Rosavilla

Keys Family assessment Centre Limited

20 Parkes Street, Brierley Hill, Dudley, West Midlands DY5 3DY

Inspected under the social care common inspection framework

Information about this residential family centre

A large national private company operates this residential family centre. It is registered to provide a service to nine families. Families usually stay at the centre for 12 weeks for their assessment.

This residential family centre was registered on 8 June 2022. The centre has a new manager who applied to register with Ofsted on 12 August 2024.

There were two families living in the centre at the time of the inspection.

Inspection dates: 12 to 14 March 2025

Overall experiences and progress of children and parents, taking into account	inadequate
How well children and parents are helped and protected	inadequate
The effectiveness of leaders and managers	inadequate

There are serious and widespread failures that mean children and parents are not protected or their welfare is not promoted or safeguarded and the care and experiences of children and parents are poor.

Date of previous inspection: 15 March 2023

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Inspection judgements

Overall experiences and progress of children and parents: inadequate

Ofsted brought this inspection forward due to specific concerns received in notifications. Furthermore, the provider had informed Ofsted that the centre would be closing. This was due to challenging occupancy levels and staffing issues. The provider had reduced the centre's occupancy levels in line with the planned closure.

The planning for families' transitions to the centre is poor. Risk assessments are undertaken on the day or after families move in. It is not always clear who has completed them, and they also lack managerial oversight. One parent's own vulnerability had not been considered prior to placement including not taking account of them living with unknown adults also undergoing parent assessments. Managers had also failed to verify unknown risks for one parent.

Medication arrangements in the centre are ineffective and unsafe. This has resulted in a number of medication errors. This includes one child receiving medication over the prescribed dosage in addition to another child having access to medication for parental mental health. When serious errors occur, staff seek medical attention for parents and their children. However, they do not consistently follow risk assessments for administering medication. The management oversight of medication in the centre is poor. The independent visitor has raised repeated shortfalls in relation to this. Action taken has so far been ineffective.

Management oversight of family's assessments is inadequate. One family's final report identifies the use of various visual and interactive tools. These are to help parents understand and take part in the assessment process. However, this is not evident in the family's assessment records. The family's final report lacks analysis of the assessment objectives and requirements. The majority of evidence in the report is self-reported by parents. There is little evidence of challenge particularly given concerns about disguised compliance. Concerns about the family's background history have not been adequately explored either. The assessment does not reflect areas of risk and vulnerability for the child.

Sessional work to support the assessment process is not consistently evidenced. The assessing social worker for one family had recorded this in their 'notebook'. They were on leave during the inspection and the notebook could not be located. The centre manager was of the view that the notebook was not in the centre. Other records for this family lacked analysis and evaluation.

Parents report to have positive relationships with some staff. However, they also report concerns and friction within the staff team. One parent is aware of feelings of disgruntlement between staff and the manager. They advised that staff blamed the manager for this. This questions staff's professional boundaries and professionalism. The parent felt that this was impacting on their experience of living at the centre

which had created feelings of uncertainty for them and doubt about their assessment.

Parents have mixed views on the centre and the assessment process. One parent described this as '50/50' and another said they would not wish to be here if they 'knew then what they know now'. They also identified that staff have a lack of cultural understanding. One parent said that comments made by staff illustrate this. Senior managers are already investigating these concerns.

The environment requires improvement and there are safety issues. For example, in the lounge area there were small objects strewn across the floor. This could be hazardous to a small child residing at the centre. Some areas are unclean and not well maintained. One bedroom ceiling still has signs of a flood occurring. An issue also remains with the centre's drains, which continues to make the room uninhabitable. This is despite maintenance repeatedly visiting to review the issue. This bedroom was not occupied during the inspection, and the centre manager continues to make efforts to resolve the issue.

One assessment illustrates better a parent's parenting capacity. The assessing social worker has formed a positive working relationship with the parent. This has enabled them to establish a clear understanding of the family's needs and risks in addition to the parents vulnerabilities. Sessional work has been completed in line with the parent's learning needs. This ensures that the parent has a full understanding of the concerns. This assessment clearly evidences the rationale for the recommendations.

How well children and parents are helped and protected: inadequate

There are significant shortfalls in relation to the help and protection of children. Managers and staff are not fulfilling their safeguarding roles and responsibilities consistently. Since the last inspection, the centre has received 44 complaints against staff in addition to 24 allegations. However, the centre's records do not reflect this. This highlights serious concerns about managerial oversight and safeguarding practice.

