

**Report by the Local Government and Social Care  
Ombudsman**

**Investigation into a complaint about  
London Borough of Haringey  
(reference number: 24 014 203)**

**19 August 2025**

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# The Ombudsman's role

We independently and impartially investigate complaints about councils and other organisations in our jurisdiction. If we decide to investigate, we look at whether organisations have made decisions the right way. Where we find fault has caused injustice, we can recommend actions to put things right, which are proportionate, appropriate and reasonable based on all the facts of the complaint. We can also identify service improvements so similar problems don't happen again. Our service is free.

We cannot force organisations to follow our recommendations, but they almost always do. Some of the things we might ask an organisation to do are:

- > apologise
- > pay a financial remedy
- > improve its procedures so similar problems don't happen again.

We publish reports to raise awareness of significant issues, encourage scrutiny of local services and hold organisations to account.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

## Key to names used

|      |                               |
|------|-------------------------------|
| Mr Y | The complainant               |
| Ms X | His friend and co-complainant |

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## Report summary

### Adult care services – safeguarding

Ms X complained the Council did not act when she raised concerns about Mr Y's welfare. She also complained about the Council's handling of her complaint. Ms X said the Council's actions caused distress to Mr Y, his family and Ms X. The Council was at fault. It has not evidenced it considered if it needed to act to safeguard Mr Y. This left Mr Y at risk of harm and caused Ms X, Mr Y and his family uncertainty. The Council's complaint handling was poor and this caused frustration to Ms X.

### Finding

Fault causing injustice and recommendations made.

### Recommendations

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

In addition to the requirements set out above, to remedy the injustice caused the Council should carry out the following actions within one month of the date of this report:

- apologise to Mr Y and Ms X for the injustice caused by the fault identified in this case. We publish [guidance on remedies](#) which sets out our expectations for how organisations should apologise effectively to remedy injustice. The organisation should consider this guidance in making the apology we have recommended in our findings.
- pay Mr Y £2,000 for leaving him at risk of harm.
- pay Ms X £200 to acknowledge the time and trouble she has spent pursuing this complaint.

Within three months of the date of this report the Council should:

- undertake a lessons learned exercise with all relevant staff and develop an action plan to prevent the same problems recurring in future;
- as part of the action plan, review its safeguarding policy to ensure the Council considers safeguarding referrals, rather than requiring a completed form;
- provide training to relevant staff on accepting safeguarding referrals based on whether it meets the threshold, rather than whether they are in a certain format;
- provide training, with reference to [our guidance](#), to relevant staff on effective complaint handling. This should include identifying the appropriate procedure, sending responses on the correct templates and resolving issues quickly using a common sense approach;
- provide an update on progress against the Council's action plan to deal with the backlog in email communications and police reports and any further action planned if progress is not as planned; and
- refer this report, the lessons learned outcomes and the Council's two action plans to the Cabinet Member for Adult Social Care and the relevant scrutiny committee and keep both regularly updated on progress.

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The Council has accepted these recommendations.

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## **The complaint**

1. Ms X complained the Council did not act when she raised concerns about Mr Y's welfare. She also complained about the Council's handling of her complaint. Ms X said the Council's actions caused distress to Mr Y, his family and Ms X.

## **Legal and administrative background**

### **The Ombudsman's role and powers**

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. (Local Government Act 1974, sections 26(1) and 26A(1), as amended)
3. We may investigate matters coming to our attention during an investigation, if we consider that a member of the public who has not complained may have suffered an injustice as a result. (Local Government Act 1974, section 26D and 34E, as amended)
4. We may investigate complaints made on behalf of someone else if they have given their consent. (Local Government Act 1974, section 26A(1), as amended)
5. An organisation should not adopt a blanket or uniform approach or policy that prevents it from considering the circumstances of a particular case. We may find fault in the actions of organisations that 'fetter their discretion' in this way.
6. Under our information sharing agreement, we will share this decision with the Care Quality Commission (CQC).
7. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. (Local Government Act 1974, sections 26B and 34D, as amended)
8. We exercised discretion to consider events in this case back to June 2023. Ms X continued to pursue this matter and the Council did not fully or meaningfully respond to her complaints.

### **Legal background**

9. A council must make enquiries if it thinks a person may be at risk of abuse or neglect and has care and support needs which mean the person cannot protect themselves. An enquiry is the action taken by a council in response to a concern about abuse or neglect. An enquiry could range from a conversation with the person who is the subject of the concern, to a more formal multi-agency arrangement. A council must also decide whether it or another person or agency should take any action to protect the person from abuse. (section 42, Care Act 2014)
10. Councils should have clear procedures to deal with social care complaints. Regulations and guidance say they should investigate and resolve complaints quickly and efficiently. A single stage procedure should be enough. The council should include in its complaint response:
  - how it considered the complaint;
  - the conclusions reached about the complaint, including any required remedy;

