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The Management of ligatures in Mental Health and Learning Disability Services

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Type of document	Standard Operating Procedure
Target audience	All clinical staff working in mental health, learning disability, CAMHS, and drug and alcohol services.
Document purpose	*The aim of this document is to assist and guide CWP staff in the responsibilities, management and reporting of all ligature incidents. Also discussed is the recommended equipment and correct disposal of the ligature cutters*

Approving meeting	Clinical Practice Standards Sub Committee	Date 31-Oct-19
Implementation date	19-Nov-19	

CWP documents to be read in conjunction with	
GR15	Environmental Clinical Risk Assessment Policy
CP5	Clinical risk assessment monitoring policy
CP24	Cardiopulmonary Resuscitation (CPR) and Medical Emergency Policy
CP6	The management of challenging behaviour, violence and aggression
CP17	Guidelines for best practice following the unexpected death of a service user
GR1	Incident reporting and management policy
SOP3	Physical observations assessment and the management of altered levels of consciousness (including NEWS 2, PEWS, Pregnancy EWS, AVPU, GCS)
HR19	Policy for supporting staff involved in traumatic events at work including incidents, complaints, claims and inquests

Document change history	
What is different?	Policy recoded in line with policy library reshape – CP76 to SOP13
Appendices / electronic forms	N/A
What is the impact of change?	*This document will guide CWP staff to correctly manage ligature incidents including incident reporting.*

Training requirements	Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	*Dr Elizabeth Shaw, Dr Lisa Beddoes*
Corporate services	*Clinical Education Team, Dr Anushta Sivananthan*
External agencies	n/a

Financial resource implications	None

External references
1. Healthcare Quality Improvement Partnership (2017) National Confidential Inquiry into Suicide and Homicide: Annual Report 2017, London 2. https://content.hee.nhs.uk/bitesized-teaching/assets/pdf/Ligatures_Wound.pdf 3. https://www.ncbi.nlm.nih.gov/books/NBK459192/ 4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3132378/#ref2 5. https://www.quora.com/How-do-forensic-doctors-distinguish-between-hanging-and-strangulation-injuries 6. Strangulation Injuries | 2010-08-02 | AHC Media: Continuing Medical Education Publishing (reliasmedia.com)

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
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- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
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Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart 1 – Nursing and Medical Management of Ligatures

Triggers

- Patient may have a history of self - harming behaviours

- Patient may have displayed a deterioration in their mental health state

- The patient may have spent time away from communal areas of the ward, or locked in a bathroom or toilet

- Patient may have self-harmed recently whilst on the ward

Warning Signs

- Patient's deteriorating mental health state

- Significant social stressors affecting the patient

- Personal circumstances having an impact on the patient

- Patient commencing or changing medication

- The patient finds it difficult to safely manage trauma or emotional distress, whether recent or over a long period

- All ligatures should be responded to as an emergency. staff need to quickly assess the situation and the risk of physical harm/injury to the Patient and alert colleagues for assistance.
- Initial visual observations of the patient should be completed, looking at skin colour – Consider whether the ligature is tight enough to cause hypoxia / cyanosis / tissue damage to the external / internal airway, if so, the ligature must be removed immediately.
- If the ligature is causing no obvious airway obstruction / tissue damage then least restrictive practices and verbal de-escalation techniques can be used, until the ligature is removed.
- If there is no immediate danger, staff may be able to support the patient to remove the item themselves, whilst continually monitoring for changes in risk of harm.
- For looser ligatures, again physical observations need to be completed including respiration rate and AVPU, and staff must follow any clinical responses from PEWS including accessing GCS
- Post ligature removal observations should be recorded on NEWS 2/ PEWS charts, especially in the cases of ligatures that have caused airway obstruction, or actual or potential tissue damage. Staff actions must then be led by the news 2 / PEWS score, and clinical responses including medical referral / assessment.

