INQUEST
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PRESS RELEASE
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SYSTEMIC FAILINGS IN THE CARE AND SUPPORT OF VULNERABLE BOY CONTRIBUTED TO DEATH IN PRISON

A jury at an inquest into the death of 15 year old Liam McManus today returned a damning verdict finding that *"systemic failings"* in both the prison and the community contributed to his death. These failings meant that an accurate picture of Liam was never established by the prison resulting in him never receiving the right level of support.

Liam was a troubled child who had suffered significant loss and trauma in his short life. He had been taken into care as a young child and had lived with his aunt and uncle since he was seven. He had a history of self-harm and his vulnerability was well known to both Social Services and the Young Offenders Service. Liam had also been involved with a mental health worker for over two years.

Liam had been recalled to custody for breaching the terms of his licence. He had only 23 days left to serve before release when he was found hanging from a bed sheet tied to the window of his single cell on 29 November 2007. Liam was the thirtieth child to die in state custody since 1990. This is the second inquest in less than two years into the death of a child in HMYOI Lancaster Farms.

Throughout the seven week inquest the jury heard evidence of failings by many agencies involved in Liam's care. The jury recognised that the following factors contributed to his death:

- A failure by the Young Offenders Service to ensure that 'protective factors' of visits from Liam's YOS worker, mental health worker and family would be in place during his sentence and subsequent failure by all to register when they did not take place.
- A target driven and top-down approach by the Youth Justice Board rather than a caring culture that addressed the individual needs of vulnerable children.
- A decision by Social Services to introduce Liam to his birth mother who lived a chaotic lifestyle, yet close his file shortly afterwards due to there being insufficient staff in the team.
- A failure by prison staff to recognise Liam's risk level and needs. The jury noted that this included a practice by the officers of accepting Liam's response to questions and not referring to important documentation which provided critical information about him.
- A practice by the prison of keeping these documents in a room which was completely separate to the wings, resulting in wing officers not having immediate access to the information.
- An inadequate induction process.

- An ineffective interpretation of the Personal Officer policy which should have meant that Liam was given the continuing support of one officer.
- Incomplete and inconsistent training of officers.
- A failure by all agencies to have the same assessment criteria for vulnerability and therefore communicate effectively.
- A failure to hold a DTO planning meeting despite guidance that this should take place within ten days. This would have given those working with Liam an opportunity to share their knowledge of him and assist prison staff in supporting him appropriately.
- Transferring Liam to a new wing on a night when there was reduced staff levels, meaning that other prisoners had no association during the day and were restless. This lead to heightened shouting and bullying through the windows on the night of his death, including calls for him to 'string up' which the jury recognised would have been frightening and intimidating.

The jury found:

> *…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 McManus that contributed to his death.*

In addition to the findings of the jury the coroner reported that there were serious inadequacies in the performance of Social Services who had lost significant documents and had closed Liam's file just before he was due to go into custody without apparent review on the assumption that Liam would be safeguarded by the prison. He also recommended that the YOS ensured that important information about young people was sent to Young Offender Institutions in a format that was readily accessible to the officers. The coroner indicated that he would be writing to the Youth Justice Board to ensure that his recommendations would be implemented.

Liam's aunt and uncle commented:

> *It seems to us that Liam's serious vulnerability was never picked up by anyone in HMYOI Lancaster Farm and we are happy that the jury have recognised this. We hope in future that prison officers will take that bit of time to read all the information that comes into prison so that vulnerable children are given the care and consideration that they need.*
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> *We also hope that those dealing with vulnerable children take on board the evidence heard at this inquest, the jury findings and recommendations of the coroner so that deaths like Liam's can be avoided in the future The most important thing now is that no other family should have to go through what we have been through in the last two years.*

Deborah Coles, Co-Director of INQUEST, said:

> *Liam McManus was an extremely vulnerable child placed in an environment that did not have the necessary safeguards in place to keep him safe, despite his known vulnerability, by all the professionals involved with him. Yet again an inquest jury have found systemic failings resulting in a child's death and yet despite the deaths of thirty children since 1990 lessons are not learned. The ongoing systemic failings exposed by these child deaths in custody should be looked at as part of a public inquiry into the treatment of children in conflict with the law.*

Mark Scott of Bhatt Murphy, solicitors for Liam's aunt and uncle, made the following statement:

> *This case raises fundamental questions about how the state treats vulnerable children who offend. It is time for there to be a public inquiry to ensure that lessons are learned.*

Liam McManus' aunt and uncle were represented at the inquest by INQUEST Lawyers Group members Mark Scott of Bhatt Murphy Solicitors and Colin Hutchinson of Garden Court Chambers.

Notes to editors:

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. Its casework priorities are deaths in prison and in police custody, in immigration detention and in secure training centres. INQUEST develops policy proposals and undertakes research to campaign for changes to the inquest and investigation process, reduce the number of custodial deaths, and improve the treatment and care of those within the institutions where the deaths occur.

Further Information	www.inquest.org.uk
Full text of the narrative verdict	www.inquest.org.uk/pdf/narratives/Liam_McManus_verdict.pdf
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