

2673339

Registered provider: Homes2Inspire Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

The home is privately run and provides care for up to 3 children with social and emotional difficulties. At the time of the inspection, there were 2 children living at the home and one child had moved out of the home.

The 2 children living at the home contributed to this inspection.

The home is led by a registered manager.

Inspection dates: 28 and 29 January 2026

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 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: 17 June 2024

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Recent inspection history

Inspection date	Inspection type	Inspection judgement
17/06/2024	Full	Good
27/11/2023	Full	Requires improvement to be good
18/10/2022	Full	Good

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Children have been offered key-working sessions that focus on their identified risks. However, the effectiveness of this work is significantly limited due to the inconsistent relationships between staff and children. Although some children have begun forming connections with individual staff members, overall, relationships lack the depth, trust and consistency required to support meaningful risk-reduction work.

Both children have been supported to make positive progress in relation to their education. One child's attendance has improved from 0% to 36% attendance, demonstrating some measurable progress. The other child, who has been out of education for a significant time, has tried alternative education plans. The child has been supported by the education coordinator who has worked closely with her to identify her interests. This is helping to inform appropriate decisions about her educational pathway and next steps.

The home is welcoming and children say that they like their bedrooms, which are personalised and decorated to the children's individual tastes.

One child had a fear of attending health appointments. She has made some progress in this area because of the support that staff have offered.

Children are supported to celebrate special holidays and occasions, such as Christmas, Easter and birthdays. Both children received a cake to celebrate their one-year anniversary of living in the home.

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

There have been significant shortfalls identified with regards to the protection of children during this inspection.

There is a significant lack of understanding and robust response to children who are at risk of exploitation. Staff's professional curiosity is not consistently evident. As a result, key warning signs of child sexual exploitation have not been acted on. This has led to missed opportunities for staff to safeguard vulnerable children. Staff have failed in their due diligence to keep children safe.

Staff have failed to protect a child by leaving them on their own with unknown adults overnight. This occurred at a time when the child had been assessed as high risk of child exploitation. Despite the obvious and significant safeguarding concerns, staff did not take appropriate action to prevent the situation or protect the child. Furthermore, managers did not respond with the required level of urgency or professional scrutiny. This demonstrates a fundamental lack of safeguarding understanding and oversight, leaving children at continued risk of harm.

On one occasion, 2 children left the home late at night and subsequently contacted staff requesting a taxi to return. Staff informed the children that a taxi could be arranged but that the cost would be taken from the child's incentives. This response failed to consider the child's assessed high risk of exploitation at the time. This demonstrates a serious lack of safeguarding understanding and failed to prioritise the child's immediate safety. Staff did not recognise the significance of the risks inherent in the situation, resulting in a response that was neither protective nor proportionate. This reflects poor practice and a fundamental failure to safeguard children when they are most vulnerable.

There have been 2 incidents in which other children have stayed overnight in the home without staff noticing until the following morning. These breaches demonstrate a serious lack of supervision. Although amendments have been made to the protocol relating to nighttime routines, these changes were reactive and introduced only after significant safeguarding failures had already occurred.

The manager has failed to provide staff with the training, guidance and support required to respond safely and effectively to serious incidents. In April 2025, a child was found with drug paraphernalia in their bedroom relating to nitrous oxide misuse. Despite the seriousness of this incident, no training or reflective support was offered to staff to help them understand the associated risks or how to respond to similar situations in the future. In June 2025, there was a further serious incident of nitrous oxide use involving a different child, during which medical advice had to be sought. Although training was offered to staff after this second incident, there was a 2-month period between April and June where no proactive action was taken to strengthen staff's knowledge or practice. This delay demonstrates a lack of foresight and managerial oversight, leaving staff ill equipped to keep children safe.

There is weak practice in managing and responding to children who leave the home late at night, beyond their agreed curfews. Although staff attempt to discourage this, their actions are not supported by robust or sufficiently detailed recording. As a result, managers do not have effective oversight of the frequency, patterns or risks associated with these incidents. This lack of accurate documentation and managerial scrutiny limits the manager's ability to assess escalating concerns, take preventative action, or ensure that safeguarding responses are proportionate and timely. Consequently, children are not adequately protected from potential harm when they are missing or out late in the community.

There have been two incidents in which managers failed to notify Ofsted, as required under Regulation 40. These omissions reflect a serious lack of managerial oversight and an insufficient understanding of statutory reporting duties. Failing to alert Ofsted to significant events prevents external scrutiny and undermines the regulatory safeguards that are in place to protect children. This lack of compliance further demonstrates the ineffective leadership in the home.