Ward Based Management

If a patient is found with a ligature:

- Press alarm/call for help

- Assess the scene for any danger

- Ensure the patient has a clear airway

- Remove the ligature with ligature cutters (use the blade away from yourself)

- Take physical observations, be mindful of higher rates of blood pressure and pulse after the incident

If patient hasn't lost consciousness, then:

- observe physical observations (NEWS 2 Protocol)

If patient has lost consciousness, then:

- Utilise the Emergency equipment trolley - commence CPR and utilise the CWP emergency procedure (NEWS 2 protocol)

- **Call the ward doctor for assessment - (Bleep on call out of hours).**

Medical Airway Management

- Carry out physical examination if patient is conscious, Examine for:
  - Visual disturbances
  - Conjunctival or facial petechial haemorrhages
  - Swollen tongue or oropharynx
  - Foreign body (blood, vomit etc.) in the oropharynx
  - Facial oedema, lacerations, abrasions, or ligature marks
  - Tenderness over the larynx
  - Hoarseness or stridor on respiration
  - Subcutaneous oedema or crepitus
  - Cyanosis or hypoxia
  - Arrhythmias
  - Altered mental state
  - Seizures
  - Stroke like symptoms
  - Urinary or faecal incontinence

If patient is unconscious assist with CPR and ensure Paramedics have been Called.

Please see Flowchart 2 - Medical Management - the differences between suspended Ligatures and Strangulation by Ligature.

Quick reference flowchart 2 – Medical Management - the differences between suspended Ligatures and Strangulation by Ligature.

Trait / Observations	Hanging	Strangulation by Ligature	Medical Management
Ligature Mark	Is Oblique / does not completely encircle the neck – Usually seen high up the neck between the chin and the Larynx	Completely encircles the neck below the thyroid cartilage: the base is usually soft and reddened	**Hanging –** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS - (SOP3), If not consider 999 **Ligature -** as above
Abrasions and Ecchymosis – Bruising / bleeding under the skin	Around the edges of the Ligature mark - not common	Around the edges of the ligature mark – more common	**Hanging –** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS - (SOP3), If not consider 999 **Ligature –** as above
Bruising	Of the neck muscles- less common	Of the neck muscles more common	**Hanging –** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS - (SOP3), If not consider 999 **Ligature –** as above
Neck	Stretched and elongated	Not stretched or elongated	**Hanging** – Cut patient down and remove the ligature using a Ligature cutter - assess for signs of life (DRSABCDE) – Commence CPR if required Contact 999 (Police (if death is confirmed) and paramedics) **Ligature** – as above **OR** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits NEWS 2 / PEWS – (SOP3), If not consider 999
Subcutaneous Tissue	White / hard under he mark	Ecchymosed under the mark	**Hanging** – assess for signs of life (DRSABCDE) – Commence CPR Contact 999 (Police (if death is confirmed) and paramedics) **Ligature** – regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS – (SOP3), If not consider 999

Hyoid Bone	Fracture may occur	Fracture is uncommon	**Hanging –** Cut patient down and remove the ligature using a Ligature cutter - assess for signs of life (DRSABCDE) – Commence CPR if required Contact 999 (Police (if death is confirmed) and paramedics) **Ligature -** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS – (SOP3), If not consider 999
Thyroid Cartlidge	Fracture is less common	Fracture is more common	**Hanging** - Cut patient down and remove the ligature using a Ligature cutter - assess for signs of life (DRSABCDE) – Commence CPR if required Contact 999 (Police (if death is confirmed) and paramedics) **Ligature** – complete a full C-spine / airway assessment, **if a fracture is suspected** immobilise the C-spine and call 999, **if no fracture suspected** regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS – (SOP3), If not consider 999
Larynx and Trachea	Facture Rare	Fracture / foreign body / fluid vomit may be found in the oropharynx / Tenderness over the larynx	**Hanging** – as Above **Ligature** – Airway Examination / utilise mechanical suction if required / if a fracture is suspected immobilise the C-spine and call 999, if no fracture suspected regular Clinical / nursing observations / Assessment - is the airway patent, are Respirations / O2 saturations within Normal limits, NEWS 2 / PEWS –(SOP3), If not consider 999
Carotid Arteries	Damage may be observed	Damage very Rare	**Hanging** - As Above **Ligature** – complete a full Neck / airway assessment **if Damage is suspected** - call 999, if no damage is suspected regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999

