2541440

Berry Gifford Ltd

Monitoring visit
Inspected under the social care common inspection framework

Information about this children's home

A private company owns this home. The home offers care and accommodation for up to three young people who have experienced childhood instability, resulting in trauma and associated complex behaviours.

This is the first inspection of this home since it was registered in February 2020.

Inspection date: 2 to 3 July 2020

This monitoring visit

This monitoring visit took place because of concerns that the two young people living in the home, both aged 15 years, were in a sexual relationship.

The inspection found significant safeguarding failings, which have compromised young people's welfare and safety.

Staff were informed by the young people on 15 June 2020 that they were in a sexual relationship. The registered manager has failed to ensure that staff take effective action to address and/or effectively manage this concern.

Specifically, there have been six incidents between 17 June 2020 and 1 July 2020 when the two young people are believed to have engaged in sexual activity. Staff failed to intervene and manage this risk despite an escalating pattern of incidents. As a result, both young people have been exposed to potential harm.

The registered manager has failed to ensure that staff effectively supervise the young people and take action to reduce risk. Records show that staff have not consistently followed strategies set out in the young people's risk assessments. As a result, staff have not promoted young people's safety and welfare.

Managers and staff have failed to recognise the seriousness of the two young people in the home having a sexual relationship. The record of this meeting shows that staff advised both young people to 'keep their behaviour off site', and the registered manager made it clear that 'nothing should be done on site'. This message condones the sexual relationship and demonstrates a lack of understanding by staff and the registered manager about the risk this behaviour poses to the young people both inside and outside the home.

Staff do not implement strategies to manage known risks in relation to the young people's mobile phone use. For example, the staff do not undertake regular checks on a young person's phone in line with the agreed protocol in place. This is indicative of poor staff oversight and management of risk.

The inspector found that individual support to young people to help them understand more about healthy and safe relationships is limited. This is a missed opportunity to help the young people to understand the risks they are exposed to and how to keep safe. Furthermore, staff do not consistently pursue or sufficiently investigate concerns raised by young people about alleged incidents that have occurred while they have been out in the community. This means that potentially serious concerns are not addressed, and young people are not provided with support.

Staff responses are inconsistent when young people go missing from the home. Records show that, on some occasions, staff complete searches of known areas and contact family members and associates. However, on other occasions this robust practice is not followed, and staff searches are minimal. As a result, staff do not always take all available steps to ensure that young people are located quickly and returned safely to the home.

Impact risk assessments are poor and do not consider the risks to and from young people already living in the home or to new young people moving in. Poor care planning has left young people at risk of harm and has had a negative impact on their experiences. In addition, two young people have moved on from the home sooner than anticipated because staff could not effectively manage their behaviours.

Young people's plans and case records are not individual to the needs of each young person. In some of the young people's case records, it is difficult to distinguish between information that was known at the point of referral and information that has come to light since the children have come to live at the home. This is confusing and unhelpful to staff and affects their ability to plan and review young people's care. In addition, incident reports lack key information and do not outline the actions staff take to keep young people safe. These shortfalls have the potential to undermine the registered manager's ability to provide the necessary oversight and review of serious incidents.

The registered manager has not notified Ofsted about serious incidents in the home.

This has meant that the regulator has not been able to provide the necessary oversight of escalating concerns in the home.

Six requirements are raised as a result of the shortfalls identified. Two of these requirements are subject to a compliance notice. Since the inspection, one of the young people has moved out of the home, leaving one child in placement. This has reduced the risks associated with this relationship. However, Ofsted is concerned that further admissions to the home may place children or young people at risk of harm. This is due to significant concerns about very poor matching and deficits in staff practice. As a result, a notice restricting accommodation is also issued.

Recent inspection history

Inspection date	Inspection type	Inspection judgement

This is the home's first inspection since registration.

What does the children's home need to do to improve?

Statutory requirements

This section sets out the actions that the registered person(s) must take to meet the Care Standards Act 2000, Children's Homes (England) Regulations 2015 and the 'Guide to the children's homes regulations including the quality standards'. The registered person(s) must comply within the given timescales.

Requirement	Due date
The positive relationships standard is that children are helped to develop, and to benefit from, relationships based on— mutual respect and trust; an understanding about acceptable behaviour. In particular, the standard in paragraph (1) requires the registered person to ensure— that staff— help each child to develop socially aware behaviour; encourage each child to take responsibility for the child's behaviour, in accordance with the child's age and understanding; communicate to each child expectations about the child's behaviour and ensure that the child understands those expectations in accordance with the child's age and understanding; help each child to understand, in a way that is appropriate according to the child's age and understanding, personal, sexual and social relationships, and how those relationships can be supportive or harmful; help each child to develop the understanding and skills to recognise or withdraw from a damaging, exploitative or harmful relationship. (Regulation 11(1)(a)(b)(2)(a)(ii)(iii)(v)(vi)(vii))	03/08/2020
The protection of children standard is that children are protected from harm and enabled to keep themselves safe. In particular, the standard in paragraph (1) requires the registered person to ensure— that staff—	03/08/2020

assess whether each child is at risk of harm, taking into account information in the child's relevant plans, and, if necessary, make arrangements to reduce the risk of any harm to the child; help each child to understand how to keep safe; have the skills to identify and act upon signs that a child is at risk of harm; manage relationships between children to prevent them from harming each other; understand the roles and responsibilities in relation to protecting children that are assigned to them by the registered person. (Regulation 12(1)(2)(a)(i)(ii)(iii)(iv)(v))*	
The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that— helps children aspire to fulfil their potential; and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to— understand the impact that the quality of care provided in the home is having on the progress and experiences of each child and use this understanding to inform the development of the quality of care provided in the home; demonstrate that practice in the home is informed and improved by taking into account and acting on— feedback on the experiences of children, including complaints received; use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13(1)(a)(b)(2)(f)(g)(ii)(h))	03/08/2020
The care planning standard is that children— receive effectively planned care in or through the children's home. (Regulation 14(1)(a))*	03/08/2020

The registered person must maintain records ('case records') for each child which— are kept up to date. (Regulation 36(1)(b))	03/08/2020
The registered person must notify HMCI and each other relevant person without delay if— there is any other incident relating to a child which the registered person considers to be serious. (Regulation 40(4)(e))	03/08/2020

Information about this inspection

The purpose of this visit was to monitor the action taken and the progress made by the children's home since its last Ofsted inspection.

This inspection was carried out under the Care Standards Act 2000.

Ofsted is aware of the challenges that COVID-19 (coronavirus) is currently posing to those we inspect. During this visit, the inspectors took into consideration the impact of any measures being taken to slow the spread of COVID-19 by the home. This has included the effect these have had on staffing arrangements

Children's home details

Unique reference number: 2541440

Provision sub-type: Children's home

Registered provider: Berry Gifford Ltd

Registered provider address: Berry Gifford Ltd, Branston Court, Branston Street, Birmingham, West Midlands B18 6BA

Responsible individual: Misheck Hakulandaba

Registered manager: Amber Allen

Inspectors

Gareth Leckey, social care inspector
Helen Malanaphy, social care inspector

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