The effectiveness of leaders and managers: inadequate

On 2 occasions, a child has been able to access confidential information on staff laptops. Although one of these incidents was investigated and that member of staff received training, managers failed to ensure that practice improved or that systems were strengthened to prevent recurrence. One child reported during the inspection that they were able to view files again. This latest concern is now being investigated by managers and leaders. However, the repeated nature of these incidents shows a failure to enforce basic data protection expectations. As a result, children's personal information has not been kept safe, and leaders have not ensured that staff understand or follow essential confidentiality procedures.

Two allegations have been made during the inspection period. One was incorrectly recorded as a complaint rather than an allegation, indicating a poor understanding of safeguarding thresholds and procedures. Although both matters were investigated and the relevant safeguarding agencies were notified, the incorrect recording demonstrates a lack of managerial oversight and insufficient knowledge of how allegations should be recognised, recorded and escalated.

The manager has failed to develop meaningful relationships with children's parents. This has limited opportunities for effective information-sharing and collaborative risk planning.

Children have not consistently been given the opportunity to engage in return home interviews, and there is no evidence that the manager escalated these gaps to the placing authority. This lack of oversight and challenge shows weak leadership and a failure to ensure that essential safeguarding processes are followed, leaving gaps in understanding children's risks and experiences.

Managers and leaders were open and transparent throughout the inspection and demonstrate an awareness of the significant shortfalls in practice. They have begun to make some changes to improve the standard of care that children receive. However, this is in the early stages and has not yet resulted in sustained or measurable progress. The willingness of managers to acknowledge weaknesses is positive, but it does not mitigate the serious failings identified across safeguarding practice.

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; 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; take effective action whenever there is a serious concern about a child's welfare; and are familiar with, and act in accordance with, the home's child protection policies; that the home's day-to-day care is arranged and delivered so as to keep each child safe and to protect each child effectively from harm. (Regulation 12 (1) (2)(a)(i)(ii)(iii)(iv)(v)(vi)(vii)(b)) This specifically relates to leaders and managers ensuring that staff have a sound understanding of exploitation risks.	13 March 2026

This includes understanding how to respond appropriately to ensure children's safety. This also relates to leaders and managers ensuring that staff have the training, skills and knowledge that are relevant to the risks related to the children they are caring for. This also relates to leaders and managers ensuring that staff are confident in steps that need to be taken when children are missing from the home.	
*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; ensure that staff work as a team where appropriate; ensure that staff have the experience, qualifications and skills to meet the needs of each child; 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. (Regulation 13 (1)(a)(b) (2)(a)(b)(c)(f)) This specifically relates to leaders and managers having a good understanding and oversight of the risks for the children and emerging risks. Leaders and managers should ensure that they are taking a proactive approach to emerging risks. This includes ensuring that staff are supported with the skills and knowledge required to respond to the relevant risks.	13 March 2026

Leaders and managers should develop meaningful relationships with family members, where appropriate, to strengthen information-sharing and ensure that relevant insights inform children's risk management. Leaders and managers should liaise with relevant agencies to ensure that children are consistently given the opportunity to participate in return-home interviews. If children are not being offered this, they should escalate this concern accordingly.	
In particular, the standard in paragraph (1) requires the registered person to ensure— meet each child's behavioural and emotional needs, as set out in the child's relevant plans; 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 (2)(i)(vi)(vii)) This relates to staff developing positive relationships with children that support them to reduce their risks.	13 March 2026
Case records must be kept— securely in the children's home during the period when the child to whom the case records relate is accommodated there. (Regulation 36 (2)(c)) In particular, ensure that confidential information is not accessible to children.	13 March 2026
The registered person must notify HMCI and each other relevant person without delay if— there is an allegation of abuse against the home or a person working there; there is any other incident relating to a child which the registered person considers to be serious.	13 March 2026

(Regulation 40 (4)(c)(e)) Leaders and managers must ensure that serious incidents, including allegations, are reported to Ofsted.	
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*indicates that these requirements are subject to compliance notices.

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: 2673339

Provision sub-type: Children's home

Registered provider: Homes2Inspire Limited

Registered provider address: Black Country House, Rounds Green Road, Oldbury B69 2DG

Responsible individual: Carla-Marie Dore

Registered manager: Steven Hall

Inspector

Becky Thompson, Social Care Inspector

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