Face	Usually pale and Petechiae are not common	Congested, Livid and marked with petechiae / conjunctival Haemorrhage / Oedema, signs of Hypoxia / cyanosis will be observed / Subcutaneous oedema / crepitus may be observed	**Hanging – as above** **Ligature** - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations (SOP3), within Normal limits If not consider 999
Visual Disturbances	N/A	Present due to prolonged Hypoxia / cyanosis	**Ligature** - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999
Signs of asphyxia	External signs less marked	External signs / signs of Hypoxia / cyanosis well marked / Hoarseness / Stridor on respiration	**Hanging –** as above **Ligature** – assess for signs of airway damage / stridor breathing - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999
Tongue / Oropharynx	Swelling and protrusion less marked	Swelling and protrusion is more marked	**Hanging** – as above **Ligature** - assess for signs of airway damage / stridor breathing - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999
Saliva	Often runs out of the mouth	absent	**Hanging** – as above **Ligature** - assess for signs of airway damage - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999
Bleeding	Not common from the nose, mouth and ears	Common from the nose, mouth and ears	**Hanging –** as above **Ligature** - assess for signs of bleeding and attempt to control any bleeding- regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits (SOP3), If not consider 999
Involuntary Discharge	Of faeces and urine – less common	Of faeces and urine – more common	**Hanging –** as above **Ligature** - regular Clinical / nursing observations / Assessment - is the airway patent, all NEWS 2 / PEWS observations within Normal limits ((SOP3), If not consider 999

Quick reference flowchart 3 – Ligature incident

Summon help, if emergency help is required Ring (9)999 and/or 2222 depending on your in-patient or community setting.
Shout for Emergency Trolley (inpatient only) or disposable ligature cutter to be brought to incident.
If you are near to Emergency Trolley or ligature cutter retrieve it yourself.

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Obtain ligature cutter equipment. Assess for dangers prior to entering, if safe, enter area.

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Using disposable cutters	**Using wire cutters and/or 'Tuff Cut' scissors**
Cut ligature quickly away from the trachea or at weakest point by knotted part. To cut ligature use serrated edge of cutter in sawing motion whilst applying significant downward pressure. (Ensure staff fingers are not in contact with bladed edge at any time).	Cut ligature away from the trachea or at weakest point by knotted part. Place ligature between wire cutters or scissors and close applying significant pressure.

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If necessary and available use a combination of cutting devices.
If disposable ligature cutter is deemed to be ineffective use spare device and/or cutters.

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Check for signs of life (ABC) as per CP24 Cardiopulmonary Resuscitation (CPR) and Medical Emergency Policy.

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CPR is commenced		**CPR is not commenced**
Continue CPR until Paramedics inform otherwise.		An assessment must be made by a doctor for laryngeal injury as soon as possible i.e. A&E, duty doctor.

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Post incident key points;

- Medical assessment of patient's airway
- Retain all ligature parts (try and preserve any ligature knot)
- Preserve the room/space, do not remove any items
- Lock or secure area until further instructions from senior managers
- Replace disposable ligature cutter if necessary and order a new one

1. Introduction

Guidance on supporting patients who tie ligatures

Patients may attempt to harm themselves in many ways which could include tying things around their necks, which may be described as a ligature. These terms are used interchangeably throughout this guidance. The severity of these incidents can vary significantly and patients may tie things around their necks for many different purposes and functions, including suicidal intent, to self-harm, as a communication of distress, as a coping strategy, and in response to negative beliefs and feelings. Trying to understand and formulate these behaviours and the functions and intent behind them is important as part of planning a patients care and treatment.

To support staff in working with patients who tie things around their necks the following guidelines have been developed:

- All patients will have an individualised safety/care plan to address risk behaviours, developed and shared with the patient. The team needs to consider what approach works well for the patient and then apply it consistently, ensuring that all staff are familiar with this individualised approach. Care plans need to be reviewed and updated regularly, whenever there is a change in the nature and degree of risky behaviours.
- All ligatures should be responded to as an emergency. On discovering that a patient has tied something around their neck, staff need to quickly assess the situation and the risk of physical harm / injury to the patient. Staff must alert colleagues for assistance. In some situations this assessment may indicate that it is not always necessary to pull an alarm to alert staff, but only if they consider that the situation can be safely managed by the staff member / colleagues who are immediately available in the vicinity of the incident.

