

1280623

Registered provider: Wrottesley Care Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This is a privately owned children's home. The home is registered to provide care for up to three children with complex needs.

There is a suitably experienced manager in post. The manager registered with Ofsted in February 2024. She is working towards the diploma level 5 qualification.

Since the last inspection, two children have moved out of the home. At the time of the inspections, one child was living in the home, and they were present during the inspection and spoke to the inspectors in October. The child was not present during the inspection in November.

The inspection started on 1 October 2024. Inspectors returned on 13 November 2024 to gather additional evidence in line with [Ofsted inspections and visits: deferring, pausing and gathering additional evidence](#) policy.

Inspection dates: 1 and 2 October and 13 November 2024

Overall experiences and progress of children and young people, taking into account	inadequate
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How well children and young people are helped and protected	inadequate
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The effectiveness of leaders and managers	inadequate
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There are serious and/or widespread failures that mean children and young people are not protected or their welfare is not promoted or safeguarded and the care and experiences of children and young people are poor and they are not making progress.

Date of last inspection: 20 March 2024

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Recent inspection history

Inspection date	Inspection type	Inspection judgement
20/03/2024	Full	Good
13/12/2022	Full	Good
27/09/2022	Full	Inadequate
16/03/2022	Interim	Improved effectiveness

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Children's safety, experiences and progress have been compromised by poor leadership and management and failure to take effective action to improve the quality of care in the home. As a result of these findings, two compliance notices have been issued under regulation 12 and regulation 13. A notice of restriction of accommodation has also been issued so that no more children can move into the home. This will be kept under review.

Children do not receive effective planned care as managers do not have their most up-to-date plans from the local authority. Managers have not escalated requests to the local authority for the children's most up-to-date plans effectively. This disorganised approach to the care planning arrangements for children has contributed to the children's needs not being fully understood by staff and managers.

The manager ensures that staff are skilled and equipped to meet all children's needs when considering children to move into the home. However, two children's placements ended abruptly. This was due to an escalation of risk, which impacted on other children living in the home and the staff. The manager exhausted all options before making this decision, and the team displayed great resilience during this period. Since this time, the manager and team have reflected on the children's endings and have had a period to stabilise the home before exploring options for any further children to move in.

Relationships between staff and the child are warm, affectionate and loving. The child has built strong relationships with the staff who care for them. This helps the child to build trust and feel safer and relaxed in their surroundings.

Managers and staff understand the importance of education. The manager and staff are persistent with the child in motivating them to want to learn and finding ways to engage them. The manager has been proactive in advocating for the child to ensure that their education, health and care plan is accurate. As a result, she has worked in partnership with schools and the placing authority to find the child a suitable provision that reflects their learning needs, after a substantial period of time out of education. This helps the child to maintain a daily routine that supports their academic needs.

Managers and staff are committed to making sure that children get the best from the time they spend with their families. An inclusive approach supports children to maintain positive relationships with their families and people who are important to them.

How well children and young people are helped and protected: inadequate

There have been repeated failings to respond to significant safeguarding incidents when children have been at risk and have been harmed. Incidents have not been responded to effectively, recorded or reported in line with regulation. The manager and staff do not demonstrate that they have the skills and knowledge to keep children safe.

There has been one significant incident that has not been reported, recorded and responded to appropriately by staff and managers. Two children left the home during the night for several hours, without staff knowledge. It was only when the children contacted the manager to be collected from the city centre that the staff realised the children were not home. Leaders and managers failed to explore and be professionally curious as to why the children were in the city centre, and no further action was taken. Despite knowing this information, this was not recorded or reported to the relevant people, including the children's placing authorities. This prevents the children's corporate parents from taking any action needed to safeguard the children. Neither child has been given the opportunity to engage in a return home interview by someone independent as the placing authorities remain unaware of this incident. This placed both children at risk of harm.

Staff have failed to follow children's plans and risk strategies to keep children safe, which resulted in children harming one another. Furthermore, the police were called as staff were unable to manage the incident safely. Managers failed to identify and address shortfalls in practice and make improvements. No strategies have been implemented despite the children harming one another, and concerns continued around their fragile relationship. This does not ensure that children are protected from harm.

