Liam McManus was verified dead on the morning of the 29th November 2007 at Lancaster Farms, Far Moor Lane, Lancaster.

Liam McManus died from hanging which caused his death.

Lancaster Farms was chosen as the most suitable placement on the understanding that a range of protective factors would be in place during his sentence.

External circumstances, such as illness, sickness, absence and confusion, meant that during his 22 days in custody, no-one from outside the prison visited him. Over 3 weeks, he wrote 7 letters to family and friends and repeatedly asked when his Youth Offending Team Worker would visit.

A range of witnesses gave evidence to suggest that maintaining links with the outside world was the key to young people settling well, ~~[illegible]~~ stabilising and coping well with custody.

None of these links or positive factors were maintained and this contributed to the actions of Liam McManus that led to his death.

A DTO planning meeting should have taken place within 10 working days. This did not happen.

Had the meeting been arranged, those who knew Liam well, his family, his YOT worker, his CAMHS worker, his prison Case-worker, his family-Links worker etc., would have had an opportunity to share their knowledge of him.

This holistic view would have helped prison staff to support Liam appropriately during his custody. None of the agencies involved took the lead in organising the DTO meeting and each agency was unsure whether it was their responsibility to lead on this.

The DTO Planning meeting not taking place was only one of a number of departmental and procedural inadequacies identified that contributed to the actions of Liam McManus that led to his death.

~~St. Peters Centre Young People's Service~~

Liam Minors was transferred to Windermere 2 on the 28th November during a lock down training day. Liam's care was not compromised due to the transfer, but evidence did show that this was not best practice.

An evening of reduced staffing levels led to a level of association on Windermere 2. As Liam liked to keep himself to himself by eating in his cell and watching television, the impact on Liam would have been minimal. However, the containment, for a sustained period did affect the actions of others, resulting in a level of prolonged shouting.

The content of the shouting ranged from a general "shout out", asking where new prisoners were from, to vicious and nasty abuse including invitations to "String up".

Whilst some of the shouting, for example, "Shout out" was obviously directed at cell 44, extreme phrases such as "String up" and "bang you out" were common parlance on juvenile wings.

On the balance of probabilities, it is likely that these words were directed at the new boy in cell 44 and were not intended as a personal attack on Liam.

Words and phrases such as these are intimidating and more likely to have affected Liam's frame of mind and will have contributed to the actions of Liam

Before Liam went into custody at Lancaster Farms, St Helens Children and Young People's Service assessed Liam as a high risk case but still reintroduced him to his birth MOTHER who, evidence showed, lived a problematic and chaotic lifestyle. When Liam's social worker was about to leave the service, lack of human resources meant there was no replacement and Liam's case was closed without consideration for the potential consequences.

Child Adolescent Mental Health Service (CAMHS) supported the decision to reintroduce Liam to his birth mother and were identified as a key protective factor when Liam was in custody. Whilst it was clear that CAMHS had supported Liam previously through difficult issues and times, in this instance, there was no contact with Liam and no provision to cover sickness absence.

The Youth offending service are expected to act as the lead agency whilst offenders are in custody and beyond.

The Youth Offending Team had identified themselves as one of the protective factors that needed to be in place if Lancaster Farms was a suitable placement. In every 'phone call Liam made, he asked when his Youth Offending Team worker would visit. However, an increased and complex workload and an inspection of the service, compromised the team's ability to

Communicate and function effectively.

Poor Communication with the prison, managers not noticing that the 10 day deadline for the DTO planning meeting would not be met; and no cover for a period of planned absence during and beyond Liam's sentence were defects in the YOT system.

The Youth Justice Board's (YJB's) target setting and policy processes adopted a 'top down' approach. This led to targets driving behaviour rather than a caring culture with time built in to address an individual's needs. For example, the ONE hour target in prisoner reception led to important paperwork being completed and signed in advance.

Some of the processes and procedures within the prison were inappropriate for the reception, induction and day to day management of a vulnerable 15 year old boy.

Liam's late arrival, hurried reception and admission onto a wing to meet an 8.30pm lock down deadline, resulted in his risk level and previous history not being accurately digested and understood. Officers took Liam's word and relied on his responses without referring to important and critical documentation such as: the Asset, vulnerability Alerts, Pre Sentence Report, Post Court Report etc.

These documents were kept in the Case-work office which was completely separate from the wing.

An ineffective interpretation of the Personal Officer Policy, officers with incomplete and inconsistent JASP training, an 'induction' process with sessions where trainers ~~did not~~ failed to attend; and where modules were inappropriate for the length of Liam's sentence and his age - all contributed to an accurate picture of Liam and the full extent of his needs never being established.

Each of the organisations and agencies involved had individual interpretations of the definition of vulnerability and risk, and no common scale of recording or understanding.

Whilst some of the defects and factors identified may appear to have had a minimal impact, collectively, they contributed to systemic failings in the care and support of Liam that contributed to the actions of Liam Manns that led to his death.

Despite the constraints of a plethora of policies, procedures and guidelines, a number of individuals went above and beyond what was required of them whilst supporting Liam both in the community and within the prison system.