- Initial visual observations of the patient should be completed, looking at skin colour – Signs of hypoxia / cyanosis. Consider whether the ligature is tight enough to cause hypoxia / cyanosis / tissue damage to the external / internal airway, if so, the ligature must be removed immediately and approved physical interventions used to do this if required, following CWP policy.

- If the ligature is causing no obvious airway obstruction / tissue damage then least restrictive practices and verbal de-escalation techniques can be used, until the ligature is removed. Visual observation of the patient must be maintained continuously until the ligature is removed, and immediately post ligature removal. A SPO2 O2 Sats probe could also be applied to monitor the Oxygen saturations prior to and post ligature removal in all cases if the patient allows.

- If there is no immediate danger, staff may be able to support the patient to remove the item themselves, whilst continually monitoring for changes in risk of harm. If staff are in any doubt however, or if there are any immediate risks for the safety of the patient or staff, help must be sought immediately, including by sounding alarms if necessary.

- Staff must remain with patient throughout any incident of them tying something around their neck, until this has been safely removed and the patient is risk assessed as safe and able to maintain their safety.
- Post ligature removal observations should be recorded on NEWS 2 / PEWS charts, especially in the cases of ligatures that have caused airway obstruction, or actual or potential tissue damage. Staff actions must then be led by the NEWS 2 / PEWS score, and clinical responses.
- For looser ligatures, again physical observations need to be completed including respiration rate and ACVPU, and staff must follow any clinical responses from NEWS 2 / PEWS including accessing GCS

- Where a patient refuses to have a full set of physical observations recorded, as a minimum respiratory rate and ACVPU must be recorded, and their refusal for other observations must be

documented. Further attempts should later be made to record their physical observations if the patient will allow this.

- Following any incidents of tying ligatures / items around the neck, staff will hold a debrief with the patient. This will be offered as soon as appropriate after the incident. Staff need to consider the level of therapeutic observations (see below) for the patient, as it may be necessary to support with observations until de-brief of incident takes place and risk assessment indicates that these can be safely reduced. In offering a debrief, staff can support the patient to try to understand the function and meaning of the incident. This could include:
    - Exploring the events, situations and experiences which led up to the incident occurring (including triggers)
    - The patient's intentions and beliefs about their behaviours
    - How they could use alternative coping behaviours and skills to reduce their distress and prevent themselves from acting on these urges. For example, help the patient to explore what they were able to do, or could try to do before tying the ligature, what could they do differently next time they are struggling, and what could staff do to support them to prevent a similar incident occurring again?
    - Planning with the patient how they will cope following this incident, and strategies and support needed (including support from staff) to help them to maintain their safety on the ward and reduce their distress.
- In addition to debriefs with patient, staff need to complete debriefs with colleagues to support each other and consider whether there is any learning from these incidents which needs to be incorporated into care planning.
- Following any incident of tying ligatures, staff will need to consider how to therapeutically use observations to support a patient. It is important to consider overall assessment of risk and risk formulation. For example, where patients have a history of engaging in multiple episodes of ligature tying in quick succession, staff should consider use of short-term level 3 supportive observations following the first ligature to try to prevent subsequent incidents. It is important to document the rationale for the level of observations implemented following an incident.
- Medical review will be needed, which may include using emergency services if there are any immediate concerns regarding the physical health of the patient.
- Care plans need to be reviewed, including in case-planning to facilitate MDT review and input into the treatment plan, informed by risk incidents over the preceding week Discussions will include consideration of interventions to try to prevent/reduce the behaviours and these will be incorporated into care plans.

2. Definitions

Strangulation is defined as asphyxia by closure of the blood vessels and / or air passages of the neck because of external pressure on the neck. It is subdivided into three main categories: hanging, ligature strangulation and manual strangulation. The distinction between these three entities is attributed to the cause of the external pressure on the neck:

- Hanging - either a constricting band tightened by the gravitational weight of the body or part of the body
- Ligature strangulation - a constricting band tightened by a force other than the body weight
- Manual strangulation - an external pressure by hands, forearms, or other limbs.