Staff have failed to prevent children from repeatedly climbing onto the roof of a local shop. On the third occasion this happened, one child was arrested and did not return to the home due to managers serving immediate notice. This child did not have the opportunity to say goodbye to the staff who cared for them after living in the home for over a year. This child's placing authority raised a complaint due to concerns about how the child received their belongings, which included the use of bin liners to store their clothes, and of their experience moving out of the home. The responsible individual has responded to this, acknowledging the practice concerns, and has taken steps to rectify this so this does not happen to another child in their care. The manager and staff have since written letters to the child, reflecting on the positive memories and wishing them luck for the future.

There are significant weaknesses in the assessment and management of risk for children living in the home. Known risks are not well documented or understood. Strategies for staff to follow to keep children safe are not always identified or reviewed. There has been a high number of new staff working in the home following these serious incidents, which means that new staff are not aware of the child's current risks or of how to keep them safe.

There have been incidents when staff have used physical intervention with children to keep them and others safe from harm. Records of restraint incidents lack the required information and management evaluation and learning. This prevents effective oversight of whether the intervention used was necessary, proportionate and effective. As a result, some poor restraint practice has continued unchallenged. Additionally, despite behaviour management plans, guidance and strategies are not fully embedded into staff practice, and as a result, children have received inconsistent care and boundaries.

Managers have completed a review of the premises to assess the suitability and location of the home. However, it does not consider how to minimise known risks to the children in the local area. As a result, staff are not provided with all the information they need to safeguard the children when they are out in the community.

The manager does not always notify Ofsted and key professionals when there are serious incidents. The lack of information-sharing reduces the regulators and professionals' understanding of safety and quality of care in the home. This weakens the overall safety oversight for children.

Staff and managers use thorough, consistent approaches when managing allegations. Liaison with professionals, such as the local designated safeguarding officer, police and social workers, is effective.

Incidents of self-harm have been managed well and have reduced from one child's starting point. Staff and managers work in partnership to support the child with their emotional health. Staff demonstrate an ability to seek specialist help when this is necessary. There are good links with mental health professionals. The multi-agency approach means that the child's needs are responded to effectively.

The effectiveness of leaders and managers: inadequate

Poor leadership and management and a failure to take effective action to improve the quality of care in the home have compromised children's safety, experiences and progress. The manager has failed to implement safeguarding procedures. As a result, they have not fulfilled their statutory safeguarding responsibilities.

Leaders and managers' monitoring is ineffective and fails to protect children from harm or improve the quality of care they receive. They do not monitor, review and evaluate significant incidents, including missing-from-home episodes. These shortfalls result in a failure to identify shortfalls in the quality of care provided to children. For example, managers have repeatedly failed to address regulatory breaches in regulation 13, the leadership and management standard, such as effective oversight and professional curiosity of incidents and inability to recognise shortfalls in staff practice. This continued failure to meet requirements means that children's care continues to be compromised.

Managers' monitoring fails to protect children from harm. Two children left the home together in the early hours without staff knowledge. Despite managers being aware of this incident, they failed to take effective action to safeguard the children. Managers did not explore how both children were able to leave the home during the night or take any effective action to report, record or reflect on how they could improve practice to minimise this occurring in the future. Following whistle-blowing concerns, an investigation took place. However, this was not completed by someone independent from the incident to ensure that the process has a fair outcome based on facts and robust evidence. Some significant actions to safeguard children from the investigation remain outstanding. For example, children's plans have not been updated to include new risks and how to direct staff to keep them safe. In addition, staff have not received any further training to support them when children go missing from the home. Failure to meet these actions does not ensure that children are protected from harm.

Partner agencies have mixed views about the service. Some professionals are pleased with the care provided to children. However, others recognise that the manager and staff have failed to safeguard children and plans for their care have been disrupted as a consequence of this.

There has been a high staff turnover since the last inspection, and only two core staff members remain in post. The new staff are happy to work in this home and feel supported. The manager is well regarded and is nurturing towards the team. This means that staff work in an environment where they feel well supported.