Complaints are not always responded to in line with the organisation's policy. They are not investigated thoroughly, and outcomes do not always make sense. With regard to some complaints, there is no evidence of follow-up work with staff. One parent complained that they were unable to gain access to the centre. They had been out with their child, and no one answered the door on their return. Another parent took a photo of a waking night worker appearing asleep stretched out on the sofa. Yet, this complaint was not upheld, and the rationale for this outcome was unclear.

Risk assessments do not detail all known risks. One parent's risk assessment did not consider their mental health needs. This included previous self-harm and attempts to end their own life. Staff do not always follow the guidance contained in risk assessments and neither do they follow the centre's safeguarding procedures. One family stayed out past their curfew. There was no record of staff contacting them or

attempting to locate them and the on-call manager was not alerted. The family returned and an unexplained mark was observed on the child. Staff followed the correct safeguarding procedures to ensure the child was safe.

Assessing social workers do not always consider emerging risks after families move in. Serious allegations about one parent were not promptly explored or verified. The family's assessing social worker did not share this information with the manager. In addition, there was no risk assessment completed. Senior managers only became aware of this after an internal audit. The family's assessment has since been completed with recommendations despite the unknown risks. This is inadequate practice and questions the centre's decision-making process. The manager was unable to locate the record of the decision-making or of any discussion with the assessing social worker.

There is poor staff reflection following safeguarding incidents. Records do not illustrate follow up actions or de-briefs. The manager does not consistently notify Ofsted of safeguarding incidents. When they do, notifications are often late or do not contain accurate detail. This compromises the external oversight of the centre.

Parents and staff do not feel listened to by the centre's manager. Staff have escalated concerns by whistleblowing to directors rather than with senior managers. This indicates a lack of trust, which several staff members raised to the inspectors. This does not promote a safe and open culture for good safeguarding practice to thrive.

Overall, the ending of assessments is appropriately risk assessed. Staff sensitively support families through this process. Life story work is completed for children. This will help them to understand their life journey as they grow older.

The effectiveness of leaders and managers: inadequate

There are widespread shortfalls in the leadership and management of the centre. Managerial oversight is poor. The centre manager has poor knowledge and understanding of residential family assessments. Senior managers were unaware of the extent of the managerial shortfalls. The centre manager was not present for the complete duration of the inspection.

The staff team is fractious. Morale is low and staff feel unsupported and do not trust senior managers. Staff have raised concerns about their own well-being. This has had an impact on their capacity to support and monitor families safely. There have been times when staffing levels have been under pressure. The manager and social work staff have covered absences. This has had a detrimental impact on the quality of parenting assessments.

Staff have not all received relevant training for their roles which includes medication and epilepsy training. Records of training are confusing and lack clarity. This hinders the manager's ability to monitor the training needs of staff in addition to overseeing

staff's skills and abilities to support families undergoing assessment. It is not clear whether all staff fully understand the individual needs and risks of each family.

Internal systems to monitor the service are poor and ineffective. However, the independent visitor had identified some of the shortfalls in addition to a detailed audit recently completed by the centre's quality manager. The provider has an action plan in place to rectify them. However, this has been ineffective so far.

In recognition of some of these shortfalls, the provider has de-registered the service. Two families who were resident at the time of the inspection have now moved out. The centre is now closed.

What does the residential family centre 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, Residential Family Centre Regulations 2002 and the national minimum standards. The registered person(s) must comply within the given timescales.

Requirement	Due date
A person shall not manage a residential family centre unless he is fit to do so. A person is not fit to manage a residential family centre unless— he has the qualifications, skills and experience necessary to manage the centre. (Regulation 7 (1) (2)(i)) In particular, the registered person should be able to demonstrate that the Centre manager has the skills and experience to oversee the running of the centre and the quality of assessments. In addition, when concerns arise about their capability they should be taken seriously and thoroughly investigated.	14 May 2025
The registered person shall make arrangements for residents to have access to such medical advice or treatment as may be necessary. The registered person shall make arrangements for the recording, handling, safe keeping, safe administration and disposal of medicines received into the residential family centre. The registered person shall ensure that— all parts of the residential family centre to which residents have access are so far as reasonably practicable free from hazards to their safety. (Regulation 11 (1) (2) (4)(a)) In particular, the registered person must ensure that there are safe and satisfactory arrangements for the administration of medication in addition to stringent measures to monitor the effectiveness of these arrangements.	14 May 2025

