Managing Ligature Risks – Preventing Death By Hanging

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Suicide by hanging is the act of intentionally killing oneself via suspension from an anchor point or ligature point by a ligature, or by falling from a height with a noose around the neck.

It is one of the most commonly used suicide methods and has a high mortality rate; Gunnell et al. suggests at least a 70 percent success rate for death. Many attempts leave the victim with life changing disabilities.

The materials required are easily available, and a wide range of ligatures can be used. I have personal experience of working as an Expert Witness and working as a custody officer, in the environment where ligatures have been made from bras, shoe-laces, belts, scarfs, towels, bedding and rope.

Three factors need to come together for a death to result from the ligature asphyxiation, which we call the ligature risk triangle. These are:

- The means to create a ligature
- The availability of a ligature point
- The opportunity to complete the act without interruption

Staff attending our training are often surprised at what a person can create a ligature from; how they can find a ligature point; and at how simple, with the understanding and management of the person and environment, they could have stood a significant chance of preventing the event occurring.

In the event of finding a person suspended, staff generally are unaware of how to deal with the situation, as standard first aid training is completely inadequate and unsuitable for such an event.

Many people consider this to be a prison custody issue but the bottom line is that every single service provider needs some awareness of the issues, as some recent court cases and news reports highlight:

- The Priory Group in April 2019 were convicted at court for Health & Safety failures and fined £300,000, plus costs, plus potential civil litigation claim which may follow. This was due to the fact a 14 year old girl in their care died as a result of hanging. She had the opportunity, the means to make a ligature and the available ligature point to succeed. Further problems where highlighted whereby staff, upon finding her hanging did not have keys to enter her room; no means to urgently summons help from other staff and were not trained in what to then do in this situation.

- In 2018 a teenage girl, Child R, in a secure children’s home died from asphyxiation because she had the opportunity and means to attach a ligature.

- In 2018 the inquest into an adult female ligature death in a hospital bedroom in Kettering identified the issue concerning observations for those at risk.

- In 2019 a jury “condemns Nottingham prison after death of inmate”, and concluded that there was “inadequate quality assurance, inadequate training and inadequate audits”.

There are many other cases and news reports we could refer to, but these provide a flavour of the wide variety of sectors affected by the need for managing ligature risks.
This is a safeguarding issue for all parties involved in the education, care, medical, security and custody sectors. Any person at risk of mental ill health is at risk of attempting a ligature asphyxiation, and many people wrongly believe that to ‘hang’ oneself you need to be able to drop.

In reality, you need minimal distance for a ligature death with common items such as radiators, door frames, bath taps and bed frames being used. The Care Quality Commission (CQC) advises that a typical ligature point is between 0.7 and 4 meters from the floor and the secure custody sector work on the principle if something stands proud, or a gap of, 2mm or more, it can be used as a ligature point.

Typically, risk assessments for ligature risks are conducted by health and safety risk assessor staff who have been trained in the slip, trips, and falls style of risk assessing. This kind of assessing is completely inadequate for ligature risk room assessments and, likewise, quality assurance assessments are typically conducted by managers with no specialist knowledge in ligature risks.

Specialist knowledge can identify foreseeable ligature risk and educate staff how to identify risk, eliminate risk, adopt safer systems of work, and remove at least one aspect of the ligature risk triangle.

The CQC are now assessing work places for their ligature risk management and inspectors are being encouraged to ask for documentary evidence such as ligature audits and risk assessments. We would encourage the CQC to establish the competency of the staff creating the documentation as the existence of the documentation may be of little value if not completed by suitably competent people.

The CQC also have the option of prosecution for ligature deaths or injuries where high risk ligature points were not identified; or when identified, prompt action to eliminate had not occurred; or staff failed to consider the risk presented by service users when deciding location of service user and/or level of observations.

Regulation 12 of the Health and Social Care Act 2008, Regulations 2014, are concerning safe care and treatment. Providers must ensure that premises used are safe by assessing the risks and doing all that is reasonably practicable to mitigate any such risks; ensuring that staff have the qualifications, competence, skills and experience to provide safe care;

Article 2. The Human Rights Act places a positive obligation upon the state to protect life.


Our full day ‘Managing Ligature Risk’ training courses are designed for key individuals who provide services to people at risk of ligature harm or death, such as all police and prison custody staff, mental health unit staff, hospital ward managers, registered care home managers, education managers, union representatives, health and safety risk assessors etc. Learning how the most innocuous fixture, fitting or space can provide a ligature point to enable staff who assess for, or audit, ligature points to know what to look for and safer ways of eliminating the risk. For example, soft silicone type fillers can easily be picked out to make a ligature point and, where possible, hard anti-pick mastics should be used when any repairs are conducted, as part of the repairs process.

Staff should know how to methodically conduct an inspection from ceiling to floor, covering a room or space in sections.

Work places should consider their suicide intervention pack being readily available in strategic areas, with personal issue ligature cutting tools, and teaching staff how to actually use the equipment.

Standard first aid training is inadequate for dealing with a hanging victim which is why we cover on the one-day course how to cut the person down and manage the casualty, and also how to preserve the ligature knot where possible.

The consideration that this was actually murder needs to be embedded into the process as part of the incident response plan.

Audit procedures should be clearly identifying who carries out what checks and when, and what form of record keeping is maintained.

Could your current assessor and auditor stand in a court of law and justify their qualifications and competency to be conducting the task?

Do you have appointed people conducting this role?

Is your business exposing itself to future preventable deaths and/or court prosecutions and liability claims?

Training needs analysis assessments should then consider whole staff awareness training concerning how to respond to finding a service user in a ligature. We provide a basic 3 hours awareness programme which includes staff being able to use the ligature cutters.

Ligature deaths and injuries are preventable on many occasions, if one part of the ligature risk triangle is removed through suitable and sufficient assessment of risks, regular audits by competent staff, quality training by trainers who have competency in the area, quality incident response plans, readily available life-saving equipment and a positive work place culture to proactively reduce the foreseeable risk.

Further information can be obtained from Joanne Caffrey, Total Train Ltd.