EDITORIAL

Just a statistic?

We would all like to think that, once a child becomes looked-after, they are at least safe. Following Freedom of Information requests, however, *The Times* has reported that, in the years between 2011 and 2021, 450 children died whilst in local authority care. To put this into more visual terms, it represents a fully laden Boeing 747 or most of the soldiers of a battalion of the British Army.

Shortly after this disclosure, children's charity Article 39 obtained an order from the Freedom of Information Tribunal requiring the disclosure of a report by the Child Safeguarding Practice Review Panel analysing 89 incidents between June 2018 and June 2020, in which 20 looked-after children died and 69 children in local authority care suffered serious harm.

The theme of vulnerable children placed in unregulated accommodation was highlighted both by *The Times* and by the Child Safeguarding Practice Review Panel. The Panel identifies, as one of four key themes, a 'high level of placement breakdown evidenced in most of these children resulting in emergency unregulated placements and disruption of any mental health support'. According to *The* Times, 50 of the children who died in local authority care were living in unregulated (for which we mean illegal) accommodation.

Over ten years, the mortality rate for looked-after children is more than 16 times higher than the overall UK child mortality rates. Such a parent, as the state has become for every looked-after child, must have questions to answer about the standard of its parenting.

Reading these bloodless statistics, it also strikes you that we are not given the names or details of any of these individuals, who all died much too young. Each had hopes, dreams, talents and loves, but these are not remembered. Stripped of all this, they are robbed of their last possession; their humanity. In other circumstances, a tragic loss of young lives may be remembered annually at the Cenotaph and carved in stone, but not this 'lost battalion'. Even their existence has been suppressed until the government has been forced to admit their loss. The least this publication can do is to tell the story of just one of them.

Samuel Howes was just 17 years old when he died on 2 September 2020 after jumping in front of a train. His death will be one of those included in the data obtained by *The Times* and the circumstances of his short life and death were recorded by the Coroner in his inquest. The details below come from his 'Report to Prevent Future Deaths' and the details of the witnesses' evidence, reported by the charity Inquest.

Samuel was from Purley in South London, the youngest of four siblings. He was a talented musician and performer and a fan of Crystal Palace Football Club. When he was 13, Samuel started to struggle with OCD, anorexia and self-harm. He turned to cannabis to self-medicate for anxiety, progressing to Xanax. He was referred to Croydon Council's safeguarding team and also began to receive CAMHS mental health support. In the three years before his death, Samuel had been admitted to the Accident and Emergency Department over 40 times and had 178 contacts with the police.

Just before his 16th birthday, Samuel was made the subject of a care order to the London Borough of Croydon. A social worker told Samuel's subsequent inquest that the sight of his self-harm at their first meeting reduced her to tears. Samuel was initially placed in foster care, but after a series of placements broke down, unable to meet his complex needs, he was placed in a children's home and then into semi-independent placements. The latter (not surprisingly) also struggled to deal with the level of his needs as his mental health deteriorated and his drug-taking escalated.

Mental health professionals had previously advised that a placement in secure accommodation may act as a 'circuit breaker', but the local authority told Samuel's family that he was not being considered for this. Five weeks before his death, Samuel told social workers that his mental health was '0/10' and that he wanted to jump in front of a train. Although Samuel's social worker thought that he needed to go into secure accommodation, the Director of Children's Care decided not to put any immediate safety plans in place.

On 30 August 2020, Samuel was arrested by British Transport Police and held in police custody. He was under the influence of alcohol and was described as banging his head repeatedly and self-harming so badly that his clothes were confiscated. He was left naked on the cell floor. At the inquest, in March 2023, the police officer described Samuel's behaviour as 'attention seeking' and 'fairly normal'. A custody nurse and a psychiatric liaison nurse should have seen Samuel. He was not seen by either. The psychiatric liaison nurse was told by custody staff that Samuel was 'well known and violent' and did not need to be seen.

Samuel went missing on the evening of 1 September 2020 and died the following day by jumping in front of a train. The jury at the inquest criticised the inadequate responses by many agencies including mental health and social care. It was found that there were inadequate provisions for Samuel's complex needs and the possibility of a rehabilitative placement (or any other alternative treatments) was not pursued.

Samuel was one of our children. His blood is on all our hands.

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January 2024

Volume 34 Issue 1