3. Responsibilities

It is the responsibility of all clinical staff to ensure that they have read the related policy (GR15: Environmental Clinical Risk Assessment Policy).The appropriate Service Lead (Clinical Ward Manager) is responsible for ensuring that; a) all staff have attended the mandated training programme and had an opportunity to practice using the ligature equipment b) all staff are aware of the availability and location of the emergency equipment trolly and ligature cutters. Further advice and/or inhouse training will be provided on request by Clinical Education Team.

4. Specific Procedure

All ligature cutters are solely intended for use in emergency situations involving ligature incidents. Ligature cutters are specially designed to offer an effective and safe method of cutting a ligature attached to a person.

5. Ligature Equipment

Whilst risk can never be eliminated, the role of the organisation is to ensure risks are assessed and managed to safeguard people's health and well-being (see CP5 Clinical Risk policy). The Trust acknowledges that incidents involving the tying of ligatures may occur despite preventative strategies being in place. Therefore, all inpatient wards will have ligature cutter equipment in each clinical areas where resuscitation equipment is provided and there must be two disposable bladed ligature cutters available on the in-patient setting (See Appendix 1.1) at any given time. For inpatient areas one disposable bladed ligature cutter will be stored with wire cutters (see Appendix 1.2) in the airway drawer of the emergency trolley or top / airway section of the grab bag.

Additional ligature cutters such as 'Tuff Cut' scissors (see Appendix 1.3) must be easily accessible to staff but inaccessible to patients. 'Tuff Cut' scissors must never be removed from the resuscitation trolley / bag, except for use, and must be assessed for damage that inevitably occurs as a result of usage and replaced if necessary. 'Tuff Cut' scissors can be used as a backup and should be stored in the Automated External Defibrillator carry case.

6. Checks

Daily ward / department checks must include ensuring that all ligature cutter equipment is kept in the designated storage area and each item is in good working condition and replaced if necessary.
Checks must include ensuring that additional backup disposable ligature cutters are available for each set that is in the clinical area.

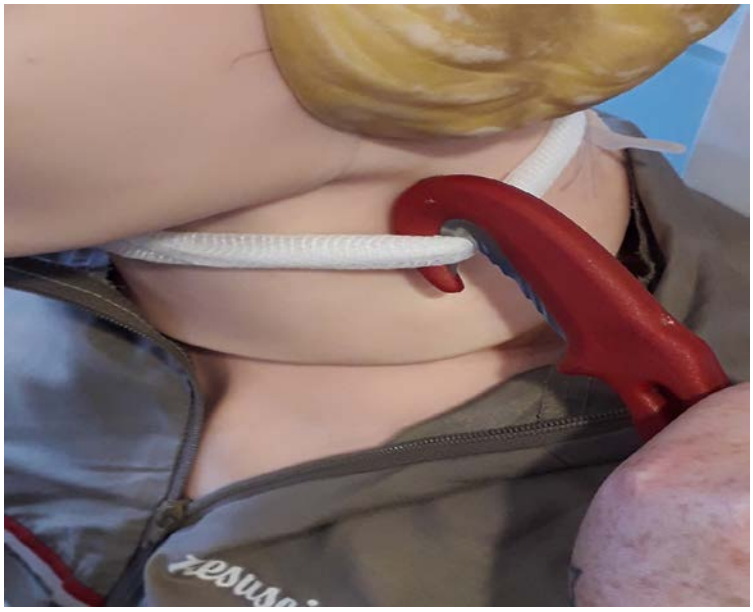
Ligature cutters must not be moved from designated locations without ensuring all staff in the department are aware.

7. The Use of Ligature Cutters in Practice

Staff should ensure their safety before attending a ligatured person. The individual may have weapons about their person (e.g. sharps which have been used as part of a self harm attempt.) Staff should also be aware of the location of the ligatured person, as well as other people who could present a risk. Staff should ascertain whether the ligature itself may present a risk e.g. pressurised lines and live electrical cables may be used to hinder rescue.

A disposable ligature cutter is most effective when used to cut softer and thinner materials e.g. Shoe laces, string, clothing, linen, headphone cables and similar. The ligature cutter will cut tougher materials e.g. leather, towelling, some steel cables, electrical flexes, but more effort may be required and the cutting process may take longer. Staff should avoid cutting through any knots, as in addition to damaging potential evidence, it also makes a removal attempt more difficult owing to multiple layers at the point of the knot.

