The review was completed in line with the Ombudsman's order and focused on:
1. Delays in diagnosing and addressing the root cause of damp, mould and mould mites
2. Consideration of household vulnerabilities
3. Engagement with other professionals and agencies
4. Communication with contractors and the resident
5. Handling of temporary rehousing requests
6. Organisational learning from similar cases
7. Complaint handling and record keeping

**Key Findings**

Damp, Mould and Mould Mites
While treatments were arranged, the review found that the landlord did not move quickly enough to a full diagnosis of the underlying cause. Opportunities to escalate following repeat reports were missed, and advice from specialist contractors was not translated promptly into a clear plan of action. This resulted in prolonged issues and avoidable distress.

Since the events in this case, the landlord has strengthened its damp and mould framework, ensuring a "diagnosis-first" approach and clearer ownership of complex cases.

Consideration of Vulnerabilities
Although vulnerability information was recorded, it did not consistently inform service delivery. Adjustments such as tailored communication, appointment planning and proactive risk assessment were not applied as robustly as they should have been.



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The landlord has since embedded automatic vulnerability triggers within its high-risk case management and damp and mould procedures, supported by targeted staff training.

Multi-Agency Working

The review identified missed opportunities to work more closely with health and support professionals who raised concerns. Improved referral pathways and clearer protocols are now in place to ensure households receive appropriate joined-up support.

Communication

Communication with both contractors and the resident was inconsistent. Contractor feedback about unresolved root causes did not always result in timely escalation, and the resident experienced missed updates and delays.

The landlord has strengthened contractor reporting requirements and introduced clearer expectations around resident communication and follow-up.

Temporary Rehousing

Requests for temporary accommodation were not assessed or recorded against a clear framework at the time. The landlord has since updated its procedures so that all requests are formally considered, documented and communicated, particularly where health risks are identified.

Wider Learning

The review identified a small number of other reports of possible mould mites during the same period, which were managed more promptly and did not escalate. A broader organisational review has been commissioned to identify patterns and apply learning consistently across the stock.

Complaint Handling and Records

There were delays at both complaint stages and weaknesses in tone and clarity. Record-keeping gaps also limited effective oversight. The landlord has since refreshed its complaint handling arrangements and introduced a single evidence-bundle approach for complex cases.

Actions and Improvements

The landlord has completed or is progressing a comprehensive action plan, including:

1. A strengthened damp and mould framework aligned with legislative requirements
2. Clear escalation triggers for repeat or high-risk cases
3. Improved vulnerability identification and reasonable adjustments
4. Formal recording of decant decisions
5. Enhanced contractor reporting and oversight
6. Organisational learning and internal audits to monitor effectiveness
7. Senior leaders and the governing body now provide regular oversight of progress.

Conclusion

This case highlighted shortcomings in pace, coordination and communication. The landlord accepts the findings, has apologised, and has used the learning from this case

to drive meaningful service improvements. The focus going forward is on early diagnosis, stronger case ownership, and ensuring residents: particularly those who are vulnerable - receive a timely, caring, empathetic and effective service.