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, The 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 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— 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; 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; and take effective action whenever there is a serious concern about a child's welfare. (Regulation 12 (1) (2)(a)(i)(ii)((iv)(v)(vi)) Specifically, staff and managers must be clear on their responsibilities to protect children who go missing from home and take effective action for any safeguarding concern to be reported, recorded and appropriate action taken. Risk assessments and children's plans about peer-on-peer conflict and going missing from home must give clear direction to staff in how to keep children and staff safe, that children are supported to understand how to keep safe following incidents and that staff are supported to manage relationships between children living in the home effectively.	12 January 2025

*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— lead and manage the home in a way that is consistent with the approach and ethos, and delivers the outcomes, set out in the home's statement of purpose; use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13 (1)(a)(b) (2)(a)(h)) Specifically, there must be effective oversight of all incidents within the home and professional curiosity should be used to explore if practice needs to be addressed. Additionally, there must be an effective system to overview the quality of care in the home to make ongoing improvements.	12 January 2025
The care planning standard is that children— receive effectively planned care in or through the children's home; and have a positive experience of arriving at or moving on from the home. In particular, the standard in paragraph (1) requires the registered person to ensure— that children are admitted to the home only if their needs are within the range of needs of children for whom it is intended that the home is to provide care and accommodation, as set out in the home's statement of purpose. (Regulation 14 (1)(a)(b) (2)(a)) Specifically, ensure that all up-to-date local authority documents are on file for children living in the home and that this is reflected in children's plans. Ensure that children have a positive experience leaving the home.	12 January 2025

The registered person must ensure that— within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home, a record is made which includes— the name of the child; details of the child’s behaviour leading to the use of the measure; the date, time and location of the use of the measure; a description of the measure and its duration; details of any methods used or steps taken to avoid the need to use the measure; the name of the person who used the measure (“the user”), and of any other person present when the measure was used; the effectiveness and any consequences of the use of the measure; and a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure; within 48 hours of the use of the measure, the registered person, or a person who is authorised by the registered person to do so (“the authorised person”)— has spoken to the user about the measure; and has signed the record to confirm it is accurate; and within 5 days of the use of the measure, the registered person or the authorised person adds to the record confirmation that they have spoken to the child about the measure. (Regulation 35 (3)(a)(i)(ii)(iii)(iv)(v)(vi)(vii)(viii)(b)(i)(ii)(c)(iv)) Specifically, ensure that records of incidents of restraint contain all information in line with regulation 35, implement strategies in children’s plans and ensure there is effective oversight of all incidents.	12 January 2025
The registered person must notify HMCI and each other relevant person without delay if—	12 January 2025

a child is involved in or subject to, or is suspected of being involved in or subject to, sexual exploitation; an incident requiring police involvement occurs in relation to a child which the registered person considers to be serious; there is an allegation of abuse against the home or a person working there; a child protection enquiry involving a child— is instigated; or (concludes (in which case, the notification must include the outcome of the child protection enquiry)); or there is any other incident relating to a child which the registered person considers to be serious. A notification made under this regulation— must include details of— the matter; the other persons, bodies or organisations (if any) who or which have been notified; and any actions taken by the registered person as a result of the matter; must be made or confirmed in writing. (Regulation 40 (4)(a)(b)(c)(d)(i)(ii)(e) (5)(a)(i)(ii)(iii)) Specifically, ensure that Ofsted is notified of all serious events without delay.	
The registered person must review the appropriateness and suitability of the location of the premises used for the purposes of the children's home at least once in each calendar year taking into account the requirement in regulation 12(2)(c) (the protection of children standard). When conducting the review, the registered person must consult, and take into account the views of, each relevant person. (Regulation 46 (1) (2))	12 January 2025

Specifically, ensure that the review of the location is kept under review and includes all known risk within the home's location.	
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*These requirements are subject to a compliance notice.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people, 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 Children's Homes (England) Regulations 2015 and the 'Guide to the Children's Homes Regulations, including the quality standards'.

Children's home details

Unique reference number: 1280623

Provision sub-type: Children's home

Registered provider: Wrottesley Care Limited

Registered provider address: Office 28, 28 Cleveland Street, Wolverhampton
WV1 3HT

Responsible individual: Shalana Malcolm

Registered manager: Sarah Hartle

Inspectors

Marianne Grandfield, Social Care Inspector
Chrisoula Contoyianni, Social Care Inspector

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