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- whether it is satisfied all necessary action has been or will be taken by the organisations involved; and
  - details of the complainant's right to complain to the Local Government and Social Care Ombudsman. (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009)
11. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make particular decisions for themselves. The Act (and the Code of Practice 2007) describes the steps a person should take when dealing with someone who may lack capacity to make decisions for themselves. It describes when to assess a person's capacity to make a decision, how to do this, and how to make a decision on behalf of somebody who cannot do so.
  12. A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be in that person's best interests. The decision-maker also has to consider if there is a less restrictive choice available that can achieve the same outcome. Section 4 of the Act provides a checklist of steps decision-makers must follow to determine what is in a person's best interests.
  13. Sections 9 and 10 of the Care Act 2014 require councils to carry out an assessment for any adult with an appearance of need for care and support. They must provide an assessment to everyone regardless of their finances or whether the council thinks the person has eligible needs. The assessment must be of the adult's needs and how they impact on their wellbeing and the results they want to achieve. It must also involve the individual and where suitable their carer or any other person they might want involved.
  14. Councils must carry out assessments over a suitable and reasonable timescale considering the urgency of needs and any variation in those needs. Councils should tell people when their assessment will take place and keep them informed throughout the assessment.
  15. The Care Quality Commission (CQC) is the statutory regulator of care services. It keeps a register of care providers that meet the fundamental standards of care, inspects care services, and reports its findings. It can also enforce against breaches of fundamental care standards and prosecute offences.
  16. The Council's complaint procedure says it would review the complaint to determine the correct process. It says the Council will acknowledge the complaint within two to five working days. It says it would respond to the complaint within 10 working days.

### **How we considered this complaint**

17. We read Ms X's complaint and spoke to her about it on the phone.
18. We considered evidence provided by Ms X and the Council as well as relevant law, policy and guidance.
19. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

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## What we found

### What happened

20. This is a summary of events, outlining key facts and does not cover everything that has occurred in this case. We have purposely avoided giving precise details and information to protect Mr Y's anonymity.
21. Ms X contacted the Council in June 2023. She reported concerns about Mr Y, who experiences seizures. The Council told Ms X to fill out a safeguarding form. Ms X completed the safeguarding form and sent it to the Council a week later.
22. The Council recorded a referral from another person. The referral reported Mr Y accidentally caused damage to his property following seizures resulting in his landlord wanting to evict him.
23. Ms X contacted the Council at the end of June 2023. She reported Mr Y had been in hospital following a seizure, which led to damage to the property and placed him at significant risk of harm. Ms X confirmed Mr Y was now back at home, but she asked the Council to contact her. The emergency service which attended the scene at the time also sent a referral to the Council raising concerns about Mr Y.
24. Ms X chased the Council in July 2023. The Council asked Ms X to resend her referral form. Ms X resent the form. She raised concerns with her local councillor after no response from the Council.
25. Ms X chased the Council again in August 2023. The Council rejected Ms X's referral as she had not followed the correct process. The Council reconsidered Ms X's reports. It decided to refer Mr X to his GP because of the concerns. A manager then decided the Council needed to complete an assessment of Mr Y's social care needs, ability to make decisions for himself and complete referrals for the home environment.
26. Mr Y's landlord issued him an eviction notice in September 2023.
27. The emergency services again referred Mr Y to the Council in October 2023. It made the referral after Mr Y had a seizure and raised concerns about his care and support and living situation.
28. The Council recorded a police referral in January 2024. The police noted its concerns about Mr Y's home environment, his seizures and considered Mr Y a "possible vulnerable adult". Ms X repeated her concerns to the Council.
29. The emergency services sent another referral in June 2024. The referral details concerns about Mr Y's home environment and his seizures. The Council decided it would allocate a social worker to Mr Y.
30. In July 2024, the Council recorded it tried to contact Mr Y but could not. It noted it would complete a visit a month later.
31. Mr Y was admitted to hospital in September 2024. The Council recorded he suffered an injury from falling while having a seizure.
32. Ms X complained to the Council in September 2024. She said Mr Y was vulnerable and needed help. Ms X said she had been contacting the Council for over a year without response. Ms X confirmed Mr Y had suffered a serious and life-changing injury following the last fall.
33. Ms X chased the Council a week after her complaint. She explained the situation and confirmed Mr Y's landlord was evicting him.

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34. The Council issued a stage one corporate complaint response in October 2024. The response confirmed it received a referral from the emergency services in June 2024 and allocated a social worker to complete an assessment. It said the social worker tried to contact Mr Y but could not speak to him. The response confirmed a social worker would complete the assessment.
  35. The landlord evicted Mr Y at the end of October 2024. Ms X asked the Council to escalate her complaint to stage two.
  36. In November 2024, the Council told Ms X it considered the complaint under its corporate complaint procedure, but it related to adult social care. The Council asked Ms X to submit a new complaint under this process.
  37. At the end of November 2024, the Council accepted its response to the stage two request was not suitable and directed Ms X to us.
  38. Ms X was not satisfied with the Council's response and has asked us to investigate. Ms X would like the Council to appropriately support Mr Y and financially compensate him.
  39. In response to our enquiries the Council stated this case "was a serious oversight by several staff working in the Council at the time". Given the issues raised in the case we were concerned others may also be affected. We made further enquiries to establish the extent of some of the issues we had identified. The Council confirmed it had over 1,100 unread emails in its social work inbox, including over 500 police reports. The Council provided an action plan, detailing how it intended to deal with this backlog. The plan included allocating daily time to clear the backlog with specific targeted action.