The registered persons should ensure that appropriate systems are in place to ensure and maintain a hazard free environment for children and their families.	
The registered person shall prepare and implement a written child protection policy which— is intended to safeguard children accommodated in the residential family centre from abuse or neglect; and sets out the procedure to be followed in the event of any allegation of abuse or neglect. The procedure under paragraph (1)(b) must in particular provide for— liaison and co-operation with any local authority which is making child protection enquiries in relation to any child accommodated in the residential family centre; the prompt referral to the local authority in whose area the residential family centre is situated, of any allegations of abuse or neglect affecting any child accommodated in the residential family centre; notification (in accordance with regulation 26) of the instigation and outcome of any child protection enquiries involving any child accommodated in the residential family centre, to the [Chief Inspector] and the child's placing authority; written records to be kept of any allegation of abuse or neglect, and of the action taken in response; consideration to be given in each case to the measures which may be necessary to protect children in the residential family centre following an allegation of abuse or neglect. (Regulation 12 (1)(a)(b) (2)(a)(b)(c)(d)(e)) In particular the registered person must ensure that the manager and staff understand their role and responsibilities when safeguarding children. This includes implementing the centre's policy on safeguarding children. The registered person must ensure that risk assessments contain information about known and potential risks to children and their families. This includes emerging risks	14 May 2025

during assessments and what strategies staff should implement to keep children safe. This must be completed in liaison with the family's placing authority and adequately escalated when placing authorities are not fulfilling their role and responsibilities in sharing information of a safeguarding nature. In addition, the registered person must ensure that, following incidents of a safeguarding nature, the manager and staff, follow their internal procedures to ensure that all actions are undertaken to keep children safe and that they are clearly evidenced. The registered person must ensure that the regulator receives timely notification of events in line with regulation 26.	
The registered person shall, before providing a family with accommodation in the residential family centre, or if that is not reasonably practicable, as soon as possible thereafter, draw up in consultation with the placing authority a written plan (in these Regulations referred to as "the placement plan") setting out, in particular— the objectives and intended outcome of the placement; an assessment of the risks, if any, which a resident at the residential family centre may pre-sent to their own health, safety and welfare or that of other residents or staff at the centre]. The registered person shall keep under review and revise the placement plan as necessary. In preparing or reviewing the placement plan the registered person shall, so far as practicable— seek and take account of the views of the members of the family; take account of any relevant assessment or other report relating to any member of the family which may be provided by the placing authority. The registered person shall supply a copy of the placement plan and any revision of it to the placing authority and to the parent within the family to which it relates. (Regulation 13 (1)(b)[(c) (2) (3)(a)(b) (4))	14 May 2025

In particular, the registered person must ensure that they thoroughly consider and assess the needs and risks for each family member, prior to them moving into the centre and during their assessment as the need arises. This includes escalating concerns with the family's placing authority in a prompt and timely manner.	
The registered person must ensure that the parents' capacity to respond to the children's needs and to safeguard their welfare is monitored or assessed by a suitably qualified person in accordance with the requirements of this regulation. All assessment or monitoring of parents' capacity to respond to the children's needs and to safe-guard their welfare must be carried out in accordance with appropriate and generally recognised methods for such assessment and, in particular, having due regard to guidance issued by the Secretary of State relating to the assessment of children in need and their parents under section 7(1) of the Local Authority Social Services Act 1970. The methods of assessment or monitoring must be capable of evaluating the parents' capacity to change. The registered person must ensure that conclusions or recommendations are made as a result of the assessment or monitoring and that— such conclusions or recommendations are objective and based on verifiable evidence; and the evidence on which they are based is capable of being presented in a manner that is clear, accessible and appropriate to the persons who will need to consider them.] (Regulation 13A [(1) (2) (3) (4)(a)(b)) In particular, the registered person must ensure that parenting assessments are evidence based, and analytical with clear and detailed recommendations, which are safe and in childrens best interests.	14 May 2025
The registered person shall ensure that all persons employed by him— receive appropriate training, supervision, and appraisal. (Regulation 17 (5)(a))	14 May 2025