To optimise the use of the ligature cutter, the rounded and blunt end should be initially placed flat against the person's body so that it can be positioned under the ligature. Where possible, it is recommended to attempt to cut the ligature to the side of the neck away from the trachea (picture 1 below). The natural soft tissues and hollows may ease the insertion of the cutter blade. This will also reduce any pulling onto the airway upon cutting (as may occur if the cutter is inserted at the back) and reduce likelihood of causing further trauma to the airway, as may occur if inserting from the front.



Picture 1 - Cut the ligature to the side of the neck

Once the ligature cutter has been located between the person's body and the ligature, the ligature cutter should be turned so that the sharp edge of blade faces the ligature i.e. with the opening away from the person. At this point staff should pull away from the person's body, using a rocking or sawing motion, so that the ligature cutter cuts through the ligature material.

In situations where the person resists actions to remove the ligature, it may be appropriate for staff to restrict the person's ability to struggle to facilitate the safe removal of the ligature, especially where the struggling behaviour increases the risk(s) presented by the ligature or by the use of the ligature cutter by staff. In such situations, staff should employ appropriate holding skills, sensitive to the needs of the person, in accordance with current practice guidelines and training (see CP6 The management of challenging behaviour, violence and aggression policy) to facilitate the safe removal of the ligature.
All complete or incomplete suspension incidents must be considered high risk with regard to manual handling, because of the loads involved and possible requirement to adopt awkward postures. Staff should carry out a dynamic risk assessment and apply safe handling principles to the best of their ability in the situations that they find themselves. Staff must not place themselves at unnecessary risk and must not attempt any technique or manoeuvre they feel would be hazardous for them. Where the perceived risks involved with supporting the weight are considered too great, it may be appropriate to cut the ligature and allow the person to fall unhindered to the ground.

7.1. Complete Suspended Strangulation (hanging)

The priorities are to release the pressure the ligature is causing on the neck and to remove the ligature. Where possible, and safe to do so, the patient should be elevated by taking a secure hold around the thighs or hips to reduce the tension on the ligature (picture 2). This can be particularly useful to reduce airway compromise if staff are not able to cut the ligature immediately and will enable the patient to be supported when the ligature is cut. It may be safest to approach from the front so that the patient will fold towards the shoulder (i.e. towards to handler, and not away from them) after the ligature is cut.

Picture 2 - Where possible, and safe to do so, the patient should be elevated by taking a secure hold around the thighs or hips to reduce the tension on the ligature, and will enable the patient to be supported when the ligature is cut

All strangulation attempts should be treated as a suspected spinal injury. Staff should support the neck, as far as is possible. No specific techniques exist to allow for support of the c-spine as the individual is lowered to the ground following hanging, so staff should try to support the head to the best of their ability in the circumstances.

As soon as the body weight is supported, or handlers are clear if the dynamic risk assessment indicates allowing an unhindered drop, the ligature should be cut at a central point between the patient's neck and the suspension point so that there is minimal interference with any potential evidence. If supported, the person should then be lowered to the floor.

If the ligature remains in place around the person's neck (or other body part) it should be removed using a ligature cutter.

7.2. Incomplete Suspended Strangulation (semi seated or kneeling)

The priorities are to release the pressure the ligature is causing on the neck and to remove the ligature. Where possible, the ligatured person's upper body (and head) should be supported and elevated by taking a secure hold around the upper torso (and head) to reduce the tension on the ligature (picture 3). This is useful to reduce airway compromise if is not possible to cut the ligature immediately, and will enable the patient to be supported when the ligature is cut.

Picture 3 - Where possible, the ligatured person's upper body (and head) should be supported and elevated by taking a secure hold around the upper torso when the ligature is cut.

DO NOT pull on the ligature to remove or unhook it (e.g. – from over a tap or door handle).
As soon as the body weight is supported, or handlers are clear if the dynamic risk assessment indicates allowing an unhindered drop, the ligature should be cut. Ideally this should be at a central point between the person's neck and the suspension point. If supported, the person should then be lowered to a supine position, maintaining manual inline stabilisation of the patient's neck to protect from potential further spinal damage.

If the ligature remains in place around the person's neck (or other body part) it should be removed using a ligature cutter.