### **Our findings**

40. The law says a council "must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case". The Council received repeated concerns from Ms X. It also received referrals from another person, the police and emergency services. The Council has not evidenced it considered if it should make safeguarding enquiries despite several concerns and referrals from individuals and professionals. This is fault. The Council did not consider if it needed to safeguard Mr Y and so placed him at risk of harm.
41. After one referral the Council triaged this case. It recommended a referral to a doctor. The Council changed this recommendation after management oversight. The Council then recommended a care and support needs assessment and assessments considering Mr Y's ability to make decisions around his care and support and living situation. The Council confirmed it would meet his assessed needs and consider referrals to other agencies. The Council has not evidenced it completed any of the actions it decided it should. This is fault. Mr Y's circumstances were not assessed, leaving him at risk of harm.
42. The Council recorded it rejected Ms X's referral because it did not follow the correct process. The Council has a duty to consider safeguarding concerns. It is unacceptable for a council not to consider concerns because a process is not completed in a particular way. The Council has not shown it assessed the situation and fettered its discretion by applying a blanket policy to a safeguarding referral. This is fault. The Council did not assess Mr Y's circumstances, leaving him at risk of harm.



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43. The Council allocated a worker to complete an assessment after the fourth professional referral, a year after the initial concerns were raised. The Council did not attempt to contact Mr Y for a month. When it tried to contact him but could not, it recorded it would try to visit one month later. The Council has not evidenced it completed this visit. The Council should assess the safeguarding concern and act within a reasonable timescale. Taking one month to contact Mr Y then another month to arrange to visit him is not a reasonable timescale. This is fault. This placed Mr Y at risk of harm during this delay.
44. Mr Y injured himself while falling during a seizure. Ms X and Mr Y's family feel the accident could have been prevented. We cannot say what action the Council would have taken if it had properly considered this case. We cannot say if the Council had acted to safeguard Mr Y and provided support, he would not have been injured. However, the Council did not assess Mr Y. Ms X, Mr Y and his family are left with the uncertainty of asking if his injuries would have happened if the Council had acted, completed the assessment and supported Mr Y.

### **Complaint handling**

45. Ms X's complaint reported she had raised concerns for over a year. The Council only commented on the three months before the complaint. It did not fully consider and respond to the complaint. This is fault, frustrating Ms X.
46. The Council considered this complaint using its corporate complaint procedure. This matter was about adult social care, so it should have used the adult social care complaint procedure. This is fault, frustrating Ms X.
47. The Council offered Ms X the right to escalate her complaint to stage two. It then refused to escalate the complaint to stage two. It said it should not have used the corporate complaint procedure. It asked Ms X to put in a new adult social care complaint. The Council's policy says it would decide the correct complaint process. The Council should have considered this complaint under the correct procedure. It should not need Ms X to resubmit a complaint because it did not do this. This is fault, frustrating Ms X.
48. In failing to robustly investigate the case via its own procedures the Council lost the opportunity to identify and begin to address the systemic issues involved. This adds to the risk of others being affected by the Council's failings.

### **Recommendations**

49. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

In addition to the requirements set out above, to remedy the injustice caused the Council should carry out the following actions within one month of the date of this report:

- apologise to Mr Y and Ms X for the injustice caused by the fault identified in this case. We publish [guidance on remedies](#) which sets out our expectations for how organisations should apologise effectively to remedy injustice. The organisation should consider this guidance in making the apology we have recommended in our findings.
- pay Mr Y £2,000 for leaving him at risk of harm.

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- pay Ms X £200 to acknowledge the time and trouble she has spent pursuing this complaint.
50. Within three months of the date of this report the Council should:
- undertake a lessons learned exercise with all relevant staff and develop an action plan to prevent the same problems recurring in future;
  - as part of the action plan, review its safeguarding policy to ensure the Council considers safeguarding referrals, rather than requiring a completed form;
  - provide training to relevant staff on accepting safeguarding referrals based on whether it meets the threshold, rather than whether they are in a certain format;
  - provide training, with reference to [our guidance](#), to relevant staff on effective complaint handling. This should include identifying the appropriate procedure, sending responses on the correct templates and resolving issues quickly using a common sense approach;
  - provide an update on progress against the Council's action plan to deal with the backlog in email communications and police reports and any further action planned if progress is not as planned; and
  - refer this report, the lessons learned outcomes and the Council's two action plans to the Cabinet Member for Adult Social Care and the relevant scrutiny committee and keep both regularly updated on progress.
51. The Council should provide us with evidence it has complied with the above actions.

## **Decision**

52. We have completed our investigation. We have found fault by the Council, which caused injustice to Mr Y and Ms X. The Council has agreed to take the action identified in paragraphs 49 and 50 to remedy that injustice.