In particular, the registered person must ensure that all staff, including management. receive training relevant to the needs of parents, in addition to training in relation to professional boundaries and curiosity. This requirement was made at the last inspection and is restated.	
The registered person shall establish a procedure ("the complaints procedure") for considering complaints made to the registered person by a resident or a person acting on behalf of a resident. The registered person shall ensure that any complaint made under the complaint's procedure is fully investigated. The registered person shall provide a written copy of the complaint's procedure on request to any resident and any person acting on behalf of a resident. The written copy of the complaint's procedure shall include— the name and address of the [Chief Inspector]; and the procedure (if any) that has been notified by the [Chief Inspector] to the registered person for the making of complaints to the [Chief Inspector] relating to residential family centres. The registered person shall, within 28 days after the date on which the complaint is made, or such shorter period as may be reasonable in the circumstances, inform the person who made the complaint of the action (if any) that is to be taken. The registered person must ensure that a written record is made of any complaint or representation, the action taken in response, and the outcome of the investigation. The registered person shall supply to the [Chief Inspector] at its request a statement containing a summary of the complaints made during the preceding twelve months and the action that was taken. The procedure mentioned in paragraph (1) and any written record made under paragraph (6) may be kept in electronic	14 May 2025

form, provided the information so recorded is capable of being reproduced in a legible form. (Regulation 20 (1)(2)(3)(4)(a)(b)(5)(6)(7)(8)) In particular, the registered person must ensure that complaints are responded to in line with the organisations policy. They must ensure thorough investigation, evidence-based outcomes and adequate managerial oversight, in addition to maintaining good quality records. When concerns arise from complaints in relation to staff practice such as boundaries and professionalism, then appropriate action should be taken to ensure this is rectified as soon as possible.	
Subject to paragraph (6) and any requirements for electronic monitoring imposed by a court under any enactment, the registered person must ensure that electronic or mechanical monitoring devices for the surveillance of residents are not used in a residential family centre, except for the purpose of— safeguarding their welfare, or that of other residents accommodated in the centre; or assessment or monitoring carried out under regulation 13A. The registered person must ensure that any use of such devices is subject to the following conditions: the residents are informed in advance of the intention to use the device; and its use is no more intrusive than necessary. Where the use of such devices is used for the purpose at paragraph (1) the registered person must also ensure that— the resident being assessed or monitored consents to the use of the device in question; and its use is provided for in the placement plan. The registered person must ensure that staff at the residential family centre are appropriately trained and	14 May 2025

understand the requirements imposed by this regulation before they use any such devices. Paragraphs (1)(c) and (d), and (2) of regulation 19 apply to any information or material obtained by means described in paragraph (1) as they do to any other record under that regulation. (Regulation 21A (1)(a)(b) (2)(a)(b) (3)(a)(b) (4)(5)) In particular, the registered person must ensure that any form of surveillance is thoroughly risk assessed and proportionate. This should be explained clearly to each parent on admission to the centre. Systems should be in place to ensure clear records of when any form of surveillance is used and when the rationale for such is reviewed. This requirement was made at the last inspection and is restated.	
The registered person shall establish and maintain a system for— reviewing at appropriate intervals; and improving, the quality of care provided at the residential family centre. (Regulation 23 (1)(a)(b)) The registered person must ensure that management at every level has effective and regular monitoring systems in place, to assist them in identifying and acting on shortfalls to improve the quality of the service provided. This requirement was made at the last inspection and is restated.	14 May 2025

Recommendations

- The registered person should ensure that there are adequate systems in place to monitor the maintenance of the centre. This specifically relates to ensuring that communal areas are kept clean and any damage such as flood damage and drainage, is rectified quickly. (Residential Family Centres: NMS 11.2)
- The registered person should ensure that they maintain clear and detailed records of any allegations made against a particular member of staff or parent. This must

include any follow up action and decisions reached. (Residential Family Centres: NMS 18.4)

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and parents using the 'Social care common inspection framework'. This inspection was carried out under the Care Standards Act 2000 to assess the effectiveness of the service, how it meets the core functions of the service as set out in legislation, and to consider how well it complies with the Residential Family Centre Regulations 2002 and the national minimum standards.

Residential family centre details

Unique reference number: 2662158

Registered provider: Keys Family assessment Centre Limited

Registered provider address: Maybrook House, Third Floor, Queensway, Halesowen, West Midlands B63 4AH

Responsible individual: David Carser

Registered manager: post vacant

Telephone number: 0121 728 7800

Email address: info@keys-group.co.uk

Inspectors

Sarah Berry, Social Care Inspector
Lydia Isaac, Social Care Inspector

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