7.3. Post removal of a ligature (non-fatal)

Immediately following the removal of any ligature staff should apply appropriate airway management techniques that they have been trained in. Staff should be guided by SOP3 Physical observations assessment and the management of altered levels of consciousness (including NEWS 2, PEWS, Pregnancy EWS, AVPU, GCS) to monitor the person closely. A medical assessment for laryngeal injury should be sought as a matter of urgency. It is important that the ligatured person receives psychological support post incident due to the risk of adverse psychological trauma.

8. After Use

Staff must make immediate arrangements for replacement of the ligature cutter if required. The used ligature cutter must be disposed of safely in a suitable sharps container unless it is required by the Police, for checking and / or disposal of. In the event that the blade is contaminated during use staff must check with the Nurse in Charge or Police first, before it is disposed of.

9. Preserving Forensic Evidence

If the person is subsequently pronounced dead staff must follow policy guidance (see CP17 Guidelines for best practice following the unexpected death of a patient). The police will treat any such death as 'unexplained' and potentially a crime scene until proved otherwise. Do not touch or disturb the area or other evidence until the police give permission. If this now means emergency equipment is unavailable, staff must ensure they have access to replacement emergency equipment within three minutes, the nurse in charge must communicate this with the surrounding wards. Do not cut or untie the other end attached to the ligature point, to preserve forensic evidence.

10. Incident Reporting

All unexpected deaths and near misses to fatality are viewed as potential Serious Untoward Incidents (SUI) and there is a requirement to review and evaluate practice following such incidents in line with policy and national guidance (see GR1 Incident reporting and management policy). It is imperative that a full and accurate contemporaneous record of all unexpected deaths, suspected suicides and near misses are captured by those managing the incident. The guidelines prompt staff to keep a record which will form the foundation to the incident report. Many staff, people using mental health services, carers and others feel unprepared to deal effectively with an unexpected death, especially where suicide is suspected. Staff are to follow the relevant reporting processes (see Appendix 2 and Appendix 3)

11. Staff support

CWP will ensure immediate support and appropriate debriefing for the staff involved in an unexpected death or near miss to a fatality. Staff will have an opportunity to informally discuss and explore the circumstances of the unexpected death or near miss to a fatality and their reactions (if appropriate for them) outside of formal review processes. The staff will be given information about further organisational support that is available to CWP staff (see HR19 Policy for supporting staff involved in traumatic events at work including incidents, complaints, claims and inquests).

Appendix 1 – Ligature Equipment

1.1 Disposable Whitby Safety/Rescue Cutter

1.2 Wire Cutters (image supplied for demonstration purposes, but cutters may differ in in-patient settings)

1.3 Tuff Cut Scissors

Appendix 2 – Ligature Incident Reporting Process (During normal working hours)

Stage 1	• Datix incident form to be completed at the time of the incident
Stage 2	• Incident to be reported to the Ward Manager and Modern Matron (or nominated deputies) to review
Stage 3	• Review incident with key stakeholders and cross reference with the ward Ligature Management Plan and audit report to establish whether if the risk is already identified or is a new risk
Stage 4	• Review findings to be reported to Suicide Prevention – Environmental and Clinical Risk Workstream to assess Trustwide impact
Stage 5	• Communication to be circulated to other localities (where appropriate) and to the Trust Executive Team. This will detail any remedial actions which need to take place and future plans to address the risk where applicable
Stage 6	• Situation will remain under review in the Suicide Prevention – Environmental and Clinical Risk Workstream until any necessary actions (where applicable) have been completed

Appendix 3 – Ligature Incident Reporting Process (Out of hours)

Stage 1	• Datix incident form to be completed at the time of the incident
Stage 2	• Incident to be reported to the 1st tier on call/ bleepholder
Stage 3	• 1st tier on call/ bleepholder to report the incident to the 2nd tier on call Senior Manager
Stage 4	• 2nd Tier on call Senior Manager to review incident and cross reference with the ward ligature management plan and audit report to establish whether the risk is already identified or new risk
Stage 5	• Joint decision with Estates on call manager should be taken as to whether to notify 2nd tier on call Senior Managers in other localities so that they can alert wards
Stage 6	• Matter to be handed over to the Modern Matron on the next working day to carry out procedures detailed in 'normal working hours' above